

6

Health and dependency in later life

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INTRODUCTION

An enduring stereotype of human ageing is one of inevitable ill-health and mental and physical incapacity leading to disability and dependency. It underpins ageism (Bytheway, 1995) and reflects personal constructions of normal ageing (Bond *et al.*, 2004; Bond and Corner, 2004). In this chapter we explore concepts of health and illness, disability and dependency. We examine the reality of health and dependency in later life from the perspective of older people and compare the provision of formal and informal support within different European societies. The chapter has two broad themes. We describe first the nature of health disability and dependency in European societies. A final section provides a general overview of healthcare systems within Europe.

We start by highlighting the importance of the way that health and ageing are represented in European cultures. We consider the health beliefs of older adults and their beliefs about ageing. An important idea is the way that beliefs about health and ageing are entwined and the impact that this relationship has on the nature of ageism. Our review of health and dependency in later life then focuses on the nature of disability and the contrasting discourses of the 'medical' and 'social' models of disability. We review the World Health Organization's (WHO)

model of functioning and disability (World Health Organization, 2001). We then examine different uses of the concept of dependency with a particular focus on physical and psychological dependency. Using data from the Office for Official Publications of the European Communities, we provide an overview of the experience of health, disability or dependency in selected European countries.

In the remainder of the chapter we describe the evolution of health and social care systems in Europe and highlight recent key reforms and the political debates challenging the way that healthcare and social care policy is developing in the context of ageing societies. We provide a typology of different health and social care systems in Europe and examine the competing paradigms for the development of healthcare and social care systems: privatisation and the pressure for increasing individual responsibility on the one hand, and ideas of collective responsibility represented within the traditional social protection systems of the original six member states of the European Economic Community on the other.

REPRESENTATIONS OF HEALTH AND AGEING

In different societies and within those societies, both health and ageing are defined from a range of perspectives and seen through a variety of lenses. Images of health and ageing provide symbolic representations of such perspectives using oral and written language and other mediums such as traditional art, photographs or film. Images of the ageing body reflecting disease and disability and the dominant stereotypes of later life readily come to mind. Wrinkles, grey hair, edentulousness and physical or mental frailty are images of the ageing body represented through the media and popular and traditional culture. Although such images are normally self-evident, we should not be misled by the common sense nature of such images since they are only representatives of a particular symbolic order defined within a specific culture or society (Blaikie and Hepworth, 1997).

In biomedical science and the public's perception, both ageing and health are bodily affairs. But the public's explanations of ageing and health and those of biomedical scientists often differ. Within European societies, public explanations are likely to include biomedical explanations since we have all been taught to think, at least in part, in biomedical terms (Blaxter, 1983; Calnan, 1987; Cornwell, 1984). Although we may all accept and take for granted some biomedical knowledge – like the germ theory of disease – it is clear that our explanations of health and ageing are often complex, subtle and sophisticated and based on belief systems and cultural meanings that extend beyond biomedical knowledge.

HEALTH BELIEFS

The beliefs of older people about health and illness, like those of younger people, are both particular to the individual and reflect the dominant ideologies of particular cultures or societies. Individuals act with agency. Agency embodies not only ideas from social action theory (Gerth and Mills, 1948) and explanations of

objective human action in terms of intention and rationality (Mead, 1934). Agency is also about individual action, which is passionate and intuitive and distinctly subjective (Lash and Urry, 1986). Individuals' conceptions of health and illness are influenced by a sense of self (Charmaz, 1983) and especially their sense of control over mind and body (Stainton Rogers, 1991). In recognising agency we cannot ignore the role of structure in defining health and illness. Beliefs about health and illness are ideological (Calnan, 1987; Charmaz, 2000; Crawford, 1984). Within Europe and North America the values of capitalism and individualism are mirrored in our conceptualisations about health and illness (Nettleton, 1995). They are imbued with notions of self-discipline, self-denial, self-control and willpower. Health may be seen as a metaphor for generalised well-being (Crawford, 1984).

One approach to the study of health beliefs that bridges individual agency and social structure uses the Durkheimian notion of social representation (Durkheim, 1964). This approach influenced Claudine Herzlich (Herzlich, 1973; Herzlich and Pierret, 1985; Herzlich and Pierret, 1987) in the investigation of how French people make sense of ideas like 'health' and 'illness'. She concluded that people's experiences and conceptions of health and illness can be properly understood only in relation to the cultural context of their lives. Study participants' perceptions of health and illness go well beyond biomedical explanations of health.

From interviews with Parisians and participants from Normandy, Herzlich (1973) concluded that different understandings and explanations for health and illness are not polar opposites of each other but remain discrete conceptions. Study participants distinguished between illness that was produced by ways of life and positive concepts of health that came from within the individual. Health was identified as having three dimensions: 'health in a vacuum', 'reserve of health' and 'equilibrium'.

- *Health in a vacuum* was the term used to describe the idea of health being the simple absence of disease, a lack of awareness of the body or not being concerned about the state of the body.
- *Reserve of health* represents health as an asset or investment rather than a state. Two aspects were characterised: physical robustness or strength that enables one to work and play, and resistance to illness that enable one to defend one against disease or recover from illness.
- *Equilibrium* was used to highlight the notion of positive well being described by study participants to include notions of internal harmony and balance.

The descriptions of illness described by study participants were less clear. They were able to distinguish between four classes of illness: serious illness that may be fatal, chronic conditions, trivial illnesses, and childhood ailments. Interpreting these data, Herzlich (1973) suggests three metaphors that clearly distinguish between three social representations of illness: illness as 'destroyer', illness as 'liberator' and illness as 'occupation'.

- *Illness as destroyer* was an image held by people who were particularly engaged or active in life and for whom illness interfered with their lives by limiting their ability to continue with their daily activities and responsibilities.
- *Illness as liberator* reflects the ability of individuals to be freed from the responsibilities of life and to receive the privileges of sympathy and care from others.

- *Illness as occupation* describes the reaction of individuals who respond to illness as a challenge to overcome. In responding to the challenge of illness all other activities and responsibilities are relegated while the individual concentrates on recovery.

Older people in Aberdeen, Scotland, were found to define health and illness in similar ways (Williams, 1983). Health was perceived *negatively*, as the absence of illness; *functionally*, as the ability to cope with everyday activities; or *positively*, as fitness or well-being. Since, within the modern world, health continues to have a moral dimension, ill-health and moral wrongdoing are interconnected. Health is therefore constructed in terms of willpower, self-discipline and self-control (Blaxter, 1983).

Despite differences in the characteristics of study participants and cultural variation between France and Scotland, Blaxter (1990) has observed that there are several areas of agreement. Four representations of health and illness prevail: freedom from illness, ability to function, fitness, and the idea of health as a reserve. In a survey of health and lifestyles, Blaxter (1990) asked a cross-section of adults for their ideas about health (Table 6.1). Most survey respondents offered multiple concepts of health. Gender and life-course position influenced responses. Younger men tended to describe health in terms of fitness whereas younger women focused on energy, vitality and being able to cope. Survey respondents who were middle-aged emphasised overall physical and psychological well-being. In later life the focus was on function, particularly among older men, although ideas about contentment and happiness were commonplace.

Table 6.1 Representations of health.

<i>Definition</i>	<i>Sample response</i>
<i>Health:</i> as not ill	Someone I know who is very healthy is me, because I haven't been to a doctor yet.
despite disease as a reserve	I am very healthy despite this arthritis. Both parents are still alive at 90 so he belongs to healthy stock.
as 'the healthy life'	I call her healthy because she goes jogging and doesn't eat fried food
as physical fitness	There's tone to my body, I feel fit.
as energy or vitality	Health is when I feel I can do anything.
as social relationships	You feel as though everyone is your friend, I enjoy life more, and can work, and help other people.
as function	She's 81 and she gets her work done quicker than me, and she does the garden.
as psychosocial well being	Well I think health is when you feel happy.

Source: (Blaxter, 1990, ch. 2)

BELIEFS ABOUT AGEING

The importance of health to older people is widely documented (Bowling, 1995; Farquhar, 1994, 1995). Taken-for-granted common-sense knowledge leads many

older people to accept that ill-health is an inevitable part of human ageing (Bond and Corner, 2004). Older people often expect to experience mental and physical symptoms in later life and consequently fail to mention symptoms to their doctors, even when effective treatments exist (Williams, 1990). But not all older people accept physical or mental decline in later life as inevitable. We have all observed biological changes associated with ageing such as the emergence of wrinkles, the balding of heads and the greying of hair. And we will have also observed differences in the rate of ageing among our close friends and relatives. But whether we attribute ill-health to our own experience of ageing will depend on the culture, time and place in which we live and our own personality (Bond and Corner, 2004). Corner (1999) found that study participants who were 'dominated' or 'oppressed' were more likely to attribute 'old age' to many of the medical conditions for which they were being treated. They had a sense of fatalism about their conditions, and a belief that 'it was just old age'. But for the 'empowered', a sense of control gave them a different perspective on health and ageing, one that recognised the association between ill-health and old age and one that challenged its inevitability. However this was a minority view and the majority continued to describe ageing using negative stereotypes reflecting our ageist culture.

AGEISM

Our modern European consumer culture admires youth and the beauty, energy, grace, moral fortitude and optimism of youthful bodies. In contrast, ageing bodies represent ugliness, degeneration and moral failure. These negative stereotypes of older people go beyond images of the ageing body to incorporate moral interpretations of physical decline in the 'normal ageing' body to describe behavioural and attitudinal aspects. Older people are perceived as senile, rigid in thought and manner, and old-fashioned in morality and skills (Butler, 1987). In everyday life we use metaphors such as 'crinkly', 'crumbly' and 'gaga' to describe older people. It is the systematic negative stereotyping of older people on the basis of age and the associated prejudice and discrimination against older people that defines ageism in contemporary European society.

The institutionalisation of ageism in later life is reinforced by the legal, political, educational, and health and welfare structures of many European societies. Ageism is internalised in the attitudes of individuals toward older people, which are reinforced by these same structures in society. Older people are equally ageist. The language used by older participants in Corner's (1999) study was principally negative, reflecting that used by the media and popular culture. Participants described the problems of old age for society and the 'burden' of the ageing population. Participants were concerned with becoming a 'burden' themselves and the dominant stereotype they presented was of later life being one of ill-health and dependency.

One feature of ageism in European societies is the rationing of health services on the basis of age. Health economists have long argued that the demand for

healthcare in a modern industrial society will always outstrip supply and therefore that rationing will always be necessary (Maynard, 1993). Rationing of healthcare services is achieved explicitly using market mechanisms such as price in European states in which privatised medicine predominates. Where socialised medicine survives, implicit rationing is achieved by doctors using 'clinical freedom' and explicitly through the control of resources and the use of waiting lists (Bowling, 1999; Dudley and Burns, 1992; Evans, 1991; Henwood, 1990; Jennett, 1995; Pettersen, 1995; The Lancet, 1991; Wicclair, 1993).

DISABILITY

The difficulty with the term 'disability' is that it is a complicated multidimensional concept experienced and characterised from a variety of different perspectives: people with disabilities living in a range of social contexts, their significant others such as partners and family members, and members of formal institutions and professions such as doctors, teachers and social workers. Disability has political, social and psychological dimensions. Consequences of disability are social exclusion and oppression (Oliver, 1996), stigmatisation of 'spoiled identities' (Goffman, 1968) and issues of self-identity and self-esteem.

In understanding disability, the dominant discourse has been the dialectic between the 'medical model' and 'social model'. For the 'medical model', disability is a personal issue that is directly caused by disease, trauma or other health problem. It is often seen as a personal tragedy that can sometimes lead to the blaming of the individual for his or her condition and the labelling of people with disabilities as 'victims' or 'sufferers' (Oliver, 1996). These processes are part of the medicalisation of disability (Oliver, 1990). The solution for the individual is perceived as medical treatment in order to 'cure' the condition, manage the symptoms and maintain the individual's adjustment to the disability and subsequent behaviour change. Thus the development of biomedical science and medical interventions is seen as the main political response to disability.

In contrast, for the 'social model', disability is not an attribute of the individual; rather it is constructed by society through social interaction within the context of the political, social and physical environment. The personal responses of individuals to disability and its consequences are central to a social model. They cannot be understood as merely a reaction to the condition or as a response to the oppression by the social structure (Foucault, 1973). An understanding of disability has to be located within a framework that takes account of the life histories of people with disability and their informal caregivers, their material circumstances, the meaning disability has for the individual, and the struggle to be included as citizens of their societies. The solution requires social action to change the physical environment as well as attitudes to people with disabilities. Disability has political and societal solutions rather than simply medical ones.

Within this dialectical discourse there are a number of models of disability (Altman, 2001). From a medical or public policy perspective, disability remains a useful concept for summarising the impact of disease and biological ageing on older people. The approach has been to consider the outcomes of disease and ageing processes using the World Health Organization's classification of impairment, disability and handicap (World Health Organization, 1980) and its more recent presentation the International Classification of Functioning and Disability (ICIDH-2) (World Health Organization, 2001). The recent version moves away from the idea that disability is a consequence of disease or ageing – the medical model – to focus on the components of health. It goes some way to accommodating the traditional criticisms of the medical model of health, disability and ageing and addressing some of the concerns expressed by people with disabilities by embracing the social model.

The WHO model of functioning and disability is shown in Figure 6.1. The centre of this model is human activity and interactions with agency (health condition, body function and structures and social participation) and structure or context (environmental and personal factors).

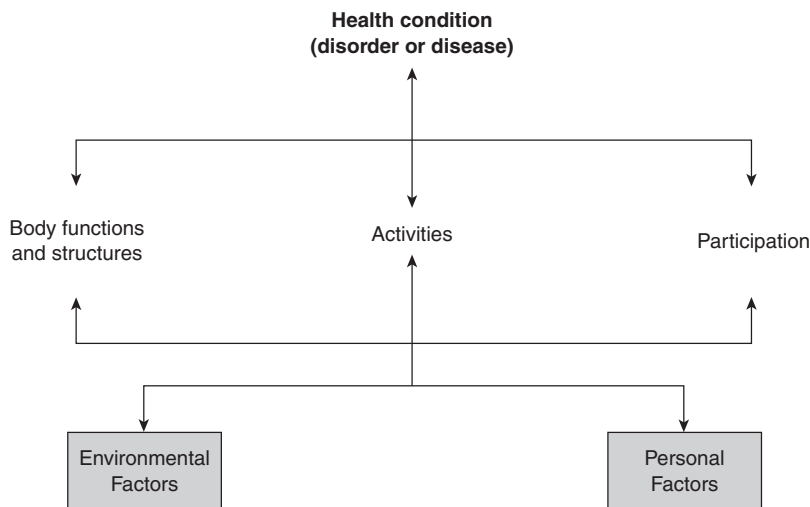


Figure 6.1 World Health Organization model of functioning and disability

Source: WHO (2001)

The individual components of the model are defined in Box 6.1. Human activity has traditionally been operationalised in medical and social research in terms of activities of daily living (ADLs) in order to measure levels of disability. This approach usually focuses on physical function but increasingly is also used to reflect the impact of cognitive function. The strength of the WHO model is the recognition that ADLs are context-specific, being influenced by either environmental (or social) and personal (or psychological) factors. However, it is noteworthy that in the

implementation of the model into a measurement tool only body structure and activity have been developed. These are grounded in the existing measures of impairment and ADLs. Measures of participation, and environmental and personal factors, were not developed as part of the new model when it was accepted by the World Health Assembly in 2001. The successful development of methods for describing and measuring these aspects of the model is essential if the credibility of ICF as a social model is to be accepted. At present it remains very much a medical model.

Box 6.1 Components of international classification of functioning, disability and health (ICF)

In the context of health:

- Body functions are the physiological functions of body systems (including psychological functions).
- Body structures are anatomical parts of the body such as organs, limbs and their components.
- Impairments are problems in body function or structure such as a loss of a limb or reduction in use of any body structure.
- Activity is the execution of a task or action by an individual including activities of daily living and other activities of everyday life such as work and leisure activities.
- Participation is involvement in a life situation.
- Activity limitations are difficulties an individual may have in executing activities.
- Participation restrictions are problems an individual may experience in involvement in life situations.
- Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.
- Personal factors are social and psychological attributes including gender, ethnicity, age, class, fitness, lifestyle habits and personal coping styles.

Source: WHO (2001), www.who.int/classifications/icf/en/, accessed: 16 August 2004.

What types of indicators of participation would make this an acceptable social model? And what are the environmental and personal factors that would need to be addressed? Participation denotes an individual's degree of involvement – the lived experience of people in different social contexts. Individual contexts are influenced by the physical and social environment as well as personal factors experienced across the life-course. The variety of lived experiences and associated social contexts makes participation a difficult concept to measure. One way to understand what participation means for people with disability – and particularly older people with disability – is to investigate the barriers to participation. Goffman in his essay on the total institution (Goffman, 1961) characterised life as being divided into three key elements: work, leisure and family. To these we might add community in terms of involvement in political, voluntary and religious organisations.

Older people, and particularly older people with disability, are increasingly excluded from the world of work (see Chapter 8) because of statutory retirement policies, attitudes of older people towards paid work and the negative attitudes of employers towards older workers. Yet exclusion from the world of work remains one of the strongest barriers to participation. Ageism and disabilism are partly the result of societies' preoccupation with the value of youth who are 'our future' and who generate the wealth. Access to work for many is the source of resources to enable involvement in a range of leisure activities. Yet the most popular activity, watching television, is pursued by all age groups and disability levels. But a key judgement here is whether the tastes of minority groups are catered for by the broadcasters. Leisure activities outside the home remain more problematic for older people with disabilities. Even when finances permit, exclusion from popular leisure pursuits occurs. Physical barriers such as poor wheelchair access to historical monuments and attitudinal barriers such as the stigmatisation of people with dementia or movement disorders in restaurants and other public places are examples of barriers to participation. Similar physical and attitudinal barriers also prevent older people with disabilities from being included in community life, particularly political and voluntary organisations, although increasingly the involvement of the 'user' or 'consumer' in organisations focusing on their needs and concerns is occurring; see, for example, the involvement of people with disabilities in the UK National Health Service (Department of Health, 2001). Participation in family life remains a positive experience for many older people with disabilities who have remaining 'family'. However, age segregation is playing an increasing role in the social life of older people. A recent study in the Netherlands identified a clear deficit of young adults in the networks of older people, with the extent of the deficit increasing with age. This study also found that the overwhelming proportion of the younger network members identified by older people were family and kin (Uhlenberg and de Jong Gierveld, 2004).

Of course social exclusion, the exclusion from participation and involvement in all aspects of social life, is not just the lived experience of people with disabilities. Other social groups, usually minority groups, also experience exclusion. Throughout European history, religious minorities, minorities from different faiths, have been excluded and oppressed by the majority faiths. People from different ethnic and cultural backgrounds, lower socio-economic groups and women have all experienced oppression and social exclusion. Being a member of an oppressed social group is an additional barrier for people with disability to full participation in European societies. The experience of 'intersectionality' (Hulko, 2002) – being oppressed on a number of these dimensions among older people or people with disability – increases their social exclusion from everyday life.

DEPENDENCY

Many of the negative stereotypes of later life are brought together in the single word 'dependency'. Ageism is manifested in the way we define dependency in old

age. The images of later life highlighted by Butler (1987) in his analysis of ageism are often used metaphorically in comparison with childhood (Hockey and James, 1993). Rather like Shakespeare in the oft-quoted verse of the seven stages of man (and woman) in *As You Like It*, 'deep' old age (sometimes referred to as the fourth age) is seen as the coming of the second childhood. The use of metaphors of childhood provides implicit frames of reference for everyday social interaction and encourages infantilisation and practices of infantilisation – the treatment of older people as if they were children. Thus implicitly the use of the term dependency is infantilising of older people.

Yet the term 'dependency' is institutionalised in public policy through its use in describing the economic indicators known as dependency ratios. A key issue for policymakers is the maintenance of economic growth. One of the perceived barriers to economic growth is the absolute decline in the proportion of the population who are economically active. In economic models the idea is overly simple: the greater the proportion of the population who are economically active the smaller the proportion of the resources that need to be diverted to the economically inactive (the dependent population). Thus for policymakers concerned with national, European and world economies, any decline in the proportion of people economically active or the ageing of the population inevitably means that older people will be an increasing economic burden. In contrast, children, the other main dependency group, are seen as the future. This is also an argument that has often been used in the support of rationing health services for older people (Callahan, 1987). Given the hegemony of economic policy the fallacy of this argument is often overlooked.

Dependency ratios

Formally, dependency ratios are a measure of the relative sizes of the economically active (often defined as those in paid employment) and the economically inactive (all those not in paid employment including children, unpaid homemakers, people in full-time education or skills training and the majority of older people). Three ratios are routinely calculated: total dependency ratio, gerontic dependency ratio and neontic dependency ratio. The ratios are calculated by dividing the number of dependent people (older people or children) by the number of people of working age. The actual statistics calculated will vary because of the use of different age cut-offs over time and between different countries, but the general trends are relatively robust as economic indicators.

As was noted in Chapter 1, different European societies are ageing at dissimilar rates because of different demographic population profiles. These differences are reflected in the dependency ratios in each country. Data for selected European Union countries (Figure 6.2) show that the gerontic dependency ratio (number of people aged 65 or over expressed as a percentage of the number of people aged 15–64) is projected to rise in all EU states by 2050. The ratio is projected to double from some 24% in 2000 to 49% in 2050 among the EU-15 states. There are striking differences across European countries, with the highest ratios of some 60% in 2050 projected for Italy and Spain.

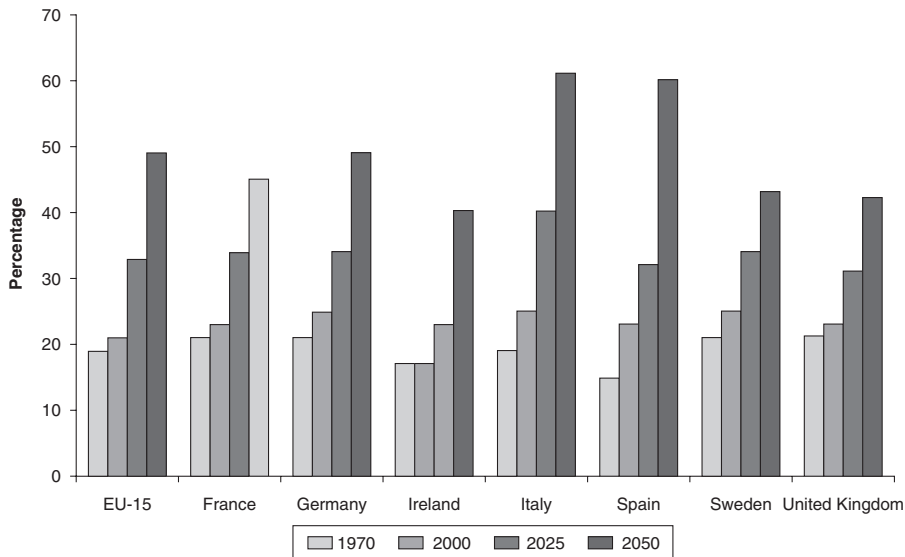


Figure 6.2 Old-age dependency ratios in selected EU states (population aged 65 or over as percentage of population aged 15 to 64)

Source: Eurostat, central scenario (2004d)

It would be very easy to become alarmist about these changing dependency ratios (Katz, 1992). They provide food for thought in relation to pensions policy (see Chapter 7), but it is often assumed that the ageing of the population and associated shifts in the dependency ratios will damage European economies through increased consumption of health and welfare services (Clark and Spengler, 1980; quoted in Bond, 1992). Not only does this use of dependency ratios reinforce ageism but it ignores the invisible contributions that older people make to the European economy in their personal consumption and productivity. Assumptions about the use of health and welfare services are based on historical data and take no account of changing patterns of morbidity and mortality in later life (see Chapter 2). Similarly assumptions about labour force participation of women and older people are subject to change.

Types of dependency

A number of writers have voiced concern about the way the term 'dependency' is used. Wilkin and colleagues (Wilkin, 1987; Wilkin and Thompson, 1989) have reviewed the meaning of dependency as reflected in different usages and identified two broad approaches to classification. First, it can be classified in terms of activities of daily living for which an individual is dependent on others; and second, in terms of the causes of dependency. Walker (1982), in the development of the

concept of structured dependency (Townsend, 1981; Walker, 1981), has also highlighted a number of uses of the term. His concept of life-cycle dependency mirrors at the individual level the dependency ratio and is the concept of dependency at the centre of Hockey and James' (1993) analysis of ageing along the life-course. Walker (1982) also highlights political and economic dependency. Political dependency relates to loss of personhood and citizenship with the curtailment or restriction of individual autonomy and empowerment. Economic dependency is the dependence of individuals on financial support from families and informal social networks and the State. Central to this chapter, however, is the concept of physical or psychological dependency (Wilkin, 1987). Chronic ill-health, disability and mental or physical frailty are all dependency-creating attributes and the majority of people who are physically or psychologically dependent are also likely to experience economic and political dependency. An important issue here will be how different actors perceive the older person's physical and mental state and how it is subsequently defined.

Physical and psychological dependency

At the centre of many ideas about dependency is the idea that it is part of a social relationship. Physical and psychological dependency therefore refers to an individual's physical and social needs that result from illness, impairment or disability and, importantly, the individual's reliance on others for assistance in meeting these recognised personal care and health needs. But reliance on others is not necessarily all one way in a social relationship. For example, caregivers of dependent individuals may experience fulfilment as a result of their caregiving actions. Reciprocity therefore remains an important element in understanding dependency that will lead to a discussion of interdependency in later life. But first let us explore further aspects of physical and psychological dependency.

An innovative idea developed by Isaacs and Neville (1976), which has survived the course of time for the purpose of service planning at the population level, is one that tries to identify categories of personal need and determine the reliance that individuals have on others. The central concept here is 'interval need' defined by the time interval that an individual can be left before his or her needs should be met. The simple classification distinguished personal and health needs as 'long', 'short' or 'critical'. A more complex classification has been used for population planning purposes (Bond and Carstairs, 1982). Individuals' needs are classified according to their health status, in particular their level of physical or mental disability. The original classification identified four categories: independent, long-interval dependency, short-interval dependency, and critical-interval dependency. People who are independent may have medical conditions but experience little or no functional incapacity. An individual's functional capacity may be affected by physical illness (e.g. arthritis) or mental illness (e.g. dementia) or more likely a combination of physical and mental illnesses. But functional capacity will also be affected by environmental and social factors such as the quality of the built environment (see Chapter 10),

the presence of a strong social support network (see Chapter 9) as well as personal and psychological factors (see Chapter 3). Therefore people defined as long-interval dependent may have needs like shopping or cleaning that can be met by someone else at no specific time and not necessarily on a daily basis. Those defined as short-interval dependent may have needs such as showering, bathing or washing which need to be met at specific times of the day and at least once a day. Different social and cultural perspectives will mean that these are not uniform categories but defined by each individual. However, in population studies it is pragmatic to ignore such diversity. People who are critical-interval dependent have needs that are unpredictable, such as assistance with toileting or supervision because of cognitive impairment; they probably require 24-hour supervision. Again individual needs will vary, perhaps because of different perspectives of risk. Table 6.2 illustrates interval needs for different functional incapacities.

Table 6.2 Categories of physical or psychological dependency.

<i>Dependency categories</i>	<i>mobility</i>	<i>Personal Care</i>	<i>House Care</i>	<i>Continence</i>	<i>Mental Health</i>
Independent	Able to do all mobility activities	Able to do all personal care activities	Able to do all house care activities	Continent	No mental health problems
Long Interval	Difficulty walking on level surface outside. Unable to travel by bus	Difficulty with: • dressing • washing hands or face Unable to: • wash hair • bath or shower	Difficulty with: • light housework • preparing/cooking a meal Unable to: • heavy do shopping • wash clothes • iron clothes	Incontinent of urine only	Mild memory impairment or mild depression or anxiety
Short interval	Unable to walk on a level surface outside	Unable to: • put on shoes • dress • wash hands or face	Unable to: • light do housework • prepare or cook a meal • make bed	Not continent of faeces	May have mild disorder
Critical interval	Unable to: • get out of chair • walk	Unable to • use toilet		Incontinent of urine and/or faeces	Severe memory problem, depression or anxiety

Source: Bond J and Carstairs V (1982), Fig. 5.

EXPERIENCING HEALTH, DISABILITY OR DEPENDENCY

Health and the capacity to remain independent are important aspects of older people's lives. Ill-health and incapacity are often the first topics in conversations involving older people. When meeting each other, older people almost inevitably enquire about the other's health. A negative response will often be followed by a detailed description of the signs and symptoms of any maladies, and hospital experiences can be reported with great enthusiasm. Yet it is important to remind ourselves that not all older people experience poor health, disability or physical or psychological dependency. Of course, ill-health and disability can be a major source of pain and suffering to many older people and lead to loss of independence and autonomy, self-esteem and dignity, mobility, and social interaction and participation in everyday life. But the diversity of experience in later life is now widely recognised at a policy level (Joint Taskforce on Older People, 2000) and there is recognition of substantial evidence to support this picture in national and European data.

Even in countries like the United Kingdom where there is a long tradition of collecting health statistics about the population, these remain notoriously difficult to use to describe the experience of health in the older population. Traditionally, epidemiologists have used both mortality and morbidity data. Because of the high prevalence of co-morbidity in later life, both mortality and morbidity statistics may mask what is really going on. By co-morbidity is meant the presence of more than one disease or chronic illness; for example many older people will live with arthritis and heart disease. Survey researchers have therefore developed self-report techniques for assessing health status and incapacity. Yet successive surveys of older people in Europe and North America consistently find that older people rate their health as good while morbidity data suggest that their health is poor. Self-report data may not reflect absolute levels of morbidity, but rather the expectations of older people about their health at their age in life. However, self-ratings of health have been, time after time, reliable predictors of survival and mortality (Idler and Benyamini, 1997). In response, one approach has been to focus on measurement of disability and incapacity, although again these often rely on self-reports. Such measures have their limitations. Many studies suggest that older people's evaluations do not necessarily equate with those of other family members or formal assessments by health professionals. They also are often culturally specific and therefore biased against ethnic minority groups (Blakemore and Boneham, 1994) within European societies.

From the European Community Household Panel 1998 we can get a general picture of the level of ill-health and incapacity among older people (OPOCE, 2003). Unlike the data from individual national surveys, the questions used to map self-perceived health are comparable in both question wording and the number of categories allowed for participants' responses. Figure 6.3 shows for selected European countries the percentage of people in different age groups who rated their health as either good or very good and shows that health status declines with age. Figure 6.4 summarises this information for all fifteen EU states and shows that women are less satisfied than men with their health in all age groups. The

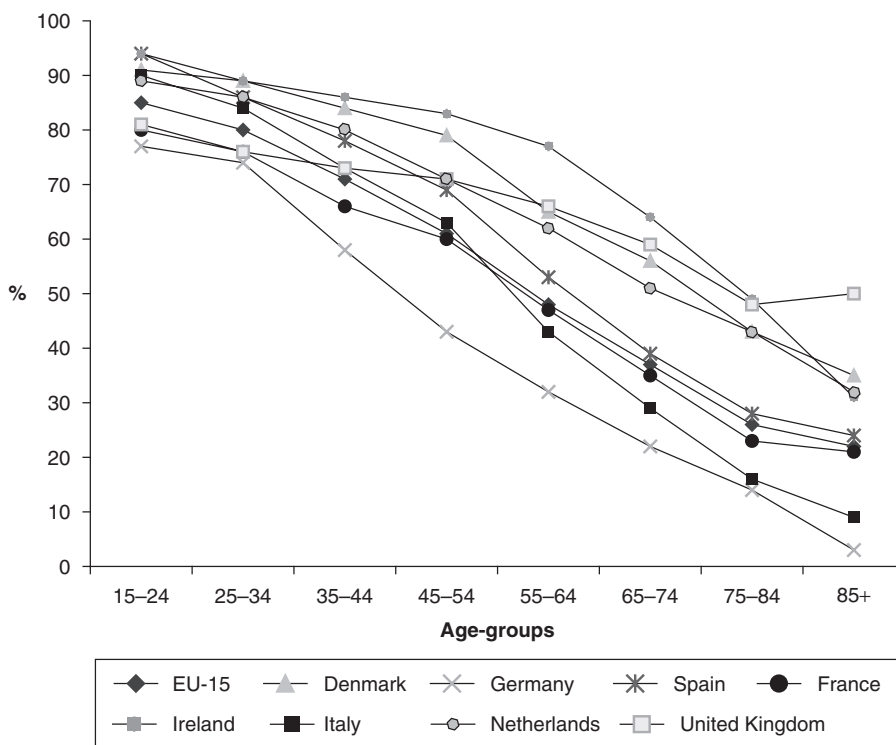


Figure 6.3 Self-perceived health by age in selected EU states

Source: ECHP UDB Eurostat (2003)

slight increase in the percentage of men aged 85 or over satisfied with their health status probably reflects a survival effect or sampling error.

Using data from different national surveys like the General Household Survey in the UK, Figure 6.5 shows the percentage of the population who report having a chronic condition. We need to treat these data with caution since they use different although similar questions, and much of the variation between countries may be accounted for by the survey methods used and variations in the prevalence of non-responses. The data presented indicate an increase with age in the proportion of men and women in selected countries who report a chronic condition. The decrease in proportion of those reporting among the older age groups may reflect the survival affect, the exclusion from the survey of older people resident in long-term care institutions or different expectations of younger and older people.

Figure 6.6 compares the percentage of the population limited in terms of walking, by age, in different European countries. These data are also drawn from national surveys and the questions asked differ in both wording and response categories and should be interpreted with considerable caution. The data, however, highlight the relationship between the age of men and women and the extent of incapacity among people living at home in the community.

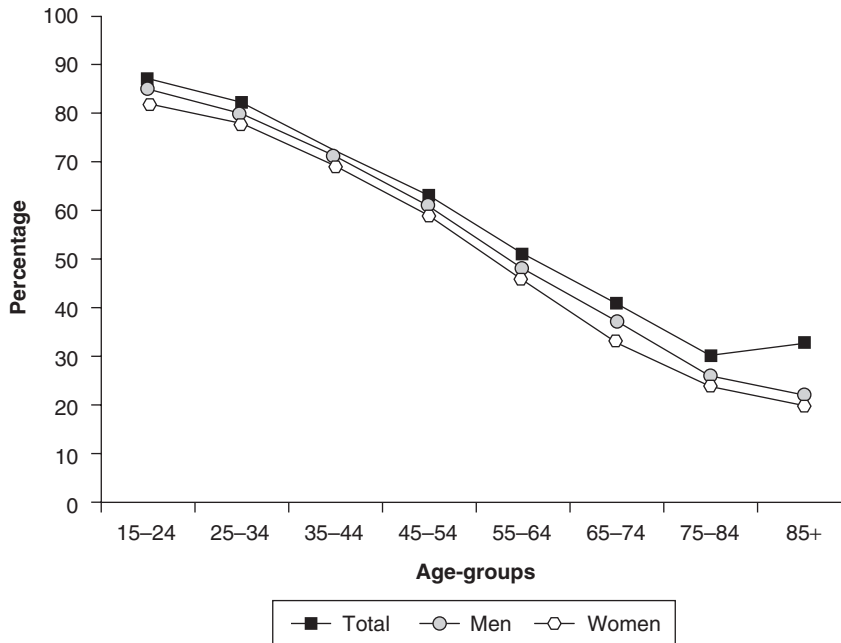


Figure 6.4 Self-perceived health of men and women in EU in 2001

Source: ECHP UDB Eurostat (2003a)

Using data from the European Community Household Panel in 1999, Table 6.3 shows the proportions of people in Europe with disabilities or chronic physical or mental health problems who are in need of support with everyday activities, by age group and severity of impairment. Differences in the ways that different cultures report disability and ill-health means that these data should only be used as a rough guide to the level of physical and psychological dependency among the older population in Europe. In Table 6.3 we have grouped survey respondents into four groups of countries according to geography: the Nordic countries (Denmark, Finland and Sweden), the Continental countries (Austria, Belgium, France, Germany, Luxemburg and the Netherlands), the southern European countries (Greece, Italy, Portugal and Spain) and the UK and Ireland. As we will see below, these geographical groupings also reflect cultural similarities and different models of healthcare and social care systems (see also Chapter 7). The rates of physical and psychological dependency assessed in the survey show a similar profile for three of the country groups; the exception is the Continental countries where rates are significantly higher for both age groups presented.

Increasing incapacity and ill-health with age can also be seen in health service utilisation data. For example, Figure 6.7 shows the average number of consultations with a medical doctor, by selected countries. Some caution is needed in interpreting these data because of the different way data are collected between countries and the small numbers surveyed in the oldest age groups. Use of medical services

HEALTH AND DEPENDENCY IN LATER LIFE

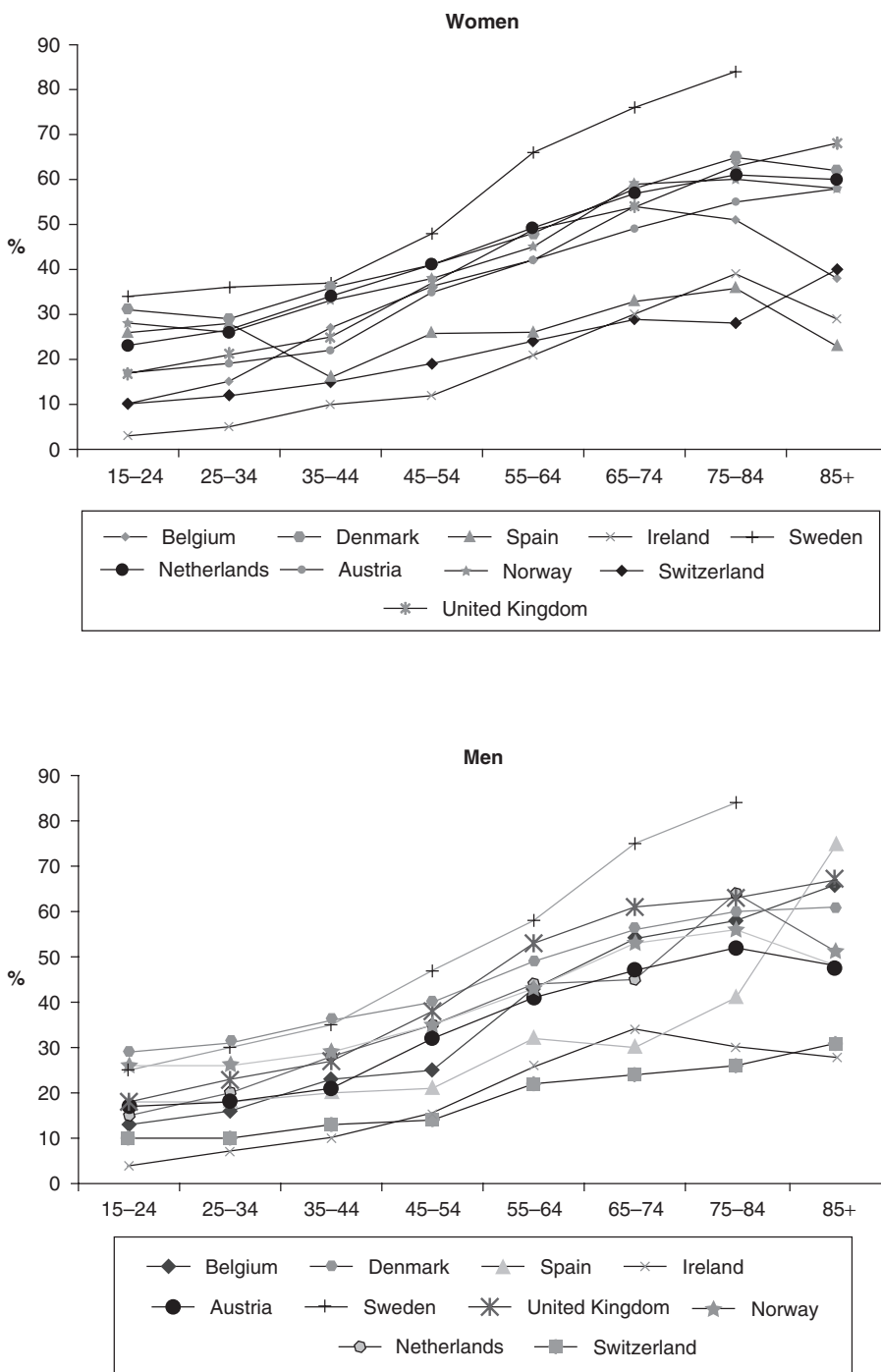


Figure 6.5 Population with chronic conditions by age in selected EU states

Source: European Commission (2003a, Table 2.2)

Table 6.3 People with disabilities or chronic physical or mental health problems who are in need of support with everyday activities by age group and severity of impairment in Europe (percentages).

<i>Countries</i>	<i>Age</i>	<i>Group</i>
<i>Nordic countries</i>	<i>65–79</i>	<i>80+</i>
Severe impairment	14.4	26.4
Moderate impairment	23.7	23.8
Total	38.1	50.2
<i>Continental countries</i>	<i>65–79</i>	<i>80+</i>
Severe impairment	20.6	37.9
Moderate impairment	34.7	34.1
Total	55.3	72.0
<i>South European countries</i>	<i>65–79</i>	<i>80+</i>
Severe impairment	13.5	27.7
Moderate impairment	19.4	19.5
Total	32.9	47.2
<i>United Kingdom and Ireland</i>	<i>65–79</i>	<i>80+</i>
Severe impairment	13.5	34.5
Moderate impairment	21.5	26.6
Total	35.0	61.1

Source: European Community Household Panel (ECHP) (EUROSTAT, 1999).

increases with age in all the selected countries but there are significant differences between Norway and Sweden on the one hand and other selected European countries on the other. These differences do not reflect differences in the prevalence of chronic conditions (see Figure 6.4) and therefore may be the result of the way medical services are organised in different European countries. It is these differences to which we now turn.

HEALTH AND SOCIAL CARE FOR OLDER PEOPLE IN EUROPE

The needs of older people for healthcare and personal care have traditionally been met informally by families and their social networks and formally by the state. Throughout the twentieth century the increasing hegemony of the medical profession and the subsequent medicalisation of health and illness (Freidson, 1975) has seen the development of formal ‘illness’ services organised by the state. In contrast, personal social care for older people has traditionally been provided informally by families (predominantly by women) and, until the last half of the twentieth century, formal personal social care tended to be available for only a

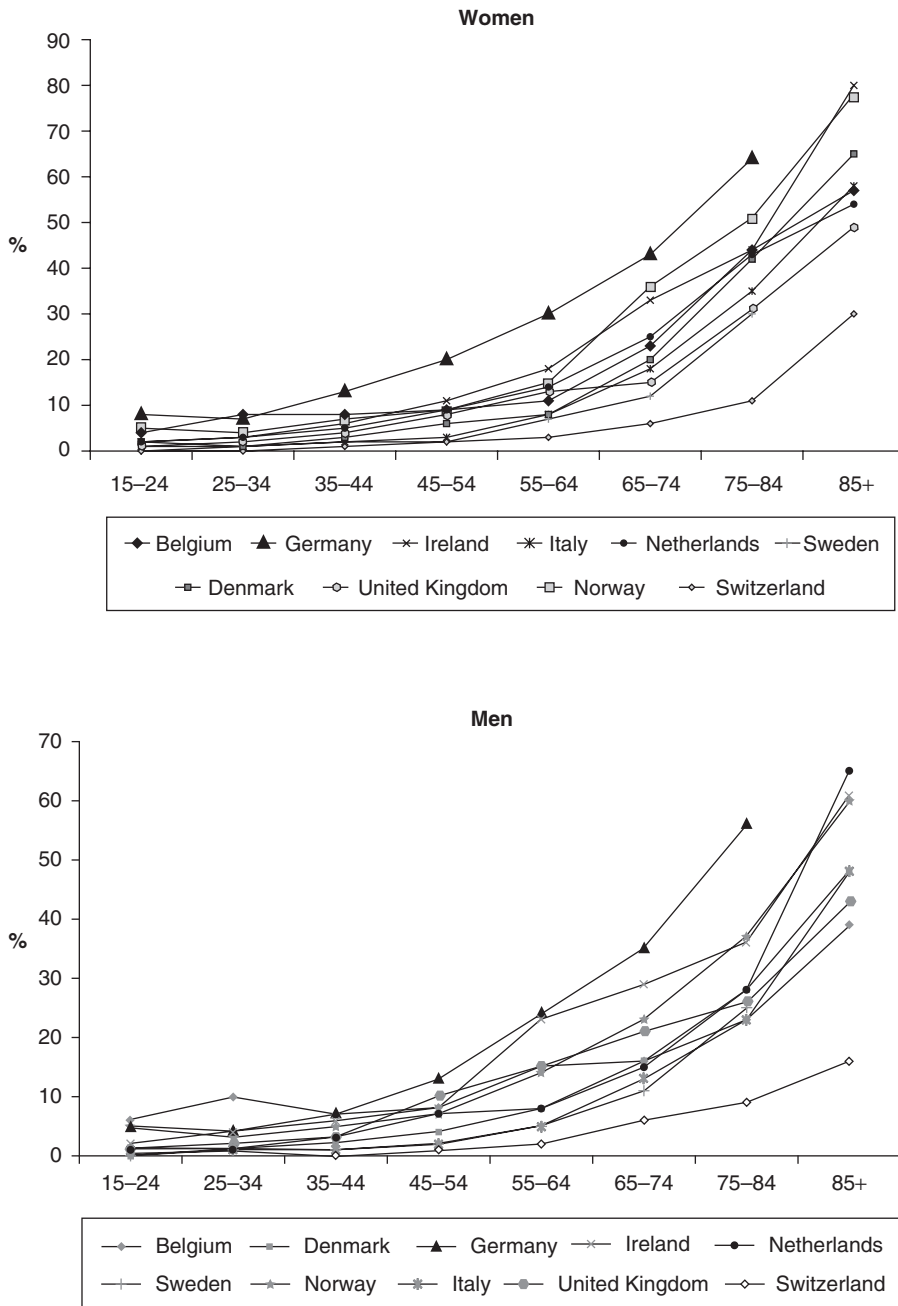


Figure 6.6 Population limited in terms of walking, by age in selected EU states

Source: European Commission (2003a, Table 3.1.1)

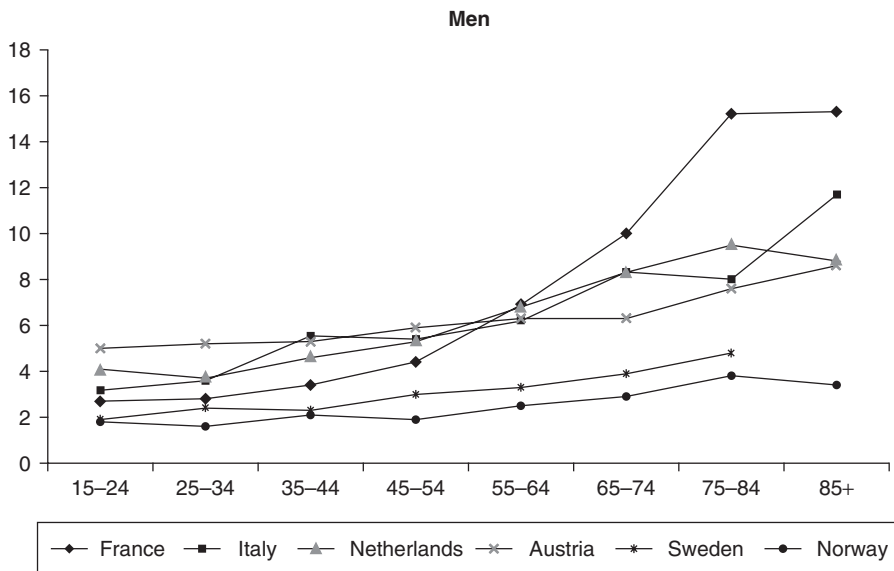
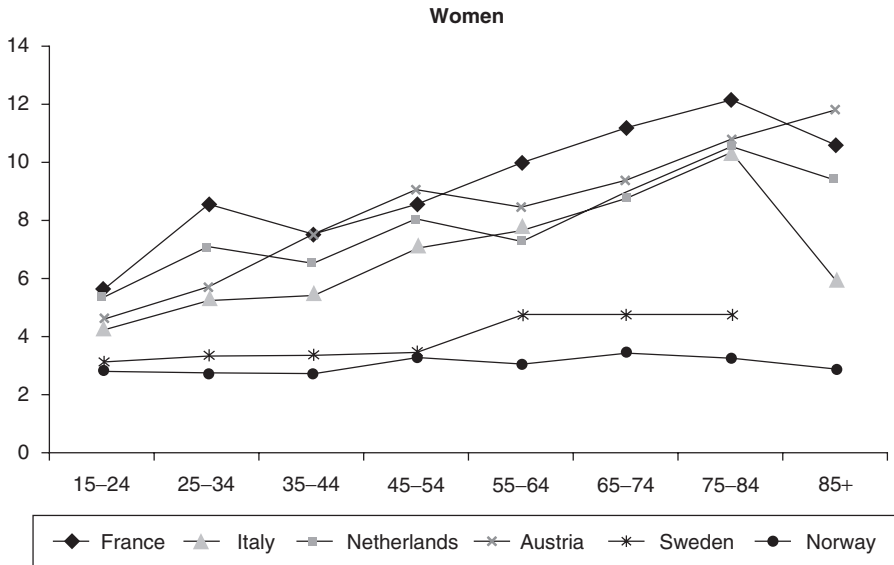


Figure 6.7 Average numbers of consultations with a medical doctor by age in selected EU states

Source: European Commission (2003a, Table 2.8.2)

minority of financially better-off older people. The development of formal social care services for older people in recent decades reflects the changing demography of families, changes in the role of women and changes in the nature of communities. Formal personal social care services have therefore tended to develop

Table 6.4 Gender of informal caregivers and whether the older person is living within or separately from the caregiver's household in Europe.

	<i>Nordic countries (%)</i>	<i>Continental countries (%)</i>	<i>South-European countries (%)</i>	<i>United Kingdom and Ireland (%)</i>
Men	36.4	40.1	24.9	40.6
Women	63.6	59.9	75.1	59.4
Total	100	100	100	100
Inside of carer household	23.6	55.5	59.2	30.4
Outside of carer household	73.6	43.6	37.8	65.8
Inside and outside carer household	2.8	0.9	3.0	3.8

Source: European Community Household Panel (ECHP) (EUROSTAT, 1999).

independently of healthcare systems in most European countries. Yet, for older people, perhaps more than those of any other group, the necessity for 'joined-up thinking' between the providers of healthcare and personal social care is increasingly recognised.

The continuing importance of informal caregiving for the provision of personal care is highlighted by data from the European Community Household Panel in 1999 (Table 6.4). Again (as in Table 6.3) the information is presented by four geographical areas, rather than individual countries. The table shows the gender of informal caregivers and whether the older person is living within or separately from the caregiver's household. The proportion of caregivers who are women is higher than the proportion who are men in all 15 countries of the EU in 1999, but in southern European countries women caregivers outnumber male caregivers 3:1. The place of residence of the older person and the caregiver also suggests interesting differences between the groups of countries. Noteworthy is the higher proportion of older people who live in separate households in the Nordic countries, the UK and Ireland. This may reflect the model of healthcare and social care system and something which we turn to below.

The ageing of the population and the development of new effective technologies have led to an increase in resources being spent on healthcare, while the ageing of the population, demographic and social change in families and the increased quality of formal long-term care (including personal social care provided at home) have led to increases in resources demanded for long-term care. Spending on formal long-term care now represents an important proportion of total healthcare and long-term care expenditure as measured by the percentage of gross domestic product (GDP) (Table 6.5). With the continuing ageing of the population (see Chapter 1), irrespective of improvements in disability-free life-years (see Chapter 2), the demand for healthcare and long-term care resources is anticipated to increase during the next fifty years (Schulz *et al.*, 2004).

Table 6.5 Total public expenditure on healthcare and long-term care (percentage of GDP).

<i>Countries</i>	<i>Total health and long-term care</i>	<i>Healthcare</i>	<i>Long-term care</i>
Denmark	8.0	5.1	3.0
Sweden	8.8	6.0	2.8
Finland	6.2	4.6	1.6
Belgium	6.1	5.3	0.8
Austria	5.8	5.1	0.7
France	6.9	6.2	0.7
Holland	7.2	4.7	2.5
Germany		5.7	
Greece		4.8	
Spain		5.0	
Portugal		5.4	
Italy	5.5	4.9	0.6
United Kingdom	6.3	4.6	1.7
Ireland	6.6	5.9	0.7

Source: European Commission and the Council (2003).

The exponential increase in demand for healthcare and long-term care over the last 20 years or so, and the forecast increase, has led to a reconsideration of social protection in many European countries and to the restructuring of the welfare state (Taylor-Gooby, 2001). Underpinning structural changes has been the containment of costs to the state and the introduction of explicit rationing (Bond, 1997), both of which undoubtedly have consequences for the quality and quantity of healthcare and social care for older people. A key instrument of cost containment has been the selective privatisation of healthcare and long-term care, both through the increasing use of non-governmental organisations in the provision of services and the transfer of some of the increasing cost of services on to the individual and the family. Selective privatisation is reflected in the dual nature of healthcare and social care which can be considered in part as a public good and in part as a commodity. As a public good, healthcare and social care are relatively consolidated and a widely legitimated social right of citizens; as a commodity, healthcare and social care reflect the ideology of consumerism contained in many private health schemes. However, despite the ideological drive by most European governments towards increased privatisation and market solutions to the challenge of rising demand and costs, there remains strong public support for the welfare state. Such support may be limiting the extent to which co-payments for health and long-term care are being introduced.

Changes to European healthcare and social care systems

In the evolution of healthcare systems within the European Union we can differentiate two key processes of change:

- within the institutional and organisational framework
- in the policies and programmes.

Table 6.6 shows the characteristics and interrelationships between these two processes.

Table 6.6 Institutional evolution and main health policies in the EU-15 in the last 40 years.

<i>Period of time</i>	<i>Institutional evolution</i>	<i>Main health politics</i>
1960–1970s	Centralisation and bureaucratic delivery system	Universal coverage through general taxes finance
1980s	Decentralisation, provider–purchaser split and quasi-markets	Politics of cost–containment, rationing an efficiency
1990s	Central state as regulator and finance and regions with full competences in planning and management	Quality of services, patients rights and equality programmes
2000s	Coordination between health and personal social services and partnership between authorities and private agencies	Prevention, rehabilitation and programmes for frail elderly people and excluded groups in need Long-term care as new ageing social policy

In terms of the institutional and organisational framework and the provision of health services, four stages can be distinguished. First, during the 1960s and 1970s there was a development of healthcare systems based on greatly centralised organisational models. These systems were bureaucratic and were financed through taxes in the Nordic and Anglo-Saxon countries, and through social security contributions in other continental and southern European countries. Second, during the 1980s, healthcare systems faced a process of decentralisation, with greater power for planning and management awarded to regional and municipal authorities. This facilitated the purchaser–provider split, the separation of the management of services from the funding of services. It provided opportunities for non-governmental organisations (NGOs), particularly in long-term care services, to manage services and led to greater consumer and user involvement. Third, in the 1990s a model for state finance and regulation was consolidated in most European healthcare systems, with further advances in the privatisation of healthcare and long-term care. Territorial and social inequality emerged as an important policy issue reflecting the needs and greater involvement of the user. Finally in the first decade of the twenty-first century priority is being given to models that place an emphasis on internal and external coordination between private and public providers on the one hand and healthcare and social care systems on the other hand.

In terms of healthcare policies and programmes, the 1960s and 1970s supported policies of universal coverage. Rates of coverage varied enormously between

Table 6.7 European models of healthcare and social care systems

	<i>Anglo-Saxon</i>	<i>Continental</i>	<i>Nordic</i>	<i>Mediterranean</i>	<i>Eastern Europe</i>
Right to social protection of the dependent	Mixed right: universal in healthcare and assistant in personal social services	Universal right with two levels: contributive and non-contributive	Universal right in health and in long-term care	Mixed right: universal in healthcare; in social services contributive limited assistance	Universal right limited in healthcare and residual assistance in social services
Financing	Taxes and co-payment for those exceeding an assistance income level	Social security contributions, taxes and co-payments	Taxes and some co-payments	Taxes, contributions and co-payments for those exceeding an assistance income level	Taxes and co-payments
Type of social benefit	Services and monetary and assistance	Services and monetary assistance with a universal ceiling	Universal social and health services	Monetary help and secondary assistance type services	Residual services and some monetary assistance
Responsibility for organisation and management	Municipal	Social Security, Regions and Municipalities	Municipal	Regional and Municipal	Municipal
Provision of services according to importance	Companies, NGOs and municipalities	NGOs and companies residual role for municipalities	Municipalities and recently companies	Municipalities, NGOs and increasingly companies	NGOs and municipalities
Policy of support for informal care	Support limited to the carer/ family and high individual responsibility	Broad support for the carer/ family which has ultimate responsibility	Supports and replaces the family	Residual support for the carer/ family	Very residual support for the carer/family

different European countries as did the financing mechanisms. To compare two different cases: the British NHS has been a universal system since its inception in 1948 and has been financed through general taxation. In contrast, the Spanish health system achieved universal coverage only in 1990 (in 1978 it covered 89% of the population) and changed its financing from social security contributions to general taxation in that year. During the 1980s, in central and northern Europe in countries with right-of-centre governments, the emphasis of healthcare policies was on cost containment and the extension of co-payments by users, although older citizens often continued to receive services free at the point of delivery irrespective of their ability to pay. The countries in southern Europe with left-of-centre governments continued to subscribe to policies that allowed the universalisation of healthcare. However, during the first few years of the 1990s cost containment policies became part of the political agenda throughout member

states of the European Union. The 1990s were characterised on the whole by the development of healthcare programmes that emphasised quality, the importance of user rights and the extension of community-based services for frail and older people. These changes occurred first in northern and central Europe and later in Spain and Portugal. At the beginning of the twenty-first century, greater emphasis is being placed on prevention and rehabilitation. Recent European debates continue to focus on the types of institutional and organisational reforms that can guarantee the following criteria: access for all, healthcare and social care quality, and the financial viability of systems (European Commission and the Council, 2003).

How have these changes affected the position of older people? Three points can be made:

- Universal coverage is now available throughout the EU states for older people, although there still remains evidence of age discrimination in the rationing of healthcare and social care resources.
- In some member states there remains a scarcity of resources and services for older people with severe mental health problems or chronic illness.
- Older people often need greater personal care or support than is available within the current healthcare and social care systems (Pacolet *et al.*, 2000).

Types of healthcare and social care systems in Europe

Although the changes that influenced the development of European healthcare and social care systems were similar throughout the second half of the twentieth century, there are still very real differences in the nature of systems. Each system will reflect the underlying values and ideologies of different societies as well as their historical, economic political and social development. Different systems will also generate their own vision of the reality of ageing, reflecting also cultural stereotypes of ageing and the historical, cultural and professional backgrounds of professionals working with older people.

A useful heuristic device for the analysis of systems is to construct a typology of healthcare and social care systems based on economic, ideological and institutional characteristics (Esping-Andersen, 1990). Of course, no typology is definitively right. (For example, a slightly different typology is used by Naegele and Walker in Chapter 7 when discussing social protection systems for income and poverty in later life.) Equally it is unlikely that any pure type will exist in reality. There are no pure types, but rather hybrid forms such that each country's healthcare and social care systems are a mixture of market, family and civil society (Arts and Gelissen, 2002). In constructing our typology we have considered healthcare and social care systems on two levels:

- as a set of social protection institutions and practices that tend to be maintained and reproduced over time
- as processes for social and institutional innovation that reflect the pressure of demographic change, changes in government, new social aspirations and new economic, political and social ideologies on the role of health in developed countries.

In considering the European Union of 25 countries in 2005, we can identify five contrasting models named in accordance with their geographical dimension: Anglo-Saxon, Continental, Nordic, Mediterranean and East European (Table 6.7).

The Anglo-Saxon model

If we look at the paradigmatic case of the United Kingdom, we see a universal healthcare system financed through taxation and with extensive citizens' support. In contrast, the social care system is means-tested (except in Scotland where a devolved government supports the public funding of long-term care) and personal care remains the responsibility of the individual and family and social support networks. During the 50 years of the welfare state in the UK the principles enunciated by the Beveridge Report (Beveridge, 1942) have remained broadly the same. Changes in policy have, however, been a distinctive feature of the last 25 years with successive governments responding to the increasing demand for healthcare from an ageing population with increasing expectations (partly fuelled by these changes in policy). It was the Thatcher administrations of the 1980s that led welfare reforms throughout Europe with the introduction of cost-containment measures and market-oriented reforms such as the purchaser-provider split (currently known as the commissioner-provider split) and the development of an internal market and increasing access to the private market in healthcare. When New Labour were elected in 1997 there was some suggestion that the pro-market vision would decline with greater collaboration between the agents involved being facilitated by changes in policy (Le Grand *et al.*, 1998). In 2006, the developing policies support additional public funding and so continue the pro-market theme of the 1980s and 1990s. Recommendations by the Royal Commission on Long-Term Care (1999) for a universal service free at the point of delivery for the care component of long-term care (with the exception of Scotland) was not adopted by the government in 2002. The established division between healthcare and social care systems in the UK therefore remains.

The Continental model

The Continental care system founded on Bismarkian principles is typical for most countries in central Europe (Austria, Belgium, France, Germany, Luxemburg and the Netherlands). It has been based on the combination of healthcare systems financed by social security contributions and private healthcare provision (NGOs including insurance companies, religious and other not-for-profit organisations and commercial healthcare companies) and a social security system managed by large NGOs for people without resources. There is a central role for the family, and in some countries such as Germany children have a legal responsibility to support their parents in later life.

From the early 1990s there have been significant changes in the policies in countries having the Continental model. The healthcare systems have begun to be financed mainly through taxation but have introduced charges as part of their cost-containment policies. Changes in family structure and the role of women have led to the development of protection policies for personal care or long-term care as an

extension of statutory social insurance: first in Austria (1993), then in Germany (1995), Luxemburg (1999) and France (2002). In the case of Belgium, Flanders has created a long-term healthcare system. In the Netherlands the healthcare system has been extended to cover new social health needs. The new system does not replace the statutory responsibilities of families to support older people, but rather compensates for social changes in family structure and roles.

The Nordic model

The Nordic model (Denmark, Finland, Norway and Sweden) is based on the principle of citizenship, which guarantees free universal healthcare and personal social services financed through general taxation. Social care users pay partial contributions according to their levels of income. Over the years the Nordic countries have progressively extended the healthcare and social care system to accommodate the changing needs of an ageing population. However, they have not been unaffected by the increasing demand and the associated increased costs and have responded by introducing market-oriented approaches to the management of the services. User charges are increasingly being used to dampen demand.

The Mediterranean model

The Mediterranean or southern European model (Greece, Italy, Portugal and Spain) is characterised by its recent development compared with the established models of central and northern Europe. Healthcare systems financed from taxation that led to the guarantee of universal healthcare for the entire population did not emerge until the late 1980s and early 1990s. Private provision of healthcare still remains widely available, but the new healthcare systems lack resources and the capacity to respond to the ageing population. Consequently specialist health services for older people remain relatively under-developed.

Within the Mediterranean model the social care system is poorly developed. The family and social support networks provide the majority of personal care, and residential long-term care is provided by religious organisations. However, increased recognition of the changing roles of women and the changing family structures has led some countries (particularly Italy and Spain) to develop rudimentary social care services in support of families.

As in other European countries, privatisation of providers and other market-oriented policies have been used in response to increasing demand for healthcare and social care from their populations. Private healthcare and user charges remain an important feature of the financing of services. Although the state guarantees financing and regulation of services, the actual planning and management has been decentralised to regional and local authorities. In response to the increased demand from families for social care support and the poorly developed public social care system, the private sector in social care has expanded markedly. Yet there remains continuing debate around the need to develop publicly funded universal healthcare and social care systems that meet the long-term care needs of the ageing population in the light of changes to family structure and roles.

The model of transition in eastern Europe

To describe social protection systems in the countries of eastern Europe implies an exercise of unavoidable simplification given the diversity between the countries involved (Czech Republic, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia). However, we can highlight some of their more general characteristics.

The healthcare systems of these former members of the Soviet bloc have evolved since 1990 from centralised to decentralised systems. There has been decentralisation of both purchasers and providers and partial privatisation of both purchasers and providers. In general they are national or regional systems more or less independent from central government and based mainly on Bismarkian principles. The healthcare systems are hospital dominated and primary care as we understand it in other European countries is poorly developed. They have mixed low-level funding that affects the reality of any universal cover and greatly challenges the quality of services provided. Yet healthcare reforms in these countries have, to date, continued to support the principle of universal availability of health services to the population. But these reforms have not removed the uncertainty of financing arrangements. Being part of the European Union since 2004 might favour convergence with other European healthcare systems in the coming years (Threlfall, 2003).

For eastern European countries, community-based social care services are virtually non-existent and represent a very new policy direction with much of the social care provision being traditional state-controlled residential institutions. The future development of social care systems is likely to rely on NGOs, particularly religious and other not-for-profit organisations.

CONCLUSIONS

For public policy the ageing of the population in Europe is seen as a major challenge. For some commentators it is a disaster waiting to happen (Clark and Spengler, 1980, quoted in Bond, 1992; Hertzman and Hayes, 1985; Thane, 1988), while others interpret demography more soberly within its historical, political and social context (Katz, 1992; Laslett, 1996; Mullan, 2000; Robertson, 1991; Robertson, 1997). As we have seen in Chapter 1, there is no doubt that the population of Europe is ageing and that for many countries the rate of ageing is something that no human society has experienced before. Of course it is not the increase in the absolute numbers of older people that is taxing the minds of politicians and policymakers but the relative proportion represented in the increasing gerontic dependency ratio discussed above. Based on these data, the prevailing belief is that an increasing ageing population inevitably means increasing demands on the resources of society particularly for healthcare and social care services and the funding of pensions. Whether the assumptions underlying these beliefs are correct is not really the point. It would appear that healthcare costs are increasing across Europe. But there are other explanations for rising costs, not least of these being

the successful scientific activity of bioscientists and clinicians and the economic activity of pharmaceutical and healthcare companies. The challenge can easily be reconfigured as: how do we continue to provide cost-effective healthcare and social care for our ageing population within an equitable and moral framework rather than blaming older people for one of the triumphs of human advancement?

How will healthcare and social care systems evolve in the EU and, in particular, how will they evolve for the benefit of older people in the coming years? It is probably an understatement to say that the answer to these questions is complex! On the one hand the different models will tend to maintain their institutional traditions, values and methods of care. On the other hand, the more-or-less common demographic (ageing), institutional (decentralisation, belonging to Europe), economic (cost containment, mixed healthcare system management) and ideological (demand for quality care) problems and experiences will tend to favour a certain kind of asymmetric convergence regarding the vision and development of the functions of the healthcare and social care systems in general and, in particular, regarding the care of older people.

FURTHER READING

- Bond, J. and Corner, L. (2004) *Quality of Life and Older People*. Buckingham: Open University Press.
- Charmaz, K. (1983) Loss of self: a fundamental form of suffering in the chronically ill. *Sociology of Health and Illness* 5(2), 168–195.
- Hockey, J. and James, A. (1993) *Growing Up and Growing Old: Ageing and Dependency in the Life Course*. London: Sage.