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EUROPEAN SOCIAL POLICY FOR THE ELDERLY

« Personne ne peut croire que la conduite d'une économie est une chose simple. Peut-être sommes-nous, en fait, arrivés à un point où il manque un idéal pour définir une telle conduite de gestion. » J.K.GALBRAITH (Pour une économie meilleure)

1. INTRODUCTION

The concept we have of old age and our attitude towards it have a great impact on the principles guiding old age policy. As Cicero wrote it[1], one should not separate old age from life itself; it is a part and parcel of it, and one should, above all, manage this field, which indeed is wider than before, on account of longer life expectancy.

A first observation is that old age by no means coincides with retirement. Of course, there is a reality that has to be taken into account: a number of people, among other things, as they get older, find it more difficult to live on a day-to-day basis; this is the whole question of the risk of physical or mental dependency. Nevertheless, it should be avoided to develop the sense of fear concerning the ageing of the population: a large number of people will keep for a long time the possibility of living without having to depend on others; old age and the services to society can be conjugated in all tenses and very often the moral, emotional, financial contribution and services help the descendants.

But the great current debate, in most countries, on account of social, political and economic changes, is about the end and means of our economies as regards social welfare. The latter has a direct repercussion on the principles guiding old age policy: according to the political philosophy of the states, the risk of dependency will be either a matter of family solidarity or a matter of community responsibility, or both at the same time. Some political regimes are developing the idea of a State whose social policy is reduced to the minimum, concurrently with a maximum economic competition; other regimes, on the contrary, consider that economic efficiency can still rhyme with social solidarity.

2. GENEROUS IDEAS

From, doing research and comparing the solutions contemplated in our different states, it is, beyond all doubt, possible to specify, strengthen and bring closer together political and realistic strong opinions, in order to encourage optimum use of human and social resources and give back its aura to old age.[2]

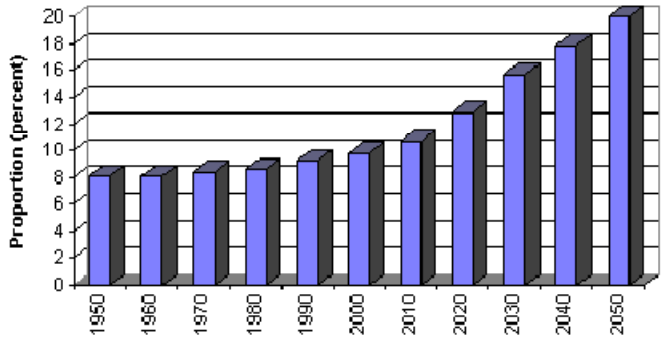
But for different reasons, one of which being an ageing population on a global scale[3], a very open discussion on the matter took place within the great international organisations rather than at the level of national studies.

I found it appropriate to bring closer together the targets of the big international organisations such as UN, WHO and the Council of Europe, on the eve of the third millennium, and then, to see where the European Union stands in the protection of the elderly. Indeed, for the past twenty years, such organisations have shown a special interest for the ageing of our populations.[4]

First and foremost, they tackled the problem of assessing the proportion of elderly people; and their conclusions on global ageing are much more spectacular than any national statistics.

World population: Proportion of the Elderly (60 years old and over)

Evolution 1950 - 2050



Source: United Nations : Division population: World population prospects (The 1994 Revision)

They did a great deal of research on ageing, on the one hand and on the protection of the elderly, on the other. It is clear that the organisations strove to define coherent policies on the subject, instead of considering that such policies were the exclusive responsibility of the different states. Everything has been searched, thought of, proposed and written in this field, in a great ethical, social, political and economic reflection. Last year, in particular, these international organisations have declared 1999 International Year for Older Persons; they drew up many full and accurate reports, which give an overall picture of ageing.

All these documents represent an important moral guide for the working-out of policies relating to the elderly. However, our different states are the only ones responsible for the rights and protection of their elderly citizens. And we shall see that despite all international research and reports, very often what is lacking at the national level is a global view of the social end budgetary questions, of the elderly themselves, and of the relations between generations in the society. This different perspective gives rise to excess budgetary expenses, an opposition between the

working and non-working population, and a rejection, at last in people's attitudes, of elderly people.

On the eve of the 21st century, it is indeed urgent to turn to better account the modern scientific assets and the experience acquired in the working-out of our social policies. We will give an example of this later by examining the social policy of the Council of Europe towards the elderly. Then we will see in a more precise manner what the rights of the elderly dependants are and, among them, those suffering from Alzheimer's disease, considering that, in the face of such a disease, the difficulty of providing for everyday life is at its greatest, both for the patient and for his family circle.

With these considerations in mind, we shall see if there is an European political will as regards a public health common policy and, if there is none, we shall see if the national trends within the Union make it possible to reconcile an adequate protection of these patients with a rigorous allocation of resources.

2.1. *United Nations*

> *«The elderly have to be encouraged to regard themselves as actors in their lives and in the running of society, and not merely as passive and needy people. »* Ambassador J.T. ALVAREZ from the Dominican Republic (Message to the United Nations on the occasion of the launching of the International Year of the Older Persons)

By their Resolution (47/5), the General Assembly of the United Nations decided that 1999 would be the International Year for Older Persons-IYOP, the aim of this initiative was to promote a society for all ages.

In this way, the importance of the ageing of the population is solemnly recognised and at the same time the expectations and the promise of well-thought-out social, economic and cultural policies, and in particular on the ethical level, in order to maintain world peace and development in the new century.

The main UN contribution has been to set off an important reflection on the elderly person's status and to take into account the problems deriving from the global ageing, and in particular the very precarious situation of many elderly people.

This very dynamic approach has placed the work towards the elderly within the framework of global ageing. The UN instruments represent a precious source of inspiration and orientation of the public policies dedicated to ageing and the elderly people.[5] The UN draws the attention of the states to the situation of elderly people, who, contrary to women and children, are not covered by an international convention aiming at protecting their rights.

First of all, the 62 recommendations of the UN Plan of Action on Ageing represent a comprehensive basis on which to build a general and integrated social policy in our societies[6]; they are very general but in most cases, they are still up to date:

List of the UN recommendations on Elderly People (1982)

- Health and food: Recommendations 1-17
- Protection of elderly consumers: Recommendation 18
- Housing and environment: Recommendations 19-24
- Family: Recommendations 25-29
- Income and Employment Security: Recommendations 36-43
- Education: Recommendations 44-51[7]

Secondly, the general principles of a policy on Old age (« UN principles for the Elderly ») were adopted in the UN General assembly resolution (46/91 by the 16th of December 1991.

The various governments were encouraged to integrate into their national programs the principles advocated in this text, the main points being the following:

UN Principles for the elderly (16.12.1991)

- Independence: to be able to live at home, to have adequate income
- Participation: to be able to share one's experience and knowledge, to take part in the definition and implementation of the policies concerning them
- Care: to have access to medical care, to social services, respect of human rights, of fundamental liberties
- Personal fulfilment: to have access to cultural and spiritual resources
- Dignity: to be treated with justice, respect.

A conceptual framework and an operational framework were carefully defined for 1999 and for the future/

Four dimensions of the conceptual framework (1999)

1. Situation of the Elderly: to develop a positive and active way of looking at ageing.
2. Fulfilment of the individual throughout his whole life: to encourage initiative-taking
3. Inter-generation relations: this is the whole theme of the inter-generation concept[8]
4. Population growth and ageing: how to ensure that there is a favourable environment for inter-generation exchanges, how to ensure continuity between the flats for elderly people and long-term care institutions integrated in the community.

The operational framework, defined for 1999 and beyond, is conceived to facilitate the integration of the planned activities and to provide for their duration:

Four dimensions of the operational framework (1999)

1. *To increase public awareness of the 1999 theme*: a society for all ages, the UN proposing an ideal based on a society open to all generations [9] [10]
2. *To encourage a vision of long-term and global priorities*, which requires an integrated process, within the framework of a global economic and social policy.
3. *To mobilise the non-traditional actors*, the media, the private sector, young people, etc.: indeed, if elderly people are not, strictly speaking, outcasts, national development programmes tend to make them invisible. The media (for instance, the press) can play a major role in making the public aware of the problems of an ageing population, and is helping to neutralise ageing-related remarks and behaviour[11] However, there is another pitfall to avoid: the promotion of active ageing necessitates a middle course between being marginalized and a policy of activity which risks imposing too strong a pressure on the elderly.
4. *To improve the research networks*, the exchange of information and co-operation within the great world networks that now cover all continents.

For the future:

- The United Nations underline that, over the next two decades, two of the great trends will be fast-growing ageing in the developing countries and a great proportion of elderly people in developed countries.
- They contemplate the possibility of drawing up a long-term plan going up to the year 2020
- They recall that the implementation of the International plan of action on ageing depends, at the national level, on the presence and functioning of a national infrastructure supporting policies and programmes connected with ageing.

2.2.The World Health Organisation (WHO)

The World Health Organisation (WHO) [12] urges the members, as the XXIst century was drawing near, to take measures for better health. In its press release WHO/99/WHO dated 5th May 1999, it launches a project to « Help people to remain active as they grow older ».

On the 7th of April 1999, declared World Health Day, WHO chose to join in the International Year for Older Persons by making « Active ageing makes the difference » the theme of the day. Dr Gro Harlem Brundtland, its Director general, declared, in the message addressed on that occasion that *« health and the quality of life*

throughout the existence strengthen the capacity of people to fulfil themselves, to build a community where the different generations live in harmony and build a dynamic economy. »

In its World declaration on health[13] WHO asserts, on behalf of the world community, that « the improvement of the health and the welfare of the people is the ultimate goal of the economic and social development. We set a high price on the moral values of equity, solidarity and social justice [...], and we recognise that to develop the world health situation, we must put into action the « policy of Health for all in the 21st century. » by the implementation of appropriate regional and national policies and strategies. »

For WHO-Europe, 870 million people are concerned, being the citizens of 51 states.[14] The Programme HEALTH 21 (« Health for all in the 21st century ») enables to take up this challenge by implementing the best strategies which result from the collective experience acquired by Europe for the past 10 to 15 years.
It is within this framework that Goal number 5 stands:

Healthy Ageing

« Health policies should prepare the individuals to healthy ageing, by a planned and systematic action to promote and protect health throughout the entire life span. The possibility of fulfilling oneself in the social, educative and professional spheres, as well as physical activity, improve the health of the elderly, their self-esteem, their independence and their active contribution to the society. It is particularly important to set up new programmes to enable them to maintain their physical strength and to correct visual, auditory and mobility deficiencies before they lead to dependency. Community-based health care services should contact elderly people to help them in their daily life. More and more their needs and wishes as regards housing, income and other factors that increase their autonomy and their social productivity should be taken into account. »

WHO's aim to « take care of health » throughout the entire life span in order to ensure healthy ageing is worthy of interest. It is a matter of long-term prevention of dependency, of holistic health care, in order to remain autonomous. The philosophy behind HEALTH21 is based on explicit ethics:

The three fundamental ethical values of HEALTH21

1. Health is a fundamental human right.
2. Equity as regards health and a working human solidarity[15] among and within the countries and among the inhabitants.
3. The participation and the responsibility of individuals, groups, institutions and communities for sustained health development.

So WHO Europe emphasises quite surprisingly that the ethical aspects as regards health are of paramount importance. Like WHO, they base the health policies on a

precise set of values, and they refer explicitly to the Universal Declaration on Human rights.

2.3. *The Council of Europe*

The Council of Europe wanted to be associated with the United Nations initiative towards the elderly, on account of its experience and knowledge, as regards the protection of human rights and more particularly the rights of the elderly[16] taking into account the challenges of the globalisation of economy and of social reforms under consideration. Among the recent profound changes of the modern world, the most important is probably the ageing of the population.[17]

Declaration of the Council of Europe
Parliamentary Assembly

- declares that such changes[18]are fraught with threats for Elderly people and social cohesion
- underlines that protection is only one aspect of the reflection on the future of the elderly.
- proposes a process with three aims : Protection, Participation, Promotion ; these three themes are indissociable, as for instance participation can only occur if elderly people do not feel the burden of threats towards them and if they are given a sense of dignity, through another image of themselves[19]

One of these major themes, Protection, and more specifically Dependency, has been the subject of a Recommendation[20] of the Ministerial Committee of the Council of Europe[21]

Recommendation on Dependency

« *The Committee of Ministers...*
Considering that the respect of the autonomy principle of the dependant must guide any policy in favour of the dependants ;
Considering the cover of the dependency risk should be an integral part of any social security system ;...
Recommends to the Governments of the Member States :
To see to it that public opinion is made aware of the set of problems relating to the dependency as they appear in this recommendation ;
To direct the political measures in this field according to the principles under-mentioned ;
To ensure that legislation takes into account the general principles and measures attached to the present recommendation or to adopt provisions consistent with these rules when they introduce new legislation. ;... »

Therefore it cannot be denied that the Council of Europe has not been blind to the ageing of the European population ; on many occasions, it has played the part of forerunner and mover in research on the subject and has encouraged the states to take up the major challenge of old age dependency. The original feature of its approach is putting the question into a future perspective.

The recommendation on dependency underlines, among others, the principle of freedom of choice, which is of paramount importance in order to guarantee the respect of dignity and the self-determination of the dependant. This choice must be free and well-informed, which supposes, on the one hand, accessible, objective and complete information and implies, on the other, that care must be provided both at home and in institutions (priority being given to home care); this choice calls for the intervention of public authorities with some degree of financial contribution which, corresponding to the level of dependency, compensates the financial cost entailed by dependency and this has to last as long as necessary ;

The second principle lies in the importance of prevention and rehabilitation, as dependency is not a priori a permanent but evolutionary state ; a coherent policy has to provide for a system of rehabilitation, bearing in mind that the principle of non discrimination, as far as access to care according to age is concerned, should be respected.

Rights of the Elderly to social protection

« In order to ensure the right of the elderly to social protection, the Parties undertake to take or promote, either directly or in co-operation with public or private organisations, appropriate measures with a view to :

1. *enable the elderly to remain as long as possible full members in society, with*
a) adequate resources to enable them to have a decent life and to take an active part in the public, social and cultural life ;
b) the circulation of information concerning existing services and facilities for elderly people and the possibility for them to have access to them ;
2. *enable elderly people to choose freely their way of life and to lead an independent life in their usual environment as long as they want and as long as possible, with :*
a) housing that corresponds to their needs and their state of health or adequate help to fit out their house ;
b) medical care and services corresponding to their state
3. *to guarantee appropriate care to elderly people who live in institutions, respecting their private life and participation in determining the living conditions in the institution.*

2.4. *The European Union*

The European Commission published, on 21 May 1999, an important communication, entitled « Towards a Europe for all ages - Promoting prosperity and solidarity between the generations »[22] This communication aims at enlivening the debate with the member States and among them ; it presents the implications of ageing in Europe for employment, social protection, health and social services. It

proposes a strategy including efficient political measures in these fields, based on stronger co-operation among all the actors, and on solidarity and equity among generations.

This program shows the Commission's interest for ageing-related problems and for the different answers to this challenge ; it has the merit of tackling the great issues relating to ageing.

2.4.1. The Commission wants to adapt employment policies to ageing :

Ageing and Employment

« The first aspect is the relative decline of the labour force and the ageing of manpower. Radical changes will take place in the next twenty years. In the period from 1995 to 2015, the age group of those between 20 and 29 will lose 11 million individuals (-20%) whereas 16.5 million people (over 25%) will be added to the age group of those between 50 and 64. It is therefore necessary to emphasise the ageing issue in the management of human resources, a factor that has been neglected so far. This means as well a rethinking of the policies which, instead of promoting new outlets and training throughout the entire life span, encourage leaving the labour market too early. »

2.4.2. It considers it necessary to adjust retirement pensions to ageing :

The imperative of intergeneration equity

« The second aspect is the pressure exerted by the number of pensioners and the decrease of the working population on the organisation of pensions an on the Treasury. In the next twenty years, the number of people over retirement age, i.e. over 65, will increase by 17 million. Within this group, the number of very old people (over 80) will increase by an additional 5.5 million people. Intergeneration equity requires to pay more attention to the long-term viability of public expenses. A larger basis for social security systems must be provided for thanks to a higher rate of employment for those of an age to work. Moreover, retirement schemes should be made less sensitive to the population growth and other changes. »

2.4.3. The European Commission declares that the needs for health and care should be met by healthy ageing. It insists on a preventive approach rather than a curative approach, on rehabilitation facilities, on the improvement of access to treatment for all, on the quality and quantity of care to very old and fragile people.

Needs for health and care.

« There is a growing need for medical care and general care of the elderly. The big rise in the number of very old people who need care will exert a growing pressure on

the systems of professional care, which will have to be developed to face the new situation.
Currently, it will be necessary to develop policies aimed at limiting the increase in the number of dependants by promoting healthy ageing, preventing accidents and by post-disease rehabilitation ».
To this effect, *« the Commission will turn its attention to social and medical research related to ageing within the framework or the fifth programme of the European Community research. A key-part of this programme, with a budget of 190 million euro, covers in particular population ageing and handicaps. Such action aims at supporting multidisciplinary research, technological development and applications as regards : the demographic, social and economic aspects ; treatment leading to the postponement and the improvement of the handicap ; an efficient and not too costly allocation of medical and non-medical care to the elderly, by including comparative research in the funding of care and retirement ; preventing and treating age-related diseases and handicaps.*

2.4.4. The Commission underlines also the risk of exclusion for the elderly :

The Elderly and risks of exclusion

One can see « *the growing diversity of the resources and the needs of the elderly. The situation of the latter as far as the family, housing, education, health as well as income and wealth are concerned represents a major factor for their quality of life. Fortunately nowadays a great majority of old people are well off. Nevertheless, the fact that most elderly people benefit from better conditions than in the past should not make us blind to the permanent risk of social exclusion and age-related poverty. »*

2.4.5. These different aspects of ageing problems have led the Commission to formulate political conclusions. These are very important. Among them, I will mention the conclusion concerning health policies, care for elderly people and associated research, which derives directly from the above-mentioned observations :

Political conclusions of the European Commission

« *In the fifth programme of Community research, the Commission will give a special attention to medical and social research relating to ageing. This will cover a large scale of activities including fundamental, technological and social research. The health aspects of ageing are equally at the centre of the work aimed at developing public health instruments at the Community level. Finally, The Commission will support the efforts made by the Member States to formulate adequate answers to ageing in the field of health and care by studies on the functioning of the different systems.*

On the other hand, the Commission has also undertaken to encourage the debate on the demographic influence on our societies, while promoting an «Europe for all ages », anchored in a strong sense of solidarity and equity among the generations. The Commission, as a conclusion, adopts important options formulated as follows :

Options of the European Commission :

« Considering the extent of the demographic changes at the dawn of the 21st century, the European Union can and has to modify the obsolete way of treating the elderly. Both on the labour market and after retirement, it is possible to facilitate and strengthen the role of the elderly who have embarked on the second half of their lives. The competence of the elderly represents a huge reserve of resources, which, so far, have not been sufficiently recognised and resorted to. Policies and adequate services of health and care can prevent, push aside and minimise the dependency of the elderly ; moreover the demand for these services will create new outlets as far as employment is concerned. »

« All generations could draw a major benefit from political changes aiming at enabling the elderly to become or remain more active and encouraging them to do so. The adoption of measures of encouragement can motivate a larger number of elderly people to opt for active ageing, and so to reduce their dependency and disability. This would contribute to reconcile the deep wish of the elderly to live a longer and better life with the legitimate preoccupation of society as to the means of minimising the cost of world ageing ».

One can only be too pleased to see the European Commission play an essential and important part in the definition of the old age policy of the Member States and appeal to the contribution of all. The formulated trends go in the direction of the respect of dignity of the Elderly : they are in perfect harmony with the options of the UNO, WHO and the Council of Europe and they underline that ethics must be at the basis of our social policies on the subject.

Researchers cannot ignore the importance of the budget to be allocated : let us remain that the above-mentioned key-action is supported by a budget of 190 million euro .

3. THE SOCIAL EUROPE

If the social Europe exists as a legal construction, we have, nevertheless, no option but to note that it is treated like a poor relation in the Community construction[23]. This being said, the European Council, in its Cologne meeting, on the 3rd and 4th of June 1999[24] has associated Mr Romano Prodi, appointed President of the Commission to its debate in order to tackle some fundamental questions concerning the European policy in the next years ; among the conclusions, two of them are of particular significance for the elderly : indeed they relate to :

1. A Charter of the European Union fundamental rights :

   « The European Council considers that at this stage of the Union development, it would be appropriate to put the fundamental rights in force in the Union into a charter, in order to ensure a greater visibility ».

2. An agency for Human rights :

> « The European Council records the interim report of the Presidency on Human rights. It proposes to examine the opportunity of setting up a European Union Agency for human rights and democracy. »

In spite of this undoubtedly interesting progress, one can wonder whether from now on there is a social European citizenship, likely to serve as the backbone of a « Federation of Nation-States » according to the expression of Jacques DELORS [25] as there are no compelling provisions in the European Union in terms of the protection of the elderly (for instance, as far as chronic diseases or dependency are concerned).

In fact, the trend of the European construction towards social competence is a long march whose significance has to be correctly measured :

3.1. *From the Treaty of Rome to the Treaty of Amsterdam*

The constitution of the European Union, established on the 1st of January 1958 by the Treaty of Rome, was essentially based on economic considerations, a long distance away from a Community labour law and social protection ; nevertheless, right from the beginning, the Treaties included social aims and objectives, even though, in the mind of those who drew up the Treaty, such expectations were to result from the very functioning of the common market, and the economic prosperity that would derive from it. Such views account for the small number of social measures that were taken until 1985.

It is the European Single Act that re-launched the drawing up of European social laws, by making it possible to adopt in some fields[26] guidelines by a qualified majority (instead of unanimity) ; but it is only in Maastricht, in 1992, that an agreement on the social policy of 11 Member States will be appended to the treaty[27]; this agreement has given a new impetus to the social policy by extending the Community competence, and by increasing the number of fields that can be voted on by a qualified majority. And the integration of this text into the Treaty will have to wait for the Treaty of Amsterdam of the 2nd of October 1997, so establishing the existence of a « minimalist » social Europe.

Currently, the member States still show strong philosophical differences in terms of social policy ; the consensus on a European social model is far from being reached, because of the traditions and models inherited from their national history, and belonging to different cultures of solidarity. Yet, one can note convergence, and it is admitted that social cohesion is a major factor of a powerful economy, and that social conflicts would jeopardise a large single market. For François Martou, « social security is the precondition of an efficient economic policy, and not a cost. Because the development of a society is only effective when a project associates everybody and where there is the be0lief that there will be better living conditions for everybody. »[28]

But this observation is not enough to establish a social policy ; if one refers to the initial way of considering the social policy in the Treaty, « the improvement of living conditions must very naturally result from the gradual setting up of the common

market », the British refusal to be associated in Maastricht with the development of a European social dimension is a good example of this.[29]

Let us add that the change in the economic situation from 1990 as well as the convergence requirements in terms of public finance with a view of creating a single currency had modified to a large extent the interest of the governments for the development of a social Europe.

3.2. *Difficulties of social integration*[30]

3.2.1. *The European competence in the social field*

The study of the Community protection in terms of the dependency of the elderly suffering from chronic diseases shows the limits of article 152 of the Treaty (article 129 before). This provision had opened the way by partially remedying the competence gap in terms of social policy and by establishing Title X « Public health ». Nevertheless, because of the exclusion stated in paragraph 4 of this provision, the competence of the European Union is very subsidiary and only the Member states can legislate on the subject. After eight years, this provision has become obviously inadequate : today the requirements in terms of health protection have become part of the other Community policies. It is therefore a question of institutional development ; though it is incomplete, it is quite spectacular and it points to an evolution of the basic principles.

3.2.2. *Meaning of these difficulties*

The reference to two major historic models (the German Unifications of 1871 and 1991, and the USA development at the dawn of the XXth century) makes it possible to understand better the difficulty of establishing an integrated European social policy.

The 1871 German integration does not correspond to the « standard » Anglo-Saxon model of the evolution of law, proceeding from the right of the individual, developing into political rights, and culminating in social rights : in 1871, the King of Prussia crowned emperor at Versailles initiates the integration of his empire through social reforms ; by doing so, his Chancelor O.von Bismarck gives the working class a social citizenship and amalgamates all the Germans into one single nation knitted together by social security. The 1990 reunification is a repeat of the 1871 integration, but at a much faster pace.

The American integration, on the contrary, first established the civil rights, and then the political rights and only tackled the social rights in the end : indeed, if the civil and political rights are much emphasised in the United States, social rights are less developed than elsewhere, the social field has only been within the federal competence since the great depression of the thirties, with the establishment, under Roosevelt, of a partial social security (for instance, with retirement schemes). Therefore, it can be said that the social citizenship, in the United states, has never

come of age : as the federal State has only inherited a limited social responsibility, a total lack of continuity is a constant feature in the development of social policy. The bitter political conflicts for the reform of sickness benefits illustrate this.[31]

The system of medical insurance resulting from these options is probably, among the industrialised countries, the system which is the furthest away from the Bismarck system, insofar as it is based on private insurance and social aid, and insofar it does not, far from it, provide an identical protection for all citizens ; fortunately, some States like Oregon or California endeavour to improve the medical insurance of their citizens.

The option of the United States can seem strange, but it is certainly coherent insofar as social rights are not fundamental ; as to the European Union, it will have, in the XXIst century, to take up the challenge of social cohesion in a more vigorous way and at a faster pace than the United States did it in the XXth century.

The USA have developed a highly integrated political structure that Europe has not attained yet, with the result that the « breaking points », on each side of the Atlantic, are different : in the USA, there is a breaking point between civil and political rights, on the one hand, and social rights on the other, and social citizenship comes as a last right ; in Europe, there are two breaking points : the first one between civil and political rights, which explains the delay in political integration, and the second one, in relation to social rights.

History will tell us whether the European Union will follow the Anglo-Saxon model[32] [33]of successive forms of citizenship or a model of integrated social citizenship [34]comprising individual, political and social rights.

This latter development, which would be desirable insofar as it would maintain social cohesion in the face of the globalisation of the economy, would, nevertheless, necessitate a new drawing up of the Treaty and favourable circumstances, which presently seem uncertain.

3.3. *The European Union, Dependency and Alzheimer-related diseases*

We can see that in Europe health care policies are very different from one State to another, according to the solidarity commitments of the State. Our social policies today have to face both the ageing of our populations and the stepping back of the State as far as social security is concerned, because of the difficulties encountered by our economies. Is this stepping back of the State in the field of social security a progress ?

Presently, the states still largely benefit from family assistance. As an example of this, one can note that family solidarity in France occurs for 2/3 of the budget spent by social security. Thus there is a « profit », or a lesser cost, which is obvious as far as the State budgets are concerned. Now one can see that some States make the families bear a large part of social cost ; rather than that policy and with the Alzheimer disease very likely to be on the increase, it would be appropriate, if the States want to go on benefiting from family assistance, that they encourage and support the family in their action.

Indeed, in most of our countries, the psychological and financial responsibility is borne almost exclusively by the families concerned. It seems that these families cannot, in general, and will not be able in the future, to ensure on their own an obligation that is also a collective obligation of solidarity.

There is a connection between family ethics and the management of public money : the very cohesion of our societies is at stake and progress in that field will result from global political decisions.[35]

3.3.1. *General situation of the people suffering from senile dementia (Alzheimer and related) and of their families.*

With the present scientific knowledge on the Alzheimer disease, it is not possible yet, despite the expectations that a number of discoveries aroused, to define a curative strategy. Therefore one can do nothing but see that the effort must be aimed, as a priority, at the patients' daily well-being and at all that can improve the patient's quality of life, family and carers' support[36] on the one hand, and on the other contribute to control expenditure. Solutions have been found between social solidarity and family solidarity.

3.3.2. *Political philosophy in the public health field.*

One can note that, with identical needs, the way of meeting the needs can largely vary from one system to another because of different health and social policies and practical approach. Some States develop specific policies adapted to the situation of that type of patient ; others, while spending a great deal, do not meet the person's needs so well.

The responsibility for the political questions regarding the health protection systems varies from one State to another : for some States, this protection will be the responsibility of the Central State, like national defence, education or public health ; to illustrate this, we will examine later the situation in Sweden. Other States establish a radical distinction, legally and administratively, between disease in the strict sense and care and services to the dependency resulting from disease[37].These States fund medical, health and social protection within the framework of social insurance ; care and services to dependency depend then, generally, on different funding and administrative structures. It results from this that the integration of care and social services, which is necessary, are then jeopardised by a difference as to the structural responsibility. Problems of co-ordination between social and medical services, between hospital and community services arise ; and so an area, which is not covered by social security, can emerge[38]

3.3.3. *Situation of informal carers*

Families, generally, are a major contributor of aid to a relation suffering from cognitive disorder[39]. However, it should be noted that the possibility of care within

the family is considerably reduced as the birth rates decrease and the women's participation in the labour market increases : these two changes account for a significant reduction in the number of people available for the supply of informal aid. Moreover, as the number of people needing support increase (see Table I), as volunteers are fewer, as professional services are inadequate, the demand for care in special homes and in specialised hospitals will be stronger, with all the human and financial consequences resulting from this change.

Table I: Present number of people suffering from dementia- Estimation at the down of 2000

Countries	Population over 65 (1990)	Number of people suffering from dementia (1990)	Estimated population of over 65 (2000)	Estimated population of over 65 suffering from dementia (2000)
Belgium	1.468.400	110.130	1.691.126	126.834
Denmark	796.300	59.722	790.851	59.313
France	7.843.400	588.255	8.839.728	662.979
Germany	9.581.400	718.605	10.843.467	813.260
Greece	1.210.000	90.750	1.667.636	125.070
Ireland	396.100	29.707	399.741	29.780
Italy	8.311.300	623.347	9.442.529	708.189
Luxembourg	50.600	3.795	57.895	4.242
Netherlands	1.896.500	142.237	2.055.178	154.138
Portugal	1.354.500	101.587	1.364.470	102.335
Spain	5.145.300	385.987	5.877.599	440.819
United Kingdom	8.825.586	661.918	8.940.204	670.515
TOTAL	46.879.386	3.515.950	51.970.424	3.897.774

Source: European Parliament, Report on Alzheimer disease, by D.Poggiolini, 26.2.96 Meeting document A4-0051/96, PE215.515

Therefore there are options to be taken for our public health policies. Chronic diseases, among which senile dementia, represent as to the great number of patients and the greater cost, a new basic financial risk for social security ; it is a major risk of the existence linked, at the present stage of medical knowledge, with longer life. This new long-term risk is a question of political choice in a number of countries. The Alzheimer disease, and resultant dependency, mean a gradual process of long term needs for care ; this long term requires a flexible integration of aid, medical care and social services. Only an integrated insurance for both risks, medical and social, will guarantee that the person gets non-stop services without being the victim of quarrels between the two various funding agencies.

Presently, only a few countries have undertaken to cover adequately long-term care and services for the patients suffering from the Alzheimer disease. Some States, influenced by a deregulating trend existing on the other side of the Atlantic, try to find commercial solutions to the problem of long-term care and services.

3.3.4. *What is the attitude of the European Union on the subject ?*

Facing that situation, the European Union was concerned about the inertia of public national and international authorities. The European Parliament had considered that the Alzheimer disease (and related syndromes) had to be regarded as a major scourge under article 129 of the Union Treaty. The European Union had recorded the inadequacy of the political and financial commitments of the Member states for a coherent action to control the disease.

A concrete and formal step of the European Parliament was the A40051/96[40] resolution to improve the protection of the people suffering from the Alzheimer disease ; the resolution was unanimously adopted on the 17th of April 1996.[41] It will be noted that a dynamic process started at that time, through contacts and efficient co-ordination, in particular with a main office « Alzheimer Europe », and that even a Community programme was developed to remedy the inadequacy of some member States[42]

3.3.5.National Policies

Sweden

Sweden is a good representative of the Scandinavian systems of public health protection of the patients suffering from senile dementia (including Alzheimer and Alzheimer-related dementia). These systems have been developed for a long time and are constantly improved for better efficiency and respect of budgetary requirements.

There are distinctive features in the Swedish system :
Sweden has one of the highest rates of elderly people in the world, and at the same time, it has a very limited proportion of people available for non-medical support at home (in 1989, 81 per cent of women work for a living).

The Swedish state is responsible for ensuring equal access to all benefits, whatever the income or the place of residence. Practically all aid and care for dependants is distributed by the public system and funded by public funds. There is a national legislative framework, which defines the type of services to be distributed, and the way they have to be organised. ; but aid, care and services are adjusted as closely as possible to the person's needs. Moreover, one can rely on duly trained and qualified staff.

It is to be noted that the formal well developed resources under the responsibility of the public sector represent invaluable support for the family, which then can

continue with non-medical aid to a dependant relation[43] [44] Furthermore, the law on « care for the elderly » adopted by Sweden in 1990, makes carers' support one of the major objectives of old age assistance for the decade.

This policy provides for economic assistance as well as services that respond to the carers' needs in the most satisfactory manner ; it integrates also a measure that was already implemented in 1989, which grants a loan to take care of related dependants ; the cost of that loan is funded by sickness benefits in the case of emergency care or the final stage of life. In the case of long -term care, the cost is funded by the local government or by local taxes. When the condition of an elderly person requires constant care and attention, a member of the family may be employed by the local government within the framework of a job as a paid carer.

Finally, the new law encourages the development of services primarily meant for the support of the carers. This new priority, i.e. the support of the carers, makes the local authorities of the health and social sector responsible for the economic support of the carers. In future, the emphasis is laid on the complementary character of medical and non-medical care. It has to be noted that in this way the importance of institutions can be significantly reduced for the benefit of home care policy, which is favourable both on the humanitarian and on the expenditure levels.

Prospects : In order to meet the increase in the number of dependants and the increase in resulting care and services, Sweden has adopted the following policy :

- rationalising measures in the management of institutions ;
- increased efficiency in the organisation of formal services ;
- support and development of informal aid services.

It can be said that the medical, health and social policy of Sweden is a very satisfactory answer to the major society problem that the Alzheimer disease and other forms of dementia represent. This same model of social democracy can be found in the four countries of the Nordic Council (Sweden, Norway, Denmark, Iceland), an institution that has greatly contributed to the development of good practices in the field of social protection. It corresponds to the real needs of the person suffering from cognitive disorders so well that their study is particularly interesting for those who try to adapt their systems of health and social assistance to old age requirements of our populations and to the growing number of persons suffering from the Alzheimer disease.

Germany

Germany, confronted with an ageing population and the repercussions on the health and social policy of assistance to people suffering from senile dementia, has taken a major turning point in its assistance to patients suffering from chronic diseases (a category to which senile demented people belong to).

Before this important 1994 reform, the German system defined the rights and conditions of access to care services by basing them on a radical, legal and administrative distinction made between « disease » and « dependency ». The risk of dependency was not covered by the general system of health and social services.

Then it was up to the health and social security services to take over in a number of cases.

The impact of the reform on the type of services offered and on the patient's right to be reimbursed is considerable. It puts an end to the restrictions placed by the local government on this type of services, in view of the lack of obligation to provide social services for chronic patients ; this was a problem, because research made in Germany showed that potential care on behalf of the families was constantly on the decrease.

The German reform, by its law of the 26th of May, 1994 concerning the dependency insurance has created a fifth branch of social insurance, beside sickness, accidents, old age and unemployment benefits. [45]

From now on, the dependency-insurance is therefore an integral part of social security ; it has become a real right, independent of resources and without recovery of the maintenance obligation. The German legislator has considered that the dependant has to be maintained, as much as possible, in his usual environment and he laid down the principle under which caring for people in their own homes has the priority over being placed in a home. In concrete terms, it can be said that now there is a distinction between at home and a home.

This reform is a major turning point compared with the traditional concept of social protection : it claims social progress, via the person's growing protection, while accepting economic pressure, which the system faces by global and long-term calculations, regarded as the most adequate and economical standards.

It has to be emphasised that the German legislator, unlike Scandinavian countries, and in a perspective of financial control, has clearly limited the access to the social benefits of this new insurance.[46] The political decision to make family entirely responsible for a growing number of « minor » dependency cases creates a « non-cover » area, which can be regarded as detrimental to the Alzheimer patients[47] ; therefore in some cases, this concept departs from the patient's real needs, for purely financial reasons.

The great merit of the German government has been to take a clear stand to involve the State in the solution[48] by integrating the insurance into the present system of social security by distribution, inherited from the Bismarck system, so rejecting private insurance for this kind of risk.

In conclusion, Germany has gone in the right direction as far as social and health policies are concerned, and this is particularly favourable to the patients suffering from Alzheimer's disease.

The Netherlands

The Netherlands, which have a system of social insurance, have for social and health assistance to dependency a model which reflects the principle of national responsibility and solidarity. This model found expression since 1968 in the establishment of the national insurance for dependants (Algemene wet voor bijzondere ziektekosten : A.W.B.Z.).

The Netherlands have also introduced the concept of « made -to-measure » care, under which managers, called « care brokers » decide on appropriate care and services and on the appropriate body. This method reduces the expenses of public budgets, develops to the maximum the potential of self help care and enables dependants to stay in their natural environment as long as possible, by maintaining the social networks created.

The above-mentioned A.W.B.Z. law covers dependency as much as at home as in a home. For that reason, it can be said that the patient suffering from Alzheimer's disease is not segregated for age reasons (since the insurance covers dependency whatever the age, the resources and the disease).

Elderly people suffering from Alzheimer's disease can rely

on a model of health care based on the responsibility of a democratic and efficient system ; this responsibility lies with public central powers, which define the broad outlines, whereas the provincial and local authorities are entrusted with the implementation of the policy : it is the Dutch model of decentralisation.

on a general law of special medical costs insurance (AWBZ) in force for almost 30 years, which creates a national insurance that covers the medical, health and social assistance as much at home as in a home for dependants.

Several « White books » (1970-1975-1982-1990) came to specify the protection policy of the dependants while underlining the necessary global approach concerning care and services. Ten years ago, the government, faced as everywhere else with increased health costs, had set up a commission (Dekker project)[49] entrusted witrh the review of a health and care policy in a perspective of deregulation (recourse to commercial insurance). The Simons project was a continuation of this, but, finally, the ABWZ is still implemented today and covers all essential assistance and care and continue giving the patients suffering from senile dementia a complete medical, health and social protection, as much as home as in a home.

Several important concepts on this matter have been developed and have given rise to interesting innovations :

1. Case management : « personalised plans of services », co-ordinated by a person in charge are established for the elderly.
2. Responsible society : efforts are made to develop the work of informal carers (generally, the family) and of volunteers .
3. Substitution : in order to reduce the costs, efforts are made to replace care in institutions like hospitals, day centres, by external services when they are less costly (day care) or by community-based services (home care).

Various pilot projects have been implemented in The Hague and Rotterdam, in particular ; these projects have shown their limits ; so, in the project developed in The Hague, it has not been possible to keep in flats the people suffering from serious psycho-geriatric problems and who are not supervised by informal carers, a typical difficulty at a certain stage of the Alzheimer's disease. These first experiences have highlighted the need for informal help.

Features of informal help :

Research shows that the elderly person's husband or wife represents the most important source of informal help. Other help is provided for by children, relations, neighbours, friends, and acquaintances, a cleaner, a home carer, or a district nurse. It also appears that the number of people willing to give informal help is on the increase, in spite of a priory ideas. The people needing most help are women on their own, with little education and income ; their group often runs the risk of lacking the help they need, either formal or informal. It is therefore indispensable to develop mutual aid.

In the Netherlands, volunteers form two distinct groups : some people work with traditional voluntary organisations, and other work with organisations where services are provided for by professionals. The major problems of these organisations are the ageing of their members and the recruiting of new participants. It is interesting to point out that the idea to introduce for each citizen of 18 and over an obligation to dedicate part of their free time to activities of mutual help has been publicly debated in the Netherlands ; this idea was inspired by a Swedish document « Time to help »(1984) which encourages such measures. In this perspective, the volunteers would take a training course for which local governments would be responsible[50]

One cannot disregard the interest of such an option, considering the problems that the demographic and social evolution will bring to the funding of adequate support services for all, and considering the need to reduce the role of the State.

In conclusion, one can say that the Netherlands as well have favourable rules for the patients suffering from Alzheimer's disease. The studies made by the Dutch underline that the unquestionable basis of a policy of protection of the people suffering from Alzheimer's disease is adequate support of the members of the family, housing adapted to this type of situation, well-trained professional personnel, and by guaranteeing that specialised institutional care for this type of disease will always be available in case of real necessity.

France

So far, the French governments have never succeeded in getting an adequate political consensus stemming for a surge of national solidarity. The « Prestation Spécifique Dépendance » voted on the 4th of July, 1997 remains like a straitjacket.

P.S.D. straitjacket.

- Within the framework of a law of assistance linked up with the resources of the people concerned, and recoverable on succession
- Within the framework of a department, with all the inequalities of the system, due to the different financial possibilities of the departments.
- Within the framework of a defective supply of services, where the absence of true choice means some decline on the social level.

- Within the framework of lower qualifications of the people working in the field concerned.

The lack of coherence resulting from these different limitations to solidarity greatly hinders the implementation of this law, and the present experience indicates that it entails considerable additional cost.

The French situation is completely different from the situations in Germany, Scandinavia or the Netherlands[51], where the State insures the dependency risk by everyone's solidarity. As to the French governments, they go step by step, combining limited arrangements funded by departmental authorities with proposals of private insurance.[52]

Southern Europe

For a long time, the countries of Southern Europe have had a traditional approach of the problem, based on the family duty to provide for their members' different needs, according to a natural obligation of solidarity, which is an integral part of the family institution[53], without any implication or responsibility of the civil society[54];this was completed by the supply of some help from public, secular or religious bodies.

Since the great constitutional reforms of the four countries of Southern Europe (Portugal, Spain, Italy, and Greece), important changes concerning medical, health and social protection have taken place.

Spain, for instance, must be considered as pilot as regards the protection of senile dementia and the resulting dependency : it has radically changed its institutions, following its new political regime, and the constitutional recognition of the economic and social rights.[55]

Since then, Spain has therefore had a regime of national solidarity for all medical , health and social protection. Public authorities organise social services within the framework of article 92 of the Constitution ; Spain offers an integrated programme of dependency protection (El Plan gerontologico nacional 1992), with gerontological plans implemented by some regions (for example, in Catalonia, Pla general de la Gen gran, which contains provisions of global and multidisciplinary protection making possible full assistance to the persons suffering from senile dementia.[56] In addition to public services, associations and foundations, such as the Barcelona ACE Foundation, very usefully co-operate in fulfilling the objectives of the plans.

4. CONCLUSIONS

The different international organisations that we have examined have determined the ethical principles that have to govern the progress of Ageing and Health policies. It is certain that, for a great number of governments, it is imperative to anticipate the ageing of the population and from now on to take the measures that will ensure a decent life for the elderly ; as to the most developed countries their responsibility

concerns essentially the risk of excluding the elderly from society. As to the other countries, the risk also resides in the dangerous disappearance of social and family cohesion : the evolution in the transitional economies of Central and Eastern Europe should attract our attention, considering the future access of some of these countries to the European Union.

On the territory of the present member countries, the European Union occupies a privileged position to promote policies related to ageing : the Amsterdam Treaty and its article 152 is only a weak basis as regards health, but the programmes that the Commission has to implement in its different fields of competence have, from now on, to take into account the obligations deriving from the ageing and the health of the population.

The 1999 documents shows that now, they represent an important aspect of the common social policies in terms of employment, social protection, health and social services.

Notes

[1] *« Old age is, somehow, the last scene of this play which is existence.* » (De Senectute).

[2] DELPEREE,N. : *Les malades d'Alzheimer : Politiques européennes de prise en charge*, RBSS 2nd quarter 1998, p. 283-301

DELPEREE,N. : *Psychiatrie et vieillissement : du droit civil au droit social*, RBSS, 1st quarter 1999,p.89-102

[3] United Nations : Fourth consideration and assessment of the implementation of the international program on Ageing, Chapter *« Ageing of the world population.* » :

« *Over the last years, the world population has continued its remarkable evolution, developing from high to low death and birth rates. At the heart of this transition, lies the increase in the number and proportion of elderly people (see the above chart). This fact, important an generalised growth, represent an unprecedented development* ».

In 1950, there were about 200 million elderly people in the world ; in 2050, there will be 2.000 million of them.

[4] Contrary to preconceived ideas, one can notice a fast growing ageing of the population in the developing countries : in a large number of countries it will only take between 15 and 30 years for this phenomenon to occur whereas this evolution has extended to between 50 and 100 years in the presently developed countries : so the UN points out that it took France 115 years (from 1865 to 1980) to see the proportion of their elderly (65 years of age and over) go from 7 to 14%. In Japan, it was a matter of 26 years (1970-1996) for the same phenomenon ; in Jamaica, it will take 18 years (2015-2033) and in Tunisia 15 years (2020-2035).

[5] Plan of action on Ageing (Resolution 37/51-1982)

UN Principles for the Elderly (Resolution 46/91-1991)

Proclamation on Ageing (Resolution 47/5-1992 programming the International Year for older Persons for 1999.

[6] United Nations : International Plan of Action on Ageing, 3rd part : « *Recommendations for the Action* ».

[7] The recommendations 52-62 concern elderly people in an indirect way only ; they deal with research and planning concerning them.

[8] It is a question of establishing a new dialogue between the generations, based on family and society interdependence, in reaction to the evolution of the relation between the young and the elderly.

The emergence of the family in an « inverted pyramid » is a good example of this evolution : whereas, before, this pyramid had a large base, representing a great number of children, and getting smaller and smaller as it was reaching the summit, representing a smaller number of adults and elderly, the pyramid

now is inverted and represents a family that can include only one child, two parents, four grand-parents and eight great-grand-parents.

[9] A society for all can be imagined as a society that adjusts its structure and functioning , its policies and plans to the needs and skills of everyone, making it possible for each one of them to fulfil themselves.
A society for all, on the other hand, would make it possible for generations to help one another, guided by the double principle of reciprocity and equity, as indicated in the conceptual framework (doc.A/50/114).

[10] Another great priority is the working out of strategies aiming at ensuring a satisfactory support for the elderly. Whereas the number of women getting on the labour market and the number of very old people increase, family care services decrease and yet the demand for care is to increase. In other respects, in all the regions of the world, governments usually prefer home care to placement in nursing homes for dependent elderly, both for humanitarian and financial reasons. Therefore, there seems to be a conflict between two distinct objectives : to propose equal opportunities for women as regards employment on the one hand, and to encourage the family to play a role in the support of the elderly on the other. .

[11] At present, there is a tendency to insist on the negative aspects of ageing, especially with the increased cost of benefits and social services ; but there is no mention made of the contribution that elderly people are or have been able to bring to the society, among other things their contribution to the economic progress

[12] WHO, which was created in 1948, is a United Nations specialised agency ; on the international level, it has the main responsibility for health and public health questions.

[13] Declaration adopted by the 51st Health General Assembly in May 1998.

[14] For the general options of this region, we refer to the Alma-Ata Declaration, International conference on primary health care, Alma-Ata, SU, 6-12 September 1978.

[15] « *The working out of a policy consists in agreeing on a project for the future and in agreeing on the way of implementing it and on the way of using the resources and of mobilising the partners in an appropriate manner. The choice among different options must, however, be based on a precise set of values, which in their turn have to be based on the strong ethical foundation of the Universal Declaration on Human rights.[...], equity as regards health and a working solidarity are such essential ethical values of a holistic health policy. In the European region, there are two tendencies that should carefully watched. In one case, there is a serious lack of equity among the member States ; and in another, there is a health gap, which separates more and more the groups of each country.* »

[16] The European social Charter of the Council of Europe provides for the following guarantees :
1.a classical system of control, based on regular reports made by the contracting parties, and examined by expert committees, and then sanctioned, when commitments have been violated, by recommendations from the Committee of Ministers.
2. A procedure of collective claim, introduced by the Protocol of November 1995, such claim being based on violation of the Charter.

[17] The experts note that « great efforts will have to be made in most countries to try to adapt the supply of services in 2020 to demand » (DE JONG-GERVELD, Jenny and van SOLINGE, Hanna : « Ageing and its consequences on the socio-medical system »)

[18] They are demographic ageing, globalization and the present social changes.

[19] See Council of Europe Document, Parliamentary Assembly, AS/SOC(1999,16).

[20]A recommendation is not binding like a law, but it plays the part of a guide, it is a reference to set up and specifies the requirements towards the different governments and groups.

[21] Council of Europe, Recommendation R(98/9) of the Committee of Ministers to the State members concerning Dependency, 18 September 1998 + Appendix to this recommendation.

[22] COM(1999) 221 Final

[23] « Presently, the federal welfare is underdeveloped in Europe in comparison with what prevails at the economic and monetary levels.[...]. The social Europe [...] is a dwarf that has to be gradually made taller. The first step consists in creating a light system of co-ordination that could be called the Lisbon process, i.e. to start the process which is a year's time, at the Lisbon summit of the summer 2000, will enable to lay the foundations of this social Europe, to make the first steps » in FERRERA, Maurizio : « *The passion of the social* », in newspaper LE MONDE 25.5.99, p.IV

[24] See Conclusions of the presidency of the Cologne European Council, 3 and 4 June 1999, in Daily Europe Bulletin 7480

[25] DELORS, J. : « *Introuvable peuple européen* », in Journal LE MONDE, 13-14 June 1999, p.13
[26] The workers' safety and health on the place of work.
[27] Protocol 14 on social policy
[28] Conclusions of the 75th social week of the Belgian MOC, in LE SOIR, 14.5.1997
[29] DELORME, Nicole : « *From the Treaty of Rome to the Single Act* », in L'Europe sociale ; Problèmes politiques et sociaux, Documentation française 797, 6th February 1998, p.16 : *« Britain's relentless opposition to any significant social progress is confirmed in 1991 and force the twelve member States to compromise. A complicated legal mechanism is then built up to enable Britain not to be associated with the social efforts of its eleven partners. A social policy with two different speed limits results from this and it is materialised by the coexistence of common social provisions of the Union treaty and of provisions of the social policy agreed upon by the eleven Members, about which one may wonder how it will contribute to the implementation of a true European social policy ».*
[30] Hereafter, some short explanation about the European institutions :
The *Commission* is composed of 20 members chosen by the States for their competence and guaranteed to be independent.
It has a triple role :

- It is an initiator body : it has the right to initiate actions and the power to propose acts
- It is the executive body of the Treaties, taking individual measures according to the regulations to execute community law.
- Finally, it is the guardian of the Treaties, with the power to take legal proceedings against Member States, which are at fault, and to impose sanctions.

The *European Parliament* is a co-legislator : representing 370 million European citizens, it is the largest multinational assembly in the world.
Its powers are threefold :

- Legislative power
- Power of the budget
- Supervision of the Executive

The Council of the European Union unites the representatives of the Member States and constitutes the legislative body of the Union : it adopts rules and directives, key elements of community law derived from the Treaties which are of an obligatory nature.
In the domain of social affairs, the directive is the most common judicial instrument : it binds States as to the objectives to be achieved, while leaving each certain choices concerning the means which this should be achieved and also the form that this should take in national law.
*The **Court of Justice*** ensures that laws are respected in the interpretation and application of the Treaties.
The principle of subsidiarity was introduced by the Treaty of Maastricht in the new article 3B : this refers to the most adequate level of decision appropriate to the area concerned. By virtue of this principle, the Community only intervenes if and to the extent that the objectives of the envisaged action cannot be satisfactorily achieved by the Member States and can therefore, due to the extent or effects of the envisaged action, be better accomplished on a Community level.
[31] In 1965, the Federal Government and the States will launch two big programmes of health care with deficiencies and spectacular over-cost : « Medicare », federal programme for the over-65, and 'Medicaid », common to the States and the Federal administration. With health expenditure representing 14% of the GNP, «t the American health care system can be regarded as the most expensive one in the world » (Report 141 of the French Senate, Social affairs Commission, 1994-1995 : «Health care in the USA »
[32] Since the Beveridge Reform, there were marked differences between the social system of the United Kingdom and of the USA ; but since the tatcherism of the eighties, these differences have largely whittled down. Those in favour of « blairism » see in it an humane tatcherism.
[33] This trend seems to be represented by the « Liberal Manifest » of T.Blair, the « Third Way » or « blairism » ; its main characteristics are limited State intervention and the priority of financial objectives over social needs. Cfr. « *Messrs Blair and Schröder want to convert the left to social-liberalism* », in LE MONDE, 10 June 1999.
[34] « *Let us invent a way of intervening on the industrial and financial mechanism, which will not be a system of state control, which respects free enterprise, but which will make ample room for social*

solidarity and the human being : the quality of his life, his work, his health, his personal fulfilment [...] A social treaty that would apply the same methods as the methods adopted for the euro, with social cohesion criteria, in line with better living conditions in Europe, is one of the preconditions for the social equality of the European societies » COHN-BENDIT,D. : « *Does Europe imitate America ? Let us invent the opposite* », in Le Monde, 6/7 June 1999.

[35] Cfr. MARTOU, Fr. , supra.

[36] Research indicates that informal carers (family, etc.) who have to face dementia cases represent a high-risk group as far as health is concerned ; this can speed up the development of the disease with the people suffering from Alzheimer disease or related symptoms.

[37] The impact of such an option is substantial as far as the supply of services and the patient's right to have access to them or to be refunded are concerned : when there is no real obligation to supply social services, this distinction makes it possible to reduce this type of services, and even to refuse them.

[38] This area which is not covered by social security will be the financial responsibility of the relations of the community ; it will be covered either by the patient's or family's private means (through the maintenance obligation) or by public authorities, in the case of the penniless.

[39] The typical aid relation to the Alzheimer patient is the relation wife-husband or child-parent. The support responsibility is very heavy and it extends, as an average, over a period of ten years, very often resulting in the deterioration of the physical or mental health of the person that provides the aid.

[40] The promoter of this resolution was Dr. Danilo POGGIOLINI

[41] The importance of such a resolution remains unfortunately relative : the Parliament participates in the legislative process only as co-legislator : it is the Commission that has the monopoly of legislative initiative. In this capacity, it can act at any time to facilitate an agreement within the Council, or between the latter and Parliament.

[42] Concerning this failure, see DELPEREE, Nicole : *« The patients suffering from Alzheimer disease : European policies of public funding* », in RBSS, 2nd quarter 1998, P.299-300

[43] The Swedish example is particularly interesting insofar as it shows how community-based services can be funded by public funds. Presently, this sector represents between 10 and 15 per cent of Swedish employment, and about 500.000 new jobs are contemplated over the next five years. And so the gap between the working and non-working population can be largely bridged.

One of the great Swedish principles is to guarantee the access of all to services of equal quality. Services are considered above all as a means to improve the quality of life, and the population is ready to pay more taxes for quality of services.

The postman in Sweden is regarded as a « neighbourhood assistant » : assisting the elderly in their shopping, delivering tablets are services provided for by the postman.

[44] An important study on non-medical care was made in 1979 ; this study has demonstrated that the dependants get almost three times as much non-medical care as medical care. Moreover, care of the elderly could not function without the contribution of the informal system of care. Now, being the carer of a person suffering of senile dementia is very demanding on the carer ; research brings out symptoms of psychosomatic diseases, emotional disorders, depression, anxiety and remorse on the part of the carers concerned .

[45] 1. From now on, there are services for dependants, at home since the 1st of April,1995 and in institution from the 1st of July, 1996.

2. This dependency-insurance bridges an important social gap for the patients suffering from Alzheimer disease. Indeed, until 1989, dependency was not covered as such while the number of dependants (Alzheimer an related, among others) is estimated at 1.6 million, two thirds of which are treated at home ; a first reform, inadequate, started on the 1st of January, 1989 until the law organising the covering of this risk.

[46] There is a minimum limit of 90 minutes of daily care, under which one has no access to Level I benefits.

[47] This leaves room for a profitable service of activity, but there is a risk for increased price, and even of poorer quality of services.

[48] Article 20 of the Fundamental Law (Grundgesetz) makes universal access to services of social support a public responsibility ; article 28.2 makes local governments responsible for the access of the elderly to social services.

[49] The Dekker commission proposed to reduce the State intervention to the planning of hospital resources, the control of the quality of the services, the guarantee of the rights of the sick ; the commission recommended a basic insurance with insurance companies for the whole population.
[50] The idea of a civic service in France, both for young women and young men, has also been examined.
[51] In Luxembourg, the protection of dependants, which, for a long time, has been bound on national solidarity, was still further improved by the law of 19 June 1998 introducing a dependency insurance implemented on the 1st of January,1999.
The Flemish Region (Belgium) has adopted a decree on the dependency insurance of the elderly, with a view to encourage their autonomy with solidarity funding by the Health services. Because of its complexity, the implementation will be effective in 2001.
The other two Belgian regions, like the Federal government, rely on medical and paramedical people as well as on the private sector, even if they have to arbitrate conflicts between dependants and professionals.
[52] See VERNEUIL, Didier : « *L'assurance dépendance, une réponse au vieillissement de la population* », in Le Monde, 14 June, 1999
[53] MORIN, Edgard : « *Un modèle de civilisation : la Méditerranée* » in Manière de voir, n° hors série, March 1997, Culture, idéologie et société. :
« The Mediterranean is not only a storm area, it remains the cradle of some of the main world civilisations, it remains a place where it is still possible to reinvent an economy where there is a good relationship among the members. »
[54] There is a specific social difficulty in the countries of Southern Europe, which resides in the disparity between rural and urban areas. The industrialisation and urbanisation process has brought about a decline in the traditional structures of social and family support ; however, in rural areas, and to some extent in small towns, solidarity, as a whole, remains very strong.
[55] Spanish citizens have a complete set of laws at their disposal to defend their economic and social rights. They have in particular the amparo recourse, a recourse to the constitutional Court and a «defensor del pueblo »
[56] Generalitat de Catalunya, Department of social welfare, 1993

RÉFÉRENCES :

1. -Commission européenne*: "Vers une Europe pour tous les âges –Promouvoir la prospérité et la Solidarité entre les générations*. » COM(1999)221 Final
2. -Conseil de l'Europe, Assemblée parlementaire, AS/SOC(1999,16)
3.-Conseil de l'Europe, *Recommandation R(98/9)* du Comité des Ministres aux Etats membres relative à la Dépendance, 18 septembre 1998 + Annexe à cette recommandation .
4.-Conseil de l'Europe: *Charte sociale européenne,* Turin 18.10.1961, révisée, Strasbourg 3.5.1996; Protocole additionnel (Strasbourg 5.5.1988)
5.-NATIONS UNIES: *Plan d'action pour le vieillissement* (Résolution 37/51 de 1982)
6.-NATIONS UNIES*: Principes des Nations unies pour les personnes âgées* (Rés.46/91)
7.-NATIONS UNIES : *Quatrième opération d'examen et d'évaluation de l'application du Plan d'action international sur le vieillissement*
8.-OMS: *Déclaration sur la santé*, 51e Assemblée mondiale de la santé, mai 1998.
9.-OMS-EUROPE: *Déclaration d'Alma-Ata*, International conference on primary health care, Alma-Ata, USSR, 6-12 septembre 1978.
10.-OMS-EUROPE: *SANTE 21: La Santé pour tous au 21e siècle, Introduction à la politique-cadre de la Santé pour tous pour la Région européenne de l'OMS*, Série européenne de la Santé pour tous,n°5, OMS, Copenhague
11.-OMS-EUROPE: *SANTE 21: La politique-cadre de la Santé pour tous pour la Région européenne de l'OMS*, Série européenne de la Santé pour tous,n°6, OMS, Copenhague.

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4. CONCLUSION

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