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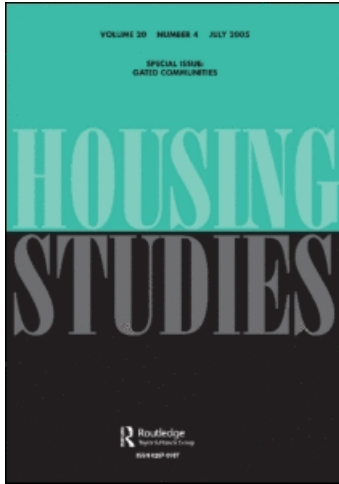
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Changing Housing for Elderly People and Co-ordination Issues in Europe

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ABSTRACT *The inter-sectoral policy systems of housing for elderly people in the EU-countries change with the implementation of ageing in place and by general processes of modernisation of society and welfare state. For implementation of the innovations the relevance of co-ordination between the sector housing, care and social services depends on the state of development of the sectors in a country. However, modernisation threatens co-ordination by decentralisation, privatisation and transfer of choices and responsibilities to the individual. This paper is an international comparative study describing how countries of the European Union are dealing with the topic of co-ordination. Nowadays especially policy actors at the regional and local level have the responsibility for inter-sectoral co-ordination. Looking at the practices of these actors the development of a shared vision on ageing in place seems to be very important. Central government should facilitate this approach and control the results. The term 'managed co-operation' describes very well this new way of management of co-ordination.*

KEY WORDS: modernisation, restructuring welfare state arrangements, policy development, housing for elderly people

Introduction

In European and other Western countries there have been a flood of innovations in the past few decades in the areas of housing and care for older people. One important driving force behind these innovations is the desire for 'ageing in place' (Pastalan, 1997). This can be defined as creating a situation whereby older people can remain in their own familiar surroundings for longer, so delaying or possibly obviating the need to move to specific institutional residential care facilities. These efforts are being interpreted in different ways within Europe, something that can be explained on the basis of the differences in the way the three most relevant areas of policy are controlled. Housing, care and social services are the three key policy sectors (Houben, 1997). Housing refers to both the 'public housing' controlled by the state and the housing market, which involves owner occupiers and other private individuals. In this inter-sectoral approach 'care' is generally used to refer to a sub-sector of the health sector and entails support for general daily life activities such as getting up, washing,

getting dressed, eating etc. Sometimes it also includes managing the household. The 'social services' sector is also sometimes referred to as 'social care' or 'social assistance'; in some countries domestic support is classified under social services instead of under care. Core elements of social services include social work, meals at home, identification of social problems, and educational and recreational activities supplied in community centres. The fact that three policy sectors are involved in ageing in place means that this is a complex issue, where attention needs to be given to inter-sectoral co-ordination.

Mutual co-ordination between the sectors is especially relevant to supply for the multiple needs of elderly people in their fourth age, and less of an issue for elderly people in their third age. This difference in ages is significant. Taking into account the current institutions relating to pension and household cycle, the third age can be said to start at the end of paid work and start of the 'empty nest'. Most elderly adults at the start of the third age, in view of their health and mobility, make no extra demands on the facilities of the aforementioned policy sectors. During the third age, however, the number of those requiring such support increases. The fourth age starts at the moment that people experience such an accumulation of physical, mental and social limitations that the structural provision of care and social services becomes unavoidable (Baltes, 1997). In addition, some sort of adjustment to their housing situation is often required, either through architectural measures or by relocating to a more suitable home. The average age of admission to residential institutions, about 85 in the Netherlands, would also seem to give a good indication of the lower threshold of the fourth age.

An essential feature of the flow of innovations in the last few decades in these three sectors is that a small number of standard combinations of housing, care and welfare functions have been replaced by a much larger variety of functions on offer (Pacolet *et al.*, 1998). This process of differentiation in functions can be seen as a symptom of general, long-term modernising trends in the increasing functional differentiation of labour (Houben, 1997). The functional differentiation has caused management principles to change as well. These now revolve around funding flexible combinations of separate functions which can then be geared to the needs and wishes of individual senior citizens. Implementation of these innovations ensures that the policy agenda is even more dominated by more problems of co-ordination because the variety of elements to be co-ordinated is increasing. In addition, the requirements for a co-ordinated approach are changed by the transformation of European welfare states during the last two decades. Decentralisation processes mean that regional and local authorities increasingly decide what functions and combinations of functions are provided. The introduction of market principles and the institutions' responsibility to bring in their own quality assurance, are resulting in more variety in quality levels. Due to these changes, the number of decision-making levels is increasing. The globalisation process has continued and intensified in the 1990s, making even higher management levels relevant, viz. the continental level, promoted by, for example, the advent of EMU and in some cases interventions by the IMF and the World Bank. Therefore, more and more decision-making levels are being created to co-ordinate the variety of functions and provide the required mix. So the intra-sectoral and inter-sectoral co-ordination issues sometimes dominate the policy agenda.

The aim of this paper is to highlight the co-ordination issues within a context

of these simultaneous changes: implementing ageing-in-place based on a growing variety of functions and combinations of them in housing for the elderly on the one hand, and transformation of welfare states since the late 1970s on the other hand. The main question of this study is: assisted by theoretical notions, how can issues of co-ordination in these changes be typified? The analyses presented are based on an international comparative study. The most important aspects of the methodology used are the study of publications, information from experts and theoretical reflections on changes in modern societies and welfare states. The first findings have been presented to experts in Europe in a detailed discussion document, before more final conclusions were drawn (Houben & Mulder, 1999a, 1999b). Due to the nature of the data available, the conclusions that will be presented here are provisional.

The paper first describes the relevance of co-ordination in terms of the differences attributed to institutions, and efforts and performance in the three sectors in the 15 EU countries. For analytic purposes we classify them using the well known and criticised typology of Esping-Andersen. This is then used to summarise the specific characteristics of the sectors housing, care and social welfare services in these countries. Combined with the differences in the approach of ageing in place, a short description of the relevance of co-ordination for four clusters of EU-countries is given. The second focus is on the wave of innovations and two main approaches to ageing in place are found in the EU-countries. The wave of innovations based on ageing-in-place are analysed from the general perspective of functional differentiation. This modernising trend creates new elements, which have to be co-ordinated. Third, the paper focuses on this trend and simultaneous general, post-modern changes in welfare states. From that perspective in the inter-sectoral policy system of housing for the elderly in the 15 EU-countries three forms of transfer of responsibility between policy-actors in the system can be observed. The relevance of co-ordination by regional and local actors is increasing. Sustained by notions of the structuration theory alternative types of focuses in co-ordination policy can be observed. Next, the main issues in the three types of co-ordination policies are presented. Finally, implications with regard to the desirable management of co-ordination are discussed.

The Relevance of Inter-sectoral Co-ordination in EU Countries

Ageing in place is interpreted in various different ways in Europe. To what extent can the differences be attributed to institutions, efforts and performance in the three relevant policy sectors in the present 15 EU countries? Esping-Andersen has carried out some pioneering work in dividing Western countries according to types of welfare state. At the beginning of the 1990s he produced the following findings (Esping-Andersen, 1990). In order to make householders less dependent on the free market during the period of industrialisation, all kinds of social provision came into being, particularly in the event of employees having an industrial accident or becoming unemployed, sick or elderly. In Scandinavian countries such as Denmark, Finland and Sweden, and to a certain extent in the Netherlands, it was the trade unions and related social democratic parties who were zealous advocates of welfare provision being devised by the government. That is why these are called social democratic welfare states. Since a direct interest in welfare provision is also created among the middle classes,

many people in these countries make use of it. This approach is therefore referred to as the 'universal model'. In Central European countries, on the other hand, welfare provision is more focused on the working stage of life and are developed on a sectoral basis, while the Church provides help for the very weakest. Belgium, Germany, France, Italy and Austria are therefore counted among the corporatist countries. These countries have a less extensive policies, and until a few years ago or even still today, they have no insured care facilities for vulnerable, more elderly people (Pacolet *et al.*, 1998). Just like other Anglo-Saxon countries such as the US and Canada, the UK—particularly during Margaret Thatcher's term of office as Prime Minister—has been classified as a liberal state, because it was focused solely or mainly upon the underprivileged. For this reason these countries are also referred to by the term 'residual model'. The middle classes therefore benefit less from the provision than in the other models referred to above. The Southern European countries, Portugal, Spain and Greece, were not included in Esping-Andersen's study. In later discussions he classified them as 'emerging corporatist welfare states' (Esping-Andersen, 1996, 1997). Opponents have pointed out that government intervention is so limited and the existence of clientelism too significant to justify using the label 'emerging corporatist welfare state' (Gelissen, 1999; SCP, 2000). Nevertheless, signing of the 'social' Treaty of Amsterdam and recent efforts by these countries to join the EMU might indicate that a certain type of welfare state could be introduced in stages. Doubts have also arisen in debates concerning the classification of the UK and the Netherlands. It seems to be more useful to see them as hybrids, i.e. the UK as a combination of a liberal and social democratic welfare state and the Netherlands as a combination of social democratic and corporatist welfare state.

This section builds on these types of classification and allocation by looking more specifically at the housing, care and welfare sectors. Table 1 sets out the results of this more focused analysis, which results in each country being placed in a cluster. The clustering that was found seems to be useful in order to provide a background explanation for the different interpretations of ageing in place and the inter-sectoral co-ordination that exists in this context.

Table 1 shows that Portugal, Spain, Greece and Italy are generally characterised by a low gross national product, little state intervention in public housing and a relatively low quality of housing. In these countries a relatively large number of elderly people live with their children. Members of the family have a duty to provide care, which also applies to relatives who are not part of the nuclear family. Where collective care facilities do exist, these are mostly paid for through insurance. Social service facilities are also scarce. Facilities in these countries are less well developed than in the other European welfare states (and in Greece they are almost entirely absent). However, in some respects Italy is an exception among this group of countries. Its gross national product is significantly higher than in the other three countries, and the government also pays more attention to the area of public housing (comparable to the situation in Finland). Based on sparse publications and contacts with experts, it seems that there is hardly any inter-sectoral co-ordination between housing, care and welfare in these countries. The relatively low level of effort in all three sectors outlined above provides an explanation for this. The situation is different in the other clusters discussed below.

The second type of cluster consists of a cluster of Central European countries, mainly

Table 1. Characteristics and efforts of EU countries by sector

	Southern	Central	Western	Northern
	Greece, Spain, Portugal, (Italy)	Ireland, France, Belgium, Austria, Germany, Luxembourg	UK, Netherlands	Denmark, Sweden, Finland
<i>Type of welfare state:</i>	Emerging corporatist	Corporatist	Liberal/Social Democratic/ Corporatist	Social Democratic
GNP (1998)	-- / -	+ / +	+ / +	+ / + +
<i>Housing:</i>				
With family/relatives	++	++ / --	--	--
Government's role	--	+ / +	++	++ / -
Quality of housing	-	+ / +	+ / + +	++
Regulations conc. adaptable building	- / +	+ / +	+ / + +	++
<i>Care:</i>				
Duty to provide for Financing	Family ++ Insurance	Family + Insurance	Fam. + / State + Insur. / tax.	State ++ Taxation
Intramural care	-- / -	+	+ / + +	+ / + +
Community care	--	+	+	++
<i>Social services:</i>				
Workers in care, welfare, etc.	--	-	+	++
Child care	-	+	+	++ / +

Note: ++ = above average; ± = average; -- = below average.

Sources: Anttonen & Sipilä, 1996; de Boer, 1999; de Marti, 1997; Esping-Anderson, 1990, 1996, 1997; European Parliament, 1996; Gelissen, 1999; Haffner, 1997; Knijn & Kremer, 1998; Ministry of the Environment Finland, 1999; Moregas, 1997; Paolet *et al.*, 1998; Pijl, 1999; Pitaud 1997; Pynoos & Liebig, 1995; SCP, 2000; Woetmann Nielsen & Ambrose, 1999.

welfare states with a corporatist tradition. The gross national product in these countries ranges from average (Belgium, France and Austria) to high (Luxembourg and Germany). The family still plays a crucial role in housing and care, but to varying degrees. In corporatist countries a very extensive and diverse range of civil-society welfare institutions has been created alongside a decentralised government. There are relatively few people employed in the education, health and welfare sectors, which certainly in Germany is combined with a low percentage of working women. The efforts made by the government in the area of public housing are average to fairly high, while the quality of the housing stock is reasonable (except in Austria, where the quality is below average). Care facilities are mainly paid for through insurance, and until recently they were not available, or in some cases are still unavailable, for elderly people in the fourth stage of life. Welfare facilities are the province of private and local initiatives. In these countries it seems to depend on the policy perspective of local and regional policy-makers as to whether problems in the area of inter-sectoral co-ordination are perceived and placed on the policy agenda. The considerable diversity of civil-society welfare institutions may provide an explanation for this.

The third cluster consists of the UK and the Netherlands. These form a hybrid

between the corporatist model of the countries of Central Europe, the social democratic model of the Scandinavian countries and the liberal model, which gained a following in the 1970s with the emergence of neo-liberalism. After a period of building up a social democratic welfare state, the UK went through a period of quite far-reaching liberalisation. The country still has a highly elaborate health-care sector with possibilities for governance at local and regional authority level. In the UK the provision of social services is mainly the province of local authorities and charity organisations. Although the British public housing sector became highly 'residualised' during the period of liberalisation, there is still sufficient involvement to create a popular interest in co-ordinating housing, care and welfare so that ageing in place can be put into practice.

In the area of housing for older people in the Netherlands, the emergence of liberal views during the 1980s and 1990s gradually focused the supply of functions in the three sectors increasingly on people with lower incomes; consequently there was a gradual residualisation. In the Netherlands, in accordance with the corporatist model, health-care and social facilities are paid for through insurance schemes (collective or otherwise). This is because the financing of family care and homes for the elderly was transferred during the 1990s from the taxation system to the collective insurance system. In addition to government policy-makers, insurers have therefore also become active players in the policy domain at regional level, where decisions about care budgets are made. Social services and public housing have now become highly decentralised down to the local level, as a result of which co-ordination with regional allocation decisions in the domain of care is no longer guaranteed and has actually disappeared from the policy agenda.

The fourth cluster of countries comprises Denmark, Sweden and Finland. These are classified as social democratic welfare states. They are relatively rich countries, with a high gross national product. Unlike the welfare states further south, the focus is on the individual, not on the wider family or the nuclear family. Evidence that the welfare state is built on the universal model can be seen from the fact that there are many people working in the education, health-care and welfare sectors. Particularly in Sweden this is accompanied by a high rate of labour participation among women. In these countries members of the family do not have a duty to provide care, except for under-age children living within the family. Care and welfare facilities are mainly paid for from fiscal revenue. There are numerous facilities of this kind. The quality of the housing stock is also generally high in comparison with other European countries. The government's involvement in public housing can, traditionally, be described as high (high subsidies, high percentage of subsidised rented property); this does not, however, apply to Finland. It is interesting to see that in these countries the regulations concerning adaptable building (see Table 1) are most highly developed (Ambrose, 1997; Woetmann Nielsen & Ambrose, 1999). In the Scandinavian countries it seems that due to the high level of government involvement in all three sectors, efforts to co-ordinate housing, care and welfare are more or less self-evident. Tensions seem to arise more between the different layers of government when relevant policy players observe that the region, which finances institutional care, or the municipality, which controls non-institutional care, shift responsibility for shortcomings on to each other (Liebig, 1995).

One conclusion seems to be that differences between countries in terms of sectoral efforts and inter-sectoral co-ordination are mainly due to the diverse

basic principles outlined here and the way the three sectors are controlled in European welfare states. Among the countries with a relatively high level of provision it is mainly those with a fully or partly social democratic model, namely Sweden, Denmark and the UK, where the problem of co-ordination is perceived and where it therefore makes its way onto the agenda at certain times. That is particularly the case in situations where, for budgetary reasons, innovation is considered to be desirable due to the substitution of institutional care for innovative forms of ageing in place. In countries of this type, the implementation of ageing in place means making changes to sectoral efforts and inter-sectoral co-ordination, while in countries with weaker or less developed sectors it mainly means building up and developing sectors and mutual co-ordination. However, ideological differences in the approach to ageing in place are also important. These will be discussed in the next section.

Ageing in Place: Creating New Elements To Be Co-ordinated

Until the 1970s, housing older adults in special sheltered housing and residential care facilities was widely considered a sign of a highly developed care system. The Netherlands and the Scandinavian countries stood out from England, Germany, France and particularly the southern European countries because they had a relatively high percentage of older adults living in such care facilities. In the 1970s this started to change. A combination of considerations concerning the importance of autonomy, privacy and the older adults' right to choose on the one hand, and the necessity to reduce the costs of collectively financed facilities, particularly residential care, on the other, lead to a spectacular drop in the number of older adults living in residential care in the northern countries. At the same time the southern countries grew more prosperous and started to introduce collectively financed care for older people on a limited scale. In the 1990s, in almost every country the focus shifted to a further extension of home care and other possibilities to grow old in one's own familiar surroundings (Pastalan 1997; Pynoo & Liebig, 1995). Within the EU-countries two approaches to ageing in place can be distinguished. Although both approaches are found in all countries, there are marked differences in emphasis and affinity. It is possible to relate these approaches to clusters of EU countries.

The first approach takes the residential situation of able-bodied older people as its starting point. For most elderly people in European countries that is a home of their own, in a village or in an urban neighbourhood (Commission on Family Housing, 1994; Moregas, 1997). The vision of ageing in place in housing suitable for older people involves structural adaptation of the home and living environment for people with handicaps and the availability of basic facilities within walking distance. Care and nursing at home can be stepped up as a person becomes more in need of help. On the welfare work front, efforts are made in the form of an 'older persons' adviser' and a volunteer aid scheme, to support independence and social participation in the event of any deterioration. At the same time, the use of devices in the field of home technology can help to allow people to live independently for longer. In this approach, ageing in place in housing for older people means that an elderly person does not have to move, or does so only during the last stage of his or her life, because the supply of residential care, and welfare services changes to meet their needs. A much greater affinity with this approach has been found in the countries of Central

and Southern Europe, where the family system forms the core of mutual solidarity and home ownership is the predominant administrative structure in public housing. In Northern countries the importance of this approach is increasingly being recognised (Evers & Van der Zanden, 1993; Pacolet *et al.*, 1998; Pastalan, 1997; Pynoos & Liebig, 1995). It is noticeable how investment has been taking place in this option for some considerable time now, particularly in the UK (Means, 1996; Tinker, 1997, 1999).

The second approach is based on the situation where, for whatever reason, the first approach cannot be implemented properly or cannot be implemented at all, particularly for vulnerable older people in the last stage of their life. The central idea here is that an elderly person cannot continue to live in his or her usual home in a village or neighbourhood any longer. Moving to a specific residential care facility for older people is therefore seen as unavoidable. In this case ageing in place in housing suitable for older people is geared towards offering such a flexible combination of functions in the project that a second move is no longer necessary. The size and quality of the apartment are comparable to what is usual in the ordinary, normal housing sector, so that people can continue to live in the way to which they are accustomed. Accessibility and adaptability help to ensure that self-reliance is not adversely affected by any mobility problems (Fich *et al.*, 1995; Lindstrom, 1997; OECD, 1992; Tinker, 1995). This second approach seems to be typical of Northern countries including the Netherlands, where for a long time, and in some cases well into the 1980s, the emphasis was on institutional care and on building specific housing projects for older people (Dooghe & Vanden Boer, 1993; Houben, 1997; Pynoos & Liebig, 1995; Reignier, 1994). It is interesting to note that experimentation is taking place in these countries with a synthesis of elements from the first approach, namely so-called neighbourhood-oriented approaches for urban settings with the concept of care zones. A care zone should be seen as a geographical clustering of homes in the vicinity of a facility where care and welfare functions are provided and delivered to the home if required (Lammers & Reyndorp, 2000).

For further analyses of policies presented below, it is important to look at the supply of these approaches from a functional point of view. Traditional and innovative forms of housing for older adults can be seen as various combinations of functions in the areas of housing, care and welfare. The most important characteristics of the concept of ageing-in-place are:

- The function of 'care' as it was provided in the traditional intramural/residential facilities is 'spatially disconnected' from these facilities, and also offered in other specific housing projects for older adults and in community centres.
- Care is customised and instead of being provided in a standardised manner as was the case in the traditional intramural/residential setting, is tailored to the specific needs of older adults, showing more respect than before for their choices and self-reliance.
- Social service functions like physical exercise activities, recreational activities, education, and counselling are also spatially disconnected from institutions, customised to the needs of older adults and offered in community centres.
- The housing function is no longer subordinated to demands of efficiency in care provision; especially in the innovative housing and care projects, the housing function takes on a more mature character: the dimensions and

comforts of the flats are comparable to those of the average apartment in the regular housing market.

- The housing function, particularly the bathroom and kitchen, is adapted to accommodate the mobility problems people encounter as they grow older; this strengthens people's self-reliance and extends the period they can live independently. These adjustments are not only made in specific housing projects for older adults but also in mainstream houses.

This analysis shows that ageing in place demands greater functionality of the various services on offer. First of all, the ageing in place requires 'spatial disconnection' of housing, care, and welfare functions. This means that care which used to be offered in an intramural setting is 'extramuralised'. What used to be a standard package with a set combination of functions is made flexible: the mix and quality of functions is adapted to the changing needs of older adults. An important characteristic of this functional approach is that all actions and means are directed towards a clear aim. This aim is solving problems and satisfying the needs and desires of a target group. For some time now, this functional approach has been common practice in technologically advanced activities such as specialised medical treatment. In low-tech work processes in the fields of housing, care, and welfare this functional approach is now also gaining ground. This is stimulated not only by the growing professionalism of those who work in these sectors, but also by their clients, consumers who, thanks to the achievements of individualisation, have developed an increased assertiveness and capacity for self-direction.

The allocation of financial streams also needs to be changed to facilitate the implementation of ageing-in-place (Houben, 1997). The public administration term 'function-orientated structuring' means that in future no longer will a limited number of standardised facilities with a combination of functions be financed, but a tailor-made mix of housing, care, and welfare functions. The increased flexibility in financing allows the service offered to be better suited to the preferences and recognised needs of the client as well as to his or her spending power and household budget. But to realise customised combinations of functions, co-ordination activities must be reinvigorated. The opportunities and constraints of this renewal of co-ordination must be seen in combination with general changes of the EU welfare states. This will be discussed in the next section

Co-ordination within the Context of Three Types of Transfer of Responsibilities

In the description and analysis of the co-ordination issues, the processes of implementing ageing in place and general transformation processes in welfare states in the last decades are discussed together. In order to come to terms with this problem it is useful to imagine the inter-sectoral policy system of housing for elderly people organised as a matrix in which actors on several levels are active. The matrix consists of columns containing the functions which serve the sectors of housing, care and social assistance. The rows contain the decision-making levels at which it is decided which functions will be supplied in which quality and quantity and in which combinations. Besides the levels which, in some countries, were originally managed by the state, processes of

decentralisation and privatisation have led to new decision-making levels lower down. To simplify things for the purpose of this discussion, one can imagine the regional and the local level and the market, which is generally local in nature. The lowest level is that of the individual. Before an individual can make use of collectively funded facilities it is established whether he/she is entitled to a function and at what price.

The international relevance of this matrix becomes clear when ageing in place and a number of simultaneous changes in management and funding are incorporated. These changes can be identified as three forms of responsibility transfer (de Boer & Roose, 1997; Liebig, 1995; OECD, 1992; Pitaud, 1991, 1992; VROM 2000; Walker & Maltby, 1996; Weekers & Pijl, 1998). The three types of transfer are labelled as:

- horizontal transfer
- vertical transfer
- transfer to the individual.

Horizontal Transfer

The term 'horizontal transfer' refers to consequences of function differentiation within and between the three sectors. First, within the care sector it involves splitting the traditional residentially based care into home care and residential care. This means that the home care package must be expanded more than is necessary within a system which emphasises institutional care. This intra-sectoral form of transfer will chiefly concern elderly people within the target group who, in relative terms, require the lowest level of care. Shifting this care out of institutions will contribute to the separation of housing and care. Transfer from one sector to another, especially from care to housing, seems to involve the greatest number of innovations. This is partly because the accommodation of people with mobility handicaps, who were traditionally housed in institutions, require more modified housing. Housing adaptation and the construction of adaptable houses should gradually lead to the entire housing stock becoming accessible and useable for people with handicaps. Besides this intra-sectoral differentiation in the housing sector geronto-technological aids also help these people to remain living at home for longer.

Looking to the social services sector, the inter-sectoral transfer to social assistance functions has been facilitated since the 1970s by centres which provide services for elderly people resident in the neighbourhood. Intra-sectoral differentiation in the social assistance sector in the last decades is indicated by the advent of innovative activities such as the elderly persons' counsellor, support for people with psycho-geriatric afflictions and community work in residential facilities for elderly people (Leisenring *et al.*, 1998). All these forms of splitting and horizontal transfer, prompted by intrafunctional differentiation, are taking place simultaneously with the vertical forms of transfer discussed next.

Vertical Transfer

This refers to the processes of decentralisation, deregulation and privatisation which have been common in the 1980s and 1990s. Decision-making on the correct mix of housing, care and social assistance functions and the quality level

of these functions is shifting downwards from the national level to lower decision-making echelons. It can also refer to the changing roles of public bodies such as the District Health Organisations in the UK, which are switching from being providers of care to purchasers in the market. The rise of commercial organisations in the care market can also be seen as a form of vertical transfer. It also creates new types of policy actors.

Transfer to the Individual

A specific form of vertical transfer is that which shifts towards the individual user of housing, care and social assistance functions. This concerns the transfer of responsibilities for financing and management to the individual and sometimes to the informal carers (Dooghe, 1994; Weekers & Pijl, 1998). Measures have been or are being taken in all three sectors to pass more control to the individual, for instance with individual rent subsidies or the provision of care budgets instead of care in kind. When elderly people have a certain level of purchasing power they are increasingly being required to make higher contributions to the services. In the case of higher-income groups this can cause them to shift to the free market, while on balance the spending capacity for lower-income groups is decreasing. In response to these higher contributions and the government withdrawal from this sector, an increasing number of residential care products are being developed along with supplementary health care schemes. The shift to the individual is becoming increasingly evident in a growing division between not-for-profit and commercial care facilities for people in the third and fourth ages.

The Focus of Co-ordination Policy at the Regional and Local Level

Looking to these forms of transfer the vertical transfer of responsibilities implies that lower decision-making levels will increasingly need to develop their own policy. The horizontal transfer of responsibilities and the shift towards the individual require the development of new products, services and procedures and entails collaboration across the boundaries of individual policy departments and sectors. These forms of transfer generate the creation of new policy-forming bodies such as steering committees, project groups and commissions mainly at the local level, which have the task of developing inter-sectoral policy. These new administrative bodies, in interaction with policy-makers from various (sub)sectors, must facilitate the co-ordination between the three sectors. Policy players include all those who are involved in the formation, determination and control of the policy, for instance managers and civil servants in government bodies, staff workers and managers of non-profit organisations and companies and representatives of the policy target group. Interaction in policy development consists, for instance, of consultation, discussion of a policy document or research report, allocation of budget items, the making of agreements, the conclusion of contracts etc.

Structuration theory defines the behaviour of policy players within a policy system according to:

- policy content: the policy content is evident from the explicitly and implicitly

accepted policy vision and the jargon used by the members of the project group or commission;

- positioning between the actors: this relates to the question of how the policy players exert their power in relation to each other in the commissioning group;
- legitimisation: the question of how policy players legitimise their policies depends on which sanctions they apply to steer the policy in the direction they wish.

The structure of such a group or commission is expressed in a policy content and mutual relationships which are accepted by the members, together with the related agreements as set down on paper and non-explicit aspects such as habitual ideas and routines. In so far as the members reflect the stability of their group or commission by 'reproducing' their structure, then their interactions will be reasonably predictable (Giddens, 1984). However, as soon as policy players no longer recognise structural characteristics of interdepartmental policy-making, such as the dominant viewpoint or the positioning between the players, then these structural aspects will have an increasingly limited influence on the behaviour of the actors. To the degree that initiating and change-oriented behaviour of the policy players increases, space will be created for new structural characteristics such as a new mission and different relative positioning (Schüler, 1998). It is this change in the production of the structure which simultaneously leads to 'restructuring' of the group or commission operating in the inter-sectoral policy system of housing for elderly people.

Research into inter-sectoral co-ordination amongst the local actors should focus principally on how policy players behave towards each other in practice within existing and new bodies (Ortmans, 1995). We can distinguish where the focus of co-ordination development chiefly lies:

- in the area of the policy content;
- in the area of the positioning between the players;
- in the area of legitimisation.

Looking at how actors handle co-ordination, these focuses can be related to the three forms of responsibility transfer, i.e. horizontal, vertical and according to the individual. The three forms of responsibility shift and the categorisation according to the dominant basic characteristic in the restructuring process have been related to each other in Table 2.

With regard to the horizontal shift, the policy content aspect is the main initial factor. The three policy sectors have to reach agreement on a shared vision on ageing in place and on how they are to rearrange tasks from one sector to another and within a sector, and what the reasons are for this. When it comes to the vertical shift and the shift to the individual then the relative positioning of players is the main factor. In the case of the transfer to the individual, legitimisation is important as well and in some cases policy actors of the central level are involved. The next section takes a closer look at issues of each type of co-ordination policy.

Main Issues in Three Types of Co-ordination Policies

When the main issues of the three types of co-ordination problem are discussed it will become evident that changes in health care play a dominant role. This is

Table 2. Forms of responsibility transfer and types of focus in co-ordination policy

Type of transfer:	Focus in co-ordination policies		Legitimation
	Policy content	Relative positions	
Horizontal	Development of a shared vision on ageing in place	Repositioning of players due to restructuring of sectors	More contributions and choices for the individual
Vertical			
To the individual			

not surprising in view of the difference in nature and costs of the services produced by the housing, care and social services sectors. It should be considered that the costs of care increase significantly in the fourth age. The increased need for care involves an increase of spending not only on medical treatment but also on care. The expenses incurred by the elderly themselves in the form of contributory payments, and above all the spending from collective facilities and/or insurance, rise exponentially for people in the last years of life. Using Canadian calculations as a basis, it has been estimated that spending on medical treatment and nursing home care in the last year of life is eight times as great as that in the fifth year before death (WRR, 1997). It will be clear that in the last years of life the involvement of the health care system, especially the care sector, far overshadows the involvement of the housing and social work sectors. This also means that in many countries the issue of inter-sectoral co-ordination seems to have been pushed aside by that of co-ordination within the health care sector itself.

Co-ordination Issues Regarding the Development of a Shared Vision on Ageing in Place

Taking into account all the literature regarding inter-sectoral co-ordination, it is noticeable that relatively frequent reference is made to the development of a shared vision and less to imperative policy instruments. This content oriented approach concerns:

- research and knowledge transfer through exchange of ideas about the best practice;
- financial incentives for experimentation;
- the development of standards for accessibility, establishment of needs and quality control;
- innovation programmes for developing and testing new approaches;
- programmes which promote the involvement of clients, volunteers and other relevant parties in the development of local policy.

A possible explanation for the use of this approach may be that ideas of how the new policy can actually be put in practice are still insufficiently developed. As previously mentioned, Pastalan (1997) pointed out that the current emphasis on

'ageing in place' has a strong mantra function. A second factor may be that the development of a vision is stimulated by trailblazers who experiment with a new approach. These people are intrinsically motivated and take a more independent attitude to rules and funding systems. An example of this can be seen in Sweden where, in the early 1980s, small-scale forms of assisted residence were developed by local innovators as an alternative to the traditional institutional care (Dooghe, 1994). A third factor is that inter-sectoral co-ordination always presents a difficult policy problem which is therefore, where possible, effected through 'management by speech'. Because the professional status of the actors is at the local level, mobilising their expertise seems the best way for developing a shared vision.

Developing a common vision on ageing in place is not easy. Practical experience with innovations shows that various ways of looking at things due to differences in discipline and policy priorities can form a barrier. Generally speaking, housing specialists are mainly interested in the architectural and market-related aspects of the existing or projected housing. Care and social workers, in contrast, focus more on how an elderly person and his/her network can best function. As well as the different priority placed on 'hard' or 'soft' aspects of provision, the interpretation of tasks is also strongly influenced by the current policy and available funds in each sector. This tension of opposites is illustrated very clearly by the situation in England.

The shift to community care which took place in the UK in 1990 has given greater weight to regular housing issues and specific housing for the elderly (Means, 1996). Smith & Malinson (1997) point out that the shift to community care in England means that the issue of properly managed housing should move higher up the agenda. They show that due to the 'dismantling' of the English housing system in the past decades it is now insufficient, in terms of quantity and quality, to meet the needs of the rising number of the elderly who require care but live independently. Formulated in terms of the desired target groups for welfare state provision, it can be said that initially a classic process of residualisation took place, i.e. a concentration on people who due to low incomes were unable to meet their own housing needs. Subsequently the definition of the target group was expanded to include, among others, elderly people who are no longer able to manage their home situation and need assistance. With respect to the latter group, separate residential projects can be set up or they may be housed together with other people with socio-economic and/or socio-psychological problems. This concentration of problem groups in social housing complexes is experienced as a serious disadvantage for the residential climate of these facilities. Social workers in search of a solution to this problem are therefore inclined to transfer people with disruptive behaviour elsewhere. This type of solution, however, is in direct conflict with the principle of ageing in place. Moreover, the admission of people with serious psychic problems to residential institutions is rendered more difficult because the psychiatric sector has also undergone a strong shift to community care and only the most serious cases are now admitted. For housing specialists this means that their target group is not only characterised by a low income, but also increasingly by problems when it comes to living and coping independently and with regard to social behaviour. On the other hand, it is becoming essential to devote attention to the social circumstances of tenants, to formulate this in the professional code of conduct and to increase collaboration with the care and social services sectors.

In practice the principle is increasingly being applied that smaller problems are solved by the housing manager on his/her own and in the case of larger problems contact is sought with groups in the other sectors (Franklin & Clapham, 1997). The professional detachment of the average housing manager in the second half of this century has led to him/her not being involved in the necessary inter-sectoral policy development to facilitate the shift of care to the community (Allen, 1997).

When studying what is, and what is not, feasible in inter-sectoral co-ordination it is important to realise that when developing the best approach for vulnerable senior citizens (i.e. those in the fourth age) the health-care perspective is often the dominant one. In most modern societies a relative increase in spending on health care compared to other types of provision in Western welfare states can be observed. The annual growth in this spending can be chiefly attributed to the professionalisation of health care through increased emphasis on the scientific aspects of medical treatment and medicalisation of care, combined with a high priority on the policy agenda. It should be noted that the medicalisation of ageing issues can displace the housing and the social care and welfare perspectives on these issues. A medicalised approach can easily lead to a type of care which 'takes over' the patient, inhibiting his/her own activity and initiative. If, however, one attaches importance to keeping people active, letting them manage themselves and keeping them involved in society, then adaptable building and a more 'activating' approach in care and welfare services need to be chosen. It also significant within which type of welfare state this debate between two perspectives takes place. The Scandinavian countries focus particularly on social participation and a correspondingly broad system of social welfare and social work. In Denmark, as part of the horizontal shift, nursing homes have been converted to residential facilities where home care is supplied (RVZ, 1997). This form of 'separating housing and care' implies that the dominance of the medical model confined to the nursing home is being reduced. Consequently, within the Dutch debate on the separation of housing and care other perspectives are suggested in addition to arguments for more client-oriented care. One of these perspectives is the 'citizenship approach'. This contains two aspects. First, the separation of housing and care means that one's own home is not used as a site for therapeutic activities. Second, reference is made to the principle of consumer sovereignty "that the inalienable right to housing also applies to senior citizens requiring (a high level of) care in residential care homes and nursing homes" (RVZ, 1997).

Co-ordination Issues Regarding Repositioning Policy Actors

In an international comparative study of housing for the elderly, Liebig states that there is a tendency in policy discussions about desirable housing to look chiefly at the required horizontal co-ordination and to neglect the vertical (Pynoos & Liebig, 1995). The preoccupation with horizontal co-ordination is thought to relate to a certain myopia at national level, whereby topics which concern national policy are given more attention than those relevant to government and policy bodies at lower planning levels. Particularly due to the trend towards territorial and functional decentralisation, the influence of more regionally and locally oriented bodies is also increasing in countries noted for their central control. However, the implementation of vertical transfer reveals great

differences in tempo between the housing and social services sectors on the one hand and the health care sector on the other. Within the latter sector the process of restructuring is proving enormously difficult in comparison to that in the housing and social services sectors.

One of the essential aspects of the reforms in the health sector is that the roles of some players are increasingly disengaged. The government is withdrawing, as far as is necessary, from the role of supplier and funds-provider and is confining itself to setting the rules applicable to the other players. Furthermore, the roles of insurer and provider are being linked in order to promote efficiency. Contracts are concluded between these two parties with regard to the care that should be provided, its quality and the accompanying budgets and costs. Generally speaking it is intended that health care insurers and care providers should enter into regulated competition with each other.

A notable feature of OECD studies is that this type of intra-sectoral reform is extremely difficult to implement and only succeeds if there is broad-based support (OECD, 1992, 1996). If consultations with interest groups are not conducted properly then there is a danger that these groups will simply push through their own interests. This puts heavy demands on policy-makers, who need considerable management skills to create acceptance for such changes which involve established interests and positions. The reforms seem to work better when they are introduced gradually and, preferably, have already been tested in experimental form.

The most notable forms of restructuring in Europe would seem to have taken place in England, Denmark and Sweden. For some decades England has been experiencing a reduction of the collective budgets. In 1990 a horizontal strategy was commenced with the strengthening of community care. This move was prompted because residential and nursing homes were growing too fast due for the income support which senior citizens with a low income received when they stayed in these homes (Walker & Maltby, 1996). Following two White Papers and a new National Health System and Community Care Act (1990) based on these Papers, an attempt was made to give better form and content to community care and to increase co-ordination between medical and social care. Initially, GPs were given a central role, based in part on regular home visits to the over-75s, in which they would identify any problems, including those to be expected in the future (prevention), and refer the client to relevant organisations. The Social Services Departments (SSDs) were restructured, from service providers working on the basis of intake and indication organisation to providers of a care spectrum and product/market combinations based on the needs of the elderly and to a manager and buyer of services. The Kent Community Care Scheme is the best-known innovation programme where management plays an important role and in which it has been shown that good community care reduces the need for residential and nursing care (Evers & Van der Zanden, 1993).

In Denmark the process of horizontal transfer, as well as vertical, started as early as the 1970s and both were radically stepped up in 1987. At that time the construction of nursing homes was halted, a systematic housing approach was introduced in accordance with a special model, and home care was significantly strengthened. At the same time the management was decentralised. Recently, however, attempts have been made to prevent further shifts between the counties and the municipalities. The counties administer the budgets for hospital

care and the municipalities the budgets for all sorts of social services and housing facilities. Now that the number of older patients in the hospitals is increasing and placing a heavier burden on the regional budget, it can be asked whether this is due to a shortage of facilities at the local level and the resulting upward shift of responsibility.

In Sweden a system of shared responsibility operated until the beginning of the 1990s: the regions were responsible for the care and the municipalities for social services. Due to a lack of mutual co-ordination, the regional task of care for the elderly was shifted to the municipality in 1992. Simultaneously it was determined that the municipality should pay the costs of patients in hospital who block hospital beds due to a lack of geriatric care. Furthermore, the state was to provide extra subsidies for a five-year period to stimulate the construction of alternative residential care projects. Besides this, separate programmes have been initiated to enable the construction of small-scale forms of assisted home residence and to increase the number of one-person rooms in nursing homes. Despite this more centrally initiated encouragement, it remains the responsibility of the municipality to determine which quality requirements they set for housing, care and social services. In practice it transpires that in a period of economic recession, such as that which hit Sweden in the early 1990s, budgetary problems at state and municipal level lead to cuts in spending (Dooghe & Vanden Boer, 1993).

Co-ordination Issues in Creating more Choices for the Individual

Co-ordination problems in the process of restructuring can arise with all three types of responsibility shift because a barrier can be formed by legislation and regulations or fixed agreements. Since codification always lags behind developments in society it can sometimes hinder or even prevent these changes. Furthermore, jointly formulated policy documents and covenants may fail to deal with an important aspect which was first discussed and arranged at a later date, thus causing the implementation to stagnate. It seems that organising the shift to the individual by means of a client-linked budget, thus creating a wider range of choice and powers for the care recipient, is primarily a legitimisation issue, more indeed than in the case of horizontal or vertical transfers. This is because this form of transfer has only recently come onto the agenda and is still creating a number of dilemmas (Weekers & Pijl, 1998). Besides this, the introduction of client-linked budgets affects the market position of home care organisations, the labour-law-related attainments of wage earners and the interests of people who provide informal services outside the official job market. Moreover, the reforms in the health care sector are tending to shift the emphasis to the supply side, via horizontal and vertical transfers, instead of towards the demand side (WRR, 1997). The horizontal and vertical shifts are now gaining acceptance and thus require less legitimisation in advance. Finally, the guiding norms and values in care provision and mutual solidarity within a particular welfare state can also be a hindrance.

The shift towards the individual is generally reflected in a rise in the contributory payments by those with average and higher incomes and a strengthening in the position and range of choice for those with lower incomes. Two opposing approaches can be taken regarding the situation of low-income groups:

- in one option, elderly people with a low income are provided with housing, care and social services (in kind) without a range of choice (or with very limited choice) within closely defined requirements for personal income and capital;
- in the other option, elderly people with a low income are provided with extra financial support within defined limits, thus allowing them to make more personal choices from the available range of housing, care and social services.

The responsibility shift towards the individual is especially marked in the care sector, where the relevant package of care increases in proportion to the complexity and size of the care requirements. The transfer within the housing sector is progressing more gradually and is reflected in the rise of the housing quota and the range of choice available when choosing a new home.

Dooghe (1994) describes how in most European countries care tasks are conducted by members of the immediate and wider family and by volunteers. Ongoing individualisation and increasing job-market participation by women serve as starting points for greater encouragement of informal care providers and volunteers. Financial support can be regarded as a token of public recognition and encouragement.

The most notable trend is represented by concessions to informal care providers. In the UK, for instance, this has taken the form of care allowances which are paid to care providers such as friends, family members, volunteers or other persons. The UK government provides an Invalid Care Allowance for people who give up paid work and spend at least 35 hours a week looking after a person who requires care. The aim of this innovation is to introduce new forms of engagement and solidarity. It should be said, however, that remuneration for informal care providers can be a controversial issue. In the US family members and spouses are excluded from this measure because care provision is seen as a natural duty. In the UK the authorities had to wait for a decision from the European Court of Justice before married women could be considered for the Invalid Care Allowance (Evers & Van der Zanden, quoted in Dooghe, 1994). This measure allows a payment if at least 35 hours of care per week is provided.

Dooghe remarks that the Scandinavian countries in particular show greater flexibility regarding the introduction of invalid care allowances. He links this to the fact that the welfare state in these countries has a relatively high level of social security payments and is controlled by the government. It has already been noted that the Scandinavian countries make large investments in job-market participation by women and the corresponding social facilities. In Norway, for instance, more than 30 per cent of all home care providers are related to those they care for. People who have worked for more than five years on the basis of care allowances and who are unable to find new work then receive a basic income until they reach the age of pension entitlement. A similar system has also been widely developed in Finland, especially as a substitute for formal home care. The standard remuneration varies, depending on whether or not the care provider is a relative of the recipient and has other sources of income. In the case of 24 hours of care per week the average sum is less than half of that for the professional at the start of his/her career.

A second trend noted in various European countries in the 1990s was the introduction of attendance allowances; this is money given to those requiring care to enable them to pay informal care providers. In the Netherlands this

option is becoming increasingly common through experiments in the field of client-linked budgets.

There is, however, a need to distinguish between different types of welfare state. As previously noted, Scandinavian countries focus strongly on job-market participation and thus also on a strongly expanded social security system. In Finland, for instance, the social services sector is highly developed and provides many employment opportunities (Dooghe, 1994). As already noted, in Denmark, as part of the horizontal transfer, nursing homes have been converted to residential facilities where home care is provided (RVZ, 1997). This form of 'decoupling of housing and care' weakens the dominance of the medical-oriented model in which the care recipient is confined to a nursing home. This Danish model also involves a legislative change to ensure that the responsibilities of each sector are well defined.

This option was first applied to disabled people and then extended to the elderly. It is thus natural that the definition of 'disabled' should include the condition 'not older than 65 years'; this also relates to the aims of this allowance. In the UK, for instance, the Disability Living Allowance is provided for handicapped people aged under 65; this allowance has a care component and a mobility component. Those aged 65 and above receive the Attendance Allowance which increasingly focuses on the care component (Dooghe, 1994; Weekers & Pijl, 1998). In this scheme a distinction is drawn according to the degree of care needed by the client. France also applies a similar age-differentiated system. In both the UK and in France these schemes are funded from the social security budget, with regional and local government playing a large role. In Germany the *Pflegeversicherung*, introduced in 1995, enables payments to be made to care recipients at home and is differentiated according to the level of care required (Dooghe, 1994; Weekers & Pijl, 1998). This scheme is based on a mandatory insurance programme conducted by the semi-public and private insurers.

Implications for Managing Co-ordination

The inter-sectoral policy-systems of housing, care and welfare for elderly people in the EU countries is typified by the simultaneous introduction of innovations as a result of the implementation of ageing in place and new, post-modern methods of control in policy and financing. The three forms of transfer described are leading to a strong 'fragmentation' of this inter-sectoral policy system. The vertical transfer to lower government levels and market players, together with the horizontal transfer, are creating new co-ordination problems if only for reasons of quantity. Indeed, we are seeing an explosive growth in inter-sectoral management and working groups at regional and local level in order to facilitate the necessary inter-sectoral co-ordination. Moreover, the indicated forms of transfer together with the increase in elderly people with a relatively high income and capital is promoting the creation and expansion of public/private partnerships.

The three forms of transfer imply a form of management which can respond to this dynamism. An OECD report proposed the term 'managed co-operation' to describe a desirable form of management (OECD, 1996). This term reflects the ambivalence between the desire to delegate to the lowest possible levels and nevertheless to retain certain essential controlling functions at the central level. In order to achieve the latter, techniques such as monitoring, benchmarking and

earmarking of budgets are thus increasingly being employed for functions regarded as essential. Delegation implies that regional and local policy players take responsibility for inter-sectoral co-ordination. In order to realise ageing in place, these regional and local policy players need to adopt quality control and the stimulation of innovations as normal management tasks (Means, 1999). Local-level policy players in the housing, care and social assistance sectors need to invest in 'partnership' and 'joint strategic actions' in order to realise ageing in place (Allen, 1997; Means, 1996; Smith & Malinson, 1997). As an indicative development, publications have appeared, especially in the UK, containing operational instructions on how to act, which knowledge and skills relating to the other sectors should be possessed by policy players, and how far each actor's sphere of responsibility extends (Means, 1999). It is notable that the 'interface' between the policy sectors needs to be realised through joint, content-related exchange. This approach is in line with the earlier description of co-ordination based on the development of an inter-sectoral shared vision on the multiple needs of elderly people. It can be seen as an indication that in this policy system principles of knowledge-management are introduced (Nanoka & Takeuchi, 1995; Senge, 1990). That type of management is aimed at making explicit the expertise and paradigm of actors and formulation of good practices and quality-aspects. In the post-industrial knowledge society not only policy-makers and professionals but also the growing numbers of well educated elderly people want transparency regarding tasks, responsibilities and products of providers of housing, care and social services.

As well as the shift from national levels to lower decision-making levels, at the same time responsibility for financing and control and for co-ordination is being transferred to the individual. In all three sectors measures are being or have already been introduced to give more control to the individual, for example through an individual rent allowance or by making care budgets available. Sometimes for older people in the fourth stage of life this is combined with an 'older persons' adviser' instead of care being provided in kind. Where older people have greater buying power, they are expected to make higher contributions of their own. For people on higher incomes this can lead to leaving the collectively financed system. For people on lower incomes, higher contributions of their own can mean that their ultimate spending power is reduced. In response to these higher contributions and the withdrawal of the state, the commercial market is developing more and more residential care products, as well as supplementary care insurance products. This is a symptom of residualisation and diminishing co-ordination power of the government. These phenomena may undermine the social and moral foundations of the 15 EU welfare states. Through efforts to give the European Union a stronger social profile, some thinking is taking place on how to give shape to new functional ways of co-ordination by promoting social quality (Houben, 2000).

Typical for the trend of innovations in housing for elderly people is that 'ageing in place' is an inspiring notion. This notion can be seen as an element of a future vision of the welfare state in the post-industrial society. The new liberal discourse of the 1980s seems to have been replaced by the neo-social democratic discourse of the third way (Giddens, 1994). Whatever one may think about the 'uniqueness' of the third way, it does take a fresh look at the relationship between the individual and the community. This renewed interest is justified by the fact that individuals have gained more control and co-ordination power over

their own lives as general level of education has risen, and there are those who are calling for the community to handle this capacity of individuals better (Cornelis, 1995; Ester *et al.*, 1993; Evandrou, 1997; Inglehart, 1990). The resulting paradigm for government can be referred to as 'life politics' (Giddens, 1991). An approach of this kind pays heed to the need for individuals to develop their own identities in the modernisation of society at the start of the twenty-first century. Until the 1990s 'emancipatory' policy was based on a number of general principles enabling deprived groups to be designated as the target group, whereas now life politics involves enabling individuals to design ethical lifestyles for themselves aimed at self-realisation. The comparison of the two types of social policy also shows that life politics requires initiative, communication and co-ordination skills and commitment on the part of individual members of society (Walters, 1997). This means that it is not so much a question of the state or local government imposing new norms for the role of the elderly, but, by means of life politics, mobilising and facilitating the independence, initiative and talents of citizens to create a meaningful existence for themselves. Ageing in place can be seen as one of the corner stones of the transformation of the welfare states in Europe.

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