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Social Policy and Models of Services for the Elderly International Perspective

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Social Gerontology Journal

2 (10) /2015

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Wydział Pedagogiczny,
Uniwersytet Pedagogiczny im. Komisji Edukacji Narodowej w Krakowie
EXLIBRIS Biblioteka Gerontologii Społecznej
www.bgs.up.krakow.pl

ISSN 2450-0232 (wersja papierowa)
ISSN 2719-9045 (wersja elektroniczna)

Skład:
Studio Grafpa, www.grafpa.pl

Druk i oprawa:
Zespoł Poligraficzny Uniwersytet Pedagogiczny w Krakowie

„Biblioteka Gerontologii Społecznej EXLIBRIS", Nr Rej. Pr. 2898, jest uwzględniona
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From editors

We are proud to present the new issue of our magazine. It is devoted to the problems of services for seniors and the wide concept of senior policy together with practical solutions and examples from various countries.

The history of senior policy is not long (tab. 1). The analysis thereof proves that demographic ageing and consequences of this problem are the focus of interest of international debate.

The issue of long-term care and social services raised in this volume is becoming more and more important, especially in the context of the WHO's prognosis stating that in 2050, more than 1/5 of the society will be aged 60 or more. The sub-population of persons in late old age will be a large part of that group. We must consider the possibilities of optimization of individual and environmental factors affecting old age preventive care and making the old age healthy and happy. Of special importance is the planning of continuous actions aimed at promotion and protection of health, especially the implementation of new programmes allowing older people to maintain physical fitness and correct sensory deficiencies (sight, hearing), as well as limited mobility before they become dependent (WHO, Health for All in the 21st century, p. 16). Positive ageing is not only about being healthy and not being limited by diseases and ailments of the old age, but also depends on the subjective level of satisfaction with life (Mackowicz, Wnek-Gozdek 2015), therefore actions aimed at improving the quality of life of seniors should also take into consideration the possibilities of fulfillment of higher order needs.

The entities creating global postulates and directions of the social policy *Towards a Society for All Ages* are (including, but not limited to) UN, UNESCO, UNDP – UN Development Programme, WHO – World Health Organization, ILO – International Labour Organization, the World Bank, OECD, HelpAge International, EURAG and other numerous senior and pro-senior organizations, the European Union together with the Par-

liament and the European Council, the European Commission etc. Those institutions and associations (federations) initiate social, international dialogue and debate on the problems of the ageing world. What is the outcome of the above activity? Further, detailed questions are necessary: What is the situation of older and old people in individual regions and countries of the world? What are the trends in national social policies towards the problems of ageing societies? What can we do to make things better? What are the role models and which "good practice" should we follow? Getting to know the rules of senior social policy can contribute to their popularization in countries with lower quality of life of older persons.

Table 1. International ageing social policy – selected initiatives

IMPORTANT DATES OF INTERNATIONAL SOCIAL POLICY ON OLD AGE (selected initiatives and activities)	
YEAR	**EVENT**
1974	Recommendation of the UN Expert Committee on Ageing calling for the development of a general strategy aimed at „aging well."
1976	Association Internationale des Universités du Troisième Age (AIUTA) is established.
1982	The World Assembly on Ageing (Vienna) Recommendation of the UN Expert Committee on Ageing calling for the development of a general strategy aimed at „aging well."
1990	Establishment of the International Day of Older Persons by the UN (1 October).
1991	United Nations' Principles for Older Persons To add life to the years that have been added to life.
1993	The European Year of Older People and Solidarity between Generations.
1994	UN's International Conference on Population and Development (Cairo).
1995	The first celebrations of the International Year of Older People.
1998	WHO: The World Health Assembly, Strategy Health for All in the 21st century.
1999	The International Year of Older People under the motto Towards a society for all ages.
2002	2nd International Assembly on Ageing (the so called Madrid Plan – International Plan of Action on Ageing) – the United Nations.
2002	The Ministerial Conference of the UN Economic Commission for Europe on Ageing, UNECE (Berlin).
2007	Initiation of the United Nations Programme on Ageing.
2008	Rights of Older Persons as the leading subject of the UN's agenda.
2012	The European Year of Active Ageing and Solidarity Between Generations.

Source: Szarota 2010, p. 192–197, Szarota 2014, p. 237–248.

Although we did not get any articles on those issues written from the point of view of countries where the quality of life of older people is the highest (Switzerland and Norway), however – thanks to our Authors – we get to know the solutions employed in Sweden and Germany, the Netherlands, Japan, the USA and the United Kingdom – i.e. countries from the top ten HelpAge International list of senior-friendly countries. In the contrast to the above, it is difficult to expect detailed analyses in countries, where authorities do not care about the lives of old people. Maybe in future volumes, we will attempt to analyze the situation of older people in developing countries. All the more so, according to WHO forecasts, in 2050, 80% of older people will be living in low- and middle-income countries.

The articles contained in this volume are a great summary of the principles of 19 national social policies on older people. Their order of appearance in the volume has been determined by the place of a given country in the ranking developed each year by HelpAge International organization (fig. 1).

The first three texts present an overview of the subject while the others relate to specific systemic solutions in a given country.

The basic variable in those studies is the quality of life of old people measured in enabling environments, income security, health status and capability. Another important factors include: life expectancy at 60-year-old, health life expectancy aged 60, pension coverage, national policy on aging.

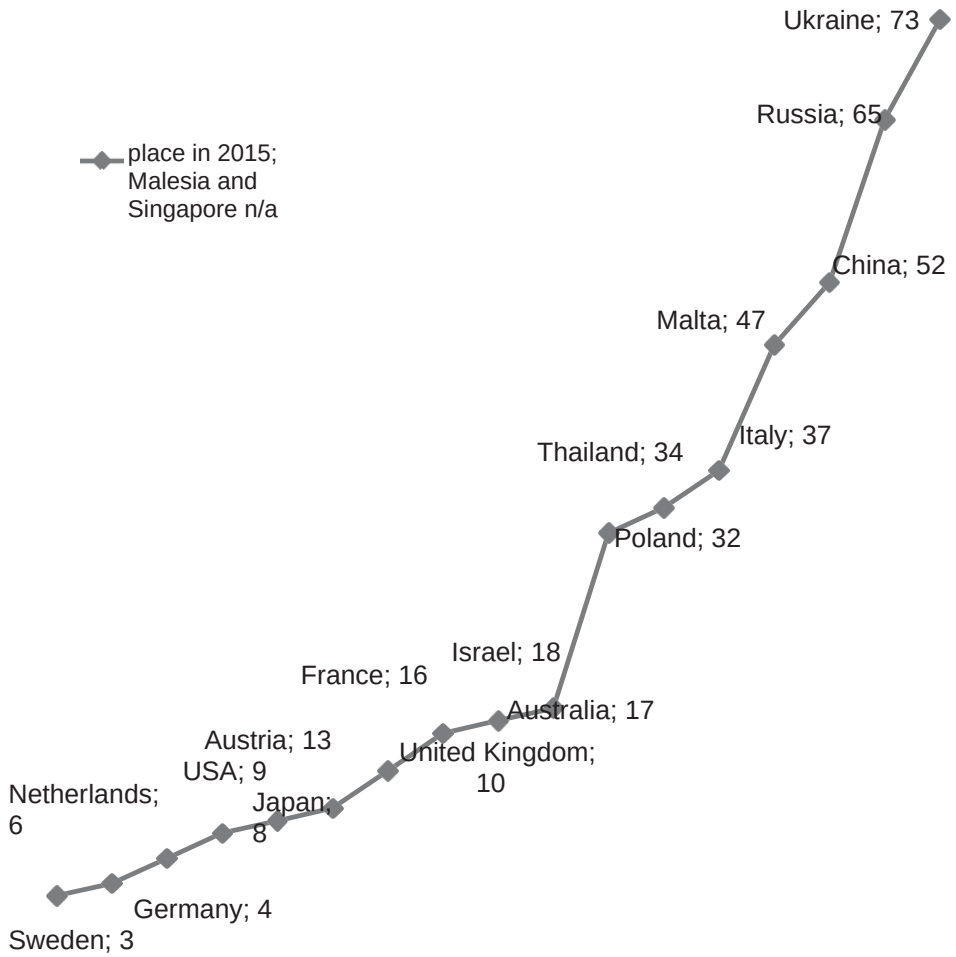
HelpAge International is a global network of non-profit organizations at national, regional and local levels. Its headquarters are located in London. HelpAge is operating mainly in developing countries and its mission is to help older people from all over the world in order to improve their quality of life permanently. It helps older people defend their rights, make their voice, especially the voice of people in a difficult life situation, be heard. It opposed discrimination and carries out activities aimed at combating poverty among old people.

It has been established by five organizations from Canada, Columbia, Kenya, India and the United Kingdom in 1983 with a view to build and international, important platform for making necessary changes. As of 2015, it gathers 115 organizations from 76 countries. It has its own offices and representatives in virtually every corner of the world. HelpAge in Africa has its members in Cameroon, Ethiopia, Ghana, Kenya, Lesotho, Mauritius, Mozambique, Nigeria, Sierra Leone, South Africa, South Sudan, Sudan, Tanzania, Uganda, Zambia and Zimbabwe. In Latin America, the network operates in the following countries: Argentina, Bolivia, Chile, Colombia, Costa Rica, the Dominican Republic, Haiti, Peru. North America: Canada and the United States of America. South Asia is represented by: Bangladesh, India, Pakistan and Sri Lanka. HelpAge has also been operating in the East Asia and Pacific region (Australia, Cambodia, China, Fiji, Indonesia, Korea, Malaysia, Mongolia, Philippines, Singapore, Thailand, Vietnam), in the Caribbeans (Belize, Haiti, Jamaica), as well as Eastern Europe and Central Asia (Albania,

Armenia, Bosnia and Herzegovina, Kyrgyzstan, Moldova, Russia, Serbia, Ukraine). It also carries out activities in Lebanon and Gaza – Occupied Palestinian Territories. HelpAge Network affiliates in the European Union are based in the following countries: The Czech Republic, Denmark, Finland, Germany, Ireland, Malta, Netherlands, Slovenia, Spain, Sweden, Switzerland and United Kingdom.

HelpAge International has been supporting the development of non-governmental organizations working with older people. It supports local projects, orders expertise analyses, gathers and propagates knowledge, raises funds and implements programmes for protection of older people, as well as helps older people in their rehabilitation. It provides aid to countries suffering from conflicts, natural disasters, countries undergoing

Figure 1. Countries analyzed in the articles on the axis of the Global AgeWatch Index 2015



Source: Global AgeWatch Index 2015, www.helpage.org

economic transformation and experiencing difficulties, provides assistance in crisis situations and helps refugees settle in their new home countries. HelpAge International has been successfully cooperating with the European Union on challenges brought by global ageing, human rights and humanitarian help. Through its Brussels-based office, it has been constantly cooperating with the European Commission, the European Parliament and other EU's institutions in Brussels. In this way, it actively contributes to the shaping of the trends in global and national senior social policies and monitoring of situation of older people in countries all over the world (Szarota 2010, p. 122; www.helpage.org). The volume also contains reports, reviews and information on good practice concerning digital education of seniors.

Our authors come from various corners of the world. We would like to thank them for sharing their knowledge. Enjoy the reading.

Editors,
Zofia Szarota & *Jolanta Maćkowicz*

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www.helpage.org

WHO, Health for All in the 21st century, www.who.int/en/

ARTICLES

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Beata Bugajska[2]

Towards creating a comprehensive care system for elders: an overview of long-term systems across the developed countries

Keywords: aging, long-term care, older adults

Abstract

As a result of two trends: the increase in average life expectancy and the decline in the birth-rate, population aging in many developed countries has been progressing rapidly. As the baby boomer generation (cohorts born between 1946 and 1964) ages, considerable attention has to be given to the increased demand for affordable and efficient long-term care (LTC). The term LTC encompasses a broad range of primarily low-tech services provided by paid professionals and unpaid family members to individuals with chronic health conditions or disabilities who need help with daily activities of living (e.g. bathing, meal preparation, cleaning). This article aims to provide a brief overview of the long-term care systems in different developed countries. Considering that current demographic trends, the aging population, and the number of people affected by chronic health conditions is increasing at an alarming rate, it is not surprising that there is a growing interest in developing interventions and creating policies that could lower the cost of providing long-term care and at the same time ensuring that all individuals have an access to health care. Some countries dedicated to introduce asocial long-term care insurance as a way of ensuring affordable access to long-term care. In this paper we review long-term care systems in developed countries such as Japan, Australia, the Netherlands, the United States, Sweden, Poland, and Germany. Although achieving superior outcomes such as longer life expectancy and decreased mortality rates at a relatively low cost is difficult, we suggested a few solutions on how to improve long-term care.

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Introduction

In the context of increasing numbers of older adults with chronic health conditions, the long-term care system has become an important issue for many countries which strive to deliver high quality care in a cost-efficient manner. Long-term care (LTC) refers to a variety of services that are offered to individuals who cannot care for themselves for long periods of time. The term LTC includes services that are medical and non-medical, and fulfill the needs of fragile older individuals who suffer from chronic health conditions, physical or cognitive disability, or other health-related conditions (HHS, 2013). LTC can be provided in a broad range of ways – for example, in home, in the community, assisted living communities, or nursing homes (Spector & Fleishman, 2001). Finding a way to pay for long-term care services is a growing concern for older adults, persons with disabilities, and their families. It is also a major challenge for state and federal governments. Understanding long-term care in an international context can lead to greater understanding of approaches to improve patients' outcomes both in terms of their health and economic aspects. In this paper we review long-term care systems in Japan, Australia, the Netherlands, the United States, Sweden, Poland, and Germany. We chose those countries because we wanted to provide a description of different models. In some countries older adults are offered long-term care through private sector whereas in other the long-term care is universal. The aim of this paper is to familiarize a reader with different types of long-term care systems across the globe and also encourage to a public debate on the issues older adults face.

Long-term care system in Japan

Given that Japan has the highest life expectancy in the world, it is appropriate to begin with its long-term care system. Japan is facing a rapid grown in aging population. Currently, the country has the highest proportion of older adults in the world; Japanese people aged 65 and over constitute 26% of the total population (Statistics Bureau, 2015). The efficacy of their health care is reflected by the country's highest in the world life expectancy which is 86 for women and 80 for men (2009; World Health Organization, 2011). The increasing rates of older adults highlighted the need for long-term care system. In terms of informal care, the eldest son's wife used to prove care for an elderly person. However, social norms have changed, which resulted in a significant decrease in the proportion of older adults living with a child or other relatives (decreased from 87% to 48%; Muramatsu & Akiyama, 2011). In order to cope with the growing expenses of LTC resulting from an increased number of older adults, in Japan implemented a mandatory public universal Long-Term Care Insurance in 2000 (Campbell & Ikegami, 2000; Tsutsui & Muramatsu, 2005). As a consequence, a variety of nursing homes become affordable for many Japanese individuals aged 65 and over whose physical and mental disability prevented them from

living independently. Eligibility for long-term care is based strictly on the assessment of disabilities, regardless of the availability of potential family caregivers and the economic status of the elderly. In Japan, long-term care insurance is separate and different from health insurance. Japan has a universal health insurance system where the financial contributions are provided either by a mandatory employment-based system, or a "community-based" system under which municipalities insure residents who are not covered by the employment-based system. On the other hand, the long-term care insurance covers care that is both home-based and institution-based. Fifty percent of the insurance is financed from the general tax and the other fifty percent from the premiums of the insured. The way it works is that all individuals older than 40 are required to pay long-term-care insurance premiums. They may access services at age 65 but those between ages 40 and 64 can use long-term-care services under limited circumstances. The premiums and user fees are the same in each region of the country and are determined based on income, thus the long term care insurance offers comprehensive and affordable care to older Japanese. The government also regulates the costs of medications and equipment. For both health insurance and long-term care insurance, the government is responsible for making policy, oversighting health care providers and tracking usage and costs.

Long-term care system in Australia

According to data for 2014, the average life expectancy was 79 years for Australian men and 84 years for Australian women, making the Australian have one of the world's longest life expectancies. The percentage of the population age 65 and over is 14.7 % in 2014, and is expected to reach 27% by 2051 (Australian Bureau of Statistics [ABS], 2014). It is projected that the number of Australians aged 85 and over will increase from 380,000 in 2009 to over 1.8 million in 2050 (ABS, 2014). With increasing rates of older adults, Australia has become more aware of the importance of providing cost-efficient long-term care, which resulted in the growth of nursing home care. In Australia, long-term care is provided by public and private sectors and divided into three forms: community care, low-level residential care (hostels), and nursing-home care. Residential care of the elderly is predominantly provided by the nongovernmental sector: by religious, not-for-profit, and private sector providers. Long-term care is provided to older individuals after a special kind of assessment which is unique to Australia. So-called Aged Care Assessment Teams (ACAT) comprise various health care providers (e.g., geriatricians, physiotherapists, occupational therapists, and social workers) and help in making a decision about whether an older person should remain home or is no longer able to live independently (Cubit & Meyer, 2011).

Recognizing increasing number of older people who could no longer remain in their own homes, the Australian government developed and implemented the Aged Care Act in 1997. Under this act the Australian government subsidizes residential aged care

facilities (RACFs) (including independent living units and nursing homes). In order to receive funding from the Australian government the care facilities have to meet compulsory accreditation standards and show continuous improvement in the quality of care and services provided to residents (Department of Health and Ageing, 2007). Because the care is funded by the government, it highly regulates prices charged to patients. Not-for-profit organizations such as religious or charitable organizations play a significant role in proving a long-term care in Australia (Cullen, Grey, & Lomas, 2014). Due to the fact that more and more individuals prefer to stay at home to prevent or delay admission to nursing homes, Australia has been experiencing a significant growth in services provided to older adults' homes. These services include personal care, transport, preparing meals, and gardening,

Long-term care system in Poland

Similar to other developed countries, Poland's population is aging. The population over 65 years of age represented 13.5% of the total population in 2010. Although the number of people aged 65 and older in Poland is lower than the European average (17%) (Eurostat, 2015), this percentage in Poland is expected to increase slowly but steadily so that by 2030, 27% of the population is projected to be 65 or older. Poland provides free healthcare to all of its citizens through the National Health Fund (NFZ), the publicly funded healthcare system. Currently 98% of the population is covered by a health insurance provided by the government (Sagan et al., 2011). All health policies and regulations are determined by the Ministry of Health. Health insurance contributions are collected by two social insurance institutions, namely the Social Insurance Institution and the Agricultural Social Insurance Fund, then pooled into the National Health Fund and distributed between its 16 regional branches. Due to limited financing, the NFZ limits the number of procedures health care professionals can perform. Within the health care system there are three types of residential long-term care facilities: care and treatment facilities, nursing and care facilities, and palliative care homes, coordinated by territorial governments. Chronic medical care homes provide nursing, rehabilitation, and pharmacological treatment for individuals who are dependent or disabled but do not need further hospitalization. Nursing homes were designed to provide care depending on the client's health status. In addition, they offer the help of physiotherapists and psychologists. Palliative facilities (also called hospices) are designed to enhance the quality of life of patients who are faced with incurable disease. They provide nursing, pharmacological treatment, psychological and religious services. Care and treatment facilities, nursing homes, and palliative facilities offer 24-hour care. Eligibility is based on a standardized assessment which examines a person's level of independence. There are also private non-profit care homes run by Caritas, a public benefit organization (OECD, 2011). In addition to publically funded long-term facili-

ties, older adults may choose to live in private LTC homes where the fee is negotiated by the organization and the client. Another form of residential care exists in the public sector, mainly in the social assistance (welfare) system. There are two kinds of social assistance homes: residential and adult day care homes (Golinowska, 2010). A residential social welfare home is an institution that provides around-the-clock accommodation. There are several kinds of residential homes, depending on the kind of care needed. For example, there are residential homes for the physically disabled, mentally ill, and chronically ill. The adult day care homes provide assistance for families. Adult day care services are limited to 5 days per week and no more than 12 hours per day. Older adults with cognitive impairment and mental disorders or patients with dementia are eligible to use adult day care homes. Care is provided free of charge and includes various therapeutic workshops and classes (Sagan et al., 2011). In 2008, less than 1% of the Polish population over the age of 65 received long-term care in an institution setting; in comparison, the OECD average is 4.2%. The need for long-term care insurance is receiving more and more attention. This solution was also discussed what in so-called *Green Book of long-term care*, created in 2010 by a team of experts in the area of long-term care.

Long-term care system in the United States

The population of adults aged 65 or over in the U.S. in 2010 was estimated to be 40 million, which represented 13% of the population (U.S. Census Bureau, 2011). Due to the aging Baby Boomer generation, it is projected that by 2030 the number of individuals aged 65 and over will be about 72.1 million and it will constitute 19% of the U.S. population (Administration on Aging, 2012). Although the health-care system in the United States is largely operated by private sector businesses, Medicare the federal government's health insurance program provides health care for nearly all elderly Americans and individuals with disabilities. Unfortunately, Medicare does not cover long-term care. Therefore, most long-term care is provided by informal caregivers (e.g., families and friends) and Medicaid, which is another federal/state health program. Medicaid covers long-term care but only for people with a low income, who live in poverty or who become poor. However, those who receive services paid by Medicaid varies from state to state. LTC in the United States is becoming increasingly unaffordable. Those who are not eligible for Medicaid have to pay out-of-pocket for their medication. As a result of increasing out-of-pocket spending, many older adults become poor and have to rely on Medicaid. According to estimates Medicaid supports care, in part or in full, for about two-thirds of all nursing home residents (Feder, Komisar, & Niefeld, 2000). Although older adults in the United States may buy a private Long-Term Care Insurance, this is still a relatively new product with which many older adults are unfamiliar and the premiums are high. Moreover, many people believe that Medicaid will

cover their expenses. Therefore, only a small percentage of Americans have bought the insurance. Nevertheless, many individuals emphasize the absence of an insurance system that would protect them from the financial risk of needing long term care (Pestieau & Ponthiere, 2010). Taking into account the demographic changes and increasing needs for LTC, policymakers are currently working on changes to ensure that LTC is available and affordable to Americans.

Long-term care system in Sweden

The older population in Sweden currently stands at 1.7 million, which represents 18.8% of the total population. The number of older adults in Sweden is projected to increase to 25.2% by 2030 (Davey, Malmberg, & Sundström, 2014). Similar to Japan and Australia, Sweden enjoys one of the highest life expectancies in the world. The current life expectancy is 79.8 years for men and 83.6 years for women. Because Sweden has the second-largest proportion of people aged 80 and over among the European countries at 5.3%, it has become a priority to the government to address equal access to long-term care for Sweden's older population. Sweden consistently ranks at or near the top for nearly all health outcomes (e.g., mortality rates, high life expectancy); because of this it necessary to examine the Swedish system and how it compares to other long-term care systems across the globe and what model it can provide to other countries (OECD Health at Glance, 2013). Long-term care in Sweden is government funded; therefore, every citizen of Sweden is eligible for care. The Elderly Reform Act introduced in 1992 shifted the financing and administration of nursing homes and home services from the government to the municipalities (Sundström, Johansson, and Hassing, 2002). Because long-term care is financed primarily through taxes collected by county councils and municipalities, the system is highly decentralized, meaning that each municipality decides its own rates for elderly services. Although regional and local authorities have broad power to provide and manage the delivery of health care, health policy is mandated by the government. In addition, the government is responsible for overseeing and evaluating the long-term care system. The elderly's ability to live independently is assessed by a general practitioner. An older person may be referred to different types of long-term care service such as home care, institutional care, day activities, home nursing care, meal services, personal safety alarms and home adaptation. There is a significant decrease in the number of Swedish older adults using institutional care. This phenomenon is caused by two factors. First of all, the total cost of institutional care, measured per capita of the Swedish population age 65 and over was approximately €3,000 in 2007 whereas the cost of home care per individual was less than €2,000 (Fukushima, Adami & Palme, 2010). Secondly, one of the Swedish health care system's priorities is to keep older adults independent. Thanks to the advantages in medicine, even extensive medical care can be delivered at home, allowing people to live independently longer.

Long-term care system in the Netherlands

At the moment, the proportion of older adults in the Netherlands is 16%, but the percentage of individuals aged 65 and over is projected to increase to 26% in 2035 (Statistics Netherlands [CBS], 2010). The average life expectancy in 2014 was 81 years; 78.8 for men and 82.7 for women (Eurostat, 2015). As in many other countries, the government is concerned about increasing health care costs because the Netherlands has one of the highest health care spending in the world; 12% of its gross domestic product, second only to the United States at 17.4% (OECD, 2012). Under the Health Insurance Act of 2006, private health insurance is mandatory for everyone. The Dutch are required to pay a flat-rate premium and an income-related contribution to a risk-equalization fund, which covers 50% of total health expenditure. However, those who cannot afford to pay the premium are provided with a monthly income-related allowance by the government. The Netherlands also introduced the Sickness Fund Acts under which low-income citizens are provided with basic coverage for general practitioner care, specialty medical services, physiotherapy, pharmaceuticals, and up to a year of inpatient hospitalization (van Kemenade, 1997). The Netherlands, as the first country in the world in 1967 introduced long-term care insurance as a part of health care (Jurek, 2013). A national insurance system for LTC (e.g., nursing homes) is provided to all of eligible inhabitants. This insurance is mandatory and provided by the government. All the cost related to providing long-term care are covered from the premiums, government subsidies and out-of-pocket expenses. Every person is provided primary care by a general practitioner who also serves as a gatekeeper for specialist and hospital care. In general, there is a lot of elderly who receive professional LTC. The proportion of institutionalized older adults (approximately 10%) is relatively high in comparison to other European countries (Smits, van den Beld, Aartsen, & Schroots, 2013). In addition, almost 18% of people 65 and over receive home care (Allen et al., 2011). The Dutch rely also on informal caregivers; three fourths of all elder LTC is provided by spouses, relatives or friends (Broese van Groenou, 2012). The increasing demands for elderly care were also recognized by Community-based organizations, which help with arranging nursing homes and home services (e.g., assistance with bathing or preparing meals) (Smits et al., 2013).

Long-term care system in Germany

Germany and Italy have the highest proportions of older people in their societies, after Japan. The percentage of people aged 65 and over in Germany in 2014 was 21% of the total population which is the highest in comparison with other European countries (Eurostat, 2015). Life expectancy at birth was 78 years for men and 83 years for women in 2014 (CIA World Factbook, 2014). With increased life expectancy and low birth rates, Germany is aware of increasing demands for professional long-term care. This is reflected by introducing a mandatory and universal system of long-term care insurance

(LTCI), which covers almost the entire population in Germany. The long-term care system in Germany provides a mix of public and private financing. It is worth mentioning that in comparison with the United States, Germany spends less of its gross domestic product (GDP) on institutional care (0.80 percent of GDP versus 0.98 of GDP percent in the United States) but more on home care (0.64 percent versus 0.39 percent in the United States) (Schulz, 2010). The eligibility of LTC is based on the extent of the need for care, regardless of age, income or financial resources (Schulz, 2010). The assessment for eligibility is conducted by geriatric-trained nurses and physicians, who evaluate both the home and social environments of the elderly and assign him or her to one of the three care levels (Büscher, Wingenfeld & Schaeffer, 2011). Depending on the severity of the frailty, elderly people in Germany may request home care, nursing home care or a combination of both. Home care is provided by professional staff (care providers) with whom the LTC insurance funds conclude a supply contract (Schulz, 2010). If an elderly person is cared for by informal caregivers (e.g., family members), they receive gratuities, which amount depends on the level of care. Additionally, if the caregiver is unable to provide the care (e.g., due to illness or vacation), the LTCI fund pays the costs of a respite caregiver which allows the frail elderly to remain home. In terms of financing, the insurance fee for long-term care is 1.95% of the employee's gross salary (2.2% for adults without children). Every member of the social health insurance scheme is automatically covered by social LTCI; however, employees who are not covered by social LTC insurance have to buy a private LTCI that correspond to those of social LTCI. It is also worth mentioning that the federal states oversee the quality and efficiency of LTC institutions and are also responsible for ensuring that an efficient and cost-effective long-term care is provided.

Conclusion

The increasing number of older adults will boost the number of dependent elderly. As the population ages, all of the developed countries will be forced to deal with the issue of long-term care. In the years to come, the pressure to improve long-term care systems in developed counties will grow, which will result in necessity for their governments to create new policies that aim at providing affordable and high-quality care. It is likely that in the years to come, countries that do not have a social long-term care insurance will have to consider implementing this model of providing care. The focus of this paper was to review current trends in aging and models of providing long-term care in the international context. This paper also serves as a ground for a more general discussion on how to improve long-term care in terms of health outcomes and costs. Although some countries provide high-quality care to their elderly patients, they struggle with increasing financial costs. To address these problems, the governments will have to implement an extensive set of reforms to strengthen their long-term care system.

Many individuals remain unsatisfied with LTC because the costs of the health care industry are rising and as a consequence older adults often have to take out loans to pay

for the their medical bills, especially in countries such as the United States. New policies can protect older adults from falling into poverty and can make treatment more accessible and affordable. While trying to maintain high quality services, countries will have to ensure equal access and affordable care for all citizens. Although it is a difficult task, there are a few solutions. Each of the abovementioned countries has experience that could provide lessons from which other countries might learn. The main challenge is to reduce the dependence on institutional care by exploring effective ways to maintain older adults' functional abilities and promote independent living. Therefore, it is extremely important to implement policies that prioritize health promotion and preventive health programs. In addition, it seems that the root of the problem with increasing rates of institutionalized individuals is insufficient screening of the chronically ill elderly and monitoring their health. Therefore, health care professionals should address this issue through early detection by periodic screening. Interventions should also include educating patients and their caregivers about the course of disease and promoting skill-based training to support the elderly patient's functioning. Another area of improvement is the need for creating a uniform and comprehensive assessment tool that will be helpful in detecting diseases at their early stages. This would allow for an early intervention and treatment. Subsequently, elderly people could delay or even prevent their need to receive long-term care. At the same time, having a comprehensive assessment tool would undoubtedly help in the procedure of recognizing a level of dependence.

In many of the discussed countries, long-term care services are still largely provided by informal caregivers. In some cases this situation is due to the fact that older adults prefer to stay at home and be cared for a spouse or a family member. There are also cases where older adults have to stay at home and rely on relatives for informal care because they cannot afford to stay in a nursing home. Taking care of an elderly person may result in caregiver burden and cause many psychological and physical symptoms. In order to decrease the burden and at the same time allow older adults to be cared for at home, the government should institute programs that provide the opportunity for a break from caring, for example, by day centers, with a host family, or in overnight residential care. While trying to decrease the increasing costs of long-term care, we should remember about the psychological and physical needs of an older person. Therefore, not only caregivers and health care professional should be educated in that matter, but also the whole society.

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Senioral social projects in the perspective of selected European countries

Keywords: senior, care, support, social Europe, good practice

Abstract

What could a happy old age look like and is it possible at all? According to Zofia Szarota (2012, s. 15–22) the fulfillment of a happy old age is possible, however, appropriate action should be taken early enough to achieve this goal. Education for old age should contain "five criteria, areas of human activity: biological criterion (healthy eating habits, looking after one's health, hygienic lifestyle, physical activity), mental criterion (self-knowledge, healthy egoism, self-acceptance, realistic optimism, positive thinking of one's future, avoidance of stress), social criterion (not succumbing to negative old age stereotypes, maintaining social activity, bonds with family and friends, engaging in the activity of various organizations and associations, assuming new social roles, sharing oneself with others), intellectual criterion (shaping cognitive curiosity, evoking and fostering interests, pursuing one's passion, creative spending of leisure time, maintaining intellectual prowess through cognitive and educational activity, being open to ongoing changes), as well as economic criterion ("sensible" life – saving money for a decent retirement, ensuring one's reasonable financial status and decent living conditions)". Unfortunately, fulfilling all of the above criteria depends on the social policy of a given country, its economic factors, as well as increase in the awareness of both younger and older social generations. Some societies have model examples of old age while others need radical changes. However, it is worth looking for best solutions and follow international leaders setting social standards with regard to care and support for the older generation.

This paper is an attempt to present some interesting initiatives and solutions concerning social support for older people. The examples have been drawn from the experience of West-

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ern European countries which, being richer and having better institutional systems, have developed interesting support models that can be currently implemented in Poland. Some of those solutions, in a limited form, had already been functioning in our country in the past and now we should return to them and give them a new, better quality. Other solutions require adaptive changes reconciling the needs of beneficiaries with market, legal and institutional capabilities.

Introduction

This paper is an attempt to look for some interesting initiatives and solutions concerning social support for older people. The examples have been drawn from the experience of Western European countries which, being richer and having better institutional systems, have developed interesting support models that can be currently implemented in Poland. Some of those solutions, in a limited form, had already been functioning in our country in the past and now we should return to them and give them a new, better quality. Other solutions require adaptive changes reconciling the needs of beneficiaries with market, legal and institutional capabilities.

To combat the common view that the population of older people is a heavy, multi-dimensional burden for the state and the society is a challenge for the European social policy. The perspective of demographic ageing of Europe[2] has been forcing politicians to undertake measures that will reduce negative consequences of ageing of the society in advance. According to Piotr Szukalski (2012, p. 6–7), the most commonly listed threats related to the quantitative predominance of older people over younger generations, is the increase of public expenses on social and medical benefits, nursing and care services, as well as institutional support. Apart from growing expenses, there is a risk of decrease of the size of the group of people in productive age with simultaneous tendency for ageing of work resources. Financial budget revenues are lower while expenses are becoming higher and higher. In the public opinion there is a myth that older employees represent a low level of innovation, they are reluctant to introduce changes, they learn slowly and it is difficult for them to acquire new skills, they often fall ill, become disabled and therefore cease to be attractive on the labour market. Those unfavourable opinions do not help strengthen the position of older people in the social or professional environment. For the public opinion, old age is more about costs than profits and the society is rather reluctant to invest in this social group[3].

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[2] E. Trafiałek (2012, p. 9) writes that (…) the decrease of the number of people in productive age which began in 2012 will result in the increase of the number of people aged above 60 in future years at the rate of 2 million per year. As a consequence, in 2060 there will be only 2 persons in productive age per 1 person aged 65 or more in the EU. The current proportions are 1:4".

[3] For example, it is easier to receive financial support for fund-raising charity events for sick children and orphanages than for older people and day care facilities for older and disabled people.

In order to minimize the above risks, the activity of older people should be strengthened at each stage of human development. This requires popularization of the concept of ageing and old age, strengthening of senior's activation so that the could remain professionally active, fit and independent for as long as possible, so that their guardians could receive public support and so that corporations could recognize positive values in older people and their professional experience for their own business development.

Participation of seniors in economic development

Many economists see in older people many opportunities for maintaining high economic growth in Europe, creation of jobs and an economic chance for prosperity. They recognize the opportunity of economic growth in promoting the concept of four branches of economy: green, white, blue and silver. The *green economy* means a conscious prevention of negative impact of human civilization on natural environment, responsible use of its resources, searching for renewable energy sources, as well as aware and sustainable consumption. This also encompasses the development of tourist amenities and services, as well as creation of recreational business with environmental safety in mind. According to forecasts, seniors will have much share in this branch of economy. Their free time will be animated by a number of institutions aimed at relaxation activities, promoting various forms of activity, including health and well being, activities for the benefit of community integration, helping people to break out of their isolation and loneliness. Those initiatives will also compensate for senior's lack of basic skills, for example in the area of new information technologies used in everyday life.

The *white economy* is connected with health care services. In the future, its activity will require high specialisation of services for older people.

The *blue economy* is based on innovative solutions promoting generation of new jobs, multiplication of social capital, development of entrepreneurship, introduction of new technologies and business models serving the general good – the social good, including older employees. In this area, the goal is to protect employee's rights, to modify organizational structures of companies in order to take into consideration senior, professionally experienced personnel, to make the working time of employees more flexible, to change the values and principles preferred by employers with regard to their employees, to effectively manage professional potential of older employees as masters and experts.

The area of *silver economy*, aimed at satisfying the needs of older people, is crucial to economic development. According to forecasts, this area will be developing dynamically in the future. Today, for many business entities, the key customer is the young and middle-aged generation. In many cases – except the so called luxurious, medical and recreational commodities – the potential and consumer capabilities of the older generation are underestimated. Today, for many branches of marketing, this generation is not as attractive as the dynamic and rapidly changing young generation. In the opinion of traders, the older

generation does not use as much goods and services as the younger generation. With time, this approach will surely change. In the future, the target group for many companies will not only be older people, but also people entering their senior age. In market goods and services they will find practical and usable value, suitable for their age, mental and physical capabilities. The group of silver economy customers, according to Piotr Szukalski (2012, p. 7), will additionally encompass institutional structures for seniors and such structures will be interested in the implementation of innovative technologies creating new consumers' demands. The development of silver economy means the development of its branches. Szukalski (ibidem, p. 8) expects that those branches will refer to: *professional activity of older generation*, their independence and self-reliance in everyday life by using "civilizational prostheses", as well as innovative solutions for intelligent buildings, *leisure time industry* combining education, entertainment, tourism, recreation, house pet care, as well as the area of *well-being and grooming, self-esteem,* the area of *intragenerational and intergenerational integration and the area of financial services* related to personal consultancy enabling efficient use of capital gathered during old age. The activities in the area of silver economy are intertwined with other areas: white, green and blue. In the above economies, older people are becoming more and more important customers. This potential has been recognized by companies, politicians, public administration, industrial and social organizations, however, it has been little recognized by seniors themselves. This tendency results from the views, stereotypes and approach of the older people themselves. One of them is to put responsibility for health on doctors and specialist while not being aware of one's own contribution to their well-being. Seniors are also reluctant to participate in care costs despite the wealth gathered for many years. They are more eager to give all their wealth to their children and families instead of using it to improve their quality of their life (reverse mortgage). Demographic changes also force the employers to adjust their work conditions and workplaces to the needs of senior employees. In the future, senior employees will be the predominant group of employees. In this regard, the concept of age management will be justified (more broadly: Kijak, Szarota 2013, p. 30–33; Podkański 2012, p. 11–19).

The concept of lifelong learning is also becoming of utmost importance. In order to maintain independence and self-reliance in everyday life, seniors must update their knowledge and develop new skills (more broadly: Szarota 2012, p. 7–18). Despite their apparent reluctance to use contemporary digital equipment, they must know that those technologies will be developed even further and enter into our everyday life more and more aggressively. Computer and mobile phone skills acquired once may be insufficient in further family, social and professional life. Similarly, a passive lifestyle preferred by contemporary seniors will not work in the future. The society will require older people to participate and engage in self-organization, self-care and participation in community activities. With the expected functioning of single-person households and disappearance of family bonds and change of the family model in the future, seniors will be obliged to create decent conditions for their old age on their own.

Good social practice in the European Union countries with regard to senior support

Today, the term "dignified old age" is defined differently in individual European countries. This is determined by social conditions in each of the countries. Some European politicians call the economic differences between individual countries as two-speed Europe. There is Western Europe with its well-developed economy and social benefits and there is East-Central Europe, the second speed Europe which, due to its past experience and poorer economy has significantly lower social standards. The role of the European Union is to achieve uniform standards in the social policy of member states, especially with regard to the older population. It will require a lot of legal regulations at both EU, national, sub-national and local level. Probably, those decision will be intertwining with the four types of economy discussed earlier and will be related to: environmental protection, health care, education, employment, retirement age, social package, coordination of social security systems, combating energy poverty and searching for renewable energy sources used to increase the quality of life of citizens, immigration policy of member states etc. Those regulations must also take into consideration the community tendencies for economic migration and free flow of employees within the EU and thus ensure continuous social security of employees and payment of retirement and pension benefits in any country of their residence. This regulation also provides for a free choice of medical services provided by member states, as well as a broad access to social benefits, which to some extent could be abused by citizens of poorer member states (Anioł 2011, p. 1-8).

An integrated transfer of proven social solutions for seniors in the European Union will not be possible for some time yet. Social Europe will maintain its economic gap for a long time. This is affected by internal social policy of individual countries depending on their economic growth, as well as domestic social and economic problems together with supranational difficulties

Before the harmonization of social policies with regard to older people in the European Union is put into practice, it is worth to analyze the experience of individual selected countries relating to care and support for older people that are worth mentioning.

The Great Britain experience

One of the interesting solutions in the British system of care for chronically ill seniors, which is not present in the Polish health care system, is the consolidation of social services. Those include medical, nursing, rehabilitation, therapeutic, transport and catering services that can be used by patients. The majority of patients referred to hospitals are patients with paresis following brain stroke in order to regain motor skills enabling them to function in everyday life. With time, the burden of medical consultations is assumed by local geriatric care represented by an interdisciplinary medical and therapeutic team. This solution helps home caregivers of dependent persons, lifts the burden of eve-

ryday nursing and care from their shoulders during the period of the patient's stay at the centre and, what is most important, strengthens patients physically and mentally in the period of recovery (see: Dziubińska-Michalewicz 2004, p. 2; Szulc 2012, p.108). Another good senior support practice in the British social and medical system is the close cooperation between the medical staff and social workers. Quick flow of information, in-depth diagnosis, cooperative medical and social intervention ensure better, more efficient help for those who need it. In the Polish system, there are no such close relations between medical personnel and social workers. However, such relations had appeared in the Polish tradition of social work in the past. At the moment of passing the Act on Social Welfare in 1990 (Dz. U. 1990, No. 87, item 506), social workers left the health ministry and became employees of the new ministry, the Ministry of Labour and Social Policy. Until then, they had been working as the health service system staff. Many of them worked in medical outpatient clinics and had everyday, direct contact with community nurses and attending physicians.

In the British social support system, the local actions supporting older people in their own place of residence are also worth mentioning. Those include, for example: occupational therapy in private homes conducted by professionals, laundering services, help in everyday activities, such as shopping, cleaning, dealing with official matters, preparing meals, assisting in transport, providing legal and social consultations. In Polish support systems, there are similar forms of help provided by community caregivers or older people's caregivers hired by social welfare centres. Some of the services are treated as specialist care services, such as work with a speech therapist or psychiatric care. To a very small extent in Poland, the work of professionals is supported by volunteer work. In the British system, there is a broad network of volunteers organized "by associations of people before their retirement age. Care-giving services are provided as part of self-help groups in exchange for a guarantee of receiving the same help in the future. On the basis of the Act on non-formal home caregivers of 1996, local authorities are obliged to take into consideration the work of non-formal caregivers in their actions and decisions and to support them in providing assistance. Those non-formal caregivers are usually family members (Dziubińska-Michalewicz 2004, p. 3; see also: Szulc 2012, p. 108).

Swedish practice

Care services for chronically ill people in Sweden are professional and very well-developed. Apart from medical and nursing care, patients at home receive rehabilitation and physical therapy. Medical services are employed by self-government authorities and are at the patient's everyday disposal. Home assistance is very well developed and, like in Poland, encompasses care-giving and specialist services together with broad support for sick and disabled people in to improve their living conditions, including e.g. elimination of architectural and transportation obstacles and barriers. Care-giving services are also provided to animals in one's household. At the moment of placing a patient in

a hospital, social services, neighbours, friends or social organizations start to look after the property. Worth mentioning is the obligatory procedure of maintaining frequent, regular contacts between social workers and their patients. Usually, it has the form of a telephone contact. Home assistance services are paid. They are partially funded by patients and partially by the commune. If family or help provide home assistance, this scope of work can be funded by the commune authorities. In Poland, such a solution appears only in the senior policy principles as a tool for supporting non-formal care givers and is to be introduced as a systemic solution in the nearest future. In Sweden, if seniors are non-formal care givers, they receive a formal, legal assurance that in exchange for their commitment, they will be covered by a free home support system in the future if need be. In the Swedish system, there is also a home assistance benefit in place. It is given to the caregiver: a family member or a friend. In Sweden, there is also a social acceptance of various forms of collective housing of older people (see: Szulc 2012, p. 103–110; see also: http://dps.pl/domy/index.php?rob=swiat&id=48). For example, there are care homes (blocks of flats) consisting of small, single or double-person apartments managed by the commune. Apart from the residential section, there are also common areas. Such homes also provide medical help. A similar solution is in place in the German community support system[4]. Also, this system resembles the long forgotten specialised housing offer in Poland, targeted to physically and mentally able seniors (pensioners), operated by housing co-operatives, called Happy Senior Homes, colloquially referred to as pensioners' houses (Piłat 2010). Apart from a single or double-room apartment, the tenants – members of the co-operative, could receive specialised services, such as medical and nursing care, paid meals in a co-operative canteen or leisure time activities in a common room. Apartments in such a co-operative were intended only for older people with steady income, after prior payment of a partial financial contribution. The apartments operated a rotating system. It meant that when one of the tenant died or was moved to a social care home, the apartment became the property of the co-operative, who assigned it to another person from the waiting list. During the period of transformation into market-oriented economy and general economic chaos, some of the cooperatives had to sell their assets in order to survive and so the tenants were able to buy ownership title to their apartments. In such a situation, the apartments became the property of the family. The apartments became occupied by seniors' grandchildren, the tenants were becoming younger and more independent so they gave up on community services, such as common rooms or canteens which were an additional burden of the tenant's financial account. In today's perspective, this solution from 1970s–1980s is not very popular, the developers are now more eager to build apartments for young families than for older

[4] Those are special residential houses for older people with separate apartments supervised by medical personnel on duty at a reception desk / porter's lodge or houses with apartments for people with limited mobility who are unable to maintain a household on their own. Therefore, they often use additional services, such as meals, organisation of leisure time or nursing care.

people. It is a shame that this model of housing is not coming back. It has a lot of potential for the development of senior volunteering, self-help and self-organisation of older people, which could relieve the system of institutionalised social support.

German solutions

Many European politicians support German solutions that are aimed at ensuring dignified old age for persons requiring long-term care. The purpose of the statutory obligation to pay care and nursing insurance introduced in 1990s is to ensure that older people with low and moderate income can pay the costs of home and institutional care. In the case of home care, the interested person can receive services provided by a competent entity or accept a financial equivalent of such a service with the intention to use it for the benefit of the closest persons who give up work in order to provide direct care for sick persons at home. It is worth mentioning that in the German system, non-formal caregivers (family members, closest friends of the dependent person) are covered by a free system of training and psychological support aimed at combating everyday nuisance and tiredness. (see: Szulc 2012, p. 103–110). This solution will probably be introduced in the Polish system and employees will have to pay an additional insurance premium. Financial and non-financial support for non-formal care givers has already been referred to in governmental documents setting the goals of national senior policy contained in the Principles of Long-Term Senior Policy in Poland for the years 2014–2020.

Austrian model

The system of care for older people in the Austrian system is not much different from typical European trends. However, one of the most valuable solutions is the coverage allowance for long-term care. This benefit is of universal nature. It is paid to anyone in need of long-term care. It does not depend on the income of the person in need. The purpose of introducing this benefit by Austrian authorities was to:

- "Promote independence of persons with regular care needs
- Allowing people to choose the type of care they need
- Support family caregivers
- Create new jobs and types of service
- Encourage people to choose home care instead of institutional care" (Ruppe 2013, p. 66)

Other solutions, such as the "Care Phone" (Pflegetelefon) and the website: www.pflegedaheim.at are also aimed at facilitating care of older people. Those are the instruments of the Austrian Ministry of Social Affairs whose purpose is to publish comprehensive information on home care management, the functioning of the care service centre, organization of advisory visits, as well as preventive measures (ibidem, p. 66). In Poland, similar role is played by regional divisions of the National Health Fund. Their websites contain information on long-term care institutions and support requirements. Unfor-

tunately, information on support in case of: illness, disability, age-related physical and mental impairments. low income, accidents etc. is not coherent. Such information is dispersed in many other ministerial institutions (social support system, Social Insurance Institution [ZUS], State Fund for the Rehabilitation of Handicapped People [PFRON], Farmers' Social Security Fund [KRUS] and programmes operated by public and non-public institutions. This distribution does not facilitate the quality or comprehensiveness of activities.

Another Austrian example that is worth following is the concept of the functioning of day clinics dealing with "geriatric remobilisation and (...) institutions dealing with (author's note) continuation of hospital therapies (...) or initiatives aimed at introduction of rules of management of hospital discharge" (more broadly: Ruppe 2013, p. 71). The initiative of dynamically developing structures of mobile geriatric teams aimed at: in-depth diagnostics, multi-dimensional therapy and social reintegration has also been working well. Alternative housing forms, such as "combined flats" for older people in need have been developed as well.

All of the above solutions appear in the Polish system, however, those models work best in the area of community psychiatric care. However, in other areas of institutional and non-institutional support, they require further reorganisation and clarification.

French inspirations

In France, social services for older people are more integrated. It results from the Care Service Strategy (SAP) developed and implemented in 2004. The strategy refers to the concept of social coherence. Under the strategy, the market of care services was established and new, permanent jobs were created. The achievement of the goals of the above strategy has been planned on three levels: client's level, professional caregiver's level and entrepreneur's level. *The client* – the beneficiary is given the so called CESU Voucher. There are two types of such vouchers. One of them is purchased by the interested person at the bank, at which they have an account. It is used to cover the costs of care services. "For households using intermittent help of external caregivers, using vouchers is beneficial as it limits administrative formalities connected with the engagement of an employee. Moreover, the services paid for are recorded by the client's bank, which allows the client to use a tax credit at the end of each fiscal year." (see: Surdej, Brzozowski 2012, p. 11). The second type of the voucher is available only at licenced entrepreneurs approved by the central state institution responsible for the development of ANSP care services. CESU Vouchers can be issued to employees by private companies, being an additional, non-monetary form of remuneration. (…) they can also be issued by private and public institutions: insurance companies, pension funds, as well as local and regional authorities (see: Surdej, Brzozowski 2012, p. 11 and subs.). The second level is the *person providing care services.* The caregiver receives a governmental support under the adopted strategy. Its goal is to give the caregiver the opportunity of acquiring

and improving qualifications faster (a system of easier validation of knowledge and skills has been introduced), better access to specialist trainings, guaranteed improvement of working conditions and, what is most important, ensure salary increase. An additional instrument is used to ensure salary increase – a subsidised allowance paid in addition to the salary. Unemployed persons have the possibility to combine unemployment benefit with casual jobs in the care sector.

The third level is the *entrepreneurs'* level. Activities in this area are related to the promotion of professionalisation of SAP services and support for private companies operating in this sector by allowing organisational amenities and tax credits (e.g. minimisation of administrative formalities through the development of voucher system, introduction of low VAT rate, increase of the scope of the support offer etc.). The whole care service system is strictly supervised. The supervision is carried out by ANSP agency, which also sets standards in this regard (ibidem, p. 11).

French solutions are comprehensive in nature, they create mechanisms for the development of the care service market. They are available to all the citizens in need. In the Polish perspective, the market of care services is in the phase of pilot activities. (care service standards are currently being implemented by Social Welfare Centres). Time will tell whether such services are universal and enter into the market, becoming subject to competition law. It is important whether the services are targeted to other groups in need apart from the clients of the social welfare system.

Italian examples

The Italian model of senior support gives preference to a solution, in which one of the children lives with his/her older parents and looks after them or visits them, organizing and supervising the care that is being provided. The Italian system, just like the Swedish and German one, guarantees financial allowance for families providing home care. If the family is unable to provide direct care, the financial support can be used for hiring a caregiver. Currently, care services for older people are usually provided by immigrants from Poland, Romania, Ukraine and Moldova (see: Perek-Białas 2012, p. 114). An additional help for families is the statutory employee's right to three days of holiday in each month in order to provide direct home care for older people. To some extent, it allows employees to reconcile employment duties with the duty of care and private life of professionally active members of the family. There are works pending on this solution in the Polish system as well (principles of the pro-senior policy), however, it will require a number of agreements between the decision makers and employers, who must find replacement workers for the time of employee's absence and incur related costs.

It is also worth to refer to Italian experience concerning the operation of social economy enterprises. Social co-operatives employing people from socially disadvantaged groups are typical for the Italian system.(http://www.owes.fundacja-proeuropa.

org.pl/sites/default/files/2007.10.pdf) Such co-operatives could create new jobs in Poland and employ older employees in the future. Senior employees could search for economic niches for their activity, for example in the area of care services or manufacture of goods targeted to older and disabled clients only.

International activation of seniors

Support for older people is not only about care and nursing services, but also about activities aimed at triggering civil activity of seniors, encourage them to participate in the creation of public policies and inspiring them to take part in various local projects. There are many examples of activation of seniors in the communities of the old Europe and some of them can become a source of inspiration for other local communities. In Hollingdean (UK), an initiative for the analysis of issues of poverty and marginalisation was established. In this aspect, the focus of interest was on nutrition methods, problems with access to stores, their topographic locations, quality of nutrition plants, register of local entrepreneurs producing and supplying food, eating habits and preferences of local residents, forms, methods and techniques of nutrition education etc. The authors of the project engaged not only representatives of local authorities and city councils (Department of Health Promotion, Department of Social Policy) or leaders of non-governmental organisations, but also the residents themselves. They established contacts with various social groups – children, adults and older people. They were also interested in religious and ethnic groups etc. The purpose was to obtain various points of view on issues related to food and eating. The authors used every opportunity to gather information and ideas (local festivities, school meetings, senior club events, meetings of hobbyists, they also created focus groups and conducted open workshops). At the same time, residents were given an opportunity to freely analyse their situation and seek for possible solutions. The material gathered became the basis for creating an outline of a local strategy for increasing citizen's access to healthy food (more: The Foundation for Social and Economic Initiatives (FISE) 2010, p. 52–55).

In Spain, with the help of the residents, a "Municipal plan for elimination of barriers" was developed. The founder of this project was a non-governmental organisation – ONCE Foundation acting for the disabled people. The challenge was to diagnose all the architectural barriers appearing in the urban area of Valdemoro city. The organisation identified all the parking lots for the disabled, city bus stops, quality of pavements, access platforms, availability of taxi ranks, public utility buildings and typical communication routes in the city. The materials gathered were used to prepare directives and instructions for city authorities to eliminate barriers while maintaining universal rules reconciling the needs of all the disabled persons, older and sick people, as well as mothers with children. (Ibidem, p. 45–46).

Another interesting project that brings generations together is the initiative of the English SynfoniaViVa orchestra (more: *Identity*…, 2011, p. 88-97), which attempted to

increase integration of local community through music workshops. The project initiated by the orchestra was attended by the representatives of local youth and senior groups. During the project, the goal was to change the mutual perception of the two groups, to recognize the contribution of each group to social development, to integrate various age groups through music workshops and joint public performance and, ultimately, to bring generations together.

Another interesting and attractive project is the international project for integration of social groups with fewer development opportunities. The project is entitled „Library for everyone" (more: *Identity*…, 2011, p. 79–87). It is carried out simultaneously in Austria, the Czech Republic, Germany and Sweden. The project is implemented as a local partnership by local public libraries together with institutions dealing with foreigners. The inspiration for the project was the idea that "for some time, we have been witnessing people of various nationalities and from various cultures meet in the European community. Those people have the same desire – to build a new, friendly home. Libraries can answer this need. They are centres of various activities as they bring together people of various generations, people who share the same hobbies or interests." (Ibidem, p. 79). Libraries participating in the project offer a number of educational and cultural activities for various age groups. In their community work, a lot of emphasis is put on adaptive programmes for minority groups, as well as activities aimed at intergenerational integration. For example: in Austria, national minorities are offered free translation services and language courses, meetings and events encouraging unemployed women to integrate with the local community and there are social consultations concerning matters important to a given group and community. In Sweden, a cafe opened next to one of the public libraries is very popular. Its services are rendered in two languages: Swedish and Kurdish. The library allows foreigners to take part in free computer and language courses, the children can count on help with their homework and adults, including older people, can participate in various fine art workshops. In Germany, the offer of public libraries is aimed at helping students and adults learn German language and includes social support together with various educational and artistic activities for adults, including older people. In the Czech Republic, the municipal library in Prague offers events for foreign children, adults and seniors. Those events include concerts, workshops, meetings, theatre performances, public debates, Czech language courses and information materials presented in two languages, as well as help with translation of texts and proper writing.

Similar engagement of citizens can be found in Poland. Many public libraries operate social projects activating older people. Usually, they include initiatives aimed at combating social and digital exclusion. Those are usually free computer courses, information and education activities, cultural meetings, events, parties, as well as indoor and outdoor events organized with the participation of older people. Seniors also participate in a number of social projects. For example, the Provincial Public Library in Kraków

together with the Foundation for Economy and Public Administration has been implementing the project entitled "Needed – Active – Senior" since September 2015. The authors invited persons after 60 year of age to participate in the program, persons who want to make changes in their life and environment but are not sure how to do it. The participants of the project will acquire knowledge on mechanisms and possibilities of involvement in actions for the benefit of their communities and then they will put such knowledge into practice. The project provides for the following activities: civil coaching workshops, a studio visit, as well as organization of an Active Senior Day. The authors of the project assure that the beneficiaries of the project will have an opportunity to spend some quality time, acquire new skills and information, as well as establish new contacts and relationships (http://www.rajska.info/o-bibliotece/...).

Seniors' activity is apparent in the area of public matters. Many municipalities, including Kraków, have appointed their Senior Councils. Their job is to represent the interests of their local senior communities, initiate new enterprises, providing consultancy and opinions on activities important for the local community. The representatives of the senior environment are recruited from actively functioning formal structures operating in local communities, including: social organizations engaged in various statutory tasks, district and employment-based senior clubs, Universities of the Third Age, day care homes, civil committees, parish clubs and teams. On the domestic market there are also many companies that support various community programmes under their "Socially Responsible Business" (CRS) philosophy. One of the examples is the social programme initiated by the Orange Foundation under the name Orange Workshop. Its goal is to establish and support 50 common multimedia rooms throughout Poland. Common rooms are supposed to be the vital place for local residents of a given town, both children, adults and older people. The aim of the workshops is to bring generations together through common meetings that create passions, hobbies and interests, organisation of special events, training courses, workshops and other activities related to local needs. The workshops are to facilitate access to new technologies, increase digital competences of local residents, build community bonds and intergenerational integration (https://pracownieorange.pl/o-programie).

Summary

Probably there are many social programmes in the European public sector aimed at pro-senior activities stimulated by governmental and self-governmental administration and social activists. Sometimes, such activities are reinforced by corporate capital, which helps many projects actively solve problems and issues of local communities. Many of the promoted activities for seniors is worth following and duplicating. However, small budget, lack of systemic and legal solutions and institutional structures is still an obstacle for a number of communities. Not all European countries have a high gross national

product (GNP) index and not all of them can count on financial support under EU's social programmes. Poorer countries have to seek their own solutions based on domestic capabilities, work out their own inspirations aimed at civil cooperation, development of volunteer work and self-help groups in order to ensure better care and support for their seniors.

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Social policy on ageing in select asian countries

Keywords: Asian countries, population ageing, social policies, programs, long-term responses

Abstract

Most Asian countries have experienced rapid socioeconomic changes along with the demographic and epidemiological transition which has necessitated policies on ageing. The policies and programs initiated in many of the Asian countries are similar in their response to address the challenges of ageing, yet they vary in terms of care and service provisions. There is an attempt to strengthen and sustain family and community networks, social security measures, health care facilities, and enhance opportunities for older people. Many countries have shown political will and adopted legislative mechanisms to meet the needs of growing number of older people as well of the adult population caring for parents. There is greater emphasis in policy response to provide for adequate quality and quantity of health, economic and social care. Governments have adopted a development approach as well as a welfare orientation to address the needs of their ageing population based on Madrid International Plan of Action on Ageing guidelines. But some of the Asian countries, depending on the proportion and absolute numbers of their ageing population, have developed comprehensive plans for policy and action with a long term view to improve the quality of life of the growing and emergent groups of older people, while some other countries are still struggling with their resources to respond to their young and ageing population simultaneously. In this paper I reflect, based on analysis of literature, reports and documents review, on the social policy initiatives on ageing of select Asian countries, namely China, Japan, Malaysia, Singapore and Thailand, and emphasise that countries have an opportunity to learn from

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each other. The extant policies, practices and models of services and programmes developed by some of the countries can serve as models for others to adopt, given their own resources and political will. How countries respond will of course depend on their demographic and epidemiological transition.

Introduction

Signs of ageing can be observed in many of the countries of Asia, with the process most advanced in Japan, although China and India with their large population base take a lead in having the largest numbers of older persons. The fastest growing among the older people are those aged 80 years and above. The population of older persons defined as 60 year and above, is projected to increase in many of the Asian countries, by twofold or even threefold by 2025 from the latter part of the twentieth century. Ageing of the population provides special development challenges and opportunities for policies, programs and services in both rural and urban areas. While existent facilities and provisions need expansion and enhancement of capacities and entitlements, there is growing need for providing new services and programs to meet the growing needs of the ageing population (United Nations, 2006).

Some of the Asian countries became conscious of developing policy on ageing by participating in the First World Assembly on Ageing held in Vienna in 1982. Subsequently the 1992 Proclamation on Ageing of the United Nations, and various other internationally agreed principles helped concretise their action plans, but these did not lead to any long term perspectives. Also many Asian countries did not have any clear cut policy on older people. It was just before the turn of the twenty first century, that the signatory countries from Asia to the *Macau Plan of Action on Ageing for Asia and the Pacific* (Macau POA, ESCAP 1999) began setting concise policy recommendations and attempted to have goals and targets. However, it was the *Madrid International Plan of Action on Ageing* (MIPAA) adopted at the Second World Assembly on Ageing held in Madrid in 2002, which outlined a precise policy response and an action plan for meeting the growing and expanding needs of the ageing population in many of the Asian countries (United Nations, 2002).

Consequently, many countries in Asia framed their policies and programmes in line with MIPAA which outlined three Priority Directions: (i) Older Persons and Development; (ii) Advancing Health and Well-Being into Old Age; and (iii) Ensuring Enabling and Supportive Environments for Older Persons (United Nations, 2002). However, all of the countries have not been able to implement the policies effectively, mainly due to limited resource allocation and lack of strong administrative will. Based on MIPAA guidelines respective countries recognize the need to have policies for improving the situation and circumstances of older persons by empowering them. Governments take note that

older population like the younger age groups is a heterogeneous segment with special needs based on age and gender. And, importantly that older people are to be made part of the development process of the country. The first Priority Direction of MIPAA which deals with older persons and development, states in Article 16, that 'older persons must be full participants in the development process and also share in its benefits'. For persons to continue to be a resource in later years it is important that they enjoy equality of opportunity throughout life. This means that there should be opportunities for continuing education, training and retraining as well as vocational guidance and placement services. Taking lead from MIPAA many Asian governments initiated programs which can fully utilize the potential and expertise of older persons in all the fields possible. MIPAA also suggests to governments to explore the possibility of benefitting from the varied resources of older persons. As well as recognize that older people have the right to live a life of dignity and this right must be given to them.

Some countries in Asia, namely China, Japan, Malaysia, Singapore and Thailand have taken the population ageing challenge seriously and have put policies on ageing and older persons in place in line with the priority directions of MIPAA. Broadly these include health care and long-term care, social protection and security, older workers and labour force participation, housing, ageing-in-place and enabling environments, intergenerational relationships, guarding against age discrimination, reducing old age poverty, etc., to anticipate and head off future problems (Shankardass, 2014). While some of these countries have common issues and policy priorities in population ageing, they also show diversity in policy development and implementation (United Nations, 2008). Nonetheless, respective governments have allocated funds for the programs to be realized and implemented.

Given below are policy responses of the five Asian countries mentioned above, namely, China, Japan, Malaysia, Singapore and Thailand. The data given below is based on analysis of literature, reports and documents review over the last few years as a consultant to United Nations and also because of my professional interest and work on ageing. I have analyzed policy and programmatic responses in different countries to the ageing of their populations.

People's Republic of China

China, with maximum number of older people in the world, has managed, since the beginning of this century, to bring ageing issues into the overall strategy of national economy and social development and is trying to perfect the framework of its ageing institutions, and improve the well-being of older persons by promoting affordable medical care and services for older people (Shankardass, 2014). China has set up an inter-agency/inter-ministerial committee on ageing to monitor and implement policies and programmes for older people. The Chinese State Council has established the China National

Committee on Ageing (CNCA) consisting of 26 government ministries and national NGOs to plan, coordinate and guide work on ageing nationwide. CNCA has established committees on ageing and offices at all levels throughout the country which works as a complete system, all the way from the central government down to the grassroots level. The State has established a supervision and evaluation system to conduct mid-term and final checks on the implementation of plans, to ensure that they are properly put into practice. It has also established a statistical work system which will provide basic data on older people to help the formulation of plans, monitoring and evaluation through appropriate indicators (ESCAP, 2007a; 2007b).

The government has strengthened formulation of laws, regulations and policies regarding older people, covering such areas as social security, welfare, services, hygiene, culture, education and sports, as well as the protection of the rights and interests of older people and related industries. There is a medical subsidy program which reduces the burden of medical costs for older persons. Further, for ailing and older people with special needs, daily care at home and hospice care is being provided efficiently by grassroots medical institutions empowered to do so. Social service amenities and mobile services provide care and housekeeping services, emergency aid and other free or reduced-payment services to older people as part of the "Starlight Program". Construction of senior citizens' lodging houses, elderly people's homes and nursing homes for the aged have been promoted to provide institutional services for seniors with different financial and physical conditions, especially, for those over 80, who are sick and disabled.

China has established a new three-pillar system of social pooling, individual accounts and voluntary supplementary corporate schemes, which is a worthy step in providing safety net to its retired workers (Yan, 2011). It has encouraged development plans for older persons by involving the whole society in elder care. However, despite government and community efforts, there is delay in implementation plans due to lack of incentives and inability of beneficiaries to pay for contributions (Beland and Yu, 2004; Williamson and Deitelbaum, 2005). The vulnerable older people enjoy the State's "five guarantees" system, which means that their food, clothing, housing, medical care and burial expenses are taken care of and subsidised by the government. The State encourages people to sign a "family support agreement", which stipulates how the older person is to be provided for and what level of livelihood he/she will have. Village (neighbourhood) committees or other relevant organisations supervise the implementation of the agreement.

China has taken concrete steps to promote a positive image of ageing and there are plans at various stages for older people to participate in social development. Government allocates special funds every year for large-scale activities for older people, such as cultural, educational, social and economic. Through a range of promulgations on barrier-free design codes, the government has enhanced barrier-free facilities for older people. The basic laws of China all clarify the rights of senior citizens and stipulate the legal

punishments for acts infringing on their rights. All provinces, autonomous regions and municipalities directly under the central government promulgate policies and regulations on the protection of the rights and interests of senior citizens.

Japan

Japan, with high life expectancy and large proportion of older people, has a sound legal policy framework for improving the health and welfare of older persons, including the issue of health promotion and well-being throughout life and of universal and equal access to health-care services. There is regular revision of socioeconomic systems and practices that treat older people differently because of their age and infringe on their rights. There are programs which strengthen intergenerational solidarity and promote participation in the local community with barrier-free living environment, based on universal design concepts. There are provisions for subsidising Senior Citizens' Clubs engaged in a comprehensive range of social activities in local communities which increase the social participation of older persons, as well as for volunteer activities for older people (Shankardass, 2014).

Legal reforms have facilitated economic participation of older people. Steps have been taken to ease or eliminate age restrictions on jobs and to secure equal employment opportunities for all, regardless of age. Anti-age discrimination legislation protects the rights of older people in employment and in service accessibility. The Law to Partially Amend the Law Concerning Stabilization of Employment of Older Persons (Law No. 103, 2004) has provisions where employers are obliged to take measures to ensure employment up to age 65. Subsidies are provided to employers for 'Promoting Continued Employment' as well as to employers having more than a pre-determined proportion of older workers (Naohiro, 2008). These efforts have helped to expand employment opportunities for middle-aged and older job seekers. Japan demonstrates the value of the continuing participation of older workers as part-timers or in positions that permit their wisdom to remain in the system and provide support for younger workers. This helps in mitigating intergenerational work conflict which is becoming significant in urbanising and industrialising developing countries. Japan is also the only country in the region that has provided social insurance to homemakers that ensures access to financial security in later life to women who have no occupational history (United Nations, 2008).

Comprehensive plans to target people from 40 years onwards are being implemented by the municipality, based on the Law for Health and Medical Services for the Elderly. The policy "Healthy Japan 21" contains 70 specific measures to ensure that people live healthy lives when they grow old. In May 2004, the government announced the Health Frontier Strategy for promoting measures to combat lifestyle-related diseases and prevent the need for nursing care with the objective to further extend healthy life expec-

tancy. There is development of advanced medical and assistive devices to support healthy and active participation of older people in the activities of society. Social welfare and medical facilities have been strengthened in residential areas as well in nursing homes for older people. Long-term Care Insurance Plan has been implemented and systematic improvements have been made to ensure a high-quality care service infrastructure that responds to the needs of older persons who require care.

In Japan by various initiatives, such as putting in place standards for barrier-free environments in existing residential sites and new public housing projects, and prioritizing housing for older people, the living environments of older persons has been improved. Also significant efforts to address the issue of emergency situations for older people have been made. Priority is given to older people in disaster preparedness and management. Age-friendly plans are in place to protect hospitals, residential homes for older people and areas with a high percentage of older people from disasters. In addition, special measures have been outlined to be taken up by municipalities to support the evacuation of older people requiring assistance during disasters.

Malaysia

Malaysia, a small country, has a strong political commitment in favour of older persons and has achieved a lot in the last 5–8 years. It has adopted a development approach with greater attention to active and productive ageing. NGOs with membership of older people such as National Council of Senior Citizens Organizations and Golden Age Welfare Association are getting actively involved in the decision-making process by participating in dialogues and forums of relevant ministries, especially in preparation of national plans and in pre-budget dialogues reflecting on and expressing their needs. Re-training and skill up gradation of older workers is an important exercise undertaken by the Ministry. It has initiated establishment of six sub-committees under a National Senior Citizens Policy Technical Committee set up by the Social Welfare Department to address respectively social and recreational; health; education, religion and training; housing; research, and publicity concerns.

Malaysia has introduced specific programs to increase community participation of older people and in social and recreation activities as part of the strategy to promote healthy lifestyles. Many initiatives are now being taken up to encourage intergenerational activities, establish lifelong learning programs especially for developing learning skills in ICT, with flexible entry requirements in the private and public institutions of higher learning and expand volunteerism among older people. Hospital care and health clinics have been made 'elderly friendly' by giving older persons priority in waiting lines and comfort in treatment. Along with training in geriatrics, specialized training in rehabilitation medicine, palliative care and nursing care management is also being encouraged and provisions being made for their delivery. Government provides specific privileges

to older persons, concessions for travel and special considerations in housing to enable ageing in place and in community and to promote independent living. Government has created standards for maintaining barrier-free environment and has given special attention to developing assistive devices to reduce dependence of older persons on others (Malaysia, Department of Social Welfare).

Through the design, implementation and expansion of preventive, supportive and rehabilitative programs, a culture of mutual respect, caring and sharing of resources and responsibilities among the family members is fostering intergenerational solidarity between older people and the younger generation. Yet, the country continues to face organisational and resource limitations in meeting the severe challenges of the current old-age security system, adjusting the current medical care security system and service system to meet the medical and social needs of the huge rapidly growing older population. There are implementation hurdles in diffusing central policies to local authorities at the village and grass root levels to increase awareness for the need to respect older people and create a favourable environment for care and support to the seniors. Nonetheless, specific programmes, innovative initiatives, planned processes and legislative enactments of this country can be good learning model for other countries in the region (Shankardass, 2014).

Singapore

Singapore has an integrated policy response to ageing and older persons with adequate allocation of funds (Loong, 2009). The political will to strengthen these programmes is visible in the appointment of a Minister in the Prime Minister's office to drive and coordinate policies that "give elders opportunities to stay active, healthy, and engaged" and to oversee policy implementation across various government agencies. There is a comprehensive multidisciplinary approach to address the well-being, health and social care needs of older persons, which is coordinated by integrating inter-ministerial level of the government with prominent NGOs in the country and seniors themselves. It is part of the "Many Helping Hands" approach which involves collective responsibility from all sectors (Shankardass, 2014). The role of the State is to enable the individual, the family, the community and the government to each play its part in providing support for the well-being of older persons.

There are provisions in the Singapore Penal Code that pertain to protecting seniors from financial, physical and sexual abuse. Also, the Women's Charter which deals with family violence has expanded its scope to include older adults, and protects them against psychological or emotional abuse as well as physical. Through legislative reforms, Singapore has revitalised traditional family values in care of older persons along with support to caregivers. Tax exemption is given to adult children caring for ageing parents when they live with them or provide financial assistance. Children's obligation to support their

parents and/or provide them with financial assistance has been legally mandated. Also, encouraging informal social networks for care of the aged is a significant policy initiative on ageing.

There is focus on strengthening the health-care infrastructure, training of family physicians and allied health-care workers in chronic disease management and care of older persons. Funds from the national budget are set aside to keep seniors in the community healthy and socially engaged. The government has made adequate provisions for barrier-free and accessible environment, especially with regard to housing and public spaces, as well as through public transport system of buses and rails which enables older persons to participate in economic and community activities. The government has embarked on large-scale exercise of public education on ageing and there are special funds marked for promoting intergenerational bonding, active ageing and for community programs to take these initiatives forward (Meng, 2010). The establishment of Council for Third Age, an independent civic group, in 2007, is to oversee these activities and also organize special programs for maintaining greater mental and physical well-being of older citizens by encouraging practices for independent living, lifelong learning, healthy lifestyles and sports, leisure, recreational and voluntary activities. The government has earmarked special funds to be administered by the Council for Third Age.

Thailand

The government has shown great political will to face the challenges of ageing in Thailand since the last few years (Shankardass, 2014). It issued the 2nd National Plan for Older Persons (2002–2021), which is an indicative master plan identifying integrated strategic framework and actions covering five sections, namely, (i) Preparation for quality ageing; (ii) Promotion of well-being in older persons; (iii) Social security for older persons; (iv) Development of management systems and personnel at the national level; (v) Conducting research for policy and programme development support, monitoring and evaluation of the 2nd National Plan for Older Persons (Thailand, 2001).

Act on Older Persons in force since 1 January 2004 covers significant issues on elderly rights, national mechanism on the elderly, tax privilege for children who take care of their parents and the elderly fund. Tax exemptions are given to income-earning children who take care of their older parents and parents-in-law and tax deduction entitlements for health insurance policies purchased by any children for their older parents and parents-in-law. It serves as an incentive for children to look after their parents and parents-in-law and promotes healthiness of older people.

Government promotes the skill development of older persons after their retirement (ESCAP, 2007a). The establishment of Brain Banks throughout the country facilitates coordination of use of skills of older persons as per their requirement and gender. This promotes their well- being, employment in later years and postponement of retirement.

Government has also shown special consideration to older persons affected by emergencies and disasters by providing assistance in various forms. There is emphasis on establishment of elderly clubs in every sub-district of all provinces of the country. Government has developed Minimum Standard of Housing and Environment for Older Persons including accessibility of prototype public toilet and physical environment and facilities in primary care units. Government has also established 'An Appropriate Environment for Elderly Research Unit'.

Proclamation of "Healthy Thailand" as a national issue has ensured quality of life at all ages. It has brought special attention to seminars on orientation for retirement, on sports, recreations and health promotion for older people and has led to setting up of Standards of Welfare, Promotion and Protection for Older Persons. There is special budgetary support for the promotion of health of older people. The Health Security Project of the Ministry of Public Health ensures access of older populations to healthcare services for prevention, promotion, treatment and rehabilitation. Government has established special clinics for older people in hospitals and arranged Green Channel/ fast lane for older persons in using the medical services of the out-patients section, as well as made provision of mobile services. In addition, there is promotion of mental health for older people by disseminating relevant documents, manuals and knowledge through older persons' clubs and organisations. Thailand's Bureau of Empowerment for Older Persons has launched a national campaign called, 'Sunday, the Family Day' for strengthening love, relations and care among family members of all ages. This has initiated a caring system for older people at the community level, whereby trained Community Volunteer Caregivers in collaboration with the public agencies involved, and local administration organisations, provide care to older persons especially those who have no caregiver but need assistance to perform their daily activities.

Since 2005 there is law concerning the facilities within buildings so that they are accessible and usable by disabled persons and older persons (Thailand, 2001). 'Standards of Practice for Institutional Care for the Elderly' have been developed which includes care and support for caregivers, training of caregivers and of health personnel. Protection of the rights of older persons is given due consideration by dissemination and distribution of the Act on Older Persons, 2003. There is a Committee to monitor and appraise the implementation of the Act on Older Persons.

Conclusion

All the countries mentioned above have taken strong initiatives in this century to meet the challenges of ageing by allocating specific resources. China, through policy action, has been pushing forward healthy sustainable development of undertakings for its ageing population since the adoption of MIPAA in 2002 (United Nations, 2006). The government has attached importance to publicising and popularising laws, regulations and

policies concerning senior citizens. Japan has been constantly revising the socio-economic system to ensure its suitability for the coming ageing of society as well as supporting individual independence in addition to sustaining a secure lifestyle for older people through an appropriate combination of self, mutual and public support. Malaysia, which until 1995 had no specific policy for older persons, now has a national policy which guides several action plans. The approach of the government is to empower older persons, families and community with knowledge, skills and an enabling environment to promote healthy, active and productive ageing along with providing optimal health care services at all levels and by all sectors. Singapore has developed its principles in policy for ensuring holistic well-being of older persons into four strategic thrust areas, primarily – employability and financial security; holistic and affordable health care and elder care; ageing-in-place; and active ageing. Thailand formatted formal national policy on ageing based on MIPAA guidelines and the government has imperatively set indicators to appraise its implementation and development. Each of these countries, in facing the challenges of population ageing, indicates commitment of the government towards formulation of policies that reflect the developmental aspects and needs of older persons in the country (Shankardass, 2014). How countries are responding depends on their demographic and epidemiological transition.

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Four pillars of aging policy in the United States

Keywords: long-term services and supports, Social Security, Medicare, end-of-life, United States

Abstract

To understand aging policy in the United States, it is critical to understand the federal budget, which along with national defense is dominated by Social Security, the publicly funded pay-as-you-go universal retirement program, and health care programs largely targeting the elderly (Medicare) and the poor, including the poor elderly (Medicaid). Not only is a large portion of the U.S. federal budget spent on elders, spending under these categories is mandatory: in other words, Social Security, Medicare, and Medicaid are entitlements, guaranteed by law. Politicians therefore have limited ability to allocate funds elsewhere. Discretion is further limited by the fact that currently, the U.S. budget is operating under a deficit. These budgetary pressures have evoked a variety of policy responses, which vary according to political affiliation. No matter the ideological vantage point, however, the spiraling cost of existing commitments has prevented serious consideration of other, emerging public policy issues in aging, such as the perilous state of systems for providing long-term services and supports (LTSS). Still, one bright spot is increasing attention to end-of-life issues – most likely because this is viewed as a cost-saver. It is because of Social Security, health care, LTSS, and end-of-life care that aging policy is central to the current budgetary and political debate

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in the U.S., a position that will only grow with time with the aging of the unprecedentedly large "baby boom" cohort born between 1946 and 1964. The irony is that these programs are in fact hugely popular among recipients and potential recipients. That is not to say that Social Security and programs providing health care to the poor and the elderly do not need reforming: there is enormous waste in the system. Yet sensible proposals for reform are often stymied by political obstructionism. So, too, are attempts to plan more systematically and thoughtfully about the growing aging population in the U.S. An advantage of the U.S. federal system of government is that in some cases progress can be made at the state-level such as with LTSS and end-of-life care; the downside is that this creates enormous cross-national disparities and that it fails to utilize the tools and the power that central government alone can provide.

Introduction

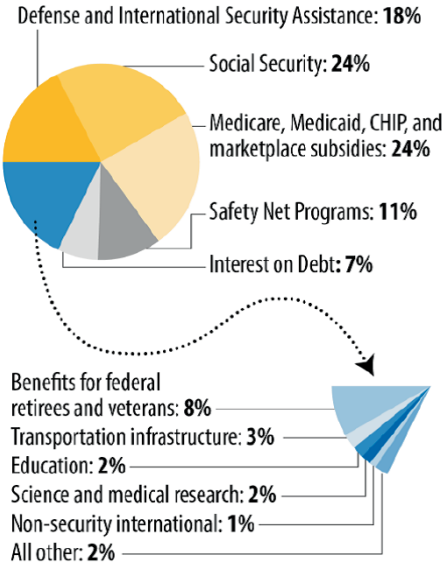
To understand aging policy in the United States, it is critical to understand the federal budget, one of its key drivers. Figure 1 shows how the budget, which will amount to $2.8 trillion (€2.5 trillion) in 2015, is allocated (Center for Budget & Policy Priorities, 2015). Nearly a quarter of spending (24%) goes toward Social Security, the publicly funded pay-as-you-go universal retirement program. A further 24% goes toward healthcare programs. Although these programs cover populations other than elders, the bulk of spending is on older people. Additionally, 8% of federal spending goes toward federal retirees and Veterans. Spending under these categories is also mandatory: in other words, these programs are entitlements, guaranteed by law. Politicians therefore have limited ability to allocate funds elsewhere. This discretion is further limited by the fact that currently, the US budget is operating under a deficit – that is, the US is spending more money than it is collecting in revenue (Congressional Budget Office, 2015).

Interest payments on this debt thus comprise a significant portion of the budget, a portion that is projected to rise over time as the population ages and the need to fund those commitments – that is, entitlement programs – increases (See Figure 2).

Between 2010 and 2050 the population aged 65 years and older in the U.S. will more than double from 40.3 to 88.5 million, or from 13% to 20.2% of the total population (Federal Interagency Forum on Aging-Related Statistics, 2012). The population with the most significant health needs – the population eighty-five years and older – will nearly quadruple, going from 5.5 to 19.0 million during this time period, or from 1.9% to 4.3% of the total population. In light of population aging, the U.S. has made promises in the way of Social Security and health care to its elderly citizens that it is poorly prepared to deliver on.

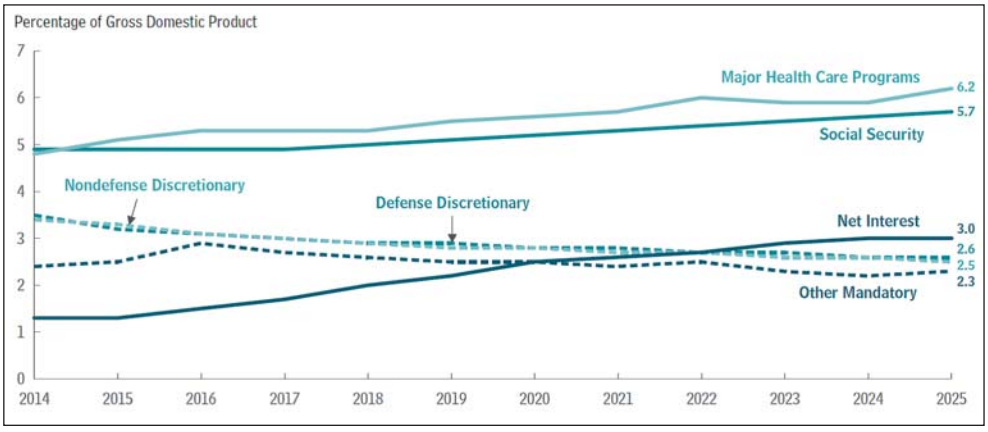
These budgetary pressures have evoked a variety of policy responses, which vary according to political affiliation. To conservatives, these pressures underline the failings of

Figure 1. The 2014 U.S. Federal Budget: Breakdown by Major Program Areas



Source: Center on Budget & Policy Priorities (May, 2014) analysis of Office of Management and Budget Data, FY 2016 Historical Tables

Figure 2. Projected Outlays for Major Budget Categories, 2014–2025



Source: Congressional Budget Office (January 2015)

"big government" and the pitfalls of shifting responsibility for old age security out of the private sphere and into the public. Liberals, on the other hand, see the social safety net as inadequate and poorly managed due to lack of investment. Both sides agree, however, that reforms are needed – although the extent to which they are needed, and the specific

reforms that are seen as necessary, differ sharply. No matter the political vantage point the spiraling cost of existing commitments has prevented serious consideration of other, emerging public policy issues in aging, such as the perilous state of systems for providing long-term services and supports. One bright spot is increasing attention to end-of-life issues – most likely because this is viewed as a cost-saver.

Social Security

More than three-quarters (77%) of Social Security funding goes toward older people (Center on Budget & Policy Priorities, 2012). (The remainder provides income for younger disabled persons and survivors, including children.) Funded out of a payroll tax, split between employees (who pay 6.2% of income) and employers (who pay the same), the program is funded as a pay-as-you-go system, although surpluses are meant to be earmarked to a Social Security Trust Fund – which, unfortunately, has been repeatedly raided to narrow the federal budget deficit and for other purposes over time. The most current estimates from the Social Security Trustees project indicate that the trust fund will be depleted by 2034 for the old age and survivors' portion of the program (Social Security Administration, 2015). However, such projections depend on a range of assumptions and forecasts – about, for example, growth in the economy and employment rates – which are hotly contested and are, to some extent, unpredictable (Blahous, 2015). So, too, are the implications of future funding deficits, which are estimated at about 1% of GDP over the longer term (Munnell, 2014). While it is clear that shortfalls are inevitable, steps for addressing them range from cutting benefits (by raising the retirement age, for example) to increasing revenues (by raising the cap on income that can be taxed). Some argue that a major overhaul of the program is needed, while others see the need for only minor tweaks.

The debate over the future of Social Security is colored by the current political focus on inequality in the U.S., and the sense that the political system is working only for the wealthy, a view endorsed by 61% of Americans (DeSilver, 2013); moreover, the public largely believes that this trend towards growing inequality in income and influence is only increasing over time (Pew Research Center, 2014a). Such beliefs diverge along political lines, with Democrats (liberals) more likely to agree with this assessment than Republicans (conservatives). The facts about inequality are well-known: income and wealth are concentrated to an extent not seen for nearly a century (Kreuger, 2012). More importantly, however, income and wealth among poor and middle-income people has not risen, in real terms, while large increases in income and wealth has been seen among the wealthy (Saez and Zucman, 2014; Stone, Trisi, Sherman, & DeBot, 2015). Such inequality is cumulative over time, resulting in an aging population with fewer chances of attaining a secure retirement than their predecessors. Most Medicare beneficiaries – 83% of whom are seniors – have limited income and asset levels. For example, 92%, 53%, and 27%

of beneficiaries have incomes below $75,000 (€67,530), $25,000 (€22,510), and $15,000 (€13,506), respectively (Jacobson, Huang, Neuman, & Smith, 2014). Similarly, 59%, 46%, and 24%, respectively, have savings below $100,000 (€90,023), $50,000 (€45,011), and $10,000 (€9,003). Moreover, 50% had home equity below $66,700 (€60,051) and 25% below $12,250 (€11,029); 21% had no home equity at all.

A dearth of income and assets in retirement has increased the importance of the Social Security safety net. For a full 21% percent of households with a recipient 65 and older, Social Security represents their entire income, while for nearly 60%, it represents 50% or more of their total income (Social Security Administration, 2014). Minorities are even more dependent on Social Security than whites, with, for example, 41% of Hispanics relying solely on Social Security for retirement income (Social Security Administration, 2014). Moreover, benefits are modest: the average Social Security benefit for retired workers was $15,943 in 2014, only a bit higher than the federal poverty level of $11,670 (Ruffing & Van de Water, 2015). This benefit amounts to about 41% of the median worker's income, compared to a 58% average across OECD nations (Ruffing & Van de Water, 2015).

Thus debate over Social Security reform is constrained by the very real need for the program and considerable public support for it, with 87% of the public believing that it "has been good for the country" (Kohut, 2012). Indeed, it is known as the "third rail of American politics" – a reference to the live electric rails on American train lines that kill anyone who comes into contact with them. The last major proposal to reform the program, G.W. Bush's bid to transfer a portion of beneficiaries' Social Security contributions into individual retirement accounts, garnered intense opposition and has dim prospects for revival, particularly after the 2008 stock market crash. Realistic proposals for reform, therefore, are limited to calls to raise the full retirement age (which has already been raised from 65 to 67 for people born after 1954); means-test benefits so that wealthier people receive less than they already do under the currently progressive benefit structure; or change the mechanism by which benefit amounts are adjusted for inflation to a less generous one. However, benefit cuts of any kind are unpopular: over two-thirds of the public opposes them, including most political conservatives (Pew Research Center, 2014b). More popular are proposals to increase revenue, by raising the amount of income on which the payroll tax is levied or by increasing the payroll tax, measures which appear to have significant public support (Tucker, Reno, & Bethell, 2013). Indeed, many experts agree that such adjustments would likely address much of the Social Security funding shortfall. Unfortunately, the current political stalemate in Washington means that even moderate proposals for reform that have wide public support are unlikely to be instituted.

Medicare

Medicare is arguably one of the biggest threats to the federal budget, more so than Social Security. The future costs of the program are unpredictable both on the demand side –

because it is challenging to predict the future health needs of the older population – and on the supply side, where the costs of labor and future technology as well as the evolution of the insurance and health care industries are highly unpredictable. Thus, it is difficult to project future liabilities in the same way that we can predict Social Security costs. However, there is little doubt that future Medicare costs will be high, both in light of the sheer number of elders being served and the persistence of cost increases that outpace inflation. Historically (1969-2013), average annual costs per Medicare enroll increased by 7.5%, compared to 9.1% in the private sector (The Henry J. Kaiser Family Foundation, 2015b). Over the same time, inflation went up 6.3% per annum, on average (Bureau of Labor Statistics, 2015). Per capita Medicare program increases are expected to moderate to an average of 4.1% from 2014-2024, down from 7.0% during 2000-2010 (The Henry J. Kaiser Family Foundation, 2015b). However, these expected increases still outpace the expected average annual projected inflation rate of 3.4% over the same period, creating continuing pressure on the federal budget.

In addition to its increasing costs, the program also suffers from an outdated structure. The Medicare program grew incrementally, initially having two parts: Part A, which mainly covered hospital expenses, and Part B, which covered outpatient expenses. The two parts were financed differently, with Part B charging premiums. Over time, the program has added a Part C – private insurance plans that cover Part A and B services – and a Part D, which covers prescription drugs. In addition, many participants (called "beneficiaries") supplement their Part A, B, and D coverage with plans that cover gaps in coverage. This is all very confusing for beneficiaries, who need to make the choice of whether to stick with traditional Medicare Part A and B coverage or join a Part C plan. If they do so, they must then choose among plans. In addition to its confusing structure, the program has been slow to update how services are delivered and what benefits are covered. For example, it has only slowly begun to cover mental health as comprehensively as it covers physical health (Ostrow & Manderscheid, 2010), and the lack of dental coverage is becoming increasingly indefensible as evidence on the link between dental and physical health becomes stronger (Ornstein, et al. 2015). Reforms are needed.

Yet Medicare reform is far more complex than Social Security reform. Unlike Social Security, which is a cash benefit program, Medicare pays for services using third parties and consequently involves an enormous array of stakeholders – health care providers, insurance companies, pharmaceutical companies, and beneficiaries. Any change to the Medicare program thus creates ripple effects and unintended consequences; and because Medicare is such a big player in the healthcare market (comprising 20% of all health expenditures nationally) (Centers for Medicare & Medicaid Services, 2015), these ripples extend beyond Medicare to the healthcare market as a whole. Unsurprisingly, any change to the program creates political opposition. Because of the enormous dollars involved – $597 billion (€537.9 billion) in 2014 (The Henry J. Kaiser Family Foundation, 2015b)

– stakeholders have organized sophisticated lobbying resources, which often play a key role in setting regulation and influencing legislation.

Few tools for addressing cost were built into the Medicare program at its inception: the program was originally devised to simply pay medical bills – what is known as "fee-for-service" medicine. The trade association representing doctors, the American Medical Association, actively opposed "government-run healthcare," and secured provisions that protected doctor's independence, allowing them to determine the "reasonable and necessary" costs of services (Marmor, 2000). Thus, if a service was included in the program's benefit package and it was delivered via a Medicare-certified provider, it would be covered at the market rate. This proved a recipe for the inefficient delivery of care and spiraling costs: when providers are largely paid according to volume, they are naturally inclined to provide larger amounts of well-reimbursed services. These incentivizes are particularly problematic in light of the growth of for-profit health care – in 2013, for example, about 21% of all hospitals were for-profit (The Henry J. Kaiser Family Foundation, 2015a), up from18% in 2006 (Selvam, 2012). Consequently, considerable policy attention has been aimed at changing the financial incentives built into the program.

This concern has helped drive the growth of managed care in the Medicare program as well as other forms of "prospective payment," whereby reimbursement is based on the appropriate costs of services, determined beforehand, rather than retrospectively, as under traditional fee-for-service payment. Forms of prospective payment range from DRGs (diagnostic-related groups), which pay a flat rate for a hospital stay that is adjusted to reflect the patient's diagnosis and risk level, to capitation, in which a managed care organization is paid a per-person monthly rate to cover a defined package of benefits – under Medicare, this is typically the full Medicare benefit package. Governments favor prospective payment because healthcare costs become more predictable. It also shifts risk and helps control cost, because providers or insurers are challenged to deliver on their commitments within a given budget. Advocates also emphasize the ability of managed care plans to be more flexible in delivering services: they are not limited by the defined package of benefits covered under Medicare, allowing them more room for experimentation and to provide enhanced benefits. Lastly, managed care plans have greater flexibility in negotiating with providers, particularly with respect to price, where they are not bound by the limitations of the traditional fee-for-service Medicare program.

Thus, Medicare managed care, which began as a provision for "prepaid health plans" in the original Medicare legislation but only took off in the 1990s, has grown to become a significant part of the Medicare program, enrolling 31% of Medicare beneficiaries (Jacobson, Damico, Neuman, & Gold, 2015). However, the evidence on whether managed care saves government money is limited. Under the 1982 Tax Equity and Fiscal Responsibility Act legislation, payment for managed care plans was pegged at 95% of the cost of traditional Medicare services – thus, by definition, managed care was cheaper. Over time, however, this requirement was lifted and, to incentivize managed care plans

to participate in Medicare, rates began to rise, relative to traditional Medicare. At its peak, it was estimated that managed care plans were paid 14% more than was spent on comparable individuals receiving traditional Medicare services (Biles, Casillas, Arnold, & Guterman, 2012). From the beneficiary's perspective, managed care plans offer a more streamlined service, with enhanced benefits and fewer bills to manage than the traditional fee-for-service program; the complexity of the traditional program, which requires beneficiaries to pay as many as three premiums for different parts of their coverage (Part B, Part D, and, in some cases, for supplemental insurance, can be overwhelming. Consequently, managed care has built up a considerable constituency within the older population, who oppose efforts to rein in costs – which they view as "cuts." Proposals to bring managed care reimbursement in line with traditional Medicare were part of the 2010 Patient Protection and Affordable Care Act sponsored by the Obama administration, but have been politically difficult to implement.

Nonetheless, managed care plays a large role in conservative proposals for reform, which take managed care's efficiency as a given. These reform proposals envisage a Medicare program where insurers compete for market share. However, such proposals hinge on beneficiaries being given a fixed amount – a voucher (also known as "premium support") – that can be used to purchase insurance coverage. Such an arrangement has clear benefits in limiting government liability and in making government expenditures more predictable and manageable over time. From a beneficiary standpoint, however, there is concern that the voucher amount would be insufficient to cover premiums, leading to a situation where wealthy people would be able to purchase generous coverage, while less well-off people would only be able to purchase cheaper, less generous coverage and incur high out-of-pocket costs. This latter possibility is a significant politically drawback because beneficiaries already feel that their out-of-pocket costs are high: despite benefit expansions over the years. Even with the relatively recent addition of prescription drug coverage, beneficiaries out-of-pocket costs average nearly $5,000 per year and rise with age (Cubanski, Swoope, Damico, & Neuman, 2014)

Public support for such reforms, however, does exist. In 2011, a poll found that 46% of the public would support changing Medicare "to a system in which people choose their insurance from a list of private health plans that may offer different benefits at different premium amounts and the government pays a fixed amount (sometimes called a voucher) towards that cost" (The Henry J. Kaiser Family Foundation, 2011) – although 50% were opposed to any changes to the program. However, survey responses varied considerably based on how the question was framed, indicating the public's low level of understanding of the issue and their potential susceptibility to political persuasion. Broad support for the Medicare program overall is strong, at around 69% (PollingReport.com, 2015).

In summary, Medicare reform is enormously complex, not least because it intrinsically linked with the problems of the larger U.S. healthcare system. However, because

it is so complex, and so many stakeholders are involved, it is also difficult to change due to considerable lobbying by the various interest groups affected. In 2014, for example, the largest spending group, pharmaceutical companies, spent $230 million lobbying nationally (OpenSecrets, 2015). Medicare's complexity also deters informed public involvement, resulting in behind-the-door policy making, often within the bureaucracy, and opportunities for grandstanding on the political front, with little substantive public discussion.

Long-Term Services and Supports

The US faces many challenges with respect to long-term care (known as long-term services and supports, or LTSS, in the US.). As in many nations, the system for helping people with needs for physical or cognitive supports operates separately from the medical system, both in terms of its financing and its delivery. This separation has many consequences, the most significant of which is limited financing; however, the system also suffers from being poorly integrated with the medical system and lacking the infrastructure to ensure access and quality.

Probably the most critical issue is financing. The US has no public LTSS program available to all citizens. This is a problem because LTSS is beyond the financial means of most Americans: in 2014, the median annual cost of long-term care was $42,000 (€37,852) for assisted living and $77,380 (€69,781) for a semi-private room in a nursing home (and nearly $88,000 (€79.358) for a private room) (Genworth Financial Inc., 2014). The median annual cost of community-based care was estimated at $43,000 (€38,776) to $45,000 (€40,580) annually (for 44 hours of homemaker and home health service per week). And yet, public financing for these services is only available under Medicaid, the state-run public health insurance program for the poor, which requires potential recipients to impoverish themselves, forfeit their savings, or accrue medical expenses in excess of their income, before they can become eligible. A few states operate state-only funded programs; however, these provide limited services and are typically targeted at low-income individuals as well. Consequently, the bulk of LTSS is provided by unpaid family members, although a small population has private insurance for LTSS – about 7% of the population aged 65 years and older (Melnyk, 2005) – and many others pay out-of-pocket towards the substantial costs of care. Thus the need to pay for or provide LTSS results a significant financial risk – particularly for low-income families already under considerable stress.

In 2014, 22.0% of the nation's $220 billion (€198 billion) LTSS bill was paid out-of-pocket and 12% through insurance and other private sources; nearly two thirds (61.0%) was paid for by Medicaid and other public programs (5.0%) (National Health Policy Forum, 2014). It has been estimated that the total estimated value of unpaid family caregiving is $450 billion (€405) annually (Feinberg, et al., 2011). More than 11 million Ameri-

cans need LTSS, including 9.6 million (86%) who live in the community and 1.5 million (14%) who reside in a nursing home (Feder & Komisar, 2012). Most – 56% – are aged 65 years and older; a large minority – 44% – are under aged 65 years. Most community residents with LTSS needs – 78% – rely exclusively on unpaid, informal care; just a fraction – 8% – only receives paid care (Kaye, Harrington, & LaPlante, 2010).

Repeated attempts to establish a system for financing LTSS have failed, primarily due its potential high costs. Early Medicare proposals included a LTSS benefit but were later dropped due to cost; LTSS would also have been covered under the 1988 Medicare Catastrophic Care Act – which met considerable opposition from financially better off elders who were asked to subsidize their less well-off counterparts and was repealed a year later; and LTSS was included as part of the 2010 Affordable Care Act as the Community Living Assistance Services and Supports (CLASS) Act, which, again, was repealed just a few years after it was passed (Miller, 2011; Miller & Nadash, 2015). The CLASS Act represented a fatally flawed effort to cater to the American aversion to mandates: it tried to establish a voluntary public insurance program covering LTSS. However, with no restrictions based on disability or health status (although people currently claiming benefits could not apply), such a program could not be determined to be actuarially sound, as required by law. There was no way to avoid an insurance death spiral, whereby those opting for insurance are more likely to be high-risk, driving up premiums and deterring lower-risk individuals from participating. The clear lesson is that risk pooling (in other words, mandated participation across all levels of risk) is necessary for an actuarially sound program – and yet, any such mandate is highly unlikely in the current political environment.

Given the slim prospects for movement on the financing side of LTSS, the focus has shifted to other issues. Indeed, following the failure of CLASS, the Obama administration set up a commission to address LTSS more generally. Although the ensuing report punted on the question of financing, there was general agreement about other areas where progress could be made, including the need to focus delivery on community-based, rather than institutional care options, improve the workforce, and promote high-quality, integrated, person-centered care – all of these are non-controversial approaches that are, to varying degrees, already embedded in policy (Commission on Long-Term Care, 2013). For example, the 2010 Affordable Care Act contained several measures encouraging states to invest more heavily in home and community-based care (Harrington, Ng, Paplante, & Kaye, 2012). Even before these initiatives, the movement toward community-based options had been substantial with, for example, the number of Medicaid participants receiving home and community-based services increasing from 2.1 to 3.2 million between 2001 and 2011 (Ng, Harrington, Muscumeci, & Reaves, 2014). The healthcare reform law also directed substantial funds toward experiments in integrating care across the medical and LTSS divide (Miller & Nadash 2014). More recently, the once-a-decade White House Conference on Aging (in July 2015) prompted the Obama

administration to propose an overhaul of regulations to better ensure and improve quality in nursing homes, addressing widely-acknowledged persistent quality problems in the nursing home sector (The White House, 2015). Other efforts to improve quality in LTSS include increasing efforts to publicize the quality of LTSS providers: for example, the federal government now reports on nursing home and home health agency quality via websites that assess facilities using a five-star ranking system, and which also provide more detailed data about providers (Mor, 2005). Government is also experimenting with "pay-for-performance," whereby providers get financial rewards for improving quality (Miller, Doherty, & Nadash 2013). All of these efforts require good data that can be used to assess provider performance, a tricky prospect to pull off.

In summary, LTSS in the US presents significant ongoing issues. The federal government has been limited in its ability to tackle prevailing challenges on a national level, so decision-making has largely been delegated to the state level, where limited finances due to the lingering effects of the Great Recession have prevented bold action. In the absence of pressure from the public, it is difficult to see how this deadlock on real planning around the need for LTSS will be broken.

End-of-Life Care

One of the more positive developments in aging policy has been increasing discussion of end-of-life issues in the U.S. These discussions have taken a variety of forms, from attempts to pass "death with dignity" laws to the increasing recognition of palliative care within the medical system. All of these efforts represent significant movement in the public's ability and willingness to make policy to address the contentious issues raised by the end-of-life. However, the conversation is also colored by fears about the motivations behind change – that policy change is spurred by the need to control spending and by the low value placed on older and disabled lives, rather than by a desire to improve the dying process.

Attracting the most attention is the discussion around "death with dignity", also known as assisted suicide or physician-assisted suicide – all terms for measures that enable people to end their own life with the assistance of a health care provider. Regulation is set at the state level: the earliest state to move on this was Oregon, which voted to legalize assisted suicide in 1997. To date, only four other states have allowed such practices (two via judicial, rather than legislative means) (FindLaw, 2015), but the number of "death with dignity" bills proposed across states has increased considerably, with 25 states considering such legislation in 2015 (Death with Dignity National Center, 2015). Public opinion also appears to be swinging in the direction of supporting assisted suicide, with polls reporting that 68% favor it, up from 52% in 1997 (Dugan, 2015). Substantial opposition to such laws remains, however. Religion is an important factor: in liberal Massachusetts, for example, which recently defeated a bill, Catholics comprise

44.9% of the population (Catholic News Agency 2012). Organized medicine is also opposed: the American Medical Association (1999-2015), the leading membership organization for physicians in the US, has issued policy statements in opposition. Lastly, disability groups have been effective in questioning the bias embedded in how the quality of disabled lives is judged (Coleman, 2015). Although this issue has not taken on the partisan character of many aging issues, opponents of such bills lean right, while supporters lean left (Dugan, 2015). Thus, on occasion, the issue has become a flashpoint in the US's right to life debate, as in the high-profile case of Terri Schiavo, where then Governor Jeb Bush of Florida intervened to prevent a woman from being taken off life support.

Another important part of the effort to improve end-of-life care is the integration of palliative care into mainstream medicine. Palliative care is an approach that focuses on reducing suffering; it may supplement, rather than replace, traditional curative treatment, and it is not solely provided at the end-of-life. Models vary but typically involve hospital-based multidisciplinary teams, which work with patients to provide symptom relief, identify patient goals, help patients make complex medical decisions, and provide practical, spiritual, and psychosocial support. Since the National Hospice Study established in the early 1980s that palliative care was effective in reducing costs and relieving suffering (Greer, Mor, Morris, Sherwood, Kidder, & Birnbaum, 1986), it has become increasingly part of health care. The 2014 consensus report from the Institute of Medicine (IOM, 2014), *Dying in America,* endorsed the approach as the standard of care. However, there is a long way to go before palliative care becomes widely available. On average, physicians receive only limited training about palliative care (17 hours in total) and only an estimated 6,500 physicians are board-certified in palliation, roughly a third of what is needed, according to the IOM.

Reformers also focus on the extent to which the Medicare program structurally supports end-of-life care and decision-making. Medicare's hospice benefit, which has been part of the program since 1982 and aims to provide comfort care at the end-of-life, has significant problems. Although it is well used (with an estimated 32% percent of all Medicare recipients who died using hospice), patients often enter it too late and fail to get the maximum benefit; 28.4% used the benefit for three days or less (Teno, et al. 2013). Moreover, hospice providers are often poorly integrated with the service delivery system and seem to be particularly vulnerable to fraud (Carter, 2011; Davis, Strasser, & Cherny, 2015).

More recently, in 2015 the Obama administration revived plans to reimburse doctors for conversations with Medicare patients about their preferences about end-of-life options if they became too sick to speak for themselves. This is the same Medicare benefit originally proposed for inclusion but ultimately dropped from the 2010 health care reform legislation, which was famously depicted as "death panels" by the Republican vice-presidential nominee, Sarah Palin – so successfully that poll found that 41% of the

population believed this blatantly false description of the policy being proposed (CNN Opinion Research Corporation, 2009).

The evolution of legal tools (set at the state-level) to ensure that patient wishes are honored has accelerated over the last few years: advance directives, for example, are well-established. These include do-not-resuscitate orders, which specify the circumstances under which resuscitation takes place; living wills, which document broad preferences regarding end-of-life care; and health care proxies and durable powers of attorney, which delegate medical decision making to specified individuals. However, these instruments are underutilized: health care providers may not know they exist or fail to follow them. More recently, states have experimented with a different mechanism, generally known as POLST (physician order for life-sustaining treatment). All but five states have or are developing a POLST program (National POLST Paradigm, 2012-2015). Its distinguishing characteristic is that it is a standing medical order designed to follow the patient from treatment setting to treatment setting; unlike advance directives, POLST orders are only created when an individual likely has a year or less to live. In Oregon, the state that has implemented them most widely, these mechanisms have been found to be effective in honoring patient preferences by reducing costly hospitalizations at the end-of-life (Fromme, Zive, Schmidt, Cook, & Tolle, 2014). Furthermore, unlike advance directives, physician compliance with POLST is high.

Conclusion

Aging policy is central to the current political debate in the U.S. This stems from the aging of the "baby boom" generation born between 1946 and 1964 and the prominence of well-established programs that serve older people: Social Security, Medicare, and Medicaid. As significant portions of the federal budget, these three programs loom large in the broader debate over whether and how the federal government can meet its fiscal obligations in light of population aging. The irony is that these programs are in fact hugely popular among recipients and potential recipients. That is not to say that Social Security and programs providing health care to the poor and the elderly do not need reforming: even Donald Berwick, a former administrator of the Medicare and Medicaid programs and a well-known, prominent liberal, argues that there is enormous waste in the system (Berwick & Hackbarth, 2012). Yet, sensible proposals for reform are often stymied by political obstructionism. So, too, are attempts to plan more systematically and thoughtfully about the growing aging population in the US. An advantage of the US federal system of government is that in some cases progress can be made at the state-level such as with LTSS and end-of-life care; the downside is that this creates enormous cross-national disparities and that it fails to utilize the tools and the power that central government alone can provide.

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About social exclusion in rural areas in France: the case of elderly

Keywords: rural areas, ageing, social exclusion

Abstract

Rural areas are frequently considered as likely to generate isolation, loneliness and risks of social exclusion for vulnerable people who live there. With investigations in two types of rural areas – fragile rural environments and rural areas subject to periurbanisation, we analyse interactions between the characteristics of the populations and characteristics of territories in the occurrence of social segregation and exclusion processes. The analysis will be based on the situation of pensioners and elderly people. We will show how residential and social trajectories of the people constitute an essential factor of inclusion vs exclusion in these territories.

Introduction

Since many decades, social exclusion becomes not only problem of poor people, who don't have enough to satisfy their primary needs but also problem of people, who don't find a place in social interactions. With dependency problems, this question takes a new sense. The exclusion of elderly is to consider as a situation of nonsocial participation or as non-take up to public services or social and cultural exchanges. Any geographic, climatic and social conditions let the people away from services or amenities. Through the analysis of social interactions, Chicago school and human ecology (Park, Burgess, Mc Kenzie, 1925) allow to understand social exclusion in an innovative way. For the first time, they think together the geographic and social characteristics of an environment and the mentalities or the art of life the people who live there.

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Empirical work in rural environments and about old people, make us test this frame of conceptual references to analyze the place of ageing people in the rural land. We are especially interested with rural environments, which are geographically isolated.

We have recognized three groups of elderly in these areas:

- ageing people who are living here since many decades, and often are born here
- ageing people who are born in this place and then leaved for a job and finally returned here for retirement
- and ageing people, who arrived in this environments just for retirement

In the way of Chicago school and with the concept of neighborhood effects (Sampson, Morenoff, and Gannon-Rowley, 2002), we consider neighborhoods not simply outcomes of individual choices and behavior; but as social ensembles that exert their own causal powers. We try to show how the situations of disadvantage are connected or not with the geographic isolation of any pensioners groups. In this paper, we would like to put in discussion the connection between territory and social exclusion, in the case of rural areas through the perspective of life curse. To understand the social inclusion vs exclusion of elderly in these rural areas, we analyze the consequences of their social and residential mobility and the dynamic or static tendency of the territory.

Immersion and surveys in French rural areas, 2004–2011

Over a period of several years, we conducted research in two types of rural areas.

The isolated rural areas that we studied, through a two-year immersion at different times of the year to take account of seasonality, are geographically distant from urban centres and therefore more distanced from the urbanisation trend than other rural areas. That being said, they are affected by some of the general trends such as the decline of the farming population, a certain ageing of the population and a discreet diversification of the population groups living there. Areas subject to peri-urbanisation, where we conducted interviews include small municipalities (of less than 2,000 inhabitants) located at a distance from an urban centre but which are gradually "de-isolating" owing to the development of transport and the arrival of new populations looking for affordable property. Our remarks will be informed by prior research work and the data resulting from this recent research[2].

[2] This prior work provided us with the following resources: observation journals of the public space in four municipalities in Creuse, Ardéche and Savoie; a corpus of 24 interviews with 68- to 95-year-olds in Ardéche and Creuse; a corpus of 12 interviews with people aged over 75 in Savoie, a corpus of ten interviews with elected representatives, 15 interviews with professionals and organisations working in social and medical care for the elderly.

I. About rural environments: the risk of vulnerability and relegation

With the reduction of pauperism, it becomes relevant to consider social exclusion in connection with the concept of vulnerability. Vulnerability contains a predictive dimension. It is supposed to be the situation of people, who can meet risks in their existences. The damages could concern their health, social and economic situation, environments… According to Villagrán de León (2006), we can think vulnerability as predisposition of populations to be affected by a prejudicial event or as their inability to face the damages and disasters, which could arrive. The exposure to these risks depends on the social and environmental contexts in which people live. External difficulties, and coping capacities are connected with the disadvantage and the resources of the social background, the home and the local environment, and the neighborhood[3]. Perceptions of the "rural world" generally oscillate between the romantic myth of harmonious communities living in idyllic landscapes and off-putting images of deserted wastelands bereft of modern conveniences and home to a few remaining old people with obsolete lifestyles. Nevertheless, the country knew the last half century many evolutions. Landscapes but also people who live here and economic activities are changing and the frontiers between cities and country wear away. In this context, the analysis of exclusion's and vulnerability's problematics must be renewed.

1.1. Geographical and social morphology's

For many decades, the demise of traditional farming methods and the diversification of economic activities sounded the death knell for cultural homogeneity in rural France (Mendras, 1992). "Rural area" has over time become the accepted term for describing the countryside and is used in the plural to signify the diversity of rural morphologies (Gucher, 2014). The territories in which our investigations took place are, for two of them, in the category of "precarious, fragile countries", aged and sparsely populated. These territories are characterized by a rural area in predominantly agricultural and with a declining low industrial fabric. The other two territories are considered as 'near cities countries' and more specifically 'rural developing of urban sprawl' and are characterized by a significant residential tenure. Agriculture is still substantial but suffered a strong pressure on land.

In those fragile rural areas, the problems of aging have both individual and collective scope insofar as the course of ageing for individuals is situated on the frame of the weaknesses of the territory and the territorial dynamics are weakening because of the ageing of the population. However, in any rural areas we investigate, the process of urban

[3] The P-S-R (*Pressure-State-Response*) model, developed by OCDE is a reference in the measurement of environmental vulnerability. It combines three dimensions: Pressure as extern environmental problems; State as the current state of the environment and Response as the effort of people to cope with these problems (PNUD 2004 in Sirven, 2007).

sprawl brings a demographic renewal which limits the phenomenon of ageing, creates new social issues related to the diversification of populations.

Fragile countries studied are located in isolated, sometimes mountainous areas. They present specifics landscapes, with large fields and forest, hills and mountains. The climatic conditions are rough, with a lot of snow in winter. The population is located in little villages but also in isolated hamlets or farms. In these areas, agricultural activity was, during a long time, the single economic activity, low-yield, marked by the logic of self-sufficiency. This activity has been just as much a way of life – understood as "peasant culture" as a professional activity oriented to the production. The depopulation of these regions generally corresponded to the scarcity of farms. Crafts, small trade, some tourist activities and also services become the single supports of economic and social life.

Traditionally, in this context, rural older people are considered as particularly vulnerable to isolation and loneliness. The common view presents rural areas as containing barriers to participate in normal relationships and activities in economic, social and cultural spheres. A double bind between ageing population and territory is often presented: on one hand, ageing people are considered as vulnerable because they don't access with facility to all amenities and services they could need; on the other hand territories are considered as suffering from the scarcity of young, of dynamic population and of economic boosters.

1.2. The specific case of ageing people

Rural areas today are all strongly through unevenly concerned by growth in the elderly population and by old age (Dumont, 2006). These one located on the attractive outskirts of urban clusters are subject to land-related pressure and the influx of urban populations, while isolated rural areas are more concerned about their ageing populations and depopulation, even though they are starting to see the benefits of the marked trend in counter-urbanisation, whereby households are choosing to forgo the city for the countryside without maintaining relations with the urban area (Thomsin, 2001).

The criteria generally used to investigate exclusion of the elderly in rural environments are insufficient economic resources, limited mobility, problematic access to scant services, poor relational networks and a low sense of security (Walsh, O'Shea, Sharf, 2012). But the low level of social relations and commitments is still often interpreted as the result of modest economic means. These recurring research focuses tend to present exclusion as a corollary of poverty. This last remains the key subject of the majority of research, which concentrates on the intrinsic vulnerability of the population[4] to the detriment of regional specificities. Our research work led us in part to eschew approaches focused on economic aspects and instead analyse interactions and connections between rural areas and life courses and ageing. This approach takes account of the changes cur-

[4] Ageing and rural poverty, a research report produced by Rural Community Network, Ireland, 2004.

rently taking place in most rural areas in France and ageing processes, which also call for a number of adaptations. It appeared to us that exclusion can be seen just as much from the viewpoint of being denied access to the things that make the lives of others as it can from a symbolic standpoint of a feeling of marginalisation vs. affiliation.

Today, as we said previously, different population groups coexist in rural areas. These last are home to urban populations mainly looking for rural environments close to the urban areas in which they work land accessible for construction and, more generally, an affordable living environment. But they are also home to the retired, who are choosing to live in rural areas either as a return to the place they grew up in or in search of an ideal living environment more conducive to ageing, for economic and social reasons. Some areas are also seeing the arrival of people in socially vulnerable and precarious situations imagining they will find a more welcoming living environment away from the city (Gatien, Popelard, Varnier, 2010). Farmers, long the emblematic and majority population in rural areas, are now more often than not a minority presence, and the socio-cultural models they uphold are coming into contact with urban-based models (Hervieu, Viard, 2001).

Consequently, the rural environment is now home to the development of diverse behavioural sets (Perier-Cornet, 2003), a territory used for different ends by players seeking to fulfil different needs. These situations are likely to generate conflicts in behaviour and interests liable to weaken the local social cohesion underlying the principle of village life. Rural areas are less and less marked by networks of acquaintances and increasingly home to the coexistence of inhabitants with diverse levels of belonging, including permanent inhabitants, native and non-native secondary residents, and tourists with varying degrees of loyalty to the area. Rural areas, then, are faced with deep-seated changes that call into question their ability to produce hospitable social cohesion for people rendered vulnerable by age and for new arrivals.

While the issues of territorialised social relations and local social integration mainly concern newly-settled populations, on a more global scale they affect all the social transactions expressed in these areas. What, then, is the social place for the native or recently-arrived elderly in these shifting contexts? Do long-standing generational roots – sometimes going back over a century – suffice to foster social inclusion at an advanced age? And, inversely, what is the situation in terms of the integration of pensioners having moved to rural areas later in life? Social withdrawal, and even social exclusion, can be seen as resulting from the individual ageing process, but also as a result of the interaction between the people, groups and living environments in question. With that in mind, we will focus as much on the characteristics of rural areas as on those of their populations with a view to pinpointing the influences they exert on each other, which may foster social inclusion and participation and/or exclusion and withdrawal. We consider at first the access to social rights and services, as factors of the breakdown of citizenship. Then, we analyse the weakening of the "moral and social density" of rural areas concerned by demographic reshuffles and look at the issues of withdrawal from and continued presence

in spheres of social activity and the role played by what we call "integrating communities" in the support of these forms of participation. We will then highlight the dynamics of sociability and solidarity networks as a possible component in the protection against exclusion.

1.3. Ageing in "high-pressure" rural areas: social cohesion and integration issues

The characteristic shared by the rural areas that we focused on in our research is, to a varying degree of intensity, the pressure between traditional rural models on social organisations and new, developing models informed by city dwelling. Even if isolated rural environments remain more distant from the strong repopulation trends of areas in the process of peri-urbanisation, the socio-economic issues involved in the survival of territories – subject to ambitious development policies – lead at local level to opposing perspectives between those looking to maintain traditional farming-origin roots and those seeking to transform local structures (Gucher, 2008). Processes of hybridisation of socio-cultural models promoting social harmony in rural areas are underfoot, but the acculturation phenomena they entail do not occur without tensions or clashes.

The rural environment has become a medium for a range of social representations and constructions, bringing into contact groups of players with different and even antagonistic projects. Perrier-Cornet (2003) identifies three models of "the country under pressure". The model of the *country as resource*, a place of (farming) production, is defended by native active or retired farming populations. The *country as lifestyle* model, upheld mainly by city dwellers, is based on residential and recreational uses of rural space. The *country as nature* model, reflecting the increasingly powerful contemporary aspirations of safeguarding nature and the natural environment, is supported by diverse populations brought together by the same ecology-minded approach.

These models of the "country under pressure" constitute the framework of perceptions and aspirations held by the inhabitants of rural areas. The co-presence in the same territory of population groups with different frames of thought both enriches and weakens the moral and social homogeneity that used to mark the rural world. The givens that formed the cornerstone of the harmonious social practices of the inhabitants of these areas are giving way to questioning and new ways of doing things, upheld by new arrivals or local players – politicians, organisations and so on – mindful of opening up to other forms of social life.

As a consequence, the native elderly are confronted with a fast-paced transformation of their living environment. Attached as a whole to the moral codes of the quasi-unchanging world in which they have led their lives, emblems of a past that refuses to embrace modernity; this population is situated at the epicentre of the tensions. Some of the local players focused on the future and progress describe the rural retired as conservative, as hindrances to territorial development, and see them as clinging to the remnants of an old order perceived as moribund and devoid of a future. The native elderly,

then, are liable to become "strangers in time". And the policies envisaged appear to seek to bypass this population and deliberately focus on ideal and future populations. For other players, the long-standing presence of the native elderly and their knowledge of local history constitute an advantage from a heritage standpoint. These perceptions are accompanied by the political will to support the elderly in the ageing process. On these perceptions depends the status given to the native elderly and their eventual social disqualification. While there are no doubts as to the social integration of natives, as the numerical balances of the population remain in favour of the autochthonous population, their gradual disqualification can be observed when and where modernisation and development approaches gain the upper hand.

Furthermore, the social integration of individuals arriving late in life can be problematic, particularly in isolated rural areas. Recently arrived pensioners are not seen in the same way. Generally younger, with urban backgrounds and proponents of residential mobility, they are perceived more as individuals with projects and skills that could be of use to the community. They are included in the broad group of new arrivals and appreciated – subject to their resources – on the strength of their contribution to the renewal and revitalisation of rural communities. The social integration of this newly arrived population hinges on two essential conditions: 1) that their personal financial and social resources do not place them under the care of the local community and 2) that their hopes and expectations of the community are commensurate with the possibilities and ambitions of local action.

The authors who are working on neighborhood's effects emphasize the influence of the social network and the importance of local resources on the well-being of residents (Atkinson, Kintrea, 2002; Hulchanski, 2007). However, we understand in the interviews the impact of the life curse on the possibility of integration in these rural areas for these population's groups. The accumulation of constraints or breakages of life often leads to a strengthening of vulnerabilities. The weight of accumulated disadvantages influences the capacity of adaptation in the new environment. Each new event modifies and jeopardizes the life course (Wheaton & Reid, 2008). It's a great challenge to distinguish the impact of the new environment and the impact of life's trajectory, and adversity in the past in production of vulnerability in ageing.

Generally speaking, rural areas "under pressure" are (at least transitionally) weakened in terms of social cohesion and lose their capacity to integrate. The impact of these trends on the elderly populations living in these areas differs in line with the depth of their local roots and with local contexts. The hybridisation of ways of life occurring in rural peri-urbanised areas does not always seem to favour the emergence of new, inclusive dynamics replacing older mindsets based on social and cultural homogeneity. The relegation or exclusion of the elderly is always connected to the existence of integrating communities, such as the municipality, possessing the founding virtues of social cohesion.

II. Political ways and human community relationship as bulwarks against social exclusion

The geographic and social morphology of rural environments could be so considered as factors of vulnerability for ageing people and principally for those who are new arrived in these areas. The risk of segregation and loneliness isn't a myth. But our investigations emphasize the role of policies and of social networks as protection for vulnerability in the old age. We investigate the impact of the local environment, the social cohesion and the moral density, the role of the local amenities and policies on the wellbeing of retirees in rural areas. We prove that the weight of this objectives resources must always be considered according to the capacity of the people to use them, depending on their social trajectory and life curse (Gucher, 2012). Some conditions are nevertheless necessary to make easier the life of retirees in rural environments and encourage their social inclusion. They depend on the territorial development and on the social history of the places.

2. 1. Social exclusion connected with territorial development and access to rights and services

A dual phenomenon of social relegation can be demonstrated in rural areas. Some areas are marginalised by their isolation, the absence of economic resources and the discontinuation of the (public) services that could maintain the vitality of the area (Berthod-Wurmser et al., 2009). In others, the phenomenon of relegation can be observed with certain population groups living far from the area's main towns (where rural amenities are developed) and those in poor and isolated rural areas. In the rural isolated areas, we observe any factors of social, geographical but also political "defavorisation" (Pampalon, Raymond, 2003). In this circumstances, we suppose a limited citizenship of the people, who live in these territories. Effectively, the access to their general rights seems to be uncertain. Moreover, they suffer under an inequality of treatments (in comparison with urban population) in the difficulties of the old age. This disparity in resources is combined with a nationally uneven offer of services and with mobility issues. The decline in the offer of public services in rural areas began in France in the 1990s and continues in a number of sectors, with a restriction in the number of public hospitals, the diminishing presence of private medical professionals and, more generally, healthcare professions in rural areas. Because of their demographic situation, and of the general orientation of public policies, isolated rural areas- as these in which we investigate- meet this general tendency of suppression of public services. Post offices, banks, small traders and health services are scarcely in these territories. Limited opportunities in terms of mobility and transport also play a role in the marginalisation of the elderly in these rural environments (Berthod-Wusmer et al., op. cit.).

Because of what it entails in the different registers of social relations, the exclusion in rural areas involves the aspect of the breakdown of citizenship resulting from prob-

lems of access to and take-up on the rights and services available to the population as a whole (Warin, 2011).

The relative economic precariousness of the retired in rural areas is partially offset, for natives, by networks of mutual assistance and solidarity. But the same is not necessarily true in areas suffering from economic problems that destabilise the way families work, generate undesired mobility and limit the population's ability for mutual assistance. Moreover, the same situations of economic and social precariousness have a greater negative impact for people having arrived in a rural area late in life and who lack the same solidarity networks.

To fight against these growing shortcomings, some parts of the country are developing innovative initiatives such as multi-sector healthcare centres and remote consultations using new technologies, known as telemedicine. However, these projects depend on the initiative of elected representatives, the engagement of a number of partners and the availability of economic resources, as well as the project engineering resources capable of, say, responding to European calls for projects such as the European Agricultural Fund for Regional Development[5]. Beyond the issues of healthcare access, services to individuals may represent an essential basis for revitalising the residential economy. But the range of support services for the ageing is being diversified mainly in peri-urbanising rural areas, where the development of a social and community-minded economic dynamic aimed at population groups of varying ages and needs is opening up new alternatives as part of the response to ageing issues. In isolated rural areas, the strictly local recruitment of staff, their lack of mobility and their low educational level makes it difficult to implement training and upskilling projects. This situation constitutes an obstacle to keeping ageing individuals at home owing to a lack of the qualified staff and services needed to provide adequate care. The issue is of particular concern for elderly individuals having moved to a rural area late in life, unable to count on supplementary support and assistance from friends and family.

2.2. Municipalities and traditional bodies a consistently efficient integrating forces

In rural areas, inclusion and social participation are clearly dependent on the life courses of the people – those having never moved and those recently arriving – and on the characteristics of the area itself (still relatively closed or fast-changing). This explains why a number of forms of belonging develop in rural areas, engaging the way in which individuals form a part of the place and its history and the ways that they activate these community roots through social relations, as well as their contribution to collective social dynamics (Sencebé, 2011).

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[5] These points issue from research carried out in 2011–2012 for CGT IRES on social action for the retired and the elderly. The research mapped out the development of these initiatives in France in the Creuse, Savoie and Nord *départements*.

Yet our work testifies to the ongoing role of the municipality as an "integrating community" essential to inclusion. An administrative and political reference, the exclusive basis for managing community affairs, and a unifying territorial framework, the municipality stands as a "territory of identity" (Guérin-Pace, 2006) that supports not just symbolic but practical affiliations as well. In isolated rural areas and peri-urbanising rural areas alike, the municipality is the anchor point via which new arrivals "enter the territory". The municipality's elected representatives and administrative services – often one or two people in isolated rural areas – respond to needs of affiliation and security. Contact with elected representatives generates a sense of acknowledgement and consideration. For natives, the municipality is the medium of a shared history to which personal life courses are anchored. For the newly arrived and natives alike, relations with municipal bodies form a bulwark against exclusion or isolation. Native and recently arrived are together concerned with local interest (Guimond, Simard, 2011). These results corroborate the work of North American researchers on the investment in so-called "fragile" communities in Bas-Saint-Laurent (Simard, 2007).

Our work has underlined the fact that the social integration of the native population is based on the use of "autochthonous capital" and on logics of self-evidence. The more recently arrived elderly develop inclusion and participation strategies in counterpoint to give form to their social integration and avoid being marginalised or excluded. But for all those involved, it is the requirements of the living environment that dictate the forms taken by social integration (Gucher, 2008). Through socially-responsible commitment, it is the issues of belonging to an integrating community that are at work (Guimond, Simard, 2011)

Social participation in the first few years of retirement involves a range of different commitments. While native individuals through habit, tradition and received notions take part in collective-interest activities and contribute frequently to a range of commitments, recently arrived individuals participate strategically in activities likely to further their integration (Gucher, Laforgue, 2010). This diversity in the commitments of the elderly to social life has also been highlighted by work in Canada (Keating, 2008). Our work contributes to the issue by emphasising that these multiple forms of involvement in sociability and solidarity networks are tributary to the nature of territorial roots, in short, to prior social and residential trajectories.

In rural areas still little influenced by urban life, the participation of the retired is essentially the responsibility of traditional bodies such as municipal councils, events committees, firemen's' clubs, school associations, sports clubs and parishes. The reach of organisations is still often limited to senior clubs. Newcomers and natives are often brought together as part of a scant number of collectives, but which play a considerable role in the needs of community life. In peri-urbanising rural areas, however, a diverse range of local participation resources are developing on the initiative of new arrivals. Here it is elective motives that unify and divide the populations, and the risk of rifts between populations sometimes transpires, with natives involved in traditional bodies and the newly arrived in

organisations. This leads to the expression of power issues, primarily in terms of private concerns but potentially in terms of the day-to-day management of municipal affairs.

The continuity of commitments appears to be fairly standard until an advanced age, but fatigue or health problems sometimes lead to a gradual or sudden withdrawal from the sphere of public commitments. The initial movement generally consists in a withdrawal from formal commitments and the abandonment of the corresponding responsibilities. Most of the time, this does not involve a withdrawal to private and domestic life but a transformation in the ways in which the individual takes part in local life. For example, when the elderly begin to have mobility problems, when fatigue sets in, participating can mean "keeping informed" of the events affecting the life of individuals and the community. These "minimalist" takes on participation of the natives of isolated rural areas nevertheless provide a guarantee of inclusion until a late stage in the ageing process.

But for newly arrived individuals, the process of withdrawal more frequently signifies a threat to social integration if their history of commitment has not been long enough to confer them with an integrated social status. The guarantee of maintained social inclusion, beyond the expression of their social usefulness, can be acquired only after a long period of assimilation efforts. These phenomena sometimes explain why an individual returns to the a place of former residence or seeks to be closer to their family, searching for more firmly established sociability and solidarity resources. But such return are not always possible.

2.3. Family and neighbours, and sociability and solidarity, as support of social participation

The characteristics of some rural areas often lead to the supposition that the people living there are isolated. The factors of geographical isolation and distance, the relief of the land, scattered settlements, as well as low geographical density, are decisive to a type of sociability in which relationships with neighbours and family play a dominant role. Yet while the frequency and forms of social interaction are limited in these geographical contexts, the moral density and social homogeneity to be found there largely offsets the situation for natives. It is far from certain that the same protection is to be found in open and transforming rural areas and for people moving to rural areas late in their life.

The native rural elderly frequently coexist in a limited territory with at least one of their children or grandchildren, and sometime with their brothers and sisters, or cousins, and, for the youngest among them, their parents. The geographical proximity of the members of an extended family plays an organisational role in everyday life, expressed through reciprocal exchanges of services that generate interdependency[6].

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[6] It is important here to emphasise that these exchanges are linked to the specific nature of the farming milieu, in which a limited social elevation of the younger generations may be observed. The property value of the agricultural land when farming activity stops constitutes an exchange value between parents and children that serves as a basis for ensuing relations.

In some, demographically stable, isolated rural areas, bonds with neighbours and family often overlap, and genealogical connections are coupled with heritage-based roots. The inhabitants of rural areas appear to know each other even before meeting, which brings the most elderly among them a feeling of considerable security. This feeling is temporarily impaired by the arrival of newcomers who are difficult to situate in local history.

Sociabilities are made more inclusive when they involve mutual assistance. Relations with neighbours are emblematic of these everyday two-way interactions and fail to be impacted by the advance of age and situations of dependency. On the contrary, they appear to foster close and long-lasting relationships, as evidenced in unprompted visits to retirement homes.

For retired individuals arriving in rural areas later in life, the family and genealogical roots do not play the same role as the main organisers of sociability as they do for natives (Gucher, 2013). Long-distance social networks develop, requiring an adjustment of expectations and exchanges. Relations are organised on an alternating register, with physical presence during the holidays, for example, and continuous presence via the telephone or another communication medium. In any case, the family cannot contribute to local sociability on a daily basis. That role has to be played by the individual in question, drawing on his or her own resources.

The possibility of diversifying social integration spheres is reduced in isolated rural areas, and multiple belongings develop in a limited number of relational circles. The elective principle is largely inappropriate in this context and may lead to isolation and even exclusion if it remains a central aspect of the relational behaviour of newly arrived retired people. In a fairly general manner, the local sociability of newcomers is driven by procedures of participation and commitment. Bonds are created and tightened by doing things with other people and through concern for and investment in common matters. Similarly, submitting to the requirements of religious and civic rituals that bind the community is a way of showing one's desire to integrate, which then authorises the inception of relationships. But for these sociability dynamics to last, individuals need to demonstrate their determination to be *of the place* and eschew what makes them different in favour of what makes them similar (Sencébé, 2004.). The intersection of networks lends them both considerable integrating power and a heightened capacity for exclusion. Because while the bonds developed therein trigger a system of reciprocal relationships, the absence of relationships with some deprives individuals of links with all.

In peri-urbanising rural areas, the arrival of new, young and less young populations contributes to a diversification of the forms of sociability. Endogenous sociabilities, characterising the populations that live in and do not leave the community, come into contact with the exogenous sociabilities of populations that are simply passing through – tourists, for example (Granié, 2003). In addition, mixed sociabilities also develop, on the part of individuals who live in the community but travel widely, notably for their work. The

newly-arrived retired are at the crossroads of these three forms of sociability. In this context, the relationships chosen by the retired can protect them against isolation but do not provide the same long-term protection as being acknowledged and integrated as "from around here". It is with the increase in age and decrease in mobility that possibilities of entering the public sphere diminish, that dependence and fragility require recourse to a trusted third party, that the isolation of pensioners arriving in the area late in life becomes manifest, and that the social integration of these last may become problematic.

Conclusion

The work we have carried out over several years has led us toward a multi-dimensional analysis of the social exclusion of the retired in rural areas. Based on analysis of the life courses of the retired and elderly living in these areas, we have also been able to demonstrate the impact that specific rural environments have on exclusion. Having completed our work, we can assert that the social exclusion of the retired in rural areas is a process that results from combinations of the transformations occurring in rural environments and the life changes that people are confronted with as they grow old. The "place" of the retired in rural areas reveals their transformations as much as it sheds light on the adjustment processes in the life courses of the different groups of the retired population living there. Social exclusion here results both from the weakening of integration mechanisms and the weakening of inclusion mechanisms. Integration dynamics are connected to the aptitudes and resources that people can draw on in line with their prior life course and to their more or less developed participation strategies, while inclusion processes are based on the available resources of a given area, both practically and culturally or symbolically. As such, rural areas at this point do not appear to all generate the same levels of exclusion of the elderly. Depending on the current trend in a given territory – on its stable or changing nature – the resources required for the inclusion of people weakened by age or other factors are not evenly available. Similarly, we underline the varying degrees of social integration or inclusion of the retired according to their local roots, i.e. distinguishing between natives and those arriving in the area late in life. Four dimensions of integration and inclusion can be demonstrated: the status[7] of the retired and elderly, social participation in all its forms, the belonging to a network of social relations, and access to the services required in the support of the elderly. But the question of identity stands as a central component in the social exclusion of the retired, as it is the strength of the identity-based resources provided in rural areas that, by supporting the continuity of the identity of people despite adjustments in practices and meaning arising in old age, constitute the most relevant protection against the atomisation of social relations and the exclusion of the most fragile. So is it possible to consider the objective characteristics of

[7] In the Weberian sense of honours, consideration and place in the social hierarchy.

territories that can often be seen as sources of fragility – remoteness, ageing, desertification, economic decline – as predictive of the social exclusion of the elderly? Likewise, the geriatric and economic fragility of the elderly are not to be seen as the decisive element in their exclusion. The origin of probable exclusion should, then, be sought in a cultural and heritage-based analysis of rural areas and through a wide-ranging approach to life courses, seen as the construction over the long term of meaningful relations. Ageing in rural areas can thus be understood as an opportunity as much as a risk of increased vulnerability.

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Karolina Mizera[1]

Ageing policy in Israel

Keywords: Israel, senior policy, pension system, community services

Abstract

The goal of this work is to analyse the socio-demographic, political and economical conditions of life of the elderly in Israel, including the description of the pension system and selected services for senior citizens. It was conducted based on the analysis of source texts, statistics and reports, coming mostly from government sites, as well as international and Israeli institutions. The results obtained were confronted with an opinion concerning the quality of life of the elderly, provided by a 40-year-old Israeli citizen. This was researched in a manner of a free-form interview, which was carried out in May 2015 in Israel. The issues discussed in the interview outlined the structure of this work.

Introduction

Israel is a country with a relatively short history, which, like a magnifying glass, focuses people of multi-cultural origins within its borders. It is a country where progress and modernity are intertwined with history and tradition. It is the homeland of the Jewish nation, where a quarter of society is made of Arabs and other ethnic and religious groups (*Israeli – a human mosaic*, no publication data).

Israel as a country is unique in many aspects, but its relatively young society is beginning to face a problem of aging. In the ranking of countries according to the quality of life for the elderly, Israel occupies a high 18th place out of 96 countries. However, the in-depth analysis demonstrates that the Israeli society is characterised by large dispro-

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portions in economical and social status of its citizens. Fairly good conditions for aging favour specific social groups, while for the remaining ones, mostly ethnic and religious minorities, they are difficult to achieve.

Socio-demographic determinants of old age in Israel

The population living in the territory of Israel in 2014 was 8.1 million people, 10.9% of which was made up of people older than 65 (OECD, 2014). Even though the percentage of elderly people in this society is increasing[2], compared to the European Union countries it is a relatively young population. In addition, the average life expectancy in Israel is longer than in the EU countries. In 2013 it was estimated do be 83.9 years for women and 80.3 years for men (CBS, 2014). In comparison, the average life expectancy in the 28 countries of the European Union was respectively 83.3 and 77.8 years (Eurostat, 2015). Considering the multi-cultural aspect of the Israeli society it is worth noting that this number is an average for all population, including both Jewish and Arab communities, while their separate life expectancy is not the same. The difference between them is approximately 3 years, in favour of the Jewish population (CBS 2014).

Table 1. Proportion of population aged 65 and over and life expectancy in selected countries

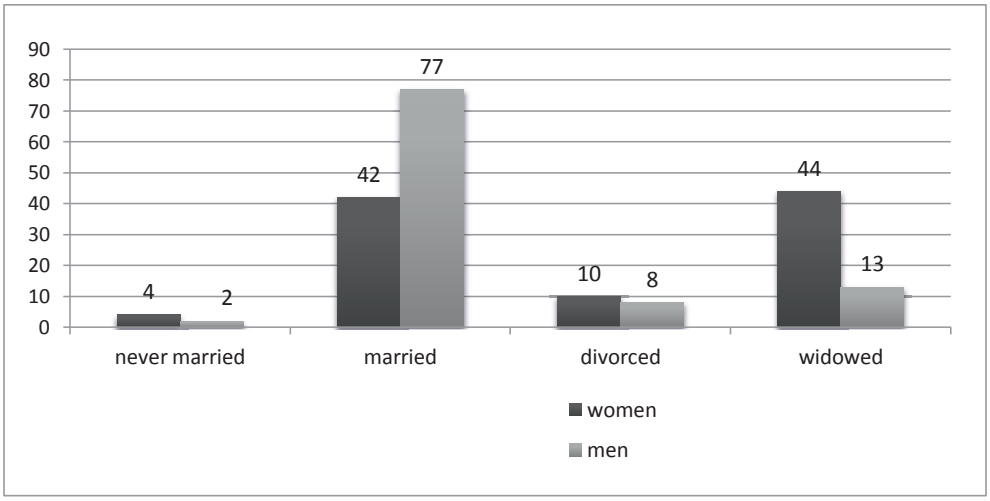
Country	Proportion of population aged 65 and over (%)		Life expectancy	
	2010	2014	Women	Men
Israel	9.9	10.9	83.9	80.3
Poland	13.5	14.9	81.2	73.0
28 countries of the European Union	17.5	18.5	83.3	77.8

Source: Own work based on: OECD.stat, Country statistical profiles: Israel, 2014; Eurostat, Proportion of population aged 65 and over, 2015; CBS Statistical abstract of Israel 2014, Life expectancy, by sex religion and population group, 2014; Eurostat, Life expectancy at birth by sex, 2015.

Since women live longer, they are the ones who remain alone in the old age. In 2010 the percentage of widows above 65 was more than three times larger than the percentage of widowers of the same age. In turn, more than ¾ of all elderly men and less than half of women were married (*Women & men in Israel* 2013, p. 4). The characteristic of the oldest group in Israeli society in terms of marital status is shown in the graph 1.

[2] In 2010 it was 9.9%

Graph 1. Person aged 65+ by marital status, 2010 (%)



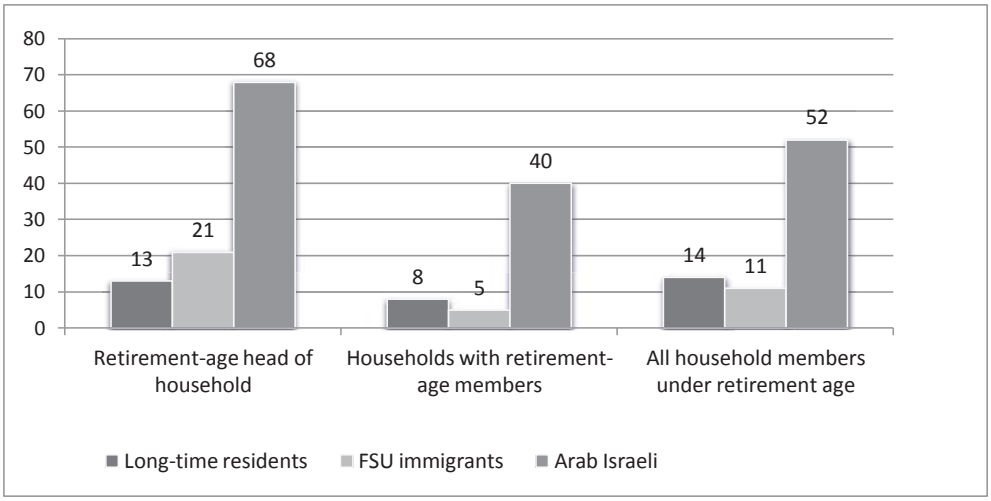
Source: Own work based on: Central Bureau of Statistics, Women & men in Israel 1990–2011, 2013.

The higher rate of widowhood among women and the higher average life expectancy results in increased need for social services. In 2013 there were 273,466 people above 65 registered in social services department, which was more than 32% of the elderly population. Out of all the women registered in social services department, almost 25% were older than 65, whereas in case of men this rate was 9 percentage points lower. The demand for the services was clearly increased among people past 75. They most often used help in connection with geriatric and health issues and disability (CBS, 2014).

According to Global Age Watch Index 2014, 91% of people past 50 declare to have family or friends they can rely on in difficult situations (Global Age Watch Index, 2014). The less pleasant picture of the support resources for the elderly in their close environment is painted in research by the Central Bureau of Statistics (CBS) in 2010, which was conducted on a smaller group of subjects (only people past 65). The results showed that 32% of respondents said they had had no one to turn to for help. Almost as many of them declared they felt lonely, and almost 41% admitted to have no contact with acquaintances. The percentage of seniors declaring the feeling of loneliness was considerably larger than in other age groups. This problem pertained especially to people past 75 (CBS, 2014). The subjective feeling of loneliness and being forlorn seems to have a broader dimension then the actual, physical solitude. According to data from 2013, the most common form of dwelling amongst the elderly is a single-family, two-person household – this is how approximately 49% of seniors live, while over 26% lives with children, relatives or with unrelated people. 24% of people in this age group live alone (CBS, 2014).

Poverty is a significant problem which concerns a considerable part of Israeli elderly population. Despite the high ranking in the Global Age Watch Index 2014 ranking, Israel

Graph 2. Percent of households below the poverty line by household type and by disposable income. Average for 2010–2011



Source: Own work based on: H. Stier, H. Bleikh, Poverty within the elderly population in Israel, 2014

ranks relatively low in the income security category (45th place). Less than 74% of people above 65 receives pension, while in Poland the number is 96.5%. This results in a high poverty rate in this age group – the income of more than 21% of people past 60 is lower or equal to the half of national average salary. At the same time the average income and consumption of people older than 60 is equal to almost 96% of the average income and consumption of the entire society (Global Age Watch Index, 2014). This is an indicator of the large economic stratification within this age group. The level of poverty amongst the elderly is diverse due to types of households as well as social groups. Among the elderly residents of Israel, long-time residents are in the best situation, since it is easiest for them to fulfil the requirements for receiving pension, and a high length of service raises the value of the pension. W 2011 65% of then received pension benefits, while among the Former Soviet Union (FSU) immigrants the percentage equalled 21%. The smallest number (8%) eligible for pension was among the Arab Israeli (Stier, Bleikh, 2014, p. 407). Those indicators are reflected in the poverty indices. The lowest index (11%) is observed in case of long-time residents and it is lower by 6 percentage points than the poverty level within entire Israeli society. The poverty index among FSU immigrants is 18%. The worst situation is that of Arab Israeli, 60% of which live below the poverty line (Stier, Bleikh, 2014, p. 409). From the perspective of the households it can be noted that for the family budget the most profitable situation is when the retirement age person lives with a younger generation. Within the mixed households the poverty level is lower than both within households consisting solely of the elderly people and those not inhabited by the elderly (Stier, Bleikh, 2014, p. 416). Data presented in graph 2 pertains to disposable in-

come, which is the income left after subtracting government intervention from taxes and welfare. It is much more favourable for the seniors than that which indicate the poverty level measured against market income. It is worth noting that while the level of poverty among long-time residents is lower in case of the elderly than for the rest of society, the seniors among FSU immigrants and Arab Israeli are in a considerably worse situation than the younger people in those social groups.

Israeli pension system

Israeli pension system consists of two age thresholds which make one eligible to receive pension. In 2004 the retirement age begun to be lengthened. Because of that the moment of crossing the specific thresholds depends on the year of birth. The first threshold is the retirement age, which is reached between 60 and 64 by women and between 65 and 67 by men. At this age citizens who prove their work income is lower or just slightly higher than a specified income threshold are eligible for old age pension. In case of other sources of income, it cannot be higher than twice the specified amount. Second age threshold – age of entitlement to old-age pension – is reached by men of 70, and in case of women it is currently being lengthened. The target age threshold is 70, but in 2014 the threshold was 68 years and 4 months. Reaching this threshold makes one eligible for old age pension regardless of their income. Age and income are not the only criteria determining pension eligibility. In addition, person must be covered by old age insurance, which is only possible for Israeli citizens who settled in Israel before reaching the age of 62. The effective period of old age insurance should cover 144 months, or at least 60 months during the 10 years preceding retirement, and the premiums must be paid in accordance with the law (*Conditions of entitlement*, no publication data).

Pensions are awarded and paid by the National Insurance Institute of Israel. The basic old age pension amounts (updated at the beginning of 2015), converted to US Dollars, are 389 USD for an individual and 586 USD for a couple (*Old age – pension rates*, no publication data)**.** In both cases the pension is increased by approx. 6% for people of 80 and older. Additionally, the pension of people who are legal guardians of children is increased by 5.6% of the base amount per each child (applicable to a maximum of two children). Citizens covered by insurance for more than 10 years before retirement are entitled to seniority increment (insurance), which means that for each additional full year of insurance the pension is increased by 2%, up to the maximum 50% of the pension. In addition, the seniors who have resigned from the old age pension they were entitled to in the period between retirement age and age of entitlement to old-age pension, are eligible for pension deferral increment equal to 5% of pension for each year in the given period (*National Insurance Programs in Israel*, 2015, p. 44–47). If the amount of base pension increased by the additions above is not higher than a specified amount and a person is not a member of a kibbutz or a cooperative moshav and fulfils the further criteria such

as having no additional income (or a limited amount of income), they are eligible for income supplement to an old-age pension (*Income supplement to an old-age pension*, no publication data). Having received that, the pension of an individual pensioner may increase on average by 32% of the base amount of pension accrual[3]. In case of couple this increase is 46% on average, and for people having children it may even be 60%. The amount of income supplement is dependent on the age of a pensioner and the number of children they have (*National Insurance Programs in Israel*, 2015, p. 47). The pension of an individual entitled to all additions in 2014 was 714 USD, and 1060 USD for a couple. In order to fully present the situation and economical standing of the elderly in the Israeli society, it has to be noted that the national minimum monthly salary is 1184 USD, and the average of all salaries is 2358 USD (*General information*, no publication data). For people who have no other sources of income and no savings retirement is connected with a significant decrease of their economical status. In addition, considering the high percentage of people who are not eligible for pension and the fact that few people are entitled for the highest pension, the assessment of the financial security of the eldest citizens of Israel is significantly decreased.

The senior policy in Israel – selected aspects

Aging society and the high poverty level among the seniors is the reason for which the elderly policy is given more and more attention in Israel. In 2007 Ministry for Senior Citizens was created. Its main areas of operation are:

- Improving life quality and level of senior citizens – efforts towards increasing the security of the elderly and informing them about their rights and opportunities;
- Building and adjusting service infrastructure in the age of aging population – responding to senior citizens' needs, improving the conditions in their place of residence concerning social services, rehabilitation and health care;
- Establishing the connection between young and old generation – conducting projects in partnership with Ministry of Education, youth movements and students;
- Improving quality of life of the Holocaust survivors – informing them about their rights and helping them to reclaim lost wealth and exact the compensations they are entitled to (Ministry for Social Equality, no publication data).

Ministry for Senior Citizens is also responsible for issuing a Senior Citizen's Certificate for the citizens of Israel past the retirement age. This certificate makes citizen eligible for various discounts, e.g. concerning television, public transportation, theatre, museum and national park tickers as well as discounts concerning health care and housing. In addition, the ministry initiates multiple projects promoting volunteering for and amongst

[3] The amount of base pension for an individual and a couple is respectively 17.7% and 26.6% of the amount resulting from calculation of maximum income for purposes of collection of contributions. In 2015 this amount, after conversion to US Dollars, was equal to 2202 USD.

seniors, creating conditions for cross-generational integration, educating senior citizens and focusing on preventing violence against the elderly (*Ministry for Social Equality*, no publication data).

The elderly policy and community services for the elderly in Israel are developed in accordance with aging in place policy. It treats the institutionalised care as the final solution and aims at enabling the elderly to age in their own home and environment for as long as possible. In Israel most of the responsibility for the care of elderly people rests on their close family. Services and solutions offered are meant to support and relieve the family, not replace them (Brick 2011, p. 8). In 2012 more than 450 million NIL, (i.e. approx. 114.5 million USD) were allocated to services for the seniors, but in fact less than half of this amount was used. This means that the elderly do not receive all the benefits they might be entitled to, and this trend has remained in place for many years (*A picture of the Nation…*, 2015, p. 41).

The first expression of the aging in place policy was the implementation of the Long Term Care Law under the National Insurance Law in 1988 (Brick 2011, p. 8). In accordance with that law, disabled citizens may apply for help of the daily assistant for such activities as running the household, washing and preparing meals. Similar services are being provided by welfare departments, non-profit organisations and private enterprises for the seniors who are (for various reasons) not entitled to home care under the National Insurance Law (Katan, no publication data, p. 3).

The disabled seniors may get similar help in Day Care Centres, which provide services for 5–6 days a week for 6 hours on average. Their operations are funded by the National Insurance Institute and Ministry of Welfare and Social Services. The seniors or their families also participate in the costs. The payment for a Day Care Centre visit is approx. 4.00 USD a day. Apart from services connected with daily functioning, those establishments also provide social and physical activities and physiotherapy (Brick 2011, p. 9).

It is a very popular solution to employ (by the families or the seniors themselves) the foreign caregivers, who live with the seniors and provide services around the clock. Such people usually come from the Philippines, but also from Eastern Europe or Sri Lanka. This solution was a rank-and-file initiative if the society, later supported by the government. The families which decide to employ foreign caregivers may apply for a refund under Long-Term Care Insurance Law. In 2008 there were 54,000 foreign caregivers employed to take care of the elderly (Brick 2011, p. 10).

Another rank-and-file solution for improving the quality of life for the elderly in their own environment are supportive communities. They provide seniors living in their area four basic services: support from Community Mother/Father – a professional, paid employee monitoring the needs of seniors and helping to satisfy them; Emergency Call System – alert system installed at the senior's house, connected with the call centre, which allows to call help quickly; Medical Services – providing home visits by the physician at a small fee and a free ambulance when needed; Social Activities – creating conditions for

active recreation, education and social meetings in the community of neighbours. First Supportive Community was created in 1998 as the NGO initiative. In 2010 there were 250 such communities. Their members pay monthly fees of approx. 30 USD, while the Ministry of Social Welfare funds activities connected with social security (Brick, 2011, p. 10–11).

These are just some of the solutions helping the seniors to function within the society. It is worth noting that benefitting from them is dependent on various conditions, such as being insured or having financial resources. In addition the quality of and access to community services also depends on geographic location (Katan, no publication data, p. 6). Seniors who live in large cities with well-developed infrastructure have access to a broader variety of services. This is also a result of the multiple expansive NGOs and private enterprises, which are more often located in large cities.

Reality of the elderly in Israel – perspective of the citizen of Israel

In order to study the life of the elderly in Israel, an interview was conducted with member of Israeli society. In May 2015 I participated in a student seminar "Bringing Together" in Israel. One of participants was a 40-year-old ground-school teacher living in the suburbs of Tel-Aviv. His responsibility for educating young people and mature age allowed me to evaluate him as person aware of problem and social issues in his country. I interviewed him for approximately one hour, talking about the issue of the life of the elderly in Israel. A lot of attention was given to the state policy concerning seniors, and the social and economic situation of seniors. My interlocutor also often referred to the general characteristic of Israeli society, the problems it is facing and the consequences of those problems for seniors.

The main conclusion that can be drawn from the collected data is the observation that the Israeli concerning the deep stratification of the Israeli society. This situation is mostly conditioned by the descent and by the social and economic status which is often a result of descent.

The narrator begun with presenting the historical setting and political situation of his country, including its multi-cultural and multi-faith aspects. All those factors contribute to the form and characteristics of the Israeli society, which – as he says – is highly disproportionate.

> *What happens in Israel? The rich getting richer, the poor getting poorer. Sometimes you can see that the middle class is starting to disappear. It's hard to find the middle class. Strong get stronger and weak get weaker.*

The reason for this situation is the social inequality of access to education, jobs and culture which is based in gender and descent:

> *There is still a lot of differences, a lot of gaps. A lot of people who don't get equal rights that they should. Women still earn less than men in the same job. You still have people who live in the*

centre the Tel Aviv etc. and those who live really south. There are still a lot of gaps between them – what they get, the road they have, the bus ticket, what services the city is giving them. You still have gaps between Ashkenazy and Sephardic, between Jewish and Arab.

Social exclusion, difficulties in access to education and jobs, low wages all contribute to the quality of life in the old age:

Situation of old people depends on whether old person is Sephardic or Ashkenazy, if he is men or women, if he lives in the centre of Israel or further. It depends on which old people you are, what you have done before, what kind of education you have.

This dependency stems mainly from the difficult access to pension benefits and community or health services. The economical situation of many of Israeli citizens does not allow them to pay insurance premiums required to receive benefits. As a result, in the old age they are left without livelihood and social security. On the other hand, people who enjoy high social and economical status gather wealth and savings which they can use up after retiring.

You can see those old people who can go to the university, live nearby the university those who have money and can afford this and many of old people have financial problems. They are stuck in their house, old and sick, or even if they are healthy they don't have knowledge or don't know how to use the internet. Those who are weaker stay in their house, outside the centre, don't know what a university is and are stuck over there. And those who are more educated or live nearby expensive places, they have money and time for leisure and hobbies.

Narrator also noticed the variety and high quality of services for the elderly in large cities. They are, however, aimed at seniors who are wealthy or come from wealthy families. He stressed that the close family often participated in the costs of senior care, which is exemplified by the popular practice of employing a foreign caregiver. This solution is often chosen by families which cannot take care of their elderly themselves. In his opinion, family and wealth are to main factors that determine the quality of life in the old age:

If you are old person in Israel you better have money. Make sure you have money. If you don't have money – make sure you have sons and daughters, who love you and have money. If you don't have this stuff you are going to have weak life, until you die.

Conclusion

The high ranking of Israel in Global Age Watch Index 2014 is a result of statistical averaging of basic categories that determine the quality of life in the old age. From the quantitative perspective the state creates good conditions of life for its senior citizens. Similar conclusions could be drawn from researching the elderly policy of the state. However, this picture changes unfavourably when qualitative analysis of the problem is employed and when one

looks at the data concerning the poverty level in this age group. The conditions that the state provides for its citizens cause the good quality of life in the old age to be easier to obtain for certain age groups, which as a result leads to the stratification of society. This effect is reinforced by the variety of cultures, religions and descents among the Israeli residents.

The disproportions in society begin in the younger age groups, but retirement further reinforces them. The conditions of pension entitlement make people who settled there in the old age (which was common due to the history of the country) ineligible for pension. The base amount of pension compared to average income of people in working age is very low, and its increase is only possible with the high length of service, which is often difficult to achieve for minorities, just like collecting savings. At the same time, appropriate period of insurance is required to become eligible for community services. In addition, the costs of care for the disabled seniors are not infrequently shared by the family, and its wealth is often determined by membership in a certain social group. Situation is made worse by the fact that the offer for the elderly is diverse depending on geographic location, which makes it difficult for people from smaller towns far from large cities to have access to it.

The picture emerging from that analysis of the data becomes even more expressive in the interview conducted with the young citizen of Israel, who pays special attention to the growing disproportions in the society. In his assessment it is the descent and gender that determine the material and social status, and in consequence the quality of life in the old age. Both the source data and the narrator's statements indicate a large role of family in the life of the elderly. This phenomenon is reinforced by the aging in place policy employed by the state, which is aimed at allowing the seniors to stay in their place of residence for as long as possible. This policy is mostly realized by activities which support families in caring about their most senior members.

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Zofia Szarota[1]

Senior policy in Poland: compensation of needs and active ageing

Keywords: old age, senior policy, *age management policy*, social assistance, long-term care

Abstract

Poland has been experiencing a number of problems related to social and demographic changes – ageing of the society in particular. However, the national social policy for older people has just begun to form. This study presents the main trends in the said policy. It presents forms of social support aimed at older and old people, having the form of benefits and social assistance services.

Negative (?) value of pensioners, i.e. the "burden" of the old age carried by Poles

Ageing of the society is a challenge for national policies, especially for the pension system, health care, social assistance and public finance. In 2014, each Pole contributed almost PLN 19 400 (around EUR 4 600[2]) for statutory liabilities. Expenses on retirement and disability pensions, care allowances etc. amounted to nearly 1/3 of the above amount – ca. PLN 6 800 (i.e. ca. EUR 1 600) and were the largest figure in the national budget (Łaszek 2015, work). Those expenses will be growing together with progressing depopulation.

Demographic forecasts show that in 2050, the percentage of Poles aged 65 or more will exceed 23% and in 2050 it will be close to 33% which means that seniors will make up one third of the nation. As a result of double ageing, people above 80 years of age

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[2] According to the exchange rate as of September 2015

will make up almost 32% of this sub-population (*Demographic Situation…,* 2014, p. 35, 37). Relations showing the economic burden ratio will change to the detriment of the economy. In 2030, there will be ca. 40 persons in post-productive age per 100 persons in productive age (*Social Policy Strategy for the years 2007–2013*).

The care-giving (nursing) potential of Polish families, measured as the proportion of the number of caregivers (usually women aged 46-64) to the number of persons in old age (80 or more), has been decreasing (see Szukalski 2012, p. 27, 37). Due to migration of young people, seniors are left alone, family bonds are weakening as the number of people in need of care is on the rise and the new models of "remote" care-giving appear at the same time (see Krzyżowski 2013, p. 36, 44-52).

Over 96% of persons aged 65 or more were administrators of their pension benefits in 2013. This is the only social group with steady and countable income and wealth gathered during their lifetime (e.g. real estates – houses, flats). The value of net income per person among seniors is statistically higher than in other households – the average monthly income for disposal in pensioners' households was almost by PLN 100 higher than the average income of all Polish households (*Retirement and Disability Pensions in 2013 …*, p. 31). Relative poverty affects 12.6% of pensioners, statutory poverty – 3,7% and very low quality of life determined by the living wage affects 4.6% of them, whereas for the people in Poland in general the figures are as follows: 16.7%, 6.5%, 6.7%, respectively (Kalinowski 2014, p. 31-38). However, if we take into consideration such variables as the living environment (city, town, village, region), level of education or health condition, there is a huge differentiation in the subjective perception of one's financial situation.

In 2011, persons aged 65 or more were members of 30.5% of the total number of Polish households (*Ludność w starszym wieku*, p. 13). According to studies, intergenerational flow of benefits in Polish families from the oldest to the youngest generations concerns mainly looking after small grandchildren, financial support and material resources (including legates) (Tomczyk 2011, p. 123-140). This thesis, illustrated in table 1 and in figure 1 has been confirmed by the studies carried out by the Polish Gerontological Society (Czekanowski 2012).

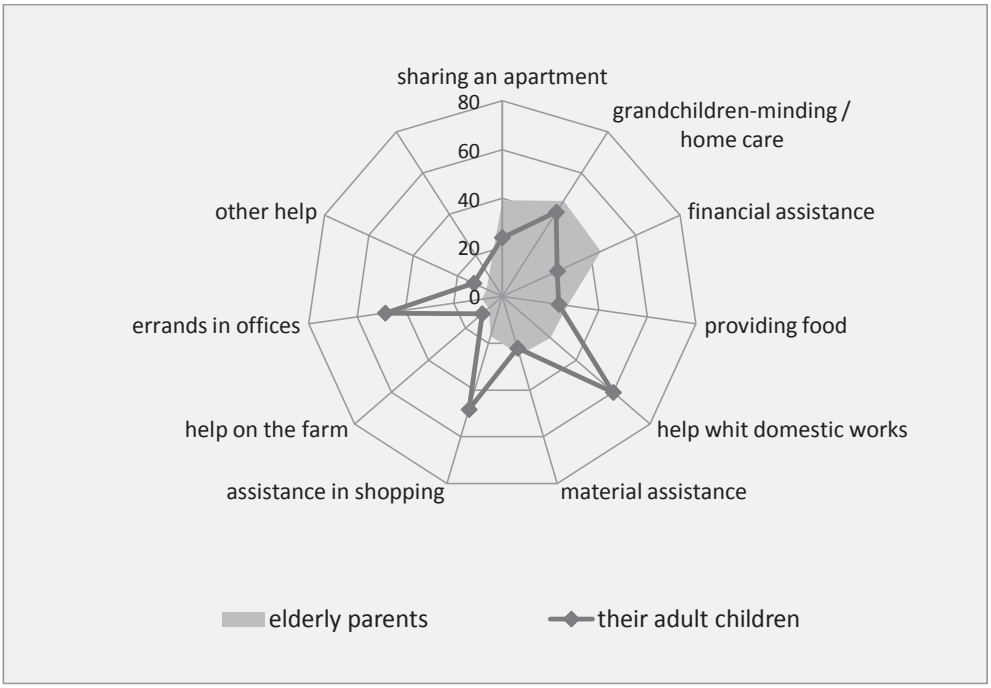
Table 1. Forms and targets of family support (in %)

Forms of assistance	Elderly parents	Help direction	Their adult children
grandchildren-minding / home care	46.4	→	40.9
financial assistance	44.3		24.8
sharing an apartment	39.3		24.0
providing food	26.9		23.4
material assistance	25.0		22.2

Forms of assistance	Elderly parents	Help direction	Their adult children
help whit domestic works	26.0	←	60.1
assistance in shopping	17.0		48.3
errands in offices	8.5		48.4
help on the farm	7.4		10.9
other help	7.1		12.8

Source: work based on Czekanowski 2012, p. 248–256.

Figure 1. Scope and transfer of intergenerational benefits within a family



Source: own work on the basis of data from table 1.

Older parents receive support in the form of help in doing house chores, shopping and visits in offices. However, the percentage of pensioners' households using external help (financial support and services) in the perspective of 4 years has increased by 3 percentage points – from 6.8% in 2009 to 9.8% in 2011. This is a symptomatic change, pointing indirectly to the weakening of the social and economic position of this group in relation to other social and economic groups (*Social Diagnosis* 2013, 2014, p. 68). Those

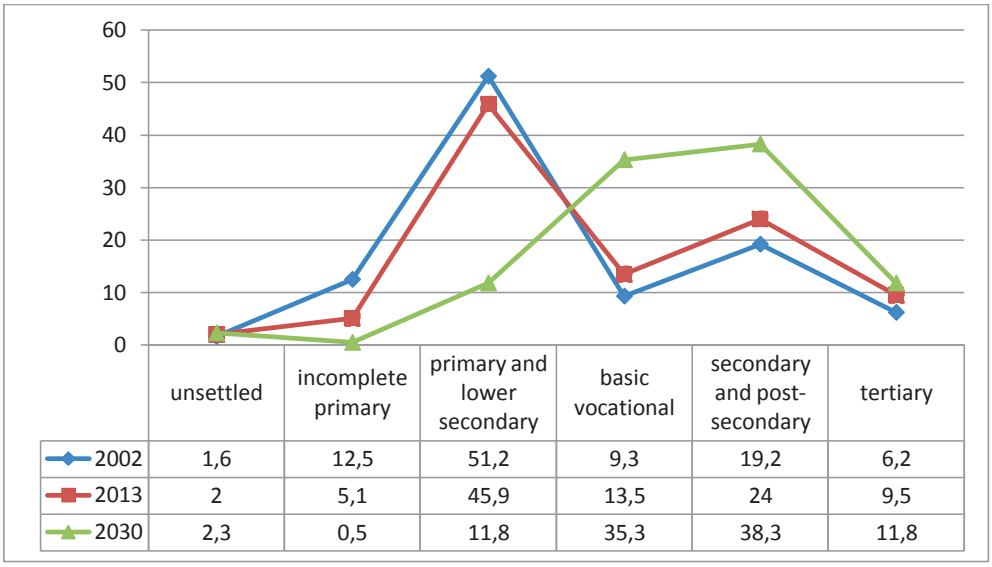
figures will surely be growing together with the progress of demographic ageing and growing consequences of increased migration.

Poland has still a rather low human capital index. Analyses conducted by the authors of *Social Diagnosis* (p. 109) show that it has been growing steadily since 2007. However, for the generation of pensioners, this index is very low and equals 31.20 (ibidem, p. 112). In the comparative studies of 2008, Polish pensioners were in the last, 16th place in the group of the European countries taken into consideration in the comparison (*Poland's Intellectual Capital*, 2008, p. 124 and subsequent). It is determined by such factors as the low level of professional activity, poor access to medical care and the feeling of alienation among older people.

Education is an important constituent of human capital. In 2013, in the group aged 65+, 9.5% had tertiary education, 24% had secondary and post-secondary education, 13.5% had basic vocational education, 45.9% had primary and lower secondary education and further 5.1% had incomplete primary education. The level of education was not established for 2.1% (*Demographic Situation of Older People* 2014, p. 9). In the decades to come, the number of seniors with higher education will be larger. In 2030, for people aged 68-72, the respective figures will be as follows (from tertiary to incomplete primary education): 11.8%, 38.3%, 35.3%, 11.8% and 0.5% (see Szukalski 2008, p. 47).

The growing level of education will have consequences in the form of new higher-order needs of older people in terms of quality. *Silver economy* services will thrive, *leisure industry* will be more and more important and the education market will be wide open to

Figure 2. Change in the level of education among persons aged 65 or more – forecasts



	unsettled	incomplete primary	primary and lower secondary	basic vocational	secondary and post-secondary	tertiary
2002	1,6	12,5	51,2	9,3	19,2	6,2
2013	2	5,1	45,9	13,5	24	9,5
2030	2,3	0,5	11,8	35,3	38,3	11,8

Source: own work on the basis of: National Census 2002; Szukalski 2008, p. 47; Demographic Situation of Older People 2014, p. 9.

education of people in non-mobile professional age and pensioners and, in particular, to education in and for the old age (for example, University of the Third Age – U3A, as well as health care and social welfare staff, social services, NGOs' leaders etc.).

Data of the Central Statistical Office show that in 2013, the number of pensioners and retirees in Poland amounted to almost 9 million, constituting over 23% of the general population. Almost 70% of that group were retirees (6.3 million). The largest age group among retirees were persons above 75 years of age (30%) (*Retirement and Disability Pensions in 2013*, p. 17, 20) The above figures should be referred to the *double ageing* process. The increased number of the "oldest of the old" is the cause of increased pressure on public spending related to retirement pensions and benefits, as well as treatment and care. So, do the retirees in Poland lead a high quality life? In the *Global AgeWatch Index 2014,* Poland was ranked 32nd among from 96 countries of the world. So, Poland's place is in 1/3 of the ranking. This is caused by the quality of factors presented in table 2.

Table 2. Quality of life of retirees in selected European countries (indices according to HelpAge 2014)

Descriptor		Country			
		NORWEY	POLAND	RUSSIA	UKRAINE
Rank AgeWatch 2014		1	32	65	82
Rank HDI 2014		1	35	57	83
People over 60 years in 2014		1,023 mln (21%)	8,3 mln (21,8%)	25,4 mln (19,4%)	9,8 mln (21,7%)
People over 60 years in 2050		29,5%	39,3%	28,8%	31,5%
The basic monthly pension in USD		~ 1012	~ 570	~ 302	~ 150
Income security	Max 100 p.	89,1	77,8	72,9	70,2
Health status		73,5	55,3	27,1	27,3
Capability		76,2	27,3	45,1	15,2
Enabling societies and environment		80,1	69,2	55,5	54,8
Retriment age		67	60-67 W 65-67 M	55 W 60 M	59 W 63 M

Source: data HelpAge International 2014

The weakest points of the national senior support system are still the insufficient number of geriatricians and badly functioning health care system. The Euro Health Consumer Index of 2014 (EHCI 2015) shows that the situation of the health care system is really bad. Polish health care system scored only 511 points out of 1000.

Other shortcomings include low level of human capital of seniors and poor representation of older people on the labour market.

Our daily old age, i.e. the role of social policy in the shaping of senior-friendly environment

In the face of ageing of humanity, actions aimed at setting priorities and policy trends with regard to old age and seniors are important. According to Adam A. Zych: *The first concept of integrated and long-term "old age policy" appeared in France in the beginning of 1960s. when the Commission for the Study of Old Age Problems prepared a report entitled: „Politique de la vieillesse" (1962), acknowledging the decisive role of the state as the creator of the old age policy* (Zych 2010, p. 124–125).

Social and demographic trends set new trends in the broad concept of senior social policy. This is a new dimension of social life in Poland.

The primary goals of current national senior policy are aimed at providing older people with an opportunity to lead a healthy, independent, active, safe and satisfying life and enable them to participate in public life fully and independently.

This policy is based on three pillars: governmental initiatives, activities of self-governments and non-governmental organisations.

The analysis of initiatives and programmes taken up under the national senior policy and implemented in the years 2007–15 requires a reference to the establishment of the Department of Senior Policy at the Ministry of Labour and Social Policy in 2012. In 2013, the social Senior Policy Council was appointed. The Parliamentary Team for U3A and the Parliamentary Commission for Senior Policy were established. The goals of the Governmental Programme for Social Activity of Older People (ASOS) for the years 2014-2020 were set (*Resolution No. 237 of the Council of Ministers,* 2014). ASOS has been financially supporting projects aimed at building solidarity between generations and promoting activity among older people. Also in 2013, the goals of the Long-term Senior Policy in Poland for the years 2014–2020 were adopted (*Resolution No. 238 of the Council of Ministers,* 2013). Its goals are expressed in postulates concerning the promotion of health and disease prevention, development of care-giving services, support for non-formal care-givers, development of alternative forms of care for seniors. The postulates also concern investments in equipment and devices used to satisfy the needs of older people as this is what is needed most. The goals also relate to the support of people aged 50+ on the labour market. They are expressed in the efforts to support and ensure healthy and active ageing, as well as to ensure independent, satisfying life, even despite some functional limitations.

While considering Polish social policy, the implemented retirement pension reforms, which introduced bridging retirement and which limited early retirement opportunities, must be taken into consideration. Despite high resistance on the part of the

parliamentary opposition and labour unions, gradual increase of the retirement age to 67 for both men and women was introduced.

Other programmes that make up the social policy reforms in the area of labour market open to people in non-mobile professional age were expressed in the establishment of the National Training Fund. Its goal is to provide funds for various forms of education and training of employees aged 45 and more. What is also worth mentioning is the programme entitled "Solidarity between Generations", i.e. a set of governmental activities aimed at increasing employment rate among people aged 50+. The government also offers support for employers employing older people by allowing various tax credits and exemptions from payment of contributions for the Social Security Fund. Those specific programmes should be treated skeptically as it does not seem that they can contribute to economic activation of seniors in any way.

Of utmost importance, yet very neglected, are actions taken up in the area of health protection. Optimization of the *status quo* consists in modernization and upgrade of infrastructure of the health care system, increasing financial expenditures on oncology, as well as facilitating access to medical geriatric specialisation. Apart from hospital care (the so called geriatric wards), in 2013, there were 379 chronic medical care homes in 2013 for 22,000 patients, 152 nursing homes for 6,400 patients and 73 hospices for 1,307 patients (*Cocncise Statistical Yearbook of Poland 2015*, p. 223). The scale of social needs is much larger. In 2015, the National Geriatrics Institute was established. It was meant to be a special centre for treatment and care for older people, as well a place of education in geriatric specialisation.

The policy pursued by local self-governments (provinces, districts and communes) can be seen, for example, in the work of provincial councils for senior policy appointed at marshals' offices. There are efforts to establish representations of older residents – commune senior councils – in every local environment. Such councils would provide consultations, advice and propose initiatives (more about local senior policy in Poland: Szarota 2014).

The civil movement is seen in the activity of non-governmental organisations. Therefore, it is necessary to point to the Polish phenomenon, a unique example of good-hearted charity, i.e. the ongoing activity of the Great Orchestra of Christmas Charity which – while helping sick children for over 20 years – has also been raising funds for geriatric purposes since 2013, in particular, funds for equipment in hospitals, care-giving facilities and devices for chronically ill persons in late and old age[3] (www.wosp.org.pl). The Fund gathers millions of zloty each year donated by ordinary people. In this way, the society, "replaces" or "helps out" the public policy of the state.

[3] Almost PLN 21 million was used to purchase equipment for 67 facilities. 2270 pieces of various equipment were bought, including 1109 electronically controlled beds, medical equipment, such as cardiac monitors, ultrasound devices and rehabilitation equipment [www.wosp.org.pl].

One of the important elements of the emerging senior policy is the cooperation with non-governmental organizations for the benefit of seniors, e.g. with the largest representation of seniors – The Polish Association of Pensioners and Disabled Persons (www.pzerii.org), whose traditions date back to the years before the outbreak of World War II, i.e. before 1939. This association is a strong social force. For decades, it has been carrying out activities for the benefit of pensioners and disabled persons. Gathering over half a million members, it cooperates with the most important state authorities and organises cultural and artistic activities for its members. It cooperates with local self-governments, supports old and disabled people in solving their everyday problems and gives advice on overcoming difficulties.

In the last decade, in the dynamic surge of intense cultural and educational movement of Polish Universities of the Third Age[4], two non-governmental organisations appeared: Polish Federation of Universities of the Third Age (2007) and Polish Agreement of Universities of the Third Age Foundation (2008). Those organisations organised the meeting of the first Polish U3A Congress in 2012. The result of their efforts is also the previously presented Governmental Programme for Activation of Older People (ASOS) for the years 2012-2013 and 2014-2020 with a separate substantial fund for non-governmental initiatives and pro-senior programmes. The issues and problems of senior policy are considered at September forums of the third age and U3A congresses, during "senioriadas" (senior picnics and meetings) organised each year in various cities. On the International Senior Day, 1 October 2015, the Polish Parliament held the first meeting of the Civil Senior Parliament, i.e. a non-political, ideologically and religiously neutral Polish representation of older people. The Civil Senior Parliament, being a representation of older people, in agreement and through cooperation with state authorities and local self-government on creating and controlling senior policy, will be representing the interest of the oldest citizens.

The activity of many other traditional and new formations, associations and social organisations for activation and social integration of other people is very dynamic (Halicka, Halicki 2002, p. 189–217)[5]. The voice of a Polish senior can become stronger, not

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[4] Polish Universities of the Third Age (U3A) have over 40 years of history. The first one was estabilised in Warsaw in 1975. In 2003, there were around 30 of them and in the academic year 2007/08 – as many as 125. After years of elite, academic work, only 9 centres took the form of open education associations in local environments. In their promotion work, they use resources and elites of local communities. According to the data of the Polish Association of Universities of the Third Age as of October 2015, there were 555 of them in Poland with over 160 thousand participants. This social force cannot be taken lightly.

[5] Among many other entities, there is the Polish Institute of Silver Economy (www.kigs.org.pl), which has been supporting cross-sectoral activities for silver economy. Its partners include governmental and self-governmental administration, entrepreneurs, social research centres and senior organisations. Goals related to social and professional activity of older people are also pursued by the Foundation for Healthy Ageing (www.zdrowestarzenie.org).

only immediately before parliamentary or self-governmental elections. This is a good start to the building of an environment which is friendly to ageing and old people.

In the Act dated 11 September 2015 on older people – i.e., according to the governmental definition, people aged 60 or more – senior policy is defined as the "activities of public administration authorities, as well as other organisations and institutions that fulfill tasks and initiatives that shape the conditions for dignified and healthy ageing" (Dz. U. of 26 October 2015, item 1705, Art. 4.). Poland must conduct a systematic and thorough analysis of the situation of older people – from demographic situation, through social and living conditions, family situation, professional, social, educational, cultural, recreational and sport activity to health condition, situation of disabled persons and their care-givers, availability of social services and prevention of ageism. Time will tell if those plans will be put into practice.

Social assistance for older and old people as an instrument of senior social policy of the state

Social assistance pursuant to the first Polish Act on social assistance of 1923 was the responsibility of the Ministry of Health and Social Welfare (Dz. U. of 1923 No. 92 item 726). Legislative solutions contained in the Act on social assistance of 1990 adapted to the new social and political conditions moved this domain of social and assistance activities to the Ministry of Labour and Social Policy. The Act provides for procedures for practical implementation of the goals of the national social policy. Together with the administrative reform, they were radicalized in 1999 and later put forward in another Act on social assistance of 2004 (Dz. U. of 2013, item 182 as amended) and amended in 2015 (Dz. U. of 2015, item 163). Those documents do not consider old age as the social issue. On the one hand, this is justified as older people is a group of millions of people with various needs and demographic qualities. One cannot treat the natural stage of human life as a dysfunctional or pathological situation. On the other hand, however, references to specific situations and problems of individuals who are victims of diseases or critical events are necessary. Therefore, the proposed solutions will serve a good purpose for this age group.

Among from the existing forms of social assistance, activities taken up in the area of compensatory and preventive actions should be pointed out.

Compensation means monetary and non-monetary benefits, rescue work and intervention in the form of – for example – organisation and provision of care-giving or nursing services at the place of residence of an old person, creation and operation – at the level determined by the standard of the Ministry of Labour and Social Policy – of social assistance institutions and centres, such as day assistance centres and day care homes, family support homes and social welfare homes. This also means extension of hospitals and geriatric centres, care-giving and medical facilities and palliative care centres, as well as the care for a high standard of geriatric services provided by community nurses. Com-

pensation is of conscious and purposeful nature, planned as a result of the conducted social diagnosis. In the area of compensatory function, one of the important gerontological issue is the development of forms and methods, as well as building resources and tools used to provide care for seniors who lost their functional skills, are alone or alienated and cannot cope with difficulties, they and their families are hopeless in the face of a chronic disease, poverty or unfortunate events.

Prevention has the form of activity (such as preventive and educative activity) of the state government and its authorities, self-government units, education facilities and counselling centres, social organisations and health service, community care-givers, senior's assistants etc. The purpose of prevention is to keep the persons under care in their natural environment for as long as possible, to create conditions for independent, acttive life in dignified conditions and at a decent level, as well as to help them in building their own positive image as older and old persons.

The existing activities have been aimed at compensation of needs, equalisation of deficits of the weakest older people through benefits from two poorly cooperating and task-duplicating ministries: health protection and social assistance. The hard and strenuous work initiated in the 1990s, aimed at the development and implementation of specific standards of social services in day care centres seems endless. Moving to a care centre or social welfare centre is the last resort chosen after exhausting every other form of social service. However, it should be noted that older people are provided with decent living conditions in day care centres, family support centres, social welfare centres and similar facilities. The problem is the low availability of nursing and care services, especially in rural areas. There is still a lack of offers for persons in need of assistance in the Polish social policy. There is a shortage of activities targeted to the social environment of such persons, especially their families. Long-term community nursing for dependent people does not work well, the problem is the lack of staff. Moreover, there is no universal care insurance or legal solutions stabilising pension funds. In the nearest future, this will result in a very bad financial and social condition of seniors.

The main goal of social assistance as an institution of the state social policy is to develop and provide benefits aimed at social and professional activation, integration and reintegration of persons and families experiencing difficulties in their lives, individuals and groups at risk of social exclusion. Social assistance understood in the above way uses various forms. The basic forms include (selected according to the needs of older persons):

1) social intervention, mainly in the form of monetary benefits (various types of allowances) and subsidies for meals in small dairy restaurants, payment of remuneration for care-giving, as well as crisis intervention, provision of shelter, food and clothing
2) social work
3) provision of specialist counseling (psychological, family and legal counseling), provision of information on rights and entitlements

4) creation and implementation of protection schemes, scheme effectiveness control
5) (specialist) care-giving services at the place of residence, in suport centres and family support homes
6) sheltered (supported) apartments
7) day assistance centres, including day care homes creating conditions for active recreation, social meetings and social activation
8) social assistance centre services (living, care-giving, support and education assistance services)
9) services of centres providing 24h/day care for disabled persons, chronically ill patients or older people (care-giving services, including organisation of leisure time and living services) under their business activity

The reform of the social assistance provides for an intensive development of prevention and intervention (rescue) forms of services for old and disabled people. Those include both existing and new offers (selection):

1) introduction of preventive services, including social work, education activities (economic training, methods and forms of organisation of leisure time, education in replacing the family in their duty of care for older, sick and disabled persons), counseling, animation (activation) of local community, support for self-help, social project, social contract etc.
2) new quality of intervention services: optimization of the standard of care services at supported apartments, day support centres, family support homes and social assistance homes, introduction of neighbor care services provided at the place of residence (more: *National Report…* 2011), social subsidy for intervention services, care cheques for expenses on care-giving services and compensation of costs of qualified care provided by assistants of dependent persons; leave of relief for family care-givers with guaranteed replacement at home or care centre – used for regeneration of one's strength.

Another effect of the state senior policy is the initiative Program Senior – WIGOR[6] providing for subsidies and launching, by 2020, day care centres in every Polish commune – WIGOR day homes and WIGOR senior clubs, each for ca. 20 older people. The purpose of the new centres is to provide day care and to activate the recipients of services. The services include: a hot meal, recreation, sports and educational activities, access to a library and reading room, audio and video equipment, computers and Internet. Homes are open on working days for at least 8 hours a day. The form of their work is based on the model combining the goals of a senior club, a library and a rehabilitation office (Szarota 2015, p. 232).

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[6] WIGOR (Vigor) – an acronym of the following Polish terms: Wiedza (Knowledge), Integracja (Integration), Godność (Dignity), Opieka (Care), Rehabilitacja (Rehabilitation). (See: *Long-term „Senior – WIGOR" programme for the years 2015–2020*, Draft dated 31 December 2014 r.).

Summary

It is impossible to list and discuss all the projects that make up the recent Polish senior social policy. This trend in the public policy is characterized by strong dynamics and is based on social dialogue with representations of seniors, as well as flexible response to demographic changes under the influence of representatives of older people. The activities are aimed at active ageing, The problem of alone, dependent persons in late old age maintaining single-generation or individual households has been neglected. The weakest link is the geriatric medical care. There are few physicians who specialise in geriatrics, there is a lack of nurses, assistants and care-givers of old people (both formal and, in particular, non-formal, family care-givers).

The neglect caused by the lack of solutions for optimisation of life space can increase isolation or even social exclusion of older people. Therefore, it is worth to promote initiatives that include older people in the social and cultural space. The so called good practice includes various projects and social campaigns, such as "senior-friendly places"[7], including those, whose goal is cultural activation (openness of cultural institutions manifesting e.g. in free participation of seniors in general rehearsals of various performances), as well as intellectual activation, spreading through the activity of universities of the third age or participation in senior clubs.

It should be noted that there is a strong consumer trend in Poland related to the silver economy. It has become obvious that if the humanitarian aspect of the problem of ageing society is not recognised, then the pressure of older consumers and social service recipients will force the development of senior policy. Whether we want it or not – the future belongs to old people.

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[7] Global Age-finedly Cities – a global initiative that has been creating a network of senior-friendly cities since 2011. Its initiatives include timetables printed in large fonts, extended green light cycle on pedestrian crossings, more benches in public places, availability of public toilets. See: Żakowski 2013.

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Ageing policy in Malta

Keywords: ageing policy, Malta, population trends, gerontology

Abstract

Malta is no exception to the unprecedented demographic changes that are being experienced by industrial countries. As a result of declining fertility and mortality levels, Malta registered a decrease in fertility rates and a major improvement of life expectancy at birth. Recent months witnessed a range of silver linings in contemporary Maltese ageing policy. In March 2013 the newly elected Government took note of the diverse issues facing the ageing of Maltese population by positioning the responsibility for ageing policy under a 'Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing' (previously 'Parliamentary Secretariat for Elderly and Community Care'). The fact that the Secretariat also migrated from the 'Ministry of Health, the Elderly, and Community Care' to the 'Ministry for the Family and Social Solidarity' spoke volumes about the novel direction that ageing policy is taking in Malta – namely, a shift from the long-held focus on 'elderly care' to 'active citizenship' issues. This paper presents current developments in Maltese public policy related to ageing. Given the increasing numbers and relative vulnerability of this group, there is hardly any policy 'programme' in greater need of thorough inspection. It includes nine short sections. Following this brief introduction, the subsequent section highlights the demographic context. The third and fourth sections discusses policy concerning productive and active ageing respectively. The fifth section submits a short review of health ageing policies. The next three sections community and long-term services for older persons in Malta, as well as the nation's in-roads in establishing legislation that safeguards older persons from elder abuse. The final section brings the paper to a close by forwarding proposals for the future of ageing policy in Malta. In the foreseeable years, an increasing number of Maltese citizens will live into ad-

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vanced age. However, there is no doubt that with sustainable and long-term policies in place, Maltese society will be more than equipped to being one of the best countries to grow old in.

Introduction

The Maltese archipelago is a European Union Member State. It consists of three islands – Comino, Gozo and Malta – at the heart of the Mediterranean Sea, 93 kilometres south of Sicily and 290 kilometres north of Libya. Comino is uninhabited, and with Gozo having a mere population of 31,143 persons, leaves Malta as the major island of this archipelago state, with as much as 384,912 residents (Census 2011 data) (National Statistics Office, 2012). Malta gained independence from Britain on 21 September 1964 when it also joined the Commonwealth, and became a Republic on 13 December 1974. Its form of government is one of a legislative house, with parliament representatives elected by universal suffrage for a term of five years. Malta joined the EU on 1 May 2004, and adopted the Euro as its official currency on 1 January 2008.

Recent months witnessed a range of silver linings in contemporary Maltese ageing policy (Formosa, 2013; Formosa, 2015; Formosa and Scerri, 2015). In March 2013 the newly elected Government took note of the diverse issues facing the ageing of Maltese population by positioning the responsibility for ageing policy under a 'Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing' (previously 'Parliamentary Secretariat for Elderly and Community Care'). The fact that the Secretariat also migrated from the 'Ministry of Health, the Elderly, and Community Care' to the 'Ministry for the Family and Social Solidarity' spoke volumes about the novel direction that ageing policy is taking in Malta – namely, a shift from the long-held focus on 'elderly care' to 'active citizenship' issues.

This paper presents current developments in Maltese public policy related to ageing. Given the increasing numbers and relative vulnerability of this group, there is hardly any policy 'programme' in greater need of thorough inspection. It includes nine short sections. Following this brief introduction, the subsequent section highlights the demographic context. The third and fourth sections discusses policy concerning productive and active ageing respectively. The fifth section submits a short review of health ageing policies. The next three sections community and long-term services for older persons in Malta, as well as the nation's in-roads in establishing legislation that safeguards and protects older persons from elder abuse. The final section brings the paper to a close by forwarding proposals for the future of ageing policy in Malta.

Demographic trends

The second half of the 20th Century witnessed unprecedented demographic changes. Declining fertility rates and mortality levels, and major improvements of life expectan-

cies at birth, had far-reaching effects on global population trends, to the extent that the present epoch has been referred to as the 'age of ageing' (Magnus, 2008). Malta is certainly no exception. The Maltese population has evolved out of a traditional pyramidal shape – characteristic of low income developed countries – to an even-shaped block distribution of equal numbers at each cohort except at the top, where older women outnumber older males. Figures based on the 2011 Census indicate that, at end of 2013, 24.6 per cent of the total population, or 105,068 persons, were aged 60-plus (National Statistics Office, 2014a). Table 3.7 provides a breakdown of the current total population aged 60 years and over for the year 2013. It highlights how the total number of persons aged 65 and over totalled 76,024 or almost 18 per cent of the total population. The largest share of the older population is made up of women, with 55 per cent of the total. The sex ratios for cohorts aged 65-plus and 80-plus in 2013 numbered 79 and 55 respectively. Amongst older cohorts, there is twice the number of women than men.

Table 1. Total population by age (31 December 2013)

Age	Males	Females	Total	Per cent of total pop.	Masculinity ratio*
All ages	212424	212960	425384	100.0	99.7
65+	33632	42392	76024	17.9	79.3
60-64	14405	14639	29044	6.8	98.4
65-69	14289	15206	29495	6.9	94.0
70-74	7301	8580	15881	3.7	85.1
75-79	6171	8015	14186	3.3	77.0
80-84	3498	5874	9372	2.2	59.6
85-89	1759	3217	4976	1.2	54.7
90+	614	1500	2114	0.5	41.0

* Number of males per hundred females.
Source: National Statistics Office, (2014a)

The advantage of women over men in life expectancy tables also means that, similar to international statistics, married men and widowed women are over-represented in later life. This has clear implications for social/health care policy, noting how by age 70 whilst the majority of women are widows, most men are still in married relationships. Such demographic statistics also highlight that older women tend to be in possession of lower levels of social and financial capital when compared to male peers. Indeed, despite the fact that women live longer, older women experience greater degrees of vulnerability.

Many also find themselves constrained in a 'caring' straightjacket, as they tend to marry men older than themselves, who would need various levels of social and health support, whilst also caring for siblings and, at times, even grandchildren.

The population of Malta is expected to reach 429,000 and 350,000 persons by 2025 and 2060 respectively (National Statistics Office, 2011). The annual number of births is projected to fall over this period, while the annual number of deaths will continue rising. From 2015 onwards deaths will outnumber births, and hence population growth due to natural increase will cease. From this point onwards, positive net migration will be the only population growth factor. However, from 2035 this positive net migration will no longer counterbalance the negative natural change, and the population is projected to begin to fall, and become increasingly aged. In fact, by 2035 the population of persons aged 65 years and over is projected to increase to around 111,700 – an increase of 72 per cent when compared to this segment of the population during 2010. By 2060, children and youths under 20 will decrease from 90,705 to around 59,300 – a drop of 35 per cent.

Productive ageing

In the period July-September 2013, the inactivity rate – persons who are classified as neither employed nor unemployed – among Maltese females in the 55-64 age bracket was – at 79.4 per cent – one of the highest in the European Union (EU) (National Statistics Office, 2014b). One finds various efforts by the Government to strengthen the presence of older workers and adults in the labour market. Publicity campaigns to promote active ageing have been carried out in various media such as radio and street billboards. These campaigns have promoted the qualities of older workers among employers, and tried to encourage older workers to improve their employability through lifelong learning (Garzia and Debono, 2009). The 2008 Government Budget included two measures meant to attract older people to the labour market (Debono, 2012). The most significant measure was the change in the legislation so that workers of pensionable age would be able to continue working without losing their pension entitlements, irrespective of the amount they earn. Until 2008, the full pension was safeguarded only if these workers' salaries did not exceed the national minimum wage. Although collective agreements in Malta tend not to focus specifically on older workers, there exist some industrial relations practices, often based on the Maltese employment legal framework, that assist older workers to remain employed. For instance, the last-in first-out practice is advantageous for older workers (ibid.). The 'Temporary Agency Workers Regulations' which came into effect in December 2011, was also launched to help older people join or remain on further in the labour market, albeit on temporary contracts.

Malta has a comprehensive social insurance scheme and retirement pension packages. Until the mid-2000s, pensions were determined by a formula based on the average of the best 3 out of the last 10 years' salaries for employees, and the average of the last

10 years' salary for the self-employed, with a pension equal to two-thirds of this average wage for those having contributed 30 years. Fewer years of contribution resulted in linearly reduced pensions, with the minimum years of contribution to collect a pension set at nine. However, a non-contributory pension scheme is available for those who for various reasons never paid national insurance contributions. In 2005, a Pensions Working Group was appointed to provide recommendations for the Government to reform the Maltese pension system. It is worth quoting from Cordina and Borg to understand the full effects of the various reforms:

[i] A gradual increase in retirement ages for females and males from the current 61 years (in 2011), to 65 years of age by [2027]…[ii] Parallel to the increase in the statutory retirement age, the required contribution period to be entitled to the full two-thirds pension is gradually lengthened, to reach 40 years by 2026 as opposed to the current 30 years. [iii] The guaranteed national minimum pension, now based on the national minimum wage, will be calculated at a rate of 60% of the national median wage... (Cordina and Borg, 2011: 6)

The pension reform also included amendments that paved the way for second and third pillar pension systems. Whilst the second pillar would make private pensions compulsory, obliging employers and workers to contribute to the setting up of a private pension fund, the third pillar would provide the possibility of setting up voluntary pension schemes. However, the Government declined to pass such reforms due to fears of putting additional financial burdens on employers and employees. As Debono (2012 : 3) remarked, the "idea was to postpone the introduction of such measures until the economy is in better shape". Yet, since 2007 "the Maltese economy entered into more difficult phases, first when it was hit by the international recession of 2008/2009, and more recently, when it started facing pessimistic economic forecasts about the EU economy" (ibid.).

Active ageing

In its drive to improve the levels of active ageing, the Parliamentary Secretary for Rights of Persons with Disability and Active Ageing (Malta) established a National Commission for Active Ageing to advise the government on the adoption of national strategy for active ageing. Following approval by Cabinet, the *National Strategic Policy for Active Ageing: Malta 2014–2020* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2013) was officially launched in November 2013. The Strategic Policy is premised upon three themes – active participation in the labour market, social participation, and independent living:

Active participation in the labour market. Bearing in mind the way that late modern societies operate, the strategic policy warrants that economic policies contribute towards promising levels of older workers, whilst enabling persons above statutory retirement age to continue working. These objectives are necessary so that societal economies miti-

gate against falling levels of working age populations and the impact that this has on dependency ratios and skills shortages, facilitating the reduction of potential future poverty amongst older persons through early exits from the labour force, and supporting the potential of older workers to play an important part in delivering future economic growth. In this respect, the Strategic Policy offered the following policy recommendations to augment the levels of older and ageing works in Malta: continuing vocational education and training for older adults; improvements in healthy working conditions, age management techniques, and employment services for older workers; taking a stand against ageism and age discrimination; implementation of tax/benefits system; encouraging mentoring schemes in occupational organisations; and strengthening the reconciliation work and informal care.

Social participation. In addition to labour policies, the notion of 'social participation' is a recurring motif in Strategic Policy. It is well-documented that individual aspirations alone are not enough to sustain participative lifestyles. The determination of older adults for optimal levels of social engagement will always encounter a range of structural barriers, difficulties that may result in unwelcome experiences of material and social exclusion. In this respect, the *Strategic Policy* offered the following policy recommendations to augment the levels of social participation in later life in Malta: ensuring an adequate and sustainable income for all older persons; providing adequate financial and social resources for older persons to live in dignity and participate in society; developing and implementing national programmes to involve older people as volunteers; supporting Local Councils in taking a leading role in the provision and coordination of late-life learning initiatives in their community; also through partnerships with the private and voluntary sector; and initiating a Digital Inclusion Programme that ensures that people in later life have the ability to engage with computers and the internet.

Independent living. As the European Commission (2012) underlines in its *Declaration on active ageing and solidarity between generations*, the Strategic Policy underlines that society should not be content solely with a remarkable increased life expectancy, but must also strive to extend healthy life years. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, whilst aiding them to ensure high physical and mental functioning that fosters independent living. This in turn entails the opportunity to live in age-friendly and accessible housing and local communities that are sensitive to the needs and services sought by older individuals, and that provide accessible transportation to enable participation in activities of independent living. Indeed, active ageing is not in conflict with the reality of increasing medical burden with advancing life. Rather, it calls for maximising older individuals' autonomy and participation to the highest possible extent, whether they are residing in the community or in care homes. This would ensure that their dignity is preserved and protection from elder abuse.

The implementation of the *Strategic Policy* is not be simply contented with the location of technocratic solutions, but remains unyielding in its quest to contribute towards a fairer society, one that is based on the principles of social justice. Indeed, the Strategic Policy is underpinned on three key values. First, that Malta is truly transformed into a 'society for all ages', one that adjusts its structures and functioning, as well as its policies and plans, to the needs and capabilities of all. The value of 'intergenerational equity' constitutes a second unfailing dimension. Ageing policy in a democratic society champions equal respect, equivalent opportunities, and comparable living standards between different generations. A final emphasis present in the Strategic Policy is empowerment, as it demonstrates a commitment to renew public policies on ageing so as to revolve around the needs and wishes of the older population.

Healthy ageing

As far as geriatric services are concerned, Malta has come a long way in the past quarter of a century. As it was recently reported,

> Geriatric medicine has been established in Malta since the year 1989 when the first consultant geriatrician post was advertised and filled in the state-run health services... the post of lecturer in Geriatrics at the University of Malta was created and the subject taught to medical students. A Department of Geriatrics was only officially inaugurated in the year 2007... An official postgraduate training programme in most specialities including Geriatrics was set up in Malta in… 2008. (Ekdahl et al., 2012)

The past 25 years also witnessed the opening of an assessment and rehabilitation hospital specifically for older persons with an emphasis on enabling them to return back into the community, and the introduction of modules on geriatric medicine for medical students. The University of Malta also established an Institute of Gerontology (now Gerontology Unit, Faculty for Social Wellbeing) to run a Postgraduate Diploma, Master Degree and Doctorate in Gerontology and Geriatrics. The Gerontology Unit "facilitates greater flexibility and collaboration between disciplines and faculties… full-time faculty members represent a balanced distribution of social science and health science professionals" (van Rijsselt, et al., 2007: 96). A key objective of the Unit is to produce qualified and trained personnel engaged in the provision and planning of services to older persons in the statutory, voluntary and private sectors. During the years 1990–2014, the Unit attracted 251 students from 50 different countries to read for the Diploma and Master Degree. Presently, geriatric medicine is recognised as a separate specialty, with the government of Malta employing 11 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics – for example, on memory, falls, and continence. This means that there is a consultant geriatrician for every 9,275 persons aged 60-plus (2012 figures) –

compared to Germany: 7,496, Spain: 7,701, United Kingdom: 8,871, and Switzerland: 9,250 (Ekdahl et al., 2012). Consultant geriatricians also teach university students following medical programmes, whilst also conducting clinical research.

Community services

Confirming its belief that the institutionalisation of older persons in residential and nursing homes should only be a last resort, nowadays the government coordinates a number of community services to aid older persons live independently for as long as possible. Table 11.1 presents data on the services' recipients in the years 2003-2013 plus percentage change.

Table 2. Community care services: 2003–2013

Service	2007	2010	2013	% change
Kartanzjan	87351	99401	109581	+ 25
Telecare (number of installations)	9414	9168	8877	– 6
Handyman (jobs completed)	1617	1676	1251	– 33
Meals on wheels (meals)	62400	86000	90000	+ 44
Home help service (beneficiaries)	3533	3635	3742	+ 6
Incontinence Scheme	3127	3468	4073	+ 115
Day Centres (regular members)	1507	1314	1505	– 0.1
Night shelter (users)	-	8	20	+ 40

Source: Department for the Elderly and Community Care, (unpublished document)

Kartanzjan. Kartanzjan is a card which is issued automatically by the Electoral Office to every person, upon his or her 60th birthday, if that person is a holder of a Maltese Identity Card in terms of the Identity Card Act (Cap. 258), to entitle their holders to rebates and concessions. These include discounts on public transport, as well as free passenger fares on the Gozo ferries.

Incontinence service. The aim of this service is to alleviate the psychological problem(s) to which a person may, as a result of incontinence, be subjected. Through the supply of heavily subsidised diapers, this service helps to decrease the physical and financial strain exerted on those families who have members with incontinence problems.

Handyman. The objective of this service is to help older adults and persons with special needs to continue living as independently as possible in their own home. The Handyman Service offers a range of around seventy repair jobs that vary from electricity repairs to plumbing, carpentry and transport of items.

Night-shelter. There are currently three night shelters in Malta. This service, which targets older persons who live alone, offers a secure and protective environment for older persons who live alone and whom, at night, for various reasons, they feel unsecure. Preference is given to older females aged 60 and over who are presently living alone, those who lead an independent life, but do not have other medical condition which may, in some way or another, give rise to any problems with the rest of the residents using the Night Shelter.

Day Centres. The purpose of day centres is to help prevent social isolation and the feeling of loneliness, and to reduce the social interaction difficulties which older persons tend to encounter. According to the government website, the main activities organised in each day centre include the service of physiotherapy sessions, occupational therapy, podology, as well as creative, social, physical, educational, and dancing activities.

Telecare Plus. This service enables the subscriber to call for assistance when required. It aims to provide peace of mind to older adults, disabled persons and those with special needs, thus encouraging them to continue living in their own home. Telecare is also a source of reassurance for the subscriber's carers and relatives.

Home care help. The home care help service offers non nursing, personal help and light domestic work to older adults or persons with special needs. The aim of such service is to allow its recipients to continue living in their community as independently as possible. It also aims to provide respite and support for informal carers.

Meals on wheels. The scope of this service is to support older persons and others who are still living in their own home but who are unable to prepare a decent meal. Each meal consists of two courses, a sandwich and a dessert. It is served in a foil receptacle, which facilitates the warming up of the meal, and is delivered in a polystyrene container.

Long-term care

In 2010, Maltese spending on long-term care (LTC) as a percentage of GDP stood at 0.7, well below the EU-27 average of 1.8 (European Commission, 2014). In comparison to other EU countries, Malta is classified as a low-spender on LTC and a medium-spender on health care. Over the long term, LTC spending is forecasted to reach 1.7 per cent of the Gross Domestic Product by 2060, remaining below the EU-27 average of 3.6 per cent. Nonetheless, the issue of public spending on LTC will become a significant part of the debate on the long-term sustainability of public finances for Malta. Inspections of government homes and LTC facilities for older persons are coordinated by the Health Care Standards Directorate.

In Malta, one finds four categories of care homes for older persons: government homes, homes participating in public-private partnerships, Church-run homes, and private homes. In 2013, government residential homes numbered eight (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2014c). They provided

residential care that consisted of a physically and emotionally safe and secure environment for persons who can no longer cope with living in their own homes. Most bedrooms were equipped with an en-suite bathroom and kitchenette, and Nurse Call facilities. Facilities included air-conditioning, central heating, and telephones in each room; and communal televisions, living and dining rooms, and chapel. Some government homes also participate in diverse public-private partnership arrangements (see pages 146). The number of older residents (60-plus) in the years 2000 – 2013 was as follows: 388 (2000), 323 (2001), 489 (2002) 603 (2003), 624 (2004), 619 (2005), 602 (2006), 611 (2007), 738 (2008), and 731 (2009), 747 (2010), 767 (2011), 835 (2012), and 942 (2013). The Żammit Clapp and Mtarfa homes have a separate licence in terms of the Mental Health Act to operate a nursing wing.

As regards financial settlements, a regulation (Legal Notice 259/2004) came into force with effect from 3rd January 2004. With effect from that date, any resident who became a resident of state-owned and -run community residential homes on or after the coming into force of these regulations, contributed 60 per cent of any pension, social assistance and bonus receivable, net of income tax, and 60 per cent of any other income received during the calendar years immediately preceding the year in which the assessment of such other income is made for the purposes of these regulations, net of income tax. Account is also taken of the value of any property (excluding the house of residence) which is, or could be, put to profitable use. Yet, the legal notice states that their contribution will not exceed €31.45 per day, or be such to leave them with less than €1,397.62 per annum at their disposal. The legal notice also states that if the resident is transferred to a home's nursing wing his/her contribution increases to 80 per cent of his/her income but with same proviso.

A second category consists of homes incorporated in public-private partnerships [PPPs] between the government on one hand, and the private sector or Archdiocese in Malta on the other. Presently, one finds a total of four government homes who are in some form of PPP agreement with the private sector. These homes have a number of services contracted to CareMalta, a private company, although the government remains responsible for the admission and provision of healthcare services to residents. With regards to Żejtun, Cospicua and Żammit Clapp the management and all the provision of care and hotel services are run by CareMalta. The government remains responsible for the admission of residents to these homes whilst also playing the role of regulator. The government provides additional healthcare services such as the provision of visiting physiotherapists, occupational therapists, and podologists in these care homes. With regards to Mellieha home the management is split into two sections, the hotel services are provided and managed through a PPP agreement with CareMalta whilst the nursing and caring services are managed and provided by the government. Another form of agreement concerns that entered with a number of care homes that stipulate that the government will place a number of older persons in these homes whereby the state either

pays up the total required payment or tops up the fee paid by the resident to reach the daily rate charged by the residence. Over the past years an increasing number of long-term care beds have been purchased as a partnership with private care homes. Table 12.3 provides a list of homes in PPPs and the number of purchased beds, by age and gender, by the government as per year 2013.

A third category of homes are care homes that fall under the auspices of the Church. In 2014, the number of Church homes amounted to 16, nine of which run by religious orders, and five being run directly by the Archdiocese of Malta (Department of Health Standards, unpublished report). Church homes operate at a loss, since fees are related to the financial means of the resident. Between 2007 and 2012 the Curia paid €1.2 million to cover losses incurred by five of the homes that were opened to the public (Ameen, 2012). For instance, in 2011 expenditure of the homes in Senglea, Santa Venera, Rabat, Naxxar and Birkirkara amounted to €4.5 million, with the Curia spending out €150,000 to make up the shortfall. As regards private residential care, in December 2013 there were 13 licensed private homes for older persons in Malta (ibid.). Whilst some homes have been purposely built to meet the needs of older residents, others consist of refurbished hotels and apartments. One home, Villa Messina, has a separate licence in terms of the Mental Health Act to operate a Mental Nursing Home. Opening a residence for older persons requires the permission of the Department of Health Standards which works in liaison with the Department for the Elderly and Community Services. Frequent checks are made to ensure that these homes maintain a high standard of care. The daily charge varies and is dependent on a number of factors – namely, the level of care needed, the level of dependency of the resident, the location of the room, and whether it is single or double occupancy. Daily fees vary from €35 to €55 daily, which includes accommodation and food, but with residents paying extra for all other services. All offer respite services, convalescence periods, and short holidays. Entertainment activities inside the homes and social outings are organised regularly.

Elder abuse

In recent months, Malta witnessed a number of developments as far as legislation on elder abuse is concerned. In its drive to enact legislation that protects older persons from elder abuse, the Parliamentary Secretariat for the Rights of Persons with Disability and Active Ageing introduced new forms of deterrent measures that will be incorporated in the Maltese Criminal Code, specifically dealing with abuse, which so far had been defined in a very broad manner, in order to encapsulate all forms of abuse but with special focus on maltreatment of older persons. This new legislation included innovative concepts to ensure maximum protection for older persons, even from relatives, so as to safeguard their best interests. From a purely academic perspective, the Parliamentary Secretariat combined civil and criminal concepts to achieve higher levels of protection

in more expeditious and effective terms, without the need to resort to either criminal or civil proceedings, which are generally very time-consuming, expensive and disheartening. The government's vision is encouraging. To cite the Parliamentary Secretary for Active Ageing, …government's efforts to deter elder abuse is only the beginning...we are in the process of drafting the second batch of amendments…[which] will make a substantial difference by enhancing professional and public awareness of elder abuse and establishing a range of legal remedies that protect older people (Caruana, 2014: 20)

Another noteworthy legislation in the pipeline concerns the possibility whereby persons convicted of crimes where older persons are victims will be automatically liable for damages upon sentencing. Hence, eliminating the need for the older person to pursue the perpetrator for damages through a civil case (Caruana, 2014).

Legislation is also urgently required to develop, strengthen, and carry out programmes for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. It is best if such legislation is preceded by the provision of public educational campaigns to identify and prevent elder abuse, neglect, and exploitation – followed by the promotion of information and data systems, including elder abuse reporting systems, to quantify the extent of elder abuse, neglect, and exploitation in the State. Another step in the right direction constitutes policy measures that encourage training for caregivers, professionals, and paraprofessionals, working in relevant fields on the identification, prevention, and treatment of elder abuse. It is imperative that the state – perhaps in collaboration with NGOs – conduct special and on-going training, for individuals involved in serving victims of elder abuse, neglect, and exploitation, on the topics of self-determination, individual rights, and other related topics. It is also important that legislation provides technical assistance to programmes that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation and for family members of the victims. The law should include provisions for immunity for persons reporting instances of elder abuse, neglect, and exploitation, from prosecution arising out of such reporting, under any State or local law. It is also imperative that following the receipt of a report of known or suspected instances of elder abuse, neglect, or exploitation, relevant authorities shall promptly initiate an investigation to substantiate the accuracy of the report. On finding evidence of elder abuse, neglect, or exploitation, steps should be taken immediately.

Conclusion

There is no doubt that there are policy issues that address requisites that if not immediate, will necessarily be so in the foreseeable future. This paper closes by brief dialogue pointers towards policy issues in anticipation of need, rather than in the face of it.

Ageing welfare through ethnic lenses. The framework presented in this book is premised upon a general model for ageing policy, on the basis that there are presently no lo-

cal studies researching the interface between ethnic groups and ageing welfare. Indeed, nothing is known about how ethnic groups might differ in patterns of productive/active/successful ageing when compared to the average Maltese citizen.

Ageing policy for older lesbians and gay men. A notable feature concerns the lack of research that exists for how non-heterosexual Maltese persons experience and negotiate ageing. As elsewhere, current discourse on older people's needs and citizenship in Malta is framed by a heteronormative perspective, which marginalises lesbians and gay men. The 'invisibility' of older lesbians and gay men at all levels of relevant policy means that they face particular risks of exclusion.

Revisiting the ecological model of ageing. Due to its long-standing obsession with 'elderly care', Malta's welfare model has neglected the need to optimise the interaction between ageing persons and their environment. This area of interest is concerned with varieties of housing arrangements for older persons; the nature of home modifications; the range of facilities for institutional care; the role of neighbourhoods and community settings; and rural and urban socio-physical contexts.

Ageing, dying and death: Palliative and end-of-life care. Increasing longevity is leading to an increased burden from chronic disease, which in turn results in considerable morbidity and increased dependence. Whilst general palliative care refers to the care offered by any health care professional to patients not responding to curative treatment, end-of-life care refers to the care given in the last few days or weeks before death.

Income poor, asset rich: Enabling user co-contributions. Most ageing households and older individuals already save for their retirement, having built such wealth over their working lives to use it to fund their retirement lifestyles (Formosa, 2014d). However, retirees tend not to use the wealth represented in building assets, which represents a significant share of their total wealth, considering that older persons have high home ownership rates.

Professionalising gerontology for capacity building. Government together with gerontology educators are responsible for preparing tomorrow's professionals to serve an increasingly ageing population. There is no doubt that an examination of workforce literature predicts that we will need substantial numbers of trained ageing specialists in the years ahead. However, it is disconcerting that Malta is already experiencing some key shortages in workforce preparedness.

In the foreseeable years, an increasing number of Maltese citizens will live into advanced age. As reported in the second section, in the coming decade about one in five Maltese will be over age 65. This explosive growth of older adults will result in a mix of opportunities and challenges. On one hand, an ageing population presents itself as an opportunity to communities because many older adults are committed, long-time residents, who contribute their time and energy to local issues. Older persons are both a social resources and key contributors to the socio-economic fabric. On the other hand, supporting the needs of older persons represents a tough challenge. Ideally, older adults

should not feel forced to move to a supportive environment, so that the 'ageing-in-place' ideal – referring to individuals growing old in their own homes with the help of environmental modifications to compensate for personal limitations – remains a realistic possibility. There is no doubt that with sustainable and long-term policies in place, Maltese society will be more than equipped to being one of the best countries to grow old in.

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Пенсионеры в России: социальная поддержка, проблемы и ожидания

Ключевые слова: старость, пенсионеры, социальная поддержка, социальная политиа

Pensioners in Russia: social assistance, problems and expectations

Key words: old age, pensioners, social assistance, social policy

Виды пенсий

По определению С.И. Ожегова (2013, с. 976) «пенсионер» – человек, который получает пенсию. Как правило, в словарях добавляется существительное «пенсионерка» или прилагательные «одинокий», «пенсионерский». Хотя в документах и формулярах мы привыкли к словосочетанию «работающая пенсионерка» и «персональный пенсионер». «Словарь русских синонимов» (2010) идентифицирует слово «пенсионер» с «престарелым», «стариком», «старухой», «старцем», «пожилым», «зрелым», «опытным».

Известный российский писатель Борис Полевой даёт в своих «Саянских записях» (1964, с. 132) интересную трактовку: «Сознательные пенсионеры, отслужили свое, получили заслуженный отдых и все-таки помогают, чем могут». Действительно, границы «пенсионного» возраста могут разниться в зависимости от страны, рода профессиональной деятельности и пола. В России пенсионером считается женщина в возрасте 55 лет и мужчина – 60 лет.

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«Пенсия» довольно молодое понятие: ему около ста лет, так как до XX века пенсий как масштабного экономического инструмента не существовало. Пенсия (от лат. *pensio* – платеж) – денежное обеспечение, получаемое гражданами из пенсионных, страховых и иных фондов по окончании работы, при достижении определенного возраста, по инвалидности и в некоторых других случаях (Большой энциклопедический словарь.- М., 2011). При этом пенсия – служит, как правило, постоянным и основным источником средств к существованию. Так, в нашей стране выплата государственной пенсии осуществляется из Пенсионного фонда Российской Федерации согласно Закону (Федеральный закон от 21 июля 2014 года N 216-ФЗ «О государственном пенсионном обеспечении в Российской Федерации»). В 2014 году средняя пенсия в России составляла 11 600 рублей[2].

В начале XXI века пенсия рассматривается как дополнительный инструмент, позволяющий получать денежное обеспечение за многолетний труд и продолжать деятельность на своём рабочем месте или перейти в иную организацию. Связано это с тем, что 55-60-летние граждане часто полные сил, не желают бросать работу и признавать себя стариками.

В Российской Федерации различают следующие *виды пенсий* (Федеральный закон от 21 июля 2014 года N 216-ФЗ, op. cit.):

1. *Трудовая пенсия по старости* - как правило, выплачивается гражданам, имеющим не менее 5 лет трудового стажа, при достижении ими пенсионного возраста (55 лет для женщин, 60 лет для мужчин);
2. *Пенсия за выслугу лет* – выплачивается государственным служащим и военнослужащим при достижении определенного возраста и выслуги. Право на пенсию в размере 50% оклада военнослужащие приобретают после 20 лет выслуги, то есть без льготной выслуги - в 37-38 лет, с льготной выслугой - значительно раньше. Финансовое обеспечение идёт через бюджет Министерства Обороны. Начисление пенсии зависит от периода нахождения на службе (календарные годы), выслуги лет (с учетом повышающих коэффициентов за особые условия службы) и ещё ряда факторов.
3. *Пенсия по инвалидности* - выплачивается в случае признания гражданина инвалидом. Пенсия по инвалидности может быть:
   - трудовой (при наличии трудового стажа);
   - пенсией по государственному пенсионному обеспечению;
   - социальной (при отсутствии трудового стажа, либо в случае, если инвалидность наступила в результате совершения уголовно наказуемого деяния либо умышленного нанесения ущерба своему здоровью).
4. *Пенсия по случаю потери кормильца***.** Право на такую пенсию имеют нетрудоспособные члены семьи умершего кормильца, состоявшие на его иждиве-

[2] Według stanu na luty 2015 roku ok. 163 Euro [przypis Z.S.]

нии, а также неработающие члены семьи умершего кормильца, занятые уходом за его малолетними детьми. Виды пенсии по случаю потери кормильца:

- трудовая пенсия (для членов семьи умершего кормильца, застрахованного в соответствии с обязательным пенсионным страхованием);
- пенсия по государственному пенсионному обеспечению (в случае потери кормильца-военнослужащего, либо кормильца, пострадавшего от техногенных или радиационных катастроф);
- социальная пенсия (для прочих категорий граждан, потерявших кормильца).

5. *Социальная пенсия* – выплачивается нетрудоспособным гражданам, не имеющим права на другой вид пенсии, в том числе:
   - инвалидам, не имеющим трудового стажа (инвалиды детства, дети-инвалиды), а также в случае, если инвалидность наступила в результате совершения уголовно наказуемого деяния либо умышленного нанесения ущерба своему здоровью;
   - членам семей умершего кормильца, не имеющим права на прочие виды пенсий по случаю потери кормильца;
   - гражданам, достигшим пенсионного возраста, не имеющим трудового стажа в 5 лет. Большинство граждан могут получать только один вид пенсии. Ограниченному кругу лиц, нуждающихся в повышенной социальной защите, дается право получать две пенсии (среди них – участники Великой Отечественной Войны; родители и супруги погибших военнослужащих; нетрудоспособные члены семей граждан, участвовавших в ликвидации аварии на ЧАЭС[3]).

Право на трудову пенсию имеют: граждане РФ; российские граждане, работающие за пределами территории РФ, признаются застрахованными, если добровольно уплачивают за себя страховые взносы в бюджет Пенсионного Фонда России в виде фиксированного платежа; иностранные граждане, постоянно проживающие на территории РФ; лица без гражданства.

Среднегодовая численность получателей трудовых пенсий в Российской Федерации представлена в таблице 1 по данным РИА Новости[4].

Таблица 1. Среднегодовая численность получателей трудовых пенсий в Российской Федерации (миллионов человек), прогноз

2014 год	2015 год	2016 год
38,58	39	39,4

[3] Elektrownia atomowa w Czarnobylu, jej groźna w skutkach awaria miała miejsce w 1986 roku. W wyniku katastrofy radioaktywnemu skażeniu uległo niemal 150 tys. km^2 terenów dzisiejszej Ukrainy, Białorusi i Rosji [przyp. Z.S.].

[4] Rosyjski portal informacyjny „Nowosti" [przyp. Z.S].

В Российской Федерации насчитывается около 39 миллионов человек старше трудоспособного возраста, что составляет четвёртую часть населения страны. Граждане пенсионного возраста вносят многогранный вклад в социальное развитие России, приветствуют позитивные изменения в обществе, проявляют интерес к социальной, культурной и экономической жизни, поддерживают солидарность поколений и являются хранителями духовных и нравственных ценностей. Они сохраняют способность к посильной трудовой деятельности, готовность передавать опыт и восполнять ресурсы, затраченные на обеспечение их жизнедеятельности.

Гражданам пенсионного возраста присущи специфические *проблемы*:

– ухудшение состояния здоровья,
– снижение способности к самообслуживанию,
– «предпенсионная безработица» и снижение конкурентоспособности в трудовой сфере,
– неустойчивое материальное положение,
– утрата привычного социального статуса.

В более неблагоприятном положении находятся женщины-пенсионерки, что существенно при сохранении долговременной диспропорции мужского и женского населения. Достаточно велика доля пожилых людей среди мигрантов и лиц без определенного места жительства и занятий. Возрастают социальные и экономические издержки семей, обеспечивающих уход за пожилыми родственниками, снижается надежность семьи как источника поддержки людей пенсионного возраста. В неблагоприятной ситуации нередко находятся одинокие пожилые люди и проживающие отдельно от взрослых детей пожилые супружеские пары.

Вспоминая выдающегося российского педагога А. С. Макаренко (2007, с. 140), хочется процитировать его высказывание: «Человек не может жить на свете, если у него нет впереди ничего радостного». В отношении российских пенсионеров в связи с этим вытекают два вопроса: чем должны заниматься экономически активные зрелые люди, которые формально уже не должны работать, и как сделать так, чтобы немощные и больные старики не были заброшены. Основная причина, по которой пенсионеры идут работать после достижения этого возраста – это нехватка денег. Как выяснили социологи, именно те, кто живёт «с молодыми», чаще всего старается найти хоть какой-то приработок. Кроме того, очень важна для таких людей возможность получить какие-либо льготы за счёт предприятия или фирмы. Моральные стимулы в этом играют очень большую роль. Работающие пенсионеры чувствуют себя востребованными, нужными. Работающие пенсионеры очень выгодны для страны. Мало того, что они не просят у государства, а зарабатывают сами, но ещё и отрабатывают пенсию, делая взносы в Пенсионный фонд. Использование потенциала пенсионеров является определённой базой для

дальнейшего развития, поскольку у общества в результате появляются дополнительные ресурсы, а у пожилых людей возможность к самореализации.

Помощь для пожилых людей в Ярославской области

В Ярославской области в течение ряда лет реализуется межведомственная региональная программа «Социальная поддержка пожилых граждан Ярославской области», позволяющая оптимизировать среду жизнедеятельности пенсионеров.

Ярославская область – развитый российский регион, расположенный в 280 км от города Москвы, на пересечении автомобильных, железнодорожных, водных и воздушных путей, центр российской государственности, православия, науки и культуры. В Ярославской области проживают более 1300 000 человек, в городе Ярославле – 594 000 жителей. К сожалению, для Ярославской области характерна регрессивная возрастная структура населения – число жителей старше трудоспособного возраста (25,2%) превышает численность населения моложе трудоспособного возраста (14,3%), и ежегодно этот разрыв увеличивается. В течение последних пяти лет прослеживается устойчивый рост населения пожилого возраста, и такая тенденция сохраняется.

Мерами социальной поддержки в 2014 году обеспечены около 400 000 жителей региона, получающие 59 видов пособий и компенсаций. За последние годы здесь осуществлен значительный прорыв в части создания комфортных условий для ежедневной работы, учебы и отдыха людей, социальной защиты населения. Меры социальной поддержки закреплены в «Социальном кодексе Ярославской области» (Закон Ярославской области «Социальном кодексе Ярославской области» от 19.12.2008 г. № 65з), который определяет категории граждан, участвующих в социальных правоотношениях, систему мер оказания социальной поддержки, а также устанавливает размеры денежных выплат и компенсаций. Инфраструктура социального обслуживания граждан региона включает 58 учреждений[5], отражена в таблице 2.

В 18 государственных стационарных учреждениях социального обслуживания проживает около 4 000 пенсионеров. В каждом муниципальном районе области и 6 районах г. Ярославля социальные услуги оказывают 25 комплексные центров социального обслуживания населения (КЦСОН). В каждом КЦСОН работают отделения надомного обслуживания, срочной социальной помощи, дневного пребывания пожилых людей и инвалидов, социально-реабилитационные и т. д[6]. Создана консультационно-информационная служба «Единый социальный телефон». Ежегодно более 10 000 пенсионеров получают адресную социальную помощь (таб. 3).

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[5] Просмотр виды услуг и видов социальных услуг в Польше (Шарота, 2013, с. 35–41).

[6] Ibidem

Таблица 2. Типы социальных учреждений Ярославской области

Тип социального учреждения	Количество
Государственные стационарные учреждения социального обслуживания, в том числе: - психоневрологические интернаты, геронтопсихиатрический центр, областной геронтологический центр - специальные дома-интерната, детский дом-интернат для умственно-отсталых детей, пансионат для ветеранов войны - дома-интернаты общего типа	18 6 3 5
Государственные учреждения комплексных центров социального обслуживания населения	25
Государственные учреждения социального обслуживания несовершеннолетних	14
Дом ночного пребывания для лиц без определённого места жительства	1

Таблица 3. Виды адресной социальной помощи пенсионерам в Ярославской области

Виды адресной социальной помощи	Количество граждан
Стационарное обслуживание в государственных стационарных учреждениях и отделениях временного проживания социозащитных учреждений	более 6000
Социальные услуги в комплексных центрах социального обслуживания населения, в том числе:	более 90 000
социально-бытовые и социально-медицинские услуги на дому	около 19 000
срочные социальные услуги (безвозмездная помощь в виде одежды, обуви, предметов первой необходимости, услуги мобильной службы, консультации по «Единому социальному телефону» и т.д.)	более 60 000
пенсионеры посещают группы дневного пребывания КЦСОН	более 13 000
пенсионеры состоят на учёте в органах опеки и попечительства[7]	около 4 000

[7] Пожилые люди - одинокие используют опеку со стороны назначенных работоспособных граждан, которые хотят быть опекунами. Таких пенсионеров ставят на учёт, это управляемый процесс, контролируемый со стороны социальной защиты. Если опека не помогает слабому пенсионеру, то его определяют в дом-интернат для одиноких, инвалидов и нуждающихся в уходе граждан.

Пенсионеры получают социальную поддержку в виде различных выплат, пособий и компенсаций: ежемесячно производятся денежные выплаты 100 195 ветеранам труда, 60 065 ветеранам Ярославской области, 18 190 труженикам тыла, 1 280 реабилитированным гражданам. Ветеранам труда и реабилитированным гражданам за счет средств областного бюджета осуществляются выплаты компенсации расходов на оплату жилого помещения и коммунальных услуг.

В КЦСОНах Ярославской области созданы «Школы здоровья», где могут проходить обучение до 1000 пенсионеров. Ежегодно около 500 жителей области, у которых старшие родственники перенесли тяжелые заболевания (инсульт, например), могут получить все необходимые навыки ухода и проведения реабилитационных мероприятий на дому в «Школах реабилитации и ухода за гражданами пожилого возраста и инвалидами». В учреждениях социального обслуживания установлены терминалы или инфоматы, предоставляющие пенсионерам доступ к порталу государственных услуг. Около 30% граждан пожилого возраста являются участниками образовательных, досуговых, культурно-массовых, физкультурно-спортивных мероприятий.

В Ярославской области действуют семнадцать социальных мобильных служб, задача которых – оказание услуг гражданам, проживающим в отдаленных населенных пунктах со слабо развитой инфраструктурой. Благодаря работе этих служб жители муниципальных районов имеют возможность получать комплекс социальных, медицинских, юридических, психологических, бытовых и других услуг по месту жительства. В 2014 году услуги получили 12 646 жителей отдаленных населенных пунктов. С 2007 года в Ярославской области социальные услуги жителям отдаленных сельских территорий оказывают 17 выездных бригад «Социальной мобильной службы». В состав бригады входят специалисты комплексного центра социального обслуживания населения: социальный работник, фельдшер, психолог, юрист, парикмахер, по необходимости – представители Пенсионного фонда Российской Федерации (ПФР) и Фонд социального страхования Российской Федерации (ФСС), специалисты органов социальной защиты.

Изображение жизни российского пенсионера

Для получения объективной картины о жизни российских пенсионеров следует представить результаты научного исследования, проведённого Всероссийским центром изучения общественного мнения (ВЦИОМ) в 2013 году, где содержаться данные о том, как оценивают свою жизнь россияне пенсионного возраста, что думают о ситуации в стране и как проводят свободное время. Опрошено в каждом случае 1600 человек, в то числе российские пенсионеры в130 населенных пунктах 42 областей, краёв и республик Российской Федерации (Материалы «Агентства социальной информации». http://www.asi.org.ru/). Следует заметить, что результаты опроса перекликаются с мнениями и ярославских пенсионеров.

Социальное самочувствие: сегодня своей жизнью удовлетворено более трети российских пенсионеров (33–36%). Неудовлетворенность высказывают респонденты в этой возрастной группы реже (25–27%), то существенно выше, чем, например, среди молодежи 18–24 лет (13%).

Мнение о том, что дела в стране идут в правильном направлении, свойственно сегодня более, чем трети (35–39%) российских пенсионеров, и прежде всего тем, кто старше 72 лет, то есть рожденным в довоенное время (39%).

Политическую обстановку россияне старше 55 лет в целом, оценивают, как среднюю (60–64%). Негативное восприятие политической ситуации в стране свойственно 56–60-летним россиянам, то есть тем, кто родился в эпоху «оттепели».

Большинство нынешних пенсионеров не ожидают существенных перемен в своей жизни: 57–59% опрошенных в возрасте старше 56 лет полагают, что через год будут жить не лучше и не хуже, чем сейчас. Для сравнения: среди молодежи таких только 40%. Российские пенсионеры, в целом, ощущают себя счастливыми: большинство из них (56–72%) сообщают, что счастливы или скорее счастливы.

Образ жизни. Оценка состояния здоровья в разных возрастных категориях россиян пенсионного возраста различаются. Так, удовлетворительным своё состояние здоровья называют 56–60 летние (51%) и 61–72-летние (47%). Негативную оценку своему самочувствию дают россияне старше 72 лет (64%). Что касается вредных привычек (например, курения), то среди 56–60-летних этой привычке, по собственному признанию, подвержены 31% опрошенных, среди 61–72-летних – 23%, а среди тех, кто старше 72 лет – 14%.

Если судить о досуговых предпочтениях (например, о летнем отдыхе), то большая часть пенсионеров провели его дома (48-70%) и это те, кому сегодня больше 72 лет, то есть довоенное поколение (70%). Второй распространенный способ летнего досуга для нынешних пенсионеров – дача (19-28%), так проводят лето 56–60 летние пенсионеры (28%). Однако, поездки на отдых имеют место: о них сообщают также 56–60-летние (например, 8% из них путешествовали летом на Черноморское побережье).

Среди культурно-досуговых учреждений наиболее востребованы среди пенсионеров театры и выставки: так, в театрах с той или иной периодичностью бывают 35% респондентов от 56 до 72 лет, на выставках – 24–34% опрошенных в этой возрастной категории.

Интернетом пользуются 32% 56–60-летних россиян, 13% 61–72-летних и 6% респондентов старше 72 лет. При этом среди 56–60-летних 7% признают, что проводят в Сети непростительно много времени. Что касается телепросмотров, то наиболее активно телевизор смотрят опрошенные старше 72 лет (95%), причем 21% признают, что слишком много времени проводят у экрана.

По поводу ожиданий в данной теме выступил заместитель Министра труда и социальной защиты Российской Федерации А. Вовченко и сообщил, что насе-

ление Российской Федерации продолжает стареть – каждый восьмой россиянин старше 65 лет (13% от общей численности населения). Пенсионеров в России в течение 2015-2016 гг. станет больше: их число будет увеличиваться ежегодно в среднем на 400 тысяч человек. Несмотря на то, что намечается рост числа пенсионеров, размер пенсий в России не будет снижаться. Так, по мнению Министра труда и социальной защиты Российской Федерации М. Топилина, средний размер трудовой пенсии в России в 2016 году составит более 13,2 тысячи рублей (Материалы «РИА Новости». http://www.ria.ru/)

Ожидаемая продолжительность жизни в Российской Федерации к 2018 году должна составить не менее 74 лет, к 2020 году – 75,7 года, в том числе у мужчин – 71,2 года, у женщин – 80 лет.

Оптимизация социальной политики для пожилых людей

Для оптимизации среды жизнедеятельности российских пенсионеров разрабатывается «Стратегия действий в интересах граждан пожилого возраста», которая началась внедряться с июня 2015 года. Основные аспекты Стратегии – решение проблем занятости, сохранение и укрепление здоровья пожилых, организация досуга, развитие рынка социальных услуг. «У многих пенсионеров есть возможность работать в свободное время, но нужно пользоваться и тем, что остается кроме работы. Это и творческие увлечения, общение, занятия спортом. В ряде крупных городов уже создается для этого необходимая инфраструктура, причем не только в системе социального обслуживания, но и в сферах культуры, образования, спорта и туризма. К этой работе привлекаются структуры гражданского общества, региональные отделения ведущих политических партий. Этот опыт нужно, безусловно, использовать при подготовке Стратегии» – подчеркнул Президент России В. Путин (Материалы «Агентства социальной информации»). Что касается развития рынка социальных услуг, повышения их качества и доступности, Президент обратил внимание на важность нового закона «Об основах социальн5ого обслуживания граждан в России», который вступил в силу с 1 января 2015 года и предполагает существенные организационные изменения, в том числе участие негосударственного сектора в оказании социальных услуг (Федеральный закон от 28 декабря 2013 г. № 442-ФЗ «Об основах социального обслуживания граждан в Российской Федерации»).

В России в интересах пенсионеров работают тысячи общественных организаций, например, Общероссийская общественная организация “Союз пенсионеров России” является основанным на членстве добровольным, самоуправляемым, общественным объединением, созданным по инициативе граждан, объединившихся на основе общности интересов для содействия защите законных прав и жизненных интересов пенсионеров. Пенсионеры принимают участие в работе таких

общественных организаций как Всероссийская общественная организация ветеранов (пенсионеров) войны, труда, Вооружённых Сил и правоохранительных органов, Всероссийское общество инвалидов, Советы ветеранов, Общественная организация «Дети войны», Некоммерческие благотворительные фонды, Геронтологические общественные организации, Клубы по интересам, Информационно-образовательный центр «Золотой возраст» при Обществе «Знание» и других.

«Университет третьего возраста» является инновационной формой социального обслуживания населения, социальной реабилитации пенсионеров, инвалидов, ветеранов Великой Отечественной войны, совместной работой государственных учреждений, общественных организаций, коммерческих и некоммерческих организаций. «Университеты» имеют различные факультеты: информационных технологий; творческого развития личности, здорового образа жизни, культурно-досуговой деятельности, психологической поддержки личности, юридической безопасности для пенсионеров. Основной целью деятельности «Университета» является повышение качества жизни граждан старшего поколения. Основными задачами «Университета» являются: создание новых межличностных контактов для одиноких пенсионеров и пожилых людей с достаточно высокой жизненной активностью; обучение пенсионеров навыкам социальной и правовой адаптации и защиты, оказанию помощи себе и окружающим в экстремальных ситуациях в быту и вне дома и т.д.

Так как общественные организации граждан являются более гибкими и мобильными, с высокой инициативой и восприимчивостью к новым изменяющимся условиям. Находясь в одинаковых условиях с нуждающимися и социально незащищенными пенсионерами, представители общественных организаций более глубоко и предметно знают их потребности, нужды; имеют больше возможностей для поддержания постоянных контактов с каждым пожилым человеком, помогая ему словом и делом. Именно эти организации способны реализовывать в своей деятельности общинный характер социальных услуг, реализовывать соседские взаимоотношения между пенсионерами. Отражая потенциал и тенденции развития гражданского общества, общественные организации могут внести серьезный вклад в работу с каждым пожилым человеком, становясь проводником и одним из механизмов поддержки пенсионеров Российской Федерации.

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Emeryci w Rosji: pomoc społeczna, problemy i oczekiwania[1]

Słowa kluczowe: starość, emeryci, pomoc społeczna, polityka społeczna[8]

Rodzaje finansowych świadczeń emerytalnych

W opracowaniu zostały zdefiniowane specyficzne rodzaje świadczeń emerytalnych dostępnych Rosjanom. W Federacji Rosyjskiej status emeryta przysługuje kobietom po ukończeniu przez nie 55 lat, mężczyznom po 60. roku życia. Mogą oni doświadczać specyficznych problemów: pogorszenie stanu zdrowia, obniżenie zdolności do samoobsługi, ryzyko przedemerytalnego bezrobocia oraz spadek konkurencyjności na rynku pracy, niestabilna sytuacja materialna, utrata dotychczasowego statusu społecznego. W najmniej sprzyjającej sytuacji znajdują się kobiety-emerytki, starsi wiekiem migranci oraz osoby bezdomne i bezrobotne. Rosną koszty społeczne i ekonomiczne wydatki rodzin, obniżeniu ulegają zasoby opiekuńcze rodziny, jako źródła wsparcia społecznego. W niesprzyjającej sytuacji znajdują się samotni seniorzy i niemłode pary małżeńskie prowadzące jednopokoleniowe gospodarstwa domowe. W odniesieniu do rosyjskich emerytów i rencistów rodzą się dwa pytania: czym mają zajmować się ekonomicznie aktywni dorośli ludzie, którzy formalnie już nie powinni pracować i jak przeciwdziałać temu, by osoby słabe i chore nie zostały wykluczone?

Podstawową przyczyną kontynuacji pracy zarobkowej przez emerytów jest brak pieniędzy. Pracujący emeryci czują się wciąż potrzebni, Ich aktywność jest bardzo korzystna dla kraju. Potencjał emerytów jest bazą dla dalszego rozwoju społecznego, pod warunkiem, że mają oni możliwość samorealizacji.

Tab. 1. Średnioroczna liczba odbiorców emerytur w Rosji (w mln osób), prognoza

2014 rok	2015 rok	2016 rok
38,58	39	39,4

W obwodzie jarosławskim (ok. 280 km od Moskwy) od szeregu lat realizowany jest międzyresortowy program regionalny „Pomoc społeczna dla starszych obywateli", pozwalający optymalizować środowisko życia emerytów. Region ten charakteryzuje regresywna struktura wiekowa ludności – liczba osób w wieku poprodukcyjnym (25,2%) przekracza liczbę ludności w wieku przedprodukcyjnym (14,3%), różnica powiększa się z roku na rok.

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[8] Tłumaczenie i streszczenie: Zofia Szarota

Świadczenia pomocowe dla osób w podeszłym wieku w regionie jarosławskim

Autorka charakteryzuje świadczenia i usługi socjalne kierowane ku jarosławskim seniorom przez 58 różnych instytucji i placówek, w tym państwowe domy pomocy społecznej dla osób starszych z zaburzeniami psychoneurologicznymi, centrum gerontopsychiatryczne, regionalne centrum gerontologiczne, pensjonaty (domy opieki) dla weteranów wojennych, państwowe centra kompleksowych usług społecznych, domy dziennego pobytu. Z usług 18 placówek pobytu stałego korzysta ok. 4 tys. emerytów. Beneficjentami różnych form pomocy społecznej corocznie jest ok. 10 tys. starszych wiekiem mieszkańców regionu. Ponadto emeryci i renciści otrzymują wsparcie społeczne w postaci zasiłków, dofinansowań, odszkodowań itp. świadczeń.

Tab. 2. Instytucje pomocy społecznej w regionie jarosławskim

Rodzaj instytucji pomocowej	Liczba
Państwowe stacjonarne placówki pomocy społecznej, w tym: - domy opieki dla osób z zaburzeniami psychoneurologicznymi, regionalne centrum gerontologiczne, centrum gerontopsychiatryczne - specjalne domy opieki, dom dziecka dla dzieci z upośledzeniem umysłowym, domy opieki dla weteranów wojennych - domy opieki różnego typu	18 6 3 5
Państwowe kompleksowe centra usług społecznych	25
Państwowe ośrodki opiekuńcze dla nieletnich	14
Noclegownia dla bezdomnych	1

W Centrach pomocy społecznej obwodu Jarosław funkcjonują "Szkoły Zdrowia", z których korzysta około 1000 emerytów. Corocznie, w "Szkołach rehabilitacji i opieki dla osób starszych i niepełnosprawnych" około 500 mieszkańców okolicy, których starsi wiekiem krewni doznali skutków ciężkiej choroby, może posiąść niezbędne umiejętności służące pielęgnacji i rehabilitacji prowadzonej w domu. Około 30% osób w podeszłym wieku uczestniczy w projektach edukacyjnych, rekreacyjnych, kulturalnych, imprezach sportowych.

W obwodzie funkcjonuje 17 mobilnych zespołów usług socjalnych, których głównym zadaniem jest świadczenie usług dla obywateli zamieszkających obszary ze słabą infrastrukturą (pomoc społeczna, zdrowotna, prawna, psychologiczna, usługi bytowe w miejscu zamieszkania). W 2014 roku ze świadczeń skorzystało 12,6 tys. mieszkańców odległych osiedli. Od 2007 roku region Jarosław proponuje usługi socjalne dla mieszkańców obszarów wiejskich. Świadcząca je brygada „Mobilnej służby socjalnej" składa się ze specjalistów kompleksowego centrum usług socjalnych: pracownik socjalny, ratownik medyczny (felczer), psycholog, prawnik, fryzjer, w razie potrzeby – przedstawiciele Funduszu Emerytalnego Federacji Rosyjskiej i Funduszu Ubezpieczeń Społecznych.

Tab. 3. Rodzaje pomocy społecznej dla emerytów w obwodzie jarosławskim

Rodzaje pomocy społecznej	Liczba osób
Pobyt stały w domach pomocy społecznej i w placówkach pobytu czasowego	ponad 6 tys.
Usługi socjalne w centrach i ośrodkach pomocy społecznej, w tym:	ponad 90 tys.
domowe usługi opiekuńcze i pielęgnacyjne (zdrowotne)	około 19 tys.
ratownictwo społeczne – przydzielanie odzieży, obuwia, przedmiotów codziennego użytku, usługi wyjazdowe i konsultacje „z jednego numeru telefonu”	ponad 60 tys.
pobyt dzienny osób starszych w centrach pomocy społecznej	ponad 13 tys.
samotne osoby w podeszłym wieku przebywające w placówkach opiekuńczych	około 4 tys.

Obraz życia rosyjskiego seniora

Wyniki badań z 2013 roku wskazują, że 32–36% starszych wiekiem Rosjan uznaje swoje życie za spełnione, niezadowoleni ze swego życia stanowią 25–27% grupę, co jest wartością znacząco wyższą niż w przypadku młodzieży w wieku 18–24 lat (13%). Przekonanie, że sprawy w kraju idą w dobrym kierunku jest właściwe ponad 1/3 (35–39%) rosyjskich emerytów, zwłaszcza tych urodzonych przed wojną (39%). Sytuację polityczną Rosjanie w wieku powyżej 55 lat ocenili jako średnią (60–64%). Większość (57–59%) obecnych emerytów nie oczekuje istotnych zmian w życiu. Dla porównania, wśród młodzieży jest to 40% grupa. Rosyjscy emeryci w większości (56–72%) uważają się za szczęśliwych lub raczej szczęśliwych. Ocena stanu zdrowia jest różna w zależności od kategorii wiekowej. Zadowalający jest on dla około połowy 56–60-latków (51%) oraz 61–72-latków (47%). Negatywna ocena stanu zdrowia występuje u Rosjan ponad 72-letnich (64%). Większa część emerytów spędza wakacyjny wypoczynek w domu (48–70%). Drugim sposobem jest wypoczynek na bardzo popularnej wśród Rosjan daczy, czyli letnim zamiejskim domku (19–28%), szczególnie wśród 56–60-latków (28%). Wyjazdy na odpoczynek są udziałem osób 56–60-letnich, przykładowo 8% podróżuje nad Morze Czarne. Emeryci w wieku 56–72 lat bywają regularnie w teatrach (35%) i na wystawach (24–34%). Internet wykorzystywany jest przez 32% Rosjan w wieku 56–60-lat, 13% osób w wieku 61–72 lata i 6% osób w wieku ponad 72 lata. Telewizję ogląda 95% osób w wieku ponad 72 lata.

Optymalizacja społecznej polityki prosenioralnej

Społeczeństwo rosyjskie intensywnie się starzeje, w 2014 roku co ósmy Rosjanin miał ponad 65 lat (13% ogółu narodu). Oczekiwana długość życia w Rosji w 2020 roku osiągnie 75,7 lat, w tym dla mężczyzn 71,2 lat, dla kobiet 80 lat.

Aby podnieść jakość życia rosyjskich emerytów od czerwca 2015 roku jest realizowana “Strategia Działań na rzecz Osób Starszych”. Jej główne problemy koncentrują się wokół zatrud-

nienia, zachowania i wzmocnienia zdrowia osób starszych, zagospodarowania czasu wolnego, rozrywki, rozwoju rynku usług socjalnych. W Rosji funkcjonuje tysiące prosenioralnych organizacji pozarządowych, np. Związek Emerytów Rosji. Seniorzy biorą udział w pracach licznych organizacji społeczeństwa obywatelskiego, jak Wszechrosyjska Organizacja Publiczna Weteranów Wojny, Pracy, Sił Zbrojnych i Ochrony Prawa, Wszechrosyjskie Stowarzyszenie Osób Niepełnosprawnych, Rada Kombatantów, organizacji "Dzieci wojny", charytatywnych organizacji pozarządowych (NGO), organizacji społecznych, klubów zainteresowań, Centrum informacyjno-wychowawczego i edukacyjnego "Złoty Wiek" przy stowarzyszeniu „Wiedza" itp.

Rosyjskie Uniwersytety Trzeciego Wieku to innowacyjna forma usług społecznych, rehabilitacji społecznej dla emerytów, osób niepełnosprawnych, weteranów Wielkiej Wojny Ojczyźnianej, forma wspólnej pracy agencji rządowych, organizacji pozarządowych, organizacji komercyjnych i non-profit. Uniwersytety prowadzą zajęcia z różnych dziedzin wiedzy: technologii informacyjnych, rozwoju osobistego, zdrowego trybu życia. Proponują imprezy kulturalne i rozrywkowe, wsparcie psychologiczne i bezpieczeństwo prawne dla seniorów. Głównym celem UTW jest podniesienie jakości życia osób starszych i przeciwdziałanie poczuciu osamotnienia osób starszych. Ruch rosyjskich UTW odzwierciedla potencjał i trendy rozwoju społeczeństwa obywatelskiego, organizacji pozarządowych, jest jednym z mechanizmów wspierających emerytów Federacji Rosyjskiej.

Nadiia Lutsan[1]

Пенсионеры в Украине: социальная помощь для пожилых людей

Ключевые слова: старость, пенсионеры, социальная поддержка, социальная политиа, Украина

Pensioners in Ukraina: social assistance fot the elderly

Keywords: old age, pensioners, social assistance, social policy, Ukraina

Виды пенсий

Согласно закону "Об общеобязательном государственном пенсионном страховании" пенсионер – лицо, которое в соответствии с настоящим Законом получает пенсию, пожизненную пенсию, или члены его семьи, получающие пенсию в случае смерти этого лица в случаях, предусмотренных этим Законом. Итак, пенсионер – лицо, получающее пенсию – регулярную денежную помощь, которая выплачивается лицам, которые достигли пенсионного возраста, стали инвалидами или потеряли кормильца.

В Украине Пенсионная реформа установила для женщин пенсионный возраст также как и мужчинам — 60 лет, но не сразу, а после некоторого переходного периода. Этот период будет длиться до 1 октября 2020 года. Во время этого переходного периода пенсионный возраст для женщин будет подниматься с 55 до 60 лет. Необходимый пенсионный стаж при этом не сокращается и остается 15 лет.

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Пенсионный возраст для обычной пенсии – пенсии по возрасту — для мужчин в результате пенсионной реформы не изменился и остался 60 лет при наличии пенсионного стажа не менее 15 лет.

Пенсия в Украине – это ежемесячная пенсионная выплата в солидарной системе общеобязательного государственного пенсионного страхования, которую получает застрахованное лицо в случае достижения им пенсионного возраста (Ярошенко, 2005, 232 с.). Пенсия в Украине гарантирует социальную защищенность пенсионеров путем установления пенсий на уровне, ориентированному на прожиточный минимум. Итак, пенсия – это государственная выплата, предоставляемая с пенсионного фонда для материального обеспечения нетрудоспособных граждан в связи с их прошлой трудовой или другой общественно полезной деятельностью в размерах, как правило, сопоставимых с прошлым заработком пенсионера.

В Украине введена трёхуровневая система пенсионного обеспечения.

Первый уровень составляет солидарная система общеобязательного пенсионного страхования. Она основывается на принципах солидарности и субсидирования и осуществления выплаты пенсий и предоставления социальных услуг за счет средств Пенсионного фонда.

Второй уровень – накопительная система общеобязательного государственного пенсионного страхования. Она основывается на принципах накопления средств застрахованных лиц в Накопительный фонд, который создается за счет страховых взносов застрахованных лиц для оплаты пожизненных пенсий или одноразовых выплат.

Третий уровень – система негосударственного пенсионного обеспечения, которая основывается на принципах добровольного участия граждан, работодателей и их объединений в формировании пенсионных накоплений с целью получения из них гражданами пенсионных выплат, в том числе из негосударственных пенсионных фондов.

Закон предоставляет право на получение пенсий и социальных услуг из солидарной системы двум категориям граждан:

1) пенсионерам, которым до дня вступления в силу данного закона уже была назначена пенсия в соответствии с Законом “О пенсионном обеспечении” (кроме социальных пенсий) или ежемесячное пожизненное денежное содержание по другим законодательным актам (при условии, если они не получают пенсию из других источников);
2) граждане Украины, которые застрахованы согласно закону и достигли установленного пенсионного возраста или признаны инвалидами и имеют необходимый для назначения соответствующего вида пенсии страховой стаж. Страховой стаж определяется как период (срок), в течение которого лицо подлежало государственному социальному страхованию и платило сбор на обязательное государственное пенсионное страхование в соответствии с за-

конодательством, действовавшим ранее, и подлежит общеобязательному государственному пенсионному страхованию в соответствии с настоящим законодательством и платит страховые взносы.

Согласно Закону Украины "О пенсионном обеспечении" (http://zakon3.rada.gov.ua/laws/show/1788-12) граждане Украины получают такие виды государственных пенсий: по возрасту, по инвалидности, в случае потери кормильца, за выслугу лет.

Пенсия по возрасту – главный вид материального обеспечения нетрудоспособных граждан, касающиеся жизненно важных интересов миллионов отечественных пенсионеров. Пенсия по возрасту назначается при двух условиях:

– Достижение конкретного возраста;
– Наличия в настоящее время необходимого стажа.

Право на такую пенсию имеют:

– Мужчины – при условии достижения ими возраста 60 лет и наличии трудового стажа не менее 35 лет;
– Женщины – при условии достижения ими возраста 55 лет и наличии трудового стажа не менее 30 лет;

Пенсия по инвалидности – выплата, которая назначается в случае наступления инвалидности, в результате которой наступила полная или частичная утрата трудоспособности по причинам:

– трудового увечья или профессионального заболевания;
– общего заболевания (в том числе увечья, не связанного с работой).

Такие пенсии назначаются на весь период инвалидности, а мужчинам в возрасте старше 60 лет и женщинам старше 55 лет – пожизненно.

Пенсия по случаю потери кормильца – ежемесячные выплаты из Пенсионного фонда, предназначенные в связи с потерей кормильца нетрудоспособным членам его семьи, которые находятся на его содержании, в размерах, соотнесенных с заработком кормильца.

Пенсия за выслугу лет – это ежемесячные выплаты из Пенсионного фонда и других источников финансирования, назначаются пожизненно в размере, соотнесенным с прошлым заработком (вознаграждением) лицам, которые имеют установленный законом специальный стаж (выслугу лет). По своим признакам и целями пенсии за выслугу лет наиболее близки к пенсиям по возрасту: здесь также требуется определенный стаж работы (службы), а в некоторых случаях – возраст.

Минимальная пенсия – 2015 в Украине устанавливается Законом "О госбюджете на 2015 год" по представлению Кабинета Министров Украины (Министерства финансов) – составляет 949 грн[2].

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[2] Według stanu na styczeń 2015 roku, zgodnie z kursem z 15 września 2015 roku 100,00 EUR = 1464,52 UAH, 100,00 PLN = 585,48 UAH [przypis Z.S.]

Право на трудовую пенсию имеют лица, занятые общественно полезным трудом, при соблюдении других условий, предусмотренных настоящим Законом:

а) лица, работающие на предприятиях, в учреждениях, организациях, кооперативах (в том числе по договорам гражданско-правового характера), независимо от используемых форм собственности и хозяйствования, или члены колхозов и других кооперативов, – при условии уплаты предприятиями и организациями страховых взносов в Пенсионный фонд Украины (Пункт "а" статьи 3 с изменениями, внесенными согласно Закону N 3284-12 от 17.06.93);
б) лица, занимающиеся предпринимательской деятельностью, основанной на личной собственности физического лица и исключительно его труда – при условии уплаты страховых взносов в Пенсионный фонд Украины;
в) члены творческих союзов, а также другие творческие работники, не являющиеся членами таких союзов – при условии уплаты страховых взносов в Пенсионный фонд Украины;
г) другие лица, подлежащие государственному социальному страхованию;
д) работники военизированных формирований, которые не подлежат государственному социальному страхованию, лица начальствующего и рядового состава фельдъегерской службы (Пункт "д" статьи 3 с изменениями, внесенными согласно Закону N 5462-VI (5462-17) от 16.10.2012) ;
э) воспитанники, ученики, студенты, курсанты, слушатели, стажеры, клинические ординаторы, аспиранты, докторанты;
е) лица, которые стали инвалидами в связи с выполнением государственных или общественных обязанностей или в связи с выполнением действий по спасанию человеческой жизни, охране государственной, коллективной и индивидуальной собственности, а также по охране правопорядка;
ж) лица, осуществляющие уход за инвалидом I группы или ребенком-инвалидом в возрасте до 16 лет, а также за пенсионером, который по заключению медицинского учреждения нуждается в постоянном постороннем уходе;
з) члены семей лиц, указанных в настоящей статье, и пенсионеров из числа этих лиц – в случае потери кормильца (http://zakon4.rada.gov.ua/laws/show/1788-12).

Министр социальной политики Павел Розенко заявил, что в Украине количество зарегистрированных пенсионеров в Пенсионном фонде превысило количество лиц, которые легально платят страховые взносы. Примерно 13,5млн. пенсионеров и около 13 млн. человек, легально работают и платят взносы в Пенсионный фонд.

Согласно данным, которые озвучил заместитель Министра финансов Владимир Матвийчук, в Украине 2015 года насчитывается 2670000 работающих пенсионеров.

В таблице 1. указано количество людей пенсионного возраста по данным государственной службы статистики Украины (http://database.ukrcensus.gov.ua/PXWEB2007/).

Таблица 1. Количество людей пенсионного возраста в процентах в Украине

2012 год	2014 год	2016 год
21,2%	21,6%	22,1%

В социальном обеспечении пенсионеров Украины существует ряд проблем, в частности:

1. Низкий уровень пенсионного обеспечения.
2. Почти отсутствует дифференциация размеров пенсий.
3. Наличие значительных преимуществ и льгот в пенсионном обеспечении отдельных категорий работников при одинаковом уровне отчислений на пенсионное обеспечение.
4. Демографические процессы (старение населения, уменьшение трудоспособного населения), последствиями которых является увеличение численности держателей пенсий и уменьшения плательщиков страховых взносов.
5. Уменьшение численности занятого населения.
6. Неблагоприятное соотношение продолжительности периода уплаты взносов на пенсионное обеспечение и периода, в течение которого выплачивается пенсия.
7. Рост различного рода льготных и приравненных к ним категорий пенсионеров.

Помощь для пожилых людей в Ивано-Франковской области

В Ивано-Франковской области в течение нескольких лет реализуется областная комплексная Программа социальной защиты населения Ивано-Франковской области в 2012-2016 годах, которая предусматривает меры, выполнение которых будет способствовать улучшению социальной защиты населения области, в частности, инвалидов, малообеспеченных, многодетных семей, ветеранов национально освободительной борьбы.

Ивано-Франковская область – один из самых густонаселенных и давно освоенных регионов Украины. Ивано-Франковская область расположена в географическом центре Европы, на юго-западе Украины, на стыке двух крупных природно-географических подразделений – Восточноевропейской равнины и Восточных Карпат. Территория области 13,9 тыс. км. В области проживает 1382571 человек, в городе Ивано-Франковск – 227030 жителей. В области сформирована структура населения, для которой характерно достаточно высокий уровень лиц старших возрастных групп и значительно меньший – трудоспособных и детей. Количество лиц в возрасте 60 лет и старше составляет 18,9%.

В Департаменте социальной политики Ивано-Франковска по состоянию на 20 ноября 2014 году на учете находится 15163 получателей пособий. Директор Департамента и социальной политики Александра Заклинская рассказала, что в те-

чение десяти месяцев 2014 года, за счет субвенции из государственного бюджета назначено и восстановлено выплату почти 20 видов социальных пособий [http://styknews.info/novyny/sotsium/2014/11/26/iak-vyplachuiut-sotsialnu-dopomogu-u-ivano-frankivsku].

Инфраструктура социального обслуживания граждан области включает в себя около 40 заведений, отраженных в том государственные учреждения социальной защиты (20), интернатные учреждения: гериатрический пансионат (3), психоневрологические интернаты (3), детские дома-интернаты (3) и центры социальной реабилитации детей-инвалидов (6), одиін дом ночного пребывания для лиц без определённого места жительства.

Ивано-Франковский территориальный центр социального обслуживания предоставляет услуги одиноким гражданам пожилого возраста, инвалидам, больным, которые не способны к самообслуживанию и нуждаются в постоянной посторонней помощи и другим, социально незащищенным слоям населения.

Отделением социальной помощи на дому обслужено 512 человек. Подготовлены и направлены в главное управление социальной защиты населения областной государственной администрации пакет документов для 17 человек на устройство в интернаты области.

Отделение социально-бытовой адаптации обслуживает граждан, имеющих частичное нарушение двигательной активности и не имеющих медицинских противопоказаний для пребывания в коллективе. Отделением проводится социально-бытовая адаптация лиц пожилого возраста, инвалидов с целью устранения ограничений жизнедеятельности, восстановление знаний, умений и навыков по ориентированию в домашних условиях, ведение домашнего хозяйства, самообслуживания, обучение трудовым навыкам, предоставление информации, необходимой для ликвидации сложной жизненной ситуации, которая сложилась и предоставление методических советов, содействие развитию разносторонних интересов и потребностей, организация досуга и отдыха (проведение лекций, бесед, встреч, создание кружков и т.п.). Отделением обслужено 577 человек.

Отделением организации предоставления адресной натуральной и денежной помощи обслужено 823 граждан, обратившихся за различными видами помощи.

Для одиноких пенсионеров и инвалидов, которые по состоянию здоровья не в состоянии приготовить себе еду, организовано ежедневную доставку горячих обедов на дом. Организована доставка горячих обедов всего 34 лицам. На оплату горячего питания использовано 31494 грн (из средств местного бюджета) [http://www.mvk.if.ua/uploads/files/dsp010312_3.pdf].

Департаментом социальной политики Ивано-Франковского городского совета постоянно проводятся мероприятия по социальному обеспечению и социальной защиты пенсионеров, инвалидов, одиноких нетрудоспособных граждан, детей-сирот, одиноких матерей, многодетных матерей, а также малообеспеченных

семей с детьми, других социально незащищенных граждан, которые нуждаются в помощи и социальной поддержки со стороны государства.

В 2014 году в Ивано-Франковском регионе было предоставлено 166 государственных социальных пособий лицам, не имеющим права на пенсию и инвалидам, 412 пособий по уходу за инвалидом I или II группы вследствие психического расстройства, 729 государственных социальных пособий инвалидам с детства и детям-инвалидам, 234 компенсаций физическим лицам, которые предоставляют социальные услуги.

Одним из видов социальных пособий также и жилищные субсидии – программа адресной социальной помощи малообеспеченным слоям населения.

Положение о предоставлении адресных социальных пособий пенсионерам, инвалидам и малообеспеченным гражданам Ивано-Франковского региона предусматривает порядок и условия предоставления гражданам помощи с учетом требований Закона Украины «Об основных принципах социальной защиты ветеранов труда и других граждан преклонного возраста», Закона Украины «О статусе ветеранов войны, гарантии их социальной защиты», Закона Украины «Об основах социальной защищенности инвалидов в Украине», Закона Украины «О социальных услугах» и Закона Украины «О местном самоуправлении в Украине».

Согласно этому положению предоставляются следующие виды адресных социальных пособий:

– одноразовые пособия;
– помощь бывшей в употреблении одеждой, бытовыми услугами парикмахера, ремонтом одежды и обуви;
– бесплатное питание.

Согласно Закону Украины “О социальной защите детей войны” от 18.11.2004 № 2195-IV, лица которым до окончания Второй мировой войны не исполнилось 18 лет относятся к детям войны и для них предусмотрена надбавка к пенсии в размере 30% минимальной пенсии по возрасту. Департамент социальной политики профинансировал выплату разовой денежной помощи 7962 ветеранам войны. Оказана финансовая поддержка организациям инвалидов и ветеранов войны. В таблице 3 представлены названия организаций инвалидов и ветеранов войны в Ивано-Франковске [http://www.mvk.if.ua/news/11845/].

Таблица 2. Помощь организациям инвалидов и ветеранов войны в Ивано-Франковску

Название организации	Сумма UAH
Городская ассоциация инвалидов войны и Вооруженных Сил	2000,00
Ивано-Франковское городское отделение Всеукраинского объединения ветеранов	2000,00
Ивано-Франковское городское Всеукраинское Общество политических узников и репрессированных	1500,00
Ивано-Франковская городская организация участников боевых действий	2000,00
Ивано-Франковская городская организация ветеранов Украины	2000,00

Изображение жизни украинского пенсионера

В рейтинге Global AgeWatch Index 2014, относительно качества жизни пенсионеров в мире, составленного международной благотворительной организацией HelpAgeInternational при поддержке ООН, Украина опустилась с 66 на 82 место. Согласно рейтингу, существенно ухудшились возможности и показатели здоровья пожилых украинцев. Отметим, что индекс Global AgeWatch учитывает размеры пенсий, часть пожилых за чертой бедности, ожидаемую продолжительность здоровой жизни в возрасте 60 лет, уровень образования пожилых людей, доступ к общественному транспорту и еще много подобных параметров, взятых из данных Всемирного банка, Всемирной организации здравоохранения, Международной организации труда и ЮНЕСКО. Самое большое достижение Украины в этом рейтинге касается уровня образования и количества работающих пенсионеров – 35 место рейтинга [http://dt.ua/UKRAINE/ukrayina-na-16-poziciy-opustilasya-v-reytingu-yakosti-zhittya-pensioneriv-152605_.html].

Какой должна быть пенсия глазами украинского пенсионера?

Общеизвестно, что украинский государственный служащий согласно Пенсионному закону при выходе на пенсию получает не менее 70% от своей зарплаты, а потом каждый год прибавку в 1%, но не более 90%. Также общеизвестно, что, простой пенсионер получает при выходе на пенсию 30-50% от величины зарплаты. Поэтому средняя пенсия в Украине составляет около 1300 грн., А средняя пенсия государственного служащего – 3120 грн., то есть в 2,4 раза больше.

В связи с военными действиями на востоке Украины существует критическое положение с выплатой пенсий в Донецкой и Луганской областях.

По большому счету, к сегодняшней пенсионной системы Украины можно предъявить немало претензий. Самая главная заключается в том, что она не спо-

собна обеспечить достойный уровень жизни подавляющего числа пожилых людей: более 80% из них живут на пенсии, которые на Западе назвали бы «несовместимыми с жизнью». В Черкасской области, например, 8% пенсионеров получают всего лишь 949 грн., а пенсии еще 69% стариков укладываются в промежуток до 1200 гривен. Если учесть выплаты до 1300 гривен, то таких пенсионеров уже наберется больше 90%, а средняя пенсия в Черкасской области сегодня составляет 1346 гривен (по Украине – 1560). Это если считать вместе с судьями, прокурорами, крупными начальниками, силовиками. В то же время, в области есть люди, чья пенсия превышает 10000 грн. (83 человека). Заметим, что именно обладателям высоких пенсий чаще всего еще и присущи существенные льготы по оплате услуг ЖКХ [http://www.realt5000.com.ua/news/utf/uk/1464591/].

Как живут пожилые Украинцы? Приблизительное количество лет, которое еще может прожить 60-летний Украинец – 18, среднее количество лет, которые человек в возрасте 60 может прожить здоровым – 13,8, 95% людей старше 65 лет, получающих пенсию, 31,9% процент работающих украинцев в возрасте 55-64 лет, около 1 млн. пенсионеров пользуются интернетом.

Оптимизация социальной политики для пожилых людей

Качество жизни пожилого человека во многом зависит от социальной защищенности, материального благосостояния (размер пенсии, льготы и т.д.), возможности рационального питания, своевременного оказания полноценной медицинской помощи, организации медико-социального обслуживания вообще.

Мощный социальной, правовой, медико-реабилитационной, психологической и культурнической деятельностью занимаются Фонд социальной защиты ветеранов Великой Отечественной войны (создан в соответствии с указом Президента Украины от 20.04.1995), Всеукраинская благотворительная организация инвалидов и пенсионеров «Лицом к истине», Союз бывших узников фашизма-жертв нацизма, Общественная организация «Забота о пожилых в Украине», Благотворительный фонд «За выживание» (работает уже 12 лет), Благотворительный фонд «Ветеран прессы», Общественная организация «Ассоциация психодрамы", Союз организаций инвалидов Украины, Киевская организация незрячих юристов, Общество Красного креста Украины (осуществляет 10 целевых гуманитарных программ), Союз православных братств Украины, Лига развития человека, Общественная физкультурно-оздоровительная и реабилитационная организация инвалидов ЧАЭС[3] «Здравобор» и др.

Так, Украинское общество глухих (существует с 1926 г.) Есть организационно-методическим и информационно-реабилитационным центром по обслуживанию

[3] Elektrownia atomowa w Czarnobylu, jej groźna w skutkach awaria miała miejsce w 1986 roku. W wyniku katastrofy radioaktywnemu skażeniu uległo niemal 150 tys. km^2 terenów dzisiejszej Ukrainy, Białorusi i Rosji [przypis Z.S.].

инвалидов по слуху, которых в Киеве около 5 тыс. (всего 60 тыс. членов УТОГ, проживающих в Украине). К структурным подразделениям культурного центра УТОГ относятся: профессиональный театр глухих (30 г.), 32 года существует музей истории глухих Украины, библиотека с книжным фондом более 28 тыс. экземпляров, картинная галерея неслышащих художников, летняя площадка с рекреационной зоной для отдыха и общения, телекоммуникационный центр с функциональными возможностями в трех залах центра и др. В Центре работают более 30 творческих объединений, клубов по интересам, в которые входят глухие художники, туристы, шахматисты и др. Украинское общество слепых (существует с 1925) осуществляет социально-трудовую и медицинскую реабилитацию незрячих.

Союзом Самаритян Украины создан Центр социальной помощи, где оказывается всесторонняя помощь и осуществляется инновационная практическая деятельность в сфере социальной защиты малообеспеченных слоев населения. Введен новый проект «Мобильная скорая помощь». По данным исследований Института геронтологии АМН, 12% всех пожилых людей и 25-30% пожилых людей прикованы к постели. Так, только в Киеве государственные социальные службы обслуживают 50 тыс. человек на дому [http://uchni.com.ua/pshologiya/23776/index.html?page=6].

В Украине при территориальных организациях ветеранов начали формироваться очаги культурно-массовой работы, досуга и развития творческих способностей пожилых людей. В таких структурах пенсионеры могут получить консультации по решению своих социальных проблем, реализации творческого потенциала, разновидные рекомендаций и консультаций медико-социального и юридического характера.

В апреле 2010 в Сумской и Полтавской областях свои двери гостеприимно открыли три центра досуга для одиноких пожилых людей в Пирятине (Полтавская область), Недригайлове и Липовой Долине (Сумская область) на базе местных территориальных центров социального обслуживания пенсионеров. Центры являются местом, где одинокие люди могут общаться, заниматься любимым делом, а также овладевать новыми навыками, такими как, например, фотодело и пользования ПК. В центрах пожилым людям также оказывают социально-бытовые услуги и медицинские консультации. В центрах начали свою работу разнообразные кружки, пресс-клубы, группа здоровья.

Проекты профинансированы в рамках конкурса «Трудности преодолеем вместе: центры социальной активности для одиноких пожилых людей» при поддержке компании Telenor Group и Агентства США по международному развитию (USAID) [http://gicc.org.ua/navchannya-ta-rozvagi.html].

Проблемы организации свободного времени пожилых людей и реализации их рекреационно-развивающего потенциала актуальны сегодня в Украине.

Что делать человеку, который вышел на пенсию? Каждый самостоятельно ищет ответ на этот вопрос, каждый пытается найти занятие для души или же во-

все не занимается такими поисками. Это также право каждого человека. По мнению экспертов, обучение – эффективное средство профилактики депрессий у людей пожилого возраста. Для жаждущих знаний людей и работают Университеты третьего возраста, где студенты овладевают интернетом, тренируют память, развивают интеллект, открывают в себе новые таланты.

Сейчас в Украине работает более 300 таких заведений, как посчитало Министерство соцполитики. И более 25 000 слушателей уже расширили свой кругозор, закончив Университеты третьего возраста. Участие в учебном процессе помогает человеку идти в ногу со временем.

Общество должно обеспечить пожилым людям полноценное участие во всех сферах общественной жизни; поддерживать гуманное, уважительное отношение к ним, то есть способствовать активному долголетию с помощью положительных факторов окружения.

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Emeryci na Ukrainie: pomoc społeczna dla osób starszych[1]

Słowa kluczowe: starość, emeryci, pomoc społeczna, polityka społeczna, Ukraina[4]

Rodzaje finansowych świadczeń emerytalnych

W wyniku reformy wiek emerytalny obywateli Ukrainy od 1 października 2020 roku wynosił będzie 60 lat dla obu płci, przy zachowaniu obowiązku minimum 15-letniego stażu pracy. Do niedawna kobiety przechodziły na emeryturę mając ukończone 55 lat. Na Ukrainie istnieje państwowy fundusz emerytalny i obowiązkowy system ubezpieczenia emerytalnego, z którego co miesiąc wypłacane są świadczenia w wysokości pokrywającej koszty utrzymania, gwarantujące uprawnionym bezpieczeństwo socjalne na poziomie zbliżonym do tego z czasów aktywności zawodowej. Ukraina wprowadziła trójwarstwowy system emerytalny. Pierwszy poziom to wypłaty z obowiązkowego ubezpieczenia emerytalnego (społecznego). Drugi – środki są pochodną skumulowanych składek funduszu oszczędnościowego osoby ubezpieczonej (otwarte fundusze emerytalne). Trzeci stanowią wypłaty z prywatnych, dobrowolnie gromadzonych funduszy emerytalnych. Prawo do państwowej, pracowniczej emerytury uzyskuje się ze względu na wiek, niepełnosprawność, w przypadku utraty żywiciela rodziny i ze względu na staż pracy. Innymi świadczeniami są renty, wypłacane osobom niepełnosprawnym, niezdolnym do pracy. Minimalna emerytura w styczniu 2015 r. wynosiła 949 hrywien[5]. Ustawodawstwo Ukrainy wyraźnie i szczegółowo reguluje kwestie przyznawania uprawnień emerytalnych i wypłacania świadczeń z państwowego funduszu. Emerytury i renty pobiera w Ukrainie ok. 13,5 mln osób. Wśród nich 2,67 mln w roku 2015 pracowało zarobkowo.

Tab. 1. Osoby w wieku emerytalnym na Ukrainie, w %

2012 rok	2014 rok	2016 rok
21,2%	21,6%	22,1%

Sytuację emerytów korzystających z ubezpieczenia społecznego charakteryzuje kilka problemów, będących skutkiem przemian społeczno-demograficznych: niski poziom emerytur, brak zróżnicowania świadczeń, uprzywilejowanie wybranych grup zawodowych przy identycznym poziomie pobranych składek emerytalnych, rosnąca liczba emerytów i malejąca liczba płatników składek ubezpieczeniowych, zmniejszająca się liczba osób aktywnych na rynku pracy, niekorzyst-

[4] Tłumaczenie i streszczenie: Zofia Szarota

[5] Zgodnie z kursem z 15 września 2015 roku 100,00 EUR było równe 1464,52 UAH, 100.00 PLN = 585,48 UAH

ny stosunek długości okresu składkowego do okresu przebywania na emeryturze, przyrost osób uprawnionych do pobierania świadczeń socjalnych.

Pomoc dla osób starszych w regionie iwano-frankowskim

Region zamieszkuje 1,38 mln osób, miasto Iwano-Frankowsk liczy 227 tys. mieszkańców. Odsetek osób w wieku 60 i więcej lat wynosi 18,9%. Od kilku lat realizowany jest regionalny program (na lata 2012–2016) ochrony socjalnej osób niepełnosprawnych, zagrożonych lub dotkniętych ubóstwem, rodzin wielodzietnych oraz weteranów walki narodowo-wyzwoleńczej. W Wydziale Polityki Społecznej miasta, wg stanu na 20 listopada 2014 r., zarejestrowanych było 15163 odbiorców usług. W okresie 10 miesięcy 2014 roku z budżetu państwa przyznano i wypłacono prawie 20 rodzajów świadczeń społecznych. Działają instytucje pomocy społecznej, w tym 20 publicznych instytucji opieki socjalnej, placówki pobytowe, opieki stałej (domy dla osób starszych (3), domy opieki dla osób z zaburzeniami neurologicznymi (3), domy dziecka (3), 6 ośrodków społecznej rehabilitacji dla dzieci niepełnosprawnych oraz noclegownia dla bezdomnych.

Miejskie Centrum Usług Socjalnych zapewnia pomoc samotnym seniorom, osobom niepełnosprawnym, chorym niezdolnym do samoobsługi oraz innym słabszym grupom społecznym. Z usług świadczonych w miejscu zamieszkania korzysta 512 osób.

Wydział Adaptacji Socjalno-Bytowej obsługuje obywateli z częściowym ograniczeniem aktywności życiowej. Prowadzone są starania o włączenie społeczne osób starszych, osób z niepełnosprawnością. Obejmują one działania służące eliminacji barier, przyrostowi wiedzy, kształtowaniu umiejętności i nawyków związanych z prowadzeniem gospodarstwa domowego, sprzątaniem, czynnościami samoobsługowymi. Udzielana jest informacja i doradztwo, rozwijane są zainteresowania, zapewniane formy rekreacji, wypoczynku i rozrywki (wykłady, dyskusje, spotkania, koła zainteresowań itd.). Wydział obsługuje 577 osób. Pomocą finansową i w naturze objęto 823 osoby. Gorące posiłki dostarczano codziennie do domu 34 samotnym emerytom i osobom niepełnosprawnym. Na ten cel wydano z lokalnego budżetu 31494 USD. Ukraińskie prawo zawiera szereg regulacji dotyczących świadczeń socjalnych dla emerytów, rencistów, osób niepełnosprawnych, osób o niskich dochodach. Znajdują one wyraz w ustawach: „O podstawowych zasadach ochrony socjalnej weteranów pracy i innych osób w podeszłym wieku", „O statusie Kombatantów, gwarancje ich socjalnej ochrony", „O ochronie socjalnej inwalidów", w „Ustawie w sprawie usług socjalnych", „O samorządzie terytorialnym Ukrainy". Ustawa „O ochronie socjalnej dzieci wojny" z 18.11.2004 Nr 2195-IV przewiduje dla osób, które do końca II wojny światowej nie ukończyły 18 lat, dodatek do emerytury w wysokości 30% minimalnej emerytury. Wydział Polityki Społecznej dofinansował 7962 weteranom wojny opłaty za udzielaną dzienną pomoc. Organizacje zrzeszające osoby niepełnosprawne i kombatantów otrzymują wsparcie finansowe (tab. 2).

Tab. 2. Pomoc dla organizacji osób niepełnosprawnych i weteranów wojny w Iwano-Frankowsku

Nazwa organizacji	Kwota w UAH
Miejski Związek Inwalidów Wojny i Sił Zbrojnych	2000,00
Miejski Oddział Ogólnoukraińskiego Zjednoczenia Weteranów	2000,00
Miejskie Ogólnoukraińskie Stowarzyszenie Więźniów Politycznych i Osób Represjonowanych	1500,00
Miejska Organizacja Uczestników Działań Bojowych	2000,00
Miejska Organizacja Weteranów Ukrainy	2000,00

Obraz życia ukraińskiego emeryta

W rankingu Global AgeWatch Index 2014, odnoszącym się do jakości życia osób starszych na świecie, Ukraina w ciągu kilku lat spadła z 66. na 82. miejsce. Zgodnie z Rankingiem, znacznie pogorszyły się warunki ochrony i stan zdrowia starszych Ukraińców. Największym osiągnięciem Ukrainy w tym rankingu jest poziom wykształcenia i liczba pracujących emerytów – 35. pozycja.

Według ukraińskiego prawa emeryt otrzymuje co najmniej 70% swojego wynagrodzenia. Każdy kolejny rok spędzony na emeryturze powiększa to świadczenie o 1%, nie przekraczając poziomu 90% świadczenia pracowniczego (wypłaty). Przejście na emeryturę skutkuje świadczeniem w wysokości 30-50% wynagrodzenia pracowniczego. Dlatego też średnia emerytura na Ukrainie wynosi około 1300 UAH a średnia emerytura funkcjonariusza państwowego – 3120 UAH, czyli jest 2,4 razy większa. Ogólnie można mieć wiele zastrzeżeń i uwag krytycznych systemu emerytalnego na Ukrainie. Działania wojenne na wschodzie Ukrainy przyczyniły się do krytycznej sytuacji tamtejszych emerytów. Występuje ogromne zróżnicowanie w wysokości świadczeń – 80% osób starszych musi żyć za świadczenia, które na Zachodzie (Europy – przyp. ZS.) uznane byłyby za niewystarczające do przeżycia, poniżej minimum egzystencji. Ale są też osoby, których emerytura przekracza 10 tys. USD (83 osoby).

Jakie wskaźniki charakteryzują starszych wiekiem Ukraińców? Liczba dalszych potencjalnych lat życia dla 60-latka wynosi 18. Średnia liczba lat do przeżycia w zdrowiu wynosi 13,8. Świadczenia emerytalne pobiera 95% seniorów, 31,9% Ukraińców w wieku 55-64 nadal pracuje. Milion osób w podeszłym wieku korzysta z Internetu.

Optymalizacja społecznej polityki senioralnej

Na Ukrainie działa wiele senioralnych organizacji pozarządowych, w tym Fundacja pomocy socjalnej dla weteranów Wielkiej Wojny Ojczyźnianej (1941-1945), ogólnoukraińska fundacja „W obliczu prawdy", Związek Byłych Więźniów Faszyzmu i Nazizmu, Organizacja „Opieka nad osobami starszymi na Ukrainie" itd. Organizacje te podejmują działania socjalne, prawne, me-

dyczno-rehabilitacyjne, psychologiczne i kulturalne. Od 1926 r. działa Ukraińskie Stowarzyszenie Głuchych, z Centrum Rehabilitacji. Od 32 lat działa Teatr Głuchych i Muzeum Historii Osób Niesłyszących. Działa Galeria Sztuki niesłyszących artystów. Od 1925 działa Ukraiński Związek Niewidomych, zapewniający społeczną, zdrowotną i zawodową rehabilitację. Związek Samarytan Ukrainy prowadzi Ośrodek Pomocy Społecznej, wdrażając nowatorskie działania w dziedzinie ochrony socjalnej osób ubogich. Wprowadzono projekt „Mobilne pogotowie", którego celem jest świadczenie pomocy osobom starszym i przykutym do łóżka w domach. Przy terytorialnych organizacjach weteranów zaczęły powstawać ogniska pracy kulturalnej, rekreacji i rozwoju zdolności twórczych osób starszych. Można tam uzyskać konsultacje i porady dotyczące problemów życiowych, zdrowotnych, prawnych i dotyczących możliwości samorozwoju. Tworzone są centra rekreacyjne dla samotnych osób starszych, działające na bazie lokalnych ośrodków świadczących usługi socjalne dla emerytów i rencistów. Prowadzą one działalność aktywizującą, realizują cele służące integracji społecznej. Problemy wykorzystania potencjału seniorów, organizacji czasu wolnego są dziś bardzo aktualne w Ukrainie. Zdaniem ekspertów edukacja jest skutecznym środkiem zapobiegającym depresji osób w podeszłym wieku. Na Ukrainie działa ponad 300 Uniwersytetów Trzeciego Wieku. Ponad 25 tys. słuchaczy zakończyło swą w nich edukację, poszerzając swoje horyzonty, zdobywając kompetencje cyfrowe, ćwicząc pamięć, rozwijać intelekt, odkrywając w sobie talenty, nadążając za zmianami.

Społeczeństwo musi zapewnić warunki dla pełnego uczestnictwa seniorów we wszystkich sferach życia publicznego, szanować i wspierać aktywną długowieczność przy pomocy pozytywnych czynników środowiskowych.

VARIA

Łukasz Tomczyk[1]

Lighthouse Keepers of Digital Poland of Equal Opportunities – information about nation-wide educational program[2]

One of the most recent examples of the involvement of social forces in educational activities that minimize digital exclusion among senior citizens is an educational project of the "Cities on the Internet" Association. The project is titled "Digital Poland of Equal Opportunities." It is hitherto the biggest undertaking in the area of digital education of Poles aged 50+. The project is carried out by the "Cities on the Internet" Association in collaboration with the Ministry of Administration and Digitization and is part of systemic solutions to the problem of digital exclusion in Poland. The key element of those activities is to educate over 2,800 volunteers that are, in turn, educators of those who want to gain new competences in the field of electronic media use. Digital Poland Lighthouse Keepers are local animators whose task is to encourage people from "generation 50+" to make their first steps on the Internet. Their activities are carried out by means of public points of Internet access – libraries, Volunteer Fire Service centers, call centers, schools and universities. Digital Poland Lighthouse Keepers are volunteers who become the agents of necessary civilizational transformation in Polish communes. Their role is to create a new quality in their own environment: to inspire, to teach and to help others use digital tools but also – and primarily – to encourage the digitally excluded to use Internet resources untutored. The most important element in a lighthouse keeper's work is proper identification of the needs of their community in order to "tailor" the offer of

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[2] The text is an extended version of the paper: Tomczyk Ł. (2015).

possible activities. In other words, to adapt the latter to the needs of senior citizens. Digital Poland of Equal Opportunities campaign has been recognized internationally by being awarded the prestigious WSIS Project Prize 2012 (Tomczyk 2013). So far (that is until 02-11-2015) the Lighthouse Keepers have trained 273 788 seniors spending over 71 thousand hours on didactic activities with the oldest group of the digitally excluded.

Digital Poland project is one of the model examples of mobilizing social forces in local environments. The commitment of educators-lighthouse keepers in the process of reducing the phenomenon of digital exclusion among the pre-digital generation partly rebuts the myth of low involvement of Poles in social affairs. Actions within the Digital Poland of Equal Opportunities project not only allow the development of information society but also redefine the mechanisms of social resources activation in Poland.

Digital Poland of Equal Opportunities project is an unprecedented phenomenon of regular and long-term activation of volunteers committed to work for the benefit of people in senior age. It is hard to find other similar, cyclic educational undertakings in Poland. There are senior centers and U3As operating on regular basis, however they fulfill different functions, mainly social and cognitive ones.

Lighthouse Keepers are an extremely valuable group from the perspective of putting the idea of active ageing into practice. This initiative is particularly important in small cities, towns and villages where there are no abovementioned senior centers and U3As. In small, local communities volunteers contribute not only to the increase of level of digital competences among "older adults" but also transform the social space by building new quality human and social capital based on the commitment of various subjects (institutions, volunteers, seniors).

Digital Poland of Equal Opportunities program also creates an opportunity for different generations to get know one another and to learn. Thanks to education senior citizens gain access not only to popular services regularly used by members of information society but, first of all, are given the opportunity to enter the world of "digital natives". The latter are, among others, their own grandchildren. Project activities reinforce the need and legitimacy of inter-generational learning which for the last several years has remained less noticed in social practices.

Social forces such as Lighthouse Keepers are not jus a simple form of voluntary service as they perform many important tasks in their environment. Lighthouse Keepers become mediums that link the resources of various institutions (e.g. free computer laboratories in schools, libraries, NGOs) with the needs of senior citizens. Conducting activities for seniors, educators enter into the role of experts, thus, guide the digitally excluded into the intricacies of digital world in a way that allows them to apply the gained knowledge and skills to their daily life. At the same time the volunteers of Digital Poland of Equal Opportunities serve as spokespersons of senior citizens by mobilizing public institutions to act for the benefit of the oldest generation. In addition, through educational

activities the Lighthouse Keepers become also stimulants of many positive changes in the lives of seniors, thus, popularize positive, active ageing.

Activity of people involved in the project and integration of local institutions allow a fresh, new look at the ways to increase human and social capital through education. Therefore, the project Digital Poland of Equal Opportunities has become one of the model solutions that need to be supported and developed. This is to be done not only in order to improve the statistics on reducing the phenomenon of digital division but – first and foremost – to build a civil society sensitive to the needs of ageing Poland.

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Reports

Sprawozdanie z I Ogólnopolskiej Konferencji Naukowej z cyklu *Sens i bezsens starości* pt. „Niepełnosprawność i starość w wymiarze poznawania, przeżywania i percepcji społecznej", 14–16 maja 2015 roku, Supraśl koło Białegostoku

W dniach 14–16 maja 2015 roku w Supraślu odbyła się Ogólnopolska Konferencja Naukowa inaugurująca cykl spotkań naukowych poruszających temat sensu i bezsensu starości. Pierwsza konferencja z tego cyklu poświęcona została niepełnosprawności i starości w wymiarze poznawania, przeżywania i percepcji społecznej.

Organizatorzy, Zakład Socjologii Edukacji i Gerontologii Społecznej wraz z Zakładem Andragogiki i Gerontologii Edukacyjnej, we współpracy z Samodzielną Pracownią Pedagogiki Specjalnej Uniwersytetu w Białymstoku i Podlaskim Oddziałem Polskiego Towarzystwa Gerontologicznego, zaprosili do udziału znanych i cenionych pracowników naukowych z różnych ośrodków akademickich w całym kraju, praktyków i przedstawicieli środowiska studenckiego. Gościem honorowym był Honorowy Prezes Polskiego Towarzystwa Gerontologicznego – prof. dr hab. n. med. Wojciech Pędich.

Konferencja miała charakter interdyscyplinarny, temat starości i niepełnosprawności analizowany był w kontekście gerontologicznym, medycznym, psychologicznym, pedagogicznym, socjologicznym, filozoficznym, etycznym, ekonomicznym i prawnym. Zorganizowano sesje plenarne, obrady w sekcjach, sesje plakatowe.

Bezpośrednią inspiracją do rozpoczęcia cyklu konferencji była postać profesora Brunona Synaka, wybitnego socjologa i gerontologa, który zmagał się z ciężką, śmiertelną chorobą. Brunon Synak w swojej ostatniej książce opisywał odnajdywanie i rozumienie sensu w sytuacji bezsensu, w kontekście nieodwracalnej choroby, której osobiście doświadczał. Jedna z sesji dedykowana była pamięci Profesora.

Przewodni temat konferencji, starość i niepełnosprawność, analizowany był w wymiarze społecznym i indywidualnym. Omawiając społeczną percepcję starości i niepełnosprawności, zwracano uwagę na rolę edukacji ludzi młodych i starych, kształcenie odpowiednich postaw wobec starości i starzenia się, na sposób prezentowania starości w mediach, które również odpowiedzialne są za kreowanie wizerunku osób starych w społecznej percepcji. Rozmawiano o poprawie jakości życia ludzi starych i niepełnosprawnych poprzez poprawę warunków zamieszkania, poprzez inkluzję społeczną, stymulowanie do aktywizowania się w różnych obszarach życia codziennego. Analizowano opiekę, rehabilitację i wsparcie osób starych i/lub niepełnosprawnych ze strony instytucji publicznych, społeczności lokalnych. Przedstawiciele środowiska studenckiego opowiadali o roli uniwersytetu we wspieraniu studentów z niepełnosprawnością. Omawiano sposoby reedukacji osób niepełnosprawnych, przystosowania na nowo do życia zawodowego, społecznego, rodzinnego. Podkreślano, że starość nie musi oznaczać niepełnosprawności, a starość lub niepełnosprawność nie musi prowadzić do wykluczenia społecznego. Zadaniem państwa oraz społeczeństwa jest zapewnienie godnego miejsca ludziom starym i niepełnosprawnym w społeczeństwie.

Starość omawiana była również z perspektywy medycznej. Mówiono o potrzebie kształcenia lekarzy geriatrów, o zwiększonym zapotrzebowaniu na usługi medyczne, o relacji pacjent – lekarz, pacjent – pielęgniarka, o wprowadzeniu ubezpieczeń pielęgnacyjnych. Analizowano zdrowotne aspekty starości szczególnie w kontekście zespołów otępiennych, depresji, omawiano narzędzia wykorzystywane do oceny samodzielnego funkcjonowania, sprawności fizycznej, kondycji psychicznej osób starych i/lub niepełnosprawnych.

Wiele wystąpień na konferencji poświęconych było tematowi rodziny konfrontującej się ze starością i niepełnosprawnością swoich bliskich, rozmawiano o jakości życia rodziny, w której sprawowana jest opieka nad starym, chorym członkiem, o poziomie zadowolenia lub frustracji w związku ze sprawowaniem opieki, o roli, jaką pełni człowiek stary w rodzinie. W sesji dotyczącej starości i niepełnosprawności w wymiarze przeżywania dyskutowano o sensie życia w perspektywie śmierci, o percepcji psychicznej, fizycznej, społecznej, duchowej osób u kresu życia, o postawach wobec własnej starości. Równie ciekawym zagadnieniem był wątek przeżywania starości i starzenia się przez osoby z niepełnosprawnością intelektualną, ich sposoby realizowania się na tym etapie życia.

Liczba uczestników, wysoka jakość merytoryczna wystąpień, niezwykle bogaty, podzielony na obszary tematyczne program, inspirujące, twórcze rozmowy i spotkania z przedstawicielami różnych, nie tylko naukowych środowisk, propozycje dalszych działań w zakresie poprawy jakości życia ludzi starych i niepełnosprawnych – wszystko to pozwala wysoko ocenić naukową i społeczną wartość I Ogólnopolskiej Konferencji Naukowej z cyklu *Sens i bezsens starości.*

Agnieszka Salon
Niepubliczny Zakład Opieki Zdrowotnej "Pasternik" w Krakowie

Sprawozdanie z Konferencji Naukowej z cyklu *Świat przyjazny starości* Jubileusz XX–lecia Szczecińskiego Oddziału Polskiego Towarzystwa Gerontologicznego Szczecin 2015

W dniach 8–9 października 2015 r. na Wydziale Humanistycznym Uniwersytetu Szczecińskiego odbyła się konferencja naukowa zorganizowana przez przewodniczącą Oddziału Szczecińskiego Polskiego Towarzystwa Gerontologicznego dr Beatę Bugajską oraz Wydział Humanistyczny Uniwersytetu Szczecińskiego reprezentowany przez prof. dr hab. Barbarę Kromolicką. Na dwudniowe spotkanie przybyło około 100 osób zajmujących się tematyką związaną z gerontologią społeczną. Konferencja jest wydarzeniem cyklicznym. Hasło przewodnie tegorocznych obrad (VI edycja) brzmiało: „Senior w rodzinie i dla rodziny".

W pierwszym dniu konferencji dr Beata Bugajska powitała wszystkich uczestników. Następnie z perspektywy historii i współczesności omówiła działalność Szczecińskiego Oddziału Polskiego Towarzystwa Gerontologicznego. W pierwszej sesji plenarnej zaprezentowane zostały trzy referaty. W problematykę konferencji wprowadziła prof. dr hab. Barbara Kromolicka, dziekan Wydziału Humanistycznego Uniwersytetu Szczecińskiego. Kolejny referat zaprezentowała prof. dr hab. Katarzyna Wieczorkowska-Tobis, przewodnicząca Zarządu Głównego Polskiego Towarzystwa Gerontologicznego. W swoim wystąpieniu zwróciła uwagę na nowoczesne technologie, jako formy wsparcia dla osób starszych i ich opiekunów. W ostatnim wystąpieniu tej części obrad planarnych prof. dr hab. Piotr Błędowski, vice przewodniczący Zarządu Głównego PTG poruszył problem miejsca człowieka starszego w rodzinie z perspektywy polityki społecznej.

Pierwszy dzień obrad zakończył się spotkaniem towarzyskim, podczas którego częstowano bardzo okazałym i smacznym tortem z okazji XX–lecia Szczecińskiego Oddziału Polskiego Towarzystwa Gerontologicznego. Wieczorem uczestnicy konferencji wzięli udział w spektaklu teatralnym.

Drugi dzień spotkania naukowego uświetniło przybycie Marszałka Województwa Szczecińskiego Olgierda Geblewicza, który pogratulował dr Beacie Bugajskiej zdobycia tytułu „Szczecinianki Roku 2014". Obrady plenarne moderowane przez dr Beatę Bugajską rozpoczęło wystąpienie dr. hab. Piotra Szukalskiego dotyczące rodzin światowych oraz relacji rodzinnych seniorów. Kolejny referat podejmujący problematykę międzygeneracyjnego przekazu wartości w rodzinie wygłosiła dr hab. Zofia Szarota, prof. Uniwersytetu Pedagogicznego w Krakowie. Problem przemocy wobec kobiet z perspektywy gerontologicznej zaprezentowała dr hab. Małgorzata Halicka, prof. Uniwersytetu w Białymstoku. Ostatni referat w drugiej sesji plenarnej dotyczący wzajemnej zależności jako postulowanego obrazu starości przedstawił dr hab. Jerzy Halicki, prof. Uniwersytetu w Białymstoku. Obrady plenarne zakończył panel dyskusyjny, w którym omawiano sytuację człowieka starszego w rodzinie z perspektywy problemów, wyzwań oraz dobrych

praktyk. Równolegle do obrad sesji plenarnej toczyły się targi promujące dobre praktyki w obszarze działań na rzecz rodziny i aktywizacji społecznej osób starszych.

W sesji popołudniowej odbywały się obrady w 7 równoległych sekcjach tematycznych oraz I spotkanie Zachodniopomorskiej Rady ds. Seniorów. W pierwszej sekcji moderowanej przez dr hab. Urszulę Kozłowską oraz dr inż. Zuzannę Goluch-Koniuszy zaprezentowanych zostało 8 wystąpień dotyczących problematyki człowieka starszego w rodzinie z perspektywy nauk o zdrowiu. Wystąpienia dotyczyły następujących aspektów: lekarz geriatra wsparciem dla pacjenta i jego rodziny (lek. med. Urszula Majewska), wydolności opiekuńczo-pielęgnacyjnej rodziny (dr Magdalena Kamińska), edukacji zdrowotnej i promocji zdrowia osób starszych (dr Lidia Marek), oceny wpływu czynników żywieniowych na problem zaburzeń snu u kobiet po 60. roku życia (dr inż. Zuzanna Goluch-Koniuszy), wpływu interwencji żywieniowej na stan zdrowia i skład ciała osób psychicznie chorych po 60. roku życia (mgr inż. Joanna Fugiel), medycyna naturalna (mgr Małgorzata Szczepanik), oceny spożycia suplementów diety przez słuchaczki Uniwersytetu Trzeciego Wieku (dr hab. inż. Joanna Sadowska, mgr inż. Magda Bruszkowska), wybranych chorób okresu przekwitania u kobiet (dr hab. Marek Bulsa, prof. US).

Kolejna sekcja, moderowana przez dr Beatę Bugajska i dr Martę Giezek składająca się z 9 referatów podejmowała problematykę sytuacji człowieka starszego w rodzinie z perspektywy pracy socjalnej i pomocy społecznej. Sesję rozpoczęło wystąpienie dr Marty Giezek na temat systemu wsparcia osób starszych w świetle strategii rozwiązywania problemów społecznych w gminie mieście Szczecin w latach 2015-2020. Prezentowane w tej sekcji tematy dotyczyły: klubów seniora jako formy aktywizacji seniorów (mgr Paulina Zabielska), klubów aktywności społecznej jako formy aktywizacji społecznej seniorów (Kamil Pawłaczyk), zadań pracowników socjalnych w zapewnieniu opieki seniorom z zaburzeniami psychicznymi (mgr Barbara Masna), uzależnień osób starszych (mgr Jacek Mariusz Ciechowicz), seniora w obszarze oddziaływań profilaktyki uniwersalnej (dr Aleksandra Sander), wsparcia społecznego seniorów w sytuacjach trudnych (dr Edyta Sielicka), kosztów opieki długoterminowej nad niesamodzielna osoba starszą (mgr Rafał Iwański), ubezpieczenia pielęgnacyjnego jako elementu systemu wsparcia rodziny w opiece nad osobą starszą (dr Beata Bugajska).

W sekcji trzeciej zaprezentowanych zostało 10 referatów omawiających perspektywę ekonomiczno-prawną człowieka starszego w rodzinie. Sekcji przewodniczyła prof. dr hab. Ewa Frąckiewicz oraz dr hab. Iwona Bąk. Szczegółowe tematy podjęte w jej ramach dotyczyły: sytuacji życia osób starszych w Polsce i na świecie (dr hab. Iwona Bąk), wykluczenia prawnego osób starszych (prof. dr hab. Kinga Flaga-Gieruszyńska), sytuacji człowieka starszego na rynku pracy (dr Renata Nowak-Lewandowska), zagrożeń ze strony systemu bankowego względem osób starszych (dr Dawid Dawidowicz), mieszkań dla seniorów (dr Monika Śpiewak-Szyjka), otoczenia przyjaznego osobom starszym (dr Artur Kotwas), zarządzania finansowego w gospodarstwie domowym seniora (dr Agnieszka Preś-Perepeczko), konsekwencji starzenia się ludności dla polskiego systemu emerytal-

nego (dr Piotr Obidziński), wpływu starzenia się ludności na rozwój gospodarczy (dr hab. Ewa Frąckiewicz, prof. US).

W sekcji czwartej dotyczącej człowieka starszego w rodzinie z perspektywy pedagogicznej moderowanej przez dr Katarzynę Serdeyńską i dr Annę Szafranek prelegenci wygłosili 10 referatów dotyczących: międzypokoleniowych doświadczeń edukacyjnych w środowisku rodzinnym (dr Agnieszka Domagała-Kręcioch), prezentacji programu Szkoła dla Babć i Dziadków (dr Marta Komorowska-Pudło), pedagogiki mądrości życiowej w obliczu starzenia się społeczeństwa (dr Julita Orzelska), roli dziadków w życiu wnucząt (dr Grażyna Kowalczyk), przekazu międzypokoleniowego w aspekcie budowania więzi (dr Edyta Kopaczewska), uczenia się w działaniach międzypokoleniowych (dr Bożena Grzeszkiewicz), miejsca człowieka starszego w rodzinie (dr Urszula Kazubowska), przemocy wobec osób starszych (dr Paweł Popek), wpływu stanu zdrowia na doświadczanie przemocy w związku małżeńskim osób w starszym wieku (dr Anna Szafranek), potrzeby edukacji do starości (dr Katarzyna Seredyńska).

Sekcji czwartej zatytułowanej: człowiek starszy w rodzinie – perspektywa psychologiczna przewodniczyli: prof. dr hab. Zbigniew Kroplewski oraz dr Celina Timoszyk-Tomczak. W tej sekcji zaprezentowano 7 wystąpień, które dotyczyły następującej problematyki: terror aktywności, czy rozwój duchowości (dr Artur Fabiś), miejsce rodziny w życiu osób w wieku 75 plus – teraźniejszość i przyszłość (dr Małgorzata H. Herudzińska), rodzina w hierarchii celów i wartości osób starszych (dr Celina Timoszyk-Tomczak), religijność seniora jako zasób rodziny (mgr Maria Ligocka), małżeństwo osób starszych – potencjał czy stagnacja (mgr Roman Szałachowski), starość w kontekście rodzicielstwa osób niepełnosprawnych intelektualnie (dr Elżbieta Pieńskowska) oraz style adaptacji do starości w kontekście relacji rodzinnych (dr Adam Kucharski).

Sesja szósta koordynowana przez dr hab. Agnieszkę Szudarek, prof. UŚ i dr Ilonę Kość oscylowała wokół miejsca człowieka starszego w rodzinie z perspektywy antropologiczno-historycznej. Dziewięciu prelegentów wygłosiło referaty dotyczące następujących problemów: człowieka sędziwego w społeczeństwie średniowiecznym (dr Rafał Simiński), starości w opiniach polskiego kronikarstwa średniowiecznego (dr Anna Michałek-Simińska), starości samotnych kobiet w pomorskich rodzinach szlacheckich w XIX wieku (dr hab. Agnieszka Szudarek, prof. US), strachu przed starością w Niemczech w pierwszej połowie XX wieku (dr hab. Dariusz Chojecki), seniora w rodzinie i dla rodziny w przekazie propagandowym okresu stalinowskiego w Polsce dr hab. Joanna Król), seniorów w działalności polskiego ruchu spółdzielczego w okresie międzywojennym (dr hab. Elżbieta Magiera, prof. US), szkół życia według Jana Amosa Komeńskiego (dr Ilona Kość), starości w społeczeństwie Indian Matsigenka z peruwiańskiej Amazonii (dr Kacper Świerk), pozycji seniorów w rodzinie kurdyjskiej (dr Fuad Jomma).

Ostatnia sekcja tematyczna, składająca się z siedmiu wystąpień, była sekcją kół naukowych i podejmowała problematykę człowieka starszego w rodzinie. Rolę przewodniczącego pełniły: Weronika Kondziołka (Przewodnicząca Koła Naukowego Gerontologii

Społecznej) oraz lic. Joanna Krzemińska (Przewodnicząca Koła Naukowego Wlontariatu). Podczas sekcji poruszono tematy: doświadczania przemocy przez osoby starsze (lic. Ariel Dołęgowski), nauczania kościoła katolickiego na temat ludzi starych (mgr Janusz Ruciński), ról z rodzinie pełnionych prze osoby starsze (lic. Paulina Gajewska, mgr Marianna Marszał), seniora w rodzinie jako opiekuna spolegliwego, bądź rezydenta dokuczliwego (lib. Weronika Kondziołka), aktywności życiowej osób starszych (mgr Katarzyna Nosek, mgr Janusz Ruciński), oceny jakości życia seniorów (mgr Katarzyna Nosek), medialnego obrazu starości (lic. Karolina Biernacka).

Na zakończenie konferencji moderatorzy podsumowali wystąpienia z sesji plenarnych i poszczególnych sekcji i podziękowali zebranym za aktywne uczestnictwo w konferencji, a także zaprosili do udziału w kolejnych przedsięwzięciach organizowanych przez Szczeciński Oddział Polskiego Towarzystwa Gerontologicznego oraz Uniwersytet Szczeciński.

dr Anna Szafranek
Uniwersytet w Białymstoku

Reviews

Recenzja książki „Starość i jej oblicza. Wybrane psychologiczne aspekty funkcjonowania osób starszych", Justyna Kurtyka-Chałas, Towarzystwo Wydawnictw Naukowych Libropolis, Lublin 2014, ss. 130.

Książka autorstwa Justyny Kurtyki-Chałas pt. „Starość i jej oblicza. Wybrane aspekty funkcjonowania osób starszych" została wydana w roku 2014 przez Towarzystwo Wydawnictw Naukowych Libropolis w Lublinie. Stanowi ona owoc przeprowadzonych badań empirycznych w ramach projektu zatytułowanego „Psychospołeczne aspekty funkcjonowania osób starszych".

Rozwój jednostki w okresie późnej dorosłości przebiega indywidualnie. Jak podkreśla Autorka: „Jakość i sposób przeżywania starości zależy nie tylko od posiadanych cech osobowości, umiejętności, kompetencji, ale również od bilansu i oceny własnego życia, a także obszaru wsparcia społecznego i posiadanych relacji interpersonalnych. Nie bez znaczenia pozostaje również obszar umiejętności radzenia sobie, z coraz liczniejszymi w tym wieku, stratami personalnymi". W związku z tym Justyna Kurtyka-Chałas wytyczyła następujący cel swojej pracy – odpowiedzieć na pytanie, w jaki sposób osobowość, postawy i satysfakcja życiowa mogą wyjaśnić funkcjonowanie seniorów oraz jakie różnice występują pomiędzy podopiecznymi domów pomocy społecznej a osobami mieszkającymi w swoich domach rodzinnych?

Pierwsza część książki to analiza literatury przedmiotu, która dotyczy funkcjonowania starszych ludzi. Zawiera opis fazy życia człowieka, jaką jest starość, charakteryzuje wybrane problemy dotyczące aktywności seniorów oraz ich życia w środowisku rodzinnym. Zwięźle syntetyzuje także teorie adaptacji do starości i wybrane aspekty doświadczania satysfakcji życiowej przez ludzi starych. Bibliografia wykorzystana do kwerendy

jest dość zróżnicowana, zawiera zarówno wydawnictwa zwarte, jak i artykuły w czasopismach. W niewielkim stopniu zostały uwzględnione również źródła internetowe.

Kolejny rozdział stanowi opis metodologii badawczej, który obejmuje założenia i cel badania, problemy i hipotezy badawcze, zmienne, techniki, dobór grupy oraz przebieg badań. Wartościowy jest wybór Badaczki wykorzystanych narzędzi badawczych. Zastosowała Ona Listę Przymiotnikową ACL, Kwestionariusz Postaw Życiowych KPŻ, a także Skalę Satysfakcji z Życia SWLS, dzięki czemu uzyskała odpowiedzi na interesująco sformułowane pytania badawcze. Podkreślenia wymaga również stosunkowo duża grupa badanych seniorów, która liczyła 304 osoby.

Następne rozdziały książki stanowią analizę i interpretację wyników badań własnych. Jest to najbardziej rozbudowana część opracowania. Rozdziały składające się na część empiryczną przedstawiają sylwetkę psychologiczną badanych osób starszych wraz z ich socjodemograficzną charakterystyką, różnice i podobieństwa pomiędzy kobietami a mężczyznami w określonych obszarach rozwojowych, jak również modele powiązań między wybranymi strukturami psychologicznymi. Uzyskane rezultaty potwierdziły zasadność doszukiwania się związków między satysfakcją i postawami życiowymi a osobowością jednostki.

Wyniki badań dla przejrzystej prezentacji Badaczka umieściła w licznych tabelach i na wykresach. Pewnym mankamentem wydaje się być trudne odczytywanie z nich danych dla osób niebędących psychologami. Czytelnik może czuć także niedosyt dotyczący przytaczania wypowiedzi badanych, ponieważ pojawiło się ich mało. Co prawda uzasadnić to można tym, iż badania miały charakter ilościowy, jednak poznawanie takich obszarów, jak satysfakcja życiowa rodzi potrzebę odkrycia świata przeżywanego jednostki, odzwierciedlanego w wypowiedzianych przez nią słowach.

Ostatni rozdział – dyskusja wyników oraz zwięzłe zakończenie dopełniają całości recenzowanego opracowania. W zamykającej książkę dyskusji Badaczka w sposób czytelny przywołuje hipotezy wraz z opisem ich weryfikacji. Odpowiedzi na postawione pytania badawcze przyniosły ciekawe wyniki, które wydają się zaskakujące w niektórych kwestiach.

Uzyskane wyniki można przenosić na szerszą populację. Przeprowadzone badania mogą stanowić inspirację dla innych badaczy do przeprowadzenia ich w większym zakresie.

Książka ta jest udanym i wartościowym opracowaniem. Autorka, która jest doktorem psychologii wykorzystuje swoją wiedzę, doświadczenie i zainteresowania do przekazania szerokiemu gronu odbiorców cenne informacje na temat ważny dla społeczeństwa. Warto również dodać, że pod względem edytorskim tekst nie budzi raczej zastrzeżeń.

Niewątpliwie zaletą tej książki jest jej przydatność dla szerokiej grupy odbiorców. Zainteresować może zarówno teoretyków, zajmujących się gerontologią i psychologią rozwojową, jak również praktyków – pedagogów, psychologów, terapeutów oraz pracowników socjalnych. Przystępny język oraz syntetyczność opisu czyni ją także potencjalnie

interesującą dla studentów kierunków społecznych, a także samych seniorów. Dla tych ostatnich największą wartość może stanowić charakterystyka ich własnej osobowości, zachowań wraz z interpretacją psychologiczną.

Pomimo dużej liczby publikacji gerontologicznych w ostatnim czasie, eksplorowanie tematyki starości i starzenia się jest w pełni uzasadnione. Za faktem tym przemawia intensywne starzenie się społeczeństwa, coraz liczniejsza populacja seniorów. Ich życie, problemy, funkcjonowanie są bardzo interesującymi obszarami do eksploracji. Szczególnie, że każdego człowieka problem ten dotyczy lub będzie dotyczył, pośrednio lub bezpośrednio. Ponadto wydaje się, że brakuje badań empirycznych, porównujących funkcjonowanie seniorów żyjących w środowisku rodzinnym i instytucjonalnym, czego dokonała właśnie Autorka.

Katarzyna Sygulska
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**Recenzja książki „Rzeczywistość seniora”,
red. nauk. Mieczysław Dudek, Jan Krukowski, Krystyna Teresa Panas,
Wydawnictwo Wyższej Szkoły Menedżerskiej w Warszawie
im. prof. Leszka J. Krzyżanowskiego, Warszawa 2014, ss. 434.**

Współczesna sytuacja demograficzna na starym kontynencie wymaga refleksji nad dalszymi kierunkami rozwoju w kluczowych dziedzinach funkcjonowania społecznego. Dynamiczny przyrost populacji seniorów obliguje do podejmowania różnorodnych działań, zmierzających do zapewnienia tej grupie wiekowej jak najbardziej optymalnych warunków życia i należnego jej szacunku. Aby te działania przyniosły zamierzone rezultaty, muszą się opierać na rzetelnej diagnozie sytuacji najstarszego pokolenia. W ten nurt wpisuje się publikacja *Rzeczywistość seniora* zredagowana przez Mieczysława Dudka, Jana Krukowskiego oraz Krystynę Teresę Panas. Refleksje rozpoczęto od jednego z najistotniejszych pytań, jakie stawia antropologia, a mianowicie, kim jest senior? Szybko okazało się, że zdefiniowanie terminu senior nie jest łatwe, gdyż posiada ono szeroki *definiens*. Podjęto więc próbę holistycznego ujęcia egzystencji seniora, tak w aspekcie indywidualnym jak i społecznym. Autorzy poszczególnych rozdziałów swoje rozważania ogniskują wokół kluczowych zagadnień, problemów, przed jakimi stają starzejące się społeczeństwa: praw gwarantowanych przez politykę społeczną (I), psychologicznego portretu człowieka starzejącego się (II, III), geragogiki (IV, V), edukacji w późnej dorosłości oraz aktywności w „trzecim wieku” (VI, VII). Osią dla rozważań uczyniono procesy ekskluzji i inkluzji osób starszych.

Pierwsza część wprowadza czytelnika w najważniejsze cele, kierunki i priorytety polityki (pro)senioralnej. Można w niej odnaleźć informacje na temat podejmowanych inicjatyw na rzecz zapewnienia seniorom jak najlepszych warunków funkcjonowania w obszarach: zatrudnienia, udziału w życiu społecznym oraz zachowaniu jak najdłużej niezależności/samodzielności. Opis prawnych uregulowań o zasięgu centralnym zostały uzupełniony przykładami inkluzyjnych inicjatyw na niższych szczeblach administracyjnych. Analizie poddano najważniejsze dokumenty i przepisy obowiązujące w Polsce/Małopolsce, Unii Europejskiej, w Wielkiej Brytanii i Stanach Zjednoczonych, co daje szeroką perspektywę.

Kolejna grupa artykułów przybliża czytelnikowi procesy indywidualnych zmagań człowieka z nieubłagalnym upływem czasu, mierzenia się z zadaniami rozwojowymi charakterystycznymi dla „jesieni życia” oraz wglądu we własne wnętrze. Starość rozpatrywana jest w kontekście powołania, które może zostać w pełni zrealizowane w przypadku zaakceptowania związanych z nią ograniczeń, ale i wyzwań. Autorzy koncentrują się wokół kwestii: osobowości, tożsamości, postaw wobec życia oraz duchowości. Stawiają ponadczasowe pytania, jak w obliczu zachodzących zmian związanych ze starzeniem się organizmu, zachować „spokój ducha” i godność osobowościową. Rozdział ten zawiera wiele subtelnych wątków dydaktycznych związanych z edukacją do starości.

Jednym ze źródeł godności człowieka jest aktywność skierowana ku innym ludziom. Kryterium to zostało rozwinięte w kolejnej części, opatrzonej prowokującym tytułem „Starość to zły nabytek" (*Aetas mala merx est)*. Zawiera ona rozdziały poświęcone rodzajom i formom aktywności podejmowanym przez amerykańskich i polskich seniorów. Szczególnie dużo miejsca poświecono roli osób starszych w budowaniu wspólnoty międzypokoleniowej oraz ich udziałowi w życiu rodzinnym, zwłaszcza w sytuacji migracji zarobkowej rodziców. Oryginalne i interesujące wątki porusza tekst traktujący o seniorach w warunkach pozbawienia wolności.

Czwarta część książki, najbardziej rozbudowana, poświęcona została różnym aspektom wychowania do starości, w starości i poprzez starość. Zdaniem Autorów, poruszających tę tematykę, proces wychowawczy powinien zaczynać się jak najwcześniej i obejmować różne grupy społeczne i zawodowe. Tylko szeroko zakrojone działania dydaktyczne, odwołujące się do systemów etycznych, mają szansę zminimalizować zjawisko ekskluzji osób starszych. Zebrane w tej części rozdziały koncentrują się wokół procesów wychowania i samowychowania do późnej dorosłości oraz kształtowania prawidłowych postaw społecznych wobec seniorów. Prezentacja teoretycznych ujęć uzupełniona została doniesieniami z badań empirycznych, dotyczących postrzegania starości i ludzi starych przez pracowników socjalnych, uczniów w wieku wczesnoszkolnym oraz pracowników banków.

Kolejna część recenzowanej pozycji dotyczy wybranych wyzwań, przed jakimi staje współczesne społeczeństwo: problemów socjalno-finansowych dotykających seniorów oraz wzrostu negatywnych postaw wobec nich, nierzadko prowadzących do różnego rodzaju przejawów wykorzystywania i przemocy. Czytelnik ma okazję zapoznać się z polską i czeską perspektywą. Jedną z dróg prowadzących do rozwiązania tych problemów i podniesienia jakości życia seniorów jest kształcenie ustawiczne, które może być realizowane w różnych formach. W książce najsilniejszy akcent położono na prezentację działań podejmowanych w ramach Uniwersytetów Trzeciego Wieku oraz studiów MBA. Polskie doświadczenia zostały uzupełnione opisem dobrych praktyk realizowanych u naszych południowych sąsiadów. Jednym z istotnych elementów podnoszenia jakości ofert edukacyjnych i tym samym satysfakcji seniorów jest ciągłe monitorowanie i analizowanie informacji zwrotnej od słuchaczy UTW i uczestników różnego rodzaju projektów, w tym wolontariatu.

Książkę zamyka tekst poświecony formom przeżywania „drugiego życia" czy „drugiej młodości". Znalazły się z nim zestawienia danych statystycznych dotyczących aktywności zawodowej seniorów w różnych krajach europejskich, przeciętnego wieku przejścia na emeryturę oraz preferowanych stylów spędzania czasu wolnego. Prezentowane scenariusze są wypadkową uwarunkowań życiowych oraz indywidualnych preferencji seniorów.

Zawarte w prezentowanej publikacji teksty mają wartość uniwersalną i są skierowane do bardzo szerokiego grona odbiorców. Mogą nimi być sami seniorzy, którzy zweryfi-

kują, na ile opisywana rzeczywistość przystaje do realiów, które są ich udziałem. Ponadto mogą oni uzyskać cenne informacje na temat praw i przywilejów, które gwarantują im różnego rodzaju dokumenty prawne oraz poszerzyć wiedzę na temat kierowanych do nich ofert edukacyjnych. Z treścią książki powinni zapoznać się młodzi ludzie, którzy przygotowują się do pracy z osobami starszymi, tak w instytucjach o charakterze opiekuńczym, jak i edukacyjnym. Dzięki lekturze uzyskają wiedzę na temat specyfiki procesu starzenia się i zmian osobowościowych, jakie mogą mu towarzyszyć. Pomoże im ona zrozumieć motywy działania seniorów i przewidzieć niektóre ich reakcje. Z pewnością przyczyni się do budowania wspólnoty międzypokoleniowej, której potrzeba była akcentowana wielokrotnie na kartach polecanej książki. W końcu, do publikacja powinien zajrzeć każdy, bowiem poświęcona jest ona kwestiom, które, w krótszej lub dłuższej perspektywie czasowej, będą nas dotyczyć. Jestem przekonana, że będzie ona stanowić inspirację do różnorakich przemyśleń, bowiem, jak napisała jedna z Autorek „w starości, jak w soczewce, skupiają się przeżycia, doświadczenia, czyny i ich rezultaty, doświadczenie siebie i mądrość" (Chałas 2014, s. 101).

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