



HELPS HOUSING AND HOME CARE
FOR THE ELDERLY AND VULNERABLE PEOPLE
AND LOCAL PARTNERSHIP STRATEGIES IN CENTRAL EUROPEAN CITIES

Housing and Social Care for the Elderly in Central Europe: WP3 Main Findings Report

Š. Pfeiferová, M. Lux,
T. Dvořák, J. Havlíková,
M. Mikeszová, P. Sunega (eds.)



**CENTRAL
EUROPE**
COOPERATING FOR SUCCESS.



EUROPEAN UNION
EUROPEAN REGIONAL
DEVELOPMENT FUND

This project is implemented through the CENTRAL EUROPE
Programme co-financed by the ERDF



HELPS: Housing and Home Care for the Elderly and Vulnerable People
and Local Partnership Strategies in Central European Cities



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Housing and Social Care for the Elderly in Central Europe

WP3: Main Findings Report

Štěpánka Pfeiferová, Martin Lux, Tomáš Dvořák,
Jana Havlíková, Martina Mikeszová, Petr Sunega (eds.)



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This report presents the results of the joint research activity conducted within the framework of the HELPS Project (“Housing and Home-care for the Elderly and vulnerable people and Local Partnership Strategies in Central European cities”), implemented through the EU Territorial Cooperation CENTRAL EUROPE Programme co-financed by the European Regional Development Fund.

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- Institute of Sociology of the Academy of Sciences of the Czech Republic (CZ)
- German Association for Housing, Urban and Spatial Development (DE)
- Municipality of Leipzig, Economic Development Office (DE)
- Municipality of Debrecen (HU)
- Hungarian Charity Service of the Order of Malta (HU)
- Veneto Region, Department of Social Services, Unit for People with Disabilities (IT)
- Poznan Supercomputing and Networking Centre (PL)
- Slovenian Federation of Pensioners' Organizations (SI)
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HELPS (Housing and Home Care for the Elderly and Vulnerable People and Local Partnership Strategies in Central European Cities) is a project operated in eight central European countries under the programme 'CENTRAL EUROPE', priority 4, area of intervention 2 and concept 6, and it is financially supported by the European Regional Development Fund. Details on the project goals and content are available at the following website: <http://www.helps-project.eu>.

This report represents one of the main outcomes from the research part of the HELPS project (Work Package 3) and it describes the background of the whole project and its objectives, methodology and the assumptions of the research, and it presents the main findings from a comparative study of the contextual factors and best innovative practices in eight central European countries. There are two reports that follow-up this main report: Catalogue of Practices and Working Paper 1/2013. All reports can be downloaded from the following website: <http://www.helps-project.eu>.

All the outputs from the research part of the HELPS project should provide solid foundations for the next two phases of the project, i.e. the introduction of pilot actions and the formulation of transnational recommendations. They should contribute to improving knowledge on housing and social care solutions in the context of an ageing society.

I Introduction and Research Methodology

The main goal of the specific call for tenders of the programme 'CENTRAL EUROPE' was an analysis, evaluation and application of innovative housing and care solutions for the elderly and vulnerable persons in Central European cities. Due to socio-demographic changes, the number of elderly and vulnerable people in Central Europe is increasing dramatically. At the same time, these groups are becoming increasingly diverse in terms of age, health conditions, financial possibilities, life-styles, consumption patterns and needs. While the overall life-span of elderly people is rising, the need for intensive care for these individuals is decreasing as health overall is improving. Similarly, with regard to vulnerable people the primary aim nowadays is to give them as much control over their lives as possible to mitigate the circumstances that make them vulnerable.

These factors have considerable impacts on the housing and care needs of such population groups: more and more elderly and vulnerable people continue to live in their flats/houses, want control over their own futures and need support for active re-integration. However, when it comes to services and structures at the disposal of the elderly and vulnerable people, it is evident that Central Europe is still dominated by somewhat paternalistic and centralistic approaches. These centralist structures often have difficulty matching the needs of such population groups. They tend to offer standardised solutions for supposedly homogeneous needs. In territorial terms they may even favour the institutionalisation and the separation of such population groups from other residential areas and/or population groups.

In innovative responses to housing and health promotion, however, the immediate neighbourhood level is playing an increasingly important role: the immediate housing neighbourhood is where the elderly and vulnerable people expect to find social contacts, services, cultural facilities, etc. Neighbourhood-based care and housing solutions increase the autonomy and self-determination of these groups and help them to maintain their abilities. Innovations are sought in terms of 'innovative' and decentralised housing and care solutions which have the potential to be transferred to other areas and on a bigger scale.

The Objectives of the HELPS Project

The main objectives of the HELPS project are to promote the development of strategies and practices:

- that improve the quality of life of vulnerable people with a strategic focus on elderly and people with disabilities;
- in the field of housing and social care;
- and that increase the autonomy of vulnerable people by allowing them to remain in their recent or, at least, standard forms of housing for as long as possible.

Particular attention is paid to the effectiveness, efficiency, and sustainability of measures, practices and strategies, especially when it concerns their management and financing. A specific objective of the HELPS project is also to develop and consolidate innovative housing and homecare solutions by supporting models of integrated local governance through a synergy of local actors, knowledge and resources (different forms of Private Public Partnerships).

The main outcomes of the project will comprise a small number of piloted newly developed or reviewed services and housing solutions. They are structured on a common methodology and adjusted according to the main findings from the project's research activities. HELPS Pilot Actions will help to strengthen the independent and active living of aged and disabled persons by:

- focusing on community-based development;
- creating local governance platforms;
- paving the way for local action plans.

Innovative piloted solutions interlinked with mainstreaming activities for the most successful outcomes will ensure the sustainability of the adopted solutions and procedures.

Target Groups

The main target groups of the project are:

- elderly people, i.e. people over the age of 65, especially elderly with age-related disability, low income, or living alone;
- people with disabilities, i.e. people who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Indirectly the project addresses the following other target groups:

- formal/informal caregivers (such as families caring for elderly/disabled relatives);
- public authorities (such as state, regional and local administrations);
- interest groups (such as not-for-profit organisations and associations, trade unions, co-ops, international networks);
- for-profit organisations (such as health-care/social service providers, real estate companies, developers, urban planning/design agencies, regional innovation agencies);
- RTD institutes (such as universities, RTD facilities, technology transfer institutions).

Project Partners

The HELPS project runs from October 2011 to September 2014. The leading partner in the project is the Friuli Venezia Giulia (FVG) Region in Italy. Overall, there are 12 partners and three associated partners from eight Central European countries (Italy, Germany, Austria, the Czech Republic, Slovakia, Slovenia, Hungary and Poland) in the project. The project team is integrated and well balanced in its composition – there are research institutes, not-for-profit organisations, and public authorities involved:

Italy

- FVG Region (public authority)
- Veneto Region (public authority)
- Institute of Social Research (research institute) – associated partner

Austria

- Samariterbund Burgenland (not-for-profit organisation)

Czech Republic

- Institute of Sociology of the Academy of Sciences of the Czech Republic (research institute)
- City of Brno (public authority) – associated partner

Germany

- City of Leipzig, Economic Development Office (public authority)
- German Association for Housing, Urban and Spatial Development (research institute)

Hungary

- Municipality of the City of Debrecen (public authority)
- Hungarian Charity Service of the Order of Malta (not-for-profit organisation)

Poland

- Poznan Supercomputing and Networking Centre (research institute)

Slovakia

- Association of Towns and Communities of Slovakia (public authority)
- Institute of Sociology of the Slovak Academy of Sciences (research institute)

Slovenia

- Slovenian Federation of Pensioners' Organisations (not-for-profit organisation)
- Ministry of Labour (public authority) – associated partner

The Objectives of the Research (Work Package 3)

The HELPS project's research activities preceded the implementation of pilots, making it possible to adjust pilot actions according to the research results and to create a common and shared basis for the evaluation of pilots. The leading partner in the research (Work Package 3) is the Institute of Sociology of the Academy of Sciences of the Czech Republic. The Institute of Sociology primarily fulfils the role of coordinator of research activities, which should yield information on the existence and possible implementation of individual sorts of practices. It is responsible for carrying out comparative analysis based on data gathered by partners in all participating countries and formulating recommendations for stakeholders at different levels.

The main goal of the project's research activities is the transnational review and evaluation of already existing innovative practices of housing and care solutions for elderly and vulnerable people in Central European cities and the elaboration of recommendations for national policies, transnational programmes and for the implementation of individual pilot actions. A unified methodology for the description and assessment of existing practices has been introduced to assure the comparability of collected data and the reliability of policy implications.

Research Design and Methodology

The research was divided into the following two phases:

- (1) An international review of the main contextual factors relevant to the assessment of innovative policies, such as:
 - basic contextual factors (demographics, macroeconomics, institutions);
 - housing systems and policies (tenure structure, housing subsidies);
 - welfare and pension systems, social and social care policies.

- (2) An international comparative analysis of best innovative practices (measures) in the following five areas:
- housing accessibility;
 - housing affordability;
 - social and health care;
 - community building;
 - access to information and/or education.

The reason for the division of the research activities into two phases was the fact that the social, economic, institutional, and housing contexts may determine the scope, design and implementation of particular practices in each country. Consequently, the possibility of the transnational transfer of know-how, methods and forms of practices may be determined by diverse contextual factors, such as housing systems, cultural patterns or social policy traditions in each country. In other words, a practice effectively implemented in one context may not necessarily be effective in other contexts. By linking the contextual features to particular measures and practices the research may better consider effective transnational recommendations that could help the implementation of pilot actions in each country.

The project partners or the experts hired by the project partners provided the coordinator with two types of information for each country: a) a description of the context of housing and social care (especially in their Preliminary Reports and the first – ‘contextual’ – part of the Final Reports); and b) a description and assessment of five innovative best practices – five per country and one per each area mentioned above (in their Final Reports). The country reports elaborated by the project partners or hired experts used a standardized questionnaire to ensure the comparability of findings. The templates for both reports are available via the following link: <http://seb.soc.cas.cz/projekty/reports.htm> and all the national Preliminary and Final Reports can be downloaded from the HELPS Project website: <http://www.helps-project.eu>. Some data on the national contexts was additionally acquired by the coordinator from EU-wide international surveys (EU-SILC, SHARE), international statistics (EUROSTAT) and an in-depth literature review.

The HELPS project primarily focuses on helping elderly people and people with disabilities to remain in their current housing or at least a standard form of housing for as long as possible and, consequently, to postpone the move to institutional care and decrease the time spent in health-care institutions. There are two complementary reasons for this orientation of the project:

- in spite of the high quality of institutional care in many countries, different national and international attitude surveys indicate that the overwhelming majority of elderly people and people with disabilities want to remain in their current homes or at least standard forms of housing for as long as possible;
- the high costs of institutional care together with accelerated demographic ageing of the European population may lead to a serious financial burden upon public budgets and therefore it has become necessary to search for financially less demanding solutions enabling the elderly and people with disabilities to remain longer in standard forms of housing.

However, supporting ageing in place and living in standard forms of housing for the elderly and people with disabilities is not just a matter of housing affordability and accessibility. It presupposes also the availability of domiciliary social and health care, easy access to information about rights and options, and the integration of the target groups into the wider community in order to prevent their social exclusion. Therefore, a description and in-depth analysis of at least one best innovative practice in each of the five above-mentioned areas was requested for each country in the Final Reports. The Catalogue of Practices, which is based on the country Final Reports, includes five practices per each

country (with exception of Italy that evaluated only four innovative practices), seven to eight practices per each area and, consequently, 39 best practices in total. According to our knowledge, such an integrative approach has not been applied so far in a project of this kind.

The selection of practices in each country has been thoroughly discussed during two WP3 working group meetings. The following criteria were used for the final selection of practices:

- the practice is new in the country, i.e. has been introduced within the past five years;
- the practice is innovative due to: a) an integrated or innovative form of management and financing that includes both public and private sectors and finance; b) its decentralized nature respecting the specific (possibly unique) local needs and preferences of the target group, which were often identified during the pilot or designing phase of the practice implementation; c) other forms of innovations, such as technical innovations;
- the practice is highly evaluated as effective and efficient (see below for details);
- the practice helps the target population to remain in their current home or, at least, in standard forms of housing (for the elderly, it supports ageing in place).

In the field of *housing affordability* the practices were composed of financial tools or different supply- and demand-side public subsidies that make housing for the selected target groups more financially affordable, such as:

- housing allowances;
- housing allowances for informal care providers (friends, family members);
- tax credits;
- vouchers and grants;
- the use of housing equity by the elderly – equity release mortgages.

In terms of *housing accessibility* the practices focused on specific tools designed to improve the physical accessibility of housing for the elderly and people with disabilities, from small repairs to universal schemes, such as:

- home maintenance and security (small repairs, insulation, heating);
- modernisation, reconstructions and adaptations of dwellings (lift, rails, stair lift or adapted bathrooms and kitchens);
- SMART homes;
- life-cycle architectural concepts, such as universal design or lifetime housing (dwellings are built in such a way that they can be easily adapted to the needs of a family in different stages of the life cycle).

With respect to the *social and health care* we searched for innovative practices in fields such as:

- domiciliary social care services;
- warden services (alarms to call for an ambulance/services in case of emergency);
- the use of technologies (ICT) for the elderly (telecare, telemedicine etc.);
- telephone/camera linked to remote operators that can call an elderly person to check his/her status, discuss problems, issues etc., and other kinds of supervision;
- help in access to medical care;
- advice and help with home maintenance;
- assistance after having been discharged from hospital care.

In the case of *community building*, the practices included voluntary organisations, day-care centres and networks for/among the elderly and people with disabilities providing:

- leisure activities;
- befriending services;

- involvement in communities and organisations;
- arranging home visits, the services of translators (for minority groups etc.);
- informal care.

Finally, in the area of *access to information and/or education* the following practices were described:

- the existence, use and access to specialised websites focusing on information for the elderly and people with disabilities;
- municipal (or local) activities, such as seminars or meetings organised to improve awareness of the available options in housing and health and social care, and other forms of education;
- advice on practical matters and floating support services (help with managing finances, advice and information in housing-related matters);
- the development of broadband internet access.

Many practices, especially those in economically more developed Central European countries, apply a so-called integrated approach, i.e. they try to consider more perspectives and fulfil several goals simultaneously. Such practices aim, for example, to increase housing affordability, housing accessibility, and the quality of social care at once. These integrated practices were especially welcomed and recommended for selection. However, the project partners or their hired experts were asked to decide what the main focus of the practice is, in their opinion, and rank it only in a single area. Consequently, in all cases the partners had to identify and describe five practices in each country, i.e. one per area.

Each innovative practice was not only described in detail but also thoroughly evaluated (see the questionnaires at <http://seb.soc.cas.cz/projekty/reports.htm> and the Catalogue of Practices). The description of practices included, besides a definition of the goals and target population, information about the scope and form of involvement of the target population in the design and implementation of practices, information about the management of practices and the role of each partner involved, and a short description of the budget for each practice (costs and income).

In the second step, each partner was asked to make a neutral and critical assessment of the practice, especially from the perspective of sustainability, efficiency and effectiveness (but also transparency or administrative simplicity). Although the practices were selected as 'best practices', the responsible persons were asked to consider not only the good sides of the practice but also possible, though minor, deficiencies and drawbacks, limits in different fields of its implementation, such as weaknesses in design (sub-optimal satisfaction of needs), unsustainable financing, incomplete legal framework, unclear responsibilities in its management, high costs of administration etc. At the end of the questionnaire, each partner or the hired expert made a SWOT analysis clearly stating not only the strengths of the practice but also its weaknesses and risks. The SWOT analysis summarised the information issued from a more detailed assessment of the sustainability, efficiency and effectiveness of the practice provided in detail in previous parts of the questionnaire.

Sustainability was understood to mean the capacity to endure. Sustainability was assessed on the basis of a cost-income analysis, level of subsidisation and its political support, the duration of the practice and plans for its duration (extension) in the future.

The methods of *New Welfare Economics* (studies by W. Pareto, J. Hicks and others) were used to evaluate the efficiency and effectiveness of the practices. *Efficiency* was defined through Pareto's lenses: if any alternative allocation of goods increases the utility resulting from consumption for at least one actor in the market and at the same time does not decrease the utility from consumption for other actors then we can say that such an allocation is inefficient and there is a room for an improvement of its performance. This is called Pareto optimisation or Pareto improvement. An example of such an inefficiency could be the existence of public subsidies (state interventions), which crowd

out private investments, impede lower taxation and distort efficient market functioning. Another example, which points to our main interest, is the situation when the state (municipality, region) spends money collected from taxpayers to produce and allocate goods or services that could be allocated similarly by private entities.

Effectiveness is closely associated with the idea of equity, social justice, and the welfare state; it relates to the area of social welfare studies focused on 'fair' distribution. As such, it is closely connected with particular welfare state regimes, particular social norms, and particular redistributive policies. The concept of effectiveness is not left to a vague 'infinite definition'. The concept was, at least partially, generalised into a common shared assumption that whatever system of state redistribution of wealth is ultimately applied, it should decrease social inequality; that is, redistribution policies should help the worse-off at the expense of the better-off. The scale of wealth redistribution may be limited (residual welfare state regime) or extensive (social-democratic welfare state regime), but in either case, all modern concepts of social justice share the assumption that wealth should be redistributed from the high-income to the low-income members of society.

Welfare economics distinguishes two kinds of effectiveness: 'vertical' and 'horizontal' (Barr 1998). Vertical effectiveness measures the degree of redistribution of income, consumption and wealth from the rich to the poor. In the case of particular subsidies it measures the extent to which such subsidies are actually allocated to those who really need help, that is, to low-income households. It also measures whether the subsidy ultimately decreases social and income inequality. Horizontal effectiveness is connected with the assumption that all needy (poor) households have equal and unrestricted access to subsidies, that is, none of the poor (needy, low income) are excluded from such redistribution. In the case of a particular subsidy it measures whether any needy (poor) household is eligible to apply for the subsidy. Some needy households can be excluded from subsidies because, for example, the programme has been set up in an inappropriate way or the potential claimants are not well-informed (or may be afraid of potential social stigmatisation).

Consequently, for the evaluation of practices we defined a set of assumptions that derive from the definitions of efficiency and effectiveness stated above.

In terms of *effectiveness* the assumptions are as follows:

- Assumption 1:** Effective subsidies assist lower-income (needy) households more than higher-income (less needy) households (vertical effectiveness).
- Assumption 2:** Effective subsidies do not exclude any lower-income (needy) household (horizontal effectiveness).

In the case of *efficiency* the main assumption is as follows:

- Assumption:** Subsidies are efficient when it is not possible to meet redistributive goals in a less costly way, that is, under an alternative setting of the subsidies.

These assumptions mean only the following: public spending should be directed at those in need and no needy households should be excluded from public help. Policies should not waste public money and should offer real value-for-money. It was not possible to conduct any more detailed quantitative analysis of effectiveness and efficiency such as comparing the costs per unit of the service or a comparative analysis of the share of implicitly or explicitly excluded households belonging to the target population. Such analysis would require much more extensive research activities and specific surveys than those planned in this project.

However, the fact that practices were not only described but also critically evaluated in a comparatively standard form makes the outcomes from this research relatively unique and valuable; especially if we take into account the fact that there is very little information about the situation in post-socialist

states in recent scientific literature. This report, and the following Catalogue of Practices, attempts to fill in this gap, as five of the eight countries in the sample are post-socialist countries.

The main purpose of the comparative analysis was not only to assess the institutional contexts and best practices separately, but especially to analyse the links between context and forms of best practices. The following research questions were the most important:

- What are the living conditions of the elderly in selected eight Central European states, especially with respect to housing affordability, housing satisfaction, housing overconsumption, and accessibility of basic services?
- What are the main differences in the scale and forms of supply of housing options and social care for the elderly and people with disabilities among the selected eight Central European states?
- Does the housing system (housing tenure structure), when other contextual factors are controlled for, influence the form (innovativeness) and scale (variability) of supply of housing options available to the elderly and people with disabilities?
- Does decentralisation and the greater involvement of local actors (municipalities, not-for-profit associations and the for-profit sector) lead to larger-scale and more innovative social services for the elderly and people with disabilities?
- Does the greater involvement of the third sector, such as not-for-profit organisations, lead to larger-scale and more innovative social services for the elderly and people with disabilities?
- To what extent and in which contexts can the demand for social care services (e.g. a high share of elderly in the population, a large number of elderly living alone, a low likelihood of the provision of informal care, etc.) stimulate the selection of services?
- Is the wealth of the country the only variable determining the range and variability of social services for the elderly and the application of innovations in this field? And if not, what are the other factors that have a significant influence on the character of social care systems?
- What factors contribute to the success of the implementation of best practices in selected areas?
- What are the main trade-offs that organisations face during the implementation of best practices? In what area is there the biggest potential for the transferability of know-how on best practices?

Below, sections II and III present an exhaustive overview of literature resulting from a review of studies and papers dealing with topics that overlap with the focus of the HELPS project. The general literature overview (section II) considers literature written in English that was identified as relevant by the coordinator of the project research. The country-specific literature review (section III) resumes the main findings from a review of publications written in local languages as assessed by the project partners. The main purpose of both sections is to provide a better framing of the research activities conducted under the HELPS project, as the research should come up with new and original findings (and not reiterations of existing knowledge). The findings from the research conducted under the HELPS project should follow (improve) the results from previous research. The literature overviews suggest that many recent studies have focused on a large variety of innovative practices in areas connected to population ageing. The emphasis is increasingly put on the promotion of 'ageing in place'. Available reports provide evidence of the actual trend in many European countries to decentralise the provision of care for the elderly. This concerns not just social care, but also, for example, the allocation of municipal financial grants for home adaptations. As regards the studies on post-socialist countries, they document that the above-mentioned trends (mainly the focus on home care) are starting to develop also in post-socialist contexts, despite the difficulties and barriers that are to be overcome.

Section IV is the first analytic part of the report. It makes use of data from accessible international surveys, namely from the EU-SILC survey. It focuses on the costs of housing borne by elderly households and on housing satisfaction of older people in CE countries. It considers also the mutual relationship of housing affordability and housing satisfaction. The analysis reveals a relatively high degree of

satisfaction with housing in CE countries. There seem to be several factors influencing the residential satisfaction of the elderly: apart from the accessibility of various services (health, postal, banking, grocery, etc.), environmental quality and housing tenure, the strongest predictor of housing satisfaction was the physical quality of the dwelling (housing accessibility) and the perceived subjective burden from housing expenditures (housing affordability).

Section V builds a bridge between the contextual information and the analysis of housing systems and social and health services in the countries studied. Its main objective is to summarise the facts about national settings with respect to housing and social care into brief 'country profiles' which makes it easier to understand the main differences between countries as revealed by the analysis.

The next two sections form the core analytical parts presenting the results of the analysis of the influence of national contexts on the form (innovativeness) and scale (variability) of the supply of housing options and social services available to the elderly and people with disabilities. Section VI deals with the influence of housing systems on the supply of housing options and Section VII with the influence of a variety of factors on the supply of social care. The findings confirm that there are important institutional factors influencing the form and scale of housing/social care options in each country that may limit the transferability of policies and know-how. The solutions in the area of housing appear to be dependent on a number of factors, among which the most interesting is the tenure structure (housing system) in the respective countries. The variability of social care services and their coverage are also determined by a scale of factors, including the macroeconomic situation, population structure, support for informal caregivers, the conditions governing the operations of third sector organisations, and the welfare system in general.

Section VIII presents the main findings from the comparison of best practices themselves. It summarises the main positive factors and obstacles in implementing new approaches and confronts the strong and weak sides of individual practices. Its purpose is to detect the main trade-offs in the implementation of practices or common and distinct features of practices in particular areas. While the previous sections outline the limits to the transferability of policies in a wider context, this section identifies such limits in a comparison of the management and financing schemes of policies. For example, 'soft' transferability has been found to be relatively easy in areas such as community building or improving access to information/education, while it has been found more restricted for practices in the area of housing affordability – due to the higher financial costs and closer link to specific (and historically evolved) national legislation, the housing system and the governmental housing policy strategy.

The last section presents the main transnational recommendations resulting from each section's main conclusions. These recommendations target central and local administration levels and reflect: a) the institutional (contextual) factors that influence the form (innovativeness) and scale (variability) of the supply of housing/social care options available to the elderly and people with disabilities; and b) the limits to the transferability of policies and practices arising from both the institutional context and the nature of best practices themselves. This section of the report should contribute in particular to the design and adjustment of the pilot actions conducted under HELPS project.

The report is complemented by the questionnaires applied within the research (i.e. the guidelines for the Preliminary Reports and the Final Reports) and the list of literature used by both the research coordinator and the project partners.

II General Literature Overview: Innovative Practices and Solutions in Housing and Care for the Elderly and Vulnerable people

In this section of the report we are going to present the literature overview, focusing especially on describing the main findings from other research projects with similar topics as the HELPS project. The main purpose of a general literature review is a better framing of research activities conducted under the HELPS project, as they are not supposed to repeat findings from previous research; instead, they should improve the existing knowledge and come up with new and original findings that could be valuable for further research and applications in this field. A detailed overview of the current state-of-art is an important condition for meeting this task.

Secondly, another aim of the general literature overview is to establish a link between the findings from other research projects and the findings from the HELPS project research. This interrelation can improve the strength of the recommendations presented at the end of this report. The general literature overview was conducted by the research coordinator using publicly available and English-language literature.

Introduction

Over the past 30 years, the issue of population ageing has become increasingly more prevalent in policy research, gerontology journals, and academic discourse as such. Importantly, the concept of ‘ageing in place’ has become one of the most elaborated concepts in the area of ageing research. It was also recently noted (Vasunilashorn et al., 2012) that the notion of ageing in place has been given increasing consideration over the past decades in academic research to include ever more diverse topics ranging from health and social care to housing and economics.

The reasons for the focus on these issues are obvious. The ageing of populations which causes a diminishing share of younger people compared to the share of people aged 65 and over can become a serious threat to existing welfare policies, as the younger generations have to pay increasingly for the elderly through welfare policies (Elsinga and Mandič 2010). Different countries respond to this challenge in different ways and a variety of measures have been proposed to tackle this issue. Many such efforts involve to a significant degree the issue of housing as an important part of the ageing issue as well as its solution. Different strands of ageing and housing research have come to concentrate on the interconnections between ageing and housing in the context of demographic shifts in contemporary societies. Current research in ageing and housing generally focuses on the following issues:

- (1) What strategies do households develop for pension and care provision in old age and what is the role of housing equity in household plans for retirement (Elsinga and Mandič 2010)? This issue was thoroughly explored in the DEMHOW research project funded by the EU.
- (2) The use of ICT in care for the elderly that could reduce expenditures on elderly care and make welfare policies more sustainable in the context of ageing populations. The aim is to introduce innovative health and social care practices that enable the elderly to remain in their home environment as long as possible and prevent them from having to move to residential care if unnecessary (Pleace 2011). Many EU funded projects have focused on the interconnections between ICT and ageing over the past decade (see the review below).

- (3) Similarly, the general architectural concepts of universal design and lifetime homes are increasingly used to enable the elderly to remain living in their home instead of moving to residential care (for the British context see, e.g., Milner and Madigan, 2004).
- (4) Retirement communities are undergoing significant change and there are a growing number of models of sheltered care that significantly differ from the traditional residential care and focus on promoting independence, integration, security as well as cost effectiveness (Croucher et al. 2006).
- (5) Some literature has also concerned itself with the ways of enhancing the standard of living of the elderly through innovative practices in social care. This can take many forms, including floating services (Pleace 2011) or financial support for informal care ('cash for care'), which is assigned to financially support relatives of the elderly in the care for a disabled or vulnerable family member.
- (6) Finally, another focus of research has been the classification of welfare regimes that is not based on the welfare classification proposed by Esping-Andersen, but rather a classification that is based on care regimes and care organisation for the vulnerable people. By care for vulnerable people we mean care for specific social groups, such as the young, the elderly or disabled-vulnerable persons.

We will start the literature overview with a review of past EU projects that focused on housing and home care for the elderly. After that, each following subsection will focus on one of the six outlined issues and in the final section we are going to present the main conclusions from the whole literature overview. Most of the literature reviewed comes from Western Europe, the United Kingdom, the United States and Australia. Where possible, the experience from Central and Eastern European countries will also be mentioned. However, as noted in the context of social care for the elderly (Genet et al, 2011), the evidence from these countries is rather scarce and limited. A shared feature of all these studies is their focus on innovative practices (in various fields) that encourage home care for the elderly and that should lead to enabling the elderly to stay in their own home and environment for as long as possible.

An Overview of Past EU Project Research

There has been a variety of research projects conducted at the EU level that focused on the interconnections between housing, ICT and ageing populations. Most of these projects reflected the interdisciplinary nature of the issue at stake and therefore included scientific fields such as population studies, economics, housing studies, health-care economics or social care. We present a brief overview and summary of some of these EU funded projects.

ENABLE-AGE Project. Enabling Autonomy, Participation, and Well-Being in Old Age: The Home Environment as a Determinant for Healthy Aging (EU Framework Five, 2002-2004)

The ENABLE-AGE Project focused on the home environment as a determinant for autonomy, participation, and well-being in very old age. The ENABLE-AGE Project involved five countries: Sweden, Germany, the United Kingdom, Hungary, and Latvia. A mixed methodology was used and three types of data sets collected: a national macro-level update of housing policies, quantitative data gathered via a longitudinal survey and qualitative in-depth studies. Respondents of the survey and the in-depth studies were people aged of 75 and over living alone in their own homes.

The study revealed the differences between the participating countries in several respects, e.g. in poverty rates, housing legislation and building norms, and knowledge about and access to services and assistive technology among older people. The results of the ENABLE-AGE In-depth Study indicated that healthy ageing at home is linked to action, identity, dignity, and survival in very old age. It was concluded that such concepts and how they impact older persons' lives must be highlighted when housing choices in very old age are considered.

Based on analysis utilising data from all three study parts, a set of policy recommendations was developed. The policy recommendations were organised within the following key themes.

Socio-economic context (e.g. to ensure decent and appropriate housing that meets the needs of all individuals; good interagency cooperation, i.e. housing, health and social care, transport, NGOs, private sector etc.; at the EU level to develop guidelines and norms to ensure appropriate housing for all older people).

Accessibility of housing (at the national level to introduce guidelines and regulations to ensure more accessible housing, when new houses are being built or existing houses are being rebuilt/renovated; to develop structures for professional counselling regarding housing adaptations; the provision of financial support and grants for housing adaptations to reduce environmental barriers and providing all citizens with accessible housing at the EU level to develop norms and standards for housing environments).

Housing and health (housing professionals, like architects, planners, public and private builders and the need to be sensitised to a holistic approach to housing solutions; health and social care professionals need to be aware of the importance of the home in the lives of their clients and to include housing solutions within a multidisciplinary approach to assessment and care planning and intervention).

Supporting people at home (to support and enhance the access of older people to: basic assistive devices, grants/financial aid, provision of health and social services; to provide better information for older people and their carers of what is available in terms of support services).

Social participation (the need for good public transport infrastructure; access to telephones and possibly other ICTs; to identify the risk factors of social isolation and target social support activities for people in this group).

DEMHOW: Demographic Change and Housing Wealth (EU 7th Framework Programme - Socio-Economic and Humanities; 2007-2011)

The aim of the DEMHOW project was to evaluate current demographic change causing shrinking and ageing populations. This significant demographic development is put into the context of the substantial changes that have been taking place in national housing systems and housing markets: Over the past few decades, there has been a substantial increase in the size of the ownership sector and today almost two-thirds of European households live in their own homes. Second, the pension systems in most European countries have come under pressure, which may have a significant impact on the social well-being of the retired population. Third, the development of national mortgage markets and the availability of financial tools that enable equity release, such as reverse mortgages, are taken into account.

One of the main aims of the study was to investigate the role that housing wealth plays in countering the consequences of ageing. The study had an international framework and compared the situation in various EU countries (based on EU-SILC data sets). The research focused on the issue of how household behaviour in the housing market is linked to institutions in the given institutional context, meaning pension systems and the development of the mortgage market. It is found that if the situation of 'asset rich, but cash poor' elderly households is to be avoided, the mortgage market in some European countries has to be more developed. This concerns especially the Southern and Central and Eastern European countries.

The project also included a qualitative study: 240 interviews with households across 8 different countries. With respect to plans for retirement or strategies already used in retirement, most people relied on the care of their partner and in countries with professional home care it (meaning professional home care) was the preferred solution, because people thought it would enable them to remain

in their home for as long as possible. Institutional care was seen as a solution of the 'last resort'. Some people also considered using the homes they owned as a source of income to pay for the care they would need when they age, but this was not very common. Most often people considered downsizing by purchasing a dwelling with lower expenditures on housing rather than moving to the rental sector. Also, the idea of equity release products was, based on the 240 qualitative interviews, not always accepted well. The reasons for this were twofold. First, many people wanted to bequeath the equity to their children. Second, there was a high level of distrust in the financial sector and institutions and generally high levels of uncertainty about equity release products (Elsinga et al. 2010).

ICT and Ageing: European Study on Users, Markets and Technologies (EU ICT Policy Support Programme, 2007-2010)

The research stemmed from the European Commission Action Plan on Information and Communications Technology for Ageing in the framework of its 2010 initiative, which notes that better leveraging of the potential provided by ICT for independent living in an ageing society is both a social necessity and an economic opportunity. The perceived benefits of introducing ICT in care for the elderly are, according to the study, the following: (1) a good level of care for the elderly, (2) manageable costs of social and health care, and (3) new market opportunities for ICT products.

The aim of the research was to examine the status of the implementation of ICTs that support 'ageing well' concepts across many European countries, including the analysis of factors that can facilitate or become barriers in the development of ICTs in housing. The study also included ethical considerations and an ethical analysis of ICT development, because the focus on the application of new technologies might in some respects be exaggerated and not well accepted by the elderly.

The following ICT-based approaches to care for the elderly were considered: Telecare, Smart Home/Assisted Technology, Home/Telehealth, Intelligent Transport and Assistive work technology. The analysis focused on the critical factors that influence the success or failure of the implementation of innovative ICTs in the given countries. It was compared ICT development with respect to several factors: the particular social care system as a contextual factor, the requirements and expectations of the target group (the elderly), the operating costs of the ICT, achieving market penetration, the interests of the private sector, and finally assuring sources of funding. The authors claim that although strong business potential for these ICT products exists, the awareness of policy makers is to date rather low (2010: 44).

The authors suggest the following: the establishment of a forum for an exchange and informed dialogue between the Member States to promote the development of ICT; informing and engaging key decision makers in social services, health services, and housing provider organisations as well as organisations funding or reimbursing such services. Finally, evidence about successes and failures in the implementation should be reported. The report includes country-specific detailed analysis of the use of ICT in different areas of social and health care, including the impact of contextual factors.

ANCIEN, Assessing Needs of Care in European Nations (7th EU Research Framework Programme; 2009-2013)

ANCIEN is an EU funded project that focuses on the future of long-term care for the elderly in Europe. It is concerned with the following questions: What will the supply and demand for long-term care (LTC) be in the future? What systems of LCT are there in Europe and how well are these systems performing in different countries? The project combines demographic analyses and econometric modelling to answer these issues.

The ANCIEN project, for example, engages in the analysis of formal and informal care in European countries. It explores the question whether informal and formal care for the elderly function as substitutes or instead complement each other. The results of this analysis suggest that the patterns of formal

and informal care, in terms of complementarity and substitution, differ from country to country and that there is no simple pattern.

The project also focuses on creating a typology of long-term care in European countries. It distinguishes four types of systems of LTC according to the system's financing. They are a) systems oriented towards informal care and with limited private financing (Germany, Belgium, the Czech Republic), b) generous and accessible systems (Denmark, Sweden), c) systems oriented towards informal care with extensive private financing (France, Spain, England, Austria), and d) systems with extensive private financing and informal care as a necessity (Hungary, Italy).

The project is not yet completed, so more results and reports are to be expected.

Healthy Ageing - A Challenge for Europe Co-funded by the European Commission (2004-2007)

The Healthy Ageing project aimed to promote healthy ageing among people aged 50 and over. The main focus was on ten major topics; most are very broad and interact with each other and with the following cross-cutting themes: socio-economic determinants, inequalities in health, gender and minorities.

With respect to the interest of this review, the topics of this project also included the following: retirement, mental health, physical activity, injury prevention, preventive health services and more. The final report presents a number of good (country-specific) practices of projects for the elderly and suggests that such projects, when implemented, should directly involve the target group, which should make them more successful.

Concerning policies for healthy ageing on the EU country level, the report concludes that most European countries have policies for healthy ageing, but often these policies have no central issue and include no special allocation of money, which can make policy implementation rather difficult.

The Healthy Ageing Project also examined the issue of preventative health services for the elderly and an analysis of their cost effectiveness. For example, the benefits of home visits and home-care interventions are discussed. The conclusion is that these measures are effective in reducing the number of days the elderly spent in hospitals and in reducing admissions to long-term institutional care (nursing homes) etc.

Active A.G.E.: Active Ageing, Gender and Employment Policies (EU URBACT ERDF; 2008-2011)

The Active A.G.E. project was funded by the European Commission and conceived as a cooperative undertaking of nine European cities from eight EU countries. The project had a range of objectives, but the main theme was the impact of population ageing on the labour market, housing, social security systems, urban planning, finances etc. Although a strong theme was the focus on age and the economy, in the sense of promoting policies that stress work-life participation and economic and social inclusion, significant attention was also devoted to home-based care for the elderly and long-term care systems.

The project explicitly focused on developing home-based care and support for families and carers reflecting the shift from institutional care to independent living of the elderly in their own home. Moreover, the aim was to improve the supply of social services available to the elderly to achieve this aim.

One of the project outputs is a case studies report from the given countries that focuses on innovations and the practice of home care. These home services vary not only from country to country, but also within the particular regions and municipalities, who often adopt different approaches. Generally, these services include non-medical assistance for the elderly, usually intended not only as support for the elderly, but also as support for the family. In addition to this, help with bureaucratic matters and social assistance (or 'assistance on call') is often offered. However, the authors ultimately concluded that the main aim should be promoting co-housing as a form of cohabitation and assistance of elderly

people. It should incorporate all the advantages of both residential care and the elderly remaining in their own home.

Social Welfare Regimes and Care for the Elderly

The aim of this section is to provide a review of scientific efforts to classify European countries with respect to home care for the elderly. Most of these efforts focus on country-to-country institutional and policy instrument comparisons of home care for the elderly.

There are a number of factors that can influence the demand and supply for publicly financed home care. These factors include income and material resources, family support and social contacts providing informal care, the organisation of formal institutional and home care in the given country, the percentage of GDP nationally spent on health care etc. (Grundy 2001). It is thus a mixture of individual household-level as well as institutional determinants. Therefore, when evaluating home care for the elderly, it is also necessary to take into account country-specific institutional factors and welfare regimes. There are also various sources of funding for home care; mainly private and public. Public expenditures for home care vary significantly from country to country. Generally, public spending on institutional care is higher than public spending on home care, although this difference is in some countries only negligible, for example in Germany (Doyle and Timonen 2007). Also, the proportion of older people receiving formal home care varies from country to country. According to Doyle and Timonen (2007), in Denmark, for example, it is about 20%, whereas in Germany it is as much as 9%.

A comparison of elderly care in European countries can in principle be done using the Esping-Andersen model (1990), which is based on an analysis of social security systems, income redistribution, coverage of risks etc. However, this and similar models are not easily applied to social care provision. Other models have also tried to bring social care into the domain of comparative social policy research. Such models have been developed, for example, by Anttonen and Sipila (1996), who distinguish (a) Scandinavian and (b) family models; secondarily also (c) the British means-tested regime, and (d) the Central European subsidiarity model of public service provision. Another model was proposed by Timonen (2005), who distinguished models according to the fact of who takes responsibility for long-term care. It distinguishes between countries where the state takes responsibility for long-term care (a focus on formal care), states where families have to take responsibility for the care (a focus on informal care), and, third, a model of countries where the state funds the costs and other (multiple) actors take part in providing these services. There is a purchaser-provider division. Concepts of 'ageing in place' and the like seem suggest a move in the direction of this third model, where the state pays for the home care of the elderly, but the care is provided by others, not only friends or relatives, but also not-for-profit organisations or private (profit) providers.

A different perspective is offered by Bettio and Plantenga (2004), who, inspired by the models above, propose a slightly differentiated perspective. They propose four clusters of countries. First there are the Southern European countries, which have undeveloped formal care for the elderly and rely most on informal care. In the Netherlands and the UK the state plays a big role in formal care for the elderly, but decision making in this area seems to be somewhat decentralised. Third, this model refers to Central Europe – particularly Germany and Austria. In these countries the focus is most on private care, which is, however, publicly facilitated-encouraged by financial allowances, insurance etc. Formal care is also prevalent and well developed in France and Belgium. In Northern European countries the main feature of home care is that it is universal, open to anyone and not income-tested. The level of care in the Northern countries is also quite high. It is important to note that this classification was developed to evaluate not just care for the elderly, but also care for all vulnerable groups (young, elderly and disabled).

Generally, a common development among most European countries is the fact that (Mort et al. 2008) care provision for the elderly is changing. There is a shift away from the institutional setting to home or domestic care services – domiciliary care. The extent to which this is taking place varies according to the classification of the welfare regimes outlined above, the culture of care, the tradition of family responsibility in care giving, and the tradition and extent of residential/institutional care. In addition, in the area of the provision of social care, there is growing evidence that in many countries it is open to market as well as non-market providers – it seems that there is a shift towards the decentralisation of these services. Houben (2001) describes this development as a genuine decentralisation process. Previously standardised forms of institutionalised forms of care are shifting to very diversified forms of care and various service providers. Flexible, separate services can be tailored to the needs of individual clients, which increases the effectiveness of the service as well as client satisfaction. However, this also puts higher demands on the coordination of the various parts of the social system. This coordination cannot take place on the national level, it must occur on the level of regions and municipalities, which is only possible in a decentralised system.

The Demographic Shift and the Residential Mobility of the Elderly

Another topic often explored in the literature dealing with care for elderly and ageing are the implications of present and future demographic shifts. In the past few decades European countries have been undergoing a process of population ageing, which will result in a decrease in the share of the active population. According to demographic projections, the share of the elderly in relation to the rest of the population should rise in European countries in the next fifty years to as much as 30%, which would have a significant impact on the pension systems and would also substantially increase the costs of health and social care. Decreasing rates of fertility and increasing life expectancy represents a serious threat to the ability of European countries to maintain their existing standards of health and social care (Börsch-Supan 2005).

Whitehead and Scanlon (2007) claim that it is very likely that there will be a substantial increase in the demand (especially from the elderly) for various forms of social housing in the future. In most EU countries, the demand for social housing already exceeds the supply, and this is likely to get even worse. The availability of social housing will decrease in the future also due to increasing income inequalities and immigration trends. In the context of European countries, two trends in social housing are taking place that are making and will make the national and centralised coordination of social housing rather difficult. First, responsibility for the provision of social housing is shifting from the national to the regional/municipal level. This decentralisation of care for the elderly and the vulnerable is taking place in many European countries (see Mort et al. 2008). Second, there has been an increase in the involvement of the private construction sector. Although there are numerous possible forms of cooperation that can exist between the private and public sectors, a common trend is that a private developer commits to including a few social housing units in any new housing construction (e.g. for a discount or for a limited time period). Whitehead and Scanlon (2007) suggest that these two interconnected developments taking place on the local level will make the coordination of social policy in this context rather difficult.

According to Elsinga et al. (2010: 96–97), the demographic shift is a threat not just to elderly households living in the rental housing sector, but also to the elderly living in the ownership housing sector, because of its effect on the sustainability of social care and health-care policy. The high expenditures on ownership housing can often be a cause of financial hardship for elderly households ('asset rich, but income poor'). On the other hand, ownership housing can also be used as an additional source of income and these households can either move to the rental sector or to a smaller dwelling. This finding is based on the assumption of the life-cycle model and the permanent income hypothesis.

According to the life-cycle model (Artle and Varayia 1978) home ownership should first increase with age as people save and become home owners and then decline with age when households become income poorer and thus release housing equity. However, this is no longer the case in many countries in and outside Europe. Evidence from the Anglo-Saxon context suggests that there are many reasons why the elderly do not release housing equity (Beer and Foulkner 2011: 96–97): (1) moving means high transaction costs, (2) uncertainty, (3) lack of information on the rental market, and (4) intergenerational solidarity as older persons view equity as an asset that they wish to pass on to their children (Olsberg and Winters 2005; Bridge et. al, 2009). To sum up, there is much evidence that the elderly reduce housing equity only to a limited extent. Feinstein and McFaden (1989) found in the case of the United States almost no evidence of decline in homeownership among households of people up to the age of 75.

It was similarly noted in the European context that elderly households may prefer to accept a lower standard of living in order to either pass the equity on to their children or have an asset for times of social and economic uncertainty. The non-existence of any financial instruments to enable equity release obstructs any systematic resolution to this issue (Angelini et al. 2011: 93). Similar evidence was found in a comparison of 17 OECD countries (Chiuri and Jappelli 2010). Ownership rates in these countries begin to decline only after approximately the age of 70. However, it was also found that differences in homeownership are strongly linked to mortgage market regulation and this is very much influenced by financial instruments that make it possible to access equity for current consumption, such as reverse mortgages.

The use of equity release products and the role of ownership housing as a source of wealth in the context of ageing populations and demographic shifts were both thoroughly discussed in the DEMHOW project. Dol and Neuteboom (2009) compared European countries in terms of household strategies to the use of housing wealth and analysed the effects of ageing populations. The analysis focused on three levels: (1) the level of country comparison, (2) the level of the institutional context in the given country (pension system, mortgage market – mortgage accessibility, labour market flexibility, and the competitiveness of the homeownership sector etc.), and (3) the level of households in the given countries. The authors consider the hypothesis of the life-cycle model and analyse the use of equity in older age. The findings are as follows: The level of homeownership is very high, especially in some East European countries. Generally, older people very rarely move. In Northern countries, when the elderly move, it is usually into the rental sector. In other countries the majority of those who move remain in the ownership sector. The authors suggest the following typology of countries: (a) In countries with a substandard pension system and an under-developed mortgage market the elderly are asset rich and cash poor. There is high level of homeownership and little chance of releasing housing wealth (this refers especially to East European countries). (b) In countries with a substandard pension system and a developed mortgage market, households do not release equity they keep it and pass it on to the next generation. (c) In countries with an advanced pension system and an under-developed mortgage market, households are often renters and when they are homeowners, the wealth is passed on to their children (France). (d) In countries with developed pensions system as well as a developed mortgage market households tend to release equity in order to increase their income (Scandinavian countries).

However, more specific analyses of the influence of tenure on the residential mobility of the elderly are rather inconclusive. According to Tatsiramos (2006), there is a significant tendency to adapt housing to changing needs in older age. Renters are said to move 3 to 5 times more often than owners. The number of owners who become renters increases with age. Also, this seems to be more prevalent in the Northern countries than in the Southern countries. In Northern Europe also transitions from home ownership to home ownership with a reduction in home size (and costs) have been noted. Similar results were presented by Angelini and Lafererre (2010), who suggest that those elderly, who

move, tend to reduce housing consumption. Especially those in lower-income groups tend to move to smaller homes and prefer flats to houses and renting to owning. Angelini and Lafererre also distinguish between two types of moves. Between moving to another private accommodation or moving to a nursing home. The latter move is more common among elderly aged 80 and over, or among those with mobility limitations, no spouse and no children. Bad health, high age, the absence of close family (informal care) and low income are thus what usually cause people to move to a nursing home. By contrast, housing quality, mobility costs and accommodation costs tend to be the motives for moving to another privately owned home. The key reason for moving is adapting to the needs of old age (e.g. a decrease in dwelling size, reducing care and maintenance costs) (Angelini and Lafererre 2010). However, residential mobility among the elderly is on the whole rather limited. Mobility rates among older people are quite high in their early 50s, but steadily decrease up to the age of 70 yrs. From this age, mobility rates remain constant or (in some countries) rise slightly (Tatsiramos 2006).

Most elderly are satisfied with their housing and do not wish to move (Pastalan and Schwarz 2001). The main advantages of ageing in place are in their opinion: feelings of independence and control, feelings of safety and security, being near family and familiarity with their surroundings. The elderly highlighted the inability to maintain the property and inadequate finance as the main barriers to ageing in place. Illness is not always perceived by the elderly as the key factor. The following factors are found to be essential for the sustainability of ageing in place: (a) information about available home modifications, (2) in-home care such as visiting nurses, housekeeping services, personal care, (3) affordable home maintenance services, and (4) health promotion and disease and disability prevention services and illness care. A different explanation for elderly attitudes in this respect was proposed in the context of the Netherlands (Steverink 2001; for similar findings from the British context see Stilwell and Kerlake 2004). There it is argued that it is not the level of disability that makes the elderly choose residential care, but rather the loss of comfort, the loss of affection, and pressure from others. Having an adapted home did not make any significant difference in this sense.

However, there is also some evidence that for future generations, due to current changes and shifts in life styles (a shift to mobility and independence), the meaning of the concept of ageing in place will change. The next generations of elderly will be less reluctant to move in older age and the patterns of residential mobility among the elderly might change (Beer and Faulkner 2011, 105–106).

Innovations in Care for the Elderly

Next we shall focus on various innovations in care for the elderly. All the innovations that will be mentioned were designed to support ‘ageing in place’ and should encourage and help the elderly to remain living in their own home for as long as possible. Brief mention will also be made of a new development in sheltered housing, which is based on creating community for active ageing.

Definition and Classification

Care for the elderly that supports ‘ageing in place’ and inclusive housing is a multidimensional concept that includes not just housing, but also health care and social care services. Generally, services provided for the elderly can be ‘assistive’ or ‘preventative’. For example:

Beech and Roberts (2008: 2) categorise various kinds of assistive services according to their intended function and distinguish:

- (1) Supportive technologies for helping individuals that perform tasks they may find difficult.
- (2) Detection and reaction technologies to help individuals manage risks and alarms.
- (3) Preventive technologies concerning dangerous situations.

Common to these innovations is the fact that institutional residential and nursing care are not as much used today as in the past and that there is more and more emphasis on delivering health and social care services in a way that enables the elderly remain as long as possible in their home (Pleace 2011:1). This 'preventative' care focuses on:

- minimising health risks and improving physical security
- improving support for independent living
- monitoring safety and well-being
- housing alterations to tackle problems caused by illness

Similarly, Peace and Holland (2001) mention several innovations in elderly housing. These innovations include various measures (e.g. lifetime homes, smart home technologies, cohousing etc.) that include the idea or concept of inclusive housing. They outline the changes in housing for the elderly in the context of ageing societies and focus on the issue of promoting independence and inclusiveness as new paradigms in care for the elderly. Finally, the meaning and implications of inclusive housing for the future are discussed.

The policy aim of these innovation is (according to Barlow et al. 2005) to provide a '...technology-supported care system which is able to deliver care where it is most appropriate, and potentially anywhere in normal physical environments, thereby increasing the flexibility of the care package and improving people's quality of life'.

A general review of services for the elderly that enable them to remain in their home was also conducted by O'Leary et al. (2010). They propose the following classification of such services (similarly also Parry and Thompson, 2005):

- housing support
- personal and nursing care
- property and related services

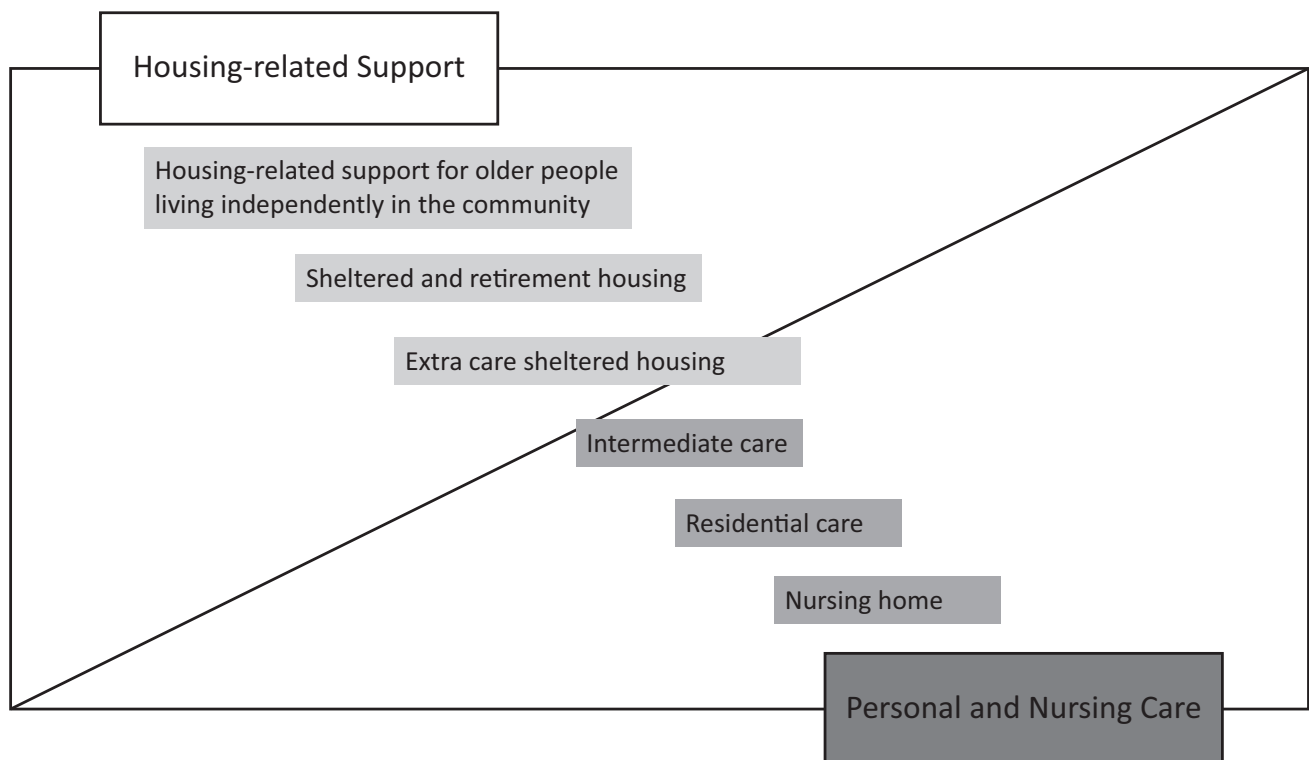
Housing support consists of a range of tenancy and housing related tasks, such as assistance with budgeting and benefits, maintaining safety within the home, support with shopping and accessing other local services, and cleaning. Support can be delivered by the local authority or other independent or private contractors, but the local authority manages the overall budget. The use of care alarms and assistive technology to enable people to remain at home can also form part of this provision. Personal and nursing care is funded, and generally delivered, through health or social services budgets, and can be contracted out to voluntary or private sectors. Such care involves personal tasks such as washing and dressing. Property-related services include care and repair services, handyperson schemes, garden maintenance services and adaptations (O'Leary et al., 2010: 28–29).

The general aim of introducing these innovations is two interconnected goals. First, to decrease state expenditures on long-term care, since home care has been found to be less expensive than institutional care. This goal seems to be essential in the context of population ageing and increasing expenditures for social and health care. Second, home care should lead to better quality ageing, greater independence and satisfaction of the elderly with their ageing.

However, home care has to be viewed in the general context of ageing and care needs of the elderly (Cullen et al. 2007: 58). Staying at home may be suitable for a portion of the elderly population, but it may not be suitable for all. At some point, repairs, small adaptations, home care services or assistive technology might be sufficient to enable the elderly to remain in their home, but at another point, as the needs for long-term care increase, a move to new accommodation becomes necessary (see Figure 1). On the other hand, as some research suggests (McCafferty 1994), there is a significant number of elderly who want to remain living in their home, but at the same time there is a need for some additional inputs in terms of physical adaptations (installation of handles, bars, assistive ICT technology),

health and social care services (but only for lower levels of disability) or unskilled domestic help (help with shopping, chores etc.).

Figure 1 Housing-related support and personal and nursing care – the spectrum



Source: Parry and Thompson, 2005

ICT and Health Care

Over the past decade there has been a strong trend towards the introduction of assistive technology (ICT) into homes as part of care for the elderly. Scotts et al. (2007: 14) describe the benefits as reducing the risk of accidents and increasing the safety, independence, and quality of life of the elderly. These schemes are usually recognised under the notion of Smart Homes, Telecare, Telemedicine etc. The services comprise ICT that include alarms, internet and telephone-based systems that monitor the well-being of older people (Pleace 2011: 10).

ICT in health care focuses either on information provision or risk management (Barlow et al. 2005: 443). The latter is the key issue as it is aimed at monitoring the individual's body and home; the information is transmitted to a care professional who decides when an emergency response is necessary. The general benefits that are claimed for recipients of these services are the following (according to Beech and Roberts, 2008: 3):

- increased choice, safety, independence
- improved quality of life
- ability to remain at home
- reduced burden placed on carers (including family members)
- support for people with serious health problems
- fewer accidents at home

As regards the cost-effectiveness of ICT in health care, some have noted that as yet there is no conclusive evidence on the matter (Barlow and Hendy 2009: 8).

Another sphere of ICT innovations for the elderly is linked to the internet. Although the elderly are less skilled at using internet technology than younger populations, this trend is shifting as the

new generations (baby boomers) reaching the age of retirement should be knowledgeable in IT. Evans (2009: 116) points to the emergence of social networking sites aimed at older people. The aim of these virtual communities is to create social networks for the elderly, preserve their sense of being part of the community and get the elderly access to information that can be essential and beneficial to them (e.g. opportunities etc.). Moreover, it is argued that online communities also enhance face to face contact and communication. The expansion of online social networks is evaluated as positive, because it supports the elderly in being part of the community.

Adaptations and Architectural Designs

Concerning physical changes and adaptations, there are two possible approaches: (a) small-scale adaptations or (b) more general architectural designs. The former (sometimes called 'handyperson services'; e.g. Pleace 2011) focus on repairing homes, addressing issues of heating and insulation, and including the installation of handles, bars and equipment for bathing, toileting etc. For example, in the context of Scotland, it was found that these services bring about increased efficiency and result in a decrease in the use of sheltered housing, admissions to nursing homes and social work interventions (Pleace 2011: 5–8). Similarly, a study by Lansley et al. (2004b) concluded that adapting homes for the elderly decreases costs compared to standard residential or nursing home care.

A complete review of various forms of home adaptations is given by Heywood and Turner (2007), who mention the main objectives, benefits and means of such adaptations. These include:

- The prevention of falls, which can be efficiently addressed with simple home adaptations (bars and handles).
- The prevention of stress and the importance of subjective well-being, which can be promoted by even small 'handyperson' services (Adams 2006).
- Improvements in heating and security, which can improve mental health as well as heart conditions (Allen 2005).
- The prevention of admission to residential care, which without adaptations would be inevitable (Heywood 2001).
- Finally, adaptations also bring about reduced strain, stress and exhaustion etc. for family carers (Heywood 2004).

Sometimes, already adapted social rented properties are monitored and listed so that the properties can be suitably matched with the needs of future tenants. There are databases of adapted properties that enable the reuse of such social rental flats or houses (this is applied across all tenures) (O'Leary 2010).

Generally, evidence and cost-effectiveness and cost-benefit analyses suggest that home adaptations lead to reduced costs, especially as a result of prevention or the possibility for the elderly to leave hospital and residential care earlier (or to spend less time in such types of care and to return home earlier). There has also been discussion about whether home adaptations can substitute domiciliary care in terms of the well-being of care recipients. Although there is some evidence that this indeed happens (Andrich et al. 1998), there are doubts whether this is a good approach since formal home care also means social contact for the elderly.

In the context of increasing disability and ageing societies, there has been a focus on architectural designs that aim to make housing more accessible to all social groups at all life stages. There are various labels attached to these concepts, including Universal Design, Inclusive Design and many others (Milner and Madigan, 2004; Scotts et al. 2007). The core idea of this concept is that a house should meet construction standards that are suitable for and satisfy the needs of all home owners regardless of their age, and enable people to remain in their home for as long as possible.

There are a few ways in which the take-up of these houses has been promoted. Scotts et al. (2007) mention regulation, incentivisation and market capacity development. Regulation is usually applied in public buildings and social housing. Nonetheless, there are examples of general regulation especially on the local level. For example, in London (London Plan Policy) new construction is required by regulation to meet certain criteria. Similar regulation of new dwellings is being applied also in Denmark, Sweden, Norway and the Netherlands (Scotts et al. 2007: 4). The use of incentives takes the form of governments providing low-cost loans for new construction and grants for modifying existing structures. However, there has been little interest from private developers and providers. The last way to enhance the capacity of the construction industry to pursue this form of design involves the promotion of accessible design principles, the publication of design guidelines, and organising supportive strategic discussions etc.

Home adaptations are in some countries financed on the basis of grants by local authorities. This is, for example, the case of the UK, where such a grant scheme operates. However, in other contexts, such as the US, there is no general programme focusing on home modifications for the elderly. In the US, there are only a few such opportunities and only specific target groups are eligible for home modifications for free (e.g. Veterans Administration Service, Farmers Home Administration). However, most elderly people are not covered by these schemes, as neither Medicaid, nor insurance companies pay for home modifications (Scotts et al. 2007: 11; EC 2010).

Even in countries with few or no direct financial support for home modifications, there has been an effort to increase the limited knowledge among renters seeking accessible housing. The proposed way of doing this has been the use of registers for accessible dwellings. These registers, national as well as local, have usually been run by non-profit initiatives. The rationale of these registers is to collect information about vacant, affordable and accessible housing units that could be provided to the disabled elderly. There are numerous examples of the use of these registers, ranging from the US (Massachusetts Housing Registry) to Norway and the UK (e.g. London or Glasgow) registers (Scotts et al. 2007:12–13).

Social Care ('Housing Support')

There are two reasons for supporting home care services (Monk and Cox 1995). First, it is expected that home care can serve as a substitute – the systematic replacement of costly services with less expensive ones. Second, it is assumed that the elderly should be encouraged and assisted to live and function in their own homes, so that they can live independently.

There is also a variety of social care services that also aim to improve the well-being of the elderly and enable them to live for as long as possible in their home. These policies aim to enable the elderly to remain at home during periods of illnesses and to enable them to live independently. These services also include support for other activities such as: help with managing finances, advice about housing and related matters, health monitoring, peer support etc. An important feature of these services is that they often claim to be tenure-neutral (they apply to sheltered housing as well as the elderly living on their own) (Pleace 2011: 19–23). Among the most commonly used home services are direct cash payments to care recipients, which have been extensively used in some countries (Denmark, Norway). Another feature of developing home care services is the decentralisation of care management and organisation. The main benefits of these decentralised models are that they should (a) lead to more creative service solutions, (b) result in services that are more professional and responsive to local needs, (c) facilitate a client-centred approach and (d) empower the elderly in their freedom of choice.

There is considerable overlap between housing support and personal care. Services are often delivered as an integrated package, and particularly in the voluntary and not-for profit sectors they may be delivered by a single member of staff. Social service departments also generally provide domiciliary

care (Curtice et al. 2002). The provision of housing support and personal and nursing care is usually not dependent on the tenure of the older person; these services are provided to people in their own home, in sheltered or extra-care housing, and in residential care, with provision dependent on circumstances and needs.

Ensuring that older people are aware of the services available to them is also a particular challenge. Older people are unaware of the services available to them, and that this is a key constraint (e.g. Wright, 2002). Also, there is evidence of people who had entered residential care, but felt they would not have had to, if they had been aware of the supports available, particularly in the areas of grants, equipment and adaptations (Clough et al. 2003).

Monk and Cox (1995) mention the main areas of policy innovations in social care with respect to care for the elderly:

- The coordination of home care with housing and health-care services.
- The development of new methods of targeting and prioritising the provision of social services for the elderly.
- Recruitment and training of formal as well as informal carers.
- The integration of formal and informal services.
- Consumer ('the elderly') and community participation in planning, organising and operating home-delivered services.
- Finding new sources of funding for home care services.
- Institutions of redress – procedures for cases of elderly dissatisfaction.
- Simplification of budgetary allocation and the organisation of care.
- Gap-filling social services for the elderly such as day care and respite care.

The focus on social care services, which can be formal as well as informal (care provided by family, friends etc.) is essential. Lansley et al. (2004b: 475) note that introducing various kinds of physical adaptations into homes of the elderly means at the same time that the elderly still have to rely on either formal or informal care. The degree of care can decrease when more physical adaptations are provided, but some level of social care (either formal or informal) still remains indispensable.

Trends and Innovations in Sheltered/Community Housing

Much research and literature has begun to focus on new forms of sheltered and community housing. These specific forms are neither a type of traditional residential/institutional care, nor do they directly conform to the concept of ageing in one's own home and home-domiciliary care. These are schemes that promote community living for the elderly, but at the same time the aim is to promote independence and social networks among the elderly etc. It is expected then that the elderly do not stay at their homes but move to these communities.

There is a wide range of new approaches to community care for the elderly; for an overview, see Croucher et al. (2006). There are many communities that are newly build for the elderly that focus on the issue of providing social and health care to the elderly and supporting their independence as much as possible. Bäumker et al. (2011) refer to the Extra Care Housing initiative, founded by the UK Department of Health. This scheme applies to new construction as well as to the upgrading/remodelling of existing buildings as part of development. Alongside social and health care the initiative focuses on facilities that promote independence and social networking. A similar concept is Co-Housing (Brenton 2001), applied mainly in the UK, the Netherlands and Denmark. This is a way of living where individuals have their own private space (and may even be the owners) but share common facilities, and social and health care is provided for the whole community.

An Evaluation of Innovations

When evaluating the innovations in inclusive housing and innovations linked to ageing in place, it is important to distinguish between smaller- and large-scale innovations.

When evaluating the general and overall cost-effectiveness of smaller-scale innovations that aim to enable the elderly to remain at their homes for as long as possible (such as smaller adaptations, some use of ICT at the home of the elderly), it is argued that these innovations are cost effective when the needs of the elderly are low or moderate. When support needs become more extensive, the costs can even exceed the costs of residential care (Pleace 2011: 24).

In a similar vein, Lansley et al. (2004b: 480) argue that the provision of assistive technologies and adaptations with formal (or informal) care is less costly compared to residential care. However, there are also some conditions to effective and efficient use. Assistive technology and adaptations are more effective for long-term rather than short-term use. It should not always be directly considered a substitute to residential care (nursing homes) but rather an alternative to some kinds of sheltered housing. Finally, for adaptations to be effective, the education, knowledge and skills of health professionals directly involved with the elderly have to be increased.

A thorough evaluation of the costs and benefits of housing adaptations (and assistive equipment such as stair lifts or level access showers and similar) was given by Heywood and Turner (2007). They outline the main areas and reasons where costs are saved:

- Home adaptations produce direct savings compared to residential care within the first year after they are put into practice.
- Adaptations also save resources with respect to home care, but only in the case of 'younger' elderly with disabilities.
- Housing adaptations are essential because they also save resources in terms of the prevention of accidents (and also admission to hospitals, residential care, medical treatment etc.).
- The provision of adaptations and equipment speeds up hospital discharges and also improves the physical and mental health of caregivers.
- However, adaptations are more efficient and cost-saving the more adequate their use is and the fewer the delays in the provision of these adaptations there are.

The countries most successful at applying large-scale innovations to accessible housing, such as Universal Design, appear to be Japan, Norway and the US. The main driver of these innovations seems to have been financial incentives and a strong regulatory legislative framework, while the financial involvement of the private sector seems to have been somewhat limited. In these countries accessible housing schemes have worked only when encouraged by financial support. Financial incentives and government regulations were thus the most successful strategies, while guidelines, branding and information campaigns were unsuccessful. Large-scale housing modification projects do not however always take care of the need they are supposed to, and the quality of modifications done often falls short of the expected outcome; quality assurance and accreditation systems are missing (Scotts et al. 2007: 16).

Some researchers also claim that excessive use of ICT in care for the elderly leads to its rejection by the target group because too much technology is involved. However, the evidence is inconclusive. Lansley et al. (2004b: 479) in their research based on interviews with the elderly claim that assistive technologies (home adaptations as well as ICT) have been accepted well by most care recipients.

Domiciliary Care (as Social Care)

This section focuses on the patterns of organisation and provision of home-domiciliary care in various, in most cases European, countries.

Doyle and Timonen (2007) compare elderly home care provision and organisation in Denmark, Germany and the US. They distinguish several factors important to the organisation of home care. First, they point out the welfare system. They distinguish three types of welfare system with respect to home care:

- Statist (state takes responsibility) (Denmark)
- Family/individualist (families and individuals are responsible) (US)
- State pays, other provide model (Germany)

Further they analyse the following factors in the provision of home care:

Eligibility criteria for the care – refers to the fact whether the service is open to anyone or not. For example, in Denmark and Germany the home care service is open to all, but eligibility is assessed by a trained professional (assessment criteria may differ substantially between countries).

Regulatory structures – this refers to whether there are strict national rules and centralisation or whether there are just basic guidelines and extensive decentralisation of care with strong municipality discretion. For example, the German system is centralised and the Danish system is very decentralised with most decision-making power delegated to the municipalities.

Also, the *quality of care* is controlled and assured in different ways. There are quality guidelines, inspections/visits from nurses (or other professionals) and recipient feedback.

Financing – financing is usually based on local and national tax revenues (Denmark and US). In Germany it is based on employer and employee social insurance contributions. There is some evidence that the German system is susceptible to the effects of ageing and that it also may run into financial problems. But still it was found that in many countries the introduction of home care meant that the need for and the demand for places in nursing homes decreased, which resulted in costs savings.

Delivery structures – this refers to whether the care provider is the public sector or a non-profit organisation or a private for-profit organisation. In Denmark, the dominant sector is the public provider, but recipients also have the right to choose a private one. In Germany for-profit and non-profit organisations have the same rights, and both can be providers. They are also favoured by public agencies. The general trend is that the private sector and non-profit organisations are more and more involved in providing these services. On the other hand, they have to fulfil certain criteria, such as falling within a certain price range etc.

Consumer power – this refers to the fact that in most countries the trend is that the recipients can choose between a public and a private service provider (Denmark, US). In Germany, they can choose between a cash benefit and direct service delivery (and also between a public and a private provider). Recipients can also choose what services will be provided and can in some cases make additional requests.

Informal care – this differs very much from country to country. Reliance on family/informal care is heavy in Germany. In Denmark, by contrast, it is rather low. There also exists the innovation of making money payments to family caregivers ('cash for care'), something that was introduced in Germany and Denmark. However, it was not very successful due to the implications for caregivers (poor opportunities when returning to the labour market, financial insecurity etc.).

Hildegard (2007) presented a similar analysis, but mostly focused on the sources of care for the elderly and analysed the patterns of formal and informal care. In Austria, Belgium and Germany the aim of

support for the elderly is to provide care through care benefits that facilitate the purchase of paid services and support family care (as noted by Doyle and Timonen 2007 above). In Germany, people with low incomes can receive an additional means-tested care benefits. In Austria and Belgium, on the other hand, in addition to care benefits, the delivery of services is subsidised. The approach in Italy is rather different and is oriented towards family support. Professional care services are provided to families with the lowest income and without the family support.

The family care approach presents difficulties when the immediate family is not available to assume the provision of care. A lack of assistance with daily activities was found only in the case of Italy. A high economic burden, especially for low-income groups, was also identified in Italy because of the need to purchase the services. In Germany, Belgium and Austria problems are less frequent, because apart from family care there is also professional care. However, instances of problems can also be identified in these countries, especially among the lower-income elderly.

The basic structure of care for the elderly is presented in the following table (cited from Hildegard 2007: 10):

Table 1 Basic pattern care resources

Supported by	Austria	Belgium	Germany	Italy	Northern Ireland
Professional services	70.8%	78.3%	78.9%	44.9%	83.0%
Relatives in same flat-house	60.7%	44.3%	38.9%	17.8%	31.8%
Relatives within easy reach	58.4%	82.6%	57.8%	23.3%	60.2%
Privately hired helpers	44.9%	17.4%	55.6%	8.9%	30.7%
Neighbours	24.7%	44.3%	33.3%	68.9%	28.4%
Friends	15.7%	46.1%	20.0%	10.0%	37.5%
Volunteers	3.4%	7.8%	8.9%	0.0%	3.4%
Total: Care resources	2.8%	3.2%	2.9%	1.8%	2.8%

It is also noted that the socio-economic class plays a significant role in this respect and that there are also social inequalities in the availability and affordability of care for the elderly. For example, it is shown in the cases of Austria and Germany that the elderly with lower incomes have bigger difficulties purchasing care services. The reported financial burden also increases significantly with the level of care dependency, which suggests that the costs of more severely care-dependent elderly people are insufficiently covered (Hildegard 2007:19).

In terms of social exclusion, living alone is the driving factor behind the general satisfaction of the elderly with their life situation. This means little social contact, depression and it seems to be coupled with lower incomes. Thus the general factors causing elderly dissatisfaction with their life situation seem to be: living alone, a lack of social contact and lower income (below 25%) (Ibid: 23).

Most of the research focused on home care, as is clear from the above analysis, has been concerned with developed Western European countries. However, as Genet et al. (2011) note on home care, there is not much about Central and Eastern European countries.

To sum up, when comparing the home care policy for the elderly in European countries, there are several common trends and several differences (according to Genet et al. 2011):

- First, countries differ in terms of policy regulation and eligibility. In Mediterranean countries in particular, policy is focused mainly on poor households; in other countries (especially in the north) there seems to be no targeting and home care is open to anyone. Organisations performing the

assessment can be independent agencies, municipalities or governmental organisations. In some countries a reassessment can take place.

- Second, some countries decentralised some of the responsibilities for policy development (e.g. Denmark, UK). The financing and organisation of home care was in some countries delegated to local and regional governments.
- Third, in some countries social and health-care policy is integrated, while in other countries it is not and these services are separate.
- There is also a great variety of home care providers. These include public, private non-profit, private for-profit, NGOs and a mix of these. This is becoming a trend in most Western European countries.
- In some countries care is provided by non-professionals. Therefore, a major focus is also the relationship between formal and informal care. In some countries formal care is viewed on the policy level as a substitute for informal care, in other countries it is not.
- Also in some countries local authorities (municipalities) may set their own priorities and set their own financing and criteria. This may cause disparities in the same country in the quality and accessibility of home care. But most generally, policy on home care is usually a national affair, while the organisation and service provision is decentralised. In some countries there are monopolistic agencies providing comprehensive care, in other countries there are specific agencies for specific kinds of care (e.g. Sweden).
- Financing usually flows from the following sources: public funding (based on insurance, regional budgets or private payments), co-payments for home care services (the level of co-payment determined by the recipient's income), the allocation of budgets to providers, cash-for-care (direct payments or vouchers for recipients to buy care; this was available, for example, in Germany, Italy and Austria).
- The share of the elderly who receive home care can vary from country to country. In some countries (France) the share is large (one-third of the population is over 65), in other countries it is rather small (about just 6% in Finland).

Formal and Informal Home Care for the Elderly

An important dimension to the discussion of home care for the elderly is the issue of the relation between formal and informal care. In promoting concepts such as 'ageing in place', informal care is often encouraged as an essential part of home care for the elderly. With the ageing of European populations, a shift is expected in the demand for health and social care, which may put pressure on the existing social and health-care systems. Informal care is regarded as a possible cheaper substitute for expensive long-term care (Bolin et al. 2007). However, there are also important differences in attitudes to informal care. Whereas in Southern European countries informal care is well accepted by the elderly, in Northern countries (in Scandinavia) the elderly have a reserved attitude to home care and prefer formal (professional) care.

According to Damiani et al. (2011) there is a big difference in the approach to home care and care for the elderly in European countries. Western European countries provide a range of services in terms of home care, including various kinds of cash-for-care programmes that encourage home care (Timonen et al. 2006: 455–474). By contrast, Southern countries rely most on unpaid, informal family care, resulting in a lower quality of care for the elderly. In Central and Eastern European countries there seems to be no regular pattern, but the predominant role seems to be played by informal care, along with above-average formal care, but a lack of investment in infrastructure and new innovative practices.

Another important topic is whether informal care can become a substitute to formal care. This is, for example, reflected in home care policies that provide monetary benefits to informal carers (family

members, relatives) who take care of the elderly. As regards formal care, when a distinction is made between domestic paid help and nursing care, it is found (Bonsang 2008; Bolin et al. 2007) that informal care works only as a substitute for domestic help and only in the case of elderly with low disabilities. When the disability is greater, or when nursing care is concerned, there is no substitution effect, but rather a complementary effect between formal and informal care. Informal care seems to be a good substitute for paid domestic help. Paid domestic help for the elderly appears to be less used in countries where informal care is provided to a greater extent by adult children. For example, Denmark, the Netherlands and Belgium are countries with extensive paid domestic help and not much informal care, whereas Italy, Spain and Germany are countries with extensive informal care but little paid domestic help. However, such a trade-off does not work with nursing care. This suggests that informal care cannot, or can only to a very limited extent, decrease long-term care expenditures.

An important topic in the discussion of formal and informal care has been the issue whether, with respect to the greater involvement of women in the labour market (Damiani et al. 2011), there will be enough people who would provide informal care (or paid informal care) for the elderly. This issue also relates to what is called the 'sandwich generation' of parents, who are expected to provide care not just for their children, but also for their elderly parents. The question of to what extent these two types of care are compatible is still not resolved (e.g. Grundy and Henretta 2006).

Conclusions

This literature review suggests that there have been many important developments in innovative practices in housing and care for the elderly (vulnerable people) in most European countries. These innovative practices are linked to various different policies, including social care, housing policies and health care. The common feature of all these practices is that they promote the notion of 'ageing in place' and support the elderly's ability to remain living in their own home for as long as possible.

On a general level, in many European countries there has been a trend towards a decentralised provision of care for the elderly. This concerns not only social care, but also, for example, the allocation of municipal financial grants for home adaptations. This decentralisation has been most pronounced in Western European countries, e.g. Denmark and the UK. In other countries, especially in Central and Southern European countries, it is rather difficult to identify the strength of these trends. Moreover, there is strong evidence (see the next section of the report) that these policies are much less developed in post-socialist countries. In these countries there are already several innovative policies focused on social and health care, there has been an expansion of the use of ICT in care for the elderly, informal care has been more and more promoted, but home adaptations (as well as general strategies such as 'lifetime homes' and 'universal design') are not widely promoted. In addition, the participation of NGOs in housing solutions in these countries is very limited, but they are more and more involved in the organisation/provision of social care for the elderly.

There is strong evidence that some of the innovative practices in home care are efficient (cost-effective). This concerns especially smaller adaptations and equipment provision (including ICT use, telecare and telemedicine). Empirical studies suggest that home adaptations are beneficial not only to the elderly themselves, but also to their (formal/informal) carers. In addition, adaptations decrease the costs for elderly care through less frequent hospital admissions, fewer injuries, and later moves into residential (nursing) care. This evidence comes mainly from the UK, Ireland and Scandinavian countries. However, it was also argued that these innovations are cost-effective when the needs of the elderly are low or moderate. Assistive technology and adaptations are more effective when long-term rather than short-term use is at issue. In other words, the efficiency of measures to increase housing accessibility is higher when the needs are low or moderate and when it is assumed that dwelling adaptations will be used for the long term.

Concerning the development of major concepts such as ‘lifetime homes’ and ‘universal design’ the empirical evidence does not suggest any major increase in their practical use. It seems that the private construction industry in particular is reluctant to adopt these measures and the expansion of this approach has been rather slow.

As regards social care, a strong feature of past development has been the increased use of domiciliary home care, provided either by paid professionals or by family members and relatives who get paid for such work, or there is a reliance on unpaid informal care. Innovations in this respect refer, for example, to cash-for-care regimes, wherein the elderly receive a payment which they use for care that they choose personally. An emerging topic in the discussion about home care seems to be the relationship between formal and informal care and whether they are mutually interchangeable or not. If formal home care, sheltered housing and residential care (nursing homes) could to a large extent be substituted by informal care (e.g. supported by cash-for-care benefits), this would mean significant cuts to public costs. However, the empirical evidence suggests that this substitution effect is limited and works only in relation to unskilled work. When more qualified social care is needed (nursing or more demanding care) it seems that formal and informal care work as complements. When the health conditions of the elderly are bad, professional social care does not crowd out informal care provided by the family and relatives, but instead has the effect of bolstering it.

Many studies that have focused on the relationship between professional/paid home care and informal care confirmed that there is no strong ‘crowding out’ effect. An international comparison showed that in countries with a strong welfare state both types of care are mutually reinforcing. These studies have important implications for policy designers. Nonetheless, it should also be borne in mind that there are significant cultural differences across different countries that may have different impacts on attitudes to formal and informal care.

In the developed EU countries (such as the UK and Scandinavian countries) the trend over the past two decades has been to support, promote and provide a great variety of solutions for the elderly. Fully independent living and institutional care (nursing homes) represent just two extremes of a continuum that includes a great variety of housing (and care) solutions for the elderly that may better suit individual needs and preferences of vulnerable people. This also has important implications for other countries where the variety of such solutions is not so great. For example, co-housing should not be viewed as a general solution but rather as one possible way of solving elderly housing issues that may not be (and will not be) suitable for everyone.

Another important issue that has important consequences for the evaluation of innovative policies for the elderly is the study of the elderly’s motives and reasons for moving to institutional care. Many studies suggest that the main reason for the decision to move to institutional care is the feeling of exclusion and disinterest from family, relatives and friends. This has important implications because some policies that promote independent living such as extensive ICT use, formal home care or home adaptations can end up being ineffective as the elderly still decide to move to institutional care regardless of all these innovative arrangements. Therefore, it also seems essential to promote policies that view the target group as not just the elderly themselves but as the elderly embedded in their surrounding social networks and community.

Finally, there have been many EU-level projects that have dealt with the issue of ageing, ICT and various kinds of innovations. However, there seems to be a lack of studies that thoroughly investigate which solutions are effective and which are not, what are the costs and benefits of the innovations and how the elderly themselves accept such policies. It also seems that such policies tend to neglect the spontaneous and ‘grassroots’ efforts of NGOs to help the elderly improve their living, social and housing conditions. One consideration is whether it might not be beneficial to focus more on supporting such NGO-driven efforts as they seem to have more detailed and expert knowledge of what is needed and demanded by the elderly.

III | Country-Specific Literature Overview

The aim of this section of the report is to supplement the general literature overview (conducted by a research coordinator on English-language literature) by the overview of literature written in local languages in seven of the eight Central European countries participating in the HELPS project (Italy did not participate in the literature overview). The purpose of the country-specific literature review is the same as for the general literature overview: a better framing of the research activities of the HELPS project and relating our findings to conclusions reached in previous studies. Additionally, this overview attempts to fill in the gap in information about the situation in post-socialist states that is basically missing in English-language literature.

The country-specific literature review was conducted by project partners or their hired experts in each of the seven participating countries and it was a part of the country Preliminary Reports. The development of policies concerning the elderly and housing differed between the countries studied, so the focus of the literature reviews in these particular countries is not the same. Consequently, the structure of these reviews differs to some extent. Nonetheless, the focus of all the country-specific literature reviews is on the housing conditions of the elderly, the quality of housing, living conditions, long-term care solutions, social housing, and attitudes of the elderly. We will present a review of the country-specific literature for each country separately and in alphabetic order; the conclusions in the final subsection will summarise the most interesting findings for all countries.

Austria

In the review of the situation in Austria we focus on the description of care for the elderly, their living conditions and finally the housing attitudes of the elderly.

Care for the Elderly

In 2010, there were about 850 residential and nursing homes with about 75,000 places for elderly and vulnerable people. There has been a significant increase in this respect (in the number of nursing homes as well as places for the elderly) in the past two decades. From the beginning of the 1990s the number of elderly people living in institutional care has been growing enormously. However, this does not mean that other forms of care disappeared. There is still a great variety of many other different elderly living forms like living in one's own flat or house, or receiving care from other family members or nursing staff from mobile services (Statistics Austria 2002). Nonetheless, stationary accommodation in Austria is the biggest and most important sector of the public health sector (Statistics Austria 2010).

As regards the level of health care, this has been evaluated as very satisfactory (Statistics Austria 2002). The vast majority of the elderly get some health care or access to health care in one year; women (85%) more often than men (79%). The demands of health services rise with increasing age. As a whole the evaluation reveals a high level of satisfaction with the analysed quality features.

More recent findings on the health-care situation of the elderly in Austria can be obtained from the 2006/2007 Austrian health survey of Statistik Austria (2007). According to this survey, 471,000 people in Austria had problems with basic living activities, such as washing, eating etc. Every fourth man and every third woman over the age of 75 has problems with at least one basic living activity. Men are mostly cared for by their wives and women mostly by their daughters or social services. Only 9% of men in need of care and 19% of women in need of care use assistance services or other social

services. Finally, about 7% of the elderly were living in nursing homes. The average age of people who move to institutional care is 82 (Statistics Austria 2010).

Living Conditions of the Elderly and Attitudes to Housing

A report on the living conditions of the elderly in Austria from 2000, organised and conducted by the Federal Ministry for Social Safety and Generations, focused not only on the living conditions of the elderly, but also on their attitudes concerning living conditions and types of care (Federal Ministry 2000). Most people reported that they wanted to stay in their own home for as long as possible. They hoped that their physical and mental health would be preserved to enable that. The reasons why they want to stay in their own homes are mainly social ties, community networks and the ability to be nursed at home.

A more recent study (Federal Ministry, 2008) of the attitudes of the elderly from 2008 indicates that the attitudes of the elderly are still quite the same. The move to institutional care is still delayed for as long as possible. Only in the worst or in an acute case people are ready for this step. The main reason for this is that many people think that moving to institutional care is like admitting one's age and stepping into the final stage of life. Having one's own flat or house is for many people a form of personal autonomy. However, moving to other accommodation, like supervised flats (this is a housing solution for the elderly that enables more autonomous living, but where the elderly can obtain social and health care), where they can have greater autonomy, is easier for many old people.

In recent years, there has been a shift in the direction of Ambient Assisted Living technologies (AAL). Pilot projects have been initiated in several locations in Austria (Schneider, Schober and Harrach 2011). On the one hand, the AAL package includes a great deal of technical equipment in the form of support systems, TV, internet, telephones, but on the other also offers services like food delivery, a clothes-cleaning service, mobile services, an emergency call system, etc. These projects are run by the Federal Ministry for Communication/Traffic, Innovation and Technology. With AAL technologies it is possible to support people in their daily actions, accommodate any limitations they have, and enable them a long, self-determined life in their own homes. Furthermore, it is able to reduce the costs in the area of maintenance.

AAL pilot projects were accompanied by research and investigations into the effect of AAL technology on the elderly, and the general attitudes of the elderly to this kind of care were also studied. The main reasons why the elderly and vulnerable people decide to move to supervised living with Ambient Assisted Living technologies were identified as the following:

- The main motive for the elderly leaving their old home and moving to a supervised flat was the geographical location of the flats. For many people it was important to move closer to their own children and have support without burdening them.
- The supervised flats are more manageable and are barrier-free.
- They have more social contacts, especially because they have close neighbours.
- People get a feeling of safety because they have neighbours and other contact persons always within reach.
- The study also included an evaluation of AAL technology. The following positive effects were identified:
 - A positive change in the well-being of the residents in terms of greater autonomy.
 - Residents get help from their neighbours or other contact persons. Residents no longer felt they were alone.
 - Residents were able to arrange their life as they wished.

Czech Republic

Commenting very generally on the demographic situation in the Czech Republic, Glosová (2006) notes that, in conformity with the overall European trend, population ageing is very intensive in the Czech Republic. This trend is expected to create very difficult conditions for the further functioning of society. Despite more than a decade of discussions about the phenomenon of ageing in the Czech Republic, relatively little work has been devoted to the question of housing for senior citizens. To review the relevant literature on this topic, we start with an assessment of the living conditions of the elderly, then focus on their preferences concerning housing and living conditions, and finally we discuss recent developments in social housing.

The Living Conditions of the Elderly

Concerning the current economic, financial and social situation of the elderly, an analysis of the current situation (Dupal 2008) indicates that there were approximately 1,677,000 senior households in the Czech Republic in 2008. Of these, about one-third reported problems with the financial affordability of their housing. The analysis also highlighted the fact that senior citizens make up a growing share of the population living in housing estates. The authors identify the problematic group of individuals who became owners during the process of privatisation of the public housing stock and are not able to maintain their apartments. In the context of possible solutions, the text refers to the 'too poor to move, too poor to stay' problem known from English experience. This situation particularly applies to people aged 75 and over. A detailed analysis of the living conditions of the elderly was given in 2002 in a report by Kuchařová (2002). In 2002, retirees in the Czech Republic had quite a good standard of living. The biggest percentage of elderly were living in their own houses or flats (48%) and in comparison with other age groups they had the highest number of rooms per person and very often were living in detached houses. By contrast, the authors also noted that pensioners were being increasingly faced with the problem of the potential financial unaffordability of housing, especially in the case of one-person households of women. According to the authors, this risk could be reduced by helping the elderly to move into more appropriate housing. However, the authors cited the existence of objective barriers to moving, one of them being the limited availability of smaller flats in the housing market. The authors also noted the high level of satisfaction with housing as another factor of the elderly's little willingness to move.

More recent findings on the situation of the elderly were presented by Svobodová (2009). She shows, in conformity with the other studies mentioned above, that people aged 60+ relatively more often tend to live in detached houses, except for those living in one-person households. Owner-occupied houses and flats are the most common form of housing in the group of seniors, and the size of their flats frequently indicates 'housing overconsumption'. This situation potentially increases the risk of a high housing cost burden. Moreover, since seniors tend to live in older houses, their housing costs can be even higher owing to the need for reconstruction and other amendments to their current dwellings. In spite of these facts, seniors still tend to be unwilling to move to more appropriate flats and are satisfied with their housing conditions. Several surveys confirm that the elderly prefer to remain in their natural environment, even if they are no longer self-sufficient, as they want to maintain their privacy and at least some independence. Therefore, she recommends not placing seniors in residential houses unless they really need it. To achieve this objective, she proposes extending the range and the number of social care services and increasing the awareness of older people about existing services. In addition, adjustments to houses and flats could increase the level of independence

of people with disabilities caused by ageing. She also notes some financial instruments that should be better targeted and that would offset growing housing costs in connection with rent deregulation.

The Preferences and Attitudes of the Elderly to Housing and Care

Several studies have attempted to study not only the living conditions of the elderly, but also their attitudes and their preferences with respect to housing and also with respect to their (social and health) care demands. A 1999 survey of the elderly's preferences (Lipner 1999) argued that privacy is one of the most important priorities (perhaps the key priority) of the elderly. The elderly tend to reject living in their children's households, yet prefer the possibility of living close to their children. The value of privacy was found to be one of the biggest barriers to moving to institutionalised care. Based on his analysis, the author recommended respecting the preferences of seniors and their need for privacy and taking pains to change the values within society, so that families are able to take on the responsibility of caring for their elderly parents.

A much more detailed and elaborate report was presented by Vohralíková and Rabušic (2004). They pointed to the limited willingness to move typical for the Czech population. Only about 14% of the elderly had moved in the past ten years. Seniors value their independence, for the most part regardless of any changes to their state of health. More than 60% of the elderly would prefer to remain in their current dwelling, even if this meant they needed assistance from another person, ideally their children. The willingness to enter institutionalised care drops with the rising age of seniors. On the other hand, when asked 'who is responsible for the quality of life of the elderly', respondents most often declared that it is the state (48%), the individual (28%) or children (12%). Only 11% had experience with professional home care, in most cases with 'meals on wheels'. The authors suggest that institutionalised care should provide clients with as much autonomy as possible. According to the findings, one of the motivations behind applying for this type of care is the need for security, 'just in case'. Therefore, the authors recommend shifting attention to so-called 'telecare', which would provide seniors with security in sudden emergency situations. The researchers warn that the waiting times for institutionalised care can be so long that by the time a senior is accepted into an institution his/her state of health is such that it requires hospital care rather than care that can be provided in homes for the elderly. According to the authors, the long waiting times are partly due to the fact that physicians prompt seniors to apply for institutionalised care 'in time' so that it is 'available' when they come to need it. This leads senior households to neglect other alternatives for care and services.

Several studies have also dealt in more detail with the issues that accompany an elderly person's intention to move. According to a survey done by the Municipality of Brno (Brno City Municipality 2011) two main reasons for planning to move were identified: the high costs of current housing (in 55% of cases) and changed needs (in 47% of cases). Furthermore and importantly, 26% of them would prefer to move to homes with domiciliary care services or homes for the elderly. Similarly, a study done by Grollová (2009) argued that financial issues are an important reason for the elderly's decision to move. When asked whether 'thinking about moving', only 10% gave a positive answer. However, the main reason for seniors' moving was 'financial' (75%). Only 7% of those living in their own houses worried about financial unaffordability, compared to 19% of those living in the rental sector.

Finally, a recent study (Kubalčíková and Havlíková 2011) focused on the real and possible role of domiciliary care in the Czech Republic, while reflecting on the elderly's needs and attitudes. This study was based on international SHARE data. From an analysis of SHARE data it is evident that the need for outside help with daily living activities increases with age. The proportion of residents who claim to have no problems with BADL (basic activities of daily living) and IADL (instrumental activities of daily living) falls dramatically with age. Importantly, only 60% of those who had problems with at least one of these activities or with mobility or transportation of objects claimed to have someone in their environment who was able to help them. These findings show that help with managing BADL and IADL

provided to the elderly by either informal or formal providers can be seen as insufficient. The possibility of solving the problem of reduced self-sufficiency by placing the person in question in a home for the elderly – ignoring the reality that these homes are constantly full – is an alternative that not even the elderly themselves favour.

Moreover, elderly people with reduced self-sufficiency expect more from social services than basic practical help with their households, shopping or laundry. The key need in this respect is ensuring their security. Domiciliary care services have the potential to cover this need; however, the costs of monitoring and supervision are so high for the provider that in fact these kinds of assistance are not delivered. Moreover, there is no legal definition of monitoring and supervision, so on the one hand domiciliary care service providers have no obligation to deliver this assistance, and on the other hand there is no interest among government and local or regional authorities in giving financial support to this type of help. The authors claim that it is the elderly people's distrust of domiciliary care services and its potential to provide help in the case of considerably reduced self-sufficiency that forces them to apply instead for a place in a home for the elderly, even though they would prefer to remain in their own homes.

(Social) Housing for the Elderly

Social housing is an issue that is strongly linked to the housing and economic situation of the elderly. The main reason is financial, but there are many others (the physical features of the housing, the accessibility of the dwelling etc.). Although social housing also targets many other social groups, especially in the context of Central and Eastern European countries, the elderly represent the key target group.

To date there is no official definition of social housing in the Czech Republic. Valentová (2005) gave an overview of the development of this issue over the past two decades and also evaluated the current situation. She drew attention to the negative experiences people had with the communist system's broad housing construction and limited public financial resources. When commenting on recent developments, she underlined the fact that the policy related to social housing was severely neglected during the first decade of transformation, especially in favour of the often fast privatisation of housing. According to her analysis relevant concepts of social housing were developed only in the late 1990s, as the level of housing construction dropped. But even in this period, concepts of non-profit housing lacked targeting. The author explained this gap by the fact that newly constructed social housing was too expensive in comparison with existing rent-regulated housing.

An important part of the discussion of elderly housing has been the costs of institutional and supported housing for the elderly and comparisons of these. Such a comparison was done by Červenková and Bruthansová (2004). The authors focused on the costs of institutional care in comparison with the costs of services provided in supported and protected housing (i.e. special housing for people with limited capabilities who want to live independently). The analysis showed that the costs of protected housing are considerably lower than the costs of institutional care. Nevertheless, the benefits of this type of housing are not just material. The higher level of independence and the responsibility of service recipients have a positive impact on the social inclusion and the health of the clients of these services. Thus, the authors recommended supporting this type of services and developing a wide range of housing types with respect to the different needs of individual clients.

Finally, there have also been initiatives that deal with the issue of elderly housing on the local level. For example, an approach proposing a specific form of elderly social housing was adopted in the Municipality of Řepy (Svoboda 2008). This concept targets those who find themselves in need, yet are still able to pay their rent. In other words, they are subject to potential housing unaffordability. According to the authors, this situation is quite common due to the rising costs of utilities and health care, which are not sufficiently covered by the increase in pensions. A strategic programme for active ageing was also adopted in the Municipality of Brno (Brno City Municipality 2011). The programme makes the

promotion of active ageing of elderly citizens a priority, which also includes the issue of housing. The document concentrates on the following areas: social and health care, housing, employment, life-long learning, leisure activities, public transport, and social participation.

However, there has also been some criticism of independent living for the elderly. For example, Vostrovská (1999) noted the risks attached to independent housing for seniors, mainly in smaller municipalities with generally lower housing standards. On the other hand, she exhorted public authorities to respect seniors' preferences and their preference to live in their own houses. However, this independent living should be supported by various supporting 'care' schemes. For example, the author recommended social counselling as a means of helping older people with making necessary renovations to their flats or houses, or with moving to a, usually smaller but more appropriate, home. The author did not consider households shared by seniors and their children to be a sustainable solution. Even in this kind of household, professional care service may be required when the senior's state of health requires full-day care.

Germany

The overview of the German situation starts with a recent policy paper concerned with the current demographic situation. We then proceed to look at the living conditions of the elderly.

The General Demographic Situation and Policy Concerns

In 2008 there were around 16 million people aged 65 and over in Germany, which amounts to 20% of the total population. Of this number, 4 million were aged 80 and over. Until 2020 this number is expected to increase to about 20 million people aged 65 and over, and of them 6 million will be aged 80 and over. Facing with this demographic trend, 'senior-friendly living' has become an important issue. Against this backdrop the German Association for Housing, Urban and Spatial Development has launched an expert commission to deal with this issue. It has reassessed the demand for age-adapted living space. The report by the Commission summarises the situation facing Germany in this respect (CGAHUS, 2009).

Seen in an international comparison, there is a distinct renting culture in Germany. The majority of citizens are tenants. Of the country's 40 million apartments, 10 million are owned by professional societies, 15 million are in the hands of private landlords such as small scale landlords leasing 4–6 apartments. About another 15 million belong to private homeowners. The share of people living in owner-occupied houses and condominiums are 4%. For elderly people this share is nearly 50%. This is a strong contrast with the UK, where 70–80% are private owners.

Faced with demographic transformations, the guarantee of a self-determined and personally satisfying age-adapted life has become an important social and economic objective. People want to age at home. They do not want to leave their homes, as they are mostly anchored in their neighbourhood community and its social environment. There are 11 million elderly households (at least 1 person is aged 65 or over) but not all of them need changes. The KDA survey (Curatorship of German Elderly Support) has shown that out of these figures about 2.5 million households contain persons with mobility handicaps that are in need of a support.

The report argues that senior housing should be fiscally supported as accommodations in nursing homes are always more costly. Thus financially feasible adequate housing design has become an important issue. Elderly friendly housing should not only be a question of being barrier-free or of ensuring

easy access to apartments and necessary equipment inside flats. An appropriate and barrier-free residential environment is also crucial. Health care, shopping facilities, local mass transport and social infrastructures located nearby can help to enable people to remain living in their apartment.

The Living Conditions of the Elderly

Several German studies have dealt in recent years with the issue of the living conditions of the elderly and their attitudes to housing and related issues. The living situation of the elderly and their expectations and perspectives were analysed in a study conducted in 2006 (LBS... 2006), according to which elderly people's willingness to change their own living situation is very high: about two-thirds of this group are willing either to adapt their flat (10.6 million people) or to move house (9.4 million people). About 9 million people 50+ are currently planning to adapt their flat. Each year 900,000 people carry out adaptation work on their housing (alterations amounting to 10,000 Euro or more) and 800,000 people move. Generally, elderly households have monetary assets above the average of all other age groups. The same is true for the capital invested in the housing stock. Additionally, many elderly households await inheritance. Thus, financing for the adaptation of the housing stock or for investment into adapted flats is available for elderly households and will still increase in the future.

The group of elderly house-movers and their special demands are very important for the housing market. People aged 50 to 70 are looking for flats without any assistance – especially in smaller apartment complexes with a lift. People aged 70 to 80 are just looking for offers which are combined with assistance services. The elderly often want a 24-hour presence of staff or flats that, if necessary, can also be used for comprehensive care. 'Normal' flats that accommodate a familiar lifestyle are sought. People over the age of 80 move when they are in need of care. They look mainly for institutional facilities and full-care services. In the future, the oldest groups will probably become more important.

In concurrence with this study is the finding (Preiß and Stolarz 2003) that the elderly prefer independent living and wish to live in an intimate and familiar setting. At the same time, the authors noted the rising willingness of the elderly to explore new forms of living for the elderly. The socio-economic panel underlined that 20% of house-owners and 50% of tenants over the age of 55 could envision change the setting they live in (the German Schader Stiftung even gives a figure of 65%).

A related important issue in the past few years has been the issue of the willingness of housing providers to adapt their housing stock to the specific needs of elderly people (Narten and Scherzer 2007). Narten and Scherze (2007) argued that providers with high vacancy rates and a large number of elderly tenants are more motivated to implement specific measures for this target group than others. The results of their study revealed that existing or assumed vacancies are the strongest motivation to do something in this area, whereas just having a large share of elderly tenants is not sufficient. The focus of the measures implemented by housing providers is thus the adaptation of the housing stock and its surroundings.

Finally, a German government report (CGAHUS, 2009) focused on the creation of barrier-free neighbourhoods, barrier-free meaning the absence of any forms of social or economic exclusion. Although this report was not particularly focused on the situation of the elderly, it is highly relevant, since the elderly constitute an important target group of such policies.

To summarise, the report dealt with:

- Independently managed trips (e.g. shopping) and accessible buildings
- Access to and an understanding of information
- Independent use of public transportation
- The possibility for independent care
- The possibility to meet others and for communication, recreation
- Security issues

The report used a broad definition of accessibility and included a materialistic perspective, meaning the constructional and technical aspects as well as 'soft' aspects such as psychological dimensions (e.g. safety).

Finally, recently the Commission of the German Association for Housing Urban and Spatial Development prepared a policy focusing on the key issues of future development (CGAHUS 2009). The report summarises the current situation of the elderly and sets priorities for the future. The key issues for the future should be:

- (1) Harmonising the building regulations of the German Lander (Bauordnungen) for new houses. By applying minimum requirements for age-appropriate standards in new buildings, the costs will be much lower than later renovation of existing housing stock.
- (2) Promoting the supply of housing designs with assisted services (e.g. food delivery such as 'meals on wheels', housekeeping or the placement of care facilities).
- (3) Certification for assisted living ('betreutes Wohnen').
- (4) The creation of funding for 'age-appropriate rebuilding' ('Altersgerecht Umbauen') in the framework of the programme 'modernise living space' of the federal development bank KfW.
- (5) In Germany there is a system to provide funding for social housing – provided by the Länder. This funding should also be used to provide grants for the elderly, low-income tenants and owners to remove barriers.
- (6) Nursing care insurance currently provides a grant of up to 2.557 Euro to make age-appropriate renovations to a dwelling. This amount should be increased in order to support structural measures and technical facilities for care-recipients.
- (7) Use urban renewal funding ('Städtebauförderung') to integrate and expand age-appropriate reconstructions of urban districts.

Hungary

In Hungary the issue of ageing has primarily been raised as a demographic problem or in relation to the questions of health insurance, old-age pensions, and social services. In the social scientific literature we can find hardly any studies or analysis that approach ageing as a complex and multidisciplinary issue. In the overview below, we discuss the relevant literature in terms of the housing conditions of the elderly and the services provided to them.

General Demographic and Economic Development

In the last 25 years population change in Hungary has been characterised by a numerical decrease and ageing. As a result of these tendencies Hungary has one of the least favourable demographic situations in Europe. In the last quarter of a century an increase in the size of the population aged 65 and over has been registered. This trend will probably accelerate in the future when the large cohorts born between 1945 and 1955 reach old age (HCSO 2007). In Hungary 13% of the population was over the age of 65 in 1990 and this share rose to 16% in 2009. According to a prognosis, by 2050 the share will be as much as 29% and by 2060 32%. This is similar to the prediction for the European Union (Monostori et al. 2010). Similar findings were also presented in a World Bank report (see Chawla, Betcherman and Banjeri 2007).

The transition from a communist regime to a market economy also gave rise to a specific form of social ageing (Daróczy and Spéder 2000). The labour market is a key site for the effective functioning of a market economy, but the number of employed in Hungary has dropped drastically. This has taken a toll primarily on the older working population, who permanently left the labour market through arrangements such as early retirement, disability benefits and the like. With this change they became 'socially old' since the value of their skills depreciated and their careers ended. On the other hand,

the regime change had an important impact: the relative well-being of pensioners increased within society as pension schemes became universal. During the 1990s there were fewer poor among the elderly than among families with many children. This was due to the fact that during the transition the value of pensions was maintained more than the value of other incomes, and elderly households were not threatened by unemployment, while as a group pensioners became younger on average. At the same time we must bear in mind that there are segments such as elderly women living alone whose material conditions make them a vulnerable group (Daróczy and Spéder 2000).

As regards future threats, Augusztinovics (2005) argued that the main challenge for the Hungarian system is the rate of employment, i.e. economic activity. If the current level of employment remains stable or drops further it will not be possible to secure livelihoods in old age based on insurance-type pension schemes. Therefore, old-age incomes as a whole need to be reconsidered and must become embedded in the system of redistribution. This is a time-consuming process, both on the professional and the political level, so it must be started as soon as possible.

Hungary's strategy on ageing (intended as a response to ageing) was outlined in the Strategy of the Government of Hungary for a National Policy on Old Age (2009). The principles of the Strategy and one of the goals of developing old-age policies is to ensure that the elderly have access to a wide range of services that contribute to their well-being and that are based on individual needs. These services should consider that elderly people have different social and cultural needs. The elderly need to have access to those services that correspond most to their own needs (the principle of 'no more and no less than what is needed'). Elderly people must be provided with the knowledge to maintain their self-sufficiency and quality of life. This may also be promoted through training. The document specifies tasks such as creating opportunities for life-long learning, improving volunteer networks and creating opportunities for self-help and self-sufficiency.

The Living Conditions of the Elderly

As regards the situation of the elderly in Hungary, the following numbers provide the broad picture. The overwhelming majority of elderly live independently, there are 41,254 people aged 65 and over living in seniors' homes. Importantly, 3% of the 65+ population receive home support, 4% receive food as social assistance, and 2% attend day-time seniors' institutions. Less than 1% use home support integrated with an emergency network and 0.6% receive basic services in seniors' homes (Academy of the Elderly 2010).

The share of households that contain only elderly is growing continuously and this reflects the demographic changes that have taken place in recent decades. The relative significance of households accommodating two or more generations is declining, and the share of those with three generations has fallen from 11% to 5% since 1970. Besides population ageing, this tendency is due to the fragmentation of households. Youngsters have easier access to independent housing and the generations live apart. The elderly constitute 40% of all households, that is 1,616,000. 28% of households have one elderly person while 12% have two or more. About 37,000 of the 2,156,000 people over the age of 60 receive some form of service from a seniors' institution. This is 2% of the elderly and it means that from the perspective of service provision there is a growing need to focus on the problems of elderly people living alone.

Housing conditions vary according to type of settlement. The main difference is that the share of elderly living in a house inhabited by four or more people is larger in smaller municipalities, especially when compared with the situation in Budapest, the capital city of Hungary. Another significant difference is that while 69% of elderly inhabitants in Budapest live in households inhabited by elderly only, the corresponding figure is 61% in smaller municipalities. Thus, the elderly in small towns and villages are in a better position as far as living with younger people is concerned. At the same time, elderly people who live alone in such places are disadvantaged due to the lack of infrastructure.

As regards development in the quality of housing, dwellings have on average become more spacious and better equipped. For example, despite the fact that the number of dwellings only inhabited by elderly has increased, the share of one-room flats has fallen from 68% to 14% since 1970. This trend applies to all types of settlements. There is a similar positive change as far as comfort level is concerned. However, on average dwellings inhabited by the elderly are less well equipped than those of younger generations.

Today in Hungary approximately 65,000 people live in parish homes (Bácskay 2003). These homes are often associated with an image of old, sick and abandoned people and primarily call to mind old-age homes. This number is 2.5 times higher than in 1970 when the number of residents amounted to 26,000. The increase in the number of beneficiaries has become a permanent feature both in terms of the trend and its speed (3–4% yearly). The number of beneficiaries is determined by the seats available that in turn is a function of economic factors and not of demand alone. Approximately 15,000 applicants apply for a place in such homes, but the institutions can only accept a small proportion of these requests due to a shortage of space. In the past ten years there has been a 30% decrease in the number of eligible applicants whose applications are accommodated. Consequently, the length of the waiting lists doubled and the number of those applicants who had been waiting for more than a year increased 5.5 times.

As regards the provision of social services and elderly care in particular, according to Mester et al. (2009), it underwent a variety of changes in the years between 2002 and 2007. There is no single, general, all-encompassing trend. However, two trends can be identified. First, the number of clients (the elderly) increased. This increase was not followed by a corresponding rise in the number of employees in the respective institutions.

Poland

The review of Polish literature on housing for the elderly, the disabled and other vulnerable social groups shows two major facts. First of all, as Lipski (2009) has shown, the sociology of housing is one of the most neglected research subjects in Poland. Secondly, Polish literature does not offer many solutions or attempts to create solutions for social housing. Nykiel (2010) demonstrated that there is almost no social housing or any other major forms of housing support for economically weaker population groups; many social dwellings were privatised and do not meet the criteria for social housing any more. The overview will start with a description of the housing and living conditions of the elderly in Poland and will continue with a brief description of the use of care services and ICT.

The Housing and Living Conditions of the Elderly

A summary of the needs of the disabled and the elderly concerning housing quality has been attempted by Nowakowski and Charytonowicz (2001). They describe the quality needs of housing for the elderly and the disabled. With respect to the elderly, they argued that their independence is a key issue for their life satisfaction. This is further related to the appropriate functional and spacious design of the house to enable the elderly leading active lives. The authors of the study suggested that the deterioration of physical fitness necessitates the installation of additional technical systems to facilitate the management of home devices and interaction with the environment.

In Poland, there are two major forms of housing related to long-term care for the elderly and disabled (or vulnerable because of their health state): nursing homes and rest houses.

In Poland (Mielczarek 2006) nursing homes are available for an elderly person when neither the family nor the municipality can provide support for this person in their original place of residence. A nursing home is supposed to provide living, care and support services to its residents. By contrast, rest houses aim to empower their residents, act as an intermediary in the provision of health services,

ensure security, and at the same time respect human rights, privacy, dignity and the right to choice. Mielczarek (2006) suggests that Polish rest houses should function according to a standard based on Western European models, such as in Denmark. Such a standard would define the operation of a rest house in three major areas: living conditions, requirements concerning personnel, and operating rules.

The author points out that in Poland the worst family is viewed as better than the best rest house. However, from the practitioner's point-of-view the author argues that a rest house operating in an appropriate manner could serve as a substitute for a home, while preventing loneliness among the elderly and securing them adequate care. He claims that adequate selection of the primary contact employee (a rest house resident has a right to select such a person among the house employees) and efficient operation of the therapeutic and care team make it possible to accommodate the individual needs of each resident and thus create an environment in which it is easier for a resident to adapt and feel safe and happy. Mielczarek also discussed the importance of the activity for the life quality of the elderly (resident of rest houses) and importance of other factors such as full support including religious, psychological and social support, ensuring independence, respect and others.

In the article by Kmiecik and Tytyk, 'Ergonomy for Disabled' (2001), the authors discussed in more detail the quality of rest housing in Poland. They drew attention to the issue of social exclusion linked to rest houses. They claimed that there is a tendency to locate rest houses in the forests, on the outskirts, away from the urban bustle. Residents actually have ensured peace there, but at the same time they feel too isolated from society, thrown out, forgotten and socially excluded (Kmiecik and Tytyk 2001). The authors also discussed a number of inconveniences found in buildings, its facilities and equipment. A lack of solutions adapted to the needs of the elderly and disabled has been identified. The main reason for that has been the lack of financial resources. However, the authors suggest making at least minor adaptations and introducing ergonomic corrections to equipment.

As far as the quality of life of the rest house residents is concerned, there is an interesting study by Grzegorzczak et al. (2007). The authors performed a survey comparing the quality of life of the elderly living in rest houses and active seniors living in their home environment. The active seniors were very often third-age university students and were generally more socially active. The study results showed that active seniors lead higher quality lives than rest home residents.

The situation of the elderly awaiting a place in a rest house has been analysed by Szweda-Lewandowska (2009). The author pointed out that persons who apply for a place in a rest house often expect to be dependent in the future and problems with immediate admission to a rest house when the need arises. The study was performed in the city of Łódź (the second-biggest city in Poland), where inhabitants over the age of 60 make up 22% of the total population.

Care Services for the Elderly and the Disabled

A complex survey called PolSenior was conducted in 2008–2011 by a consortium of six research and academic institutions which focused inter alia on the state of health of Polish seniors (Mossakowska et al. 2012). The main recommendations resulting from the project included securing equal access for the elderly to the labour market, the introduction of good practices of age management, preventive actions in terms of health, the improvement of housing conditions of the elderly, promoting physical activity among the elderly, combating elder abuse, and the prevention of social, digital and financial exclusion through integration activities, support for families of the elderly, facilitating intergenerational contacts and widely comprehensible education.

An analysis of the health-care system in Poland was performed in 2011 in a study by Paneli and Sagan (2011). The report concluded that limited financing seems to be the biggest barrier in achieving accessible and good quality of health-care services. A report summarising the results of a study on the reactions of relevant institutions to the needs of the elderly was performed in 2010 (IRSS 2010). The aim of this study was to evaluate the services and activities targeting the elderly. The study analysed

the situation of people aged 60 and over. The respondents were directors of social support centres in 2,469 municipalities in the whole of Poland. The directors (or social workers delegated to perform the task) were asked to provide information on social services given to the elderly in their respective municipalities and define needs concerning such services according to their knowledge.

According to the respondents, the most commonly provided care services for the elderly at the municipal level are:

- support for apartment repairs;
- blood sugar testing, shopping, cleaning, cooking and laundry;
- institutions renting equipment to facilitate care for the chronically ill at home and care and curative centres;
- rest houses for the elderly and rest houses with places for the elderly;
- advice and support for the elderly with alcohol or drug addiction, interventions and crisis support for the elderly and their families;
- legal advice for seniors and removing physical barriers in the home in order to increase safety;
- tourism options for the elderly and artistic classes;
- third-age universities and education on new ICT;
- intergenerational integration through cultural programmes and intergenerational integration through sporting and tourism initiatives;
- training for social workers on the problem of old age and geriatric training for people caring for the elderly.

The study presented several interesting conclusions. First, public institutions seem to constitute the majority of the providers of services in the area of living conditions. The demand for some health-care services for the elderly, such as vaccination against influenza, osteoporosis testing, and other less popular medical tests, and the rental of rehabilitation equipment is twice as big as the amount of services actually provided. The demand for daily care centres for the elderly and support centres for the elderly is 52% and 55%, respectively. There seems to be a great lack of these services. Finally, NGOs are rarely used to provide psychological support or safety services for the elderly, while on the other hand they are the organisations most often responsible for recreational activities of the elderly and are also very active in providing educational opportunities for the elderly and using the potential of this social group.

The assessment of social assistance for people at risk of social exclusion was recently analysed by a project entitled 'Twoja Szansa Plus – Study of the Effectiveness of Social Support for High Risk Groups' financed by the European Social Fund (ASM2007a, ASM2007b, ASM2007c). The report highlighted many important aspects of the issue of ageing and presented important findings. For example:

- Almost 60% of respondents had difficulties in assessing whether the received support satisfied their expectations (30% of respondents were satisfied with the received support);
- Almost all seniors (65+) used non-cash support (95%); 28% used cash support and 15% used care services;
- 57% of seniors declared that it is better to provide less cash support to more people than more support to fewer people;
- The elderly indicated shelters and Catholic church organisations as institutions where they received support;
- More than half of seniors had problems with satisfying their nutritional needs (65%) and to pay for rent, energy and water (58%);
- Only 13% of seniors were offered 'social contracts' (a contract between the social welfare institution and the supported individual)
- Meals and shelters were the non-cash support most often received by seniors (74%).

Another subject quite widely discussed by Polish experts is the social integration of vulnerable persons. While this usually refers to the disabled, the defined frameworks seem to remain valid for the elderly too. Gorczycka (2003) calls architectural barriers as the major reason for the isolation of disabled. She finds the eradication of such barriers as the first and most important condition of the existence and functioning of disabled persons. However, she names this as the second most important challenge concerning the social integration of the disabled. According to her, the first challenge for the future which relates to the social integration of the disabled is activation and motivation of the disabled persons themselves. The third challenge concerns psychological barriers that are shaping the right attitude towards the disabled through education. Finally, according to the author, adequate legislation is also an important factor in ensuring the social integration of the disabled.

The Use of Modern Technologies for the Support of the Elderly and the Disabled

As regards the use of modern technologies for supporting the elderly and the disabled, little has been done so far in Poland. Recently, however, new technologies aimed at improving the situation of the elderly, such as ambient assisted living, have been promoted. Ambient assisted living refers to what Nowakowski (2003) defines as a smart house. The aim of a smart house is to ensure the psychological and physical comfort of the target group and to save costs. A smart house is constructed in a way that allows several integrated systems to work together in order to effectively manage the house resources with minimal human participation and relatively low costs. One of the major features of a smart house is its adaptability to new technical solutions without having to undergo costly re-construction. According to the author, some other important features of a smart house are as follows:

- energy management (heating, controlled ventilation, natural and artificial lighting, protection from excessive sunlight);
- security and access control systems (minimising risks of accidents and unforeseen incidents, protection against intruders);
- fire protection, protection against gas poisoning etc.

The author mentions that this kind of system facilitates daily activities, such as online shopping based on automatic barcode readings, or kitchen appliances such as ovens that work with automatic recipes. The author also lists several scenarios in which a smart house system allows the programming and automation of activities supporting the specific needs of the disabled (such as persons with low vision or hearing etc.). Nowakowski concludes that while a smart house or apartment is a good tool to create an optimal living environment for the disabled and the elderly, it is difficult for these persons to implement this tool on their own. This is due to the costs that necessary adaptations to existing apartments involve. Therefore, the author suggests planning a system of public support to introduce such solutions in the houses of the selected population groups, such as disabled persons who wish to live independently.

Slovakia

Despite the growing importance of the topic, there are only a small number of publications in Slovakia exclusively dedicated to innovative practices in housing and social care for the elderly. Slovak publications usually focus on housing or social housing in general without paying specific attention to the elderly; or they focus on the current system of social services disregarding the housing issue. The overview is divided into three parts: (1) care for the elderly, (2) living conditions of the elderly and (3) social housing.

Social Services and Care for the Elderly

The current state of long-term care for the elderly in Slovakia has been covered extensively by Repková (2010a). She focuses on a wide range of issues, including long-term care, prevention, organisation, management, and financial issues, and reports that the quality of social services provided in Slovakia is inadequate because there is no system of community planning, support for enabling a client to remain in their natural environment is inadequate, and there is a lack of coordination between providers of social and health care.

Long-term care in Slovakia is curative in form. This means that care is provided after a problem has occurred and systematic primary prevention is absent. There are two basic types of long-term care: (1) medical care financed through health insurance and (2) several types of social services (see below). Field, ambulant and residential services are financed from public sources or they are provided by non-public organisations. Social services are supported by grants from the state budget or charity favouring local administration or civic sector. The state budget also finances with cash contributions those services that support a dependent person's stay in their own homes.

Currently, there are three important types of financial care assistance: (1) a cash contribution for home care service, (2) a cash contribution for personal assistance, and (3) a cash contribution for the purchase, user training and modification of a tool:

- (1) Cash contribution for home care service (MPSVR SR, 2011a): The purpose of home care service is to provide help to a disabled person with self-service, looking after the apartment and participating in social activities, enabling the person to remain in his/her natural home environment. A cash contribution can be provided under certain conditions to a person who is nursing the disabled person dependent on home care service.
- (2) Cash contribution for personal assistance (MPSVR SR, 2011b): Personal assistance is performed by a personal assistant and its purpose is activation and support for a disabled person's social integration, independence, decision options and fulfilment of family roles, performance of work activities, educational activities and leisure activities. The degree of personal assistance is determined by a set list of activities that the person with the disability is unable to perform on his/her own and by the number of hours required to execute these activities.
- (3) Cash contribution for the purchase, user training and modification of a tool (MPSVR SR, 2011c): A person with a disability who is dependent on the use of a tool can receive a cash contribution to purchase a tool, undertake training in using the tool or to modify the tool. A 'tool' is an item or a technological device or its part which enables the person with the disability to perform activities that he/she could not perform without it, or without which the performance of such activities would require excessive physical stress or take a disproportionately long time.

Despite the growing popularity of informal care, there are some complications that prevent its full application. Among them is the inadequate flexibility of relief services for informal carers; long-term care can have a negative impact on the carer's health and cause tensions between carer and dependent person; and the wages of carers are also inadequate and amount to one-quarter of the average wage, which is far below the minimum wage.

The Living Conditions of the Elderly

Concerning the current social and economic situation of the elderly, there are a number of studies that deal with the issue. For example, the Forum for Help for the Elderly (2008) organised an empirical study focusing on this issue. The aim of this research was to identify the current state of elderly social exclusion, as well as their income and expenditures on basic life necessities.

According to the research, 84% of the elderly feel threatened by poverty. Low pensions, high living costs and rising prices were mentioned as the main factors related to poverty. The research showed

that other 'no-monetary' issues, such as poor health or low quality health care, were also important for the perception of poverty. 65% of the elderly claimed that their monthly income was not sufficient to cover all the expenditures. Only rarely could the elderly afford cultural or other leisure activities. This constrains the participation of the elderly in social life opportunities.

A general evaluation was also provided by another study made by the Forum for Help for the Elderly (2010). This time, the research focused more on the elderly's perception of social care services and related issues. The research revealed the negative view taken of social services due to the lack of financial resources of municipalities and by the lack of social service assistants. In addition, in smaller municipalities these services are absent. Most of the elderly used home care service as a support for their independent life: in 57% of the cases this service amounted to up to two hours a day. About 40% of seniors applied for home care services because their families could not take care of them. Most of the seniors consider payments for home care service as too high – most of these payments, however, did not exceed 50 Euro per month.

A number of studies have devoted themselves to support for informal care. A report by Repková (2010b) summarises the key findings of the longer research work, which was done over three years under the 'Informal Carers in the Long-term Care Sector' project. The report contained four relatively independent studies: informal carers as part of the long-term care sector; the financing of long-term care; social and employment protection of informal carers; pro-employment behaviour of informal carers.

The study found that in Slovakia most care provided to dependent persons takes place in the family. In up to 98% of cases, the closest relatives take care of such a dependent person. It is more common in Slovakia than in the rest of Europe to view this type of care as highly individual. The perception is that in such cases responsibility lies on the dependent person, his relatives and private insurance. The study revealed low expectations of help from the state. In spite of the positive relation of the majority, only a small part of the society is actively saving finances for long-term care.

The social and economic situation of the elderly linked to the issue of housing was a topic of a similar study (Bednárík 2004). The research revealed the worsening position of the elderly, especially in connection with deteriorating health and insufficient finances. Housing issues rarely bother the elderly. Seniors also show minimal interest for improving their financial situation by employing themselves, which is caused by a negative perception of their own health conditions. The certainty of comfort and privacy in housing is as important as financial independency for the elderly. The research showed that the conditions in which the elderly live are similar to the housing of the rest of the population, with slightly higher share of those living in family houses. More than 80% of the elderly live in their own house or flat and 70% are satisfied with their current housing conditions. Only a small share of the elderly were not happy with their housing-related expenditure (28%), less than 15% mentioned lack of privacy or comfort, and 1% were not satisfied with the quality of housing in general. These are the reasons why 80% of the elderly were not considering changing their housing. In spite of the worsening financial situation, the number of seniors who are paying for social care has been increasing. Still most of them rely on help provided by other family members. The research has also shown an increased interest in a non-residential type of social care – especially seniors' clubs and food-related services.

Social Housing

Suchalová and Staroňová (2010) in the recent book tried to address the issue of social housing. Towns and municipalities in Slovakia are the main actors for the execution of independent housing policies. In general, the bigger the city is, the more attention that is paid to social housing. All Slovak cities with more than 50,000 inhabitants have offices dealing with social housing. The research also indicates that 25% of all cities do not define target groups for social housing. In the rest, 28% of cities define these

target groups in their official documents; 33% of local administrations define criteria for social housing candidates *ex post* based on applications received, and 35% define these criteria in their official documents. On the whole, 60% of local administrations perceive seniors as their target group.

Slovak cities almost exclusively use supply-side subsidies for social housing, which can be financially ineffective if the system is not set up adequately. By contrast, demand-side support is only rarely used in Slovakia.

The issue of social housing was also addressed in a recent paper by Fico (2011). The paper presented selected areas of social housing in Slovakia and abroad. The author concludes that the current attempt for effectiveness of spent funds in relation to rising debts leads to a transition from supply-side support to demand-side subsidies in housing policies. However, the lack of rental housing may have a negative impact on future housing supply. A lack of rental housing and of any attention to new approaches to the development of rental housing are also mentioned by Špirková, Ivanička and Finka (2009) and in an official document by the Ministry of Construction and Regional Development (2007).

Slovenia

Recent demographic trends show that steady growth in the population of older people in Slovenia (Černič et al. 2009) has brought to the fore the issues of care for the elderly, including housing issues. A review of the major research projects that have been conducted in the recent period is presented below. First, we focus on the issue of housing and living conditions of the elderly. Second, we turn to the issue of care and care innovations for the elderly in Slovenia.

Housing and Living Conditions

Recently, Mandič and Filipovič-Hrast (2011) investigated housing conditions in Slovenia. In terms of space and amenities, the conditions are regarded as mostly satisfactory and close to the European average. However, the lack of outside space and services in the neighbourhood are among the highest in the EU. In addition, the home-ownership rate among the elderly is one of the highest in the EU, whereas other forms of housing in between being in one's own home and being in an institution are relatively scarce. Secondly, it was also analysed how the elderly subjectively perceive their housing by using qualitative data from the DEMHOW project. It was found that the elderly recognise the importance of their housing assets, which represents a means of their ultimate security. Being aware of possible ways to start using their housing assets (by downsizing or renting out), older people in Slovenia only expressed a willingness to actually do so in the case of an emergency. However, Slovenian elderly revealed a specifically high level of readiness to use their housing asset to finance their costs of staying in a home for the elderly.

The situation with respect to tenure is rather extreme in Slovenia (Cibic et al. 2006). As regards the housing situation of the elderly, owner-occupied status (84%) predominated among the elderly, only one-tenth of the respondents live in rental dwellings. The authors also reported difficulties with the financial affordability of housing. Nearly one-third of the elderly have major difficulties paying their rent. On the other hand, the elderly who live in their own dwellings devote a significant share of their income to maintenance costs. It was also pointed out by the elderly that their children are often unwilling to share maintenance costs and prefer to wait until ownership is transferred after their parents depart. As reported, children often seem to object to their parents selling and/or changing dwellings for smaller units and are at the same time unwilling or unable to contribute financially to the maintenance costs of their parents' housing.

As regards the elderly's attitudes to housing and ageing in place, there seems to be a relatively high level of satisfaction with almost all housing quality indicators (Sendi et al. 2003). A similarly high level of satisfaction was established with respect to necessary services and amenities. What seems to

be the key issue in the housing situation of the elderly is the financial affordability of housing, housing overconsumption and little willingness to move – and to downsize. A very detailed description of this issue has been given by Stropnik et al. (2010). A related housing study revealed that the dwellings occupied by the elderly in the study are usually larger than those of younger people as the elderly are reluctant to move to smaller dwellings after their children leave home. It also showed that even those elderly considered by criteria to be relatively poor often live in rather spacious homes, even though at the same time they experience high deprivation as a result of their high housing expenses. An interesting observation from the project is also the reluctance to undertake home improvements or adaptations. These are mainly seen as a potential burden and something unnecessary for the period of life they have left. However, this reluctance is not always conditioned by a lack of financial resources; it is often caused by their social exclusion, as they do not see who could support or help them with organising the implementation of improvements.

The (rather false) conviction of the majority of respondents was that their housing unit was suitable for the needs of older persons may be attributed to a lack of knowledge or unawareness about the design, structural and spatial conditions that need to be fulfilled in order for a dwelling to be appropriate for the use and living of an older person. The majority of the elderly thus do not seem to be well informed about the various possible housing options. While the results of the survey generally revealed a relatively high degree of satisfaction of the elderly with their present housing and living conditions, the authors nonetheless argue that the situation is not as perfect as the research results appear to indicate.

Care for the Elderly and Innovations

With respect to innovations in the elderly's housing, several innovations have been proposed and the intensity of their current use in Slovenia has been analysed. Home help and home care have been analysed by Nagode (2009), who discusses the role of assistance for the elderly who live at home. Home help and remote-assistance enable the elderly to live at home longer and delay the need for the institutional care. The author analysed two types of assistance – home help and remote-assistance. Home help is the most widely used organised service for the elderly. It is regulated on the national level and implemented at the local level. Municipalities are responsible for organising this service in their environment. Data show that there are great differences throughout Slovenia in supply and access to home help for the elderly among municipalities. Also, there are substantial differences in costs for home help services, which is highly inconvenient for the users. Remote-assistance is a less developed service. It was introduced in Ljubljana in 1992 but it was never really disseminated, so in 2009 there were only five remote-assistance centres. Although this service has been mentioned in some political documents, it has never been adequately planned and implemented. The author suggests that both types of assistance should be further developed so that they can fulfil their primary objective – to help older persons to live longer in their home.

Another type of innovation in the area of elderly housing are smart homes and telecare (Kerbler 2011). Kerbler focused on the issue of future development and possibilities and assumed that the issue can be addressed by rearranging living environments into so-called smart homes. Since technologies and technology-based services are evolving rapidly, smart homes will become a part of the everyday life of the elderly in the future. The question that arises is how to implement the concept of smart homes. Based on an analysis of previous studies, it was found that the implementation of smart homes would be more easily and quickly achievable if the concept is based on the preferences, needs and desires of the potential users of smart homes.

The use of telecommunication technology is one possible solution for extending autonomous living at home (a 'life-line' telephone system or 'red-button' telephone) and was evaluated by Hlebec et al. (2003). Two surveys were carried out in 1995 and 2001, and they showed that potential users of

this option became older, weaker and increasingly dependent on others. The use of the red button telephone offers them safety, freedom from 24-hour care, security and information support. The option for the use of telecommunication technologies also relieves daughters of the elderly, who are the most important source of support for the elderly (parents). A red-button telephone system increases older persons' autonomy in their everyday environment and delays institutionalisation. The authors called for local and national authorities to become more involved in financing this option since the possibility of the use of telecommunication technologies for the elderly is regarded as important and essential.

One of the most recent innovations is the proposal for reversed mortgages, particularly in the City of Ljubljana (Cirman 2003). The purpose of the study is to propose a suitable instrument for the conversion of assets invested in real estate, which could be used as an instrument of housing policy in Ljubljana, which, like the nation as a whole, has an exceptionally large share of private housing. The share has been high throughout recent history; the privatisation of housing in the early 1990s made it among the highest in Europe. Offered a purchasing price significantly below the market price, previous tenants who became owners were often unaware of the economic consequences of ownership. The severe economic downturn, together with the growing share of elderly in the population, made many owners unable to meet the high and rising costs of maintenance and much less the major repairs required by their property. An instrument for the conversion of assets invested in housing would ease the financial burden on owners and provide them with a better quality of life. The instrument proposed within this study focused on elderly homeowners (65+). The conversion of the value of their property would offer them a better quality of life, as they would receive a monthly rent and could remain in their current homes, move into sheltered housing, or move to a home for the elderly, with enough resources to pay for the services. The study first presents the economic and legal framework needed for this instrument, continues with a risk analysis, describes in detail how this instrument could be implemented through the Public Housing Fund of the City of Ljubljana, and gives a financial estimate for the implementation of such an instrument. The last part presents a sample of possible contract and related documents for the implementation of the project as a whole.

Conclusions

The country-specific literature review of recent developments in Central European countries follows and supplements the general review presented in the previous section of this report. The purpose of the country-specific literature review was to provide additional information on the situation in post-socialist states largely missing in English-language studies. In summarising the main findings, we therefore first described the differences between the two groups of countries – post-socialist and developed countries – and second focused on the situation in post-socialist countries in more detail.

In the general literature review (previous section of this report), which was mostly based on an analysis of the situation in developed countries, we identified several trends that seem to have taken place over the past two decades. First, there has been a turn towards domiciliary (home) care in most countries, including the traditionally 'familistic' Southern European countries such as Italy. The concrete form of home care in these countries differs; in some places it is professionalised and standardised, in other countries there are cash-for-care regimes.

Nonetheless, a similar trend was identified in post-socialist countries where home care seems to be becoming more and more common (the Social Welfare Act in Hungary introduced the obligatory provision of home care in municipalities already back in 1993). There are some weaknesses in the home care provided in these countries: it is often viewed as too expensive, the supply is unsatisfactory, and the scope of services differs from municipality to municipality. Nevertheless, there is a clear trend of expansion of home care in these countries.

Another common feature seems to be the introduction of ICT technologies. In the old EU member states ICT is much more widely used. However, there is evidence that in most post-socialist countries (in the country-specific literature review, see the cases of former East Germany, Poland and Slovenia) ICT is viewed as an important part of the solution to problems in the area of elderly living and housing conditions. A distinct feature is the fact that as yet there have been no studies evaluating the costs and benefits of these solutions. This is an important weakness.

Another trend identified in the general literature review was the decentralisation of the organisation of care for the elderly: responsibility for the provision of care for the elderly is increasingly shifting to the municipal/local NGO level. To some extent this also seems to be happening in the post-socialist countries (in Hungary this responsibility was transferred to the municipalities in 1993 with the option of outsourcing these services). However, in this group of countries the trend seems somewhat chaotic and it is clear that it is still in its infancy: services provided to the elderly seem to differ largely with respect to the quality of care provided and the range of services among municipalities.

In developed countries there has been a trend towards the diversification of housing solutions and social and health-care policies. In these countries, there is a great variety of solutions offered to the elderly. Under the rubric of 'ageing in place', many different solutions have been proposed and introduced. This includes life-time homes, home adaptations, co-housing, extra-care housing, intermediate care housing, retirement villages, the introduction of ICT etc. However, post-socialist countries have not witnessed a similar move towards such a diversity of solutions offered to the elderly. It seems that in post-socialist countries considerable attention is still given to the expansion of institutional care and less attention is paid to independent living enabling the elderly to live for as long as possible in their own homes. There is also a lack of intermediate housing solutions in these countries.

If we focus only on the situation in the post-socialist countries, several important common traits emerge. In all the post-socialist countries population ageing poses a big threat and is putting increasing pressure on institutional care, which is becoming more expensive and less affordable and accessible. The number of clients continually increases, but there has not been corresponding rise in the number of employees in the respective institutions. In the post-socialist countries the issue of ageing is viewed predominantly as a demographic problem and the social, housing, and health-care aspects of this problem are often neglected.

The attitudes of the elderly in post-socialist countries are contradictory and inconsistent. On the one hand, the elderly often state (based on survey data) that it should be the state that is responsible for providing care for the elderly. On the other hand, research shows that in all the post-socialist countries informal care provided by family and relatives is very widespread. It is hard to assess whether the strong role of informal care is based on a value preference or is rather a necessity and result of inadequate support from the state. Either way, family-based informal support plays a key role for the elderly. Although the number of elderly who pay for care has been increasing, most of them still rely on help provided by other family members.

In the post-socialist countries most elderly live in the ownership sector (they are homeowners) and the rental sector is often marginalised. This leads to several problems. The elderly may have high housing expenditures, particularly as a result of housing overconsumption, but as homeowners it is much more difficult for them to downsize and move (and they are also unwilling to do so). Social housing is small in scale in these countries and where existent it has a bad reputation among the elderly; this also contributes to the limited willingness to move and downsize. The literature review also indicated that in post-socialist countries the elderly are not so open to (or, more precisely, not so prepared for) ICT innovations and home adaptations. In Germany, by contrast, the rental sector is much larger and consequently the elderly are not only more willing to move and downsize but they are also more open to various innovations. Consequently, it seems that in the post-socialist countries a significant

threat to further development of innovative housing and care solutions could be the largely distorted housing system, i.e. the marginal rental housing segment.

As regards the living conditions of the elderly, the general picture is rather mixed. The quality of housing seems to be sufficient and the elderly are basically satisfied with their housing conditions in all the post-socialist countries. This, however, conceals the fact that most elderly live in very large dwellings. This often results in housing unaffordability and economic hardship, despite declared high levels of housing satisfaction.

The long-term social and health care is more curative in form in all the post-socialist countries. This means that care is provided after the problem has arisen and systematic primary prevention is absent. Moreover, in most countries the demand for social and health-care services exceeds the supply by a factor of 2. In addition, the range of social and health-care service that would enable the elderly to live independently for as long as possible is limited. Nonetheless, there is evidence that the use of some solutions has been growing. For example, in Slovenia, the Czech Republic and Slovakia the use of professional home care is increasing. The reported weakness of this service in the given countries is that the selection is rather limited, the out-of-pocket contributions are too high and there is an uneven supply of these services across different municipalities.

Finally, the findings from past research suggest that in the post-socialist countries the elderly are often uninformed about the housing solutions available to them. Moreover, they often tend to reject them. There are basically two reasons for this. First, the elderly often live in their own homes and feel they should continue living there even if the dwelling is no longer suitable to their needs. Second, they often feel that organising a move to a different location or adapting their home would be a too demanding task, that they would be unable to manage it, and would get no help to do so from anybody else.

IV Housing Affordability and the Housing Satisfaction of Elderly Households

The aim of this section of the report is to compare housing affordability and the housing satisfaction of the elderly in the eight Central European (CE) countries participating in the HELPS project. In addition, we also compare the level of housing overconsumption, accessibility of basic services for the elderly, such as health care, and also the elderly's perception of housing quality. For this analysis EU-SILC 2007 and 2009 data were used for the eight CE countries participating in the HELPS project (the Czech Republic, Slovakia, Germany, Italy, Slovenia, Poland, Austria and Hungary).¹ The indirect purpose of this secondary data analysis is to complete the information on housing context, i.e. to demonstrate the main differences and similarities present among countries. The differences in housing affordability or inequality logically influence concrete policy reactions (forms of practices).

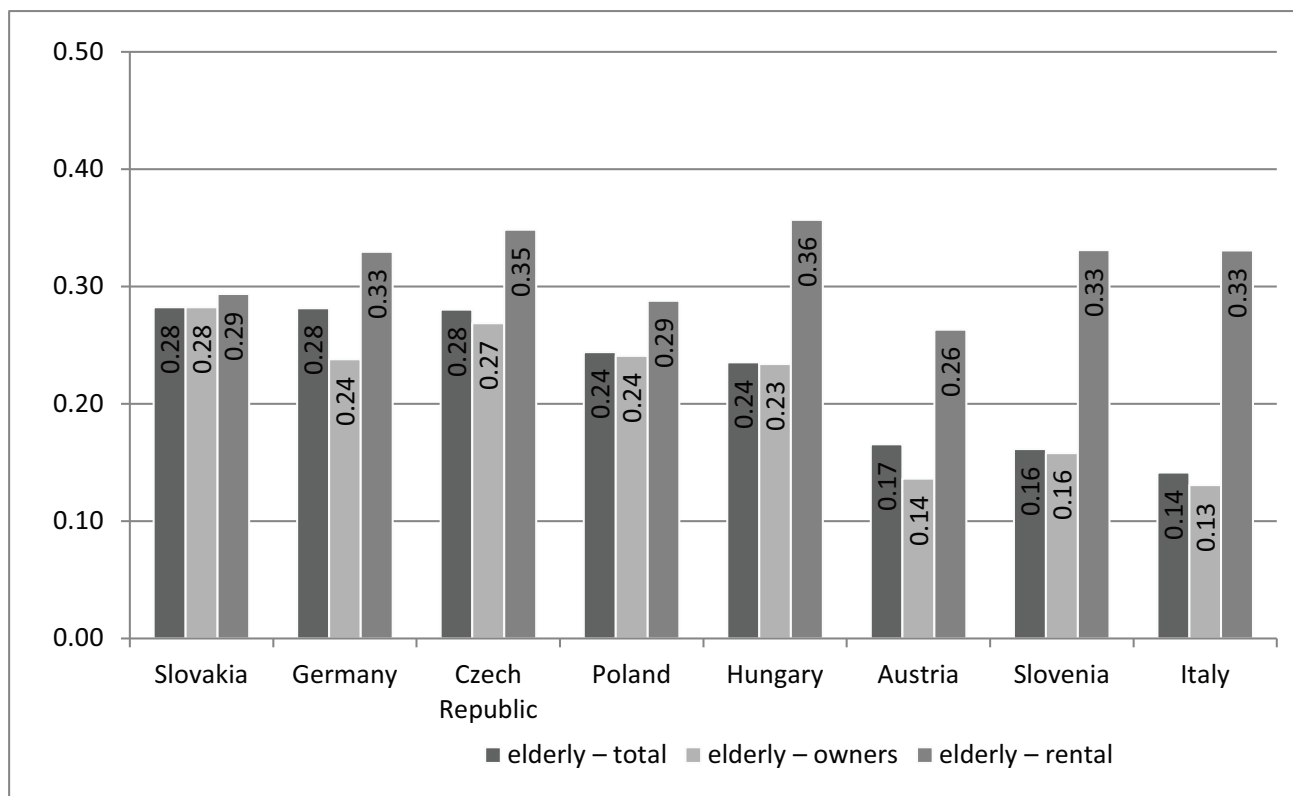
The EU-SILC 2009 data contained information about household incomes as well as household expenditures. The EU-SILC 2007 data contained also a module that focused exclusively only on housing issues. It included questions about satisfaction with housing, accessibility of various important services from the household dwelling, and evaluations of the quality of housing. Therefore, both of these data sets will be used in the following analysis. This section is divided into two parts. The first is concerned with the financial affordability of housing of elderly households. This part is based on the EU-SILC 2009 data. The second part is concerned most with the analysis of housing satisfaction, including an evaluation of the dwelling environment, the accessibility of services etc. The second part is based on EU-SILC 2007 data, because the questions about housing satisfaction and housing conditions were only included in a special module for this year.

Housing Affordability of the Elderly and Household Expenditures on Housing

The concept of the financial affordability of housing is usually defined as a relation between a household's incomes and expenditures on housing. The particular housing is affordable if this ratio is on an acceptable level. There are two common ways of setting the standard for the financial affordability of housing. First, there is the traditional ratio standard, which takes into account the overall level of housing expenditures to the total net income of the given household (Hulchanski 1995). The acceptable level of ratio is then set normatively, usually on the level of 25%, 30% or 35% of household income. Second, the residual income approach is based on a calculation of residual income, which is equal to net household income reduced by housing expenditures. In this approach, a household is threatened by housing unaffordability when net household income, after being reduced by housing expenditures, is not enough to cover other basic household needs, such as clothing, nutrition, education and so forth (Stone 2006: 162–164).

The concept of housing affordability is particularly important in the case of the households of elderly, since this is the social group that is usually regarded as one of the most severely affected by financial hardship. In the following analysis, we use mostly the ratio approach and eventually (Figure 10) also the residual income approach.

¹ The EU-SILC data sets 2005–9 were made available on the basis of contract no. EU-SILC/2007/16 between the European Commission, Eurostat, and the Institute of Sociology of the Academy of Sciences of the Czech Republic.

Figure 2 Average ratios of household housing expenditures among the elderly in the ownership and rental sectors

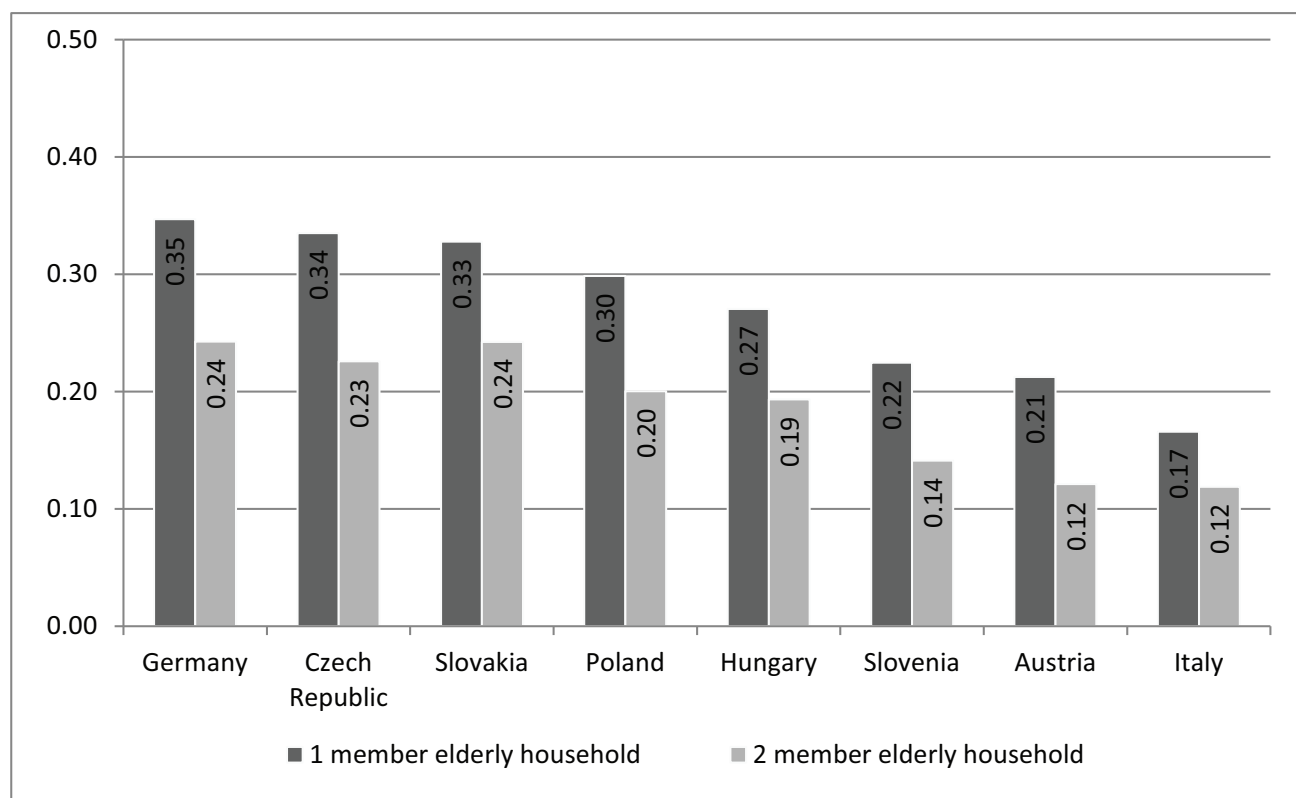
Source: EU-SILC 2009; average ratios of household housing expenditures to net household incomes – households of the elderly.

First, the ratio of household expenditures to net income is calculated for the eight Central European countries participating in the HELPS project. To estimate household net income the personal incomes of all the household members were included along with various kinds of benefits (housing allowances excluded), interests, dividends, income from property or land, and education-related allowances, and this was reduced by taxes on wealth and income and social insurance contributions. We included only those households of elderly that had an income above the minimum pension level used in the given countries, also taking into account the size of the household (based on OECD statistics – Pensions at a Glance 2011 – and the minimum pension levels valid in 2008/09).² Household housing expenditures include rent payments, regular services and charges, repairs, and the costs of utilities. For house owners, the expenditures included mortgage interest payments, mandatory services and charges, regular maintenance and repairs, taxes and the costs of utilities. The housing allowance, if one was received, was subtracted from the total amount of household housing costs. In the figures displayed, we present the median of the ratios.

First, we compute the general overall ratio of the housing costs of elderly households and compare it with the ratio of housing costs in the ownership and rental sectors (Figure 2). Households of the elderly were defined as households with at least one retired person. Mixed households, such as a household with one retired person and one still economically active (employed) member, were not included in the computation. There are significant differences between the analysed countries. In some countries the elderly tend to live on their own (this is especially true in Scandinavian countries), whereas in other countries the 'family' model is more common, wherein the elderly live with their

² This data adjustment was done because the EU-SILC self-reported data contained financial amounts of pensions that were significantly below the minimum pension levels in the given countries. Therefore this adjustment was employed in all eight cases of the analysed countries.

Figure 3 Ratios of household housing expenditures in the OWNERSHIP sector according to the type of household



Source: EU-SILC 2009; average ratios of household housing expenditures to net household incomes – households of the elderly.

relatives and wider family (Timonen 2005). However, to ensure comparability, only the households of retirees were included and the elderly living with their relatives and/or children were excluded.

Generally, when the ratio of housing expenditures is above the normative thresholds mentioned above, the given household can be regarded as being threatened by financial affordability of housing. This is very often the case of elderly households, which have been found to be one of the social groups most affected by high costs of housing.

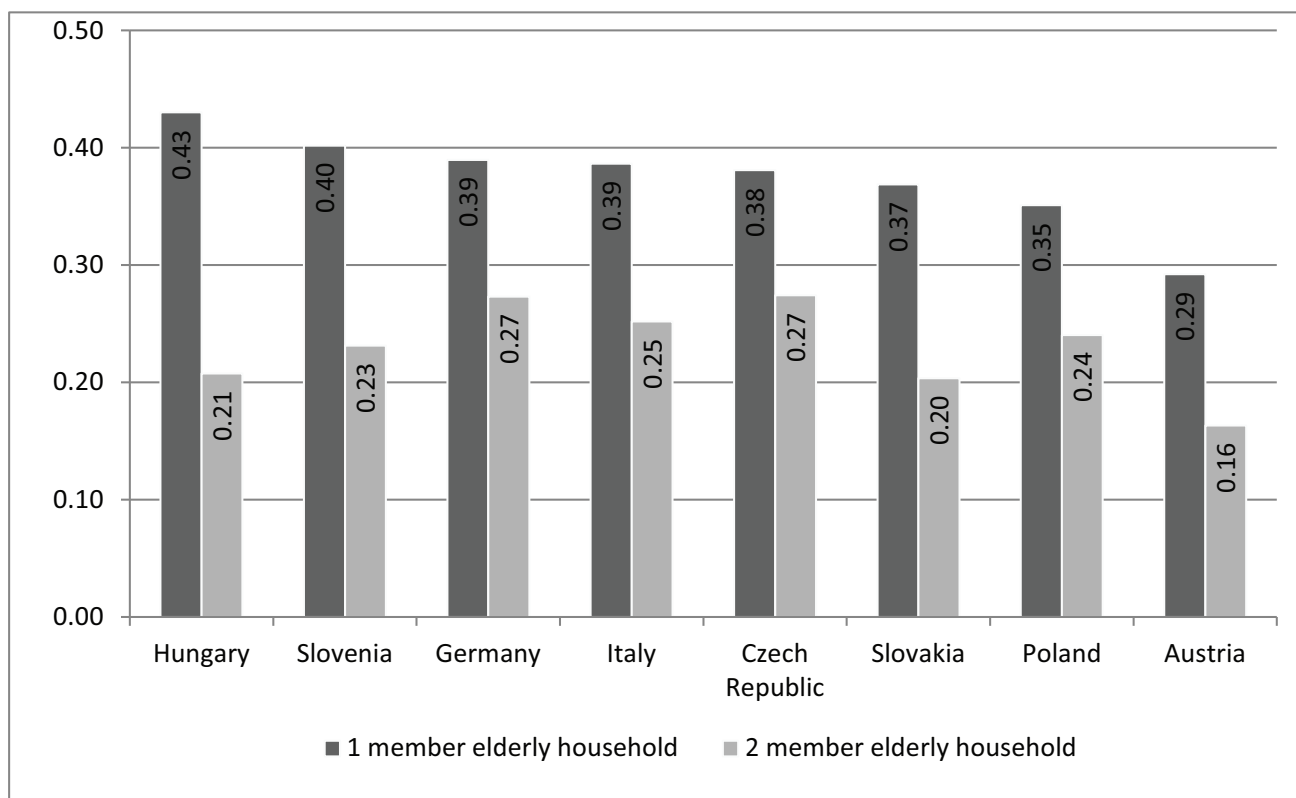
The ratio for the rental and ownership sectors is in all the studied countries below 30%. When housing tenure is taken into account, the ratio is higher in the rental sector, particularly in the Czech Republic, Slovenia, Hungary, Germany and Italy, where it is above 30%. This reflects the fact that tenants have generally lower income than homeowners and, especially, that most elderly homeowners are outright owners with already repaid mortgage loans. This simple ratio cannot account for the potential savings of tenants accumulated earlier in life (while they did not invest in their own housing as homeowners did, they could have used the same money for pension savings or other forms of investment). Moreover, in Slovenia and Hungary the number of elderly households living in the rental sector is small, which complicates international comparison. The overall relative housing expenditures of elderly households are the highest in Germany, the Czech Republic and Slovakia. In these countries the median ratio is equal to about 28%. On the other hand, the lowest median ratio was found in Austria, Italy and Slovenia.³

Second, we distinguished among elderly households according to the size of household. We calculated the ratio for two types of households: first for households consisting of just one elderly (retired) person, and second for households of two people who are both elderly and retired. Figure 3 shows

³ In Slovenia the ratio of expenditures was high for the rental sector, but below the average in terms of the ownership sector. Given the small size of the rental sector, the overall ratio is highly determined by the ownership sector.

that the median ratio of household expenditures for housing (for homeowners) is generally higher for one-person elderly households than for two-person elderly households in all of the eight countries. Figure 4 shows similar results for rental housing. In the rental sector, for one-person elderly households the level of expenditures is often above 30%. Once again, this simplified comparison of median ratios in different housing tenures demonstrates that the financial affordability of housing is the most severe in the rental sector.

Figure 4 Ratios of household housing expenditures in the RENTAL sector according to the type of household



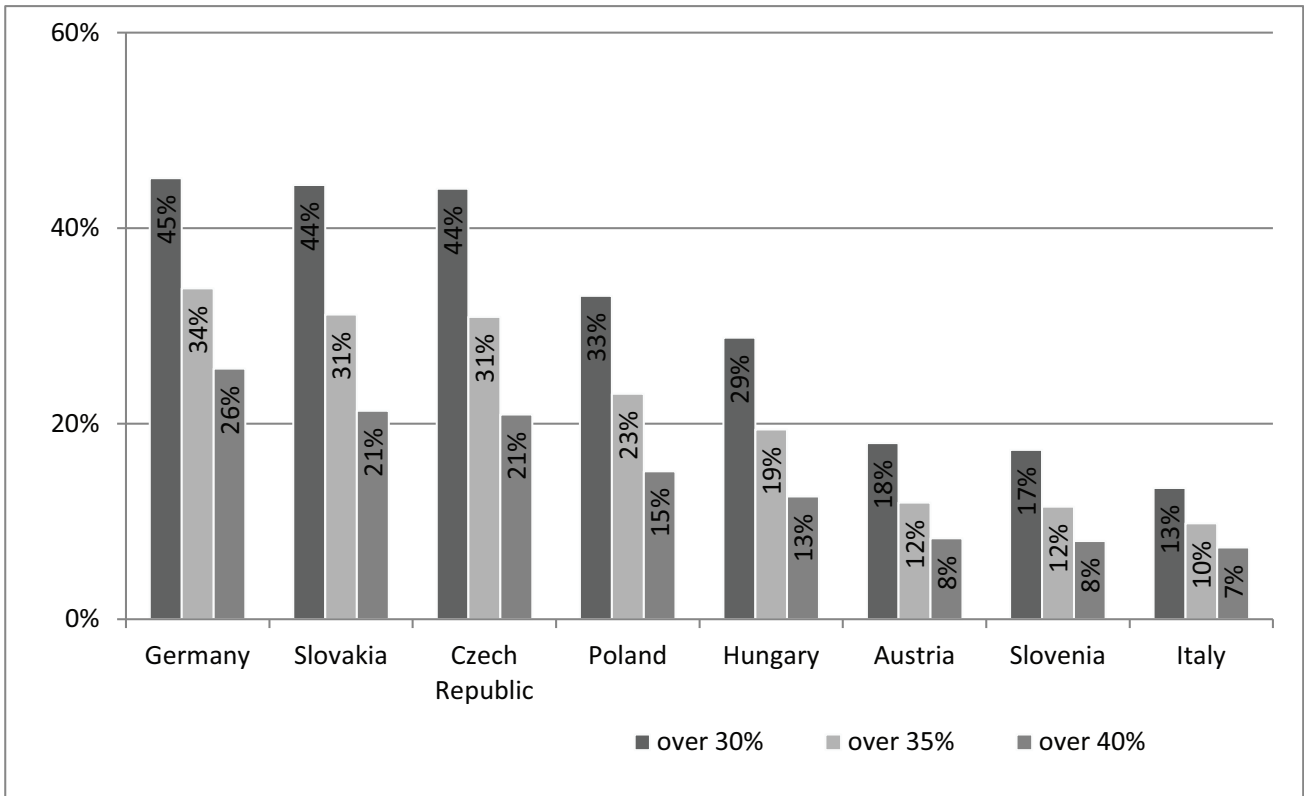
Source: EU-SILC 2009; average ratios of household housing expenditures to net household incomes – households of the elderly.

Figure 5 shows the percentage of elderly households suffering from a very high burden of housing expenditures, i.e. when the ratio is higher than 30%, 35% or 40%. The burden of household housing expenditures is highest in Germany, the Czech Republic and Slovakia, where the share of elderly households that devote more than 35% of their income to housing expenditures is more than 30% of all elderly households. By contrast, in Italy, Austria and Slovenia the number of such households is rather small: around just 10% of elderly households spend more than 35% of their net income on housing. When we apply a burden threshold of 40%, the results are very similar.

Finally, in each of the countries we compare the differences in the magnitude of the ratio of housing expenditures between the 20% of households with the highest income and the 20% of households with the lowest income. This analysis is conducted in order to compare the level of inequalities between rich and poor households of the elderly with respect to the financial affordability of housing. Figure 6 shows the differences (in %) between the ratios of the richest and poorest households. These differences, a kind of measure of social inequalities in the financial affordability of housing, are the biggest in Germany. The differences in other countries were roughly the same, but the least inequality was found in Italy.

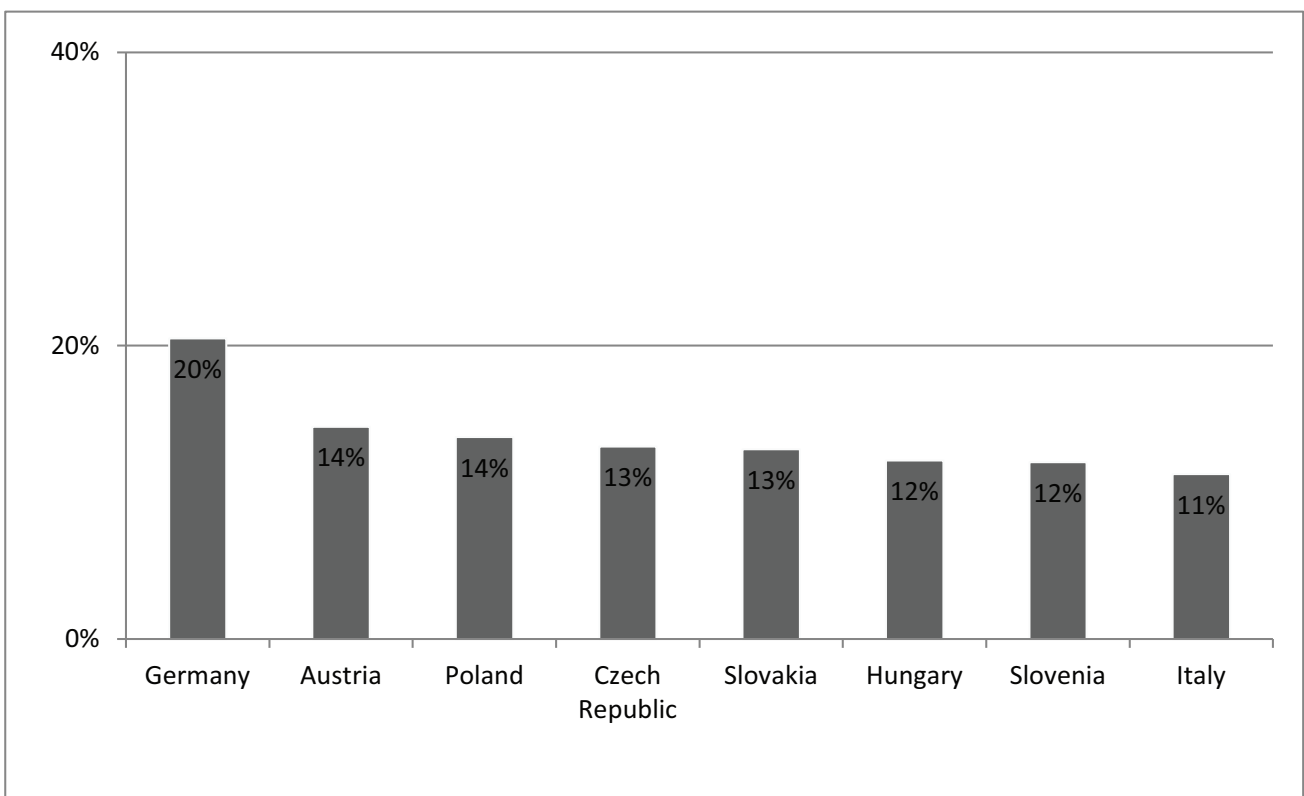
To explore the extent of hardship from a high financial burden of housing expenditures we also used a more qualitative (subjective) measure: answers to a question about respondents' subjective

Figure 5 Percentage of elderly households with ratios of expenditures on housing over 30%, 35% and 40%



Source: EU-SILC 2009; households of the elderly.

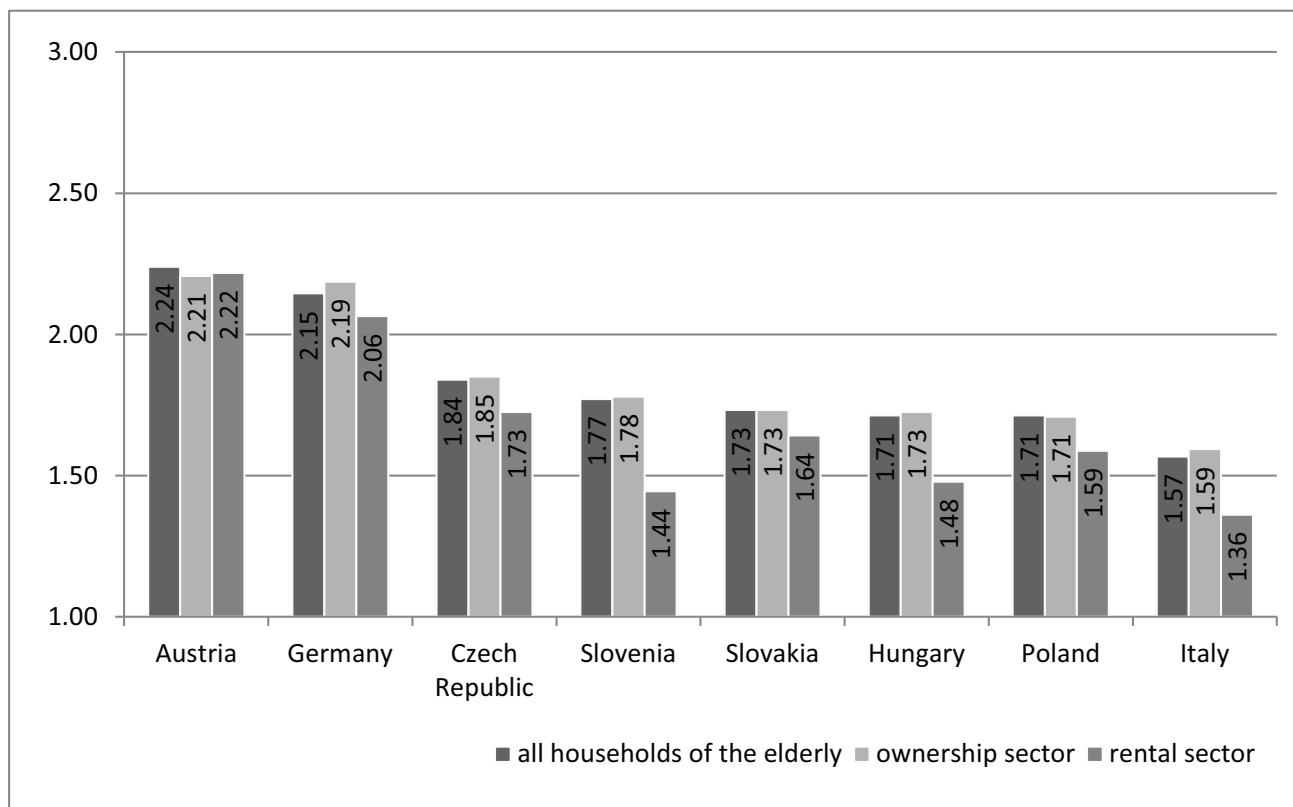
Figure 6 Differences in the ratios of household housing expenditures between the households of elderly with the highest income (5th quintile) and the lowest income (1st quintile)



Source: EU-SILC 2009; households of the elderly.

evaluation of their financial burden of housing costs (1 = housing costs viewed as a heavy burden; 2 = housing costs somewhat of a burden; 3 = housing costs not at all a burden). Figure 7 shows the mean values of this subjective evaluation of housing costs by respondents of the survey themselves. In most countries (the only exception being Austria), elderly households in the rental sector significantly more often felt their housings costs to be a burden than did households of the elderly homeowners.

Figure 7 Mean values of the perceived financial burden of housing costs (1 = housing costs a heavy burden; 2 = housing costs somewhat of a burden; 3 = housing costs not at all a burden)



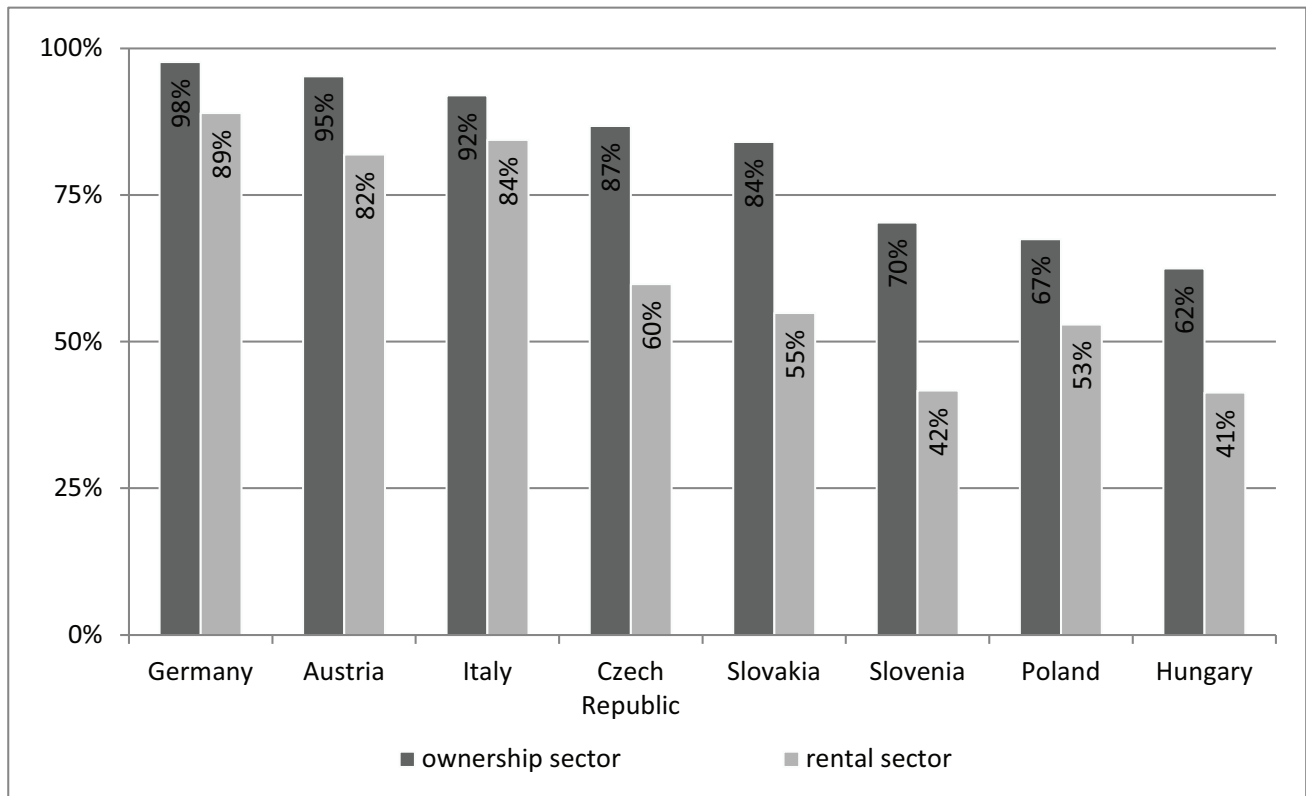
Note: Since the rental sector in post-socialist countries is very weak and the majority of elderly live in their own flats or houses, the overall figures do not differ considerably from the figures for the ownership sector. This has to be taken into consideration when evaluating the impacts of the higher financial burden of housing costs in the rental sector.

Source: EU-SILC 2009; households of the elderly.

It is often mentioned that a high ratio (low housing affordability) is caused by the fact that households 'overconsume' their housing. Therefore, we compared the level of housing overconsumption among elderly households in selected countries. Housing overconsumption was defined as when a household has more residential rooms than household members (Thalmann 1999). As Figure 8 shows, the rates of housing overconsumption are higher in the ownership sector than in the rental sector. The share of households with housing overconsumption is the highest in Austria, Germany, Italy and the Czech Republic, probably reflecting the wealth and standard of living in these countries.

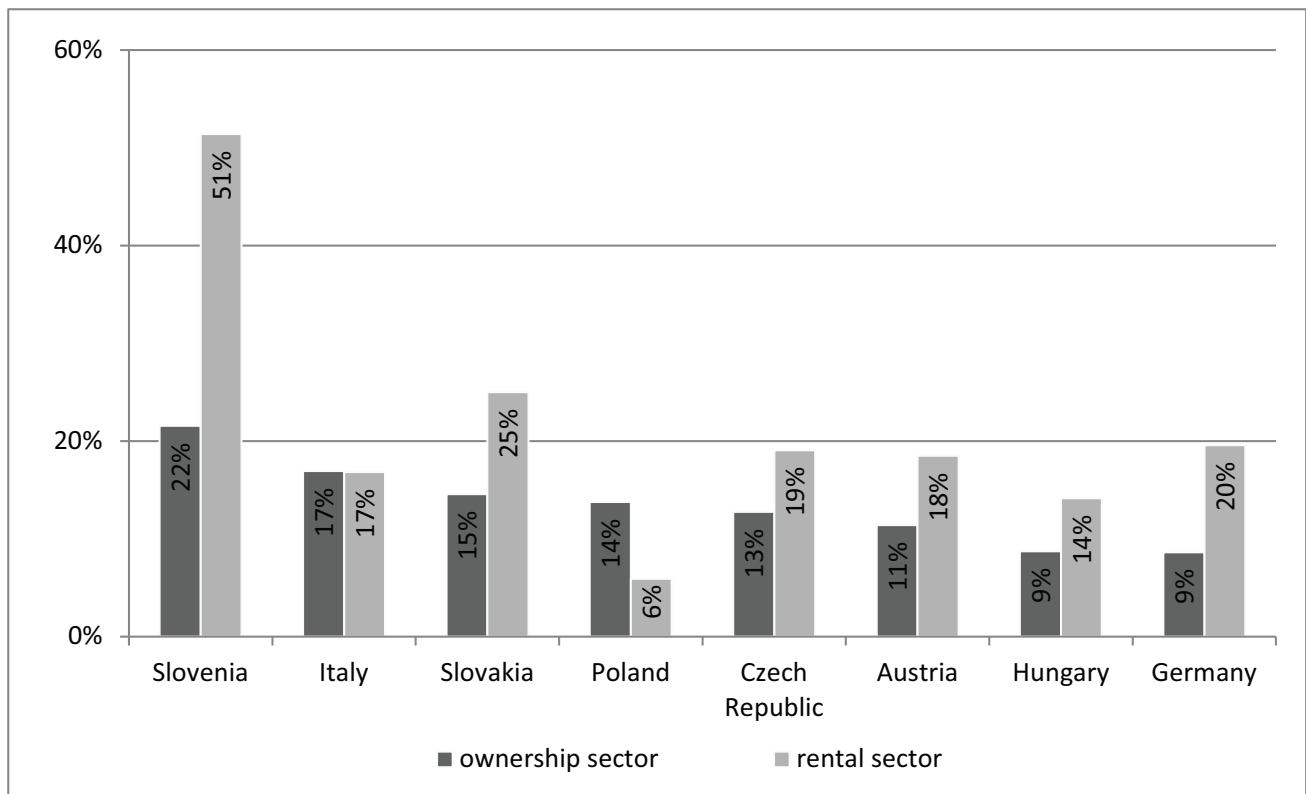
We also inquired into what share of the elderly was at risk of poverty. The poverty threshold was defined as 60% of the median of (country) net household income. Figure 9 shows the share of households at risk of poverty (with an income less than 60% of median income) in the rental and ownership housing sectors. The number of elderly households at risk of poverty is significantly higher in the rental sector. Among owners, the number of elderly households at risk of poverty is lower; in most cases below 20%. It is the highest in Slovenia (22%) and the lowest in Germany and Hungary (9%).

As well as the ratio of household expenditures for housing to net household income, a residual income approach to the measurement of financial affordability of housing was also used. First, we calculated the *net residual income*, which is equal to the difference between net household income

Figure 8 The share of households overconsuming housing split by housing tenure

Note: Since the rental sector in post-socialist countries is very weak and the majority of elderly live in their own flats or houses, the figures for the rental sector represent a much smaller share of the population than the figures representing the ownership sector. This must be taken into consideration when evaluating the impacts of the higher financial burden of housing costs in the rental sector.

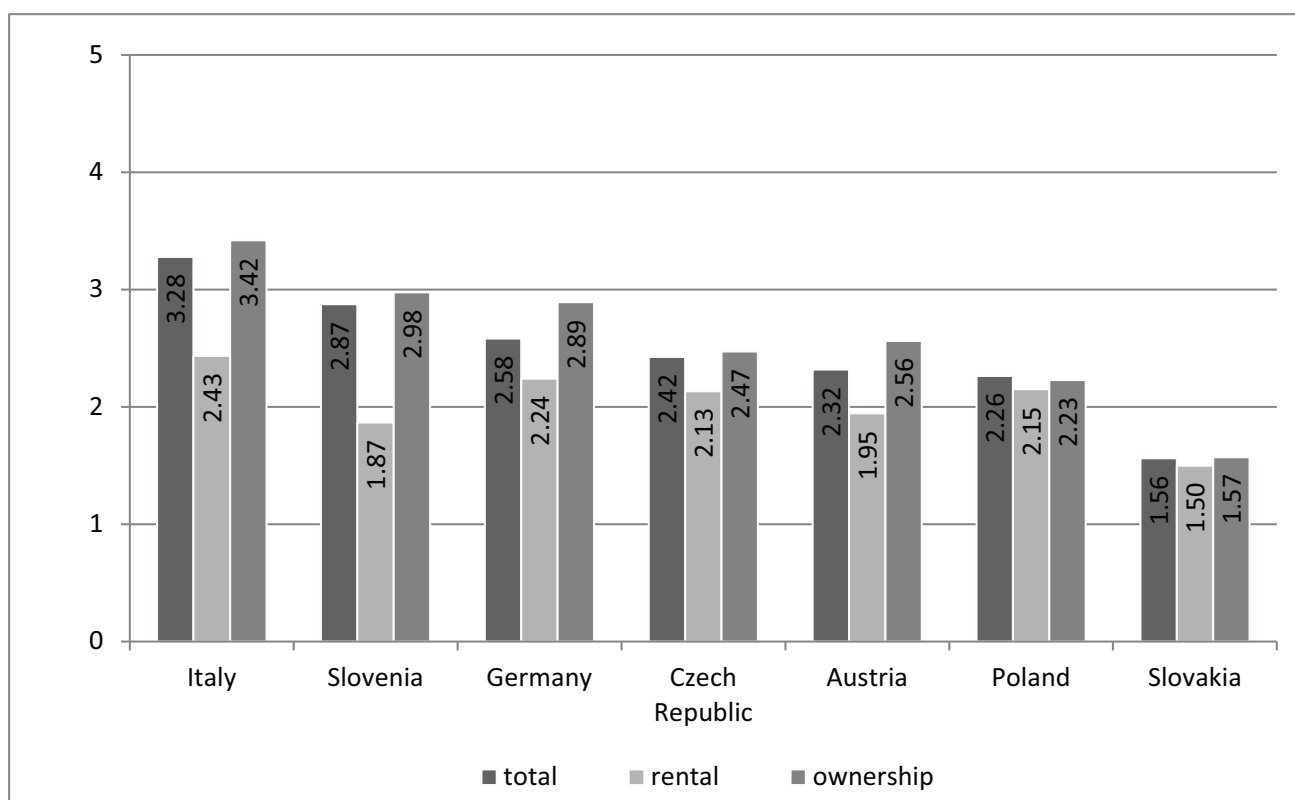
Source: EU-SILC 2009; households of the elderly.

Figure 9 The share of households at risk of poverty

Source: EU-SILC 2009; households of the elderly.

and total expenditures for housing. The resulting sum of money, following the logic of the residual income approach, should be enough to cover the basic needs of the given household. In order to specify this level of basic needs, the minimum subsistence level valid in 2009 in each of the analysed countries was used. In this way, we set the *minimum residual income* so that it would reflect the minimum subsistence level. Hungary was excluded, since there was no nationally defined minimum subsistence level in 2008. For each country, the ratio of *net residual income* and *minimal residual income* was calculated.⁴ The resulting number is called the poverty index. The values of the poverty index around 1 represent a standard of living near to the minimum subsistence level. High values of the poverty index indicate a high standard of living.

Figure 10 Poverty index in 2009 based on the residual income approach to the measurement of the financial affordability of housing



Source: EU-SILC 2009; households of the elderly.

The results in Figure 10 show that the levels of the poverty index were in 2009 in all countries above 1, which means above the minimum subsistence levels. Generally, the lowest levels of the poverty index were found in Poland and Slovakia, indicating the lowest standard of living of elderly households. In Slovakia in particular the poverty index was around 1.5 which suggests a standard of living only slightly above the minimum subsistence levels. Despite the case of Slovenia, no significant differences in the levels of the poverty index with respect to tenure were found.

An Evaluation of Housing Satisfaction

We also compared the housing satisfaction rates among the elderly in selected CEC countries. We used the EU-SILC 2007 data, which included a question on housing satisfaction. Housing satisfaction was measured on a four-point ordinal scale (1 = very dissatisfied; 4 = very satisfied). The average values

⁴ The size of the household was also taken into account, but only households of 1-person elderly and 2-person elderly households were included in this analysis.

Table 2 Average housing satisfaction rate among the elderly in selected countries

Country	Mean value of satisfaction with housing	Mean value of satisfaction with housing – ownership sector	Mean value of satisfaction with housing – rental sector
Hungary	2.64	2.68	2.53
Slovakia	2.85	2.86	2.83
Poland	2.87	2.86	2.53
Czech Republic	3.01	3.05	2.85
Italy	3.04	3.05	2.78
Slovenia	3.14	3.17	2.74
Germany	3.26	3.31	3.18
Austria	3.40	3.46	3.20

Source: EU-SILC 2007; households of the elderly.

for the eight CE countries are presented in Table 2. The least satisfied with housing were the elderly in the rental sector, who in most countries were somewhat less satisfied than those in the ownership sector. The differences in means when comparing the ownership and rental sectors are statistically significant.

Next to the overall evaluation of general residential satisfaction, we also analysed satisfaction with the physical condition of flats/houses of the elderly. The physical condition of the dwellings of the elderly was measured using indicators such as shortage of space in the dwelling and the quality of installations and facilities. Seven items inquired into the adequacy of the following features of the dwelling: a shortage of space, adequate electrical installations, adequate water installations, enough heating facilities, comfort during the winter and summer and whether the dwelling was equipped with air conditioning facilities. When the dwelling had the given feature, it was coded as 1, otherwise as 0. A summated index was then created which had (in all countries) a normal distribution and was called the index of housing quality. Means per country are given in Table 3. Values at 1 mean that the given dwelling was satisfactory in terms of all seven criteria for the given dwelling (space, heating, comfortable environment, etc.). The differences among countries are mostly statistically significant.

Table 3 Mean values of the perceived quality of dwellings of the elderly (0 = worst; 1 = best)

Country	Mean value of housing quality	Mean value of housing quality – ownership sector	Mean value of housing quality – rental sector
Slovenia	0.69	0.7	0.64
Austria	0.68	0.69	0.67
Hungary	0.67	0.67	0.65
Germany	0.67	0.69	0.64
Slovakia	0.64	0.64	0.65
Italy	0.63	0.63	0.57
Czech Republic	0.63	0.64	0.61
Poland	0.61	0.61	0.62

Source: EU-SILC 2007; households of the elderly.

The quality of dwellings of the elderly in the ownership sector was generally higher than the quality of dwellings of the elderly in the rental sector.

Similarly, an evaluation was made of the accessibility of various services that can be regarded as essential for a good standard of living. These concerned access to a grocery, banking, postal services, public transport and health-care services. Again, a summated index was created to measure the general level of accessibility of these services. The average values are presented in Table 4. A higher number means bigger problems of access to these services.

Table 4 Mean accessibility of essential services for the elderly

Country	Mean value of the accessibility of services
Poland	0.31
Italy	0.28
Slovakia	0.27
Austria	0.23
Slovenia	0.22
Czech Republic	0.21
Hungary	0.16
Germany	0.16

Source: EU-SILC 2007; households of the elderly.

Finally, we ran a regression model, where the dependent variable was overall satisfaction with the housing. This question framed not only satisfaction with housing quality, but also satisfaction with the neighbourhood, the surrounding environment and the like. Although this question contained four possible response categories (very dissatisfied, somewhat dissatisfied, satisfied, very satisfied), responses were collapsed into two categories – either satisfied or dissatisfied. This was done because of the very small number of very dissatisfied households. The binary satisfaction variable was used as a dependent variable in a logistic regression. As independent variables we included: housing tenure (ownership sector; rental sector), housing overconsumption (no; yes), elderly living alone (no; yes), quality of the environment (index), accessibility of services (index), density of the population, whether the particular household had expenditures on housing over the 35% threshold (no; yes), the physical quality of the dwelling, and finally whether the particular household viewed the costs of housing expenditures as a heavy burden – a qualitative measure of financial hardship caused by high expenditures on housing (no; yes).

The results are shown in Table 5. The most significant predictor of housing satisfaction was definitely satisfaction with the physical quality of housing. In most countries housing satisfaction was also linked to a good quality environment (defined by a lack of noise, pollution, crime/vandalism), accessibility of basic services (health care, grocery, post offices, banks etc.), and a perceived low (or not heavy) subjective burden of housing expenditures. In most countries (except for Germany, Austria and Slovakia) housing tenure was also a statistically significant factor explaining the variability in housing satisfaction. The elderly living in the rental sector were less satisfied with their housing than the elderly in the ownership sector. Also, housing overconsumption was usually linked to higher satisfaction with housing. In most countries, elderly living alone were not less satisfied with their housing than elderly living as a couple. The only exceptions were Italy, Hungary and Poland. This may be due to the fact that in these countries there is a strong emphasis on tradition and family ties, and the lack of these may also have an impact on overall housing satisfaction.

Table 5 Model of housing satisfaction. Logistic regression. Beta coefficients.

	Czech Republic	Germany	Austria	Italy	Hungary	Slovenia	Slovakia	Poland
1-person household (yes = 1)	-0.06	0.18	-0.38	-0.43 **	-0.19 *	-0.09	0.09	-0.32 **
Ratio of housing exp. > 35% (yes = 1)	0.28	-0.06	-0.19	0.10	-0.06	0.37	0.08	0.06
Housing overconsumption (yes = 1)	0.19	-0.12	1.20 **	0.48 **	0.35 **	0.24 *	0.42 **	0.47 **
Quality of the environment	-1.20 **	-0.24	-1.20 **	-1.30 **	-0.24	-1.13 **	-1.23 **	-0.70 **
Urbanisation	0.05	0.06	0.09	-0.20 **	0.08 *	0.10	0.32	-0.05
Accessibility of services	-0.89 **	-0.26	0.02	-0.48 **	-0.72 **	-0.41 **	-0.48 **	-0.58 **
Tenure (rental = 1)	-0.84 **	0.25	-0.36	-0.89 **	-0.68 **	-1.23 **	-0.28	-0.53 **
Quality of the housing	5.16 **	2.45 **	3.29 **	3.89 **	0.83 *	0.53	3.54 **	2.64 **
Housing exp. perceived as a burden (yes = 1)	-0.58 **	-0.41 **	-0.87 **	-0.67 **	-0.31 **	-0.56 **	-0.53 **	-0.45 **
R ²	0.19	0.03	0.18	0.21	0.05	0.07	0.13	0.09
N	3875	4972	2385	7543	4711	4972	4269	3674

Source: EU-SILC 2007; households of the elderly.

The level of urbanisation was significant only in Italy and Hungary. In Italy more satisfied were those living in densely populated areas, in Hungary it was the opposite. Finally, those households with ratios of household expenditures on housing over 35% were in none of the analysed countries more likely to be dissatisfied with their housing. This is in strong contrast with the rather more qualitative self-assessment of the perceived burden of household expenditures, which were found to be statistically significant in all eight CE countries.

Conclusions

The aim of this section of the report was to describe and compare the living conditions of the elderly, particularly housing affordability and housing satisfaction, in the eight CE countries participating in the HELPS project, using the main secondary data source – the EU-SILC survey. These issues (housing quality, housing satisfaction, housing affordability, etc.) are seldom compared across countries (see previous sections of this report on the literature review). If innovative practices, including their strong and weak points, are to be assessed further, it is essential having detailed ‘comparative’ knowledge of the situation in the particular countries.

In our comparative analysis of the living conditions we first focused on housing affordability. The average ratio of housing expenditures to net incomes of elderly households was in all eight Central European countries below the level of 30%. The ratio was the highest in Germany, the Czech Republic and Slovakia. On the other hand, it was the lowest in Slovenia, Italy and Austria. Similarly, the share of households with a burden of housing expenditures over 35% of net income was the highest in Slovakia, Germany and the Czech Republic.

Nonetheless, these results seem to contradict the qualitative (subjective) measurement of the burden by housing costs. The financial burden of housing costs was subjectively perceived as the biggest issue in Italy, which had otherwise a comparatively low ratio. The simple subjective measure thus may not give an appropriate and adequate picture of the situation of the elderly and might be just a manifestation of general economic hardship, social exclusion or specific changes in national housing policies (such as rent deregulation or actual hikes in utility prices).

It is not surprising that the ratio significantly differs with respect to housing tenure; in most countries it was significantly higher in rental housing than in the homeownership sector. This was especially the case of Austria, Hungary, Italy and Slovenia. The main reason is probably the lower income of tenants. However, the ratio is not suitable for inter-tenure comparison as it cannot count for potential savings of tenants accumulated earlier in life (because they did not invest in their own housing as homeowners did but could have used their savings for other forms of investment). For a relevant comparison, the total wealth of households would have to be compared. Moreover, in Slovenia, Slovakia and Hungary the sample of tenants was very small.

Another important topic in the evaluation of the living and housing conditions of the elderly is housing overconsumption. As noted in this section of the report, in all studied countries many households of the elderly ‘overconsume’ housing. Housing overconsumption is most common in the developed countries (Italy, Germany, and Austria) and less common in the post-socialist countries. Although housing overconsumption can be viewed as a deliberate choice for a better quality of life, it is often tied to excessive housing costs. The situation is somewhat complex as, despite housing overconsumption, the elderly are not willing to move and downsize. In this respect, it is important to note the findings from the country-specific literature review: in post-socialist countries the possibilities for flat adaptations and moving to other suitable dwellings are limited. Policies such as ‘universal design’, ‘lifetime homes’ or policies that would encourage even small adaptations of elderly households are often marginal or non-existent.

In the second part of this section we analysed the overall housing satisfaction of the elderly. On the whole, the elderly were mostly satisfied with their housing. The highest satisfaction rate among the elderly was found in Germany and Austria. By contrast, the least satisfied were elderly people in Hungary, Slovakia and Poland. Comparing housing satisfaction among different countries is a precarious task, as housing satisfaction can be influenced by different cultural values. Nonetheless, some general patterns seem to emerge from the descriptive and multivariate analyses. There seem to be several factors influencing the residential satisfaction of the elderly: apart from accessibility of various services (health, postal, banking, grocery, etc.), environment quality and housing tenure, the strongest predictor of housing satisfaction was the physical quality of the dwelling (housing accessibility) and the perceived subjective burden of housing expenditures (housing affordability).

V | Brief Country Profiles

The purpose of this section is to describe the main characteristics of the housing and social care systems with respect to the elderly in each of the eight Central European countries. These brief ‘country profiles’ are based mainly on the information provided by national experts within the HELPS project. Together with the literature review and secondary data analysis (Sections II to IV of this report) they represent an information base that enables us to relate contextual factors to housing and social care options for the elderly. This section represents a bridge between the wider context and particular measures (practices) in the field of housing and social care for the elderly and people with disabilities. The brief country profiles are presented in alphabetic order.

Austria

Austria represents a highly developed model of supply of housing options for seniors and other vulnerable people. It is characterised by a relatively large variety of different state and local measures aiming to increase both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing (for a detailed description of the typology, see page 93). The Austrian model can be classified as ‘social-democratic’ because a large portion of the urban population live in stable, long-term and high-quality social housing provided by municipalities, housing cooperatives or limited-profit housing organisations.

The large share of social housing in Austrian housing systems is the main reason for the relatively low (affordable) average housing costs and, when compared with other developed countries, one of the lowest average housing cost-to-income ratios of senior households. The public housing subsidies are not, however, limited to social housing: according to the information from the Austrian case study about 80% of overall new housing construction is co-financed from public sources. This high level of both direct and indirect influence of the state and municipalities (municipalities often provide land or decrease property tax when particular conditions are fulfilled) on new housing construction via different forms of subsidisation motivates private and limited-profit developers to increase housing quality, supply barrier-free housing and cut the housing cost burden. The Austrian housing policy did not follow the policy shift from supply-side housing subsidies to demand-side housing subsidies common in many other Western European countries during the past two decades – instead it continued to heavily support new housing construction and rehabilitation projects while housing allowances remained a rather marginal complement to housing policy.

The subsidisation of private housing construction and rehabilitation projects and the existence of a large segment of rental housing managed by co-ops and limited-profit housing associations (13% of housing stock) paved the way for different public-private partnership schemes and models of cooperation between public and private sectors. As in Germany, this particular institutional context might be the cause for a relatively wide spectrum of housing options offered to senior and vulnerable households in this country: the adaptation of existing flats; the construction of new senior, barrier-free or supervised flats; the existence of special retiree dwellings, flat-share communities, senior-living communities, integrated (mixed) housing, supervised flats and many others.

The high level of the old-age-dependency ratio has in recent years directed attention to support and care for the elderly. Austria, together with Denmark and Sweden, ranks among the three EU countries with the highest public expenditures on care for the elderly as a percentage of GDP, which is reflected in its relatively high standard, accessibility and variability of social care services. In this respect long-term plans for the expansion and development of social services were made in 1994. The first step

taken by the federal states was the creation and establishment of minimum standards in ambulant, stationary and semi-stationary services. Later, the regulation of social services provision was gradually improved. Care allowance reform from 2012 brought about a transfer of legislative powers and execution responsibility from the federal states to the federation. As in other European countries, policy priorities have shifted the focus towards strategies enabling people to remain in their own homes and appropriate measures have been taken to support and maintain the autonomy and self-care abilities of the elderly and other vulnerable people, including the promotion of lifelong learning, active ageing and opportunities for older people to participate in social, political, economic and cultural life.

The Austrian system of social care comprises a mixture of centralised and decentralised elements. Universal social benefits, based on social insurance, are provided at the federal level, while the major part of social services are provided at the regional level, i.e. by individual *Länders*, local authorities and municipalities. Besides governmental bodies and local authorities, there are also numerous non-governmental actors such as social partners and other interest groups and third-party experts that are involved in the formulation of social care policy priorities. In terms of the provision of social care, the system involves a number of private organisations (not-for-profit organisations, associations, charity organisations, funds or private agencies) which closely cooperate with the federal state and local authorities. Based on the *Agreement between the federation and the federal states about common measures of the federation and the federal states for people in need of care*, the federal state determines the basic legal, organisational and financial conditions and controls, while responsibility for the organisation of care is delegated to local actors, mostly public ones, although the number of private for-profit organisations has increased in this field over recent years. The federal states have the obligation to develop an extensive care service system in the form of cash and non-cash benefits. The cash benefits are conceived as care allowances, while the non-cash benefits are provided in the form of ambulant, semi-stationary and stationary services for people in need of care. If they are not provided by themselves, the federal states have to organise another institution to provide the service. Such a decentralised model results in considerable flexibility in terms of actual care and staff needs. One of the main principles of old-age policies is the option of the elderly to decide on the type of care thanks to transfer payments.

Austrian seniors can choose from a relatively large scale of social services – mobile and outpatient, semi-inpatient or inpatient services (geriatric centres, private residential and nursing homes, senior housing communities, integrated housing, mobile services, daytime clinics, supervised flats etc.). Both institutional and (particularly) home care services reach a relatively high coverage rate in relation to the total number of persons aged 65+. Due to estimates there are approximately 130,000 persons provided with outpatient services of different kinds. People in permanent need of care residing in Austria have been eligible for a care allowance since 1993 whose amount is determined by the extent of care and services needed and the reason for the need of care. The allowance is assigned to fund nursing and care measures (e.g. personal assistance) in order to enable people in need of care to stay at home as long as possible. Indeed, more than 80% of people in need of care are cared for by relatives in their own home.

The quality of care is secured both in the case of home and institutional care by the obligation for carers to hold special authorisation or licence, prove sufficient experience or to obtain special training. Requirements for professionals in social care are stipulated by the *Agreement between the federation and the federal states about social care professions*. Austria has developed a complex system of funding of social services that are principally financed by the social insurance contributions and by taxes (funding of care allowances). A portion of the costs of social services are covered by the care recipients; however, in the case of home care services the amount of the contribution is quite low in relation to the monthly old-age pension and the average level of care allowance. Special insurance schemes have also come into effect, such as self-insurance for relatives providing care for the period they do so.

Czech Republic

The Czech Republic represents a basic model of supply of housing options for seniors and other vulnerable people, i.e. having only a limited, centrally subsidised selection of measures aimed at increasing both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. However, due to the fact that the Czech Republic did not apply right-to-buy policy after 1990 and, instead, restituted a sizeable portion of the housing stock to previous owners, the housing system in this country can be classified as ‘mixed’: municipal housing, co-op housing, and legal (based on written contracts) private renting form an important part of the housing stock. In the private rental segment, there are several institutional investors next to small lay landlords, a fact that increases the probability of mutual cooperation between public and private sectors. On the other hand, there are no not-for-profit or limited-profit housing associations; NGOs own or manage only temporary (crisis) accommodation facilities or facilities of institutional care, a situation similar to that in many other post-socialist states. Consequently, the scale of innovations and mixed management schemes is limited and the main social landlord remain the financially weak municipalities heavily dependent on state subsidies.

Compared to other post-socialist states, the Czech Republic is also characterised by a relatively high number of dwellings per 1,000 inhabitants. Due to rent deregulation, it also has a relatively high average housing cost-to-income ratio among senior households, so housing allowances quickly became an important part of the country’s housing and social policy. There were several attempts to restore state support for social rental housing after 1990, but the main programme supporting ‘municipal’ housing construction realised between 1995 and 2002 often finished up in speculation and abuse; its effect on promoting housing affordability among vulnerable households was thus very limited. The other programme, protected housing support, mainly served people with mental and physical disabilities and only occasionally elderly people. Due to the non-existence of not-for-profit housing associations, passive municipalities, volatile financing of NGOs and a partial mistrust of private landlords there are very few examples of innovative schemes combining public and private financial sources. However, there is also a special state benefit for flat modification and for special compensatory aid; almost 3,000 people live in protected housing; and more than 13,000 people live in domiciliary care service homes that represent a bridge between standard housing and institutional care and that are very popular among the public.

In the field of social services there was a transition from paternalistic and state-provided social assistance and care to the modern social services in the Czech Republic over the period 1990–2006. This fundamental transformation was completed by the adoption of the *Act on Social Services* which came into effect in 2007. This Act has profoundly changed the system of social services in the Czech Republic. It defines the basic principles of the provision of social services, such as a registration requirement for social services providers, an assessment of the life situation of the user, funding of social services with an element of direct payments, a care allowance stipulation, qualification requirements for the employees of social services provider organisations, standards of quality in social services, local strategies of social services development utilising the method of community planning, and a basic framework for informal care provision.

Although types of social services and the conditions of its provision are uniformly stipulated at the national level by the Act, the planning, funding, and delivery of social services are mostly decentralised. The primary task of the Ministry of Labour and Social Affairs (MoLSA) is to prepare the relevant legal regulations and to set long-term social policy priorities. In the area of funding, the Ministry distributes a subsidy towards the operation and development of social services provided by NGOs. The MoLSA itself provides only five specialised social care institutions. Plans for social services development and financing (for two or three years), which are in accordance with national social policy priorities, are

formulated at the municipal and regional levels. Municipalities and regions provide the majority of social care services designed for the elderly (circa 87%) and they also take part in the funding of social services provided by NGOs and churches. However, in the area of social care for the elderly NGOs and churches play only a minor role; they deliver around 10% of these social services. The participation of for-profit providers within this sector is even smaller; the share of for-profit providers could be estimated at around 3%.

The Czech Republic offers basically two types of special housing solutions to older people who require more or less regular and extensive assistance from another person due to their age or chronic illness. These are domiciliary care service homes (similar to extra care sheltered housing) and homes for the elderly (similar to nursing homes). In addition to these special housing forms, there is one type of field-based social care services, i.e. domiciliary care services. Domiciliary care services engage mainly in tasks connected with practical assistance and help with self-maintenance, and are of crucial importance when considering the promotion of ageing in place. This kind of social care service is often complemented by medical home care. It is important to note that warden systems using ICT are still somewhat underdeveloped, as this service is available in only a few towns and to a limited number of users.

Social services are financed from several sources. The sector of social care services for the elderly is substantially funded by clients' contributions, which in 2011 amounted to 50% of the total cost of residential facilities, while the state budget contributed 21%, the founding bodies (especially regional and municipal authorities) funded 12%, and public health insurance covered 6% of total costs. People dependent on the assistance of another person due to their age or state of health are provided a social security benefit – the care allowance. The recipient may use the allowance to pay his/her relative/neighbour/'social care assistant' for care or may hire a social care services provider or combine both of these possibilities. Care Allowance statistics indicate that informal care plays a crucial role in social care provision in the Czech Republic (72% of care allowance recipients used the allowance solely for informal care in 2010, and 9.5% combined care provided by informal and formal caregivers). A certain number of services (such as respite care) and a certain scope of protection for informal carers is available in the Czech Republic (e.g. caregivers are in no way restricted in their employment; the period spent providing care usually counts towards the supplementary period in the pension insurance scheme; primary carers have the status of 'state policyholder' in the public health insurance area, etc.). However, a serious lack of training opportunities for informal carers and of independent monitoring of the quality of care represent the main weakness of the system of informal care.

Nevertheless, the issues of the ageing of population, along with the increasing expenditures on long-term care provision, are reflected in a number of policy documents approved by the Czech government, focusing on active ageing and the integration and involvement of the elderly in community life, and thus promoting, inter alia, the concept of ageing in place. The pivotal issue in the field of long-term care for older people is therefore strengthening the role of field-based services and the relating question of promoting cooperation between formal and informal care providers.

Germany

Germany has a highly developed model of housing options for seniors and other vulnerable people. It is characterised by a relatively large variety of different federal, state and local measures aimed at increasing both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. However, these measures are not provided directly through the system of social housing because the share of social housing is relatively small in Germany. By contrast, the majority of the German urban population live in stable and basically affordable high-quality private rental housing.

The German developed model of housing options for seniors and other vulnerable people may be classified as a 'social-market model' because most of this supply is the result of close and well organised cooperation between public institutions and the for-profit or not-for-profit private sector. The supply of housing options is often based on specific contracts concluded between public and private entities and, therefore, most often involve co-financing from both public and private sources. This setting enables innovative and relatively complex forms of particular practice management, where different stakeholders are involved in solving social and housing problems: complex organisational schemes with a clear division of responsibilities are common and thanks to long-term experience these schemes are also sustainable and effective.

The housing cost-to-income ratio of German senior households is the second highest in our sample of eight Central European countries, but the high level of housing expenditures is offset by the wide supply of housing options and the high quality of housing. As in other housing systems in Europe, in the past ten years the focus of German housing policy has moved from building new housing to the renovation and modernisation of existing housing, and housing policy itself has been largely decentralised from the national to the regional (state) level. The decentralisation of power, large segment of rental housing, traditionally active not-for-profit sector and long-term experience of cooperation between the public sector and private (market) forces laid the ground for the emergence of different innovative housing measures: rent control contracts, occupancy commitment contracts, retirement provisions, age appropriate conversion, technology-assisted housing, multi-generational homes or lifetime homes. Particular integrated practices often combine a variety of social goals, such as increasing housing affordability, improving access to information and supporting community building together.

Germany is an example of a mandated social insurance model where the state mandates universal insurance and families and not-for-profit agencies overwhelmingly provide the social care. Thus, the main responsibility for elderly care and its implementation is assumed by non-governmental insurance associations, but the actual service delivery is devolved to local actors such as the local municipalities, not-for-profit agencies and private care agencies. Social policy aiming at the elderly is only partly a matter of the Federation who designs, monitors and regulates the general framework of social policy aimed at the elderly through legislation and general guidelines. The main responsibility however relies on the federal states and municipalities. The federal social policy priorities focusing on the elderly actually include ageing in place (which has been reflected in an increase in the proportion of domiciliary care over the last two decades), improvement and assurance of quality and cost efficiency in care. The federal states subsequently implement the policies both at the federal state and communal level. They are responsible for ensuring efficient long-term care infrastructure, an adequate selection of services and the quality of long-term care institutions. Authorities at all levels are responsible for the elimination of disparities in support and for ensuring a regular supply of long-term care in all German regions which includes assuming the investment and maintenance costs.

One of the important elements of the German social care system is close collaboration between federal states, communal associations and six large non-statutory welfare organisations who are providers of formal social care. These organisations are funded through a mix of sources such as user fees, membership contributions, public subsidies, private donations and investment incomes. Besides these actors, the elderly can also make use of services provided by private for-profit organisations. Currently, more than half of the service providers are private; however, in terms of the number of employees and clients, welfare associations prevail, since private organisations tend to be very small (Doyle and Timonen 2007).

In 1995 the long-term care insurance (LTCI) system was introduced. The remit of LTCI funds is to ensure the supply of permanent care for their insured and to monitor and eliminate shortcomings in quality. Nevertheless, the responsibility for the creation, promotion and maintenance of long-term

care infrastructure remains in the hands of the federal states. Long-term care providers are supported by the federal states or by non-profit or private organisations. A supply contract (*Versorgungsvertrag*) is concluded between these institutions and the insurance funds in order to regulate the type, contents, and extent of the general nursing benefits which a care institution must provide.

The provision of long-term care in Germany is thus not financed through income tax like in many other countries, but via the above-mentioned social insurance scheme. The insurance funds assign the appropriate level of care assistance to the person in need, and bargain for the price of the care assistance with care providers. They also offer special training to voluntary care-giving staff to make home care easier and more efficient. Social care insurance funds are thus responsible for guaranteeing nursing quality on the one hand, and paying and bargaining for the costs on the other. Domiciliary care is supported within this system on the condition that it is a part of a programme of prescribed medical treatment; the elderly person is not eligible for long-term care insurance and no family caregiver is available (Doyle and Timonen 2007).

Social care services are provided in three different ways: home care provided by informal care-givers, professional home help service, and institutional care. The latter can be provided in various kinds of institutions such as old age homes, residential care homes and nursing homes if the care dependency of the recipient is high. The costs of accommodation and meals are covered by the recipient in a nursing home. Social care insurance favours domiciliary care services compared to the more expensive institutional care, which is reflected in the variety of benefits that try to facilitate home care arrangements. In addition, older people nowadays have a relatively large number of options enabling them to age at home due to programmes of modernisation of buildings, familial support and developed care structures. Furthermore, they can move to adjusted flats and use the option of assisted and/or community living.

People in need of care can choose between a cash benefit to be used to cover the cost of care services (care allowance) and the direct provision of services. The social insurance for long-term care (*Pflegeversicherung*) programme covers all older people without differentiating between them by income. Nevertheless, assistance is provided only on the condition that strictly applied functional status criteria are met, i.e. in particular the level of need resulting from the health state of the person, and above the level of benefits available via insurance it is means-tested (Hale et al. 2010). Most claimants nowadays apply for cash allowances which enable them to maintain home care arrangements with the help of informal caregivers. The amount of the allowance depends on the services required with respect to the person's health state. The allowance can be combined with benefits in-kind, i.e. with the provision of care services.

Informal carers play an important role in the provision of long-term care. The German welfare state places emphasis on the role and responsibilities of the family. Although there is quite a wide selection of formal care services, estimates indicate that 70% of all care-dependent people make use of informal (familial) care since formal care cannot satisfy their emotional needs and is often also quite expensive (Doyle and Timonen 2007). Since 2008 informal carers have been protected against dismissal based on the need to provide care. In addition, the care-giver is eligible for a carer's allowance if he/she cares for a specified minimum of hours per week.

Hungary

Hungary is an example of the super-homeownership housing system: the home-ownership rate exceeds 90%. This is the result of the application of large-scale public housing privatisation, which had already begun in the 1980s and was accelerated by right-to-buy legislation passed in the early 1990s. Recently, the municipalities own less than 3% of the housing stock, often of low quality stock located in unattractive urban areas. There is no other social housing landlord in the country and despite some

attempts to revive social housing construction (the so-called Szechenyi Programme) in the early 2000s the level of social housing output has been marginal.

Hungary is also an example of the basic model of supply of housing options for seniors and other vulnerable people, which is characterised by a very limited selection of measures aiming to increase both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. These measures (programmes, subsidies) are most often provided by the state (centre) and there are few examples of local mutual cooperation between public and private housing sectors in this field. There is almost no rental housing owned and managed by not-for-profit or limited-profit housing associations. Additionally, private rental housing is mostly a part of the black market because private tenants frequently have no written contracts with the landlords. This specific housing system can be categorised as the 'extremely liberal' model: there is almost no real market for rental apartments and people have no choice other than to become homeowners.

Due to the fact that the Hungarian economy and mortgage industry have been heavily affected by the global financial crisis, recent Hungarian housing policy has been orientated towards debt management of indebted homeowners and the allocation of housing allowances. Traditionally, housing subsidies in Hungary focused on the acquisition of owner-occupied housing and the main target groups of such subsidies were young families. Grants for the construction or purchase of barrier-free homes or for housing adaptation are available for different types of recipients. Despite this fact, however, the importance of institutional care for senior and disabled persons has grown in recent years: the number of residents in institutional care facilities grew by 25% between 2000 and 2008 and only 5% of persons over the age of 60 receive some type of home care.

As for the system of social services, it has changed significantly since the 1980s, especially in terms of the role of the government. During the years of the transition to a market economy the state gradually withdrew from direct interventions and central funding in favour of decentralisation. Already in 1993, a new Social Welfare Act came into effect to regulate social administration and social care, creating a framework for the new basic services and the forms in which they are provided. Among other things, the Act stipulates that agencies providing social services must have a licence issued by the local municipality, which should assure certain quality standards for and a regular quality assessment of services provided by regional professional organisations.

As a result of the above-mentioned reform the government nowadays only plays the role of coordinator, setting priorities, strategic goals and legislation in the area of social services, and is responsible for the financial regulation of social care services. Many other tasks were transferred to the municipalities, which can fulfil their obligations through directly managed programmes or by outsourcing them.

Social care services designed for the elderly include local basic services (food, domiciliary social and health care), out-patient day care services (clubs for the elderly), in-residence social care services (old age homes), and a network of village caretakers. However, the providers of social care services are unevenly distributed across the country, partly due to the different features of different regions, and partly due to the limited financial capabilities of many municipalities. Sufficient provision of social services is found only in larger settlements, especially in the case of home help. According to estimates, the demand for care is at least 30 times higher than its supply.

Domiciliary care is typically provided by local and regional authorities (68% in 2010); however, churches are another important service provider (23%). Other NGOs provide around 8% of domiciliary care and the private sector takes part in the provision of only 0.5%. The structure of in-residence social care facilities for the elderly is somewhat different since in this area NGOs play a more important role than churches (20% and 15% respectively in 2010). It is evident that churches have become an important provider of social services in Hungary, which is partly the result of the additional financial

support for services provided by churches (about 50% of the normative funding) from the central budget.

Social care services are primarily financed by the regions and municipalities out of tax and other revenues, but some of the costs are covered by the central budget in the form of a normative contribution. The relationship between the local and national levels involves some conflict, since the normative funds provided from the national level do not meet the legal minimum standards, so a significant number of municipalities have to run into debt in order to fulfil their legal obligations. The third source of financing is represented by fees paid by the recipients of the services. The fees are fixed and cannot exceed a certain percentage of the monthly income of the eligible person. The ratio of input from these three sources may vary depending on the type of services and the financial standing of the municipality.

The range of services has widened with yearly amendments to the Social Welfare Act reflecting an underlying strategy aimed at supporting ageing in place. Nevertheless, the accessibility of these services is somewhat limited by the fact that an increasing number of the services charge a fee. Moreover, only so-called 'basic care' is financed from the central budget, while higher quality services are accessible solely in the market, i.e. only for better-off households.

The responsibility for care of the elderly or people with disabilities is increasingly being shifted to relatives, in spite of the inadequate (or the entire absence of) financial tools and other measures (e.g. training, supervision, etc.) to support informal carers. Family members who take care of a relative for at least eight hours a day are eligible for a carer's allowance, which is conceived as an employment relationship, but which is extremely low (100 EUR/month). The number of informal carers who qualify for the carer's allowance is therefore very limited (approx. 50,000) and consists mainly of previously unemployed relatives. Another portion of informal carers are made up of migrants and other individuals who provide services on the 'black market', for which they are paid by the relatives of the elderly/disabled person or the care recipient him/herself.

Italy

Italy has a semi-developed model of supply of housing options for seniors and other vulnerable people but the variety and quality of options vary substantially between Italian regions. The overall supply of innovative housing solutions is less diverse than in the developed systems of Germany or Austria.

As in other European countries, in recent decades Italian housing policy has largely been characterised by a shift from supply- to demand-side housing subsidies (i.e. from supporting housing construction to the allocation of means-tested housing allowances) and the decentralisation of housing policy from the state to the regions (especially since 2001). The supply of new public housing has now been reduced by 90% compared to the 1980s; a similar drop has been noticed in the case of assisted and agreed housing (housing at lower than market costs owned by private landlords). The home-ownership rate grew from 59% in 1981 to 75% in 2008; 19% of the housing stock remains as rental housing, but public (called also 'subsidized') rental housing makes up only 4% of the Italian housing stock. When compared to the other eight Central European countries in our sample, the Italian housing system can be categorised as 'mixed' with a small share of social housing but a still not insignificant segment of private renting.

The Italian housing system is also characterised by relatively low housing costs: the average housing cost-to-income ratio of Italian senior households is the lowest in the sample of eight Central European countries. Thanks to a long-term tradition of activities by charities and churches, and different forms of cooperation between the public sector and private landlords, there is a wider supply of housing options for the elderly and other vulnerable people than in countries with a basic model, options such as collaborative housing, protected housing, municipal supports for flat adaptations, municipal

guarantees, etc. As mentioned above, however, the variety of housing options and the number of innovative schemes are lower than in Germany or Austria.

Social services have been a public responsibility since about 1850, when assistance to the poor was transferred from religious and charitable organisations to the government in Italy. The system was later decentralised and in the 1970s it was passed to the regional authorities, which are in charge of the legal and organisational framework applied to the care. However, the delivery of social services is assured by the municipalities. As a consequence of this system, organisational forms, standards and the range of social services vary between regions. The government defines only the essential level of services in order to guarantee social rights, and it monitors and evaluates the social policies of the regions. The national reform of social work and social services introduced in 2000 established a new integrated system of health and social care and an association of local authorities in order to manage social services. Nevertheless, the integration of health care and social care systems has not yet been completed owing to the complexity of these systems.

National policy priorities have two main objectives with respect to the elderly: to encourage older people to remain active by working longer, engaging in volunteer activities and participating in community life, and to provide accessible and effective health and social care so that the elderly can live independently, in their own dwellings. The second objective is reflected in to increase efforts to develop home care through trained health-care professionals, new forms of delivery of care and new technologies. However, there are no national laws, nor official standards regulating social care for the elderly. Professional standards can be stipulated at the regional level for public social services, but only some regions have used this opportunity. In the case of private social services, they have to be authorised by the municipality on the basis of the number of potential users and the standard of the services offered.

Italy has the lowest public expenditures on care for the elderly as a percentage of GDP of all the countries analysed and this can be attributed to the fact that the system of care relies to a large extent on informal carers. There are three kinds of financial sources for social services for the elderly and people with disabilities according to the level of governance (national, regional or local). At the national level care is funded from the social insurance system and taxes. The government sets out the budget available for social services (National Social Fund) for the respective year and assigns it to the regions based on their population and previous expenditures. The regions distribute the sources to the local authorities. The regions and local authorities can increase the budget accorded to them by the government through savings or from local taxes. The amount of funds they set aside for social services for the elderly and people with disabilities depends on the number of potential recipients and on local policies. The services are partly funded also by payments from clients, the amount being dependent on the scope of the service and on the recipient's personal income in the case of publicly provided services.

There is a relatively broad range of social services for the elderly in Italy (social centres, nursing homes, community housing, protected housing, domiciliary care services, respite care etc.); however, they are not as wide as in Austria or Germany. The provision of social care is based on cooperation between public, private for-profit and not-for-profit organisations and voluntary associations. Formal domiciliary care can be provided by municipalities or by professional operators. In such a case the recipient can use a voucher to pay for the services provided at the regional level and the recipients are free to choose their caregivers. Nevertheless, the most important part of domiciliary care is provided by informal carers, who, however, are not recognised by the law or by formal organisations. There is no special regulation of informal care and no definition of its relationship to formal care. On the other hand, informal carers can make use of respite care services, should they need a break, and they can receive a carer's allowance if the person cared for is 100% disabled. In such a case the allowance substitutes the carer's salary; however, the amount of the allowance is undifferentiated. Some municipalities

provide informal carers with training, but its availability and form depend on financial resources and partnership with associations and not-for-profit organisations. The persons cared for are eligible to receive a care allowance if they need to purchase care services, compensatory aids etc. The amount of this allowance varies based on the recipient's personal income. Institutional care is usually provided by the municipalities or by NGOs and charity organisations.

Poland

Poland has a basic model of supply of housing options for seniors and other vulnerable people. It has a limited selection of measures aimed at increasing both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. However, unlike other post-socialist countries, Poland did not apply right-to-buy policy and, moreover, revived social housing support in 1995 by promoting the construction of not-for-profit housing with controlled rents (so-called TBS housing). Some of this housing is especially designed for vulnerable and senior households. Consequently, when compared to other countries in the sample, the Polish housing system can be categorised as 'mixed' with a not insignificant share of municipal, co-op, limited-profit and private rental housing.

Another distinct feature of the Polish housing system is the traditional promotion of multi-family and multi-generation households which, according to the authors of the country reports, conforms to the preferences of Polish elderly. Many families are also recipients of new housing allowances, introduced in 2001, to cover increasing housing costs, and the housing allowance has become one of the most popular social benefits (5 million Polish families are recipients of the housing allowance). Finally, Poland is the country with the fewest dwellings per 1,000 inhabitants in the sample of eight Central European countries and therefore, together with Slovakia, faces a physical shortage of housing. This may explain Polish housing policy's focus on support for new social housing construction after 1995.

The role of the family is significant also in the sphere of social services for the elderly. The first law governing the provision of social care and the system of social benefits in Poland after 1989 was the *Social Welfare Act* from 29 November 1990. It also defines the scope of social support and its recipients. A new social care system was supposed to be introduced by the new *Social Welfare Act* introduced in 2004, but in reality the changes brought about by this Act were rather limited. The main innovations consisted of a transfer of the costs for rents in in-residence social care services from the central budget to the municipalities and families, and the improvement of standards of institutional care services (e.g. obligatory registration of in-residence social care services based on an assessment of the quality of services provided) and the status of social workers.

There is a competence hierarchy in the provision of social care. The government coordinates the social policy and relevant legislation at the national level, while the regions supervise the quality of services provided and the fulfilment of local needs in the social sphere. The municipal authorities are responsible for creating plans dealing with local social issues. Additionally, local Social Welfare Agencies decide whether a person qualifies to receive a social care service, taking into consideration his/her income, state of health, life situation and the current capacities of specialised institutions. The Social Welfare Agencies at the municipal level are also responsible for the provision of social services to the community.

Basically, there are two types of social care services available for the elderly with reduced self-sufficiency: domiciliary care service and specialist care service tailored to the needs of a particular illness or impairment on the one hand, and social assistance homes (a kind of a nursing home) and a limited number of smaller family social assistance homes on the other hand. A person who is dependent on outside help to perform everyday tasks has the right to receive social care. The costs of staying in

a specialised caring facility are covered by the recipient or his/her family, or – in the case of low-income families – by the municipality. However, the coverage of the elderly by these services seems to be insufficient and for some recipients in-residence social care services are unaffordable, as 39% of users are served by private for-profit providers and only 37% by regions and municipalities.

Therefore, informal care plays an important role within the Polish system of social care. However, the only group of informal carers recognised under Polish legislation are members of the recipient's family, who are eligible for a carer's allowance (*świadczenie pielęgnacyjne*) on the condition that they cease other economic activity. How the allowance is spent is monitored by the local Social Welfare Agency. Other informal carers are not entitled to any benefits, and public administration is not obliged to provide any formal training, respite care services or other support to the caregivers beyond the above-mentioned financial benefits. Some such services are however available, and these are financed by the municipalities from their own budgets.

Besides the carer's allowance, Poland also introduced a care allowance, particularly for people with disabilities and elderly over the age of 75. Two types of care allowance exist: a nursing allowance and a care supplement. An individual is entitled to receive only one of these two types of allowance. The care allowance cannot be granted if the person is a resident of an in-residence facility, which means that this benefit is conceived as support for the purchase of domiciliary care services.

The main source of funding is the national public budget. Besides this, each citizen is covered by mandatory health and social insurance, whose funds are contracted to agencies that provide specialised health and social services and are used for financial social benefits such as pensions or an attendance allowance. Social services can also be purchased directly from informal carers, commercial providers of services, or other entities.

Current discussions on the system of social care in Poland stress the need for innovations, since a system based on state interventions focusing on basic needs such as shelter, catering and medical help seems to be insufficient. Recent strategic documents set the promotion of active ageing and remaining in one's natural setting for as long as possible as one of the priorities of Polish social policy.

Slovakia

Slovakia has a basic model of supply of housing options for seniors and other vulnerable people; i.e. it has a very limited selection of measures aimed at increasing both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. Like other post-socialist states, there is only a limited variety of housing support, coming mostly from the central level of public administration. Cooperation between the public and private sectors (not-for-profit organisations and public landlords) is rare and innovative schemes appear only occasionally. In the early 1990s, after becoming an independent republic, Slovakia applied a right-to-buy policy and the homeownership rate quickly increased to 95%; consequently, its housing system can be classified as 'liberal', like those in Slovenia and Hungary, or as 'super-homeownership' (with very limited housing tenure choice).

Slovakia also has a physical shortage of housing and ranks, together with Poland, among the countries with the fewest dwellings per 1,000 inhabitants in the sample of eight Central European countries. This fact may explain the housing policy focus on new supply-side subsidies promoting new municipal rental housing construction with reduced rents. There is relatively long-term and stable support of the state for this form of new housing construction. On the other hand, the housing allowance plays a marginal role – less than 2% of households receive this type of benefit. The private rental housing segment is very small and there are almost no not-for-profit housing associations: the Slovakian municipalities are almost the sole social landlords.

As regards the system of social services in Slovakia, significant change was the decentralisation of social services from the state to the local and regional levels between 1990 and 2004, followed by fiscal decentralisation. The responsibility of the state has been restricted to conceptual, legislative and regulatory functions. In accordance with the principles and priorities identified at the national level, relevant policies are subsequently set by local and regional authorities who are responsible for the provision and financing of social services. The conditions of the provision of social services by non-state providers (e.g. charities, NGOs etc.) and the financing thereof were modified by *Act No.195/1998 Coll. on Social Assistance*. The new *Act on Social Services* approved in 2008 introduced new kinds of social services (e.g. monitoring and identifying the need for assistance among seniors, the rental of assistance tools), a new method of evaluation of dependence on social services, and new responsibilities for the municipalities and larger territorial units, and it established a new way of financing private providers. Further, it defined the responsibilities of providers, the rights of clients of services (e.g. to choose a provider and form of services, to be informed etc.) and it set up a process of quality assessment, a registration obligation, and standards and qualification requirements for particular occupations within social services.

However, the expected effect of decentralisation has not been met, in particular in the case of social services provided to the elderly. Regardless of the actual demand for social services, the availability of social services has not been significantly improved (thousands of people are still waiting for care in facilities), the share of people receiving home care decreases each year, and the number of professional carers is on the decline. The municipalities and higher territorial units are gradually increasing, within legal limits, the payments for social services with the aim of increasing the participation of clients and their families.

There is no special definition of care addressing the elderly population in the Slovak Republic. Elderly care is usually considered to be part of long-term care, which is understood as assistance for persons reliant on the help of others. Social care is provided in the client's environment (domiciliary care) or in an in-residence form (homes for the elderly) by means of professional providers or by non-professionals or family members. A necessary precondition when requesting some form of social service or a care allowance is to be recognised as having a certain level of disability. In-residence social care services are predominately provided by the municipalities, but the role of municipalities in the provision of services is decreasing in favour of regional authorities and NGOs.

Social services such as homes providing assistance to people with disabilities or day centres are financed out of direct taxes and public providers have to use their budget for this. Some facilities are financed directly from the national budget. Other resources like payments from clients or public health insurance resources have only a complementary function. There are only a few private providers without public resources in Slovakia. To make the social service sector financially sustainable, in 2012 the government started to finance social services through financial contributions provided to the municipalities and private providers of selected types of social services. The amount of the financial contribution depends on the type of social service and the number of clients.

As regards support for informal caregivers, they are eligible – on the condition that a recipient is recognised as having a certain level of disability, that the carer is the recipient's close relative, friend or neighbour, and that care is provided by that person for at least eight hours a day and he/she lives in the same household – for an allowance whose amount depends on the income of the person cared for. They can also obtain financial compensation for health and social insurance, free social consultancy, flexible working hours, support for returning to a normal job, respite care etc. However, the majority of informal carers provide care for free as they do not qualify for the carer's allowance and are not officially acknowledged as a caregiver. The situation is even more complicated in less developed regions of Slovakia with poor access to services and information. Thus, many seniors are dependent on voluntary help from their relatives or friends.

Official national priorities aim to promote ageing in place by developing the field of social services and respite social services, increasing the quality and accessibility of social services, training staff, and supporting the transition from institutional to community care.

Slovenia

Slovenia has a basic model of supply of housing options for seniors and other vulnerable people: there is a relatively limited selection of measures aimed at increasing both the affordability and accessibility of housing for seniors and other vulnerable people that support ageing in place and/or independent living in standard forms of housing. Due to the application of a right-to-buy policy, the Slovenian housing system is also classified as 'liberal' and 'super-homeownership': the homeownership rate was of 90% in 2011 while private renting was negligible and social renting forms only around 6% of the total housing stock.

However, when compared to other post-socialist states, there is greater variation in innovative housing options intended for the elderly and other vulnerable people, such as equity release mortgages for homeowners and not-for-profit social housing support, including support for the construction of rental housing for the elderly (managed by a special Pension Real Estate Fund) or sheltered housing for the elderly (managed by the municipalities or different public-private partnerships). The main form of housing subsidisation has therefore been on the supply side (subsidies from the Housing Fund allocated to not-for-profit housing associations or direct investments of the Fund into rental housing construction). The preference for supply-side subsidies might be due to the housing deficit, i.e. the relatively small number of dwellings per 1,000 inhabitants when compared to other countries in our sample. By contrast, housing allowances remain a relatively marginal part of Slovenian housing policy. Surprisingly, there is no subsidy directed towards adaptations of existing dwellings.

The social care policy and its priorities are formulated at the national level in Slovenia. The implementation of policy and some kinds of social care services, such as domiciliary care, are organised (and possibly partially funded) at the local level. However, the most important subject in terms of social care provision is the public sector with its network of public institutions at the local and national levels. The government has recently encouraged and supported the development of the non-governmental sector and the pluralisation of social protection programmes since 1990, which is reflected in the stronger role of NGOs in the provision of social care services over the last two decades. In addition, the process of privatisation enabled the development of the market sector, offering an alternative for those who can afford it. NGOs and private for-profit organisations thus cover the 'grey areas' in the provision of social care services.

Despite this trend, a significant amount of social care services are still provided by informal carers, i.e. by the family. Informal carers can obtain the status of a family assistant whose tasks, obligations, rights, education and monitoring must conform to special rules. An assistant can be a person who lives in the same household with the person with a disability or is one of his/her family members. He/she cannot be simultaneously active in the labour market more than as a part-time worker. A family assistant is eligible for a carer's allowance amounting to 578.55 EUR per month. However, there were only 706 family assistants at the end of 2010. Special policies dealing with the status of informal carers were elaborated in the 2000s, e.g. the *Strategy of Care for the Elderly to 2010* adopted in 2006, which among other things sets out the goal of providing families caring for a disabled elderly family member with adequate training and services, such as day or respite care at the local level, and of supporting measures to allow more flexible working arrangements (a right to part-time work without the risk of losing social security). However, the legislation dealing with the status of informal carers is still insufficient and the same applies in the case of the above-mentioned services.

Long-term care for the elderly is provided either as residential or as community care in Slovenia. Residential care is predominantly represented by institutional care (nursery homes, special social care homes and centres for care and training), which is used approximately by one-third of people in need of long-term care. Indeed, the coverage rate of institutional social care services is the highest among all the countries analysed. Social care facilities are mostly established and maintained by public authorities and the municipalities are their most important provider. The very high costs of institutional care are funded by the recipients, the insurance system and the public budget. The recipients cover the costs of accommodation, meals and social care services, but the government or municipality supplements the payment, should the income of the recipient be insufficient. Currently, the capacity of social care facilities is not sufficient and there are long waiting lists for places in such facilities.

Since the end of the 1990s non-institutional forms of long-term care have been increasingly supported and one social policy priority is to improve and extend options of domiciliary care. As a result, new forms of community and other non-institutional care have been developed with the participation of for-profit organisations and NGOs (e.g. day centres, sheltered housing, life-line care, meals-on-wheels and new forms of domiciliary care). Both government and local authorities are in charge of community care and the funding is almost exclusively public. However, the coverage of such services is still quite limited.

Social services in Slovenia are provided on the basis of a licence or concession. If the concession is accorded by a municipality, the role of the government is to ensure conformity with legal conditions and guidelines and to monitor the organisation and implementation of the service. The municipalities are required to co-finance domiciliary care to at least 50% of the costs. An increasing number of NGOs in the sector of social care operate various social care programmes co-financed from public funds. Slovenia is one of the countries with the lowest public expenditures on care for the elderly as a percentage of GDP, but an increasing amount of private expenditure on care has been recorded over the last decade, especially in the case of long-term social care services. A significant volume of social care work is performed also on a voluntary basis. Nevertheless, a substantial amount of the demand for care, which is expected to increase even further in the coming years, remains unmet.

Cash benefits such as care allowances are administered centrally. A person is entitled to a care allowance, if he/she is not able to perform everyday activities without assistance from another person. Such cash benefits are intended to cover the additional costs arising from the need to care for another person (professional or informal caregiver). The legislation determines the different amounts of the care benefit according to the kind and intensity of care needed and on the basis of the scheme used. The allowance is not means-tested; the entitlement depends on the state of health of the recipient.

VI Housing Tenure: A Determinant of Innovations in the Supply of Housing Options for the Elderly and People with Disabilities?

Introduction

The purpose of this section of the report is to present the results of analysis of the influence of housing tenure structure on the quality and scope of supply of different housing options for vulnerable households, especially the elderly and people with disabilities. The research on the mutual association between housing systems, defined basically by housing tenure structure, and the scope of housing options available to the elderly and people with disabilities is very new and has clear policy implications: if the housing system (context) determines or limits the supply of housing options to the elderly and people with disabilities, then this would suggest that measures (practices) effective in one housing system will probably not be effective in another housing system. As far as we know from a general and specific literature review (Sections II and III of this report) this kind of research is entirely absent from housing studies, so this study adds to current knowledge.

The most common categories of housing tenure are rental housing and owner occupancy. Research and policy practice distinguish also two subcategories of rental housing according to the form of provision: social rental housing and private rental housing. Social rental housing is typically allocated according to need (it targets low-income or other needy households), while market forces play a crucial role in the allocation process of private rental housing (Haffner et al. 2009). Social housing landlords are typically public or non-profit organisations (with exceptions), while private landlords are mostly for-profit, physical and legal entities (small and professional investors). The main research question is whether the structure of the housing stock according to housing tenure has an impact on the quality and level of innovations in the supply of housing options to the elderly and people with disabilities in the selected Central European countries.

The tenure structure and supply of housing options to the elderly and people with disabilities has been researched by the HELPS project partners or the country experts hired by them in eight countries of Central Europe: Austria, Germany, the Czech Republic, Hungary, Poland, Slovakia, Slovenia and Italy. We used also several other kinds of data from alternative sources with the aim of controlling for the effect of other factors that may also influence the supply of housing options to the elderly and people with disabilities. After controlling for these effects the results show that the housing system may have a substantial impact on our dependent variable: in countries with a lower homeownership rate and a higher share of rental housing there is also a higher probability that the supply of housing options to the elderly will be wider and will involve more innovative features. However, the results need to be verified on a larger sample of countries in future research.

In the first subsection, we will describe the housing context in three Western European countries (Austria, Germany and Italy) and, in the next one, the housing context in the remaining five post-socialist states. The third subsection describes data sources and data categorisations; the fourth one elaborates the main hypotheses for our analysis and describes the methods used in detail. The following subsection presents the findings for each hypothesis elaborated, and the final subsection summarises them into the main conclusions.

The Western European Housing Context

There are some common trends in Western European housing systems in recent decades, such as the increasing liberalisation of housing provision and decentralisation over housing policy (Donner 2000, 2006; Boelhouwer and van der Heijden 1992; Whitehead and Scanlon 2007; Ghekiere 1992). However, the diversity in housing systems due to their unique development in diverse institutional contexts has been maintained and this diversity is an important distinct feature to post-socialist states. The three Western European countries in our sample of eight Central European countries – Germany, Austria and Italy – demonstrate this fact.

Germany ranks among the countries that deregulated private rents to close-to-market levels (so-called ‘comparable rents’) and were the first in Europe to introduce means-tested housing benefits: the housing benefit was already introduced in 1965 and rent deregulation to a comparable rent system was adopted in the early 1970s. German housing policy very early shifted its focus from subsidising supply to the means-tested support of persons (demand-side subsidies, such as housing benefits) and the German housing system became particularly based on stable and long-term private rental housing.

In Germany, the notion of social housing also became very specific – instead of permanent social housing stock, Germany applied the approach of temporary ‘publicly subsidised housing’, i.e. housing built with the help of public funds rented out for social rents and purposes (under restrictive allocation rules) for only a pre-specified contractual period (usually 20–30 years). After that period the obligation to set lower-than-market rent expires and the landlord, who may also be a private for-profit-orientated landlord, is allowed to charge market rent. In recent years, subsidised housing was predominantly built for special groups of households, including the disabled and the elderly (Donner 2000: 159). The stock of social housing has recently also become relatively small – the share of such housing decreases each year. In 1987 in Germany (west) there were 3.9 million social dwellings while in 2001 there were only 2.3 million of them and the stock was decreasing by about 100,000 social dwellings per year: recently subsidised housing has accounted for only about 10% of the total German housing stock. ‘The fall in the amount of social housing means it is more difficult to use housing as an instrument of social policy. As the number of units falls, so does the interest of the states and the municipalities in what is left.’ (Droste and Knorr von Siedow 2007: 102)

By contrast, more than 40% of German households live in private rental housing and this housing tenure represents the pillar of the German housing system. Germany also ranks among countries with relatively high housing costs and a high average housing expenditure-to-income ratio, where, consequently, the housing benefit plays an important role: at the end of 1998, housing benefit was paid to 7% of households in the western part of Germany and to 11% of households in the eastern part of Germany (Donner 2000: 163); after the reform of social benefits in 2005 the support for housing costs was integrated into the unemployment benefit II. However, in 2009 about one million German households were still receiving an additional housing benefit. It is important to note that pensioners represent the largest share of the beneficiaries: 45% in 2009 (Deutscher Bundestag 2011: 9).

In the Austrian housing system the decisive role is played by social housing. A large portion of the urban population lives in long-term and high-quality social rental housing provided by municipalities, housing cooperatives or limited-profit housing organisations. The allocation of social housing lacks targeting and income ceilings are very high. Social housing forms 25% of the total Austrian housing stock (in the capital of Vienna it is 48% of the city’s housing stock): the limited-profit sector (housing associations) own 15% of dwellings, while 10% are publicly owned (Reinprecht 2007: 35). Housing co-operatives and limited-profit housing associations are united under the Austrian Federation of Limited-Profit Housing Associations – an umbrella organisation for 193 members managing 724,000

housing units. Private renting is also an important form of housing tenure in Austria: it accounts for 18% of the total housing stock.

The large share of social housing in the Austrian housing system and the conservative rent policy is the main reason for the relatively low (affordable) average housing costs and, when compared with other developed countries, it has one of the lowest average housing expenditures-to-income ratios among senior households.

Public housing subsidies are not allocated exclusively to social housing: about 80% of all new housing construction is co-financed from public sources. The subsidy schemes are complex and vary between provinces: basically it is a combination of grants and subsidised loans. The Austrian housing policy did not follow the policy shift from supply-side housing subsidies to demand-side housing subsidies, as was the case in Germany. Instead, it continued to support new housing construction/rehabilitation projects (though less so than before 1990) and the housing benefit is a less important complement of housing policy: despite the trend of an increasing number of recipients, in recent years only 5% of households have received the housing benefit. Housing benefits again differ considerably amongst the regions, in terms of the housing stock included, the definition of reasonable housing expenses, the entitlement level, etc.

The rents in public and limited-profit housing are set at cost rent, while in the private sector the concept of 'guided rent' was introduced in 1993: guided rent depends on the production costs of new subsidised dwellings and is applied to apartments built before 1945 (Donner 2000: 104). However, these higher rent levels can be applied only to new tenancies and rent regulation, and the subsidy rules are very complex and frequently modified. This fact makes it difficult to obtain full information for potential beneficiaries to optimise the choice of housing; even the limited-profit housing sector has provoked some criticism due to commercial activities and unfounded rent increases in this sector.

In recent decades, the Italian housing policy has primarily been characterised by the shift from supply- to demand-side housing subsidies (i.e. from supporting social housing construction to the allocation of a means-tested housing benefit), the decentralisation of housing policy from the state to the regions (reform of Chapter V of the Italian Constitution giving the regions exclusive responsibility for social housing policies), and by the transfer of public housing management from limited-profit housing associations (IACPs – Istituti Autonomi per la Casa Popolare, limited-profit associations) to the municipalities. The new public housing supply was reduced; a similar drop has been noticed in assisted and contractual housing (housing with lower than market costs owned by private landlords). The home-ownership rate quickly grew from 59% in 1981 to 75% in 2008; 19% of the housing stock remains as rental housing, but public (also called 'subsidised') rental housing makes up only 4% of the Italian housing stock, i.e. much less than in Austria or Germany. The Italian housing system can be categorized as 'mixed' with a very small share of social housing but a still not insignificant private rental segment.

The Italian housing system is also characterised by relatively low housing costs: the average housing expenditures-to-income ratio of Italian senior households is the lowest in the sample of eight central European countries. One of the reasons is that the Italian rental sector was traditionally subject to a relatively conservative and rigid rent control regime: rents in social housing are set well below cost level and housing managers (IACPs) ran a comparatively huge deficit in the past (Donner 2000: 337). The 'fair rent' concept has been applied to private rental housing since 1978. Fair rent is basically cost rent determined by the percentage of production costs and it is substantially lower than market levels. Rental policy only changed in the early 1990s. This instability led to high number of evictions and under-investments in the private rental segment. However, the low housing costs have made the role of the housing benefit marginal, as it is in Austria: the housing benefit was introduced relatively late and never really came to be significant (Donner 2000: 337).

The Post-Socialist Housing Context

When compared to Western European countries, post-socialist states have exhibited more similarities in the development of their housing systems in the last two decades. The reason is the common process of economic transformation from central planning to a market economy, which was most notably reflected in the housing field by large-scale, give-away public housing privatisation schemes.

After 1990, the new democratic governments in the post-socialist states wanted to re-introduce private property and establish a market economy (Pichler-Milanovic 2001). Governments in most countries in Central and Eastern Europe shared the view that large parts of existing public rental housing should be privatised, rent regulation rules should be abolished or replaced with a new market-friendly system, and new social housing strategies should help people who were unable to afford housing available in the free market.

However, in most countries the transfer of public housing into private hands was put into practice in a very specific way: it ultimately took the form of a massive give-away sale to sitting tenants who obtained housing wealth almost or wholly free of charge. The sitting tenants received the so-called right-to-buy, i.e. a centrally guaranteed right to buy public dwellings occupied by them under very advantageous price terms. Other forms of privatisation, such as those that would preserve rental housing through the sale of public flats to private investors, not-for-profit private housing associations, housing cooperatives, or the sale of public flats to sitting tenants at market prices were barely discussed (Lux 2009; Lowe and Tsenkova 2003).

With give-away privatisation, public housing almost disappeared within a short period in most post-socialist states. As a result, homeownership rates increased substantially to levels often exceeding 90% of the total housing stock in many post-socialist countries, and housing systems in post-socialist states came to be classified as 'super-homeownership' models.

There were a few exceptions to this general trend. For example, in Poland and the Czech Republic right-to-buy legislation was not passed and public housing privatisation was left to the municipalities as an open option (Lowe and Tsenkova 2003). However, both Poland and the Czech Republic decided to keep the original pre-1990 type of conservative rent control. Consequently, the municipalities in these two countries, though not obliged to sell public housing under a right-to-buy policy, were unable to introduce any effective way of managing the public housing stock. With their hands tied by rent control, the municipalities often saw the sale of public housing as a good way of ridding themselves of public housing. In this case again, public flats were mostly sold to sitting tenants at low prices, though the price conditions (and the scale and speed of the sale) varied among municipalities. The give-away privatisation of public housing to sitting tenants was delayed, but ultimately did happen. According to estimates (Hegedüs et al. 2012), in the Czech Republic about 75% of the original stock of public housing was sold to sitting tenants under advantageous price terms by 2010; and the share of public housing had decreased from 35% in 1991 to an estimated 10% of total housing stock by 2010. Similarly, for Poland the respective figures are 32% in 1991 and 8% in 2011.

The highest share of public or not-for-profit housing out of the total housing stock in 2010 among post-socialist countries in our sample occurred in Poland (with substantial rental coop housing) and the Czech Republic (20% and 10%, respectively); in Slovenia it formed 5% of housing stock, in Hungary only 3%, and in Slovakia less than 3% of housing stock. Although the municipalities became the main social housing landlords, they did not receive sufficient public funds to perform this new role effectively. Not-for-profit housing, i.e. housing owned and managed by a private non-for-profit or limited-profit housing association, is a new phenomenon, having only appeared since the collapse of socialism. However, there are only two post-socialist countries in our sample where not-for-profit housing now makes up a visible share of the housing stock: Poland and Slovenia where recently it constitutes only 2% of the housing stock in both cases.

The form of rent regulation, i.e. a central (state) policy that restricts the level of rent charged by public and/or private landlords, represents an important contextual feature of post-socialist housing change. In the period of communism, rents were extremely low and well below cost levels. In the early 1990s, rent reform was conditional upon the introduction of a right-to-buy policy, i.e. rent deregulation was passed only if sitting tenants were also given the 'right-to-buy' and thus a chance to avoid future rent increases. Moreover, even if right-to-buy policies were introduced, the deregulation of rents did not necessarily mean that rents increased to close-to-market levels.

In 2012, there was only one country among the five post-socialist states in our sample where no central rent control regime had been applied – Hungary. However, in Poland and the Czech Republic important progress was also made in rental policy. Since 2005 the rent control regime in Poland has acquired the character of a 'second-generation' rent control regime. The only central restrictions relate to rent increases, and caps are not set as central tariffs but instead at a 'justifiable' growth level (e.g. the increase in rent can be justified by the refurbishment of the flat, the low-capital profit of the landlord, higher costs for landlords to repay a mortgage loan due to inflation, etc.). Since 2013, the Czech Republic also acquired a 'second-generation' rent control regime – the restrictions apply only to rent increases (a maximum of 30% in the last three years) and rent caps are set as 'comparable rents'; i.e. rent should not exceed the free market rent for the same type of dwelling in the same location (similar to the rent regime in Germany). By contrast, the most conservative form of rent control – flat-rate tariffs differentiated somewhat by specific coefficients – is used in Slovakia. In Slovenia, maximum rents are calculated as a percentage of the estimated (assessed) dwelling value: 4.68% of the estimated dwelling value in 2010.

Private rental housing, a thoroughly new institution established after the change of regime, became branded as an insecure and expensive form of tenure, where landlords make no effort to have good relations with their tenants, and it is characterised by conflicts and tensions. As a result, most citizens have sought to avoid the private rental sector. In most post-socialist countries (with some exceptions, such as the Czech Republic or Poland) private landlords are typically former sitting tenants who benefited from give-away privatisation and found themselves at a certain stage in their family cycle with extra housing. As a result, the features of private rental housing are 'non-professional' landlords, the prevalence of short-term leases, weak protection of both parties to the agreement, and the frequent use of informal leases as 'non-professional' landlords try to avoid taxation.

Public opinion turned towards owner-occupation in all post-socialist states as rental housing as a whole gradually became stigmatised. The housing tenure structure in almost all post-socialist states is therefore dominated by owner-occupied housing: the housing system in these countries is called the 'super-homeownership' model. Only the Czech Republic and Poland are classified, and probably only temporarily, as 'mixed' systems in which renting still plays a significant role. This is an important aspect of post-socialist housing systems that may, hypothetically, have an impact on the quality and scale of the supply of housing options for elderly and other vulnerable people in these countries.

There are three countries, i.e. the Czech Republic, Slovakia, and Slovenia, where new social/public housing output built between 1995 and 2010 can be considered substantial (Lux and Sunega 2012). However, in the Czech Republic most new public housing output had de facto a quasi-homeownership status because the original state support for municipal housing was converted into support for co-operative (quasi-ownership) housing. In Slovenia, the relatively generous social housing programmes of the 1990s supporting new not-for-profit housing construction were recently scrapped and replaced by a housing allowance scheme. A moderate amount of social/public housing output after 1995 in relation to the size of the total housing stock can also be observed in Poland. However, subsidisation of new social housing output recently ceased, and flats built under the not-for-profit TBS programme will probably be privatized to sitting tenants. Hungary had marginal new social housing output after 1990; this housing was built only under the temporary Szechenyi programme. Consequently, Slovakia

is the only exception, where the construction of new social housing via public loans and grants can be considered substantial, and this trend appears to be stable.

Housing allowances (benefits) have been introduced in all the post-socialist states in our sample. However, their significance as real demand-side subsidies is questionable. In most countries the estimated share of households receiving a benefit is very low: less than 1% in Slovenia, 2% in Slovakia and 3% in Poland and the Czech Republic in 2010. Wider receipt of the housing benefit was found only in Hungary (8.5% of households); the housing benefit has played this more significant role since 2004. The source of benefit financing varies: in the Czech Republic, Slovakia and Hungary the benefits are paid entirely or mainly out of the state budget and in Poland and Slovenia they are financed exclusively or mainly out of the municipal budgets.

Data and Data Categories

Due to the fact that there is considerable variation between housing systems particularly in Western Europe, the scale and structure of the supply of housing options for the elderly and other vulnerable households are also diverse. For example, the housing benefit is an important element of public aid designed to increase housing affordability for elderly households in Germany, the Czech Republic, Hungary and Poland (i.e. countries with liberalised rents or market-friendly rent regulation regimes) but it plays a less important role in Austria, Italy, Slovenia and Slovakia (i.e. countries with a stricter rent regulation policy). This fact is a result of the different forms of rent regulation policy. Analogically, the housing expenditure-to-income ratio among senior households has the lowest average value in Austria, Slovenia and Italy. By contrast, in Germany, the Czech Republic, Hungary and Poland the rent control regime has largely been liberalised: in Hungary it has been fully liberalised and the other three countries have adopted 'market-friendly' rent control regimes.

The contextual factors relating to the nature of the housing system, next to other important macro-economic and demographic factors, have therefore an influence on the scope and structure of aid supporting ageing in place for the elderly and housing for people with disabilities in the countries in our sample. The purpose of this section of the report is to analyse and discuss the impact of the housing (tenure) system on the scope of the supply of housing options for the elderly and people with disabilities that allow people to stay in their current or at least standard forms of housing for as long as possible.

However, it is not possible to make an exhaustive quantitative assessment of the supply of housing options for the elderly and people with disabilities in all eight Central European states because this would presuppose a substantial amount of information and details on each of the different programmes, grants, subsidies, allocation rules, cost items, financing sources, management schemes, etc. With some caution, we are only able to make a qualitative categorisation of countries according to the fact of how the supply (offer) of different measures increasing housing affordability and accessibility for the elderly and people with disabilities, targeting ageing in place and prolonging living in standard forms of housing, varies and thus permits eligible people to choose from different options. Therefore, we are only able to qualitatively assess the diversity of measures and the possibility for beneficiaries to choose.

By doing this kind of qualitative assessment, we assume that the possibility to choose is the sign of a developed model of housing support because a greater variety of supply increases the chance that the measures will better meet the diverse needs and preferences of eligible households. The possibility to choose different measures/options respects elderly and other vulnerable people as dignified human beings with their rights and diverse preferences. Next to diversity, the existence of innovative schemes is also included in our categorisation of models. Innovative schemes are such that a) evolved in a local environment or were substantially shaped by the local context (i.e. assume a more effective saturation

of specific local needs), and b) involve a number of stakeholders from both the public and private housing sectors (cost and management sharing) making it financially and administratively sustainable in the longer term. Consequently, we categorised the diversity and scope of innovations in the supply of housing options for the elderly and other vulnerable households into the following four categories:

- **Developed model** (Germany and Austria): This is characterised by a variety of measures and housing options, often locally shaped, both in the field of housing affordability and housing accessibility. Many of the housing options are innovative in terms of both their content (technical and architectural innovations) and their management (innovative management schemes involving different stakeholders from the private and public sectors). The housing options include rent control contracts, occupancy commitment contracts, retirement provisions, age-appropriate conversions, technology-assisted housing, multi-generational homes, a housing benefit, adaptations of existing flats, co-housing or lifetime homes in Germany; adaptations of existing flats, senior flats, supervised flats, special retiree dwellings, flat-share communities, senior-living communities or integrated (mixed) housing in Austria.
- **Semi-developed model** (Italy): This model is characterised by a limited variety of different housing options in the field of housing affordability and accessibility and a limited choice of alternatives for eligible households. However, the supply includes also innovative schemes both in terms of both content and management, such as collaborative housing, protected housing, municipal supports for flat adaptations or municipal guarantees.
- **Basic model with the re-introduction of a supply of social housing** (Slovakia, Poland, Slovenia and the Czech Republic): This model is characterised by limited and more or less standardised supply of housing options for the elderly in the field of housing affordability and accessibility, most often centrally determined and funded, with little local variance and with few examples of innovative schemes (limited cooperation and co-financing between public and private housing segments). The not-for-profit and private rental segments are weak to become relevant partners in the supply of local and innovative housing options (with partial exception of Slovenia and Poland where examples are sheltered housing in Slovenia and TBS senior housing in Poland). In post-socialist countries ranked under this category, the governments re-started support for social (public) housing construction soon after the regime change; part of this newly built housing stock serves to meet the housing needs of the elderly and other vulnerable households.
- **Basic model** (Hungary): This model is characterised also by a limited and most often centrally determined supply of housing options for the elderly with very little local variance or innovative schemes. Moreover, new social housing construction was not revived after the regime change, though there were some temporary and financially limited government attempts to do so.

The diversity and scope of innovations in the supply of housing options for the elderly and other vulnerable people, from which the categorisation of countries above was derived, was researched in each country by country experts (HELPS project partners or experts hired by them) in the following three modes: a) a detailed description of all measures, subsidies and housing options for elderly and vulnerable households; b) a description of the possible choice of measures and housing options in the particular life situations of elderly people; and c) a detailed description and evaluation of two innovative best practices serving the elderly and people with disabilities: one in the field of housing affordability, and one in the field of housing accessibility.

The country experts provided the description of particular measures in their preliminary reports in spring 2012: due to the many details presented, we limited ourselves to giving only the titles of some examples above, but the full text of the preliminary reports is accessible on <http://www.helps-project.eu>. The innovative best practices, elaborated by the country experts in their final reports,

are described in detail in the study called 'Catalogue of Practices', the second major output from the research part of the project.

The description of choice in particular life situations (point b) was a part of the final report drawn up by country experts. The following life situation is one example: a woman, 72 years old, lives in a private for-profit rented dwelling alone. She had felt her age for several years but recently her osteoarthritis worsened a lot. She realised that using the bathroom started to be difficult for her, as there is only an old bath without any handles in her dwelling. She feels that without the help of another person with some of her daily life activities she would soon no longer be able to live in her home.

In all countries from our sample, there is a supply of different kinds of home care available to help the woman from our example, and often subsidised 'smart-home' facilities (ICT) are also available. With the exception of Slovenia, there are also special subsidies for dwelling reconstruction allocated to tenants or landlords, though the level of financial aid varies and generally is quite low. However, in the developed models (Germany or Austria), the woman could effectively choose from several real and affordable options. For example, in Austria she could directly ask, with the help of an NGO or property owner, for a subsidy to pay for up to 75% of reconstruction costs (so it is basically financially affordable for all). If the landlord were to oppose such reconstruction, the woman could relatively quickly move to a more accessible dwelling owned by the municipality or a limited-profit organisation in the same location for social rent; if preferred, she could opt for a subsidised supervised or senior (barrier-free) rental dwelling, which are available in each bigger municipality, or even for a flat in a senior-living community or an integrated (socially mixed) house in some municipalities. The latter two options would, however, involve some waiting time after submitting an application.

We aim to reveal the link between diversity and innovations in the supply of housing options to the elderly and people with disabilities (the typology of models presented above) and the housing system in a particular country. The main research question for our analysis is the following: Does the nature of a housing system have a significant influence on the diversity and scope of innovations in the supply of housing options to the elderly and people with disabilities? If this is the case then the nature of the tenure structure in a particular country would be an important determinant of the scope of help in the field of housing for the elderly, and this has clear policy implications. Given the limited number of countries in the sample, the results could not be generalised, but our sample consists of countries with very different housing systems and, consequently, allows for a partial analysis of this kind. If some kind of significant association appears in our sample then further research would be needed on a wider set of countries.

Table 6 shows the tenure structure in the eight sample countries in the years around 2010. It is clear that housing tenure structure significantly varies; for example, the super-homeownership model with a homeownership rate above 90% can be found in three post-socialist countries, while in Germany the homeownership rate amounts to less than 40% of the housing stock.

Consequently, we categorised the housing systems (tenure structures) in the eight Central European countries into the four following categories:

- **Social market** (Germany): most of the population lives in private rental housing and social housing forms a small and temporary housing segment operated through special public-private contracts;
- **Social democratic** (Austria): a major part of the urban population lives in social housing provided by municipalities or limited-profit organisations, and a substantial part of overall housing construction is also subsidised from public sources;
- **Mixed** (the Czech Republic, Italy and Poland): housing tenure is mixed with a substantial and increasing share of owner-occupied housing; however, rental housing (in the CR and Italy especially

Table 6 Housing tenure structure, around 2010

Country	Owner-occupied and owner co-ops	Private rental	Public rental, social rental, non-profit rental and rental co-op	Other tenures
Austria (AT)	53	18	22	7
Czech Republic (CZ)	75	9	9	7
Germany (DE)	38	43	14	5
Hungary (HU)	94	3	3	–
Italy (IT)	75	15	5	6
Poland (PL)	68	9	20	3
Slovakia (SK)	95	2	3	–
Slovenia (SI)	93	1	5	1

private renting, in Poland especially public, non-profit and rental co-op housing) still makes up a significant share of the housing stock;

- **Liberal** (also **super-homeownership**) (Slovakia, Slovenia and Hungary): the housing system is based on one tenure, homeownership – the homeownership rate exceeds 90% of the housing stock, social housing is marginal in scale and private renting is unstable and mostly part of the black market; people have generally little other choice than to become homeowners.

The two models categorised as ‘developed’ in terms of diversity and innovations in the supply of housing options for the elderly and people with disabilities are in countries that have a social market and social democratic housing systems (Germany, Austria), i.e. in countries with a substantial share of either private or social rental housing out of the total housing stock. The semi-developed model was found in a country with a mixed housing system (Italy); while the basic model was found only in countries with a mixed (CR, Poland) or a liberal (Slovakia, Slovenia, Hungary) housing system. This may hypothetically be a sign of a link between the housing system and the diversity and scope of innovations in the supply of housing options for the elderly and people with disabilities.

However, the diversity and scope of innovations in the supply of housing options for the elderly and people with disabilities (i.e. the type of model present in the country) may be determined by other factors than housing tenure, such as the country’s macro-economic situation, poverty rate, demographic ageing, housing shortage, housing cost burden or income and housing cost-to-income inequality. Table 7 presents an international comparison of the eight countries in our sample according to GDP per capita in the PPS, social protection benefits as a percentage of GDP, the old-age-dependency ratio, income inequality and the poverty rate among elderly households, average housing affordability and inequality in housing affordability among the elderly, and the number of dwellings per 1,000 inhabitants.

It is clear from Table 7 that the higher the GDP per capita (economic wealth), the higher the old-age-dependency ratio (the acuteness of the problem of population ageing) and the higher the inequalities in incomes and housing expenditures among the elderly (the gap between poor and rich seniors), the higher the chance that the country model of supply of housing options for the elderly is assessed as developed (semi-developed). In countries with higher income or housing cost-to-income inequalities the public authorities probably intervene more actively to mitigate them. The Italian ‘middle’ position on the scale may be explained by the relatively high housing affordability (the lowest housing cost-to-income ratio among the elderly in the sample) and the lowest inequalities in housing costs.

Table 7 The basic macro-economic, demographic and other selected indicators of the surveyed countries

Country	GDP per capita in PPS (EU 27 = 100)	Social protection benefits as a % of GDP	Old-age-dependency ratio	Income inequality (S80/S20) among the elderly	At-risk-of-poverty rate among the elderly	Average housing affordability among elderly households	Inequality in housing affordability among elderly households (S80-S20)	Number of dwellings per 1,000 inhabitants around the year 2000
Austria (AT)	125.0	29.9	25.7	3.5	15.1	16.5	14.5	405.0
Czech Republic (CZ)	82.0	19.8	20.9	2.3	7.2	28.0	13.1	427.0
Germany (DE)	116.0	30.1	30.9	3.7	15.0	28.2	20.5	467.0
Hungary (HU)	65.0	23.0	23.8	2.6	4.6	23.5	12.2	399.0
Italy (IT)	104.0	28.4	30.6	4.7	19.6	14.1	11.2	479.0
Poland (PL)	61.0	19.4	18.9	3.4	14.4	24.4	13.8	307.0
Slovakia (SK)	73.0	18.3	16.7	2.4	10.8	28.2	12.9	310.0
Slovenia (SI)	87.0	23.8	23.6	3.5	20.0	16.1	12.0	358.0

Source: Eurostat statistics, SILC survey and the HELPS survey.

Note: **Gross domestic product (GDP)** is a measure of economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in Purchasing Power Standards (PPS) is expressed in relation to the European Union (EU-27) average set to equal 100. If the index of a country is higher than 100, the country's level of GDP per capita is higher than the EU average and vice versa. Basic figures are expressed in PPS, i.e. a common currency that eliminates the differences in price levels between countries allowing a meaningful volume of comparisons of GDP between countries. Please note that the index, calculated from PPS figures and expressed with respect to the EU-27 = 100, is intended for cross-country comparisons rather than for temporal comparisons.

Social protection benefits are social benefits (other than social transfers in kind).

The old-age-dependency ratio is defined as the number of persons aged 65 and over expressed as a percentage of the number of persons between the ages of 15 and 64.

Income inequality among older people is the ratio of the total income received by the 20% of the population with the highest income (top quintile) to that received by the 20% of the population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income.

The at-risk-of-poverty rate among older people is the share of persons with an equivalised disposable income, before social transfers, below the risk-of-poverty threshold, which is set at 60% of the national median of equivalised disposable income (after social transfers). Retirement and survivor's pensions are counted as income before transfers and not as social transfers.

Average housing affordability among elderly households is the average ratio of household housing expenditures to net household incomes, computed only for households of the elderly.

Inequality in housing affordability among elderly households is the difference in the ratios of household housing expenditures between elderly households with the highest income (5th quintile) and the lowest income (1st quintile).

The reintroduction of social housing support in the group of countries with a basic model of supply of housing options for the elderly (all post-socialist states) seems to be best explained by the existence or non-existence of a physical shortage of housing: new supply-side subsidies promoting public or non-profit rental housing construction appeared mainly in the post-socialist countries with the lowest number of dwellings per 1,000 inhabitants (Poland, Slovakia and Slovenia). Consequently, those post-socialist countries that faced a physical shortage of housing were more likely to apply supply-side subsidies to promote new rental housing construction, which also served to satisfy the demand from seniors and people with disabilities. The Czech Republic is an exception: the relatively high number of dwellings per 1,000 inhabitants coincides with the ‘revival’ of support for new public housing construction. However, we wrote earlier that the subsidies promoting public housing construction allocated between 1995 and 2002 in the Czech Republic wound up de facto promoting quasi-ownership housing. Moreover, the recent subsidies are marginal in scale.

Data available for analysis was drawn basically from three different sources. The first source was a dataset compiled from an in-depth questionnaire survey completed for all the countries participating in the HELPS project by country experts. The dataset contains a great deal of detailed information about housing, which was used to categorise diversity and innovation in the supply of housing options for the elderly and people with disabilities, and to create the classification of housing systems outlined above. We also used data on family structure in the total and elderly population from this source (such as the share of people living as singles, in two-member households, three-member households, etc.); data on the structure of elderly households (such as elderly living alone, living with his/her partner, with his/her children, living in institutional care); data on the type of housing for both the total and the elderly population (such as a detached house, apartment, institutional care facility); and data on the share of the overall population and elderly living in urban or rural areas.

The second major source of data was Eurostat statistics: these include data on macro-economic performance (the real GDP growth rate, GDP per capita in PPS, the public deficit as a percentage of GDP, the public debt as a percentage of GDP, the unemployment rate, the employment rate among elderly people 65+, and inflation – a harmonised index of consumer prices), data on incomes and income inequalities (the at-risk-of-poverty rate among elderly people, the median relative income of elderly people,⁵ income inequality among older people,⁶ the Gini coefficient for the overall population, the aggregate replacement ratio⁷ and the aggregate replacement ratio including other social benefits,⁸ gross pension replacement rates by earnings⁹ from an OECD source, and net pension replacement rates by earnings¹⁰), data on social expenditures (social protection benefits as a percentage of GDP, social benefits other than social transfers in kind as a percentage of GDP, social contributions as a percentage of GDP,¹¹ and expenditure on pensions as a percentage of GDP), demographic data (the share of elderly with low educational attainment, natural increase per 1,000 inhabitants, the balance of migration per

⁵ The indicator is defined as the ratio between the median equalised disposable income of persons aged 65 or over and the median equalised disposable income of persons aged between 0 and 64.

⁶ The ratio of total income received by the 20% of the population with the highest income (top quintile) to that received by the 20% of the population with the lowest income (lowest quintile). Income must be understood as equalised disposable income.

⁷ The ratio of income from pensions of persons between the ages of 65 and 74 and income from work of persons between the ages of 50 and 59.

⁸ The indicator is defined as the ratio of the median individual gross pensions of the 65–74 age category relative to the median individual gross earnings of the 50–59 age category including other social benefits.

⁹ The gross replacement rate shows the level of (gross) pensions in retirement relative to (gross) earnings when working.

¹⁰ The net replacement rate shows the level of (net) pensions in retirement relative to (net) earnings when working.

¹¹ Social contributions are divided into actual social contributions and imputed social contributions. Actual social contributions include employers’ actual social contributions, employees’ social contributions and social contributions by self-employed and non-employed persons. Imputed social contributions represent the counterpart to social benefits (less eventual employees’ social contributions) paid directly by employers.

1,000 inhabitants,¹² the total fertility rate,¹³ life expectancy at birth, the share of the population aged 0–14, the share of the population aged 15–64, the share of the population aged 65+, the share of the population aged 80+, the old-age-dependency ratio,¹⁴ and the share of elderly people with low educational attainment¹⁵) and data on housing availability (the number of dwellings per 1,000 inhabitants around the year 2000).

The third source of data was the EU-SILC 2009 survey, from which we obtained data on housing costs and the housing cost-to-income ratio (the affordability ratio¹⁶ among elderly people and inequality in the housing affordability ratio among elderly people¹⁷).

Hypotheses and Research Methods

Only a complex analysis of all factors together can provide us with a full understanding of the influence of each of the factors on the dependent variable, including the factor of the housing system, and on the scope and level of innovations in the supply of housing options for the elderly and people with disabilities. The main hypothesis, evolved from the research question mentioned above, is the following:

HM: There is a significant link between housing systems (the housing tenure structure) and diversity and innovations in the supply of housing options for the elderly and other vulnerable people in the surveyed countries, after controlling for the effects of other relevant factors (variables).

We also included two complementary hypotheses in the analysis that are closely related to our main hypothesis. They are as follows:

HC1: It is a fact that income inequalities and inequalities in housing affordability in post-socialist countries (Czech Republic – CZ, Hungary – HU, Poland – PL, Slovakia – SK and Slovenia – SI) are lower than in advanced countries (Austria – AT, Germany – DE and partially Italy – IT). However, in post-socialist countries a significantly larger part of the elderly population has low income and is therefore dependent on financial assistance from the state. This may explain the use of central and universal, less innovative and less targeted housing measures (basic model) than is the case in developed countries that typically have greater inequalities but also a larger number of financially self-sufficient elderly in the population.

HC2: Diversity within the housing system (of the housing tenure structure) determines the differences in the ‘living status’ of elderly people (i.e. whether they live as single adults, a couple, in another type of household, in a household with children), after controlling for the effects of other important factors (variables).

Two methods were applied to perform complex analyses of all the factors together. It was necessary to deal with the small number of cases (only eight surveyed countries); therefore multidimensional scaling (MDS) and qualitative comparative analysis (QCA) were chosen. Despite the selection of methods recommended for use in qualitative (or a low-sample) data analysis we should note that any

¹² The crude rate of net migration plus an adjustment per 1,000 inhabitants.

¹³ Number of children per woman.

¹⁴ This indicator is defined as the projected number of persons aged 65 and over expressed as a percentage of the number of persons between the ages of 15 and 64.

¹⁵ The indicator is defined as the percentage of people aged 65+ years with an education level according to the ISCED (International Standard Classification of Education) of 2 or less. ISCED levels 0–2: pre-primary, primary and lower secondary education.

¹⁶ The affordability ratio is the share of household housing expenditures on net household income in percentages.

¹⁷ The variable is defined as differences in the ratios of household housing expenditures between the households of elderly with the highest income (5th quintile) and the lowest income (1st quintile).

quantitative analysis on such a small sample of countries is affected by sample bias, and consequently, the results cannot be generalised and should be taken with caution.

MDS falls within the more general category of methods that are used for multivariate data analysis, so it is closely related to other statistical methods such as principle components analysis, correspondence analysis and cluster analysis. MDS allows researchers to gain insight into the underlying structure of relations between entities (countries in our case) by providing a visual (geometrical) representation of these relations. MDS is characterised 'by the generality of the type of observed relations which can be submitted to the data analysis on the one hand, and by the specificity of the type of geometrical representation of these relations on the other hand' (Van Deun and Delbeke 2000). MDS 'attempts to find the structure in a set of proximity measures between objects. This process is accomplished by assigning observations to specific locations in a conceptual low-dimensional space such as the distances between points in the space match the given (dis)similarities as closely as possible. The result is a least-squares representation of the objects (countries in our case) in that low-dimensional space' (SPSS Help).

For the purpose of testing our hypotheses we applied MDS using a PROXSCAL algorithm, which is considered to be more reliable than an ALSCAL algorithm. The ALSCAL algorithm was found to provide more distorted results in some circumstances. The data are visually presented in a simplified form, which to some extent distorts the representation of the (dis)similarities of the input matrix. The degree of correspondence of the distances between points (in our case countries) implied by the MDS charts and the original matrix of distances (input data for the procedure) is measured with a stress function. The higher the value of the stress, the higher the degree of distortion of the visual distances between objects (countries) and the original distance matrix. The so-called Kruskal Stress (or Stress-1) is probably the most often used stress measure. Values of the Kruskal's stress that are in the range between 0 and 0.025 are considered excellent (i.e. minimum distortion), they are considered good in the range from 0.025 to 0.05 and admissible in the range from 0.05 to 0.1. If the value of the Kruskal's stress exceeds 0.2, the MDS results should not be used.

Two important facts on MDS figures should be stressed. Firstly, the axes are meaningless and, secondly, the orientation of the picture is arbitrary. All that matters is the distance between points in the figure. In other words, the results from the MDS figure are interpreted based on the number and content of the clusters. Clusters are groups of items or points (countries in our case) that are closer to each other than to other items or points in the figure.

QCA is a new method used in comparative qualitative sociology or comparative politics. In both disciplines there is strong tradition of case-oriented work alongside a growing body of quantitative cross-national research. QCA attempts to bridge the worlds of quantitative and qualitative (case-oriented) researchers. QCA allows studying causal conditions, even if the causality is very complex and involves different combinations of causal conditions capable of generating the same outcome. QCA can be applied to research designs of small or intermediate size, such as samples between 5 and 50 cases.

With the 'Crisp-Set' QCA (csQCA), the original application of QCA, the variables can only have two values: zero or one (a binary variable). Unfortunately, in its original form the technique cannot be used to assess the effect of the relative strengths of the independent variables (as they can only have two values). To overcome the issue of binary variables and the impossibility of assessing the effect of independent variables, extended (or generalised) forms of QCA were developed: Multi-Value QCA (mvQCA) and Fuzzy Set QCA (fsQCA).

QCA tries to overcome the small sample (N) problem by analysing all logically possible combinations of independent variables. The independent variables should be set according to the examined theory. Possible combinations of independent variables are confronted with empirically observed outcomes (values of the dependent variable) and the number of combinations leading to the same output

is then reduced using the rules of Boolean algebra. QCA rests on combinatorial rather than additive logic. Combinatorial logic focuses on the contribution of unique combinations of variables thought of as ‘causal conjunctures’ or ‘scenarios’. The goal of QCA is to identify which combinations are crucial for distinguishing one outcome from another (Soulliere 2005). Due to the limited number of cases (surveyed countries) we decided to apply Crisp-Set QCA analysis (csQCA).

As mentioned above, neither MDS nor QCA are methods designed for testing a hypothesis (or at least not in the form familiar from other quantitative methods, such as OLS analysis). However, for our main hypothesis, we used MDS to find clusters of countries that would (or would not) correspond to the categorisation according to the diversity and innovations in the supply of housing options for the elderly and people with disabilities stated above. The independent variables were normalised using Z scores. QCA was employed to discover the combination(s) of independent variables and the relationship between them, which leads to the expected state of the dependent variable.

Additionally, when using MDS we performed a sensitivity analysis: we started with the ‘basic’ variable (e.g. the share of elderly people living as single adults for HC2) and we successively added further variables to see whether and how the newly added variables changed the ‘map’ (clusters of countries and distances between countries) created by MDS analysis. If the impact was negligible, the variable was omitted from further analysis (the same held for variables whose addition led to meaningless results, i.e. with which it was impossible to identify any clusters of countries).

Main Findings

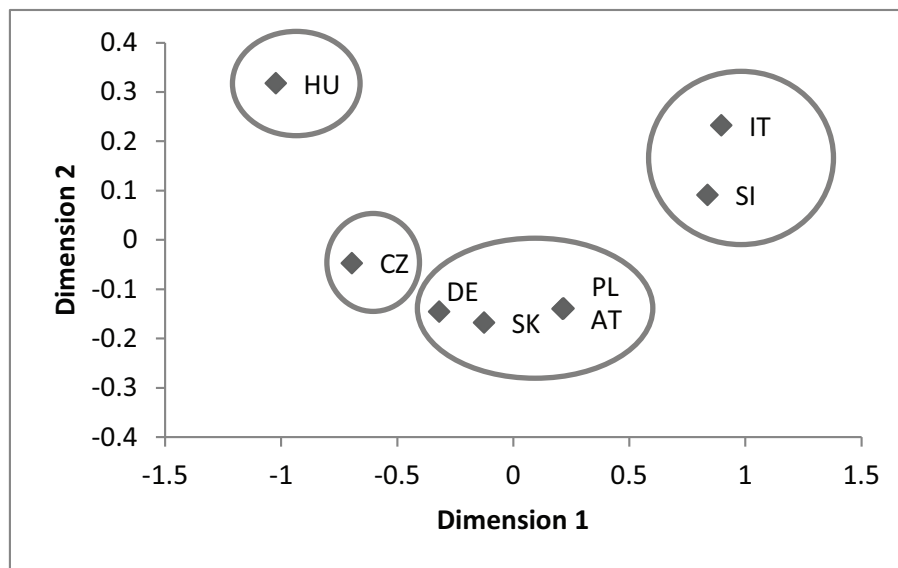
In this section we are going to present the main findings from our complex analyses. The findings and additional details on the transformations of the data will be described successively for each hypothesis elaborated above. We will start with the complementary hypotheses and this section will end with the results of the analysis of the main hypothesis.

HYPOTHESIS HC1: IN COUNTRIES CATEGORISED AS BELONGING TO THE BASIC MODEL A SUBSTANTIALLY LARGER SHARE OF THE ELDERLY POPULATION IS DEPENDENT ON FINANCIAL ASSISTANCE FROM THE STATE AND THEREFORE PUBLIC MEASURES ARE LESS INNOVATIVE AND MORE UNIVERSAL.

If we look at income inequality among the elderly in 2009 (S80/S20), it is possible to identify (according to MDS results, Stress-I = 0.02837) three groups of countries: CZ, SK and HU with low income inequalities; PL, AT, SI and DE with middle income inequalities; and IT with the highest income inequality. MDS analysis based on inequality in housing affordability (Stress-I = 0.02761) showed two groups of countries: the first group consists of only DE with the highest inequality in housing affordability, and the second group includes all the other countries (AT, PL, CZ, HU, SK, SI, IT). The clustering of countries according to income and housing cost-to-income inequalities is therefore not as clear as it might be from a simple data comparison.

Additionally, HC1 assumes that the share of elderly dependent on state aid is higher in post-socialist countries than in advanced EU countries (AT, DE, IT). We used a broad range of variables to measure the degree of dependence of the elderly on state financial assistance: the median relative income of elderly people, the aggregate replacement ratio, the aggregate replacement ratio including social benefits, expenditures on pensions as a percentage of GDP, and the gross pension replacement rate by earnings (OECD data). However, the MDS analysis did not reveal any clear and stable distinction between the post-socialist and advanced countries (AT, DE, IT), with one partial exception – expenditures on pensions as a percentage of GDP, where, however, Germany was ranked in the same cluster as Poland. The median relative income of elderly people and the replacement ratios did not produce clustering in support of the HC1. Consequently, the MDS analysis did not confirm that there is a larger share of elderly people dependent on state financial assistance in post-socialist countries than in more advanced economies.

Figure 11 Groups of countries according to income inequality (S80/S20) among the elderly, inequality in housing affordability (S80/S20) among the elderly, the at-risk-of-poverty rate among the elderly and the median relative income of the elderly



Note: Multidimensional scaling, PROXSCAL procedure in SPSS, Stress-I=0.02102.

Source: Authors' calculations, Eurostat data.

In the final step, we analysed two main relevant variables together (median relative income of elderly people and housing cost-to-income inequality) and included also income inequality among the elderly and the at-risk-of-poverty rate among the elderly. Figure 11 shows four groups of countries created by MDS. The first, fully consistent group consists of only HU and is characterised by low income inequality among the elderly, a low at-risk-of-poverty rate among the elderly, low inequality in the housing cost-to-income ratio and a high median relative income of the elderly. The second group consists of only CZ and it is characterised by low income inequality among the elderly, a low at-risk-of-poverty rate among the elderly, low inequality in the housing cost-to-income ratio, but low median relative income of the elderly. The third, 'middle' cluster comprises DE, SK, AT, PL. The fourth, the least consistent group, consists of IT and SI and is characterised by high income inequality and a high at-risk-of-poverty rate among the elderly, but low inequality in the housing cost-to-income ratio and middle median relative income of the elderly. Therefore, even when consistency among relative income, income inequality, the at-risk-of-poverty rate and the housing cost-to-income inequality among the elderly was analysed, no clear division between post-socialist and advanced Central European states emerged. Consequently, hypothesis HC1 was not confirmed by our data analysis.

HYPOTHESIS HC2: THE DIVERSITY IN HOUSING SYSTEMS DETERMINES THE DIFFERENCES IN THE 'LIVING STATUS' OF ELDERLY PEOPLE.

HC2 focuses on explaining the differences in the shares of elderly living as single adults / as a couple / in another type of household / in a household with children in surveyed countries. We test whether housing tenure has a significant impact on the 'living status' of elderly people, after controlling for the effects of other important factors.

MDS results show that there are three groups of countries according to the share of elderly living as single adults. The first group consists of PL with the lowest share of single adults. The second group comprises SK and HU with a middle share of people living as single adults, and the third group consists of DE, AT, CZ, IT and SI with the highest share of single adults. We obtained similar clusters when analysing the share of elderly living with children.

HC2 was tested using Crisp-Set Qualitative Comparative Analysis (csQCA). Both dependent and independent variables were entered into the analysis as dummies (1 – true, 0 – not true). Countries

were grouped according to the above-stated classification into two groups. The first group consisted of countries with the largest share of single adults (DE, AT, CZ, IT and SI), with the value of the dependent variable equal to one, and the second group of countries (the rest of the surveyed countries) had a dependent variable with a value equal to zero. GDP per capita in PPS was assumed to be one in AT, DE and IT and zero for other countries. The housing affordability ratio (average housing cost-to-income ratios for households of the elderly) was assumed to be high in CZ, DE, SK (with a value equal to one) and low in the other surveyed countries. The availability of housing (the number of dwellings per 1,000 inhabitants) was assumed to be high (i.e. with a value equal to one) in AT, CZ, DE and IT¹⁸ and zero in other countries. The religiosity level in the surveyed countries was measured indirectly using the Eurobarometer data on the trust in religious institutions.¹⁹ The religiosity level was considered to be high (i.e. with a value equal to one) in SK, HU, IT and PL. The liberal housing systems of HU, SK and SI got a value of one, the other countries zero.

The intermediate solution calculated using fsQCA 2.0 software²⁰ is presented in Table 8. It shows that the 'living status' of the elderly (living as single adults) depends on the level of housing expenditures, the level of religiosity, the type of housing system, housing availability (the number of dwellings per 1,000 inhabitants), and GDP per capita in PPS. More precisely, the share of elderly living as single adults is higher in countries with a lower housing cost-to-income ratio and at the same time lower trust in religious institutions. The share of single adults is also higher in countries with a lower homeownership rate and at the same time higher housing availability (a higher number of dwellings per 1,000 inhabitants) and lower trust in religious institutions. Finally, the share of single adults is higher in countries with a lower homeownership rate and at the same time a lower housing cost-to-income ratio and higher GDP per capita in PPS.

Consequently, the housing system may have a significant influence on the living status of elderly people and the HC2 hypothesis has been partially confirmed. However, the influence of the housing system is conditional upon the influence of other factors: a higher number of single adults among the elderly is found in countries with more rental housing available (i.e. in other than liberal housing systems) but only if these countries are simultaneously characterised either by a) low religiosity and high housing availability, or by b) low housing costs and high GDP.

MAIN HYPOTHESIS HM: THE DIVERSITY IN HOUSING SYSTEMS IS LINKED TO DIVERSITY AND INNOVATIONS IN THE SUPPLY OF HOUSING OPTIONS FOR THE ELDERLY.

The main hypothesis is about the existence of a link between housing systems (housing tenure structure) and the diversity and scope of innovations in the supply of housing options for the elderly and people with disabilities in surveyed countries, after controlling for the effects of other important factors.

We ran MDS analysis using the following variables: GDP per capita, the old-age-dependency ratio, and income inequality among elderly. We assumed that these variables (the economic wealth of a country, the acuteness of the problem of population ageing, and the degree of need to mitigate income inequality among the elderly) will have the biggest influence on the scope and innovations in the supply of housing options.

¹⁸ In the cited countries the number of dwellings per 1,000 inhabitants was greater than 400.

¹⁹ The share of responses 'tend to trust religious institutions' to the question 'I would like to ask you a question about how much trust you have in certain institutions. For each of the following institutions, please tell me if you tend to trust it or tend not to trust it?' was used to categorise countries (highest value – HU: 51%, lowest value – CZ and SI: 30%). SK, HU, IT and PL had the largest share of positive answers (more than 45% tended to trust in religious institutions in 2010). Source: Eurobarometer (http://ec.europa.eu/public_opinion/cf/showtable.cfm?keyID=2200&nationID=11,17,3,22,8,24,26,25,&startdate=2010.11&enddate=2010.11)

²⁰ <http://www.u.arizona.edu/~cragin/fsQCA/software.shtml>

Table 8 Crisp-Set QCA solution for the ‘living status’ of elderly people (dependent variable), GDP per capita in PPS, housing affordability, housing availability, religiosity and tenure (independent variables)

```

*****
*TRUTH TABLE ANALYSIS*
*****

File: D:/Petr/SoU/HELPS/vypInene_dotazniky/preliminary/analyzy/data_h2_qca_dummy.csv
Model: lsa = f(tenoo, ndpi, hetotal, religiosity, gdppcpps1)

Rows:      18

Algorithm: Quine-McCluskey
  True: 1
  0 Matrix: 0L
Don't Care: -

--- INTERMEDIATE SOLUTION ---
frequency cutoff: 1.000000
consistency cutoff: 1.000000
Assumptions:
~tenoo (absent)
ndpi (present)
~hetotal (absent)
~religiosity (absent)
gdppcpps1 (present)

              raw      unique
              coverage  coverage  consistency
              -----  -----  -----
~hetotal*~religiosity      0.400000    0.200000    1.000000
~tenoo*ndpi*~religiosity    0.600000    0.400000    1.000000
~tenoo*ndpi*~hetotal*gdppcpps1 0.400000    0.200000    1.000000
solution coverage: 1.000000
solution consistency: 1.000000

Cases with greater than 0.5 membership in term ~hetotal*~religiosity: AT (1,1),
SI (1,1)
Cases with greater than 0.5 membership in term ~tenoo*ndpi*~religiosity: AT (1,1),
CZ (1,1), DE (1,1)
Cases with greater than 0.5 membership in term ~tenoo*ndpi*~hetotal*gdppcpps1: AT (1,1),
IT (1,1)

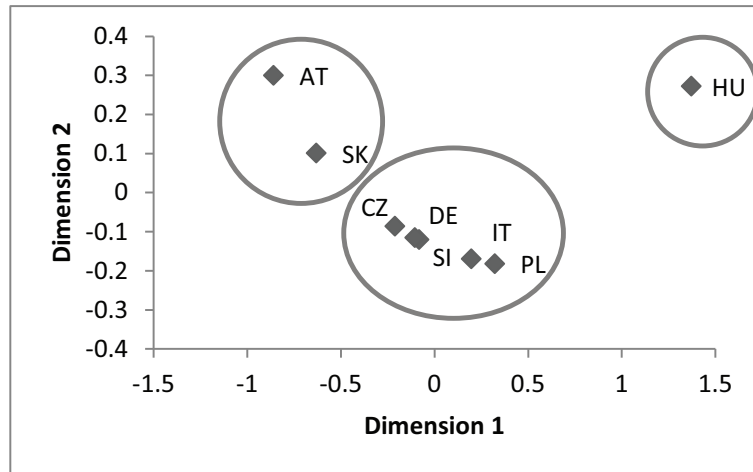
```

Note: csQCA, fsQCA software, <http://www.u.arizona.edu/~cragin/fsQCA/software.shtml>.

Source: Authors' calculations, EUROSTAT, HELPS survey and Eurobarometer data.

The resulting clusters of countries (Figure 12) do not correspond to the ranking of countries to models according to the diversity and innovations in the housing supply for the elderly and people with disabilities pre-specified above (i.e. developed, semi-developed, and basic model). However, when we added a variable representing the housing system – distinguishing a liberal housing system from other systems – the situation changed substantially (Figure 13). We could identify one cluster consisting of AT and DE and a cluster consisting of HU. Clusters of countries between these two ‘poles’ slightly differ from our categorisation (IT and CZ represent one cluster instead of IT being treated as a separate cluster; SK probably represents a separate cluster, rather than being in one cluster together with the CZ, PL and SI). However, the housing system variable significantly re-shaped the clusters of countries created from the factors that were assumed to influence the diversity and innovations in the supply of housing options for the elderly the most; and the new cluster results are more consistent with our pre-specified categorisation. Consequently, the housing tenure has a significant impact on such a grouping (clustering) of countries, which is, to a large extent, similar to the grouping of countries

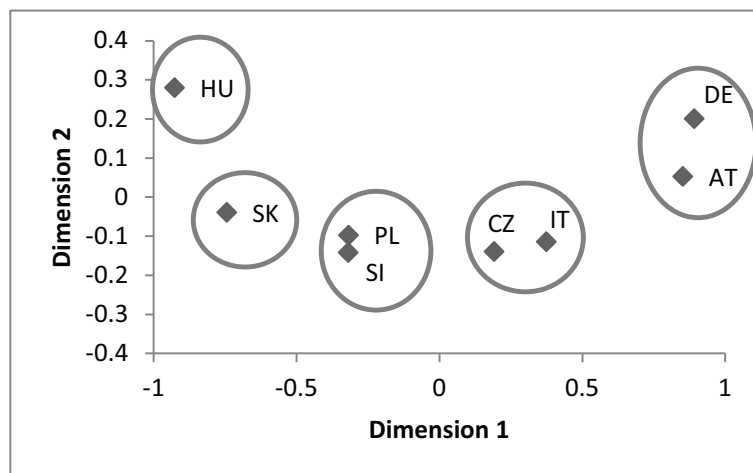
Figure 12 Groups of countries according to GDP per capita in PPS (EU 27 = 100), the old-age-dependency ratio and income inequalities among the elderly (S80/S20)



Note: Multidimensional scaling, PROXSCAL procedure in SPSS, Stress-I=0.03042.

Source: Authors' calculations, Eurostat data.

Figure 13 Groups of countries according to GDP per capita in PPS (EU 27 = 100), the old-age-dependency ratio, income inequalities among the elderly (S80/S20) and tenure (share of owner-occupied housing)



Note: Multidimensional scaling, PROXSCAL procedure in SPSS, Stress-I=0.02146.

Source: Authors' calculations, Eurostat and HELPS survey data.

according to the models of the supply of housing options for the elderly. This may be a sign of a close link. However, this link may be false and has to be verified by QCA.

The HM was tested using the Crisp-Set Qualitative Comparative Analysis (csQCA). Both dependent and independent variables were entered into the analysis as dummies (1 – true, 0 – not true). Countries were grouped according to the above-stated classification into two groups. The first group consisted of countries with a developed model (AT, DE), the dependent variable having a value equal to one, and in the second group of countries (the rest of the surveyed countries) the value of the dependent variable was equal to zero. GDP per capita was assumed to be one in AT, DE and IT and zero in the other countries. Similarly, the old-age-dependency ratio was assumed to be one in AT, DE and IT, and zero in the other countries. Income inequality was assumed to be one in AT, DE, IT, PL and SI, and zero in the other countries. The liberal housing systems (HU, SK and SI) got a value equal to one; the other countries got a value equal to zero.

The complex solution calculated using fsQCA 2.0 software is presented below in Table 9 (the intermediate solution provided the same result) and shows that the supply of housing options for the

Table 9 Crisp-Set QCA solution for the supply of housing options (dependent variable), tenure, GDP per capita in PPS, the old-age-dependency ratio and income inequality among the elderly (independent variables)

TRUTH TABLE ANALYSIS

File: D:/Petr/Sou/HELPS/vyplnene_dotazniky/preliminary/analyzy/data_h4_sel_qca_dummy1.csv
Model: grproduct1 = f(gdppcps1, oadr1, iioop1, tenoo1)

Rows: 5

Algorithm: Quine-McCluskey
True: 1

--- COMPLEX SOLUTION ---
frequency cutoff: 1.000000
consistency cutoff: 0.666667

	raw coverage	unique coverage	consistency
	-----	-----	-----
gdppcps1*oadr1*iioop1*~tenoo1	1.000000	1.000000	0.666667
solution coverage: 1.000000			
solution consistency: 0.666667			

Note: csQCA, fsQCA software, <http://www.u.arizona.edu/~cragin/fsQCA/software.shtml>.

Source: Authors' calculations, EUROSTAT and HELPS survey data.

elderly in the field of housing affordability and housing accessibility depends on the level of GDP per capita, the old-age-dependency ratio, income inequality among the elderly, and the housing system. More precisely, the supply of the housing options for elderly and people with disabilities is broader and more innovative in countries with higher GDP per capita and at the same time a higher old-age-dependency ratio, higher income inequality among the elderly population and a lower homeownership rate (i.e. with other than a liberal housing system). In other words, high GDP per capita, a high old-age-dependency ratio, high income inequality among the elderly population and a low share of owner-occupied housing, when present simultaneously, are preconditions for a broader supply of housing options for the elderly in the field of housing affordability and housing accessibility.

Again, the HM hypothesis has been partially confirmed. A higher share of rental housing in the housing system of a country leads to a more developed model of supply of housing options for the elderly and people with disabilities but only when the country has simultaneously higher wealth, a higher old-age-dependency ratio and higher income inequality among the elderly. Unfortunately, analysis on such a small sample of countries cannot test the significance of the influence of each of the factors separately. Despite this limitation we may conclude that the housing system has been confirmed by our analysis as being a significant determinant (pre-condition) of a broader and more innovative supply of housing options for the elderly and people with disabilities.²¹

However, this result should be interpreted with caution due to the limited number of cases (countries) entered into the analysis. The findings were confirmed in a sensitivity analysis by re-running the analysis with a differently coded dependent variable. If we assume that not only AT and DE rank among the countries with a broad supply of housing options for the elderly in the field of housing affordability and housing accessibility, but also IT (i.e. the value of the dependent variable for IT would be one, instead of zero, ceteris paribus), the results of the analysis would not change.

²¹ In the future, post-socialist states are assumed to have a higher relative GDP (per PPS), a higher old-age-dependency ratio and higher income inequality among the elderly. The other necessary conditions will herefore very probably also be fulfilled by post-socialist states in the next few decades.

Conclusions

Most elderly are satisfied with their housing and do not wish to move (Pastalan and Schwarz 2001). The main advantages of ageing in place in their opinion are: feelings of independence and control, feelings of safety and security, being near to their family and familiarity with their surroundings. However, the main barriers to ageing in place (or to living in standard forms of housing), as indicated in previous sections of the report, are inadequate housing accessibility and low housing affordability. The level of diversity and the level of innovations in the supply of different housing options, which increase housing affordability and accessibility among the elderly and people with disabilities, is therefore an important determinant for the successful implementation of ageing in place or for enabling both the elderly and people with disabilities to live independently in standard forms of housing for as long as possible. The nature of this supply was researched in the eight Central European countries participating in the HELPS project, which (in accordance with Section V of this report) were categorised into four main models: developed (GE, AT), semi-developed (IT), basic with the reintroduction of social housing (CZ, SI, SK, PL), and basic with no reintroduction of social housing (HU).

In this section of the report, the main research question tested was: Does the nature of the housing system have a significant influence on the diversity and scope of innovations in the supply of housing options to the elderly and people with disabilities (i.e. the categorisation of countries provided above)? The housing system was basically understood as the housing tenure structure and, consequently, the following categories of housing system were established: social-market (GE), social-democratic (AT), mixed (IT, CZ, PL) and liberal (SI, SK, HU).

The main research question was re-formulated as the main hypothesis (HM) assuming a significant link between the housing system and the diversity and scope of innovations in the supply of housing options for the elderly and people with disabilities. Next to that, we also analysed the effect of the housing system on the 'living status' of the elderly (HC2) and whether or not there is a substantially higher share of elderly dependent on public financial assistance in post-socialist states with a basic model than is the case in advanced economies with a developed model (HC1). The purpose of all the analyses using MDS and QCA was to control (though due to the small sample only partially) for the effect of other possible significant factors, such as macro-economic conditions, demographic factors, inequalities in incomes and housing costs among the elderly population.

The HC1 hypothesis was not confirmed because our analysis did not reveal any clear and stable distinction between the post-socialist and advanced countries. The median relative income of elderly people and the replacement ratios did not determine clustering that would support HC1. In conclusion, it does not seem probable that in post-socialist states classified under the basic model there is a larger share of elderly dependent on financial assistance from the state than in more developed countries classified under the developed or semi-developed model.

However, the HC2 hypothesis, i.e. the influence of the housing system on the living status of the elderly, has been partially confirmed. The influence of the housing system on the living status of the elderly is conditional upon the influence of other factors. A higher number of single adults among the elderly is found in countries where more rental housing is available (i.e. in other than a liberal housing system) but only if these countries are simultaneously characterised either by a) low religiosity and high housing availability or by b) low housing costs and a high GDP.

We reached similar conclusions for the HM hypothesis. A larger share of rental housing in a country's housing system (i.e. other than a liberal housing system) leads to a developed model of supply of housing options for the elderly and people with disabilities but only when the country simultaneously has higher wealth, a higher old-age-dependency ratio and higher income inequality among the elderly. We may conclude that our analysis confirmed that the given housing system is a significant determinant (pre-condition) of a broader and more innovative supply of housing options for the elderly

and people with disabilities. Consequently, some practices effectively implemented in one environment (a social-democratic or social-market housing system) would not necessarily function effectively in another environment (a liberal housing system).

The significant impact of housing systems on the diversity and level of innovations in the supply of housing options for the elderly and people with disabilities, though conditional upon other factors, may be explained in different ways. For example, in the context of Scotland, it was found in the general literature review (see Section II of this report) that flat modifications (such as home repairs addressing heating and insulation issues and including the installation of handles, bars and equipment for bathing, toileting, etc.) lead to greater efficiency and result in a decrease in the use of sheltered housing, admissions to nursing homes and social work interventions (Pleace 2011: 5–8). However, when evaluating the overall cost effectiveness of these innovations it was found that they are cost effective when the needs of the elderly are low or moderate (Pleace 2011: 24). In a similar vein, Lansley et al. (2004b: 480) argue that the provision of assistive technologies and adaptations with formal (or informal) care is less costly compared to residential care. However, there are also some conditions to effective and efficient use. Assistive technology and adaptations are more effective in the case of long-term rather than short-term use. Similar results were reached by Heywood and Turner (2007); the details are presented in Section II of this report.

In other words, the efficiency of measures to increase housing accessibility is higher when the needs are low or moderate and when it is assumed that dwelling adaptations will be used for the long term. While social care is provided on a tenure-neutral basis and is simply targeted according to the health and social needs of the elderly and people with disabilities, housing support must also take into account the housing tenure of eligible people. And it is much less possible to guarantee long-term use of devices and modifications in owner-occupied housing than it is in the case of both social and private rental housing.

In the social-market system (GE), public grants are basically allocated according to the contracts concluded between public authorities and private landlords that specify that the service will be offered for some period of time regardless of whether the tenants move. In the social democratic system (AT) the grants go directly to social landlords to offer their adapted dwellings to different eligible households in need for the long term. However, when grants are allocated to homeowners, the term of use cannot be guaranteed as the public authority cannot force the owner (or his/her heirs) to use the adapted flat for the long term or insist that it be used only by him/her or other eligible people (households).

The second problem represents the targeting of public help, i.e. the effectiveness of public support. While the allocation of adapted dwellings to eligible households can be explicitly specified in contracts with private landlords in the social market system (including the condition for a tenant, such as having low income and low wealth), and social landlords, by the logic of their existence, allocate dwellings mainly to people with low income and wealth in a social democratic system, the targeting of subsidies to homeowners in the liberal system is much more complicated. There might be a large share of elderly called ‘income poor, equity rich’ in the liberal system; these people may have high housing wealth. The potential public subsidies would further increase their wealth; moreover, that wealth is subject to inheritance by their relatives. Consequently, in a liberal system the public authorities face the dilemma whether to support ‘wealthy’ people or not and whether it is fair to increase the market value of dwellings of selected homeowners (and their heirs) by allocating them public grants.

The impossibility of guaranteeing the long-term use of the service, together with problems relating to fair and effective targeting, makes owner-occupied housing tenure less suitable for potential public subsidies promoting housing accessibility and affordability and this fact may decrease the overall diversity, as well as the level of innovations, in the supply of housing options for the elderly and people with disabilities in liberal systems. Mixed housing systems with a larger segment of rental housing may

therefore be more successful at providing more diversified and more innovative housing solutions for the elderly and people with disabilities. However, such a conclusion needs to be confirmed by further analysis on a larger sample of countries.

In Section IV of this report we showed that people living in rental housing have a higher housing cost-to-income ratio than homeowners and they are therefore more at risk of housing unaffordability. Consequently, increasing the share of rental housing in a country's housing system seems to lead to bigger housing affordability problems among the elderly and supporting homeownership seems instead to be a better public policy option to guarantee sufficient housing affordability among the elderly. This contradicts the conclusions made above.

However, we wrote that the simple ratio approach to the measurement of housing affordability cannot take into account the potential savings of tenants accumulated earlier in life (equal to investments made by homeowners into their own housing) and only a comparison of total household wealth would give us a full picture. In other words, tenants logically have higher housing costs than outright homeowners (i.e. homeowners that already repaid their mortgage loans) because they have to pay rent, but, assuming that tenants and homeowners have the same permanent income during their active life, a tenant could also use his/her savings for investments and these could even produce higher yields than simply buying housing. Moreover, in many countries the sample of tenants was so small that the inter-tenure comparison was of very limited value.

Despite these limitations, it is clear that more state support for rental housing may have two contradictory effects. It may provide society with a broader and more innovative supply of housing options for the elderly and people with disabilities (in terms of both housing affordability and housing accessibility), but it may also lead to lower personal responsibility among a certain segment of the population for their own economic situation in older age. Assuming responsibility to be constant, there would be no difference because 'responsible' tenants, unlike homeowners using spare money to buy housing, could invest their spare money into special retirement funds and use the yields from these investments to cover higher housing costs in older age. However, tenants could instead spend their spare money solely on consumption and underestimate the possible negative consequences of this behaviour for when they retire.

To complete the picture, we should also mention that in more balanced housing systems with a significant rental segment (such as Germany or Austria) housing satisfaction does not differ significantly between tenants and homeowners (despite the difference in the housing costs burden), and secondly, tenants are in a much more mobile position if they need to move to more appropriate (smaller, barrier-free) housing than homeowners. Landlords (both private and social) are better able to supervise the necessary dwelling adaptations than are the elderly themselves. The standard of housing and quality of life of elderly tenants may thus be better than that of homeowners, especially when poor elderly-homeowners (as witnessed in the liberal or super-homeownership models) do not have enough resources to make modernisations and adaptations to their own housing, and have little possibility to downsize their housing consumption.

VII Innovations in Social Care Services: Understanding the Context of Social Care

Introduction

The aim of this section of the report is to assess the influence of selected contextual macro factors on the scope of supply of different forms and types of social care services provided to the elderly in CE countries. Inspired by the works of Doyle and Timonen (2007), Barlow, Bayer and Curry (2006) and da Roit (2010), we elaborated a multidimensional model in order to explain the variations in the scope of supply of social care services among CE countries, which may subsequently imply the possibility to apply various innovative practices. This kind of analysis is very important in the context of the HELPS project, as it can inform us about the possible transferability of particular practices (or, more accurately, the variable selection of particular practices) from one institutional context (country) to another. This can have clear implications for the transferability of know-how during the application of new innovative practices in the CE countries. Therefore, this section presents one of the core analyses, which draws on information provided by all project partners in order to map the situation in the field of social care for the elderly in individual countries and compare the eight national settings and the innovative approaches introduced in the eight countries in order to assess the transferability of practices from one country to another and to suggest relevant recommendations, which will be considered in Section IX of this report and extensively in Working Paper 1/2013.

For this sample of countries, such research has not been yet carried out, as indicated in Section II of this report. Indeed, as far as we know, no research has conducted a comparison of the countries of the CE region so far, and there are only a few examples of comparisons of a single CE country with Western European countries. The explanation of variations in the supply of social care services among CE countries provided in this section thus presents new and original findings to contribute to the current knowledge.

Our model is based on macro data reported by the HELPS project partners and data provided by Eurostat which are grouped into two principal dimensions essential for the set-up of national systems of social care services: (1) the demand for social care services, and (2) available financial resources. In addition, for a deeper analysis we consider other sets of factors such as the social policy background and the position of NGOs in the provision of social care services. By way of introduction we should state that our analysis takes into consideration only the system of social care services for the elderly. The reason is that social care services for people with disabilities and other vulnerable people are organised in a different way and their inclusion in the analysis would require a separate chapter.

We start this section with an overview of the social care policies in CE countries and their main features. We then present the results of a comparative analysis of the most up-to-date set-up of formal social care services across CE countries, with special attention paid to the form of delivery (i.e. home-based or institutional) and to the range and variety of services offered to the elderly. Based on these variables, we identified three models of systems of social care services across CE countries: rudimentary, intermediate and advanced. Subsequently we introduce our multi-dimensional model, describe all the factors involved, and formulate hypotheses about their casual links to the above-mentioned variety of systems of social care services. We examine and describe these factors for all CE countries in a cross-country analysis.

Finally, we apply the multidimensional scaling method (MDS) to assess the 'distance' between individual countries, and to get a more vivid picture of the position of different types of systems of social

care services we elaborate a complex model using correspondence analysis. This procedure enables us to assess which factors are more significant than others in relation to the variety of social care services, and which factors may therefore influence the implementation of innovative practices within specific national contexts. Such an approach allows us to evaluate the influence of several indicators simultaneously, which results in more relevant findings on the strength of individual factors, since in reality they do not operate in isolation.

Social Policy Background: Changing Care Policies for the Elderly in the CE Countries

The set-ups of the individual national social care systems are quite similar, although not straightforward, and they are linked to the specific social and historical context of each country. Up to the 1990s, Austria and Germany built their systems of care for the elderly on the principles of family solidarity and subsidiarity (da Roit and le Bihan 2010). Formal home care in Austria was provided only in certain Länder and to a limited degree; it consisted mainly of nursing assistance. In Germany, formal care was intended only for the low-income elderly. In the 1990s, under pressure from population ageing, both countries reformed their social care systems; in particular, they introduced long-term care insurance (Austria 1993, Germany 1994) and a care allowance (Austria 1993, Germany 1995). Simultaneously, the originally fragmented systems of social care services were integrated and their selection expanded (Badelt and Holzmann 1993).

In Italy formal social care was based on a similar set-up as those in Austria and Germany, but it differed in that informal family care was the cornerstone of care for the elderly, and formal services, whether home-based or institutional, played a marginal role. Unlike Austria and Germany, this set-up has remained more or less unchanged up to the present (da Roit and le Bihan 2010) and the most significant change has been an increase in the employment of illegal migrants by families to care for their relatives (da Roit 2010). In the context of Italy, however, we cannot speak of a single system of social care services for the elderly, since this area of social policy is almost exclusively within the competence of individual regions and significant differences can even be identified between cities (da Roit 2010). The only instrument they have in common is the care allowance, which was introduced for the elderly in the mid-1980s. Since it is relatively low, some regions provide a means-tested supplement allowance (da Roit and le Bihan 2010). Since 2003 the Lombardy Region (according to the HELPS data) has provided the elderly with vouchers to obtain professional domiciliary care services, depending on their state of health. It is important to say that there are considerable differences between Northern and Southern Italy in both the allocation of vouchers (which is applied only in Lombardy) and the availability of formal social care services (HELPS; da Roit 2010).

The post-socialist countries, Hungary, Poland, Slovenia, Slovakia and the Czech Republic shared a similar history of social welfare up to the beginning of the 1990s. In the 1990s, these countries underwent – at different speeds and with slightly different approaches – a transition from a centralised and paternalistic system, in which the family and institutional care played the central role, to new types of services, service providers, financing and philosophies of provision (Hojnik-Zupanc and Světlík 1993; Széman 1993; Hryniewicz, Starega-Piasek and Supińska 1993; Matoušek and Koldinská 2007). Currently, all these countries have a care allowance intended for persons with reduced self-sufficiency, except Hungary and Slovakia; in the latter only a contribution for the informal caregiver is granted. However, some form of contribution for the caregiver is a part of the social care systems in all post-socialist CE countries, apart from the Czech Republic (HELPS).

Despite the similarities mentioned above, current discussions call the classification of the post-socialist countries in Central and Eastern Europe into question. Since their actual welfare regimes do not match the Esping-Andersen typology, the question has been raised as to whether they form a new

type of welfare regime or whether they will approach an Esping-Andersen type after a transitional period. According to Fenger's analysis (2007), at least in 2003, it was not possible to rank the post-socialist welfare states under any of Esping-Andersen's types. However, there was no empirical evidence either that these countries formed a distinct, specific type of post-socialist welfare state. Using a conceptualisation of welfare regimes closely related to social care systems (Milligan 2009), we analysed the systems of social care services in CE countries in order to assign them to the respective types of welfare regime (see the Tables 10 and 11).

Table 10 Welfare regimes – main characteristics (based on Milligan 2009)

Welfare regime	Primary responsibility for the care of the elderly	The most common source of funding of social services	The most common type of social services providers
Social-democratic	State Municipality	Taxes	Public Third sector (private for-profit providers are marginal)
Conservative	Family	Social insurance	Public Third sector (private for-profit providers are marginal)
Liberal	Family	Clients' payments	Private for-profit providers
Neo-liberal	Family	Clients' payments	A mix of market, state, and third sector

Comparing the characteristics of welfare models with the actual distribution of the distinguishing features across CE countries, it is obvious that only three countries could be clearly assigned to some of these models: AT and DE to the conservative model and PL to the neo-liberal model. The other national social care systems aimed at the elderly comprise a mix of social-democratic (state responsibility, the domination of funding from public budgets and of public service providers) and neo-liberal features (family responsibility, domination of funding from clients' payments, and a mix of public and private service providers). On the one hand, some countries are closer to the social-democratic regime (HU, SK) with a social-democratic model of funding and service providers, but with primary family responsibility for ensuring care. On the other hand, there is a heterogeneous group of states inclined towards the neo-liberal regime (CZ: family responsibility, predominantly funded by clients' payments; IT: family responsibility, a mix of public and private providers; SI: predominantly funded by clients' payments, a mix of public and private providers). Finally, no CE country represents a pure liberal or social-democratic regime.

In our analysis we will assume that the welfare regime will be one of the factors influencing the range of social care services, since it may have an impact on the application of innovative practices and of priorities in practice.

The Diversity of Social Care Services across the CE Countries

To categorise the systems of social care services for the elderly in CE countries we compared the availability of basic types of social care services according to the coverage rate of these services and the forms (and presence) of alternative services linking housing and social care for the elderly.

Table 11 Characteristics of the CE countries

Country	Primary responsibility for ensuring care for the elderly	The most common source of funding the social care services	The most common type of social services providers within the social care services
AT	Family	Social insurance Taxes	Public Third sector
CZ	Family Municipality	Clients' payments (50%)	Public (regional authorities and municipalities) – 87%
DE	Family	Social insurance	Public Third sector
HU	Family Municipality	Taxes Municipal budgets	Public (regional authorities and municipalities) – 66% Third sector – 33%
IT	Family	Taxes Municipal and Regional budgets	Municipalities (55%) Private for-profit (25%)
PL	Family	Taxes Clients' payments Social insurance	Private for-profit (39%) Public: district authorities and municipalities (37%)
SI	State guarantees the right to social service for all citizens who need them because of their social situation	Clients' payments (67.5%)	State (61% in the case of in-residence care; 81.5% in the case of field-based care) Private sector (39% in the case of in-residence care; 14.5% in the case of field-based care)
SK	Family Municipality	Taxes and municipal budgets (altogether – 87%)	Public (regional authorities and municipalities) – 84% Third sector – 16%

Source: HELPS data set.

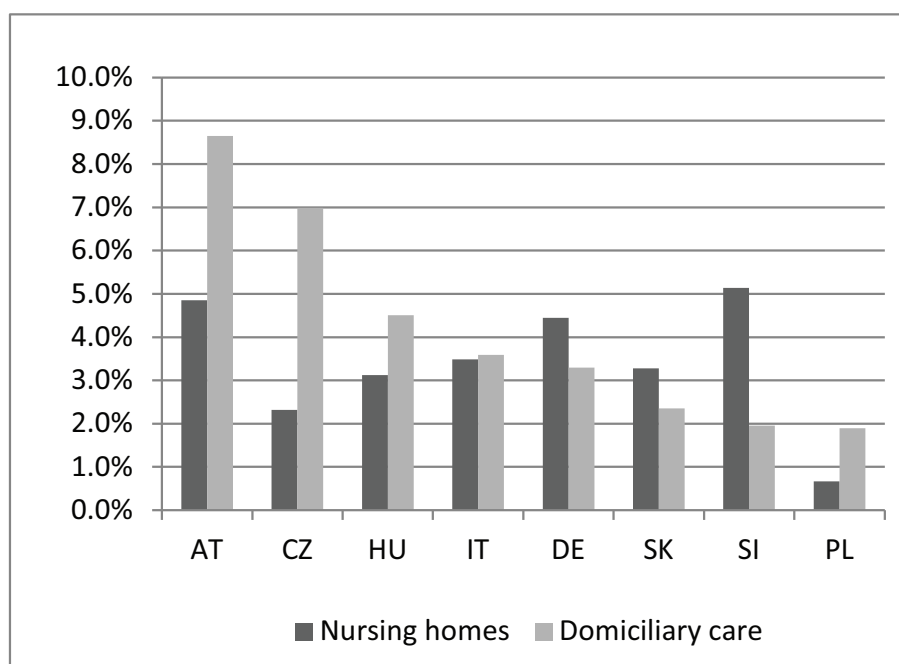
Table 12 Classification of Central European countries according to their welfare regimes

Welfare regime	State
Close to social-democratic	HU, SK
Conservative	AT, DE
Close to neo-liberal	CZ, IT, SI
Neo-liberal	PL

The Availability of Basic Types of Services

A macro view using statistical data on the coverage of the elderly population by domiciliary care services and institutional care facilities allows us to make certain conclusions about the availability of formal care services for the elderly, and on the relationship between home-based care, which is essential for promoting ageing in place, and the use of residential care in CE countries.

Figure 14 Coverage rate of people aged 65+ by formal domiciliary care and nursing homes for the elderly, year 2011²²



Note: The coverage rate is calculated as the share of elderly using the service out of the total number of persons aged 65+; data for the DE and IT date from 2009, data for AT and PL and for home care services in HU and SK date from 2010.

Source: Eurostat, HELPS data set, Authors' calculations.

The coverage rates of the population aged 65 and over by domiciliary care and nursing homes for the elderly displayed for CE countries in the figure above point to the low availability of domiciliary care services in particular in Poland (1.9%), Slovenia and Slovakia. However, according to the statements of national HELPS experts, Italy and Hungary also have a low availability of both domiciliary and residential care services in certain regions. In Italy this is the case of some southern regions, in Hungary this applies to rural areas with small communities. Finally, it should be noted that a large proportion of users of domiciliary care services in the Czech Republic use only the meals-on-wheels service; as a result, real coverage by other activities is probably significantly lower than the above figure suggests.

Overall, the highest level of coverage of the population 65+ by domiciliary care is in Austria (8.6% in 2010), followed by the Czech Republic (7%). The co-occurrence of lower coverage by domiciliary care services and relatively higher coverage by institutional care facilities in some countries (DE, SK, SI) implies a setback or lag in the process of deinstitutionalisation in these countries. A low coverage rate for both types of social care services in Poland then indicates serious problems with ensuring formal social care services for the elderly in this country in general.

Variability in the Selection of Social Care Services²³

All the examined systems of social care for the elderly contained domiciliary care services and nursing homes for the elderly. These two kinds of services represent the 'basic model' of ensuring formal social care for the elderly. However, as can be seen in Table 13, this model is extended by additional types of services and alternative links between housing designed for the elderly and care for them in the

²² It is necessary to understand the figures only as approximate since the systems of social care services in the individual countries are different, so the type of service defined as 'nursing homes for the elderly' may include not only the elderly but also younger people; similarly, in terms of domiciliary care services, the rate may be influenced by the composition of tasks provided, such as the inclusion of food delivery.

²³ The analysis presented in this part focuses on the provision of social care for the elderly who have reduced self-sufficiency, but do not require specialised care, i.e. do not suffer from advanced neurodegenerative diseases and are not in the terminal stage of cancer or another serious disease.

Table 13 Variability in social care services for the elderly including alternative models of housing and care integration

Country	Basic model	Alternative models of housing and care integration		
	Domiciliary care (DC) + homes for the elderly	Modification of the home for the elderly	Flats and houses with DC	Community and integrated housing
Austria	X	X (1)	X (4)	X(3)
Czech Rep.	X		X (1)	
Germany	X	X (1)	X (1)	X (1)
Hungary	X			
Italy	X		X (2)	X (1)
Poland	X	X (1)		
Slovakia	X			
Slovenia	X		X (2)	

Source: HELPS.

Note: X = Yes, number in brackets () indicates the number of alternative types.

majority of countries examined. Only in two countries, Hungary and Slovakia, are social care services provided only through the basic model.

Alternative types of housing and care integration can be classified into three categories: (1) modified homes for the elderly; (2) flats and houses with domiciliary care service; (3) community and integrated housing. These categories differ in terms of the target group, based on the level of a senior's self-sufficiency, for which the services are mainly designed. The lowest intensity of social care is provided within the third category, and the highest within the first category.

Modified homes for the elderly ensure care for the elderly with a high degree of dependency. However, they differ from the 'classic' homes for the elderly in that they have a small number of clients (3 to 12 persons) in one facility and they provide more tailor-made services. The main idea behind them is to provide extensive social care in an environment that is as much as possible customised to resemble the client's previous home: e.g. clients may bring their furniture with them, their daily schedule is individualised, etc. Nevertheless, this kind of social care service plays more of a complementary role in social care systems in CE countries; for example, in Poland there were only 14 such facilities in 2010, or there were 5 in Austria and all of them in Vienna.

The integration of separate housing (often barrier-free flats) with home-based social care is represented by *flats with a specific form of domiciliary care services*, which are the most common form of extension of the basic model of social care for the elderly. This category can be understood as a link between the care provided at home on the one hand, and fully residential care on the other. In this category, we cannot speak of 'institutional care facilities', since the care is provided in rental apartments or flats in private or public ownership. Nevertheless, the elderly must move to this special type of housing from their original home. This category, which is also relatively internally heterogeneous, includes:

- Flats for pensioners (IT, AT-Vienna)
- Protected apartments for the elderly (CZ-partially, SI, AT, DE)
- Residential community – co-housing (AT-Vienna, IT)
- Flats and houses with domiciliary care (CZ-partially, SI)
- Sheltered housing on a farm (AT)

The third category of alternative housing for the elderly is a relatively new one and includes *community-based forms of housing*. This form of housing aims above all to overcome the isolation and loneliness. Assistance in the case of sudden adverse events both in the household and in the area of health is provided, but not long-term assistance or care. While in Germany there are mainly multi-generational communities, in Austria there are – besides multi-generational communities – also communities exclusively for the elderly. Furthermore, so-called integrated housing is available. Integrated housing means individual flats in a block of flats where the tenants are selected in order to achieve a mixed structure of tenants including people not only from different generations, but also people with disabilities, foreigners, people and families with low and high income etc. This kind of innovative solution is developing in Italy, too.

However, according to the Austrian expert of the HELPS project, in community housing and, in particular, in the peer group of the elderly it has proved to be relatively difficult to cope with problems arising from mutual coexistence, but also connected with financing the operations of the house. Multi-generational communities have, by contrast, a long and successful tradition in Austria. Currently, this model is conceived as a model of cohabitation and non-family-based kinship. A grandmother takes care of school children and light work in the garden, while young fathers perform heavier and more arduous work such as removing the snow or mowing the lawn, etc. The mutual enrichment by the sharing of experience and access to the life of different generations is considered to be the major benefit of this type of housing.

The forms of housing and care integration described above represent the types of solutions to this issue that have already become a standard part of the systems of social care for the elderly in the countries examined. National HELPS experts, however, indicated that in addition to these types – especially in Italy and Germany – there are other forms of housing and care integration specific to just one city or region.

Implications for the Models of Systems of Social Care Services

On the basis of a comparative analysis we identified three types of systems of social care in terms of the variety of the selection and the availability of formal social care services for the elderly in Central Europe: the rudimental system, the intermediate system and the advanced system.

As *rudimental systems*, we denote those systems that consist solely of the ‘basic model’ of social care services, i.e. the system contains a home-based service, and one form of institutional care. From this point of view, the systems of social care services in Slovakia and in Hungary can be described as rudimental. Also conforming to the rudimental model are those systems with very limited availability of social care services, where it can be assumed that, instead of on formal care, the system is built on family care (Poland) and on care provided within the framework of the informal economy (Southern Italy).²⁴

The *intermediate system* is characterised by the existence of some alternative models of housing and care integration supplementing the basic model of the formal care and filling out the space between the care provided at home and institutional care, eventually, where appropriate, by creating deinstitutionalised forms of institutional care. The second feature of these systems is the relatively good availability of services representing the basic formal model of social care for the elderly. Based on these considerations, we classified the social care services systems in Slovenia, Northern Italy and the Czech Republic as belonging to the intermediate model.

The relatively high level of coverage of the population aged 65+ by basic social care services and the broad variability of its forms of housing and care integration rank Austria among the *advanced systems* and render it as an example worthy of further study and inspiration for other CE states. Germany could be classed as having an intermediate system given the relatively low coverage rate in terms of

²⁴ Since the southern regions of Italy do not form part of the CE region, they are not considered in the analysis.

domiciliary care services; but since the coverage rate in terms of institutional care services is relatively high and the country also disposes of a wide range of services (high variability), we ultimately decided to assign Germany to the countries with an advanced system of social care services.

Defining the Explanatory Model and Hypotheses

The differences between national social care systems used to be attributed to the type of welfare state in the country (Rothgang and Engelke 2009). However, an in-depth comparison of systems of long-term care for the elderly in the Netherlands and Italy carried out by da Roit (2010) suggests that the typology of welfare states may be a too generalizing and rather static explanatory tool. According to da Roit, systems of care evolve in relation to the national context and dynamically, shaped by, inter alia, the availability of informal sources of help and the funding of social care services. Therefore, we take into consideration several contextual factors specific to individual countries. Inspired by the works of Doyle and Timonen (2007), Barlow, Bayer and Curry (2006) and da Roit (2010), we elaborated a multidimensional model in order to explain the variations in the supply of social care services among CE countries, which may subsequently indicate the possibilities for applying different innovative practices.

In accordance with Doyle and Timonen (2007), we assume that the level of demand for formal social care services is one of the most significant triggers for the introduction of new practices in this area. However, there are many other intervening factors that influence the ultimate shape of the formal social care system (da Roit 2010). As mentioned above, in this section we concentrate solely on macro factors, especially financial resources, as this dimension can promote or equally inhibit development in the area of social care services. Since it is likely that different intervening factors influence formal systems of social care in a contradictory way, it is necessary to apply advanced statistical methods to reveal the impact of these factors.

For these purposes we defined two dimensions and their main indicators which supposedly shape the form of social care systems in respective countries. On their basis we elaborated a set of main hypothesis that will be tested to answer our main research question, i.e. what are the main factors influencing diversity in the supply of social care among CE countries.

The explanatory model

Dimension	Indicator
(1) Demand for social care services	<ul style="list-style-type: none"> ● life expectancy (Doyle and Timonen 2007) ● age profile (Doyle and Timonen 2007) ● old-age-dependency ratio (Doyle and Timonen 2007) ● single living status (Doyle and Timonen 2007) ● the likelihood of informal care indicated by the unemployment rate, the female employment rate, public support for informal caregivers (da Roit 2010)
Hypothesis H1: The extent of the demand (both actual and potential) for social care services for the elderly is positively related to the range and variety of social care services offered.	
(2) Financial resources available	<ul style="list-style-type: none"> ● GDP per capita (da Roit 2010) ● public expenditure on social care in old age (Doyle and Timonen 2007) ● the consumer power of the elderly: pensions, care allowance (da Roit 2010) ● the funding of social services (da Roit 2010)
Hypothesis H2a: The relative wealth of both the country and the elderly is positively related to the range and variety of social care services offered.	
Hypothesis H2b: High public expenditure on social care in old age is positively related to the range and variety of social care services offered.	

Setting the Scene: Dimensions of Social Care Systems across the CE Countries

Demand for Social Care Services

To consider the demand for social care services we first compared the following indicators: life expectancy at birth, the age profile (i.e. the proportion of the national population aged 65 and over and aged 80 and over), the old-age-dependency ratio, the living status of the elderly, and the position of informal care in each of the eight CE countries. These variables, except for the position of informal care, were chosen because Doyle and Timonen (2007) have found them to have a significant influence on the demand for social care services for the elderly, and therefore to be very likely to shape both the current and the future social care system. Alongside these indicators we also included the position of informal care, as the theory of social care implies the effect of the substitution of formal social care services with informal care (Bonsang 2009).

LIFE EXPECTANCY AT BIRTH

According to Doyle and Timonen (2007), increasing life expectancy due to improved medical treatment and improved socio-economic and environmental conditions is one of the driving forces behind population ageing. Life expectancy has increased in all CE countries; but a clear difference has persisted between the Western and post-socialist countries over the last decade, with the exception of Slovenia, where the improvement in life expectancy has been the most rapid compared to other post-socialist countries. As a result, we can divide CE countries into two groups according to life expectancy: AT, DE, IT, SI with a relatively higher average life expectancy (79.8–82.3 years in 2010) and CZ, HU, PL, SK with a relatively lower average life expectancy (74.7–77.7 years in 2010). The difference between Italy at the top and Hungary at the bottom of the notional ladder of life expectancy is considerable. It can be assumed that the demand for formal social care services targeting the elderly will be higher in the group of countries with a higher level of life expectancy.

AGE PROFILE

Although population ageing is a phenomenon common to all CE countries, it is evident from Table 14 that the position of countries analysed varied significantly in 2011. In Italy and Germany, people aged 65+ represented more than one-fifth of all inhabitants, which suggests that these countries have been facing the problem of how to provide the appropriate social welfare services to a rapidly growing number of elderly for quite a long time and it would be possible to expect more developed strategic solutions. Conversely, Slovakia and Poland had the lowest proportion of persons 65+ from all the CE countries, i.e. around 13%. However, in terms of the 80+ age group, representing the part of the population with the highest level of need for care, the situation in Slovakia and Poland is completely comparable with that in Italy and Germany, because in all these countries the very old represented approximately 6% of the population.

However, the projection of the age structure suggests that all CE countries will face a high proportion of the elderly in the population in the near future. All the CE countries will have increasingly similar shares of elderly aged 65+ and by 2050 in all these countries approximately 30% of people will be aged 65 and over. Nevertheless, this means that Slovakia and Poland will have to deal with much faster growth in the number of people aged 65+ than Italy and Germany. However, in the same period Slovakia and Poland will face relatively moderate growth in the share of people aged 80+ compared to other CE countries where this share is predicted to double between 2011 and 2050. Therefore, individual countries will have – above all – different time intervals in which to implement necessary measures within their social care systems.

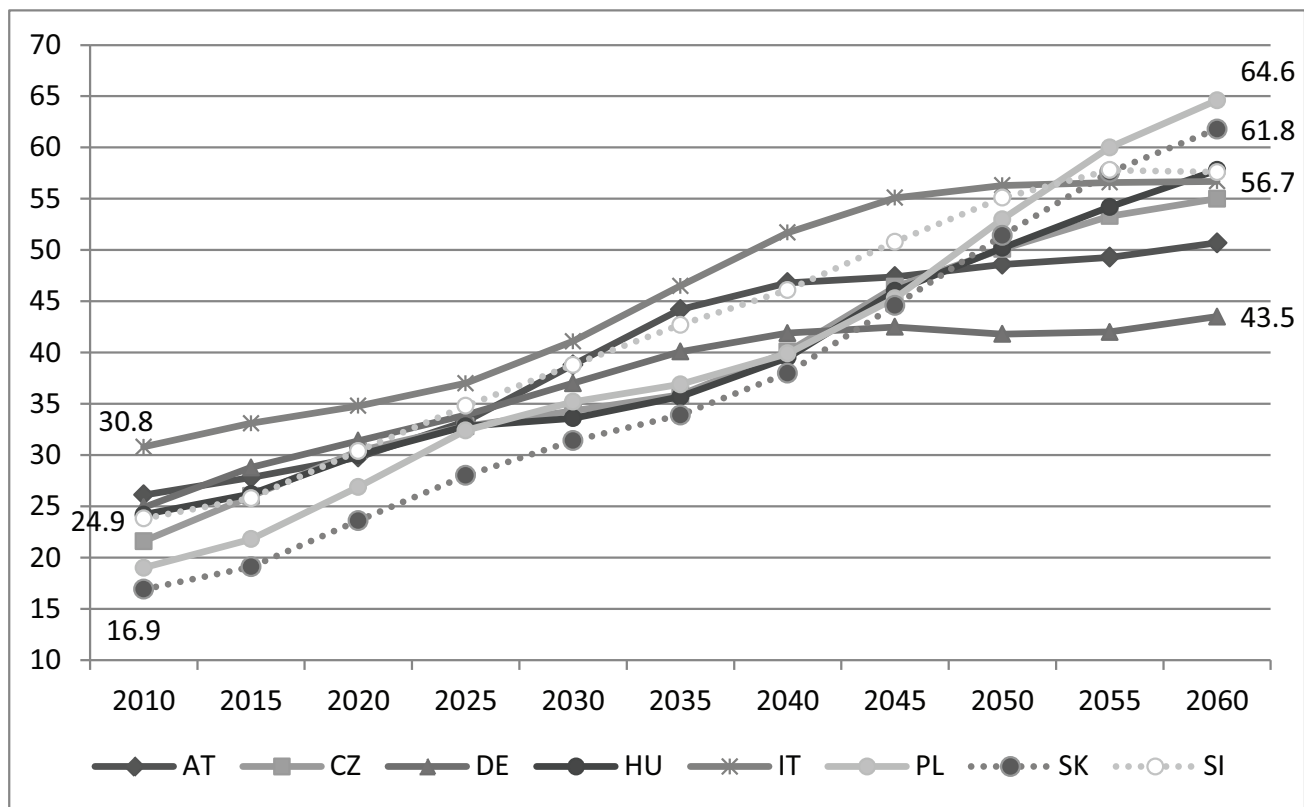
Table 14 Age groups of the elderly and their projected development

	2011			2050	
	Population 65+	The share of 65+ in the population (%)	The share of 80+ in the population (%)	The share of 65+ in the population (%)	The share of 80+ in the population (%)
Czech Republic	1,625,443	15,5	3,7	28,7	8,6
Italy	12,307,168	20,3	6	31,5	12,5
Hungary	1,667,616	16,7	4,1	29,2	9
Germany	16,840,830	20,6	5,6	32,3	14,4
Poland	5,240,062	13,6	6	30,3	9,5
Austria	1,479,148	17,6	4,9	28,4	11,7
Slovakia	668,663	12,4	6	29,6	8,7
Slovenia	338,281	16,5	4,1	30,6	10,9

Source: Eurostat. Tables: Population at 1 January; Percentage of the population aged 65 and over on 1 January of selected years; Percentage of the population aged 80 and over on 1 January in selected years; authors' calculations.

OLD-AGE-DEPENDENCY RATIO

The old-age-dependency ratio is a demographic indicator widely used in comparative analysis. It is defined as the projected number of persons aged 65 and over expressed as a percentage of the projected number of persons of working age (i.e. people between the ages of 15 and 64).

Figure 15 Projected old-age-dependency ratio over time

Source: Eurostat.

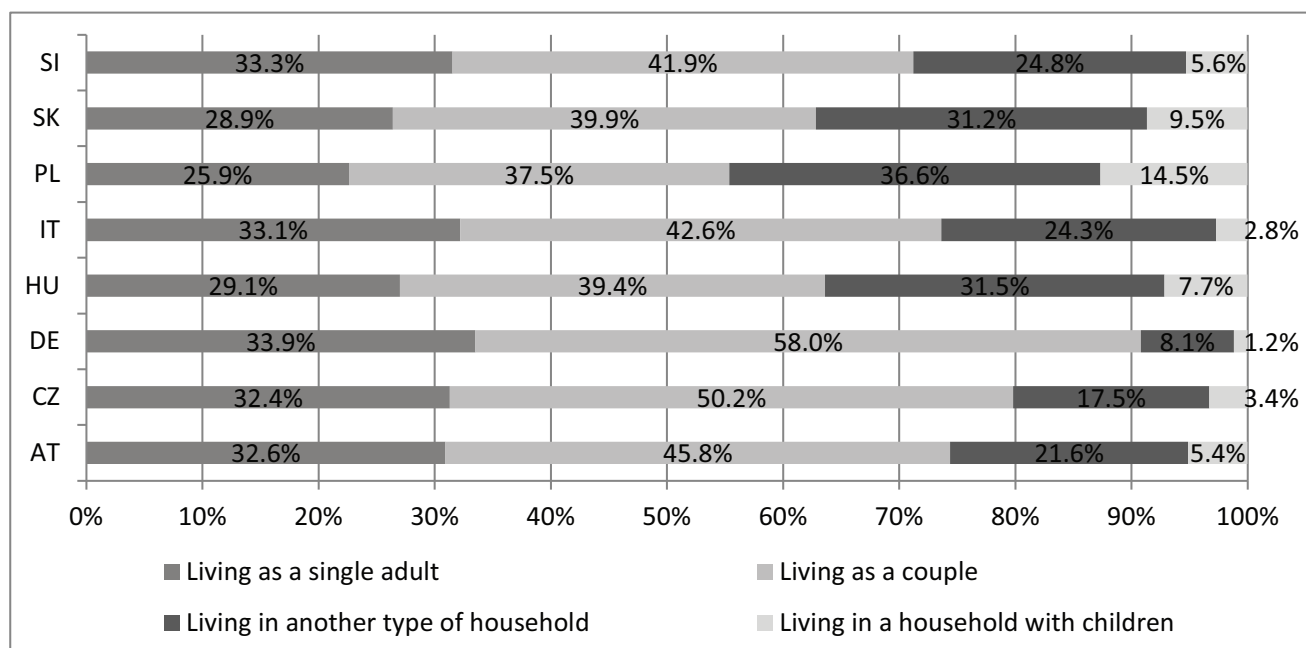
In 2010, the ratio was the highest in Italy (30.8%), followed by countries grouped around 25% (i.e. AT, DE, HU, SI) and around 20% (CZ, PL). The lowest old-age-dependency ratio was identified in Slovakia where the number of working-age people to the elderly was a ratio of almost 6:1. Therefore, there were more people who were likely to contribute to the pension scheme, but also to take care of the elderly in SK, PL and CZ than in the other CE countries in 2010. On the other hand, this ratio indicates that in Italy the traditionally family-based social care system is probably not sustainable (cf. Da Roit 2010); as a result, the demand for formal social care services as well as for immigrant carers must increase.

However, the predicted development of the old-age-dependency ratio suggests that the burden for pension systems will increase faster in SK, PL and CZ than in other CE countries, which will result in a convergence of the countries under consideration. Surprisingly, those countries that originally had the lowest ratios are predicted to have the highest ones by around 2060 (SK – 61.8%; PL – 64.6%). To sum up, the data presented suggests that while in 2010 the demand for formal social care services is probably highest in Italy and lowest in Slovakia and Poland, in the future there will be pressure to offer formal social services at a comparably high level in all CE countries.

THE LIVING STATUS OF THE ELDERLY

From the perspective of the demand for formal social care services the share of elderly living alone proved to be significant (Grundy and Jitlal 2007). The share of elderly living alone could be estimated at around 33% for the majority of CE countries (i.e. AT, CZ, DE, IT, SI). Lower shares of elderly living alone were recorded in Poland (25.9%), Slovakia (28.9%) and Hungary (29.1%). These three post-socialist countries have also the highest shares of elderly living with their children among CE countries. However, from the perspective of the living status of the elderly in CE countries, we may conclude that the demand for formal social care services should be more or less the same, except for Poland, where it could be lower than in other CE countries:

Figure 16 Household status of persons aged 65+ in 2011; collective households like homes for elderly people are excluded from these figures



Source: Eurostat.

THE POSITION OF INFORMAL CARE

There are several theories about the relationship between informal care, in particular care provided to the elderly by close relatives, and formal care services. One hypothesis claims that these two kinds of

help substitute each other. This means that where care provided by family members is widely used formal social care services will be less developed, and as a result the coverage rate of the population 65+ will be lower and vice versa (cf. Bonsang 2009). Additionally, there is evidence of a gender gap in the provision of informal care; women are more likely to take care of their older parents and of their partner's parents. However, analysis carried out by Sarkisian and Gerstel (2004) show that employment status significantly reduces the gender gap in help. They discovered that both employed women and men are significantly less engaged in the provision of care to other family members than those who are not employed. Moreover, long-term unemployment increases a person's likelihood of becoming an informal caregiver as he/she is immediately available, should the need to care for a family member arise.

In 2011, there were two distinct groups of CE countries. At one end of the pole, there were IT, HU, SK and PL with relatively low rates of women's employment and simultaneously higher unemployment rates, including long-term unemployment. It is likely that in these countries there will be greater family involvement in care provision and at the same time the demand for (and consequently the selection of) formal social care services will be lower than in other CE countries. At the other end of the pole, there were AT and DE with high rates of employed women and low unemployment rates. We can assume that the selection of social care services is more extensive and developed in these countries as a result of the higher demand for formal care services. CZ and SI were located between the two poles.

However, if we compare the likelihood of becoming an informal caregiver, as discussed above, and the public support allotted to these carers, as reported by the HELPS national experts (see Table 15), they obviously do not match. According to this data, public support for family caregivers in terms of public insurance, training, respite care services and special benefits for caregivers or for the people cared for seem to be more developed in AT and DE than in other CE countries.

Table 15 Public support provided to the family caregivers

	Public provision of social / health insurance while caring	Training of informal caregivers	Respite care and other support for relieving the stress etc. of caregivers	Carer's allowance or the possibility for the elderly to pay an informal caregiver from the care allowance
AT	++	++	++	++
CZ	++	+	+	++
DE	—	++	++	++
HU	++	0	+	+
IT	—	+	+	++
PL	—	+	+	+
SI	—	+	+	++
SK	++	+	+	++

Note: 0 = missing; + = present, but insufficient extent; ++ = present and sufficient extent; — data not available.

Source: HELPS data set.

After discussing the chosen indicators of demand for formal social care services aimed especially at the elderly, we are able to categorise CE countries as follows with respect to the level of their current demand for social care services:

- (1) countries with relatively higher demand for formal care services: IT, DE and AT due to their having the highest life expectancy, the large share of people 65+ and 80+ in the population, one-third of the 65+ living alone, and a lower likelihood of extensive informal care provision (AT, DE), alternatively the highest level of the old-age-dependency ratio (IT).
- (2) countries with an intermediate level of demand for formal care services: CZ and SI because of the higher life expectancy and one-third of the 65+ living alone.
- (3) countries with relatively less pressure on the provision of formal social care services: HU, PL and SK as they had the lowest levels for all the demographic and housing indicators examined (except for the share of people 80+ in PL and SK) and simultaneously there was a relatively high likelihood of informal care provision in these countries. However, it is necessary to point out that the projected demographic trends show that these very countries will face a rapidly increasing demand for formal care services in about 20 years.

Available Financial Resources

The second dimension of our model, elaborated in order to estimate the differences among CE countries relating to the variety of social care services offered and consequently to the promotion of innovative practices, comprises the issue of funding since the lack of financial resources may seriously hamper the development of the provision of social care services. To estimate the supply (or the lack) of financial resources which may be used for social care services innovations we examined the following indicators for each of the CE countries: GDP per capita, expenditure on care for the elderly, the level of old-age pensions, and the average level of care allowance.

GROSS DOMESTIC PRODUCT (GDP) AND PUBLIC EXPENDITURE ON CARE FOR THE ELDERLY

The GDP is defined as the value of all goods and services produced less the value of any goods or services used in their creation. As such, GDP is perceived as one of the indicators of the relative wealth of a country. For a cross-country comparison we used the index of GDP per capita in Purchasing Power Standards (PPS), which is expressed in relation to the European Union (EU-27) average set to equal 100. The development over the past ten years clearly shows that a significant difference in wealth persists between the Western countries (AT, DE, IT), which are above the EU-27 average, and the post-socialist countries (CZ, HU, PL, SK, SI), which are below the average (see Table 7). However, if we pay attention more to the distances among CE countries than to their position in relation to the EU-27 average, we can claim that the GDP of Italy is gradually approaching that of SI and moving away from the higher values of AT and DE.

However, after an examination of expenditure on social care in old age it is clear that there is no direct relationship between the wealth of a country and its public expenditure on the provision of social care services for the elderly. Although AT, the richest country, reports the highest percentage share of expenditure on care for the elderly in GDP (1% in 2008), DE, the second richest in terms of GDP, devotes to old age care one of the lowest percentage shares in GDP (0.15%), together with IT (0.14%) and SI (0.15%). Additionally, CE countries with the lowest GDP per capita (HU, PL, SK) spend a higher percentage of GDP on social care for the elderly than some richer countries (0.32%, 0.25% and 0.36%, respectively).

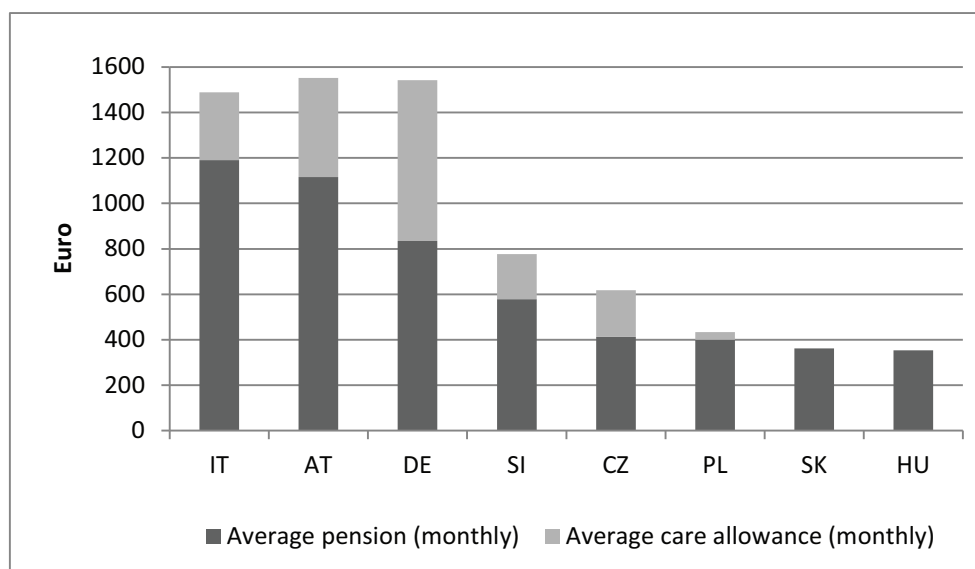
THE OLD-AGE PENSION AND CARE ALLOWANCE

The majority of CE countries strive for multi-resource funding while transferring at least a part of the costs of social care services from the public budgets to the clients of these services. Therefore, the importance of personal incomes of the clients has increased with respect to the funding and development of social care services. We examined two sources of income available to the elderly: the old-age

pension and the care allowance introduced by countries in order to increase the consumer power of the elderly to purchase social care services.

Considering the absolute cash amounts available on average to the elderly in need of care across the CE countries, the elderly in the Western countries (IT, AT, DE) with an income of approximately EUR 1500 per month are two to three times wealthier than the elderly from the post-socialist countries. However, the latter are also not homogenous in terms of incomes. The elderly living in SI and CZ have on average EUR 600 to 800 of disposable income each month, while the less wealthy elderly in PL, SK and HU have on average EUR 400 a month. Moreover, in SK and HU there is no kind of benefit (such as a care allowance) available for the elderly in need of care that would enable them to purchase formal care services according to their preferences. On the other hand, these two countries are where clients' payments play a minimal if any role in the funding of social care services. At the same time, the provision of formal social care services for the elderly by private for-profit providers is also very limited in these countries.

Figure 17 Average monthly old-age pension and care allowance in 2011 (absolute numbers)



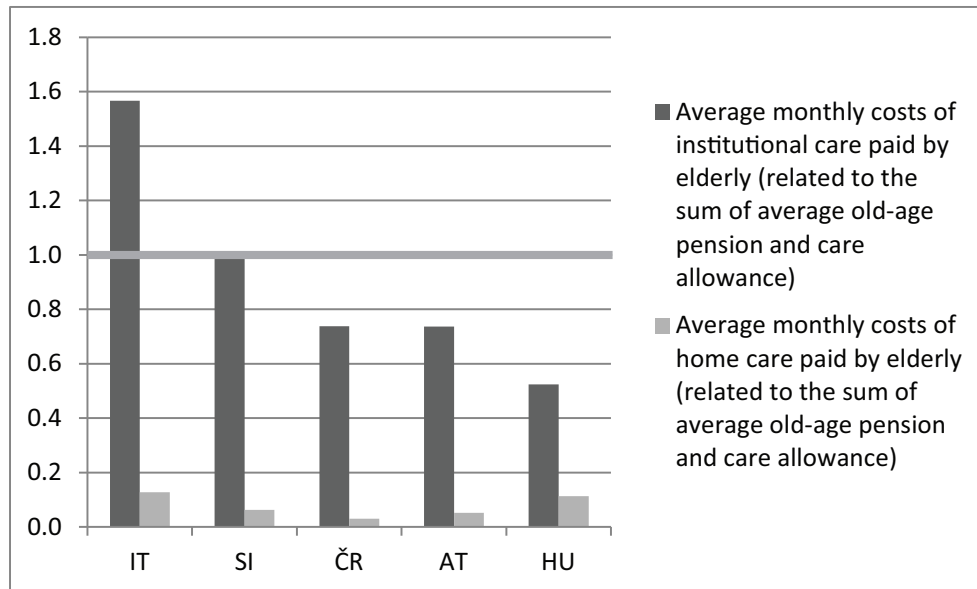
Note: Figures for pensions in IT and DE date from 2010; the figure for the care allowance in IT is not the average value but the lowest level as the data for the average value was not available (the care allowance in IT ranges from EUR 298 to 490 per month); in SK and HU there was no care allowance enabling people who need care to purchase formal social care services directly, only benefits for informal caregivers were established.

Source: HELPS data set.

Nevertheless, the better position of the elderly in IT, DE and AT with respect to their incomes may prove to be only relative when considering the real costs of social care provision covered by the users of these services. Therefore, we elaborated the following figure that shows the relationship between the average monthly old-age pensions supplemented by the care allowance (displayed in the figure by the gray horizontal line) on the one hand, and the average monthly costs of home-based and institutional social care services paid by the clients on the other. From this point of view, the elderly in HU have a relatively good position as the clients' payments are low and not as common as in CZ, SI and AT. Institutional care services are very expensive in IT compared to the average income of the elderly; in fact, only Italians with the highest incomes can afford to stay in an institutional care facility. Regardless of the significant difference between AT and CZ in the absolute wealth of the countries and the average income of the elderly, purchasing institutional social care constitutes a manageable burden for the elderly from both countries. Furthermore, purchasing formal home-based social care services seems to be cheap in all five CE countries. However, clients' payments for social care services usually do not cover the full costs of the provision of such care and their level is often regulated by an external

authority (state, region etc.). Therefore, it is not possible to conclude that there are definitely better conditions for the application of new innovative practices beyond the already existing kinds of social care services in CZ, AT and HU, since the relatively higher consumer power of the elderly living in these countries may be reduced or even eliminated if they must pay the full price of a new, not yet regulated social care service.

Figure 18 Relative costs of social care paid by the elderly in 2011



Note: Figures for IT date from 2009; the figure for the care allowance in IT is not an average value but the lowest level as the data for the average value was not available (the care allowance in IT ranges from EUR 298 to 490 per month); in HU there was no care allowance enabling people who need the care to purchase formal social care services directly, only benefits for informal caregivers were established; for DE, SK and PL the data for the average monthly costs of formal social care services was not available.

Source: HELPS data set.

Summarising the results of this cross-country comparison of financial indicators relating to the provision and development of social care services, it seems that the best conditions, i.e. the highest GDP per capita, the highest public expenditure on care for the elderly, and the best absolute and relative financial well-being of the elderly people, were found in AT. At the opposite end of the pole are SK, HU and PL because they have the lowest GDP per capita and rely on public budget funding, resulting in difficulties with funding social care services. Finally, in case of IT, DE, SI and CZ the effects of the financial indicators were rather ambiguous.

The Explanatory Model: Methods and Results

Like the analysis of the supply of housing options in CE countries provided in previous section of this report, the analysis of the systems of social care services cannot be based on simple statistical methods due to the low number of cases in our sample and the rather qualitative nature of certain variables entered into the analysis. Moreover, it is evident that a system of social care is linked to a large number of factors that shape its final form. Therefore, we selected two methods that allow us to study the effect of more variables simultaneously: first, we used multidimensional scaling (MDS) to map the proximity between individual countries with respect to their macro-economic and demographic context. Subsequently, we tried to suggest a more complex overview of factors related to different types of social care systems as defined above (rudimentary, intermediate and advanced) via correspondence analysis. The limited sample of eight cases does not allow us to test hypotheses and to generalise the findings; nevertheless, both selected methods facilitate an understanding of the mutual position of

individual types of systems of social care services against the backdrop of their national contexts and to indicate the factors with the most influence on the shape of the systems.

Both MDS and correspondence analysis belong to the group of methods enabling a multivariate data analysis, i.e. both aim to identify the underlying structure of relations between cases and to discover which factors shape the given structure. Both methods also make it possible to create a geometrical representation of the results in a two-dimensional space. For the description of MDS see the previous section of this report. To verify our typology of systems of social care services we also used the PROXSCAL algorithm and the Kruskal Stress as the stress measure and we normalised the independent variables using Z scores. As well as in the case of the analysis of housing systems, we could apply a sensitivity analysis to see which factors had an impact on the distances between countries in our sample.

Correspondence analysis is designed to describe the relations between nominal variables (types of social care systems in our case) in a multidimensional space and simultaneously to describe the relations between the categories for each variable. The resulting representation is based on the principle of assembling similar categories so that it is possible to identify related categories and their relationships to variables (Meulman and Heiser 2010). To achieve such a result, it was first necessary to carry out a cluster analysis in order to find the centres within all the categories used, corresponding to our types of social care systems. Correspondence analysis enabled us subsequently to define the position of resulting clusters in the structure of relations between intervening factors.

The data was gathered from several sources and in several steps. The most important information necessary to understand the national contexts of systems of social care was provided by the HELPS project partners and their experts via three different documents: (1) information on the range and variability of services was assessed in the country Preliminary Reports containing the question of social care measures aimed at the elderly and people with disabilities; (2) the most important resource were the country Final Reports, whose contextual parts focused above all on social care systems and describing them in detail (the average nominal old-age pension, housing status, care and carer's allowance, coverage rate of the elderly by social care services, forms of support for carers, the providers of social care services etc.); (3) relevant information about the functioning of national systems was assessed also in the country Final Reports describing and evaluating good practices, especially practices in the field of social and health care, community building and access to information and education. The macro-economic and demographic indicators such as GDP, social protection expenditure on care for the elderly, the unemployment rate, the employment rate of women, life expectancy at birth, the age structure of the population, and its prediction were obtained from Eurostat.

Results of the Analysis

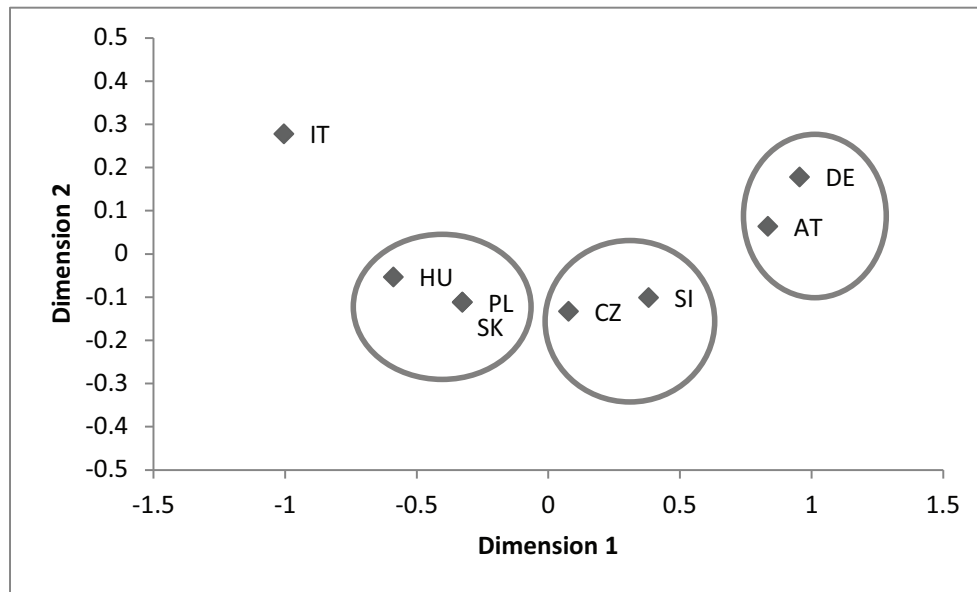
In this subsection we deal with the results of the analysis of social care systems in the CE countries. First, we will examine the findings stemming from the MDS for two dimensions of social care systems: demand for services and financial resources. Afterwards, we will focus on the complex model elaborated via correspondence analysis.

(1) DOES THE (POTENTIAL) DEMAND FOR SOCIAL CARE SERVICES ACT AS A STIMULATING FACTOR ON THE SELECTION OF THESE SERVICES? (H1)

Our first hypothesis assumed that the extent of the demand for social care services for the elderly was positively related to the range and variety of social care services offered. It was thus suggested that variables such as life expectancy, age profile, old-age-dependency ratio, single living status, the unemployment rate, the employment rate of women, and public support for informal caregivers would stimulate the selection of social care services.

The application of the MDS method for each variable separately did not explain the extent and the variability of services in particular countries. The best results were obtained in the case of the employment rate of women in 2011, where four groups were distinguished via MDS (Stress-I = 0.02670): AT and DE, with a high employment rate of women; CZ and SLO, with a mean value of this rate; HU, PL and SK with a low employment rate of women; and IT as the single example of a country with a very low employment rate of women. Although this classification is relatively close to our typology of countries, the case of Italy indicates that the employment rate of women is not the only factor that could explain the variability of social care services offered.

Figure 19 Groups of countries according to the employment rate of women in 2011



Note: Multidimensional scaling, PROXSCAL procedure in SPSS, Stress-I = 0.02670.

Source: Authors' calculations, Eurostat data.

Interesting results could also be obtained by applying the MDS to the unemployment rate variable. The operation divided the countries into three peers and two separate countries (Stress-I = 0.02848): SK, with the highest unemployment rate in 2011; HU and PL, also with relatively high unemployment rates; SLO and IT, with a mean value of unemployment; CZ and DE, with a relatively low unemployment rate; and AT, with the lowest score. Although the order of the groups corresponds more or less to the types of social care systems, the distinctions and proximities are not clear enough to show real clusters.

The last variable creating a meaningful distinction between the countries was the share of people aged 80+ in the population in 2011. It was possible to distinguish four groups of countries via MDS (Stress-I = 0.01947): IT, SK and PL, with the highest share of very elderly in the population; AT and DE, with a rather high share of the oldest people; HU and SI, with a relatively lower percentage of the very elderly; and CZ, with the lowest share of people aged 80+ in the population. However, this classification does not match our typology of countries, which means that the variable of population structure probably does not play a significant role in stimulating the selection of social care services, at least for the moment.

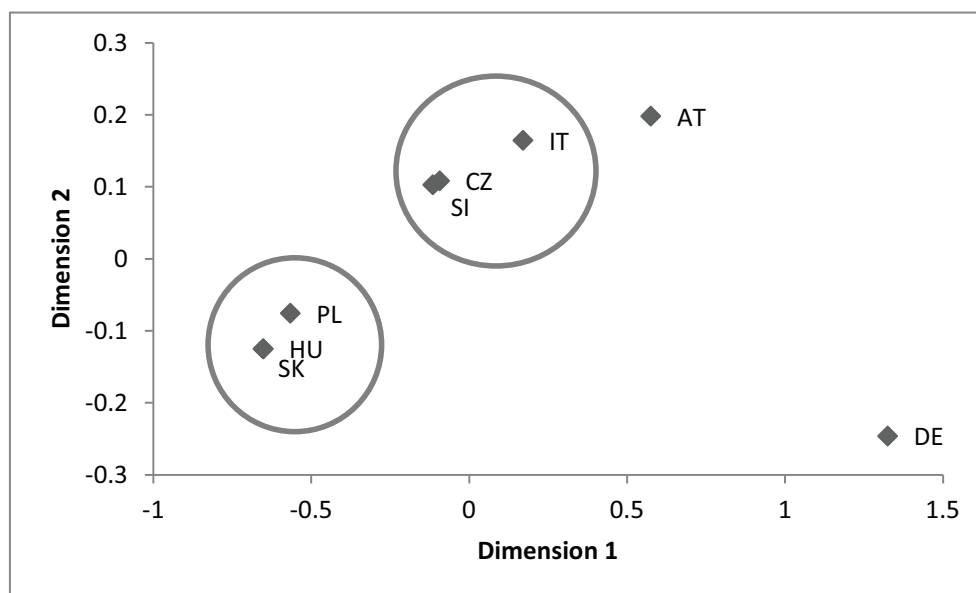
Since the analysis of single factors did not verify our assumption, we applied the MDS to different sets of variables to test different combinations of factors. Nevertheless, this procedure did not produce better results. On the contrary, every new variable added to the analysis made the distinction between the different clusters more indistinct. Therefore, our analysis did not confirm the assumption that the (potential) demand for social care services has a stimulating effect on the range and variability of these services.

(2) DO THE FINANCIAL RESOURCES AVAILABLE IN EACH INDIVIDUAL COUNTRY DIRECTLY INFLUENCE THE CHARACTER OF THE SYSTEM OF SOCIAL CARE SERVICES? (H2A AND H2B)

The dimension of financial resources was reflected in two hypotheses linked to each other. First, it was assumed that the relative wealth of both the country and the elderly influenced the range and variety of social care services offered. Second, it was suggested that the selection of social care services depended also on the extent of public expenditure on social care for the elderly. To verify these hypotheses we studied the effect of following variables on the distinction between countries: GDP per capita in PPS in 2011, the average nominal monthly old-age pension in 2011, the average monthly care allowance in 2012, and social protection expenditure on care for the elderly in 2008 (more recent data was not available for this variable).

The application of MDS to these variables separately produced the best result in the case of the level of the care allowance. It clustered the eight countries into four groups (Stress-I = 0.02756): HU, PL and SK, with no or a very low care allowance; IT, CZ and SI, with a mean value of care allowance; and AT and DE, two separate entities with a high or very high (in the case of DE) level of allowance. Although Austria and Germany do not have the same level of allowance, it seems that the care allowance, which increases the consumer power of the elderly, is related to the selection of social care services (it, for example, allows the elderly to purchase also more expensive services).

Figure 20 Groups of countries according to the average monthly care allowance in 2012



Note: Multidimensional scaling, PROXSCAL procedure in SPSS, Stress-I = 0.02756.

Source: Authors' calculations, Eurostat data.

However, the result should be interpreted with caution since the average value of the care allowance was not available for all the countries under consideration. Hence, the level of the allowance for SI is an estimate and the value for IT represents in fact the lowest level of the allowance; thus, the average value will probably rank Italy in one group with Austria.

The use of MDS on GDP per capita results in three categories of countries (Stress-I = 0.01839): AT and DE, with a high GDP; IT, with a mean value of GDP; and the other countries (SI, CZ, SK, PL and HU), with relatively low GDP. This result could indicate that a high GDP contributes to a wider selection of social care services. However, it is not able to explain the differences between countries with a lower level of wealth. Such a finding may suggest that another variable will be needed to confirm or refuse our hypotheses.

The average nominal monthly old-age pension and social protection expenditure on care for the elderly do not produce any clear and meaningful distinction between countries under consideration. The MDS analysis of separate variables thus did not completely confirm the two assumptions connected to the financial resources of the country and individuals. Therefore, we tried to combine these variables in order to identify the simultaneous effect of several factors on the selection of social care services. Nevertheless, this approach did not result in any clearer distinction of the countries under consideration. In the majority of cases the clusters remained more or less the same. Thus, although some influence of independent variables could be observed, we cannot confirm hypotheses H2a and H2b on the basis of the categorisation produced using MDS.

A Complex Model of Contextual Factors Influencing the Type of System of Social Care Services

The results of the MDS analysis suggest that our dependent variable (i.e. the range and variability of social care services) cannot be explained on the basis of one dimension of our model. It is evident that the system of social care is inter-related with other national systems (e.g. economics, social policy etc.) and it is subject to numerous intervening factors. Moreover, we can assume that the dimensions of our model are connected to each other (e.g. the consumer power of the elderly and the demand for social care services are related); hence, the aim of our further analysis will be to create a complex model taking into consideration several different dimensions which should result in a more vivid picture of the systems studied. To fulfil this objective we used the correspondence analysis.

Since correspondence analysis can – unlike MDS – include also nominal data, we were able to extend the range of variables analysed. First we enlarged the scope of variables filling the dimension of demand for social care services with rather qualitative data concerning public support for informal caregivers (i.e. the extent of the carer's allowance or the possibility for the elderly to pay an informal carer from the care allowance, and the extent of respite care and other support for informal carers).²⁵ The picture was further completed by the data on the total fertility rate, since this information suggests the potential number of caregivers for elderly parents.²⁶ In terms of financial resources, we added variables that are not included in the theoretical models of da Roit (2010) or Doyle and Timonen (2007), but that seem to be relevant in terms of the consumer power of the elderly and the economic standing of the countries analysed: inflation rate,²⁷ tax rate,²⁸ social protection benefits,²⁹ social benefits

²⁵ The extent of respite care or other support for caregivers and the level of carer's allowance were evaluated on the basis of information provided by the HELPS partners via national Final Reports. The extent of respite care was evaluated as sufficient in Austria, Germany and Italy, and insufficient in the other countries. The level of the carer's allowance or the possibility for the elderly to pay an informal carer from the care allowance were evaluated as insufficient (or completely missing) in Hungary and Poland. In all the other countries it was assessed as sufficient.

²⁶ The total fertility rate indicates the number of children born per woman. The latest data available for all eight countries dates from 2009 (data source: Eurostat).

²⁷ The inflation rate or so-called consumer price index expressed as an annual average rate of change of consumer prices (data source: Eurostat 2011).

²⁸ Current taxes on income, wealth, etc. (expressed as a percentage of GDP) cover all compulsory, unrequited payments, in cash or in kind, levied periodically by the general government and by the rest of the world on the income and wealth of institutional units, and some periodic taxes which are assessed on neither income nor wealth (data source: Eurostat 2010).

²⁹ Social protection benefits are direct transfers, in cash or in kind, by social protection schemes to households and individuals to relieve them of the burden of one or more of the defined distinct risks or needs; benefits via the fiscal system are excluded. Social benefits are paid to households out of social security funds, other government units, non-profit institutions serving households, employers administering unfunded social insurance schemes, insurance enterprises or other institutional units administering privately funded social insurance schemes (data source: Eurostat 2009).

(other than social transfers in kind) paid by general government,³⁰ social contributions,³¹ real GDP growth rate,³² public deficit,³³ and public debt.³⁴

Theoretical concepts of social care further suggest that the final form of the system of social care services is determined by the given welfare regime in the country, as already categorised earlier in this section (cf. Milligan 2009; Rothgang and Engelke 2009; Barlow, Bayer and Curry 2006; da Roit 2010). Therefore, we included this purely qualitative variable in the analysis as well. For the purposes of the analysis we labelled HU and SK as social-democratic welfare systems, AT and DE as conservative systems and PL, CZ, IT and SI as (close to) a neo-liberal system.

Finally we took into consideration the findings of Ferguson and Woodward (2009), who suggest that NGOs and churches are change drivers in the field of social services, under conditions of stable and sufficient funding, since they are often more interested in the application of innovative approaches in social work and the provision of services than public social care agencies are. Therefore, we also considered the aspect of the funding of NGOs. On the basis of information provided by the HELPS partners, we put AT, DE and HU in the group of countries with stable conditions and sufficient funding of NGOs, CZ, IT and PL in the group of countries with stable conditions but insufficient funding of NGOs, and SI and SK in the group of countries with instable conditions and insufficient funding. This enlargement of the range of variables and enhancement of the model using qualitative variables should allow us to make the complex model more accurate.

The first step in elaborating the model was to carry out a cluster analysis to uncover the underlying structure of relations between variables. The structure consists of a division of variables into a system of categories on the basis of their proximity and distances (Hendl 2006). The main goal of this analysis is to create groups of categories that correspond to our three types of systems of social care services. For our purposes we used the K-Means Cluster Analysis, which first requires making a decision about the number of clusters. The entities then adhere to those clusters whose characteristics are the closest to the characteristics of the entity. The application of cluster analysis to our enlarged set of variables produced three clusters that do indeed correlate with the types of social care systems. This is a desirable result as such clusters will enable us to study the relations of the systems to the independent variables. Moreover, the clusters were obtained with just two iterations, which means that only two steps were necessary to reassess the initial division of variables and their categories to obtain the best result.

In order to project the clusters into a two-dimensional space representing not only the clusters themselves but also the different categories related to these clusters, we eventually applied correspondence analysis. The resulting model includes all the variables and their categories, which proved

³⁰ Social benefits (other than social transfers in kind) paid by the government are transfers to households, in cash or in kind, intended to relieve them from the financial burden of a number of risks or needs (by convention: sickness, invalidity, disability, occupational accident or disease, old age, survivors, maternity, family, promotion of employment, unemployment, housing, education and general neediness), made through collective schemes, or outside such schemes by government units (data source: Eurostat 2010).

³¹ Social contributions are divided into actual social contributions and imputed social contributions. Actual social contributions include employers' actual social contributions, employees' social contributions and social contributions by self-employed and non-employed persons. Imputed social contributions represent the counterpart to social benefits (less eventual employees' social contributions) paid directly by employers (data source: Eurostat 2010).

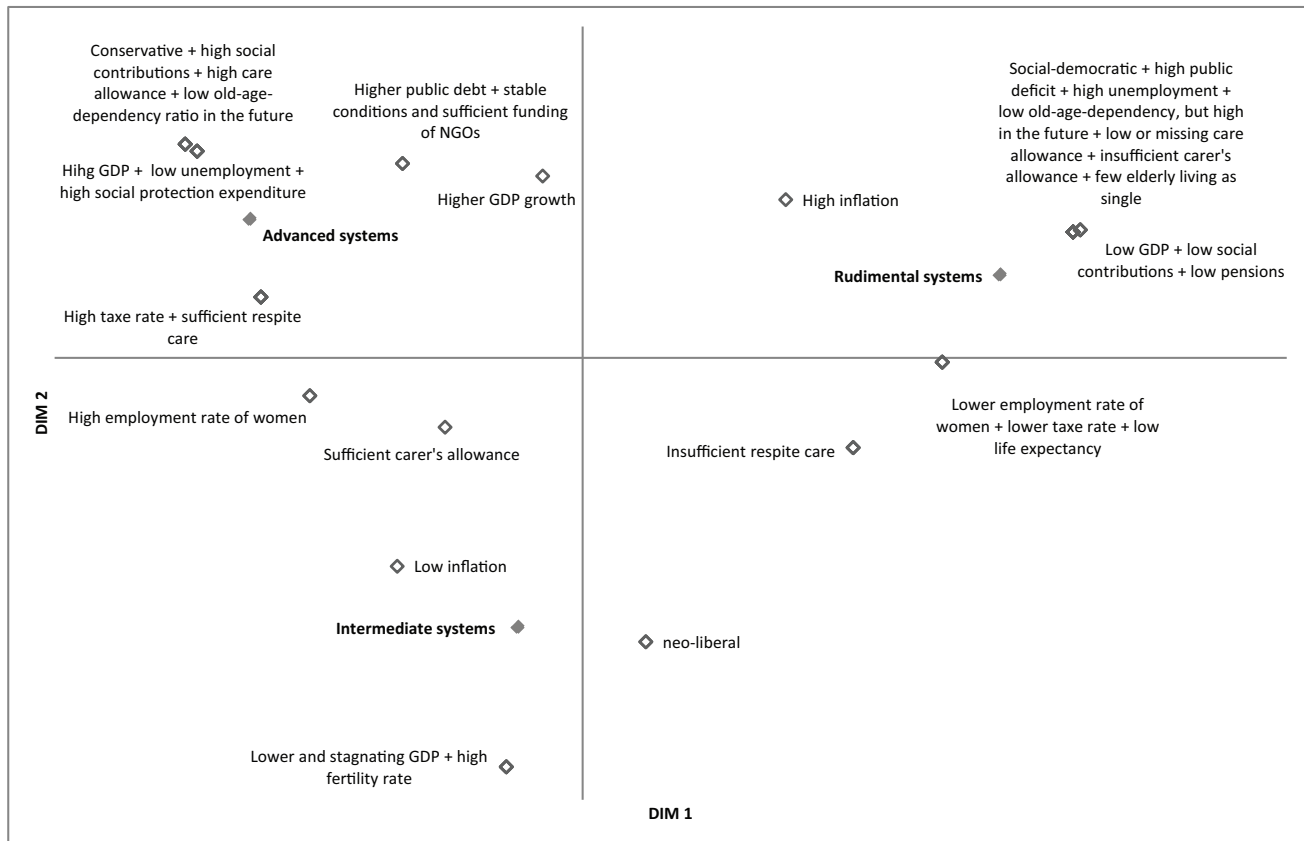
³² The real GDP growth rate represents a percentage change of GDP on the previous year. The calculation of the annual growth rate of GDP volume is intended to allow comparisons of the dynamics of economic development both over time and between economies of different sizes (data source: Eurostat 2011).

³³ The public deficit/surplus is defined as the general government's net borrowing/lending according to the European System of Accounts. The general government sector comprises the central government, state government, local government, and social security funds. The indicator is presented as a percentage of GDP (data source: Eurostat 2010).

³⁴ Public debt is defined as the consolidated general government gross debt at nominal value, outstanding at the end of the year. The general government sector comprises the central government, state government, local government, and social security funds. The indicator is presented as a percentage of GDP (data source: Eurostat 2010).

to correlate significantly with the cluster membership of individual countries. The structure of variables studied and the types of countries according to their range and variability of social care services is presented in Figure 21.

Figure 21 Model of contextual factors influencing the type of system of social care services based on correspondence analysis



Source: Authors' calculations, HELPS data, Eurostat data.

The scheme presented confirms the high complexity of the systems of social care. A relatively clear distinction between the types of systems of social care services could be assessed only when we took into consideration all the variables simultaneously and studied their impact as a whole. While a separate analysis of individual dimensions did not produce any satisfying results, a more extensive description of national contexts based on a wide range of variables resulted in a meaningful scheme that revealed the underlying structure of the factors that shape the systems of social care.

Thus, it can be assumed that *advanced systems* of social care services can develop well in countries with a good economic standing (high GDP and a low unemployment rate), a conservative welfare regime, a relatively high level of redistribution (high social contributions and taxes, but also high social protection expenditure and care allowances), stable conditions and sufficient funding of NGOs and sufficient support for (informal) carers, e.g. in the form of respite care. The disadvantage of these systems is the higher public debt of their economies. However, in terms of social care services this context shows the best conditions for introducing and operating innovative and variable practices.

As for the *intermediate systems* of social care services, they were not described in as much detail by our explanatory model, since they can be transitory in nature, i.e. moving from one type of system to another, and contain a mix of characteristics, some of which incline towards the advanced systems and some towards the rudimental systems. Nevertheless, the features in common among countries classified as intermediate with respect to their systems of social care are a relatively lower and stagnating GDP, a low inflation rate (which has an impact on the consumer power of the elderly), a resemblance to a neo-liberal welfare regime, and a relatively higher fertility rate.

The *rudimental systems* of social care services were established in countries with a comparatively poorer economic standing (low GDP, high public deficit, high unemployment rate, high inflation rate), a resemblance to a social-democratic welfare regime (with the exception of Poland), a relatively low level of redistribution (low social contributions and taxes and simultaneously low pensions and low or no care and carer's allowances), a low life expectancy and related old-age-dependency at present, but an expected high old-age-dependency in the future, and a traditional family pattern (a lower employment rate of women and a small number of elderly living alone).³⁵

It is necessary to note that the differences between the countries studied and their categories are only relative, i.e. economic standing, for example, is low or high only in comparison with the other countries in our sample. The result would be probably different if we additionally took into consideration Western European or Eastern European countries. Our objective, however, was to trace the internal differences between the CE countries that could represent barriers to the transfer of innovative approaches from one country to another. The distinctions between countries are thus slightly exaggerated, but such a micro picture enables us at the same time to formulate conclusions about the transferability of innovative approaches amongst the countries analysed.

Conclusions

Systems of social care are shaped and developed by a complex set of factors stemming from historical background and the economic and political position of each individual country. To understand the setting of social care services, it is thus necessary to study the context and evolution of systems of social care as a whole, i.e. considering the simultaneous effect of many different variables.

To be able to evaluate different systems of social care and the influences of various factors on their setting we classified the CE countries according to the range and variability of social care services offered in these countries. Based on data from the HELPS project partners we were able to distinguish three different types of systems of social care services: advanced, intermediate and rudimental. The rudimental systems are characterised by a low availability of formal social care services (and thus the important role of informal social care), reduced more or less to just basic services, i.e. one kind of domiciliary care and one form of institutional care (mostly nursery homes). We attributed HU, PL and SK to this group of countries. The intermediate systems supplement the basic model of formal care by a limited number of alternative models of housing and care integration, and have relatively good availability of basic social care services. In our sample this type of social care system is represented by CZ, SI and IT. Finally, the advanced systems are distinguished by a relatively high availability of social care services and a broad variability of services, including alternative forms of social care services. We decided to classify AT and DE as countries with advanced systems of social care.

Our initial hypotheses stressed the role of financial resources and the demand for social care services in stimulating the selection of social services and innovative approaches in this area. We suggested that the type of social care systems results from the level of demand for social care services, from the wealth of both the countries and the elderly, and/or from the volume of public expenditure on social care for the elderly.

To test these hypotheses we decided to apply the multidimensional scaling method, with which we are able to decide whether some of these factors can determine the resulting type of system of

³⁵ In this case it is difficult to decide which variable represents the cause and which represents the effect. Lower demand for social care services can be caused by strong family ties and a developed tradition of informal care for the elderly, but the causality can also be inverse, i.e. the lower employment rate of women can be caused by the low supply of formal services which forces women to take care of relatives in need on the one hand, and different generations to live together on the other. Unfortunately, correspondence analysis enables us only to describe the proximity and distances between numerous variables, but not to explain causal relationships between them.

social care services. However, the MDS did not lead us to any conclusion about the important factors shaping the form of social care systems as the variables corresponding to a single dimension were not able to cluster the countries studied according to their range and variability of social care services.

Therefore, we decided to devise a more complex model comprising both dimensions already analysed and including additional dimensions of the social policy background and the position of NGOs in the provision of social care, both based on qualitative variables. Correspondence analysis proved to be the best method to assess the structure of variables and their relationships to the types of systems of social care services.

The resulting scheme shows a relatively compound set of factors influencing the systems of social care and helps us to understand the context of social care in the CE countries by taking into consideration numerous aspects. According to our model, the advanced systems of social care services are related to the good economic standing of the country, a high level of redistribution, a conservative setting, the good position of NGOs in the system, and sufficient support for carers. The rudimental systems, on the other hand, evolve in countries with poorer economic results, a low level of redistribution, the social-democratic features of welfare regimes, a traditional family arrangement and expected rapid population ageing. The intermediate systems of social care services combine the characteristics of both preceding types and are situated in between these two extreme settings. However, they are distinguished from the other systems by their proximity to a neo-liberal welfare regime, stable prices and a higher fertility rate.

Our findings suggest that all the individual factors analysed have an influence on the final form of the system of social care services; however, they can perform this influence only in relation to other relevant factors. Thus, for example, stable conditions for the operation of NGOs and sufficient support for caregivers can stimulate the selection of social care services, but only on the condition that the country has sufficient financial resources that can be redistributed from the economically active population to those in need in the form of social benefits and care allowances, thus increasing their consumer power, so that the bigger selection of social care services can be met by a higher demand for these services. On the other hand, expected rapid population ageing cannot stimulate the selection of social care services in countries with low financial resources to provide sufficient support to providers of care and to increase the consumer power of people in need of care.

It is therefore possible to conclude that the transfer of innovative practices in social care from the advanced systems will probably be possible in some cases to the intermediate systems, but such a transfer would be very difficult for the rudimental systems. In addition, it is quite likely that innovative approaches supported out of temporary programmes will not be sustainable in the long term in rudimental systems. Nevertheless, it can be assumed that the differences between the CE countries in terms of economic standing will rather diminish with the continued development of post-socialist countries towards more advanced systems, which will also have considerable impact on their settings of social care services. Thus, it can be assumed that the room for innovative approaches will widen in all the CE countries and that practices already present in the advanced systems will in the future also be able to develop in states where the availability and variability of services is low.

The example of the advanced systems of social care services suggests that countries with an intermediate level of social care should focus mainly on support for the three following actors:

- (1) (potential) recipients of care, e.g. through the better targeting and a sufficient level of care allowance that would stimulate the consumer power of the elderly as well as other vulnerable people;
- (2) NGOs, churches and other third sector entities in the provision of social care;
- (3) (informal) caregivers, e.g. through an adequate carer's allowance, guaranteeing employment security, services such as respite care, training etc.

Moreover, these three groups of actors should be supported simultaneously so that the increasing selection of services can meet the appropriate demand for these services and vice versa.

In the case of rudimentary systems of social care the scale of possible measures is somewhat limited by the economic context of the countries. However, the focus could be directed even now to support for informal care since the systems actually rely to a considerable extent on family care. Services such as respite care, trainings and financial support in the form of a carer's allowance would help to improve the quality of care. The second step should be to improve the conditions in which the third sector operates, which would fill in the gaps in the system of social care services in these countries.

Finally, we should stress that our findings are valid only within the context of the selected eight CE countries. To verify their validity in different contexts and to generalise our conclusions, it would be necessary to carry out more extensive research on a larger sample of countries and our model would have to be tested using statistical surveys. This should be taken into consideration when interpreting the results presented in this section.

VIII Best Practices: Differences and Common Denominators

Introduction

This section of the report focuses on an analysis of already existing, innovative best practices in housing and care for the elderly and people with disabilities in Central European cities. As such, this section of the report represents also ‘an introduction’ to the second report elaborated under the HELPS project: the Catalogue of Practices.

The main purpose of this section is to identify the findings from the transnational analysis of best practices that may be relevant for an international audience and could help with the implementation of new innovative practices in relevant countries. While the previous two sections (Sections VI and VII) attempted to elaborate conclusions and recommendations on the transferability of innovative practices (measures, subsidies, ideas) by linking the contextual factors in eight CE countries to the diversity and innovativeness of the supply of housing and social care options in these countries, this section, sharing the same goal, looks at the practices themselves and elaborates recommendations and conclusions by comparing them.

Due to the scope of this international comparison of practices (39 practices altogether, five practices in seven CE countries, four practices in Italy) and thanks to the standardisation of the main analytical tools for the description and evaluation of practices in comparative research (a detailed standardised questionnaire, a unified methodology) this research activity is unique among Central European studies of housing and care options for the elderly. This international comparison of practices therefore adds new and original findings to already existing knowledge.

As mentioned in Section I of this report, examples of best practices aimed at improving the quality of life of the elderly and people with disabilities were given within five areas: (1) community building, (2) housing accessibility (including technical devices, ICT), (3) housing affordability, (4) social and health care, and (5) access to information/education. Almost each of the eight CE countries was represented by one best practice in each area. The description and evaluation of best practices was conducted by the HELPS project partners or their hired experts; this activity represented the most important part of their country Final Reports.

In sum, 39 different best practices were analysed. The objective of the research was not only to describe innovative practices but also to evaluate them. The main criteria of evaluation were: efficiency, effectiveness, transparency, and sustainability. Complete information on selected practices is presented in the Catalogue of Practices; in this report we only briefly mention selected findings from the international comparison that are relevant for elaborating final recommendations for the transferability of practices.

Selected Findings from a Comparison of Practices

There are a number of different practices applied in the eight CE countries. There are differences in the type of actors that are involved in operating each practice (municipalities, NGOs, regional authorities, central government, health authorities or private sector); the scope of the practice (integrated, i.e. a practice tries to meet multiple diverse goals at once or is strictly targeted); the structure of management; sustainability; funding schemes; or the level of participation of the elderly in their design and implementation.

Evidently, practices from the more developed CE countries substantially differ from practices applied in the post-socialist countries. The wide supply of complex social services and housing options for the elderly is typical for the more developed countries, while in the post-socialist states the scope of the selection is much more limited. Therefore, in some post-socialist countries the experts often could not make a real selection of ‘best’ practices because only one practice was found within the defined area. However, the practices from the post-socialist countries usually represent completely new and original practices, while the practices selected in the more developed countries represent rather a standard scheme in the country.

Types of Actors and the Scope of Best Practices

The German and Austrian best practices were most often directed by well-established NGOs with a long history of activity. By contrast, most practices from the post-socialist countries are characterised by the important role played by municipalities; an example is Slovakia, where all practices are municipally led. In Poland, NGOs take also part in the implementation and operation of practices, but the role of municipality is still crucial. The weak position of NGOs in the post-socialist countries is the result of the socialist legacy, because during socialism responsibility for social policy was exclusively in the hands of the ‘omnipotent’ state and voluntary activities were banned or severely limited. Since the fall of socialism, the number of NGOs has progressively grown. However, they have remained politically weak and dependent on short-term public grants and volatile donor funding; they usually do not own any property and have not acquired a substantial role in society (with the exception of church charities and NGOs in some countries, such as Poland or Hungary).

Another common feature of the majority of best practices in the post-socialist countries is their narrow scope. Most practices are implemented by a few actors (from one to three actors, public and/or private) and target one specific goal. By contrast, practices in Germany or Austria often follow an integrated approach (target multiple goals at once) and a large number of private and public actors are involved in their implementation. For example, the Bielefeld model (a German best practice) aims to increase housing affordability, housing accessibility, the quality of social care and community at once. However, it is fair to note that according to the evaluation of best practices made by the experts in their Final Reports, the weakness of the integrated approach and the inclusion of many different actors in their implementation is sometimes a consequent lack of transparency – the situation where the elderly do not know where to turn if they have a problem because the division of responsibilities is not clear to them (see Table 16).

The higher number of actors involved requires also more personal engagement in practice management and the relatively higher administration costs on consultations and mediation. Next to that, the implementation of integrated and inclusive practices presupposes specific experience with this type of management, the courage and skills to manage complex financial flows and budgets, the management skills to lead effective cooperation with the many actors involved, mutual trust among actors and tolerance of other people’s perspectives and views. The actors in the post-socialist states active in the field of social care or not-for-profit housing learn these necessary skills only gradually, and it is therefore logical that it takes many years before such new arrangements can appear in these countries.

The unstable and insufficient financing of NGOs, a lower level of management skills and a lack of experience of their representatives in comparison to Western European countries, but also the socialist legacy (the leading role of the state, the legacy of universalistic schemes, a mistrust of civil society movements, a lack of skills among some state civil servants) or a relatively higher level of general social mistrust present in all transition societies may be the factors explaining why more complex and highly innovative practices appear only occasionally and gradually in these countries.

Table 16 The strengths and weaknesses of the practices using an integrated approach – the Bielefeld practice (Germany)

STRENGTHS	WEAKNESSES
<p>Housing project: normal, affordable housing for people in severe need of care, mixing old and young with and without need of care, with or without disability, low cost provision, no extra premium for general services.</p> <p>Surrounding area: the ‘Bielefeld’ project example stands out for its focus on a residential care area that includes a 24-hour service. The guarantee of care could not just be applied to the tenants of the special housing project but also to those residents living in the BGW residential area.</p> <p><i>The combined provision of all relevant services i.e. affordable, accessible housing, care and social assistance, mixed community.</i></p>	<p>Housing project: although the aim is to provide normal housing, the housing projects are sometimes seen as something like an ‘old people’s home’.</p> <p>Surrounding area: services and the guaranteed care are only provided for a small area and <i>the coordination of services in the wider residential area is only available on a rudimentary level.</i></p> <p>There is a gap in the financing of coherent residential area management and social support. The existing financing used in the Bielefeld model is restricted to groups of people with care requirements who are on low income. In addition, <i>the financing system is very complicated.</i></p>
<p>An integrated approach, broad participation, modular design enables individual adjustments according to individual needs.</p>	<p>Communication and mediation is strongly needed → strong efforts and personnel engagement</p>

Source: Authors’ research, cited from the completed questionnaire – SWOT analysis section.

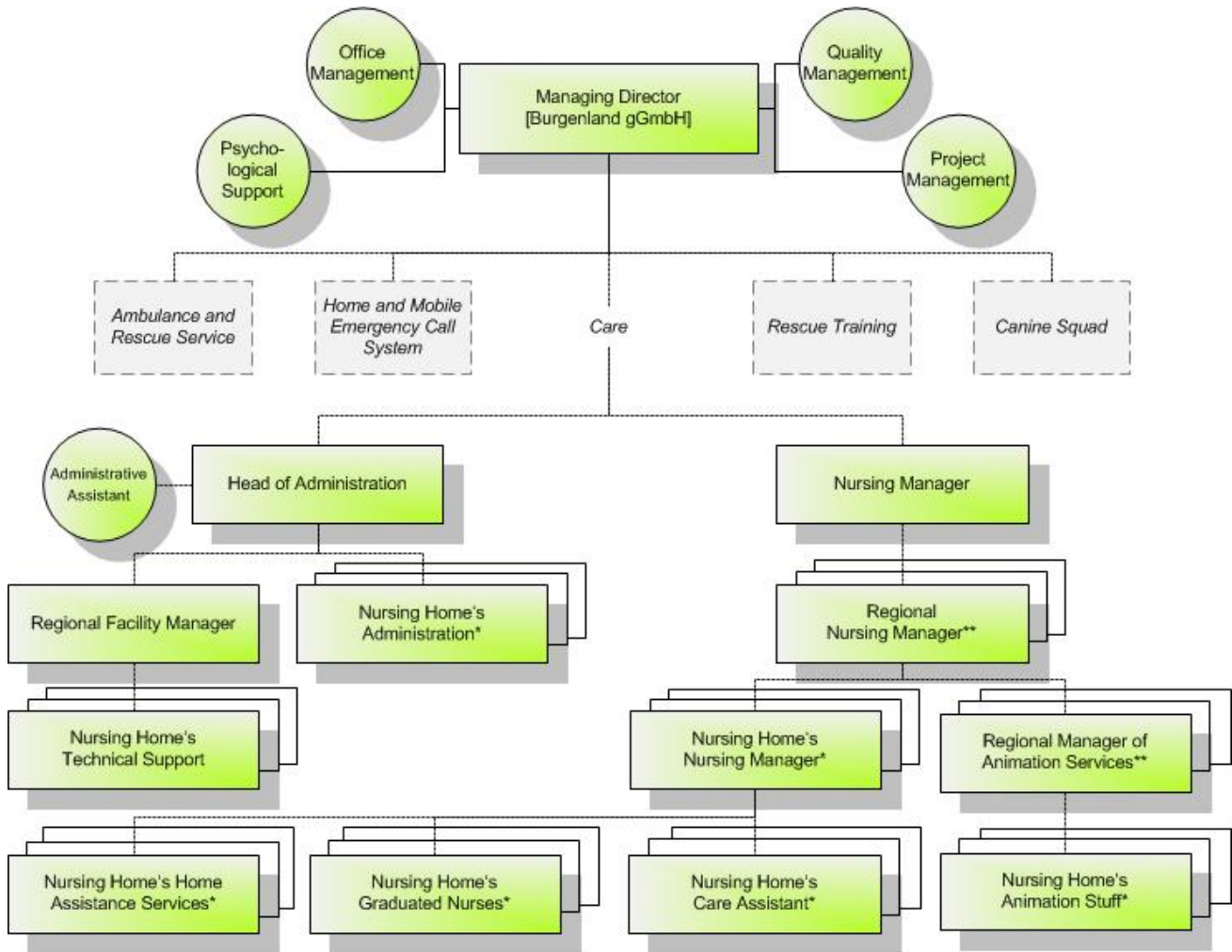
The Structure of Management

A significant difference between the best practices in the developed countries and those in the post-socialist countries can also be found in the type of management structure. The best practices in the developed countries use a relatively complex organisational structure (German, Austrian and Italian practices). They have a well-established organisational structure where the tasks and responsibilities of all the actors and employees (or co-workers) are defined in detail. There are also special manuals and internal rules on practice management (for communication, for example). Usually, the leading organisations have a higher number of employees and co-workers than the leading organisations in post-socialist countries.

The organisational schemes for best practices in the post-socialist countries are characterised by a simple management structure, a low number of co-workers and little division of tasks and responsibilities (‘everybody does everything’). The management of practices is flexible and innovative; the workers come up with new ideas that are easily and quickly implemented. However, the success and sustainability of the practices often depend on a few highly motivated persons – their exit from the management structure can therefore lead to the termination of the given practice.

By contrast, in the organisational schemes of best practices in the developed countries, the exit of one co-worker (employee) does not have a fatal effect on the sustainability of the practice. However, as mentioned above, the complicated organisational structure comes with the risk of ineffective communication between actors and the risk of misunderstanding. A comparison of the two different models of organisation is displayed in Diagram 1 and Diagram 2. The organisational structure of Samaritan Burgenland in Austria (Diagram 1) includes a range of employees in different organisational sections. By contrast, the Muži a ženy NGO (Diagram 2) in the Czech Republic has only three core employees.

Diagram 1 Organisational structure of Samaritan Burgenland (NGO), day-care in the nursing homes of Samaritan Burgenland (Austria)



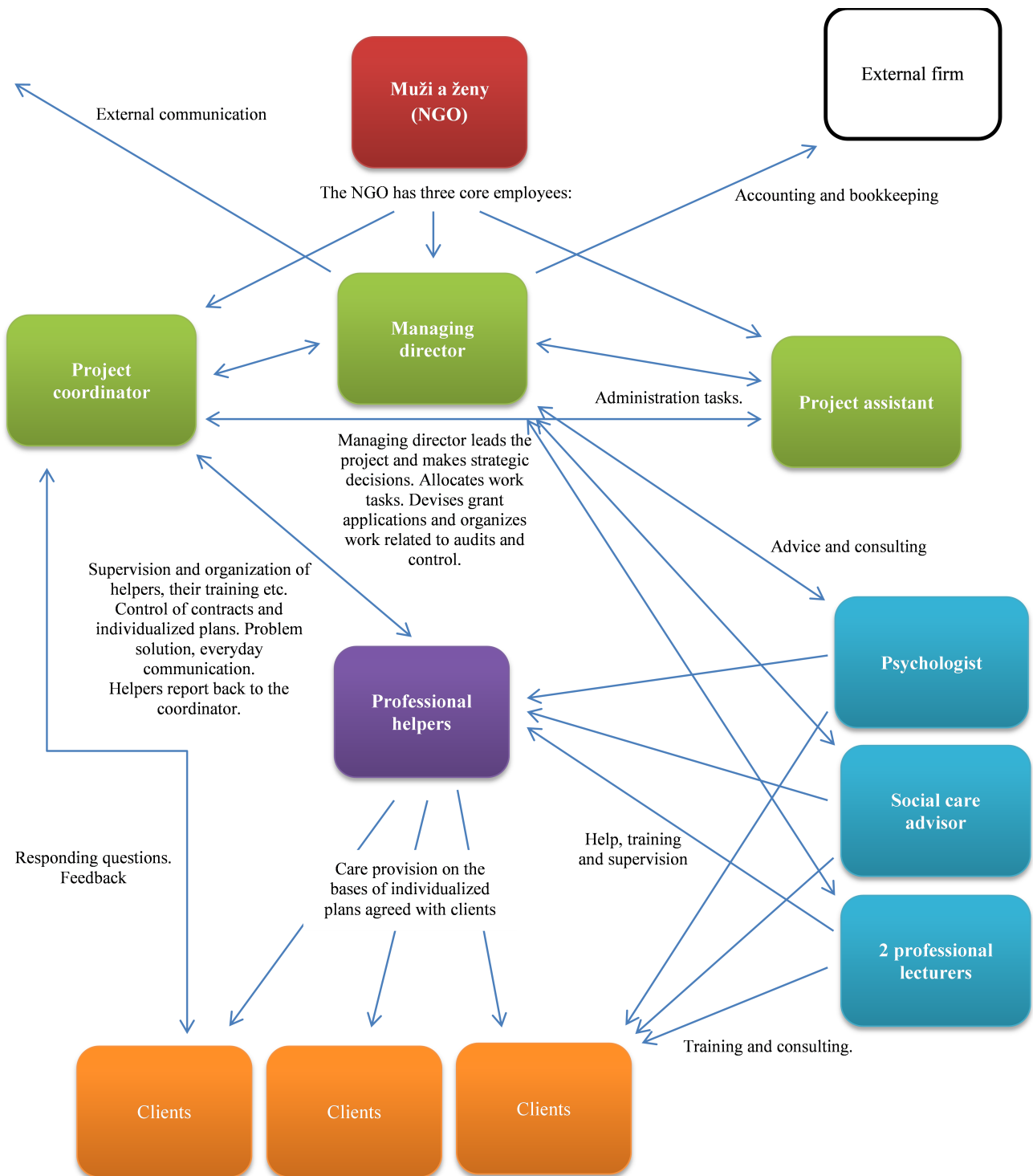
*) Nursing Homes: Neufeld, Siegendorf, Draßburg, Lackenbach, Weppersdorf, Oibendorf, Strem
 **) Areas: North: Neufeld, Siegendorf, Draßburg, Lackenbach; South: Weppersdorf, Oibendorf, Strem

Some best practices also make use of the work of volunteers. Despite the many advantages of voluntary work (such as the high motivation of the workers, lower costs, community-building, etc.) the evaluation of practices showed that the inclusion of volunteers assumes the establishment of a system of training and advice to serve them. Within the simple organisational structure known from the best practices in the post-socialist countries, this could be difficult due to a lack of capacity.

Table 17 Strengths and weaknesses of practices involving voluntary work

STRENGTHS	WEAKNESSES
Large number of volunteers.	Small number of professional staff, lack of training, lack of data analysis, lack of know-how about the administration of funds on the local level. No systematic measurement of the satisfaction rate of the users.
	<p>THREATS</p> <p>A lack of professionalism on the part of volunteers, a lack of control over them. Susceptible to abuse.</p>

Source: Authors' research, cited from the completed questionnaire – SWOT analysis section.

Diagram 2 Muži a ženy (NGO), Zrcadlová pomoc ('Mirror Help') (Czech Republic)

Another weakness of voluntary work is the possibility of abuse of the practice by criminals to gain entry into the houses or flats of the users (the clients) of the practice. Therefore, a special provision to prevent this situation is needed. A Slovenian best practice is 'Elderly for a Better Quality of Life at Home' is an example of a project based on voluntary work. In 2011, there were 3,307 volunteers participating in it. The weakness of practices like this one is the fact that the quality of the service relies on the quality of the volunteers. Table 17 shows the strengths and weaknesses of this particular Slovenian best practice.

The integration of mutual help among the elderly into best practices should not be difficult from a managerial point of view and simultaneously it leads to the re-activation of the elderly, their greater involvement in the community, and it gives the elderly the feeling that they are useful. For example,

in the Bielefeld model (Germany), the tenants can help by being involved in community activities/services or helping to prepare meals; the best practice 'Mutual Help Exchange' led by the NGO 'Veselý Senior/Lucky Senior' (Czech Republic) is based on the mutual exchange of experiences, skills and knowledge among the elderly. Programmes of mutual help between the elderly and young people are also welcomed due to the integration potential (for example, the Hungarian practice 'Skype for the Elderly' or the Slovak practice 'Chain of Experience – Generations Bridge').

Participation of the Elderly in the Design and Implementation of Best Practices

The participation of seniors in the design and implementation of the practice obviously ranks among the important features of a successful practice. The possibility to influence the design of the practice contributes not only to the fact that the needs of the elderly are better satisfied and more effectively met but it also increases their community involvement, the activity of seniors and, in consequence, maintaining of their mental resources. There are basically two models of participation of the elderly:

- (1) In the more complex practice management structure (Austria, Germany), the organisations have sophisticated internal rules to gather and use the opinions of the elderly in the form of complaint management, special manuals, regular surveys, consultations, discussions or meetings. On the one hand, this model provides a relative high certainty that the complaint or the suggestion will be answered or taken into account. On the other hand, the system can be inflexible; the length of time between a request and an answer can be long.
- (2) The second model is typical for simple management structures. There are no special institutional processes for collecting complaints or suggestions. The elderly can express their opinions via ad-hoc satisfaction surveys, accidental meetings, or if they meet anyone from the staff. This system is more flexible but depends on the availability and skills of the staff.

For some best practices included in the Catalogue of Practices, there is no real (or very little) participation of the elderly in the design and implementation of the practice, such as the best practice 'Info TV' (Austria) or the best practice 'Emergency Alarm System' (Hungary). The low participation of the elderly is considered as a weakness of the practice. It may lead to decreasing satisfaction among users and a lower demand for the practice. According to the overall evaluations of all best practices, the inclusion of observation of particular needs, wishes and opinions of the elderly and people with disabilities is essential to the long-term sustainability of the practice. Table 18 shows the international comparison of types of participation of the elderly in defining the design and provision (implementation) of the practice. There are no huge differences among countries, but the lowest participation rate was found in Hungary.

The Effectiveness of Best Practices

Also due to the fact that these practices were selected by the HELPS project partners or their hired experts as examples of best practices, it is logical that practically all of them were evaluated as being effective (i.e. well targeted). The practices assist lower-income (needy) households more than higher-income (less needy) households; and they do not exclude lower-income (needy) households. Despite these positive evaluations, we found several limitations concerning the effectiveness of practices.

For some best practices, eligibility has been limited by specific conditions, such as living in specific housing stock or a pre-defined locality. And even within these limitations, it was clear that the practice can hardly satisfy all eligible households. For some best practices, especially for different systems of accessible and affordable housing for the elderly, the demand for the practice exceeds the supply; the examples being 'Rental Dwellings Designated for Pensioners and the Elderly' (Slovenia), 'Apartment Building SENIOR' (Slovakia) or 'Nie sami/Not Alone' (Poland). It is clear that in these cases it is not possible to meet fully the demand, but it is not so clear whether or not there is a risk that some eligible households have more favoured treatment than others.

Table 18 Participation of the elderly in defining the design and provision of the practice

Forms and characteristics of participation		Forms and characteristics of participation						
		no participation	regular meetings with management	regular questionnaire	accidental, informal	others	internal rules	weakness – insufficient participation
Area of practice	community building	0	4	4	2	2	2	0
	housing accessibility	0	2	2	2	3	5	0
	housing affordability	2	2	2	2	1	1	0
	social and health care	2	2	0	0	4	1	0
	access to information	1	1	2	2	0	3	2
Country	Slovenia	0	2	2	0	1	2	1
	Hungary	2	1	0	1	1	0	0
	Germany	1	4	1	1	2	2	0
	Slovakia	0	3	2	0	1	2	0
	Austria	0	1	2	3	1	4	1
	Poland	1	0	2	0	2	0	0
	Czech Republic	1	0	1	3	2	2	0

Note: The figures represent the number of practices in the respective areas / countries in which the particular forms and characteristics of participation were identified.

Source: Authors' research, cited from the completed questionnaires, Section F.

If the practice requires financial participation from its users, it may also lead to the exclusion of low-income households, especially if the fee is relatively high. Few best practices integrate special subsidies helping low-income people to cover their financial participation. Nevertheless, applying for an allowance could be too complicated in some cases, such as for the practice 'Day-care in the Nursing Homes of Samaritan Burgenland' (Austria). Another reason for exclusion could be the inability (or difficulty) of transport to the place where the practice is realised, such as for 'Senioralni, Poznan' (Poland). However, there are always some limitations and barriers, and basically the managers of all the best practices in all the countries made a maximum effort to include as many low-income needy households as possible.

Another limitation to practice implementation can be the insufficient 'marketing' of the practice. If the practice is not well-known among the target group, uninformed potential users are excluded. For example, DOM IRIS (Slovenia) is a demonstration apartment and clinical research facility where various technical aids and technologies can be seen and tested in order to find solutions for independent living for the elderly in their home environment. At the beginning of the project, physicians in Slovenia were not informed about the existence of this service and they did not know that it belongs to the public health network, so the service is paid for by the health insurance companies and is free for clients.

Financial Sustainability

In almost all cases, the stability of funding of best practices constitutes the most common threat to their sustainability. There is a clear, and somewhat natural, trade-off between using an innovative and locally specific approach and financial stability: the more innovative and locally specific the practice is to better meet specific local needs, the less stable its financial sources. Consequently, the implementation of new and original local practices requires not only highly motivated staff but also a certain financial history, stable donors and capital from the practice leader. As mentioned above, NGOs in post-socialist states have none of these and their weaker position is reflected in the limited number of good examples.

Therefore, the best practices in the post-socialist countries are most often financed from just one source, basically the public budget; the financing is usually short term and often depends on the varied interests of the changing political representation. For example, the main threat to the practice ‘Active 50+ Fair’ (Poland) is uncertain public financing for further editions of the event. Most essential to the long-term sustainability of this practice is continued financial support from the co-organising local authorities. The support must be confirmed in annual local budgets and strongly depends on a commitment from the public authorities, which is susceptible to the risk of changing political priorities.

By contrast, some practises, especially in developed countries, have numerous financial sources: this fact eliminates financial uncertainty but increases the demands on administration and management. The advantage of established NGOs in developed countries is that they have their own financial resources (capital), financial history (important for possible lenders) or property; moreover, they often have a reputation which puts them in a stronger position for negotiations with the public authorities.

The lack of finance is reflected in the design of practices. Many practices from the post-socialist countries are very inspiring for their original ideas, low costs, and relative simplicity, such as the best practices ‘Skype in Eldercare’ (Hungary), ‘Mutual Help Exchange’ (Czech Republic) or ‘Chain of Experience – Generations Bridge’ (Slovakia). However, the scope and goals of such best practices are logically limited. Italian practices reveal another important aspect: the danger of ambitious practices with an extensive management structure, but that are financed through term-limited sources from special projects, so the practices are then not fully sustainable in the long term (the practices ‘Social Caregivers’ in Milan or ‘DREAMING PROJECT-PSP-ICT’ in Italy).

The Structure of Financial Sources

Most practices are heavily dependent on the availability of public finance. Many practices are fully financed only from public grants (for example, almost all the best practices in Slovakia). Several best practices combine public and private financial sources. Some best practices are also completely (or almost) financed by their provider; in the case of NGOs examples are ‘Info TV – The House-Own Information Channel of Samaritan’ (Austria), ‘Mutual Help Exchange’ (Czech Republic) or ‘Skype in Eldercare’ (Hungary). Private sources primarily include: fees from clients, rents, donations, and revenue from the provider’s own activities. In an evaluation of practices with a large share of private capital, the threat of commercialisation of practice was sometimes mentioned, for example for the practice ‘Festival for the 3rd Age’ (Slovenia).

A special group is represented by the best practices providing an emergency call system for elderly and disabled people (including cardiac telerehabilitation). Despite the evident strengths of these practices, after the pilot phase all the practices are confronted with financial problems. Table 19 presents the strengths and the weaknesses of this type of practice. The implementation of an ICT system has usually been funded by a public grant (examples are the practices in Germany, Austria, Italy, Poland and Hungary); the share of public grants ranges from 85% to 100% of total costs. However, after the first phase of the project (pilot action), the practice turns into a private scheme not dependent on public finance (with the exception of the Polish and Hungarian practices, which are still funded by

public finance). Due to the fact that this kind of care is not included in the system of public subsidies for social and health care, there are problems with balancing between the relatively high costs of the service and keeping it affordable for the people in need. Usually, the financial participation of the local authority is needed.

Table 19 The strengths and weaknesses of practices concerning ICT systems for the elderly

	STRENGTHS	WEAKNESSES
Slovenian model (Telecare)	<ul style="list-style-type: none"> • Strong interdisciplinary coordination, national coverage, which means that the service is accessible/available (geographically) to anyone 	<ul style="list-style-type: none"> • Even if the price is lower according to the previous service, the service is still expensive and for that reason not affordable (financially) for anyone; the service is not recognised as part of the public network.
German model (SOPHIA – Franken GmbH & Co. KG)	<ul style="list-style-type: none"> • Flexible and affordable social component for a broad range of tenants • No basic investments are required • No complicated legal hurdles involved in the implementation of the practice • Symbiotic system of technical and psychological support • Transferable to other regions • No public spending necessary, economically self-sustainable 	<ul style="list-style-type: none"> • Housing companies need to show their will to implement SOPHIA, otherwise the application of the system is not feasible. • Complicated franchise system that later had to be modified in order to create a business model to attract new partners • The need to raise acceptance among the elderly that a housing company is responsible for health and social care services. Consequently, the SOPHIA System often meets with refusal. • No inexhaustible market as housing companies do not regard the complex installation of the SOPHIA system as economically beneficial
Slovak model (Electronic guardian of seniors)	<ul style="list-style-type: none"> • The practice is not aimed exclusively at the elderly; it can be used also for children and adults with ill health. • The project uses a tool whose functionality is not limited to the client's household and therefore does not create mobility barriers. • The pilot project was approved by actors as a beneficial instrument of social and health care. • The practice cannot be abused due to very thorough examination process, which would detect almost all potential abusers, but this also limits total number of users; any abuse would be detected immediately (low number of users, close contact between users and operators). 	<ul style="list-style-type: none"> • Exists at the local level in the City of Martin • Client's financial participation covers the practice costs only partially. The rest is funded by the municipality.

Table 19 (continued) The strengths and weaknesses of practices concerning ICT systems for the elderly

Austrian model (Home Emergency Call and Mobile Emergency Call including GPS location in AT and SK)	<ul style="list-style-type: none"> • Innovative home and mobile emergency call system • Upgradeability of the system with additional products • Total service portfolio, especially an emergency service • Assistance-competence, professionally trained emergency service staff • Range of the product (single households, supervised flats, nursing homes) • Existing infrastructure such as a control centre (trained staff) • Extensive supply (cooperation with emergency service providers) • Content and technically dual system 	<ul style="list-style-type: none"> • Language-barriers between Samaritan Burgenland and the project partner because of the different native language • Financial burden, no financial aid for clients through social insurance • Hardwire systems are tied to one place • Reaching the target group
Polish model – telerehabilitation (Cardiac telerehabilitation)	<ul style="list-style-type: none"> • Sustainable, tested technical solutions • Part of a complex teleconsultation centre • Designed, developed and implemented by a top reference centre in cardiology in Poland, with much influence on cardiology operations in the country 	<ul style="list-style-type: none"> • No direct recognition as a medical procedure by the National Health Fund • Only implemented by one institution at the current stage (access limited to patients referred by the Institute of Cardiology)
Hungarian model (Emergency Alarm System)	<ul style="list-style-type: none"> • Easy to use technology • Linked to social eldercare • Creates equal opportunities by targeting the group at social risk • Incorporated into the system of social regulations • Improves the security, quality of life of the target group • Indirectly improves the quality of life of family members 	<ul style="list-style-type: none"> • The presence of two different market types (one purely technical, the other also providing a service) creates opportunity for abuse. • The partial financing of the market segment is a danger – erosion of financing leads (can lead) to the withdrawal of the market actor.
Italian model (DREAMING PROJECT – PSP-ICT – acronym for eIDeRly-friEndly Alarm handling and MonitorING)	<ul style="list-style-type: none"> • New attitude to telemedicine and positive working atmosphere • Info on the web portal ! and ++ professional integration (ASS1 + TTL: meetings, collaboration, etc.) to solve problems • User satisfaction (despite some problems with the use of devices) • The majority of older participants feel safer in their home thanks to the Dreaming equipment • Positive change of mind in health professionals about the DREAMING Project: a good experience for the future, increased professional use 	<ul style="list-style-type: none"> • Imperfect selection of frail participants • The thresholds of type 1 alarms are too low and have no real clinical impact and relevance for a clinical decision • DLS line connections (some criticisms, mainly solved; costs) • Difficulties for many with having to be trained in handling/using the devices (both for operators and subjects) • Difficulties with the set-up of the video conference – Older users remain doubtful about the use of Videoconferencing

Source: Authors' research, cited from the completed questionnaire – SWOT analysis section.

The Strengths and Weaknesses of Best Practices

Many best practices could be an inspiration for other countries. However, the evaluation of the practices shows that the strengths of practices are always countered by weaknesses and therefore it is necessary to look at both sides of the coin. Table 20 summarises the main findings from an international comparison of best practices: the main strengths and main weaknesses of different settings of the best practice. As has been demonstrated in previous sections of this report, contextual factors, such as the housing system, also play a crucial role in the effective transnational transfer of know-how. The success of a particular practice in one country does not have to repeat itself in other country because of the different contextual arrangements, fewer opportunities to obtain public subsidies, the non-existence of strong NGOs or the lack of rental housing.

Table 20 Summary of the main strengths and weaknesses of best practices

	STRENGTHS	WEAKNESSES
Cooperation of different actors	<ul style="list-style-type: none"> • innovative approach • integrated approach 	<ul style="list-style-type: none"> • possible communication problems • unclear definition of responsibilities among different actors
Sophisticated structure of management	<ul style="list-style-type: none"> • sustainability – independence on the departure of one highly motivated co-worker/employee • integrated approach 	<ul style="list-style-type: none"> • high personnel costs • lack of communication between employees • misunderstandings about who is responsible for what
Simple structure of management	<ul style="list-style-type: none"> • flexibility • low cost • informal relations with the elderly 	<ul style="list-style-type: none"> • dependency on a few capable and highly motivated employees/co-workers – exit of a crucial team member may threaten the practice implementation
Voluntary work	<ul style="list-style-type: none"> • low costs • highly motivated workers • community building 	<ul style="list-style-type: none"> • lack of training of volunteers • lack of control of volunteers • susceptible to abuse by criminals
Participation of the elderly	<ul style="list-style-type: none"> • long-term sustainability • increase in the activity of the elderly 	
One source of financing	<ul style="list-style-type: none"> • transparent financial flows, easy financial management 	<ul style="list-style-type: none"> • financial uncertainty • dependence on actual political priorities
Multi-source financing	<ul style="list-style-type: none"> • financial sustainability 	<ul style="list-style-type: none"> • administrative-intensive
Large share of public finance	<ul style="list-style-type: none"> • no fee for service 	<ul style="list-style-type: none"> • dependence on actual political priorities • threat of financial unsustainability in the case of public finance cuts
Large share of private finance	<ul style="list-style-type: none"> • financial sustainability 	<ul style="list-style-type: none"> • threat of commercialisation
Financial participation of the clients	<ul style="list-style-type: none"> • financial sustainability 	<ul style="list-style-type: none"> • exclusion of low income people

Source: Authors' research, cited from the completed questionnaire, authors' summarisation.

Policy transfer can take both ‘soft’ and ‘hard’ forms, ranging from the ‘hard’ transfer of the details of a policy to the ‘soft’ transfer of the ethos underpinning it (Stone 2010). ‘Hard’ transfers often require a change in legislation or, at least, changes in the main government policy strategies and priorities. Soft ‘horizontal’ transfers can take place without the formal intervention of the state, for example between NGOs anxious to learn from one another, and do not require major changes in legislation or the institutional framework.

The comparison of best practices in the selected five areas of intervention under the HELPS project made it clear that soft transfers are especially possible in fields where specific housing, social, economic and institutional contexts do not matter so much, and these are two such areas in particular: community building and access to information/education. The practices in these two fields are not so dependent on specific contexts and are, moreover, financially not so demanding.

The most difficult softer transfers are possible in fields where the specific context has a stronger deterministic effect and policies are often tied to national legislation and policies, i.e. especially in the area of housing affordability. Most often, the transfer will consist of only a few inspiring elements of a specific model taken from one country and applied in another country. The areas of housing accessibility and social and health care occupy a middle place between easy and difficult soft transfers. The different forms of home and urban surrounding (public spaces) adaptations have the greatest potential for transnational transfers in the area of housing accessibility. Analogically, different ICT solutions have the greatest potential for transnational transfers in the area of social and health care.

Conclusions

The evaluation of best practices shows that there is no one universal best practice. The strengths of the practices are always countered by their weaknesses and before starting the practice implementation it is necessary to look at both sides of the coin – the weak and strong sides of the innovative practice.

Innovative cooperation among many different actors requires more personal involvement in practice management and relatively higher administration costs for consultations and mediation. The most frequently described factors for the successful implementation of practices were good cooperation among the actors involved and the ability to find financial support. The implementation of integrated practices requires management skills to lead effective cooperation among the many actors involved and the skills to manage complex financial flows and budgets. Unstable and insufficient financing of NGOs, insufficient management skills and a lack of experience on the part of their representatives, but also the socialist legacy or the relatively higher general social mistrust found in all the transition societies are factors that could explain why more complex and highly innovative practices are only occasionally seen in these countries.

The strength of the organisational scheme for best practices in the developed countries, characterised by a sophisticated structure of management, is the long-term sustainability of the practice. However, the complicated organisational structure is accompanied by a risk of ineffective communication between actors. By contrast, the simple management structure is more flexible to changing needs, but the success and sustainability of the practice often depends on a few highly motivated persons – their exit from the management structure can therefore lead to termination of the practice.

The possibility for the elderly to influence the design of a practice contributes not only to the better and more effective satisfaction of their needs, but also to their greater community involvement, increased activity, and, consequently, stimulates their mental resources. Moreover, the participation of the elderly is not financially demanding. Therefore, the practice should involve eligible household already in the design and implementation phase of the practice application. Despite the strengths of voluntary work, the inclusion of volunteers necessitates the establishment of a system of training and

advice to serve them. When volunteers are included, the additional cost should be taken into account in the budget for the practice.

The stability (or the instability) of funding of best practices represents the most common threat to their sustainability. The implementation of new and original local practices requires not only highly motivated staff but also a certain financial history, stable donors and capital from the practice leader. The combination of a number of financial sources, which was most often found in the developed countries' model of best practices, eliminates financial uncertainty but increases the demands on administration and management. By contrast, having one source of financing makes the financial management transparent but leads to financial uncertainty, which is typical for the best practices in the post-socialist states. Most of the practices are strongly dependent on the availability of public finance. If that is absent, the financial participation of the clients is often required. However, the higher the assumed contributions from eligible households the greater the chance is that low-income households will be excluded from using a particular practice. Therefore, all practices involving contributions from eligible households should have a scheme guaranteeing financial support to low-income households.

The comparison of best practices in the selected five areas of intervention under the HELPS project made it clear that soft transfers are especially possible in fields where the specific housing, social, economic and institutional context does not matter so much, and there are two such areas in particular: community building and access to information/education. The most difficult soft transfers are possible in fields where the specific context has a stronger deterministic effect and policies are often tied to national legislation and policies, i.e. especially in the area of housing affordability. Most often, the transfer will consist of only a few inspiring elements of a specific model taken from one country and applied in another country.

The areas of housing accessibility and social and health care occupy a middle place between easy and difficult soft transfers. The different forms of home and urban surrounding (public spaces) adaptations have the greatest potential for transnational transfers in the area of housing accessibility; while different forms of special housing for the target population that mostly reflect the specific national housing system and traditions have the least potential for transfers in this area. Analogically, different ICT solutions have the greatest potential for transnational transfers in the area of social and health care.

IX | Recommendations

This final section of the main report summarises the general and specific recommendations stemming from the main findings produced by all the analyses applied within the research part of the HELPS project and that are to be considered in the remaining two phases of the HELPS project. This list of recommendations represents only an overview of implications resulting from the comparison of contexts and innovative practices identified in the eight CE countries. These recommendations will be further elaborated in Working Paper that will follow up the present report and the Catalogue of Practices. However, this concluding part can be considered as the main outcome resulting from the effort of all the participating project partners with the objective of mapping the situation in the CE countries and outlining possible solutions with respect to the housing and care for the elderly.

General Policy Recommendations

There is NO ONE BEST PRACTICE suitable for all. Therefore, the main imperative of governmental policies targeting the elderly and people with disabilities should be to increase the overall variety of possible housing and social care options for the elderly. Such options (practices, measures) could be provided by diverse providers and could target the whole variety of specific local needs and preferences. Success lies not in the implementation of one BEST and universal social/housing policy or practice but in the implementation of a 'POLICY OF CHOICE'. For example, co-housing should not be viewed as a general solution but rather as one of a number of possible ways of solving the issue of elderly housing that may not be (and will not be) suitable for everyone.

If the government has the objective to promote variability (POLICY OF CHOICE) and innovations in the area of housing or social care for the elderly and people with disabilities, it should primarily promote stable conditions for the operation of the THIRD SECTOR (i.e. NGOs, churches, volunteer organisations, not-for-profit organisations, housing associations), which means especially securing sufficient funding for services provided by the third sector. The third sector showed itself to be very open to the application of innovative solutions and, at the same time, effective in meeting clients' varying needs. An audit mechanism to prevent abuse and to render the grant allocation system transparent has to be established, but the third sector, as independent of political competition and bureaucracy, is more likely to produce and implement innovations than public administration or for-profit private sector agents, who are often searching for universal (easily replicable) solutions. This recommendation is especially relevant for the post-socialist states where NGOs (or not-for-profit housing associations in the field of housing) still remain financially and politically weak.

Housing Policy Recommendations

Policies must be understood in their historical and institutional context. This is especially the case for housing where substantial differences in systems and strategies are present among European countries (where there are liberal, mixed, social-market and social-democratic systems). There is little convergence of housing systems among countries and strong path dependence has been identified in housing policies. Moreover, most housing-related best practices are determined (shaped) by the CENTRAL housing system, NATIONAL legislation and subsidies. Path dependence in a system/policy and extensive involvement of the state represent serious barriers to the quick transfer of knowledge. The international transfer of innovations is possible only if the government is open and flexible enough in

the preparation and implementation of its housing policy strategy. Consequently, governments should come up with housing strategies that are sufficiently OPEN to innovations in the future and enable CHANGES in the forms of solutions to one problem – supporting a local VARIANT instead of UNIVERSAL solutions.

There are clear LIMITS TO THE TRANSFERABILITY of best practices (or measures) in the field of housing affordability and housing accessibility from one housing system to another. While social care is provided on a tenure-neutral basis and is simply targeted according to the health and social needs of the elderly and people with disabilities, housing support also takes into account the housing tenure of the target population. It has been noted that home adaptations are more effective when considered for long-term rather than short-term use. Moreover, public grants are expected to target those in a financially precarious situation. However, it is more difficult to guarantee long-term use and fairness (targeting) when allocating subsidies to homeowners. A more balanced housing system (with a substantial stock of rental housing) and more stable rental housing (the provision of long-term rental contracts, higher security of tenure), whether private or social, increases the effectiveness/efficiency of public subsidies allocated and enables the existence of more innovations and greater diversity of housing options provided to elderly people and people with disabilities. Consequently, housing policies, especially in the post-socialist countries (which nowadays often have a super-homeownership/liberal housing system) should apply a more BALANCED approach to housing tenures and apply such measures that would increase the size of RENTAL HOUSING, the security of tenants and the stability of rental housing. However, this policy shift may have a dark side: that is a danger of irresponsible consumption by tenants during their economically active life (insufficient savings and investments) and, consequently, the high housing costs burden must be met by higher state social assistance expenditures in older age. This unintended, though more potential than necessary, consequence should be taken into account when designing housing policy change.

Despite the higher housing costs burden among elderly tenants (revealed in a simple analysis of housing affordability) there is NO SUPERIOR HOUSING TENURE. The standard of housing and quality of life of elderly tenants may surpass that of homeowners, especially when poor elderly-homeowners (common in the post-socialist countries) do not have enough resources to modernise and adapt their own housing, and have a very limited possibility to downsize their housing consumption (due to pressure from children, cultural barriers, a lack of equity release products or to the generally lower willingness to move among homeowners than tenants). The policy implication is again to support a more balanced housing system, apply a tenure-neutral housing policy and increase tenure-neutral housing choice: a POLICY OF CHOICE.

The elderly would welcome physical and architectural adaptations of their flats to accommodate their changing needs: 'LIFE-TIME HOMES' or 'UNIVERSAL DESIGN'. These policies seem to be those most acceptable to the elderly themselves (according to survey data), but seem to be rather underrated in the post-socialist countries. For the state, the implementation of these concepts would lead to further savings thanks to preventive measures that would encourage developers to build adapted flats and houses so that it is not necessary to reconstruct them later when the need arises. Therefore, there is a high added value (both public support by the elderly and the incurrence of public finance savings) supporting these new forms of housing building. Several practices also showed that it is important not only to design flexible homes but also to guarantee ACCESSIBLE PUBLIC SPACE. New housing development and urban planning should take into account much more than now the need for greater accessibility of public spaces for the elderly and people with disabilities.

The innovations in elderly housing should be designed and projected in such a way that they not only take into account and concern the elderly themselves, but also their FAMILY as such. The current academic and policy research shows that for the well-being of the elderly it is essential that their relatives actively participate in the care, either formally or informally. When the intensity of contacts

between the elderly and their family decreases, this often leads to (is a key factor in) the move to institutional care etc. Innovative policy measures should thus view as their target group not only the elderly but the ELDERLY TOGETHER WITH THEIR FAMILY (informal carer).

Over the past decade there has been an expansion of the use of ICT in care for the elderly. This includes alarms, SMART homes etc. ICT was by far the most common best innovative practice mentioned by project partners in the area of social and health care. Based on extensive past research there is strong evidence that although these technologies are efficient, they are not always well accepted by the elderly themselves (due to their technological complexity). Moreover, our research showed them to be relatively expensive; at least some of the costs of ICT provision are basically covered by the clients themselves. Finally, ICT solutions cannot substitute informal/formal care totally because they may lead to a feeling of social exclusion and powerlessness. Policies promoting ICT should therefore include also: (a) intensive programmes of TRAINING (testing) where new technologies are explained to clients carefully and in detail; (b) CONTACT LINKS (call centres) to which clients can turn non-stop when assistance with technology use is needed; (c) FINANCIAL ASSISTANCE schemes for low-income clients (or the inclusion of ICT under the health-care insurance scheme); and (d) measures that would guarantee COMMUNITY INVOLVEMENT and increase the SOCIAL INCLUSION of eligible households. The best practices clearly showed that community involvement is a necessary condition for any successful programme of ageing in place. Therefore, practices involving ICT should simultaneously offer community involvement incentives.

Social Policy and Social Care Recommendations

The projection of the age structure of the population suggests that all the CE countries will have to deal with a high share of elderly in the population in the near future. Therefore, all these countries will face a growing burden on the social care systems due to an increasing number of people in need of care and a decreasing number of potential caregivers. It cannot be expected that this future demand for social care can be solved by an inflow of immigrant caregivers from other European (above all post-socialist) countries, as all of these countries will soon face a relative lack of adult people to care for the elderly and other vulnerable people. Therefore, it is necessary to introduce such measures that would encourage the development of BOTH FORMAL AND INFORMAL CARE and involve a WIDE RANGE OF ACTORS whose cooperation would assure the provision of all services needed. This imperative is further amplified by the current tendency in social policy to promote home-based social care services, since home care is not only cheaper, but it also corresponds better to the needs and wishes of the recipients of care. And it is specifically this kind of care that is able to INVOLVE COMMUNITY in the provision of care and to make use of services from different sources/providers.

The choice and implementation of such measures is however dependent on the historical, economic, political and cultural background of each individual country. Therefore, the transfer of good practices and innovative approaches from one country to another should take into consideration the CONTEXTUAL SETTING of the participating countries. The most favourable conditions for the development of social care systems were identified in those countries that have enough financial resources at their disposal, where the consumer power of care recipients is relatively high (partly due to a high level of redistribution of wealth) and that provide extensive support to carers as well as the third sector. They were not very favourable in those countries where care for the elderly relies on the family, which results in little pressure to improve and increase the selection of social care services. Therefore, in terms of social care systems support should focus mainly on three elements of the system: (a) the consumer power of (potential) recipients of care, (b) NGOs and other entities, and (c) informal caregivers providing care.

As for the recipients of care, they can purchase quality services only on the condition that they have sufficient CONSUMER POWER. There is indeed a growing degree of use of paid/professional home care in most EU countries. However, it seems that the most effective is the use of home care that is provided via CASH-FOR-CARE REGIMES. One of the instruments that aim to increase the financial resources of vulnerable people so that they can pay for the care they need is the CARE ALLOWANCE. Through this instrument the money is provided directly to the elderly, who decide independently how to use the money for care. In addition, the benefits eliminate the danger of social exclusion, as the elderly can use their personal budget to obtain care from their children, relatives, friends or neighbours. Hence, the demand for services can be stimulated by the provision of this financial incentive, if it is provided to those who are in need (GOOD TARGETING) and if its level corresponds to the incomes of the elderly and the costs of the services available (ADEQUATE AMOUNT).

Another important element stimulating the selection of social care services is a well-functioning THIRD SECTOR, i.e. especially NGOs, churches and other not-for-profit organisations. These entities seem to be the driver of changes in many areas since they are motivated to look for new and effective (as well as efficient) solutions and they are able to fill in the gaps in existing systems of social care. Finally, it will not be possible in the future to provide all the help the elderly require via formal services. Informal care will thus always represent an important part of the system. Hence, attention should be paid also to appropriate SUPPORT FOR INFORMAL CAREGIVERS, for example, by providing an adequate caregiver's allowance, guaranteeing social and employment security, services such as respite care, training etc. All these measures improve not only the conditions of care provision, but also the quality of care provided.

It is necessary to note that the above-mentioned elements of social care systems cannot be supported separately, their SUPPORT HAS TO BE INTERRELATED so that selection-oriented incentives are balanced by an appropriate demand for the services, and vice versa. It is also recommended that new forms of COOPERATION between informal caregivers and formal social services be developed, since the services provided by formal and informal providers complement each other.

With respect to the transferability of innovations, however, it must be pointed out that the introduction of sustainable practices will be generally more difficult in poorer countries since the stimulation of individual actors requires the availability of financial resources. For example, support given to NGOs and informal caregivers can stimulate the selection of social care services, but if the country does not have sufficient financial resources at its disposal that can be redistributed from the economically active population to those in need (e.g. in the form of social benefits and care allowances) and can thus increase their consumer power, the bigger selection of social care services will not be met by a higher demand for these services and a great part of these services will probably be wasted. Similarly, the increasing need for different types of care cannot stimulate the selection of social care services in countries that have limited financial resources to provide sufficient support to providers of care and to increase the consumer power of people in need of care. This is also the main reason for the unsustainability of innovative approaches supported by temporary programmes.

Thus, innovative approaches should be introduced gradually, i.e. poorer countries should modify their social care systems in steps, according to their actual available resources. One of the strategies in this respect is to DIVERSIFY THE SOURCES of funding, e.g. to enable the providers of care to use such sources as charity foundations, (low) clients' contributions etc. so that they are not dependent only on public budgets. In the countries with a (close-to-) neo-liberal welfare regimes it is also possible to support greater involvement of FOR-PROFIT PROVIDERS and private funding in implementing innovative practices. It can however be assumed that the differences between CE countries in terms of economic standing will rather diminish with the continual development of the post-socialist countries towards more advanced systems, which will have a considerable impact on the possibility to apply new practices in social care in these countries.

Furthermore, the transferability of measures/practices in social care is also limited by the fact that there are diverse legal regulations in the area of social care services provision across the CE countries. This means that in some countries it is necessary to get a license to be allowed to provide a social service, in other countries an agreement with the local authority is required or a contract with insurance agency is obligatory. As a result, the introduction of new practices will be accompanied by different administrative costs across the CE countries as well as different personnel costs due to different staff qualification requirements. These differences should be taken seriously into account when thinking about the possible transfer of know-how. Moreover, insufficient LEGAL FRAMING, the system of quality assessment and the accreditation system in some countries create barriers to guaranteeing the quality and good functioning of services. Therefore, it would be helpful to establish a better SYSTEM OF QUALITY INSPECTION and to anchor the position of providers of social services in the legal system so that the responsibility for social care services and their quality is clearly attributed to the actors participating in the provision of services.

Finally, several studies have suggested that home care is not effective or desirable by clients themselves in the case of a high level of dependence of the elderly. Thus, domiciliary care should not be considered to be a substitute for institutional forms of care, but an alternative to them appropriate when the elderly person has a certain level of self-sufficiency. Therefore, instead of eliminating institutional forms of care, an effort should be made to IMPROVE THE QUALITY OF INSTITUTIONAL CARE services and to enlarge the variability of these services so that every elderly person can choose the service that best fits his/her needs in terms of the extent of social assistance required, community life, comfort and privacy.

Recommendations for the Implementation of Particular Practices in Social Care and Housing for the Elderly and People with Disabilities

The effectiveness of practices (targeting) represents a clear trade-off to available financial sources. The higher the assumed contributions from eligible households, the greater the chance is that low-income households will be excluded from the use of a particular practice. However, the effectiveness (targeting those in real need) should always take precedence over the ambition to make the practice 'universally applied' or 'qualitatively perfect'. In other words, if the fee from eligible households is expected to be relatively high and no transparent scheme of allowances allocated to low-income households is provided, there is a high probability that the practice will not serve those in real need and will increase social tensions and exclusion. All practices involving relatively substantial contributions from eligible households should have a scheme guaranteeing FINANCIAL SUPPORT TO THE MOST NEEDY (LOW-INCOME) households.

There is another clear, and somewhat natural, trade-off between using an innovative and locally specific approach and financial stability: the more innovative and locally shaped the practice is, the lower the stability of financial sources and the greater the threat that the practice will not be financially sustainable. Consequently, the implementation of innovative local practices requires that the leader: (a) has a highly MOTIVATED STAFF; and (b) involves public and private funders (actual or potential) in the practice implementation from the very beginning of the practice design to meet their interests.

Some practices, especially when publicly financed pilot actions are finished, are expected to function under free market conditions (often ICT-type practices). In such cases a thorough MARKET DEMAND ANALYSIS, cash-flow analysis and cost-benefit analysis should be conducted before the pilot action itself. Otherwise there is a danger that the practice will not be financially sustainable.

The PARTICIPATION OF TARGET GROUPS in the design and implementation of the practice is not so financially demanding, but it has a crucial impact on the long-term sustainability of the practice and increases the probability that the practice will meet the specific needs of eligible households

effectively. Additionally, such participation leads to the greater involvement of eligible households in the community and gives them the feeling that they are being useful. All future best practices should involve eligible households (elderly, people with disabilities) already in the design phase and definitely in the implementation phase of the practice.

The inclusion of volunteers in implementation of the practice necessitates the establishment of a system of training and advice to teach volunteers the skills they need. This represents additional costs that should be taken into account when preparing the design of the practice and its budget. Moreover, the practice leader should be prepared for a high turnover of volunteers and should not expect highly professional outcomes. Some control mechanisms may be needed in cases where the work of volunteers can be abused for other purposes.

Some practises, especially in the developed countries, typically use a combination of a number of financial sources: this fact eliminates financial uncertainty but increases the demands on administration and management. NGOs from post-socialist states should first learn how to operate such combined financial flows and, before taking on such a responsibility, create their own financial sources (capital) and financial history.

The main trade-offs (and following recommendations) of best practices are summarised in following table. The practice leader should be informed about the drawbacks of the selected approach before starting its implementation and should, consequently, attempt to minimise the unintended negative consequences of practice implementation.

Table 21 Summary of the main strengths and weaknesses of best practices

Contribution (fee) from eligible households	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> financial sustainability 	<ul style="list-style-type: none"> exclusion of low income households
RECOMMENDATIONS	
<ul style="list-style-type: none"> All practices involving contributions from eligible households should have a scheme guaranteeing financial support for low-income households. 	
Participation of the elderly	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> long-term sustainability increased activity of the elderly 	<ul style="list-style-type: none"> costs of a professional participation scheme
RECOMMENDATIONS	
<ul style="list-style-type: none"> All future best practices should involve eligible households (elderly, people with disabilities) already in the design phase and definitely in the implementation phase of the practice. This involves additional costs but these are generally negligible when compared to the total costs of the practice implementation. 	
Inclusion of volunteers	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> low costs highly motivated workers community building 	<ul style="list-style-type: none"> lack of training of volunteers lack of control of volunteers susceptible to abuse by criminals
RECOMMENDATIONS	
<ul style="list-style-type: none"> Additional costs for the establishment of a system of volunteers training, advice and control should be taken into account when preparing the design of the practice and its budget. 	

Table 21 (continued) Summary of the main strengths and weaknesses of best practices

Cooperation of different actors/stakeholders	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • innovative approach • integrated approach 	<ul style="list-style-type: none"> • possible communication problems • unclear definition of responsibilities among different actors
RECOMMENDATIONS	
<ul style="list-style-type: none"> • For integrated and highly innovative practices involving many actors it is necessary to pay special attention to the establishment of a stable communication plan (channels) and a clear division of responsibilities and tasks. The sustainable and transparent division of responsibilities is a very important determinant of success. 	
STRUCTURE OF MANAGEMENT	
Sophisticated structure of management	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • sustainability: independent of the departure of one highly motivated worker/employee • integrated approach 	<ul style="list-style-type: none"> • high personnel costs • lack of communication between employees and misunderstandings about who is responsible for what
Simple structure of management	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • flexibility • low cost • informal relations with the elderly 	<ul style="list-style-type: none"> • dependency on a few capable and highly motivated employees/workers – exit of a crucial team member may threaten the practice implementation
RECOMMENDATIONS	
<ul style="list-style-type: none"> • Sophisticated management structure, enabling the application of integrated practices, involving relatively high personnel costs and a complex management (task and responsibility division) scheme. The leader should definitely have extensive experience with other practices with a simpler management structure before taking on the risk of establishing a more sophisticated structure. NGOs from the post-socialist states especially should first be involved in numerous small-scale, low-cost, informal and flexible practices before moving to more integrated practices requiring a sophisticated management scheme. 	
STRUCTURE OF FINANCIAL SOURCES	
One source of financing	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • transparent financial flows, easy financial management 	<ul style="list-style-type: none"> • financial uncertainty • dependence on current political priorities
Multi-source financing	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • financial sustainability 	<ul style="list-style-type: none"> • administrative-intensive

Table 21 (continued) Summary of the main strengths and weaknesses of best practices**RECOMMENDATIONS**

- NGOs from the post-socialist states should first learn how to operate such combined financial flows and, before taking on such a responsibility, create their own financial sources (capital) and financial history.

High share of public finance**STRENGTHS**

- no fee for service

WEAKNESSES

- dependence on current political priorities
- threat of financial unsustainability in the case of public finance cuts

High share of private finance**STRENGTHS**

- financial sustainability

WEAKNESSES

- threat of commercialisation

Source: Authors' research, cited from the completed questionnaire, authors' summarisation.

Policy transfer can take both 'soft' and 'hard' forms, ranging from the 'hard' transfer of the details of a policy to the 'soft' transfer of the ethos underpinning it. Hard transfers often require a change in legislation or, at least, changes in the main government policy strategies and priorities. Soft transfers can take place without the formal intervention of the state, for example between NGOs anxious to learn from one another, and do not require major changes in legislation or the institutional framework. The comparison of best practices in the selected five areas of intervention under the HELPS project made it clear that soft transfers are especially possible in fields where the specific housing, social, economic and institutional context does not matter so much, and there are two such areas in particular: COMMUNITY BUILDING and ACCESS TO INFORMATION/EDUCATION. The practices in these two fields are not so dependent on specific contexts and are, moreover, financially not so demanding. They could be started as 'bottom-up' practices with an innovative activity engaged in by one or a few municipalities or NGOs without the necessary involvement of the state or region. Despite the fact that they can largely vary in content among countries, they clearly possess the greatest potential for the transfer of know-how between municipalities/NGOs in different countries.

The most difficult soft transfers are in fields where the specific context has a stronger deterministic effect and local practices are tied to national legislation and policies, i.e. especially in the area of HOUSING AFFORDABILITY. The housing systems themselves influence what kind of solutions to housing affordability problems can be adopted. This is not to say that no transfer is possible, but this transfer requires the involvement of higher levels of administration in know-how sharing; it also demands much stronger promotion and dissemination activities, and will generally take a much longer time. Most often, the transfer will consist of only a few inspiring elements of a specific model taken from one country and applied in another country.

The areas of housing accessibility and social and health care occupy a middle place between easy and difficult soft transfers. The different forms of home and urban surrounding (public spaces) adaptations have the greatest potential for transnational transfers in the area of housing accessibility; while different forms of special housing for the target population that mostly reflect the specific national housing system and traditions have the least potential in this area. Analogically, different ICT solutions have the greatest potential for transnational transfers in the area of social and health care, but this requires other conditions to be fulfilled (see above). PHYSICAL ADAPTATIONS OF THE HOME AND URBAN ENVIRONMENT, TECHNOLOGY INNOVATIONS IN CONSTRUCTION AND DESIGN and ICT therefore possess strong transferability potential.

All new practices in housing/social care for the elderly and people with disabilities implemented in the CE countries should undergo a close SCREENING (EVALUATION) of their efficiency, effectiveness, level of participation of eligible households and cost-benefit (financial) sustainability during the design of the practice and the pilot action. For this purpose, QUESTIONNAIRES (TEMPLATES) elaborated by the HELPS project for the evaluation of already existing practices may be used. This has proved to be a good analytical tool for revealing the weak and strong sides of innovative practices in different fields.

X | References

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