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Current organisational framework of *elderly care services*

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CURRENT ORGANISATIONAL FRAMEWORK OF *ELDERLY CARE SERVICES*

GREECE

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COST Action IS1102 SO.S. COHESION - Social services, welfare state and places

The restructuring of social services in Europe and its impact on social and territorial cohesion and governance

In the last 20 years social services have experienced significant restructuring throughout Europe, involving cuts in public funding, devolution (from central to local governments), and externalisation (from public to private providers). Among the reasons for such changes have been stressed the fiscal crisis of the State (on the supply side) and the need to ensure greater efficiency, wider consumer choice and more democratic governance (on the demand side). Although relevant research is available on such processes, the recent global financial crisis and the awareness that, among services of general interest, social services are a major vehicle of social and territorial cohesion have brought social services back on the EU agenda.

The Cost Action IS1102 – which runs from 2012 to 2015 – brings together institutions carrying out research on these themes in different nations, from different disciplinary points of view, and with different emphases, with a view to jointly assess the effects of the restructuring processes, from 5 points of view: a) efficiency and quality; b) democratic governance; c) social and territorial cohesion; d) training and contractual conditions in social work; e) gender and equal opportunities. The Action provides a structured comparative context to share and valorise existing knowledge with the purpose of disseminating findings at the local and international scale and identifying inputs for a European social policy platform.

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GREECE: CURRENT ORGANISATIONAL FRAMEWORK OF ELDERLY SERVICES*

Dina Vaiou, Dimitra Siatitsa

Introduction

By the end of the 1990s, the Ministry of Health and Welfare characterised elderly care in Greece as a "family affair" – and indeed the family is bound by civil law to take care of its elderly members, as well as dependents of all ages. Although this continues to be the case to this date, a number of developments have contributed to significant transformations in the provision of elderly care, both in the context of the family and in society at large. Such developments, in common with other Southern European countries, include the ageing of the population, the rising participation of women in paid work and the changing family patterns, all of which have contributed to create severe deficits in elderly care in the past 30 years.

Reference to the family as the main provider of elderly care is practically a reference to women, although other members, relatives and friends may also be involved as family carers. However, it is women who, as a rule, negotiate different care arrangements, depending on the elderly person's condition. Such arrangements combine personal labour, family assistance, market services (formal or informal), home or institutional care. Here, family income and old age pensions are key factors, as is the area of residence, given the uneven distribution of elderly care services across the country.

Apart from the family, elderly care includes: (i) public services provided by the state and local authorities, which remain marginal, despite their expansion since the 1980s, (ii) voluntary care provided by private non-profit organisations and (iii) market services provided by private for-profit organisations or by paid domestic workers in the context of families. The latter have been an option for upper and middle class families prior to the arrival of the post-1989 waves of migrant women, whose low salaries made such an option available even to lower income households.

The current crisis and the successive bailout agreements have put into question the sustainability of whatever public care structures have been developed since the early 1980s. The terms of austerity attached to successive "rescue deals" and the severe cuts in salaries and pensions have jeopardised (or even cancelled) a broad range of options for elderly care, particularly among low income households. In this context, elderly care is reconfirmed as a "family/women's affair" in more dire conditions.

1. Definition(s) and classification(s)

Specifying what constitutes elderly care in Greece is not a clear-cut procedure, but in general it refers to practical, psychological and social support provided to individuals over 65 years of age

* We would like to thank Maria Karamessini and Evgenia Moukanou (Panteion University of Social and Political Sciences) for making available to us their Report to the FP6 project DYNAMO and advising us on sources and publication about elderly care in Greece

(Karamessini and Moukanou 2007: 7). One of the major confusions in this respect derives from the provision of elderly residential care by the same institutions which cater for people with chronic diseases. In general, elderly care combines social care and health services, with varying degrees of balance among the two. Combinations depend on the type of supply structure and are also reflected in the range of skills among the personnel they employ.

2. The legislative milestones

Table 2.1. Legislative milestones in elderly care services

Year	State level concerned	Legislation/Act (number/title/type*)	Content (synthetic)
1979, 1984	National (delivery: municipal)	(Open Care Centres for the Elderly-ΚΑΠΗ, pronounced KAPI)	First pilot day care centres (KAPI) were established by the Ministry of Health and Welfare in 1979 in Athens. In 1984, KAPIs came under the jurisdiction of municipalities and opened throughout the country. They are for men and women over 60 years of age, living in the relevant municipality.
1995	national	N2345/sectoral	"Elderly Care Units": all residence homes for the elderly, operated by the voluntary sector (the church, NGOs, local government) or as private enterprises, are renamed into "Elderly Care Units" and operate under the same rules and regulations regarding the delivery of services.
1998	national	N2646/sectoral	This law regards the "Development of the National System of Social Care" (the term "social care" appears for the first time in this law)
2000	national (delivery: municipal)	Day Care Centres for the Elderly (ΚΗΦΗ, pronounced KIFI)	Mostly in urban areas and under the jurisdiction of municipalities, KIFIs provide care services to frail elderly with chronic health problems who either are not able to fully care for themselves or do not have family carers to look after them.
2003	national	N3106/ structural	"Reorganisation of the National System of Social Care"
2005	national	N3329/sectoral	"Regional Organisation of the National System of Health and Social Solidarity"
2010	national	N3852/structural	"New Architecture of Local Government and Decentralised Government – Kallikratis Program": as part of a major re-organisation of local government, planning and delivery of social care services comes under the jurisdiction of municipalities, which are obliged to form "Units for the Exercise of Social Policy and Equality Policy"

Sources: Karamessini and Moukanou 2007, EETAA 2005, Petmezidou 2006, www.50plus.gr
(*) By type we mean whether the law is a *structural*, *incremental* or *sectoral* one)

3. The current organizational structure

In this section we summarise information about coverage, planning, funding and, to some extent, territorial differentiation of elderly care, organised in three sub-sections, according to the forms of supply: at the home of the beneficiary, in residential homes for the elderly and in the form of day care.

3.1 Home care

As already underlined, in Greece, as in other Southern European countries, the public sector of service provision for the elderly (as well as for children, for the disabled etc) has always been insufficient and inadequate (Getimis and Gravaris 1993; Karamessini 2008). Since World War II,

the state remains a "carer of last resort" contributing selectively and mainly through monetary transfers (subsidies and pensions) and not through the provision of services (Bettio et al 2006). Private sector services have developed significantly since the 1980s, along with rising incomes, while the role of voluntary sector has been limited. Thus, the great bulk of care has been, and is, accommodated in the family, through the unpaid work of its women members and inter-generational divisions of labour among women.

This model of family care entered into crisis in the 1990s, as a result of a combination of demographic and economic changes: life expectancy has increased and people over 80 years old have become an ever larger proportion of the population, thus amplifying the need for elder care[1]; women have been entering rapidly and in large numbers into the labour market and, because of cohort effects, the burden of care started falling disproportionately on women in their forties and early fifties, who have little time available for unpaid care at this prime time in their working lives; finally, the size decreased dramatically and mobility of households increased, thereby making elder care within the family more difficult.

As a result, a chronic care deficit is registered, which, since the early 1990s, has been filled by large numbers of migrant women, who partially replace unpaid care by family women. At the same time these women contribute to the reproduction, in different terms, of the family model of care (Vaiou et al 2007): care remains individualised, at home/within the family, involving a re-negotiation and division of labour among women, this time local and migrant, and leaving men generally uninvolved. In this sense, and although the services of migrant women are paid, we consider them as part of the "family care".

Paid elderly care at home, formerly accessible only to high income households[2], has become widespread with the post-1989 waves of migrants. It constitutes an arrangement which is socially more acceptable than "abandoning" an elderly parent to a home for the elderly with questionable quality of services (or leaving a young child in day-care for long hours). This equilibrium of elderly care arrangements among the family, the market and the state relies to a great extent on two pillars. On the one hand, pensions and subsidies which, albeit low, ensure the material conditions of existence of these arrangements; on the other hand, migrant women's low paid labour makes it accessible even for lower income households[3].

Direct involvement of the state and the voluntary sector includes various "home care" programs and, more recently, "tele-assistance" programs. More specifically:

"*Home Help*" was introduced in 1997 to provide care services to elderly dependent persons who live alone, have little or no family support and lack sufficient financial means[4]. In the first year of its operation, some 102 pilot programs were set up, funded by central government (Ministry of Interir and Ministry of Health and Welfare). Later, funding passed to the 2nd and 3rd Community Support Frameworks (CSF) and Home Help programs expanded. In 2005, the (renamed) Ministry of Health and Social Solidarity (2005) registered 1,163 such programs in operation

[1] population over 80 years old is 3.6 per cent of total population (a 43% increase between 2000 and 2010). See European Commission 2010, *Employment in Europe*, Luxemburg: Publications Office of the European Union, also available online at http://ec.europa.eu/social

[2] Local but also migrant paid domestic workers were common in high-income households. Indeed, having a live-in Philippina carer had become a status symbol to which all nouveaux riches in Greece aspired. Philippina women migrants came to Greece through bilateral contracts (Topali, 2008)

[3] The abundant supply of migrant women's labour contributed to increase demand throughout the 1990s and 2000s and up to the current crisis, underlining the gendered dimensions of migration to Greece (and to the European South in general).

[4] The Hellenic Red Cross had introduced such a pilot "home help" program in the area of Athens already since 1988 (Liakou 1998)

throughout the country, with around 50,000 beneficiaries. In terms of content, Home Help programs were designed to provide care at the home of frail elderly person, including social work, nursing and assistance services (eg. paying bills, shopping, cooking, cleaning). Such programs later extended to people with disabilities.

"*Tele-Assistance*" was introduced as a pilot program in 2000 connected with Home Help. The aim was to provide beneficiaries (mostly frail, lone elderly persons with health problems) with the possibility communicate with relatives, friends and emergency services. The program was funded by the Ministry of Health and Social Solidarity (2009), which lists 300 beneficiaries in 2009.

3.2 Residential care

The proportion of elderly persons living in special "homes"/institutions is 0.6% of people over 65, according to the 2001 census. Care for the elderly in special care units is provided by the public sector, non-profit organizations and private institutions, the majority of which are concentrated in urban areas and provide rather low quality services (Emke-Poulopoulou 1999, Papaliou and Fagadaki 2005).

Public provision is implemented through "Nursing Homes for the Chronically Ill" - hence the difficulties in definitions and the variety of beneficiaries across age groups[5]. These institutions are funded by the state budget and by fees that insurance funds contribute for their respective beneficiaries, with the balance of funds depending on the legal status of each unit. They provide long-term care for beneficiaries who lack sufficient means for other care arrangements. The Ministry of Health and Social Solidarity (2009) estimates that 2,600 elderly persons live in such homes.

In 1995, elderly residential institutions of various kinds were renamed into "Elderly Care Units" (Law 2345/1995) and operate as legal entities under private law.

Around 118 *non-profit Elderly Care Units (ΜΦΗ)* are in operation, among which the role of the Greek Orthodox Church is important, with 81 units established and run by church-based organizations (Karamessini and Moukanou 2007). They provide residence and care to around 2,800 persons (Ministry of Health and Social Solidarity 2009) and accept persons with low income as well as better off persons. Apart from the Church, funding is also secured through state grants, private donors and fees charged to the beneficiaries according to their means (eg. personal pensions, family resources, etc).

There are no reliable data for *private sector Elderly Care Units,* regarding the precise number of beneficiaries/users. Rough estimates raised their number to 3,200 elderly persons distributed among around 108 units (Ministry of Health and Welfare 2005). Some researchers argue that privately owned units operate as intensive rehabilitation centres for people with health related problems, in the absence of institutions specialized in such services. On the other hand, many Elderly Care Units operate as "private clinics", since some insurance agencies cover part of the expenses when the services are provided by private clinics but not when they are provided by residential units (reported in Karamessini and Moukanou 2007). The fees per month charged by private units vary a lot, as does the level of services [6]. Fees are covered by the elderly persons themselves and/or their families. Some insurance agencies partially cover monthly costs.

[5] These institutions were designed to address the needs of disabled persons over 18 years of age who suffer from bodily or mental disabilities and are not self-sufficient.

[6] M. Karamessini and E. Moukanou found in their field work of 2007 that such fees varied between 470 and 1,500 euros per month, but there were few units which charged much more. However, "decent" residential care cost about 1,000-1,200 euros per month

The majority of Elderly Care Units (both non-profit and for-profit) are small firms (average capacity 30-50 beds and 3 workers per shift). There are few larger units, of which the "Residential Home for the Elderly of Athens" (Γηροκομείο Αθηνών) is the biggest (capacity 500 beds and 250 employees). Licenses for Elderly Care Units are issued by the Local Authorities, which are also responsible for monitoring, supervision and control. However, many private sector units operate without license.

3.3 Day care

Day care for the elderly is supplied through the "Open Care Centres for the Elderly" (KAPI) and the "Day Care Centres for the Elderly" (KIFI). The Municipality of Athens has recently established a third type of structure, the "Friendship Clubs".

The first pilot "*Open Care Centres for the Elderly*" (KAPI) were established in the area of Athens in 1979 and were funded by the Ministry of Health and Welfare. Eleven such centres were operated by NGOs including the Hellenic Red Cross. In 1984, Open Care Centres passed to the responsibility of local authorities and, by 2003, 582 were established throughout the country, mostly in urban areas (EETAA 2005). These centres were initially planned to supply a wide range of services to the elderly: recreation and organised excursions and visits to museums and archaeological sites, basic medical and nursing care, social and phychological support, physiotherapy and occupational therapy, home help (for elderly people who live alone and have no other support), education programs. Lack of resources, increasing numbers of users (who exceed capacity) and understaffing have led to only partial operation of these services and an emphasis on recreation activities, nursing and social support. However, KAPIs are very popular care services and beneficiaries value them a lot (Teperoglou 1990; Karamessini and Moukanou 2007). Since 1989, municipalities became responsible for the cost of operation of KAPIs, while the Ministry of Health and Welfare is responsible for buildings, equipment and supervision[7]. There is no fee for the beneficiaries – around 146,000 according to rough estimates (www.50plus.gr, visited 30-7-2012).

"*Day Care Centres for the Elderly*" (KIFI) are units which provide day care to frail elderly people who are not totally self-sufficient (because of kinetic difficulties or mild mental problems) and whose families face serious economic or social difficulties. Beneficiaries can spend few hours every day in these centres where they receive free of charge nursing care and personal hygiene and may follow creative activity programs and social development programs. Some units provide also beds for rest and transport to the elderly persons homes. Day Care Centres operate under the jurisdiction of local authorities, either as public or private legal entities and they are co-funded by municipalities and the 3rd CSF. In 2011, 68 such centres operated throughout the country with 1,534 beneficiaries (EETAA 2011)[8].

"*Friendship Clubs*" are a rather new structure of the Municipality of Athens. Twenty four such Clubs operate on week days (8:00 to 20:00) at neighbourhood level and offer a variety of day care services to residents over 60 years of age who have to become members and pay a symbolic fee of 5 euros per year. Services include creative activities, physiotherapy, guided tours to museums and archaeological sites, day excursions and city walks. They also provide, in collaboration with relevant institutions, support and information on problems that elderly people are likely to face. There are about 5,000 members half of whom are active (i.e. participate regularly in the Club activities) and spend, on average, 3 to 4 hours in their local Club.

[7] After 1991, these responsibilities passed to the Ministry of Interior
[8] There are also 4 private centres country-wide, with 90 beneficiaries

4. The division of labour within the state

As a rule, legislation is promoted by the central state; regulation and control of care institutions and services takes place at central or regional level; delivery of services is local (municipalities). As far as funding is concerned, the role of Community Support Frameworks (CSFs) is essential both for planning and development and for actual operation of elderly services – hence their precarity and eventual disappearance or severe reduction when European funds disappear.

Table 4.1. The division of labour within the *state* in elderly care services

Phases	Central/ Federal	Regional/ Lander	Municipal/ Local	Sub-municipal
Legislation/regulation	v	v		
Funding	v + CSF		v + CSF	
Programming/planning		v	v	
Production/delivery			v	
Monitoring/evaluation	v (Body of Inspectors)	v		
.....				

Sources: Karamessini and Moukanou 2007; Ministry of Health and Social Solidarity 2009

5. The division of labour among providers

The supply of elderly care and the division of labour among providers is summarised in the following table:

Table 5. Elderly care services in Greece, by place of delivery and provider

	Home care	Residential care	Day care
family	mostly women relatives (unpaid) migrant women carers (paid through pensions and/or family resources)		
public sector	"Home Help" programs (delivered by municipalities, free of charge) "Tele-Assistance" programs (delivered by municipalities, free of charge)	"Nursing Homes for the Chronically Ill" (fees according to means)	"Open Care Centres" (ΚΑΠΗ) (delivered by municipalities, free of charge) "Day Care Centres"(ΚΗΦΗ) (delivered mainly by municipalities, free of charge) "Friendship Clubs" (municipality of Athens, annual fee 5euros)
voluntary sector	"Home Help Program" of the Hellenic Red Cross	"Elderly Care Units" (ΜΦΗ) (residential homes for the elderly) (fees according to means)	"Day Centre" of the Hellenic Association of Gerontology and Geriatrics
private sector		"Elderly Care Units" (ΜΦΗ) (residential homes for the elderly) (fees charged)	

Sources: adapted from Karamessini and Moukanou 2007, EETAA 2005, 2011, www.50plus.gr (visited 30-7-2012)

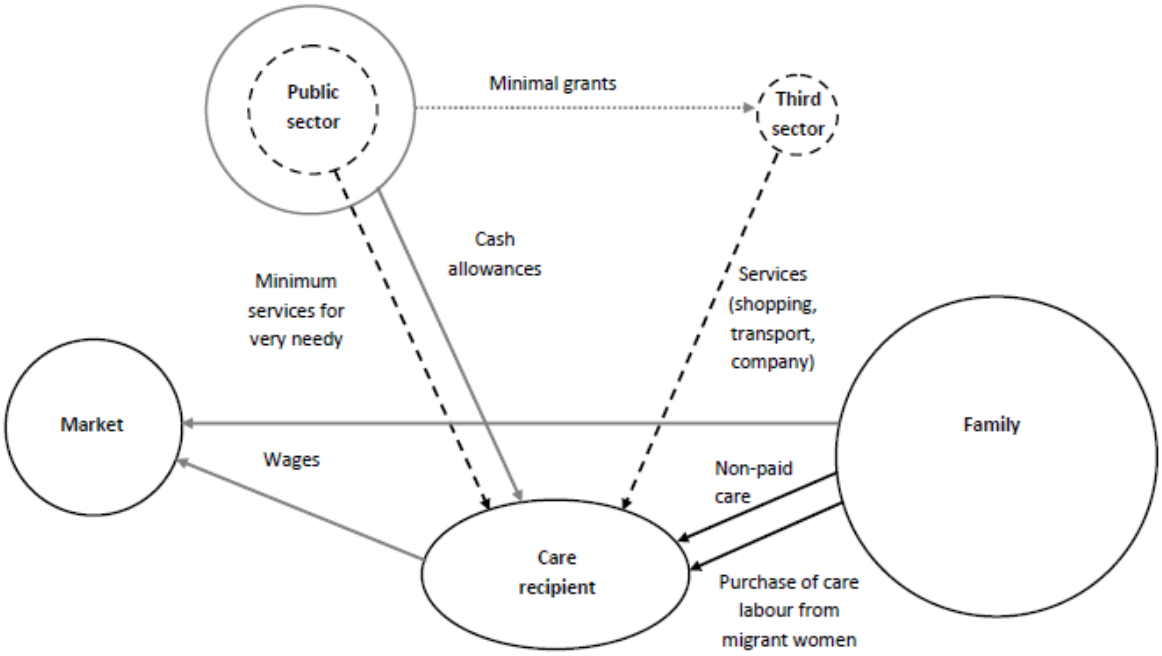

Figure 5. The division of labour among providers in elder care in Greece
Source: (Adjustment from source: Dawn Lyon and Miriam Glucksmann (2008) 'Comparative Configurations of Care Work across Europe', *Sociology*, 42(1): 101–118)

6. The impact of the restructuring and the crisis (from one or more of the five perspectives

As already underlined in the previous sections, care for the elderly in Greece is a "family and women's affair", with limited involvement of the state, the voluntary sector and the market. The family model of care incorporated a new and significant element in the 1990s, namely the paid work of migrant women (mainly from the Balkans and Eastern Europe). For this development, the role of pensions has been critical, as well as the abundant supply and low pay of migrant women.

The crisis and the terms of the successive "rescue deals" have led to measures which jeopardise, among other things, every form of elderly care arrangement (Petmesidou 2012). Severe cuts in pensions and salaries have substantially reduced disposable incomes, particularly among lower income households. As a result, paying for elderly care, either at home (for a migrant woman carer) or in a decent Elderly Care Unit, is no longer an option for the vast majority of households[9].

Public social services for the elderly, on the other hand, are prime victims of austerity policies. Drastic cuts in this domain reduce not only the range, but also the quality of these services, as a result of personnel cuts and deteriorating working conditions for all those involved in elderly care. Moreover, major re-organisations of the "architecture of local government" in the name of cost-efficiency affect the geography of supply of elderly care, for which proximity is essential. Cuts also affect the operation of NGOS (with the possible exception of the Church), since they no longer receive adequate grants and face difficulties in finding donors.

In this context, the burden of elderly care lapses back to women family members, this time under worse conditions. And the burden weighs more as women are more likely to have become

[9] The choice of "budget" care units means a dramatically lower quality of service and user satisfaction

unemployed as a result of the crisis – therefore "readily available" for the caring responsibilities they have fought to re-arrange.

7. Regional differences

Care deficits and care arrangements present significant geographical differentiations which are linked, among other things, to changes in the productive structure of the country, urbanisation patterns, geographical mobility of local population, particularly of younger people, changes in living standards and conditions, household size and so on. Concentrations of elderly people (and needs for elder care) develop in a variety of places across the country, with mountainous villages and small islands being most commonly cited. However, the most severe deficits are to be found in urban areas and in the central/older neighbourhoods in which elderly people have remained in family-owned flats.

The following table is a (crude) picture of the regional distribution of Open Care Services for the Elderly, compared to the number of people over 65 years of age. This picture is more indicative if one takes into account the multitude of islands which constitute (or are part of) several regions or the mountainous topography of other regions and the problems of accessibility.

Table 7. Regional distribution of Open Care Services for the Elderly (KAPI)

Region and population (2001)	Number of Open Care Centres (KAPI) (2003)	Population over 65 (2001)	Population over 65 as % of total population	People over 65 per KAPI
Attica (incl. Athens)	101	568,979	15.12	5,633
East Macedonia and Thrace (362038)	37	59,315	16.38	1,603
Central and West Macedonia (incl. 4 islands and Thessaloniki)	241	399,815	16.49	1,658
Epirus	30	70,288	19.86	2,342
Thessaly (incl. 14 islands)	57	136,103	18.05	2,387
Sterea Ellada	40	153,958	18.55	3,848
Peloponnese	18	207,351	17.95	11,519
Ionian Islands (7 major islands + 29 smaller ones)	7	42,992	20.18	6,141
North and South Aegean Islands (60 islands)	17	17,432	16.76	1,025
Crete	34	97,762	16.26	2,875
GREECE	582	1,831,540	16.70	3,147

Sources: EETAA 2005; ELSTAT, population census 2001 (available from www.statistics.gr)

8. Summary and conclusions

The family in Greece remains the main provider of elderly care and, as a rule, women members of the family undertake the tasks related to the care of elderly persons, although other members of the family or friends may also be involved. A major arrangement for care within families is the employment of paid carers, which has been made possible by the influx and low pay of women migrants since the early 1990s.

Pensions, however low, play a key role in the different options for care arrangements by individual elderly persons and families.

Involvement of the state in the provision of direct services is marginal, and usually related to different CSFs (Community Support Frameworks) of the EU. Such services include home care in the form of Home Help and Tele-Assistance Programs, residential care (in nursing homes) and Day Care services (KAPI and KIFI).

The voluntary sector, which includes several institutions of the Greek Orthodox Church, operates part of the Elderly Care Units (MFIs) and a limited number of other facilities.

Private Elderly Care Units (MFIs) is an area of private sector involvement, which has grown since the 1980s and offers quite different quality services, following the fees charged.

In the dire conditions of the current crisis, continuing wage and pension cuts jeopardise the continuity of elderly care arrangements worked out in the context of families. The low paid work of migrant women is no longer generally accessible, while income insecurity leads many local households to cut their expenses, paid care included. The state and local government not only do not offer a safety net for low income households to cope with cuts, but proceed to cut further the scarce and poor services they used to provide.

Thus the burden of elderly care lapses back to local women, since men do not seem eager to get involved. In the context of continuously reducing, re-organising and generally devaluing public services, the time and effort necessary for daily and long term care increases. The effects on women's work, gender relations and inter-ethnic divisions of labour are yet to be calculated - and so is the level and quality of services for the elderly.

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