OECD Labour Market and Social Policy Occasional Papers
No. 16

Social Protection for Dependent Elderly People: Perspectives from a Review of OECD Countries

Patrick Hennessy

https://dx.doi.org/10.1787/271344236402

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GENERAL DISTRIBUTION

OCDE/GD(95)85

LABOUR MARKET AND SOCIAL POLICY
OCCASIONAL PAPER

NO. 16

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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

Paris 1995

**DIRECTORATE FOR EDUCATION,
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS**

OCCASIONAL PAPERS

SOCIAL PROTECTION FOR DEPENDENT

ELDERLY PEOPLE:

PERSPECTIVES FROM A REVIEW OF OECD COUNTRIES

by
Patrick Hennessy

Division of Social Affairs and Industrial Relations,
Organisation of Economic Co-operation and Development

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SOCIAL PROTECTION FOR DEPENDENT ELDERLY PEOPLE: PERSPECTIVES FROM A REVIEW OF OECD COUNTRIES

TABLE OF CONTENTS

There is growing concern about the future provision of care for frail elderly people. Many countries have planned to reform services or the financing of care, but have found that the implementation of these plans has coincided with economic slow-down and fiscal constraints. This has heightened the difficult choices that have to be made in relation to new services for care.

All OECD countries are agreed in having as a main objective that elderly people should be able to stay for as long as possible in their own homes, and that they should be able to receive good residential care close to their own community ("ageing in place"). How successful have OECD countries been in pursuit of this goal? What barriers can be identified? Are services as effective as they could be?

Most policy debates have been over-shadowed by the question of how to pay for the necessary services. OECD countries currently deploy a range of financing mechanisms for relevant health and social services, involving varying levels of financial burden on the client. To what extent are current financing mechanisms a barrier to effective care? What new mechanisms are in preparation or being implemented? Will it be possible to extent services for continuing care without having to trade off some existing welfare commitments?

This paper is based upon the memorandum submitted by the OECD to the 6th Conference of European Ministers responsible for social security. The conference, on the subject of Dependency and Social Security, was convened by the Council of Europe at Lisbon on 29th-31st May 1995.

This report was prepared by Patrick Hennessy, Administrator in the OECD Directorate for Education, Employment, Labour and Social Affairs.

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Les soins de longue durée à assurer dans l'avenir aux personnes âgées dépendantes suscitent une inquiétude croissante. De nombreux pays ont préparé des réformes des services ou des modes de financement des soins, mais se sont aperçus que leur mise en oeuvre coïncidait avec une lenteur de la croissance économique et des contraintes budgétaires, rendant d'autant plus difficile les choix qu'impliquent les nouveaux types de soins.

Tous les pays de l'OCDE sont d'accord sur un grand objectif selon lequel il faut permettre aux personnes âgées de continuer à vivre chez elles aussi longtemps que possible ou, à défaut, de bénéficier de soins de qualité dans un établissement proche de leur entourage ("vieillir chez soi"). Dans quelle mesure les pays de l'OCDE ont-ils atteint cet objectif? Quels obstacles ont-ils rencontrés? Les services sont-ils aussi efficaces qu'ils pourraient l'être?

La plupart des débats de fond ont été dominés par la question du mode de financement des services requis. Les pays de l'OCDE mettent actuellement en place divers mécanismes permettent de financer les soins de santé et les services sociaux nécessaires et imposent au bénéficiaire une charge financière plus ou moins lourde. Dans quelle mesure les mécanismes de financement actuels nuisent-ils à l'efficacité des soins? Quels mécanismes nouveaux sont en voie d'élaboration ou en cours d'application? Sera-t-il possible de développer les soins de longue durée sans renoncer en contrepartie à certains engagements qui ont été pris en matière de protection sociale ?

Ce document prend sa source dans le memorandum proposé par l'OCDE à la 6ème conférence des Ministres européens sur la Sécurité Sociale. La conférence, sur la Dépendance et la Sécurité Sociale, a été organisée par le Conseil d'Europe à Lisbone du 29 au 31 mai 1995.

Patrick Hennessy est administrateur à la Direction de l'Education, de l'Emploi, du Travail et des Affaires sociales de l'OCDE.

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by
Patrick Hennessy,
Division of Social Affairs and Industrial Relations,
Organisation of Economic Co-operation and Development

A NEW SOCIAL POLICY ISSUE

1. There is growing concern about the future provision of care for elderly people who are frail or disabled. This is a marked departure from debates about welfare policies as recently as the early 1980s. OECD countries did not, for example, highlight this as a significant problem during a conference in 1980 on The Welfare State in Crisis (OECD, 1981). During the 1980s, however, there was increasing awareness of the considerable social policy implications of the demographic ageing of our societies. The OECD initiated studies of the likely growing costs of pensions and health care associated with more aged populations and of the possible ways these might be met (OECD, 1988). The OECD area was projected to see a long-term decline in the ratio of people of working age to those people above working age who draw retirement pensions and require above-average amounts of health care.

2. There was also growing awareness of the remarkable rate of growth of the oldest age groups in our societies -- those aged 80 and over (see **Table 1**). This was in many countries underlined by the growth in demand for places for very elderly people in long-term care institutions. In addition to problems of financing future provisions for elderly people, the perception formed that the existing services which provided continuing care were themselves in need of substantial change. In some cases, the supply was seen to be simply insufficient to meet current demands, let alone future growth. In other cases, there was a perceived imbalance in the services provided. Services were seen as tilting too far towards an institutional solution, and, where this was offered, the resulting institutions were modelled either on hospitals or on traditional collective homes for the indigent elderly, neither of which were now considered appropriate.

3. Finally, there was a critique of current policies which stressed the enormous contribution to welfare which was made by families, very largely by women, providing care for elderly people at no cost to the public purse but often at considerable cost to themselves, in employment curtailed or given up, in disruption of normal family life, and in stress. By the end of the decade, family carers had become as important in these discussions as elderly people themselves. It was becoming accepted that there was a need to balance the elderly person's wish to remain at home, the public authorities' wish to provide alternative -- and, it was believed, lower cost -- services in those homes, and the need for family members to maintain other family functions such as an adequate income (now and in the future, through pension rights), parenting and grand-parenting, and their own health and self-maintenance.

4. In the 1990s, these issues have become, in one sense, over-shadowed by current economic difficulties that have pushed problems of burgeoning public deficits and growing structural unemployment to the fore. The focus has, in another sense, been sharpened as countries have sought more control over total health and social service costs, greater efficiency in the use of those services, and a greater focus on the most urgent needs.

5. A number of countries had planned or initiated reforms of their continuing care services, only to find that implementation through the early 1990s took place in the most difficult financial context for several decades, when the choices involved became sharper and when additional resources, even at the margins, were virtually impossible to find.Those countries which had identified a need for change, but had not formulated specific reforms, were hardly encouraged to push a new and potentially expensive issue to the head of the agenda. Even countries which had hitherto managed to accommodate greater needs for care

by gradual adaptation of existing systems found themselves pushed to make sharper decisions about priorities and facing more difficult choices about public costs.

6. In effect, the OECD countries find themselves facing a "future" problem in financing the growth in care for elderly people far sooner than anticipated. However, it is current reductions in employment levels, rather than long-term shifts in the elderly/non elderly ratio, which are forcing new fiscal and expenditure choices onto the agenda.

7. In response to these concerns, the OECD has been conducting a review of policy trends in Member countries to see how they are adjusting the mix of available services and the means of financing them, in order to accommodate future growth in the frail elderly population while maintaining, or improving, the supply of appropriate care. A number of publications have already appeared from this study (OECD, 1994a and b; Hennessy, 1994), and a final report will appear shortly (OECD, 1995). This paper summarises some of the main policy issues which have emerged from this review, and which have to be taken into account by all those setting out to design new systems of social protection for the frail and disabled elderly.

OBJECTIVES AND ACHIEVEMENTS

8. There is a high level of agreement among the OECD countries as to the overall objective of policies towards the care of frail elderly people. This is that "elderly people, including those in need of care and support, should, wherever possible, be enabled to continue living in their own homes, and that, where this is not possible, they should be enabled to live in a sheltered and supportive environment that is as close to their community as possible, in both the social and geographical senses" (OECD, 1994b). This overall objective, which has been endorsed by the health and social policy ministers of the OECD countries, has been termed "ageing in place".

9. This broad statement of a socially desirable goal is useful in providing a benchmark for the assessment of both current and potential programmes in a range of policy areas, encompassing health, housing, social services and social security. It does not, however, say a great deal about the substantive content of those policies, nor about the middle-order objectives against which these might be measured. A more detailed statement of objectives might be that elderly people who are frail and unable to lead a completely independent life should:

- receive appropriate care;
- of good quality;
- in an acceptable setting;
- with a choice of providers;
- that is delivered in co-operation with other family members;
- at a sustainable cost.

10. This set of middle-order objectives all raise a number of further questions in their own right. Who is to decide what is "appropriate"? What is "good" quality? What is an "acceptable" setting? How much "choice" is possible or desirable? How much "co-operation" with other family members should be attempted? What level of cost is "sustainable" and who has to sustain it? Different services, and different countries, have arrived at different answers to these questions, leading to a wide variety of arrangements amongst the OECD countries, and (since these issues are delegated to local health or social service authorities) often within them, too. There may be a broad level of agreement around the overall objective, but there is considerable variation in the services available and the means of paying for it, and, therefore, in the outcomes for specific individuals.

11. If the goal were simply the avoidance of institutional care for the great majority of elderly people, this would appear to be attained by the OECD countries. On average, only around 5 per cent of elderly people at any one time are receiving care in an institutional setting (see **Table 2**). Those countries where this proportion is still increasing are generally those with below-average provision of facilities such as nursing homes, and where there have been perceived to be shortages. However, the receipt of care in institutions is very heavily skewed towards the higher age groups. Below the age of 75, only about 1 or 2 per cent of elderly people receive care in institutions, while, above the age of 85, the relevant proportion can rise to 30 or 40 per cent (see **Table 3**). More importantly, this rate of use is still increasing in the very elderly age groups in many countries, while the already low rate of use among the younger elderly is being further reduced.

12. In short, measured by this single crude criterion, "ageing-in-place" policies are succeeding in the sense of confining the use of nursing home-type facilities to an increasingly older and more disabled clientele in most countries. We have less information about the extent and quality of care being received by those frail elderly people remaining outside such institutions (see **Table 4** for an overview of the receipt of home help, generally the most widely available service). There is also the equally important question whether the very elderly and disabled residents of nursing homes and similar institutions are "close to the community".

13. Finally, it is noticeable that objectives that are widely accepted as appropriate for the delivery of health care in general are not always accepted as being so appropriate when applied to continuing care, whether delivered in an institution or as home and community care. Studies of recent reforms in OECD health care systems have found that there is wide agreement that these systems should provide for a minimum level of health care to be available for all citizens (adequacy), to be distributed in accordance with need (equity), with protection from costs which threaten income sufficiency (income protection) (OECD, 1992 and 1994c). In many OECD countries, the distribution of continuing care services departs from these principles, which are evidently not regarded as applying to continuing care to the same extent as to services such as acute hospital care, consultation with physicians and supply of pharmaceuticals. This order of priority in income protection during sickness could be questioned, given the potentially catastrophic effect of long-term care costs on economic status.

14. In many OECD countries, the risk of requiring some continuing care incurs financial penalties considerably higher than those attaching to acute health care services. Most home and day care services are subject to a user charge, usually income-related, and nursing home-type services are in most countries only provided largely free of charge to those with low incomes. In many countries, the user’s home and other assets are considered to be available to meet these costs before they become a charge on public funds. Even some of those countries with services made available on a universal basis have a user charge for the "hotel" component at a level which would attract resistance were it proposed for hospitals. Finally, in some OECD countries other family members are also called upon to meet some of these costs before public funds are made available.

15. The whole issue of the degree of individual and family responsibility for meeting needs is therefore a much more open question in the provision of continuing care than it is for acute health services. In this sense, while "ageing in place" is broadly accepted as a societal objective, it is not seen as a goal for which it is the responsibility -- or even within the capacity -- of public authorities alone to bring about. The way that we live our own lives, organise our own lifetime savings and expenditure, and how we live together (or not) as families is inextricably bound up with public policies for the care of frail elderly people.

THE PROCESS OF "CONTINUING CARE"

16. It is now widely accepted that, for most elderly dependent people, a mix of services is required to maintain an appropriate level of care. It is less and less accepted as right that the choice should consist largely of either a family carer, with some support from acute health services, or a long-term care institution, usually a nursing home. Most countries are developing a range of services that both fill the gap between unsupported home care and the nursing home and which can be combined in different ways to meet the varied needs and circumstances of elderly people. To better describe this new service environment the concept of "continuing care" has been developed, encompassing a spectrum of different services, from different policy sectors and agencies, which share a common goal.

17. This new service concept gives heightened priority to assessing the needs of the individual and managing the resulting package of services (Davies, 1994). The "new welfare mix" may be more responsive to different circumstances, and incorporate a wider range of options; it also requires new and enlarged management resources, as it requires more co-ordination between services, and better information about options and costs to be available to service managers, funders and users of services if it is to be more effective, rather than just more confusing. Who are the main participants in continuing care, and what are the major issues surrounding their role in this process?

Medical care in hospitals

18. Hospitals have long been the safety net in the continuing care spectrum. When other, more specialised, services are unavailable, access to a hospital bed provides a final guarantee of receiving appropriate personal care. Hospitals have, however, usually played a much greater role in the provision of continuing care. In many countries, it was the pressure on costly hospital beds, coupled with growing questions about their suitability for continuing care, which led service providers to begin developing or encouraging alternative forms of provision. Policies which set out to provide alternative forms of care often make their largest savings in the reduced use of hospital beds, invariably the most expensive of the options available. As a consequence, large reductions have been made in many countries in the number of hospital beds devoted to continuing care and, in a number of other countries where the hospital remains a major participant in continuing care, achieving such reductions is an urgent policy priority.

19. While most policy makers and analysts see a shift in the focus of care away from hospitals as beneficial in both service and financial terms, there remains a significant role for the hospital and related services in the new mix of care services. Elderly people take longer to recover from even fairly minor operations, let alone major surgery. Nursing homes do not always have the full range of post-acute care services available, and a patient discharged home prematurely may be at too great a distance if there is a relapse. While most continuing care services are being brought together in a more coherent way, there does appear to be a new risk of a gap in co-ordination between hospital-based services and other continuing care services.

20. Much continuing care results not from a long-term and slow decline in independent functioning, but from a sudden loss of faculties in an acute episode. The important role of post-acute care and rehabilitation services may therefore need to be re-emphasised, and the vital role of specialised medical services in the continuing care process underlined, by their inclusion in the care management process. The alternative may be unnecessarily prolonged recovery and disability for the individual, and additional burdens being shifted onto the other continuing care services, to which they are less well equipped to respond.

Care in long-term institutions

21. There is in most countries a distinction between the nursing home, providing continuous nursing care, and a residential care or old people’s home, providing accommodation, shelter, surveillance and

support (although in some countries, these are found within one building, in separate sections). Much policy concern about growing long-term care costs has focused on the use of nursing homes, and whether this is both a necessary and appropriate response to growing long-term care needs.

22. Experience in a number of countries suggests, however, that reducing the use of nursing homes to a considerable extent is difficult and can necessitate the introduction of intensive packages of home care. While some clearly "inappropriate" placements can be prevented with better assessment and alternative services, any financial gains from delayed nursing home entry have often been cancelled out by the cost of extra services to home-bound elderly people and their carers. This process has, however, stimulated a great deal of valuable innovation and a better balance of services.

23. No OECD country has seen an outright reduction of total nursing home beds. The pattern is one of increasing specialisation, with the nursing home sector catering mainly for very elderly people with a high level of disability. This raises issues of appropriate staff recruitment and training, and about the realism of ambitions to introduce a different, more responsive regime in nursing homes. Countries who are at the forefront of this process can, however, point to some positive achievements in this respect.

24. Is there still any role for the traditional residential care home, or old people's home? Some form of public or charitable housing for indigent and frail elderly people has been provided in local communities for hundreds of years. In more recent decades the persistence of this type of service has appeared to be related to unsolved problems of low income, suitable housing and social support, rather than disability and a need for continuing care. In many OECD countries this type of provision has been in slow decline in recent decades, gradually superseded by a combination of housing improvements, home services and more specialised "sheltered" housing for those who need it (OECD, 1992b; Tinker, 1994).

25. More recently, cost control measures have been introduced in a number of countries which have the effect of forcing local governments to decide between different services within constrained global budgets. This appears to be having a remarkable effect on the rate of decline of residential homes. In several countries the number of places still available has tumbled during the last 5 years, by as much as 10 per cent a year. It is less clear yet whether the alternative provided is better housing with home-care services, rather than increased stress among family carers. However, many OECD countries now appear closer than ever to the disappearance of the traditional "old people's home" as an accepted form of social policy provision for elderly people.

26. A new role for a different form of hostel accommodation which is being developed in a number of countries consists of specialised care for people suffering from dementia. Research has shown that people with dementia lose only certain faculties, such as recognition when a large or inter-changing number of people are involved. Providing care in a large institution deprives the elderly person of any sense of recognition and leads to heightened disorientation. It is now seen that better quality care can be provided in small groups of 5 or 6 people with a fixed group of carers, in which environment the elderly person retains a greater capacity for awareness and self care. Small specialised hostels are being provided on a growing scale in a number of countries to provide care of this kind. 27. Looking further ahead, the likely growth in prevalence of Alzheimer's disease and other causes of dementia puts a premium on developing appropriate services in greater quantity and on new forms of training for care staff. It also suggests that further investment in medical research into the causes and treatment of these conditions could be of inestimable benefit to elderly people and also pay for itself many times over.

Home and community care

27. As noted earlier, all the OECD countries have stated their preference that, where possible, elderly people with some dependency on others should be able to receive that care at home. This has been the frequently-stated wish of most elderly people, too (although we should note that this may be affected by

the perception of the alternatives; when limitations on building nursing homes were introduced in Denmark, there were some protests from elderly people wishing to see that alternative retained). The implications of this emphasis on home and community-based services have, however, gone through some re-evaluation in recent years.

28. In an earlier phase of policy, home and community care was, perhaps, too readily presented as the ideal policy solution: sought-after by elderly people, supportive to families and, finally, less expensive than alternatives. The latter perception is surely not unconnected with the rapid adoption of this policy perspective by most policy makers right across the political spectrum. Experience with such programmes, however, produced mixed results. The introduction of new programmes led to a growth in the numbers receiving services such as home help which were well in excess of any likely rate of entry into institutional care. Even carefully controlled experiments tended to show net gains in costs, or relatively small savings when services were focused tightly on the most disabled people.

29. Issues of equity were also raised when services were targeted to this extent. When scarce home care resources are tightly focused on fewer cases, "success" may be bought at the expense of leaving many elderly people with some disabilities reliant on an over-stretched family carer, both of whom could well benefit from some help. The very positive outcomes to general welfare which flow from providing services such as day care, respite care, visiting nurses and home helps to a wider spectrum of people, even at the cost of some increased admissions to nursing homes at the margin, provide a strong case for an alternative approach to setting objectives for the new home and community care services.

30. In practice, the degree to which these services are co-ordinated around agreed goals -- of any type -- often seems to fall some way short of the impression given here. New systems of co-ordination require an abandonment of traditional turf battles between professions and levels of government. The reality in too many cases is probably of a harassed social worker piecing together a service response from competing agencies with their own and different priorities. While social workers have often engaged in a turf battle of their own, claiming home and community care as their responsibility, health systems now seem all too ready to concede this territory, raising the real risk of marginalising these services in a less well-funded and lower-status policy sector. The involvement in the care management process of health personnel, such as family physicians and community nurses, seems essential if this is to be avoided. The achievements of services where it has been possible to establish genuinely multi-disciplinary assessment and allocation have been considerable in some countries.

31. Finally, what is the contribution of the family carer? Much of the debate has focused upon women of working age, and seems to express a fear that greater economic opportunity has somehow lured middle-aged working women away from their "real" job of looking after their elderly relations. However, when there are concerns about the steady decline in the ratio of working age to elderly people, and its effect on the funding base for pensions, health care and other services, there is a public interest in maintaining the employment levels of women over the longer term. To encourage a working woman to withdraw from employment and provide care on a one-to-one basis would be both inequitable, in terms of her own social, economic and health prospects, and an inefficient use of human resources.

32. In addition, this focus on working-age women has deflected attention from other, quantitatively more important, carers. Most elderly people who live with another person live with their elderly wife or husband, who is their first and most important carer. Elderly carers have a particularly strong claim for support from services, and seem to have attracted less attention in policy debates than their importance warrants.

33. Those elderly people who receive care from family members other than their spouse do not, in most OECD countries, usually live with them, but near to them. This reflects a transition in family employment and living patterns to which many services have had to adapt (Sundström, 1994). The need of families to be able to combine employment of both partners with other social responsibilities is not

confined to elderly care, and is perhaps one of the more pressing priorities for social policy as a whole in future decades. Arriving at a suitable form of social contract between working-age members of families, as both care-givers and taxpayers, and elderly members of families, as both givers and receivers of care, appears a necessary condition for new social policies to suit these changed circumstances.

WHO WILL PAY?

34. This question has over-shadowed most national discussions on the future of continuing care (e.g., for the United States, see Rivlin and Wiener, 1988; Wiener, Illston and Hanley, 1994). In a number of OECD countries there have been discussions about possible new forms of social insurance to provide better protection against the costs of continuing care, although only Germany has so far legislated for a new branch of insurance. In other countries, sources of tax finance for health and social services have been re-directed or combined to provide a more integrated source of funding for care (and a more effective cap on the total budget). Even in countries which are extending care provisions broadly within existing service and legislative frameworks, questions have been raised about the continuing ability of existing systems to provide the necessary additional funds year on year.

35. There is also the wider issue of "who should pay, public funds or private purse"? Is meeting the costs of care primarily a responsibility for public policy, via the tax system or social insurance schemes, or a private responsibility for each individual and family?

36. There is little concordance of current national policies in this respect. Some OECD countries provide continuing care in nursing homes or similar institutions on broadly the same terms as hospitals. Some user charge is normally applied, although it is less than the real cost of housing and maintenance, let alone the cost of the nursing care. In effect, these countries have accepted the case for covering the risk of needing continuing care on similar terms as other forms of health care. This applies to Australia, Canada, Denmark, Finland, Norway, Spain and Sweden. Most of these countries aim to provide a universal health system funded though taxation. Such countries seem to have some flexibility in adjusting services in response to changes in needs.

37. Other countries do not aim to cover the nursing home costs of those with resources above a social assistance level of income, but do cover virtually all the costs of those below this level (with other family members sometimes included in the income and assets testing process, sometimes not). In these countries, continuing care is effectively a personal or family responsibility, with the state's role confined to providing a safety net for those with insufficient resources and a lack of family support. This applies to Austria, Belgium, France, Germany (until the phasing-in of the new long-term care insurance in 1995-96), Japan, Luxembourg, Switzerland and the United States. These countries have a health system funded through health insurance. Their health systems have seemed to be somewhat inflexible, maintaining existing benefits but not admitting new demands which might upset professional structures and funding arrangements.

38. Two significant variations on this division should be noted. First, some of the countries in the second category, such as France, divide nursing home and similar costs into a "health" component, to be met from health insurance, and a "housing and social" component, to be met by the user above the social assistance level. This has the virtue of aligning the separate funding components with their counterpart programmes elsewhere in the welfare system -- the health services on the one hand, and housing allowances and support for low incomes, on the other. But it does also add an extra twist to administrative complexity.

39. Secondly, two countries with tax-funded national health systems, New Zealand and the United Kingdom, have in recent years moved closer to those countries in which the social assistance model is applied to long-term care. Each has seen a strong growth in the number of health-related long-term care

beds which are outside the universal health care funding arrangements. Increasingly, only those elderly people with low incomes and assets receive public support for long-term nursing care in institutions. The funding for these beds is now from the same overall budget as most other forms of care (such as residential homes, home helps and day care). Care authorities have greater flexibility in the use of funds as between institutional and other forms of care, but those who need nursing home care face much greater financial penalties than hitherto.

40. Funding regimes for home care are also varied, within as well as between countries, depending on the service. Home nursing is often free, covered by the health system, although sometimes this coverage is time-limited and user charges are made after a certain time (free nursing being provided only when it is seen as part of a medical "cure", for example, post-operation). Domestic help is, in the majority of countries, subject to user charges above a minimum income level, often up to the full charge for those with higher incomes. Only one or two countries supply it largely free of charge. Historically, it has developed as an extension of social assistance in most countries, not as part of the health system, and some income-related charge has long been seen as normal in most countries.

THE FUTURE OF LONG-TERM AND COMMUNITY CARE

41. All countries are experiencing a significant growth in the numbers of very elderly people, and in all probability, therefore, in the numbers of frail and disabled elderly people needing some care. Over the period 1990-91 to 2020-21, the average of national projected rates of growth in numbers of persons aged 80 and over is 70 per cent (averaged across the 17 OECD countries where this data is available -- see Table 1). The rate of growth is anticipated to be considerably higher over this period for the non-European OECD countries, but there will be continued strong growth of the already relatively large very elderly population in most of OECD Europe.

42. The expected rise in demand for services may be matched by a growing political influence of the older population. It has been estimated that by 2020 over 50 per cent of the electorate in the European Union area will be over 50 years of age (Wilson, 1993). It seems most likely that, over the next 30 years, there will be a discernible shift in the focus of social policies from younger to older people, and that long-term and community care will move further into the mainstream of policy. Indeed, there are indications in a number of countries that this process is already under way.

43. This is likely to put pressure on a whole range of policies, including housing and community services, social security, health (acute as well as long-term) and social services. Each may need modifying to accommodate the requirements of the enlarged population of very elderly people. Further, there is interaction between all these policy areas in providing support, either at home or in suitable institutions, and mechanisms for co-ordinating their efforts will have to be developed to enhance overall effectiveness.

44. How are these new demands on resources to be sustained? While the demographic trends point to reduced demands for services such as education, there are likely to be real difficulties in making any substantial shifts in resources from services for younger to older people, as unit costs in education, training and child health continue to increase to keep pace with professional developments and economic needs. This raises the question whether all existing commitments in the pensions, health and social services fields can be maintained while a major new demand on resources is accommodated. Some increase in the proportion of taxation and contributions devoted to continuing care seems inevitable, but the scale of this increase will be affected by decisions about wider social and health priorities in future decades.

45. It may be that pension funding will have to address possible trade-offs between age of receipt of pensions, their rate of replacement of employment income and providing greater resources to the very elderly with higher care needs. The extent of coverage of sick pay and disability pension systems for younger people may also come into question. Health systems will have to find more efficient ways of

delivering acute care in order to accommodate rising demands for post-acute and continuing care for very elderly people. This may not be possible without some trade-off in the extent of coverage for other health costs, such as pharmaceuticals and visits to physicians. Other services which are required, such as housing, technical equipment and home help services, seem likely to have to be funded on a shared basis, with elderly people contributing to the cost in relation to their income and resources.

46. None of these is a necessary condition for extending continuing care services to a wider population. All, however, may have to be considered, if an appropriate new balance is to be struck between commitments entered into some time in the past, when demographic trends and living standards were considerably different, and new commitments which will be required if the quality of life and welfare of frail and disabled elderly people is to be maintained and improved during the next few decades and beyond.

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Table 1. **Rate of growth of number of people aged 80 or over, 1960/1-1990/1 and 1990/1-2020/1**

	% Growth 1960/1-1990/1	Projected % growth 1990/1-2020/1
Australia	194	149
Austria	128	45
Belgium	93	49
Canada	177	149
Denmark	152	11
Finland	249	50
France (age 75+)	92	36
Germany (West)	196	n/a
Japan	335	204
Luxembourg (age 75+)[1]	90	41
New Zealand	114	100
Norway	125	13
Portugal[2]	n/a	143
Spain	160	47
Sweden	155	22
Switzerland	197	32
Turkey[3]	171	54
United Kingdom	109	31
United States	176	75
Group average (unweighted)[4]	159	70

Notes:

1. 1960-1987 and 1987-2020
2. 1990-2025
3. 1960-1990 and 1990-2005
4. 1960/1 average excludes West Germany, Portugal and Turkey; 1990/1-2020/1 average excludes Portugal and Turkey.

Source: OECD (1994), New Orientations for Social Policy, Table 11, and OECD Questionnaires on the frail elderly, 1991 and 1993.

Table 2. **Proportion of elderly people[1] in residential care in OECD countries, 1960-1992**

	Year	%	Source and Definition
Australia	1981	**7.0**	OECD Questionnaire -- administrative statistics; beds for elderly people in nursing homes and hostels.
	1991	**6.2**	OECD Questionnaire -- as above.
Austria	1961	**3.5**	OECD Questionnaire -- census; % in care institutions.
	1981	**3.3**	OECD Questionnaire -- census; % in nursing homes and residential care homes.
	1988	**4.6**	OECD Questionnaire; Secretariat estimate of beds in nursing homes and residential care homes.
Belgium	1961	**3.0**	OECD Questionnaire -- census; % in homes for elderly people.
	1981	**4.1**	OECD Questionnaire -- census; % in nursing homes and residential care homes.
	1991	**5.2**	OECD Questionnaire; Secretariat estimate of % in homes for elderly people.
Canada	1981	**7.3**	OECD Questionnaire -- census; % in hospitals and special care homes.
	1986	**7.5**	OECD Questionnaire -- census; as above.
	1991	**7.1**	OECD Questionnaire -- census; as above.
Denmark	1980	**6.0**	OECD Questionnaire; % in nursing homes.
	1990	**5.6**	OECD Questionnaire; % in nursing homes.
	1992	**5.4**	OECD Questionnaire; Secretariat estimate of % in nursing homes.
Finland	1960	**4.9**	OECD Questionnaire; % in old people's homes.
	1981	**7.0**	OECD Questionnaire; % in health centres and old people's homes.
	1986	**7.2**	OECD Questionnaire; as above.
	1990/91	**7.0**	OECD Questionnaire; as above.
France	1962	**3.8**	INSEE; Secretariat estimate of % in long stay wards, psychiatric hospitals and homes for the elderly.
	1975	**5.1**	INSEE; as above.
	1982	**5.3**	INSEE; as above.
	1992	**5.1**	OECD Questionnaire; as above

Table 2 (continuation). **Proportion of elderly people[1] in residential care**

	Year	%	Source
Germany	1980	**4.3**	OECD Questionnaire; % in nursing homes, residential homes and multi-purpose homes -- West Germany.
	1990	**5.3**	OECD Questionnaire; as above -- West Germany.
	1992	**5.5**	OECD Questionnaire; as above -- western länder.
	1992	**5.4**	OECD Questionnaire; as above -- eastern länder.
Greece	1985	**0.5**	EC Observer (p. 74) -- from KEPE 1985; % in residential care homes.
Ireland	1991	**5.0**	EC Observer (p. 92); number of beds for the elderly in long stay hospitals; nursing homes and residential homes.
Italy	1981	**1.9**	OECD Questionnaire; % in nursing homes and residential care homes.
	1987/88	**2.4**	EC Observer (p. 101) -- from ISTAT and other official sources; % in hospital long term, nursing homes and residential homes.
Japan	1960	**0.7**	OECD Questionnaire; % in hospitals.
	1980	**5.5**	OECD Questionnaire; % in hospitals, nursing homes and residential homes.
	1990	**6.4**	OECD Questionnaire; as above.
Luxembourg	1991	**7.4**	EC Observer (Tab. 22) -- official statistics; % in health institutions long term, nursing homes and residential homes.
Netherlands	1987	**9.7**	EC Observer (p. 79) -- various surveys; % in nursing homes and homes for the aged.
	1990	**9.1**	Social and Cultural Planning Office; as above.
New Zealand	1981	**6.8**	OECD Questionnaire -- census; % in hospitals and homes for the elderly.
	1991	**6.7**	OECD Questionnaire -- census; as above.
Norway	1960	**4.7**	OECD Questionnaire; Secretariat estimate of % in institutions.
	1980	**6.3**	OECD Questionnaire; as above.
	1988	**6.8**	OECD Questionnaire; Secretariat estimate of % in nursing homes and residential homes.
	1992	**6.5**	OECD Questionnaire; as above.

Table 2 (continuation). **Proportion of elderly people[1] in residential care**

	Year	%	Source
Portugal	1981	**1.1**	OECD Questionnaire; % in public residential care homes.
	1990	**1.8**	OECD Questionnaire; as above.
	1992	**2.0**	OECD Questionnaire; as above.
Spain	1970	**1.2**	OECD Questionnaire; % in institutions.
	1981	**2.0**	OECD Questionnaire; % in institutions.
	1988	**2.4**	OECD Questionnaire and EC Observer (hospitals); % in hospital long term, nursing homes and residential care homes.
Sweden	1960	**4.4**	OECD Questionnaire; % in residential care homes.
	1980	**6.0**	OECD Questionnaire; % in hospitals, nursing homes and residential care homes.
	1988/90	**5.3**	OECD Questionnaire; as above.
Turkey[2]	1982	*****	OECD Questionnaire; % in homes for the elderly.
	1991	**0.2**	OECD Questionnaire; as above.
United Kingdom	1980	**3.7**	OECD Questionnaire -- administrative statistics; % in long stay hospitals, nursing homes and residential care homes.
	1990	**5.1**	OECD Questionnaire -- administrative statistics; as above.
United States	1960	**3.4**	OECD Questionnaire -- census; % in hospitals and nursing homes.
	1980	**5.2**	OECD Questionnaire -- census; as above.
	1990	**5.2**	OECD Questionnaire -- census; as above.

Notes:
1. Aged 65 and over unless specified.
2. 1982 = less than 0.05 per cent.

Note on sources:

OECD Questionnaire: Replies to questionnaires on care of the frail elderly circulated by the OECD Secretariat in 1991 and 1993.

EC Observer: National reports of the European Observatory on Social and Economic Policies and Older People, published by DGV, European Commission, Brussels, 1993.

INSEE: Data from INSEE quoted in A. Jamieson (editor) Home Care for Older People in Europe (Appendix 6), Oxford University Press, 1991.

Table 3. **Proportion of elderly people residing in institutions: proportion of each age group**

			Age Group					
		All 65+	**65-69**	**70-74**	**75-79**	**80-84**	**85+**
	Year	%	%	%	%	%	%
Australia	1986	10.4.	4.1	6.1	10.4	19.9	40.5
Austria	1992	4.7	0.9	2.2	4.4	8.3	18.1
Belgium	1981	5.4	2.0	3.2	5.6	11.3	23.1
Canada	1981	8.8	2.9	4.5	8.7	17. 6	36.5
Denmark	1992	5.7	1.0	1.7	3.7	8. 4	24.0 (1)
Finland	1986	7.2	1.8	2.5	6.3	24.9	-.- (2)
France	1988	3.4	0.8	1.6	3.5	7.7	15.2 (3)
Japan	1990	4.7	2.5	3.7	5.5	8.9	-.-(4)
Norway	1992	7.1	<	2.3	>	15.9	51.4(5)
N.Z.	1991	6.3	1.4	2.4	5.3	12.7	33.2(8)
Portugal	1990	1.8	0.7	1.2	2.2	3.5	4.6(6)
Sweden	1990	5.4	1.8	2.2	4.0	8.5	23.3(7)
U.K.	1990	5.1	<	1.5 >	<	6.1 >	22.4 (9)
U.S.	1990	5.4	1.1	2.0	4.3	9.6	24.9(7)

Sources: OECD questionnaires on care of frail elderly people, 1991 and 1993.

Notes: Total living long-term in all institutions, unless otherwise shown.
1 Nursing Homes only; lowest category starts at age 67
2. Old People's Homes and Health Centres; highest category 80+
3. Highest category 85-89. Refers to homes for the elderly and long stay wards.
4. Hospitals only; highest category 80+
5. Nursing Homes and Residential Homes; age groups are 67+,67-79,80-89 and 90+.
6. Residential Care Homes only
7. Elderly population in communal establishments.
8. Elderly population usually living in non-private dwellings
9. Long-term Hospitals, Nursing Homes and Residential Homes

Table 4. **Proportion of elderly people[1] receiving home help**

	Year	%	Source
Australia	1988	**7**	Sundström, 1994 (from DHHCS, Canberra).
Austria	1987	**1**	Sundström, 1994 (from micro-census).
	1991	**3**	OECD Questionnaire.
Belgium	1989/90	**6**	Sundström, 1994 (from Kuty and Pacolet, 1991).
Canada	1990	**2**	OECD Questionnaire -- General Social Survey; % receiving help with housework from organisations.
Denmark	1962	**3**	Sundström, 1994 (from Shanas et al., 1968).
	1985/6	**20**	Sundström, 1994 (from Daatland, 1990).
	1990	**22**	OECD Questionnaire; Secretariat estimate of age 67+ receiving home help.
Finland	1980	**22**	OECD Questionnaire.
	1990	**24**	OECD Questionnaire.
France	1983	**2**	Sundström, 1994 (from Attias-Donfut and Rozenkier, 1984).
	1985	**7**	Henrard, 1991.
Germany	1992	**1-3**	EC Observer -- various surveys (p. 64).
Ireland	1987	**3**	Sundström, 1994 (from O'Shea, 1991).
	1990	**3**	EC Observer -- official statistics (p. 95).
Italy	1986	**1**	Sundström, 1994 (from Mengani and Gagliardi, l991).
	1988	**1**	EC Observer -- from ISTAT (p. 56).
Japan	1990	**1**	Sundström, 1994 (from Social Development Research Institute, Tokyo).
Netherlands	1986	**6**	Within last year: Kraan et al., 1991.
	1990	**8**	EC Observer -- administrative statistics (p. 79)
New Zealand	1993	**1**	OECD Questionnaire; number of elderly people receiving Home Support Subsidies.
Norway	1980	**17**	OECD Questionnaire; age group 67+.
	1992	**16**	as above.
Portugal	1992	**1**	OECD Questionnaire -- IGFSS.

Table 4 (continuation). **Proportion of elderly people[1] receiving home help**

Spain	1985	**1**	Sundström, 1994 (from INSERSO, 1985).
	1994	**2**	OECD Questionnaire; includes public, private non-profit and private home care services.
Sweden	1962	**6**	Tornstam, 1992.
	1983	**21**	Tornstam, 1992.
	1985	**19**	Within last year: Kraan et al., 1991.
	1991	**16**	During 1991: Swedish Institute, 1992.
		12	At one time: Sundström, 1994 (from Statistics Sweden).
United Kingdom[2]	1962	**5**	Sundström, 1994 (from Shanas et al., 1968).
	1974	**7**	Evandrou et al., 1990 (from GHS).
	1979	**9**	As above.
	1985	**9**	As above.
	1991	**9**	Goddard and Savage, 1994 (from GHS).
United States	1990	**4**	OECD Questionnaire; includes any home-delivered professional nursing, personal attendant, or homemaking service,except meals on wheels.

Notes:
1. Aged 65 or over, unless otherwise specified.
2. Data refer to Great Britain.

Note on sources:

Sundström, 1994: For full details of sources see bibliography in G. Sundström, "Care by Families: an overview of trends", in OECD (1994), Caring for Frail Elderly People: New Directions in Care, OECD, Paris.

OECD Questionnaire: Replies to questionnaires on care of the frail elderly circulated by the OECD Secretariat in October/December 1991 and in November 1993.

EC Observer: National reports of the European Observatory on Social and Economic Policies and Older People, published by DGV, European Commission, Brussels in 1993.

Kraan et al., 1991: R J Kraan and 7 others, Care for the Elderly: Significant Innovations in Three European Countries, Part III, Appendix 1, published by Campus Verlag, Frankfurt am Main, and Westview, California.

Other sources: See OECD (1995: forthcoming), Caring for Frail Elderly People: A Comparative Review of Social Policies, OECD, Paris.

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