Social Care Services for the Elderly in Greece: Shifting the Boundaries?

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Abstract

Social care services in Greece represent one of the oldest but also one of the most neglected areas of the Greek social protection system. Their development is closely connected with the marginal role of social assistance within the framework of the Greek social security system. During the past decades, a number of socioeconomic developments, more or less common across Europe, have addressed significant challenges to the institutional and familial arrangements related to the provision of social care to the elderly. These developments have important implications for the so called “mixed economy of social care” that characterise the whole system of social care provision. In this context, the aim of the paper is to unfold the provision of social care to the elderly and to discuss some preliminary theoretical considerations about the organisation of social care services for the elderly in Greece. It is argued that the provision of elderly care in Greece is on the edge of a transition and that recent developments could reshape its boundaries by altering the scope of the welfare mix components that form the system of elderly care provision.

Keywords: social care services, mixed economy of social care, elderly, Greece
1. Introduction

Social care services in Greece represent one of the oldest but also one of the most neglected areas of the Greek social protection system. Social care usually refers to the provision of support via personal social services and informal care. In the case of Greece personal social services did not develop on the basis of a rational planning taking into account the complex needs of their potential users. Their development is closely connected with the marginal role of social assistance within the framework of the Greek social security system. Thus the creation of a unified network of personal social services offering provision in line with the principle of universalism has not rendered possible. In this context, elderly care lies at the interface of personal social services and informal family care. Social care services for the elderly crucially affect the quality of life of a large part of the population. They have far-reaching implications not only for the older people in need for care but also for a growing proportion of the population that provides informal care to older family members.

This paper attempts to unfold the provision of social care to the elderly and to discuss some preliminary theoretical considerations about the organisation of social care services for the elderly in Greece. To be that accomplished the following section focuses on the conceptual framework aiming at clarifying misunderstandings, and even conflicts, of the terms usually used in social care literature. In section three attention is directed to the provision of elderly care services in Greece. The role of the different components that form the system of social care services is explored. Discussion follows the community/institutional care divide. Section four concludes arguing that social care services for the elderly in Greece are on the edge of a transition and that emerging trends may shift their boundaries.

2. The Conceptual Framework: Personal Social Services, Social Care, Mixed Economy of Social Care

We should stress right from the outset that it is extremely difficult to provide a definition of “personal social services” or “social care services” which is generally accepted among different countries and accurately reflects the range of different services, their responsibilities and organisational structure. Terms as such, on the one hand, have been used interchangeably as synonymous and, on the other, might have fairly different meaning from one country to another. Thus it is important to clarify the notion of the key terms that shape the conceptual framework of this paper.

2.1. Personal Social Services

A review of the existing literature depicts the ambiguities in the definition of personal social services. The various definitions are not ideologically neutral, but reflect different perceptions of the role that personal social services are supposed to play in a given society. The discussion is turned mainly, but not exhausted, around the universality or selectivity of services. Another frequently arising issue refers to the degree to which personal social services are discrete from or part of related services.
provided within health, employment and social protection services. Again there are contradictory views as to which definition should be adopted.

The key word for the understanding of the term is not other than the word “personal”. This does not imply simply a meeting between users and agencies. It is used to denote a communication with each other; the agency seeks to understand and interpret the needs of the user and is prepared to use her/his personal judgement for the service provision (Marshall, 1975). In this framework, the term refers to the provision of individualised care\(^1\), related to user’s specific needs and circumstances, that is based on a close relationship between user’s and agencies of social services. This definition, however, does not necessarily distinguish the personal social services from “the welfare services” in general.\(^2\)

It has been argued (Amitsis, 2001) that personal social services represent the “hard core” of the social protection systems since they usually deal with a number of complex needs that cannot be met merely through the provision of cash benefits or benefits in kind. In the Greek literature personal social services have been described with the term “social assistance in the limited sense” (Stathopoulos, 1996) or “social services in the narrow sense” (Amitsis, 2001). They referred to the provision of support to the most disadvantaged or vulnerable who were also in economic hardship; mirroring the marginalisation of social assistance within the Greek social security system. Often other terms such as “social services” or “social welfare services” have been used interchangeably as having more or less the same connotation with personal social services.

Personal social services provide social care and protection mainly to families and children, young persons (in trouble), older people, people with disabilities, people with mental health problems and to other vulnerable groups of the population that are at the risk of social exclusion. The provision of support, however, represents only a part of their activities. Their responsibilities, as Baldock (2003:370) points out, often appear to be “a ragbag of disparate social rescue activities left over from the other parts of the welfare system”. This confirms the difficulty in their recording and classification. Munday (2003) in an attempt to review the European personal services for a report drafted for the Council of Europe, summarised their responsibilities under the following activities: provision of care and support, protection, regulation, community development and care organisation, social control, social integration.

In the British literature “the personal social services” usually refer to the work of local authorities social services departments and to the work of the independent sector (voluntary and private) agencies. In this framework they are closely connected with the provision of social care to specified user groups. This is reflected in both older and more recent textbooks of social policy.\(^3\)

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1. Contrary to standardised services.
2. In the U.K., as Marshall (1975) discusses, the term “personal social services” replaced the term “welfare services” in 1968 when the then Labour government set up a Committee under Frederic Seebohm “to review the organisation and responsibilities of the local authority personal social services”. The “personal social services” was used instead of the “welfare services” because the latter term was considered too vague to define services based on their objective and too narrow to denote an administrative area, given the fact that at that time welfare departments did not include work with children.
2.2. Social Care

Defying social care in a way that is commonly acceptable across different countries is also not an easy task. In the European comparative literature social care usually refers to the personal social services and a wide range of informal support and activities provided by families, friends, neighbours, colleagues and volunteers on an unpaid basis (Munday 2003; Munday, 1996a).

Frequently, as Twigg (2003) points out, social care is defined in opposition to medical care. In this sense it refers to the provision of services that do not fall into the remit of medicine. Social workers are at the centre of services, along with other professionals such as social carers and family assistants (or variations on these terms). Distinguishing, however, social care from health care is not always a straightforward process. The boundaries between them are often blurred and disputed. For example, frail elders or persons with disabilities have joined medical and social care needs.

In pursuit of shifting the boundaries between health and social care services a new trend has emerged in the provision of social services: the provision of integrated services. As it is argued in a report prepared for the European Council by Munday (2007), integration should be understood as an umbrella term covering various approaches or methods seeking to attain greater coordination and effectiveness between services to achieve, principally, better outcomes for service users; cost advantages are also possible. In this sense, other practises aiming at the problem of service separation are less complete than integration; rather they can be understood as important tools to reach integration of services.

Social care is also closely connected with the provision of care in the community in the sense of moving away of institutional care, engaging local authorities in the provision of services and empowering local social networks (Stasinopoulou, 1993). As a mean of providing social care, is concerned with the resources available outside formal institutional structures, particularly in the informal relationships (Bulmer, 1993). Community care services can be provided at home (domiciliary care) or at structures such as day centers, etc.

The volume of the provided community care services, the degree of engagement and the responsibilities of local authorities, as well as the role of informal social networks vary considerably depending on the country under question. In the U.K. for example, social care services fall into the responsibility of local authorities. They are provided by the social services departments that operate under their auspices. These local authorities’ social services departments were introduced in the early 1970s and

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4 In addition to the health sector that medical practitioners have a leading role.

5 In fact, pulling together separated social services, such as health and social care services, refers to the horizontal level of integration. Vertical integration in social care has quite a different meaning. At the macro level refers to measures aiming at achieving better coordination among different levels of government – national, regional and local; at the micro level it refers to the better coordination of residential, community and domiciliary services for different user groups (Munday, 2007). For a European comparative study on integrated long term care services for older persons see also Billings and Leichsenring (2005).

6 Such as service coordination, cooperation, partnerships, pooled budgets, care trusts, collaboration, inter-professional or joint working.
represent a wider effort to reorganise the personal social services; an effort which focused upon the amalgamation of services and formed round the idea of generic social work. In Greece, on the contrary, until recently the role of first and second-tier authority governance in the provision of social care was limited; the role of the third sector residual; the effective unification of disparate services was not rendered possible; long-term care services were almost exclusively provided through institutional care; and the role of family in the provision of care was -and still is- extremely important.

In the framework of the Greek social protection system, the term social care was introduced by Law 2646/1998 on the “Development of the National Social Care System”. Social care is defined as the “protection provided to individuals or groups of people via prevention or rehabilitation programs and aims at creating equal opportunities for individuals to participate in the economic and social life and at ensuring a decent standard of living. The support of the family is a fundamental objective of the above mentioned programs”. This definition has two characteristic features and at least one controversy. First, it refers to participation. Participation is widely considered as a central dimension of the social exclusion concept (Burchardt et al., 2002). The social exclusion rhetoric in general terms supports the statement that one can be socially excluded even if not being materially deprived (Hills et al., 2002). In this sense, social care programmes should have focused not only upon those considered poor (because lacking adequate income), but on the entire population. Secondly, it refers to living standards. Ensuring decent living standards, however, reflects selectivity through means testing and targeting to those most in need. In this sense, social care programmes concerns just those lacking adequate income - not the entire population. In practise, the Greek social care system has been characterised by the second feature and has left aside the principal of universalism. Besides that, hardly any steps have been taken in the direction of creating a nation wide unified system combining prevention with prompt intervention (Petmesidou, 2006).

2.3. Mixed Economy of Social Care

Social care services among different countries vary to a large degree in the way they are provided. A mix of sources in the provision is usually the rule, leading to the creation of mixed economies of social care. In the European comparative literature, the development of mixed economies has been characterised as a major trend in social care (Munday, 2007; Munday, 1996b). European countries have developed the mixed economy of social care according to the historical diversity of their welfare systems.

Social care services are provided by public sector organisations, by non-governmental (NGOs) and other voluntary non-profit organisations and by private for-profit organisations. Most social care, nonetheless, is not provided by the official personal

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7 For a detailed analysis and a critical discussion on the work of the Seebohm Committee which introduced the reorganisation of the local authorities social services departments see also Townsend (1975).
8 For an in depth analysis of the role of Non Governmental Organisations (NGOs) in the provision of social care in Greece see Polizoidis (2008).
9 In Greece care in the community often is understood as care provided by the community, referring to the provision of informal care by the family and mostly by women (Stasinopoulou, 1992).
10 Law 2646/1998, article 1, paragraph 1 (FEK 236 A”).
social services. It is provided by informal networks, most profoundly within the family by family members, and it is provided on an unpaid basis. As Evers (1993) has already discussed, acceptance that all the above mentioned four components should have an active role in the provision of services has won and is still gaining ground; the real questions lies on their respective roles, responsibilities and limits as the way we understand anyone of them entails assumptions about the role of the others. In other words, the degree of activation of each sector in the provision of social care represent a key factor for the welfare mix per se and for the organisation and responsibilities of the social care system as a whole.

The growth of mixed economies in social care connotes the broadening of perceptions to take into account the resources of all components of the welfare mix (Ely and Sama, 1996) and the creation of alternatives. The role of the state is shifting from providing services to regulating the participating agencies and the overall system. The adoption of such ideas to a certain extent responds to political discourses about consumerism, users’ choice and empowerment. Although in Greece the latter issues are seldom included in the policy agenda, partly because the relative lack of state provisions has always left the other sectors a prominent role, in other European countries the exercise of choice has been employed. Direct payments, where individuals receive the cash equivalent of services to arrange their own support, represent a tool of such type. Another measure towards this direction is the introduction of the individual budgets in the U.K. As Glendinning and Means (2006) explain, individual budgets bring together for any individual the resources from a number of different services to which they are entitled. The total amount is made transparent to the individual who uses the budget to secure a flexible range of different types of support, from a wider range of providers compared to direct payments or conventional social care services. The use of such methods and tools, apart from the obvious advantages, raise particular serious concerns. Questions of equity and information and effects on the care market, care professionals and informal carers are some of them (Glendinning and Means, 2006; Kremer, 2006).

The creation of mixed economies of social care has major implications for social services integration (Munday, 2007). The provision of integrated social care and health services has already been hard enough to be accomplished. In the case that services are provided by a number of public, private non-profit and private for-profit agencies, integration is much harder to be achieved. Further, and most importantly, as Petmesidou (2006:348) stresses, a major priority to be addressed is “how to develop and balance universal provision with multiple funding and delivery arrangements in a way that enhances equity, accessibility, users’ voice and accountability”.

3. Social Care Services for the Elderly in Greece

In this section we attempt to describe the pattern of connection among the quartet of institutions – namely the family, the state, the third sector and the market - that, on the

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11 Heikkila and Julkunen (2003) point out that far-reaching empowerment strategies, although sometimes are regarded as synonymous to terms “user involvement” or “user participation”, should be distinguished form them. User involvement entails preconditions that the users’ activity has an impact on the service process. User participation means that users are only taken part in some activity.
whole, form the network of social care services for the elderly. After a brief comment on the challenges arising from population ageing, an effort is being made to examine the provision of elderly care services in the community and institutional settings.

3.1. Demographic Ageing and Informal Family Care

Greece is facing a considerable ageing of its population. According to the data of the National Statistical Service of Greece, in 1991 the percentage of the population over 65 years old was near to 14%, while in 2001 this percentage rose to 17% and is expected to reach 24% by 2030. The ageing of the population has been the subject of intense discussions under various viewpoints. From a social policy point of view, it usually raises concern for the viability of social insurance funds and retirement policies and not (or at least not that often) for the provision of social care services. Demographic ageing, however, coupled with the rising participation of women in the formal labour market and changing family arrangements, has major implications for social care services. It increases the demand for services of this kind. Nonetheless, Greece scores extremely low on both residential and community care for the elderly if compared to other European countries (Bettio and Platenga, 2004). It has been estimated that in Greece the number of elderly people in need for care is about 80,000 and that two thirds out of those are cared for by family members (Moussourou and Petroglou, 2005 cited in Stratigaki, 2006).

A number of studies have tried to classify countries according to their welfare regimes. These approaches have received from time to time various criticisms from feminist scholars and others. It is beyond the scope of this paper to examine the range of typologies suggested and their associated limitations. Debates about welfare regimes, however, did not focus explicitly on care strategies. In this framework Bettio and Platenga (2004) argue that a different typology arises if the focus is shifted from welfare models to care regimes. They propose a classification that groups countries into four clusters. Greece has been classified in the first cluster (along with Italy and Spain) that “delegates all the management of care to the family”.

Therefore, it is not surprising that care for the elderly in Greece has been characterised as a “family affair” (Ministry of Health and Welfare, 1999). Public provision still remains limited and the family continues to carry the main caring responsibilities. Women bear a disproportionate burden in caring for all family members as they provide the bulk of informal care within the Greek family. Indicative are the findings of a recent study on family carers of frail elderly persons in Greece (Triantafillou et al., 2006) where women representing 80.9% of family cares.

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12 Esping-Andersen (1990) with his seminal work The Three Worlds of Welfare Capitalism by focusing on the dimensions of de-commodification and stratification identified three distinct “welfare regimes”: Social Democratic, Conservative and Liberal welfare regimes. Later several authors (see for example Ferrera, 1996) argued for a distinct fourth type, which is varyingly typical of Southern Europe.

13 Portugal and Ireland have been characterised as atypical cases between the first and other clusters. The second cluster includes the U.K. and the Netherlands (with borderline cases Belgium and France); Germany and Austria form the third cluster; while the Nordic countries the fourth.

14 Based on ECHP data for the year 1996, Bettio and Plantenga (2004) found that the gender gap in care provision in Greece is particularly high (82.7%). For a discussion on caring as an engendered process in the Greek context see also Stratigaki (2006).
In this context, unpaid family care work along with privately financed services (by the elderly and/or their family) plays a central role in covering needs. During the last fifteen years privately financed services have expanded with the large flows of female migrant workers (often undocumented) who provide cheap and flexible care work within the family.\textsuperscript{15} This trend has partly filled the arising gap between high demand for formal care services and limited supply and has allowed elderly people and their families to meet care needs also for an added reason. It follows rules of reciprocity. Since some times it is considered socially disapproving to put one’s parent or grandparent to an institution, employing a female migrant to perform caring tasks seems to solve this problem as well (Van der Geest et al., 2004). This pattern, however, restrains further the development of formal care services (Enke-Pouloupolou, 1999; Sissouras et al., 2004), raises issues of social equity and long-term viability (Bettio et al., 2006) and leads to labour market segmentation in the elderly care sector (Karamessini and Moukanou, forthcoming).

3.2. Community Care

Until the late 1970s long-term care services for frail elderly people were almost exclusively provided through institutional care. Community care was formally introduced in 1979 via the establishment of the first Open Care Centers for the Elderly (KAPIs); while domiciliary care was introduced only in the late 1990s via the programme “Home Help” and expanded latter under EU funding. The shift to community care services has been justified on the grounds of bringing together older people with the rest of the community, meeting their preferences and improving their quality of life, avoiding the risk of social exclusion, enabling the reconciliation of work and family life for informal cares and reducing costs. Nowadays, community care for the elderly is provided through KAPIs, the programme “Home Help” and through the Day Care Centers for the Elderly (KIFIs). There are 582 KAPIs, 1,100 “Home Help” programmes and 49 KIFIs situated in municipalities throughout the country serving about 146,500, 50,000 and 1,300 users in respect (cited in Karamessini and Moukanou, 2007).\textsuperscript{16}

As mentioned before, the first pilot KAPIs were set up in 1979 by the Ministry of Health and Welfare in the area of the Athens. In 1984 they came under the responsibility of first-tier local authorities and the spread of KAPIs was encouraged. They were originally designed to offer a wide range of services to the elderly: recreation and education, basic medical and nursing care, social support (through social work with individuals, groups, family and the community), physiotherapy and occupational therapy, home help for those who live alone and have no other support (Amira et al., 1986). In cases of best examples KAPIs are staffed by an interdisciplinary team composed of social workers, nurses, health visitors, family assistants, physiotherapists and occupational therapists. In most cases, however, due to budgetary constrains not all of the above mentioned professionals are employed

\textsuperscript{15} As Bettio et al. (2006) argue Southern European countries (Greece, Italy, Spain and Portugal) face a transition from a “family” to a “migrant in the family” model of care, especially regarding elderly care. \\
\textsuperscript{16} Data for the operation of KAPIs are based on the records of the Hellenic Agency for Local Development and Local Government and refer to year 2003. The number of KAPIs users represents a rough estimation and includes a large number of elderly people that use the services periodically. Data for the operation and the number of users of “Home Help” Programmes and KIFIs are based on the records of the Ministry for Employment and Social Protection and refer to year 2005.
(Karamessini and Moukanou, forthcoming). As for the volume of the provided services, they have partially been provided mainly due to resource constraints, administrative insufficiency, understaffing and the large number of users that exceed capacity (Ministry of Health and Welfare, 1985). Nonetheless, a number of studies indicate that KAPIs are quite popular care services and that their users place great value on their existence (Amira et al., 1986; Teperoglou, 1990; Tsaousis and Hatzigianni, 1990; Ritsataki et al., 1992).

In 1997 domiciliary for the elderly was introduced by central government to meet the need for basic care services of elderly dependent people who live alone, have little or no family support and lack sufficient financial resources. The first “Home Help” programmes were funded by central government (jointly by the Ministry of Interior and the Ministry of Health and Welfare). Afterwards, with funding under the 2nd and respectively 3rd Community Support Framework they came under the responsibility of local authorities and they were expanded. At that time priority was also given to depended older persons that were cared-for by female family members. “Home Help” programmes were initially designed to provide domiciliary care through social work services, nursing services and family assistance services to frail elderly people. Later on their scope was widened to include the provision of domiciliary social care to individuals with disabilities. An evaluation report of the programme (Hellenic Central Union of Municipalities and Communities, 2002) indicates that “Home Help” users widely recognise the value of the services provided by these programmes.

In 2001 the Day Care Centers for the Elderly (KIFIs) were established in urban areas. They operate under the responsibility of local authorities and receive funding by EU sources. KIFIs provide daily care services through trained staff and specially equipped premises to frail elderly with chronic health related problems who are unable to receive care from informal networks.

Overall, since the late 1990s the availability of EU funding has allowed the expansion of community care services for the elderly provided by local authorities. These, services, although valuable for users and informal cares, are selective – targeting mainly to those lacking sufficient financial means – and limited in quantity. Local authorities have not managed to develop community care services in a systematic way over the years and the recent expansion of social care programmes occurred in a deficient and fragmented way (Petmesidou, 2006). What is more, their future prospects remain uncertain depending on available EU resources. Indeed funding through the National Strategic Reference Framework (ESPA) for the period 2007-2013 seems that is going to alter the balance of the welfare mix in elderly care.

Very recently a new tender has been announced concerning the provision of domiciliary care services to the elderly and people with disabilities. Participants in

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17 Out of the 1,100 programmes in operation, 101 receive funding from central government and the rest from the 3rd CSF (Ministry of Employment and Social Protection, 2005).
18 “Home Help” programmes are staffed by an interdisciplinary team including a social worker, a nurse and a family assistant.
19 As Petmesidou (2006) notes, in other European countries home care services were initially established to help families caring for people with disabilities and extended afterwards to the elderly, while in Greece services developed the other way around.
20 KIFIs are staffed by a nurse, a social carer and supporting personnel.
this tender, under certain preconditions, can be municipalities and municipal enterprises already run “Home Help” Programmes, any other public body, but also non-profit and for-profit private legal entities, as well as any other relevant private agency. Another interesting feature is that funding will be granted for each user of the programme (up to a fixed maximum number of users according to each agency’s capacity) and not for the programme as a whole. These are major developments, on the one hand, for the continuity of the existing local authorities’ programmes. They are given the chance to secure most requested future funds. On the other, probably we are about to witness a shift in the balance of the mixed economy in elderly care. Both non-profit and for-profit organisations could claim EU funds for the provision of domiciliary care services. As for users’ choice and quality of services it remains to be seen.

3.3. Institutional Care

The number of elderly people living in institutions providing social care is extremely low (0.6% according to 2001 census data). This has been attributed to the importance of family ethics in Greece but also to the shortage of places and their uneven distribution within the country and to the low quality of the provided services (Emke-Pouloupolou, 1999; Sissouras et al., 2004; Chartreau et al., 2005; Papaliou and Fagadaki, 2005). Institutional care for the elderly is provided by the Elderly Care Units.\(^{21}\) They are either non-profit (established by the Church, NGOs and local authorities) or for-profit (market services). To provide long term care for elderly people who lack sufficient financial resources, the Ministry of Health and Social Solidarity signs subcontracts with non-profit Elderly Care Units; but for a very limited number of places. It should be stressed that in the absence of public services providing residential care solely to the elderly, an interconnection with the provision of long term care to people with disabilities has been developed. Nursing Homes for Chronically Ill that were designed to address long term care needs of not self-sufficient adults suffering from kinetic disabilities or mental deficiencies, provide long term care also to a number of older people in economic deprivation.\(^{22}\) Further, in the provision of residential care to the elderly important is the role of the Greek Orthodox Church.\(^{23}\)

Mostly due to the absence of a unified monitoring authority statistical data on the number of the existing Elderly Care Units and their users are insufficient (some times even controversial). To make thinks more complex several units (both non-profit and for-profit) operate without having registered with local authorities.\(^{24}\) Thus it is impossible to know their exact number and the number of older people they host. What is more, a number of private clinics are operating as residential homes as well, in the sense that they provide long term nursing care to frail elderly people. In general

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\(^{21}\) All residential homes providing long term institutional care to older people were renamed to “Elderly Care Units” by Law 2345/1995.

\(^{22}\) In 2002 they were providing long term care to around 2,600 frail elderly persons (Ministry of Health and Welfare, 2002:9).

\(^{23}\) A pamphlet about the social welfare institutions of the Greek Orthodox Church (published in 2001 by the publication branch of the Church of Greece) indicates that the majority of institutions are concerned with the provision of elderly care services.

\(^{24}\) The license for the establishment and operation of all Elderly Care Units is granted by second-tier local authorities (prefectures). Local authorities are also responsible for their monitoring, supervision and control.
terms, the non-profit sector includes about 120 Elderly Care Units that provide long term care to around 2,800 individuals. The for-profit sector includes about 110 units and based on rough estimates it is believed that the number of their users is approximately 3,200.25

As stressed before the percentage of elderly people using institutional social care services is low. The dominant trend is the provision of services in the community. This emphasis on community services, coupled with strong family ties and the associated stigma of institutional care, on the one hand, and serious failures of institutional services, on the other, ignores the possible positive outcomes of high quality residential provision. As Foster (1991) has already suggested good residential care should be regarded as an integral part of care in the community. She challenged that institutional care is inherently undesirable and in this context she proposed a form of shared care. This could offer an alternative solution to frail elderly people and their informal -primarily female- family carers. Her proposal remains up to date and in line with contemporary discussions about the provision of integrated elderly care services. In the case of Greece, however, where the family continues to be the main care provider utilising the irregular work of female migrant carers this do not seem to be forthcoming.


Care for the elderly lies at the uncertain boundaries of social care. The borderlines between health and social care are hard to define. As a response an emerging trend towards the provision of integrated services is progressively coming to the front. The boundaries between the provision of social care to older people and to people with disabilities are also vague. Elderly care is provided by a quartet of institutions – the family, the state, the third sector and the market – that interconnect and form the mixed economy of care.

In this context, the provision of elderly care in Greece is on the edge of a transition. The ageing of the population along with an increase in female employment rates has put pressure on the engendered family-centred model of service provision. Provision of services in the community - the dominant trend in political discourse - presumes the empowerment of local authorities as service providers and the upgrading of the third sector to become an active actor in service provision too. Public sector instead of being the only significant provider should be considered as the regulator of the overall system. Local authorities, though, have developed social care services in a fragmented way; while the role of the third sector in the provision of social care has been described as residual. In parallel, however, available EU funds seem to enable the growth of the independent sector. As for market services, there is evidence suggesting the development of a market of care, but at the same time the work provided by female migrant carers has been leading to the creation of an informal care market. All in all, it seems that the emerging trends could alter the scope of the welfare mix components, reshape the boundaries and transform the character of service provision in social care services for the elderly.

References


Ministry of Health and Welfare (2002). The Hellenic Response to the EPC/SPC/2002/ APR/01En/rev1 Questionnaire on Health and Long-Term Care for the Elderly, Athens. [In Greek].


