Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Norway

NOVA
Norwegian Social Research

Reidun Ingebretsen & John Eriksen
NOVA – Norwegian Social Research
Munthesgt. 31
0260 Oslo
reidun.ingebretsen@nova.no
john.eriksen@nova.no

With co-financial support form the Norwegian Directorate of Health and Social Welfare

August 2004

The project EUROFAMCARE is supported by the European Union - Contract: QLK6-CT-2002-02647

This report is part of the European Union funded project

“Services for Supporting Family Carers of Elderly People in Europe: Characteristics, Coverage and Usage” - EUROFAMCARE

EUROFAMCARE is an international research project funded within the 5th Framework Programme of the European Community,
Key Action 6: The Ageing Population and Disabilities,
6.5: Health and Social Care Services to older People,
Contract N° QLK6-CT-2002-02647 "EUROFAMCARE"

http://www.uke.uni-hamburg.de/eurofamcare/

EUROFAMCARE is co-ordinated by the
University Hospital Hamburg-Eppendorf,
Institute for Medical Sociology,
Dr. Hanneli Döhner
Martinistr. 40
20246 Hamburg
Germany

doehner@uke.uni-hamburg.de

Design: Christopher Kofahl

Final Layout: Maik Philipp, Florian Lüdeke

Hamburg, 3rd September 2004

Content

Summary of Main Findings

- With increased life expectancy and large cohorts approaching old age, the population in Norway is ageing. Life expectancy at 65 years is estimated to 16.2 years for males and 19.8 years for females. Almost 30 % of the non-institutional population 67+ in Norway is found to be in need of help to shop and clean. Five percent needed care from others or could hardly manage to dress or take care of their daily personal hygiene on their own.
- Norway is a high-service country with a wide range of community services. Most Norwegians hold the opinion that the welfare state should be the prime source of care, with the family in a supporting role.
- According to the Social services act, providing help to dependent elderly in daily living is a local or municipal responsibility. The Social services act specifies that persons who are unable to care for themselves due to illness or disability, or who are completely dependent on practical or personal help to manage their daily tasks, are entitled to help. Family caregivers with "especially burdensome caring work" may be paid a municipal care wage.
- A Comparative European study (Lowenstein & Ogg, 2003) shows that the family provides somewhat less instrumental and personal care than in the other countries of the study, but that the total level of help (from family and services) in Norway is higher than in countries with more family dominated care systems (Daatland and Herlofson 2003b).
- Nevertheless, family caregivers have important roles both as caregivers and care administrators for elderly. Voluntary organisations and interest groups for elderly and for family caregivers play important roles to give information and support as well as being watch dogs and co-operating agents in relation to the formal service system.
- On a national level " The Action Plan for the Elderly" (1998-2001) has to a great extent attained its goals to strengthen home based care, expand sheltered housing and modernise nursing homes. Local variations are, however, considerable.
- In developing individualised, need- and user-oriented services, the family perspective and the needs of the family caregivers are to be taken into consideration. This regards economic services like care wages, collaboration between the formal service system and family caregivers and support to caregivers with heavy practical and emotional burdens. Support includes counselling, support groups and respite care.
- Even though the relationship between the family and the formal service system can be characterised by complementation rather than substitution, many family caregivers are under pressure due to insufficient formal care. From time to time there are calls for more voluntary and family care. Costs

as well as performance of the highly developed welfare system are under debate. With increased pressure on the service systems, the interplay between the formal service system and family care will be of great importance in the future.

- Further studies on collaboration between the formal care and service system and family care are highly relevant, both for elderly in home care and in institution. This is a natural follow-up of the Norwegian Action Plan for Care of the Elderly. As a result of "The Action Plan for the Elderly" and "The Hospital Reform" a larger proportion of care takes part in the homes of elderly. More information is needed about the consequences for family caregiving.

Introduction – An Overview on Family Care

With increased life expectancy and the large cohorts of the baby boom generation from 1946-73 now approaching old age, the population in Norway is ageing. Urbanization and higher mobility split families and affects social networks. More pressure is put on the public sector of health and social care. In recent years a main topic has been to secure necessary revenues to maintain the public services. Broad public and political debates are taking place regarding how to provide pensions and the necessary care for the elderly population with a decreasing number of people in the labour force.

In a high-service country like Norway, solidarity and obligations towards parents are highly alive, but their manifestations have changed in recent years. With a wider range of community services, such as home help and home nursing, available, the family provides less instrumental and personal care than in countries with a more family dominated service system, as demonstrated in the OASIS-study. Families still contribute substantially to elder care, and in combination with public services produce a higher total help level than countries with less developed formal care services.

In general, the elder generation prefers formal care in case of substantial dependency. Elderly in general give more help and economic support to the younger generations, compared to the help they receive. Children do, however, often represent a basis of security for the elderly as someone to turn to on special occasions. This may be seen as a measure of a loyalty contract. Help from family represents a valuable supplement to formal care. For elderly couples it is a common norm to try to 'help each other‘ and 'manage to stay together' as long as possible.

Municipal health care and social services include nursing homes, resident homes, sheltered housing, home nursing, practical help at home and respite care in institutions, as well as respite care at home for persons and families with especially burdensome caring work for family members. National authorities are responsible for national policy, laws and regulations, state hospitals, specialist health services and financial transfers. It is a national goal to provide sufficient social and health care service to enable elderly persons to live independent lives in their own homes and community for as long as they wish, and to prevent social isolation and disabilities. Under the aim of providing equal access to services of equal quality, local municipalities are responsible for supplying services, taking local variations into account and develop flexible services.

At present, the level of commercial services directed towards older people in Norway, is low. However, commercial services are expanding as municipalities contract out their public services to commercial operators. Market services have been discouraged under the Scandinavian model of care. Care should

not be for sale, but equally available across class and status groups, but new market oriented trends are noticeable.

Some informal, unpaid care is organized through senior centres. Elderly persons (60+) are also the largest group of both users and volunteers in volunteer centres. Help from these centres may function as an organised form of neighbour help. Most direct neighbour help is based on long lasting relationships and more or less unexpressed responsibilities to look after each other, bring the mail, to shop together, etc. Common agreements between friends include making a call every day just to make sure everything is ok. Help from friends, neighbours and volunteers are normally not given on a regular basis and have much less volume than help from families and public services. Voluntary organizations offer different kinds of services. The Red Cross organises visits and 'telephone friends', The Norwegian Health Association provides services to caregivers of persons with dementia - groups, journals, telephone and internet service. Other voluntary and religious organisations and groups often offer services and help with transport, recreational activities etc. on a local level.

In 2000, 12 % of the population aged 67 years and more lived either in institutions (mostly nursing homes; about 7 %), sheltered housing or assisted housing (Statistics Norway 2000).

Of the non-institutionalized population 65+ about 35 % reported to be disabled in the mid 1990s (more precisely: moderately or strongly reduced functions in daily life in a long-term perspective (at least one year); see also 7.1.6). 24 % reported to be strongly disabled (Eriksen, Næss og Thorsen 1989). Solem & Daatland (2000) point to better functioning among elderly during the last years. According to the newest findings 29 % (20 % of men and 36 % of women) of the non-institutional population 67+ in Norway were found to be in need of help with shopping and cleaning. Five percent (3 percent of men and 6 percent of women) needed care from others or could hardly manage to dress or take care of their daily personal hygiene on their own (SSB 2003 Statistikkbanken).

Norway is a sparsely populated country, with many small municipalities. There are great variations in economic structure, geographic conditions, population density and age composition between municipalities. This variation constitutes a challenge to keeping the national standards of individualized service and care. The transmission of national economic resources to the municipalities is a hot political issue.

As regards minority groups, an action plan for health and social services to the Sami people in Norway, emphasises the responsibility of the municipalities to provide services that are tailored to the traditions, needs and customs of the Sami people. The population of elderly immigrants and refugees in Norway is increasing. Some groups have strong family traditions, but demands for formal services will probably increase also among minority groups due to changes in family structures in the years to come.

As a result of "The Action Plan for the Elderly" (1998–2001) and "The Hospital Reform" (2001) a greater part of care takes part in the homes of elderly. The consequences for family caregiving have not been evaluated.

1 Profile of family carers of older people

There are basically three sources of information on family members caring for older people: 1) Survey data on time use, health and living conditions (see reference list under Statistics Norway) and 2) (Rikstrygdeverket) Administrative statistics (i.a. from The National social insurance board). Both are collected regularly, but are entailed with different limitations. The third source consists of occasional studies focusing on care, some based on the above sources, others are based on own, collected data.

More studies concentrate on care receiver than on caregiver.

1.1 Number of carers

Time use survey data

According to Norwegian time use data (Vaage 2002), 5 % of all respondents aged 16-74 gave some care / help to adults in own household in 2000 (due to old age, disability or illness). This proportion represents approximately 160,000 individuals. 8 % - or approximately 255,000 people - helped people in other households.

The overlap between the two groups of helpers is not specified. Care / help given by people aged 75+ is not included in these figures. It should also be noted that the care receiver in own household is not necessarily an older person, although (s)he will most often be so. We only know that (s)he is an adult. As to help given to other households the time use data do not specify any further details, like the age of the care receiver.

Based on the 1990 time use survey, Kitterød (1993) estimated that the total amount of informal care given by people aged 16-79 to disabled, sick as well as old people inside / outside own household represented 118,000 man year. This figure was probably somewhat lower in 2000; reduced time spent on help and care only partly offset by population increase. Based on data from the 1985 health survey, Kitterød estimated that total informal care received by people aged 67+ from people in own as well as other households, amounted to 49,000 man year. The exact number of people supplying this care is not known, however, see Vaage (2002) above.

According to Kitterød, informal care to older people is about double in size compared to formal care. However, comparing informal care with formal by counting hours could be misleading, since we do not know the intensity and kind of care given by the two agents. One hypothesis is that formal care may include more heavy care tasks and high intensity work than does informal care. Table 23 below indicates that comparing hours may give insufficient information as to the relative importance of informal versus formal care for the elderly.

According to the 1998 health survey (Statistics Norway 2000), a quarter of older people (66+) received help with daily chores from various sources, i.e. about 145,000 people. What proportion of this "help with chores" can be characterized as "care" is not known, neither is the number of carers supplying the help. Obviously older people may receive help from more than one person. The fraction family care / formal care may have changed since 1990 (the year of Kitterød's data), as indicated by time use data (Vaage 2002). The proportion of the population aged 16-74 giving family care as well as time spent on family care has been somewhat reduced from 1990 to 2000 (Vaage 2002).

Recipients of care wage

At the start of 2003, an estimated number of 1,850 persons received a municipal care wage for caring for older people (65+). Bearing in mind that the Nowegian population aged 65+ totaled 675,821 in 2002, these persons make up only a small proportion of all family caregivers for older people (Statistics Norway 2003 unpublished, Skollerud 2003).

Care wage may be paid by the municipal social service agency to persons taking on extraordinary burdensome care obligations. Care wage is not means tested and is paid irrespective of legal / formal care responsibilities towards close kin (which in Norway exist only for parents when children are under the age of 18).

Take-up of care wage indicates a minimum number of carers, because a) the care performed has to be extraordinarily heavy to qualify for this particular allowance, and b) spouses, and to some degree also other family members, harbour informal care obligations towards own, elderly kin, without applying for a care wage. Take-up of care wage is low also due to legal intricacies (Social services act § 4).

In comparison to the about 1,850 persons receiving a public care wage for caring for older people, 30,132 persons aged 65+ received assistance pension from the National social security board in 2002 (Rikstrygdeverket 2003). Assistance pension is paid to persons needing extra care due to long-term illness, injury or impairment. Information on the suppliers of this care is not available.

The number of people receiving a public care wage for giving family care to older people grossly underestimate the amount of family care.

The various surveys by Statistics Norway give more realistic estimates of family care of old people, although data cannot be fully accommodated to the requirements specified for the present review (age of caregiver and care receiver and types of help and care). Even with these limitations data from the latest time use survey is the best data source available for the present purpose.

To conclude, it is difficult to estimate the number of family caregivers to older people. The 160,000 giving help / care to own adult household members and the 255,000 (there is an unknown overlap between the two) giving help to out-

side household members do not include family care and help given by people above 80 years of age. On the other hand, both care and help are included, as is help / care not only to older people in own household, but also to the disabled and ill, and to adults generally. In the case of help to people outside own household - all help, irrespective of age, is included. Kitterød (1993) estimated family care to older people (66+) to amount to almost 50,000 man year in 1995 (based on data for care received), without indicating number of carers.

1.2 Age of carers and 1.3 Gender of carers

Amount and kind of caregiving are influenced by age as well as gender of carers. Hours of informal care to older (and disabled) people increase with age of caregiver, with a peak for middle aged women (aged 45-66 years, table 1). In general, women give 2.5 times as much family care as men. The gender difference is at its smallest for the oldest caregivers.

Table 1: Informal care given to older people and disabled, by caregiver's age and gender, 1990

Hours per month	Men	Women
All	2.9	7.5
16-24 years	1.1	3.0
25-44 years	1.2	6.8
45-66 years	4.0	12.5
67-79 years	6.5	7.0

Source: Kitterød 1993

This pattern demonstrated by data from 1990 is also seen in time use data from 2000 (tables 2 and 3), although less pronounced. As noted above, these data are less specific in terms of age and help / care given. According to table 2, care and help given to people in own as well as other households generally increase by age, most clearly in terms of proportion of people giving help to other households - from 5 % among the youngest to 14 % among the oldest. We also note that more help is given to people in other households than to adults in own household.

Table 2: Proportion of people aged 16-74 giving informal care / help, and daily hours, by age, 2000

	16-24		25-44		45-66		67-74	
Informal care / help to adults in own household	4 %	0.28h	4 %	0.28h	6 %	0.47h	6 %	–
Help to other households	5 %	1.27h	5 %	1.34h	11 %	1.26h	14 %	1.55h

Source: Vaage 2002

The time use data in table 3 indicate less difference than table 1 between men and women in family care and help. There is almost no gender difference in

care / help given to adults in own household, while women give more help than men do to other households. In terms of daily hours, figures are somewhat higher for men (among those giving such help).

Table 3 reveals a general decrease in help and care from 1990 to 2000. We note, however, that some more time is spent on help to other households, among both men and women, while the proportion giving such help was lower in 2000 than in 1990, also irrespective of gender.

Table 3: Informal care / help, given by persons aged 16-74, by gender, 2000

Gender / kind of help	Proportion		Daily hours[1]	
	1990	2000	1990	2000
Informal care / help to adults in own household	7 %	5 %	0.46	0.37
Help to other households	11 %	8 %	1.21	1.33
Men				
Informal care / help to adults in own household	7 %	5 %	0.45	0.40
Help to other households	10 %	7 %	1.24	1.42
Women				
Informal care / help to adults in own household	7 %	4 %	0.48	0.33
Help to other households	12 %	9 %	1.19	1.26

[1] Among those giving care / help
Source: Vaage 2002

Also data on the more restricted arrangement of municipal wage for caring for older family members demonstrate an increase by age (table 4). As care expected, more women than men receive care wage (more than two thirds are women), women have no clear pattern in terms of age of caregiver.

Table 4: Care wage for care for older people (65+), 2000. (N=62)

Caregiver by age	-20	30-39	40-49	50-59	60-69	70-79	80+	Sum
Per cent	2	3	8	27	27	31	2	100
Caregiver by age	**-50**			**50-59**	**60-69**	**70+**		**All**
Percentage of female caregivers	100 %			65 %	88 %	45 %		69 %

Source: Skollerud 2003

1.3 Gender of carers

included in 1.2 Age of carers

1.4 Income of carers

There is little variation between income groups in proportion giving care / help to adults in own household, while people in low income households more often give help to other households than do members of better-off households (table 5).

Little variation is seen when informal carers / helpers are classified according to employment status. We note that there is no indication that low status household members more often than high status households give help to other households, like low income household members did (table 6). We also note that many pensioners give help to members of other households, but relatively few homemakers report giving care and help to members of own household.

Table 5: Proportion giving care / help in various income groups, care-givers aged 16-79, 2000

Household income groups (1000 NOK*)	-200	200-299	300-399	400-499	500+
Informal care / help to adults in own household	3 %	5 %	5 %	5 %	4 %
Help to other households	10 %	11 %	6 %	6 %	6 %

*) 1 Euro equals NOK 8,20 (March 2004)
Source: Vaage 2002

Table 6: Proportion giving informal care / help, 16-79 years, according to socio-economic status, 2000

Socio-economic status*	1-2	3	4-5	6-9	Stud.	Pension	Home-maker
Adults in own household	5 %	5 %	4 %	4 %	4 %	6 %	3 %
Help to other households	7 %	6 %	7 %	8 %	4 %	13 %	8 %

*Socio-economic status: 1-2: Administrative leaders and politicians, academic jobs; 3: jobs requiring college education, technicians; 4-5: jobs within sales, services and care; 6-9: jobs within farming, forestry and fisheries, craftsmen, industry, transportation, and jobs without specific educational requirements (Vaage 2002, p. 23)
Source: Vaage 2002

Average income from municipal care wage for care for older people was about NOK 4,100 per month (equals Euro 500) in 2002 (Skollerud 2003).

1.5 Hours of caring and caring tasks, caring for more than one person

Due to the structure of available data there is some overlap between the first part of this section and the section on age and gender of carers (1.1.2 / 1.1.3).

Time use data from 2000 confirm that more time is spent on help to other households than to adults in own household (in the proportion 3.5 to 1; table 7), each person on average giving such care / help used 2 hour and ten minutes per day. On average, for all people in the survey, this represented less than 10 minutes per day.

Table 7: Time used on care / help per day, in hours / minutes, 2000

	Persons aged 16-74	Among those giving such care / help
To adults in own household	0.02	0.37
Help to other households	0.07	1.33

Source: Vaage 2002

Lingsom (1997:203) estimated average time spent on regular care by caregivers aged 16-79 years, to relatives in other households (irrespective of age) to amount to 4.2 hours per week in 1995. It was 3.9 hours for men and 4.5 hours for women.

According to Lingsom (1997), time use data demonstrate traditional variation with gender (women give more non-resident care than men do) and with age - care increases by age of caregiver, but drops in the oldest age group.

Table 8: Average time per month spent on non-resident care 1990

All caregivers 16–74 years	Men	Women	Caregivers		
			40–49 years	50–59 years	60–74 years
12.2	8.7	14.6	12.2	17.0	14.1

Source: Lingsom 1997

Comparing figures back to 1983, Lingsom concludes that there has been a general increase in participation in non-residential care and a decline in its intensity in the 1980's and 1990's (Lingsom 1997:204). As noticed in section 1.1.1 above, Kitterød indicated a decrease in informal care from 1990 to 2000, much based on the same data.

Romøren (2001) has estimated care for the oldest in a different way, based on data from a Norwegian municipality. He monitored a complete cohort from the age of 80 to the death of each cohort member. The total number of years of family care received by women was on average 8.8 years and for men 5.3 years (i.e. after the care receiver reached the age of 80).

Municipal wage for care for older people (65+) in 2002 amounted to on average 7.3 hours of care work per week (Skollerud 2003). This represents only a part of actual care given; a part that is recognized by the municipal authorities to qualify for this financial compensation.

Most information on caring tasks is related to the older person, and not specifically to the individual supplying informal care.

Data from the 1998 Health survey by Statistics Norway (Ramm 2001:82) show that a considerable proportion of people aged 66 and more and living at home express a need for help with daily tasks, foremost with housecleaning and shopping (table 9).

Table 9: Proportion of older people (66+) needing help with daily chores (institutional population excluded). 1998 Health survey

Housecleaning	28 %
Shopping	17 %
Dressing	7 %
Personal hygiene	4 %
Eating	2 %

Source: Ramm 2001

The proportion of older people living at home, who report considerable difficulties in carrying out certain daily tasks has been stable over the years - 20 % in 1975 and 20 % in 1998 (table 10). Despite this overall stability, the need for help has been reduced among the oldest (80+) during the 1990s.

Table 10: Proportion of older people (66+) with considerable difficulties in performing shopping, dressing or personal hygiene (institutional population excluded). 1998 Health survey

	1975	1985	1995	1998
All	20	22	20	20
67-69 years	15	17	14	15
80+	41	39	34	30
N	1,266	1,415	1,601	512

Source: Ramm 2001

As seen also from table 11, the need for help increases with age - from 15 % among 67-79 years old, to 30 % for the 80+ for "one out of three chores". When housecleaning is included the increase by age is even more pronounced - it doubled from 24 % to 49 %. Women report uniformly that they need more help than men do. The smallest age gap between men and women (5 %) is found among the oldest when the fourth chore (housecleaning is included).

Table 11: Proportion of older people (66+) needing help with daily chores (institutional population excluded), by age and gender. 1998 Health survey

	One of three chores*	One of four**
All	20	32
67-69 years	15	24
Men	11	19
Women	19	28
80+	30	49
Men	21	46
Women	35	51

*The three chores: Shopping, dressing or personal hygiene. **The fourth chore: Housecleaning.
Source: Ramm 2001

Data from the 1987 Level of living survey by Statistics Norway can be used to identify the different suppliers (from outside the household) of various forms of help to old people (table 12). We notice the importance of kin for all four chores. Quite traditionally sons do little housecleaning (and more maintenance and repairs). Less help is given by neighbours and friends, but such help is not insignificant. Social services are important for housecleaning and also for shopping. NGOs play a minor role in Norway, as does hired help, except for maintenance and housecleaning.

Table 12: Proportions of older people[1] living at home and receiving certain form of help from different caregivers outside the household. 1987 Level of living survey

	Shopping	Housecleaning	Transportation	Maintenance repairs
Son	21	3	31	26
Daughter	29	21	19	9
Other kind	17	13	20	20
Neighbour, friend	11	6	10	14
Home help / public help	18	44	9	8
Hired help	2	13	4	20
NGOs	0	0	2	1
Other	2	0	5	2
Sum	10	100	100	100

[1] The source does not indicate the exact specification of "old people", only that there is no upper limit (Kitterød 1993:404).
Source: Kitterød 1993

The role of family care in Norway compared to some other countries is seen from table 13. We notice that family care for people aged 75 and more plays a

smaller role in Norway (and Israel) than in England, Germany and Spain. This difference between Norway and the other European countries is most likely accounted for by the extensive welfare state services in Norway.

Table 13: Family help as percentage of help to older people (75+) by domain and country, 2000 / 2001

	Norway	England	Germany	Spain	Israel
Household chores	27	39	49	59	19
Transport / shopping	52	56	62	74	49
Personal care	18	36	46	81	16
N	412-413	389-392	494-498	384-385	368

Source: Lowenstein & Ogg, 2003

Table 14 indicates the balance of help and care between older parents and adult children. We see that considerably more help is provided by the children to the parents than the other way. The exception is financial support from old parents to adult children (in addition to childcare).

Table 14: Types of help and support to and from older parents (75+), from children's perspective, Norway 2000 / 2001. (N=163-6)

	Provided help to parents	Received help from parents
Emotional support	71	46
Transport / shopping	58	6
House repairs / gardening	48	9
Household chores	27	7
Child care	–	18
Personal care	9	0
Financial support	4	26
At least one type of help	87	59

Source: Lowenstein & Ogg, 2003

Gautun (1999) has studied the help pattern between middle aged men and women (born in 1946) with at least one parent alive (response rate 58 %, N=868). This strategic selection of respondents is substantiated by the high probability that this cohort (aged 51 at the time of the survey) will have parents in need of help and care.

We notice that more help is given to mothers than to fathers, one reason being that mothers more often than fathers live alone. Mothers also give more help than fathers to their children, except for economic help (table 16).

Table 15: Types of help from middle aged men and women (51 years) to father or mother the last month, 1997. Per cent

Type of help	To father	To mother
Shopping	18	32
Housecleaning	13	16
Repairs, gardening, clearing snow, etc	24	30
Information about social security, tax, etc	11	18
Advice / support in personal matters	13	22
Given / lent money	3	3
Transportation	25	41
No help	48	34

Source: Gautun 1999

Table 16: Help from parents to middle aged children (51 years) the last 12 months, 1997. Per cent

Type of help	From father	From mother
Economic help	30	22
Laundering, housecleaning, meals, shopping	8	13
Advice / support in personal matters	23	25
No help	52	52

Source: Gautun 1999

The help pattern described above - mothers receiving more help from children than fathers - is not matched by expressed needs. According to table 17 fathers express as much need for help as mothers do. One should bear in mind that fathers of the 1946 cohort is older than the mothers.

Table 17: Percentage of parents (of the 51 years old) in need of various forms of help, 1997. Per cent

Type of help	Father	Mother
Dressing	11	10
Getting out and into bed	6	7
Toilet	7	7
Eating	4	1
Personal hygiene	13	13

Source: Gautun 1999

Going into more detail, Gautun (1999, p. 44-45) has summarized the profile of her 51-years old and their help to parents. In terms of amount of help (using an additive score of the seven types of help in table 15) it should be noted that significantly more help is given a) to parents that are in need of nursing (especially fathers), b) when parents receive public home services, c) to mothers by

children working extra long hours, and d) when parents live within walking distance. Also mothers that have given help to their children before (more than a year ago) receive more help from children. However, there are no significant differences in terms of the respondents' marital status (married / divorced), gender, employment (employed / not employed), place of residence (population size) and the quality of the parent-children relationship (good - bad, 5 step scale).

As to parents in need of nursing more specifically, mothers generally receive more nursing care than fathers, especially mothers living alone (and from their daughters). The quality of the relationship children-parents is of importance for amount of help given / received. For mothers amount of help received also depends on whether she had helped her children before.

Gautun notes that married children give more nursing care than divorced, employed more than non-employed, especially children working 35-44 hours a week. Children living in rather small communities (3,000 - 10,000 inhabitants) give more nursing care than children living in larger or more urban communities. Otherwise, distance to parents is of little importance.

It is worth mentioning that fathers / mothers that receive home services also get more nursing care from children (Gautun 1999, pp. 48-49).

1.6 Level of education and / or Profession / Employment of family carer

According to the 2000 time use data there is little variation with education in proportions giving help and care (table 18). The highest proportion giving help / care in own household is found among people with college level education (6 %) and the lowest among university level (3 %). People with low levels of education seem to give more help to other households (8-9 %) than college graduates in particular (4 %).

Table 18: Proportion giving care / help according to level of education of caregiver, 2000

Educational level	Compulsory	Secondary	College	University
Adults in own household	4 %	4 %	6 %	3 %
Help to other households	8 %	9 %	4 %	7 %

Source: Vaage 2003

1.7 Generation of carer, Relationship of carer to OP

Data presented above, in section 1.1.5 Hours of caring, show that close kin (children) are important caregivers. Details were given on the help pattern between adult children and their parents. Kitterød (1993, p. 407) draws the following picture of informal care within and between households: Most of the

informal care is given to family members or close kin. Older people give care to their spouses. Care given to persons outside own household is given foremost to own parents and by women. In 1990, women spent almost 2 1 / 2 times more time on such care compared to men (12 % and 7 % of women and men aged 45-66).

Table 19 classifies persons who belong to households with care dependent members, based on the 1995 Survey of level of living by Statistics Norway (Lingsom 1997:202). In other words, the table is restricted to co-resident care. Further, it assumes "that all adult household members contribute to the care of the dependent person, although not necessarily to the same degree or in the same manner" (p. 202). This assumption is substantiated by the data, according to Lingsom.

3.2 % of respondents aged 16-79 years belonged to households with care dependent members. About half of the 3.2 % were made up of spouses or parents / in-laws, most - but not all - of them will be older people. For the 80+ years of age (and living at home), 7 % belonged to households with care dependent members; most of these were spouses.

Lingsom supplies data back to 1980, showing a small but general decrease in percentages of persons belonging to households with care dependent members, but an increase from 1991 to 1995.

From a more detailed analysis of the data, Lingsom concludes that "the risk of having a care dependent spouse (at home) increases sharply with age for married persons from under 0.5 % for married persons under the age of 50 to a record high of 20 % in 1995 for married persons 80 years of age and over. There is some indication that spouse care is coming later in old life. Improvements in functional capacity in daily activities have been recorded among the "young old" suggesting a postponement of care needs … The so-called "compression of morbidity thesis" may perhaps help explain the decline in spouse care among married persons in their sixties and seventies." (pp. 202-203).

Table 19: Percentage of persons who belong to households with care dependent members by relationship, 1995

Persons 16–79 years	3.2
Of these with dependent	
Spouse	1.1
Child	1.4
Parent / In-laws	0.5
Other	0.1
Persons 80+	7
of these with dependent spouse	6

N = 3,589 for 16 - 79 years, N = 130 for 80+ years.
Source: Lingsom 1997

For the small proportion of caregivers being paid a municipal care wage, two thirds belong to the same generation as the care receiver, and less than 30 % to the younger generation (table 20).

Table 20: Care wage (care receiver 65+), 2002. (N=62)

Caregiver from same generation	66 %
Caregiver from younger generation	29 %
Other caregivers	5 %
Sum	100 %

Source: Skollerud 2003

Table 21 specifies this small group of family carers and shows that almost 60 % are spouses and one third children or in-laws.

Table 21: Care wage, (care receiver 65+) caregiver's relation to care receiver, 2002. (N=62)

Spouse	58 %
Child	21 %
In-laws	11 %
Brother / sister	3 %
Other	7 %
Sum	100 %

Source: Skollerud 2003

1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

Table 22 shows the percentage of non-institutional people living alone, by gender and age groups relevant for this review. By increasing age, more people live alone; almost 60 % of people aged 80 years and more. This pattern is even more pronounced for women.

Table 22: Percentage of people living alone, by age and gender. Institutional population not included, 1995.

	16-66 years	67-69 years	80+	67+
Men	15 %	21 %	39 %	24 %
Women	14 %	46 %	69 %	52 %
All	14 %	35 %	59 %	40 %

Source: Daatland and Solem 2000

More recent data confirm this pattern (Daatland and Solem 2000, based on the 1995 Level of living survey). For men and women aged 80 and more the percentages living alone are exactly the same in 1995 as in 1985. Further, of men aged 67-79, 7 % lived together with children; of women 11 %. Of men in the oldest age group (80+), only 2 % lived with their children, as against 8 % of

women. Among men 80+ with children, 68 % had children living in the neigbourhood, and 30 % had children living next door. Less elderly women had children living so close by - 46 % and 33 % respectively.

Daatland and Solem (2000) conclude: Many older people live alone, but a majority has children living in the vicinity (p. 167). According to the Oasis data (2003), 70 % of all aged 75+ had contact with children at least once a week.

According to the 1985 health survey, informal care is most often given to older persons not living alone (Kitterød 1993, p. 408). Informal as well as formal care increase by age, and women receive more care than men do. In relative terms, formal care is most important to men aged 67-79 and living alone. We notice from table 23 that formal is more common than informal or family care.

Table 23: Proportion of older people living at home receiving different kinds of care, 1985.

	One person households		More persons households		
	Formal care	Informal care	Formal care	Inf. care from outside hh	Inf. care from inside hh
All	20	10	11	4	14
Men	20	6	6	2	11
67-79 years	17	4	3	1	9
80+	30	13	24	5	19
Women	19	12	16	7	18
67-79 years	14	8	11	6	15
80+	34	21	37	15	31

Source: Kitterød 1993

In summarizing residential pattern and generational contact of older people, it is noted that the majority of men aged 80+ is married. Of women of the same age only 15 % is married; thus more older women than older men live alone (Statistics Norway 1999). According to the 1996 level of living survey 40 % of all men aged 80+ and almost 70 % of all women of the same age lived alone. For the age group 67-79 the figures are 21 % and 46 % respectively (Statistics Norway 1999, p. 74).

1.9 Working and caring

One may suggest that family care depends on women's participation in paid work. Lingsom (1997) has demonstrated that this in not the case in Norway. In fact, women in paid work provide more family care than women without paid work do.

As noted above, giving informal help varies moderately with employment status: People with a low status job give help to the same degree as people

with high status jobs, both to adults in own household and to other households. The only group standing out is pensioners in giving help to other households. We note that homemakers report giving relatively little help.

Table 24: Giving informal care / help, 16-79 years according socio-economic status. Per cent.

Socio-economic status*	1-2	3	4-5	6-9	Stud.	Pension	Home-maker
Adults in own household	5 %	5 %	4 %	4 %	4 %	6 %	3 %
Help to other households	7 %	6 %	7 %	8 %	4 %	13 %	8 %

* Socio-economic status, jobs graded according to educational level and industry - 1 being highest and 9 lowest. For a detailed explanation, see table 6 above.
Source: Vaage 2002

1.10 General employment rates by age

Table 25: Employment for men 16-74 years and 60-66 years from 1980 to 2000.

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Men 16-74 years	78	78	76	75	75	76	76	77	76	73	72	70	70	69	70	71	73	75	76	75	75
Men 60-66 years	72	72	72	69	67	66	64	63	61	59	56	55	55	53	52	52	56	54	52	53	53

Source: Solem 2001

Employment rates among older people are high in Norway. In 2001, 72.3 % of men and 62.3 % of women aged 55-64 were employed full or part-time. These rates are the 5th and 3rd highest among 30 OECD-countries (OECD 2002). As also seen above, employment rates decline by age. 25 % of men and 20 % of women in Norway were in paid work at the age of 66. In other words, most people are outside the labour force before 67, which is the age of retirement of the National pension scheme.

Table 26: Employment for women 16-74 years and 60-66 years from 1980 to 2000

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Women 16-74 years	52	53	56	56	57	58	61	62	62	59	59	59	59	59	60	61	63	64	66	67	67
Women 60-66 years	39	41	42	41	43	42	42	42	40	38	40	41	40	40	39	39	42	41	41	42	42

Source: Solem 2001

According to Statistics Norway (1999, p. 78), 48 % of people aged 60-66 was employed in 1998. The rates have been declining for men (down from 72 % in 1980 to 54 % in 1998), but increasing for women (up from 38 % to 42 %). More of these women than men work part-time, which is the common pattern in Norway. According to the level of living survey, people working at least one hour a week are seen as employed.

Table 27: Proportion employed in 2000, by age and gender

	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-66	67-69	70-74
Men	44	74	85	91	90	90	90	88	83	60	32	14	5
Women	44	64	78	81	83	84	85	79	71	48	23	9	2

Source: Solem 2001

1.11 Positive and negative aspects of care-giving

A Norwegian study on caregiving spouses of elderly persons with dementia found that the majority of the spouses report negative effects of caregiving on their own health (Ingebretsen and Solem 2002).

On the whole, most of the spouses show fair or good adaptation, but for some the changes, stresses and strains are simply too much to manage. As personal consequences of dementia care giving, some spouses point to the pleasure and pride of being able to accomplish the role as a caregiver, some point to - after all - their personal growth towards more independence and maturity. Negative consequences are related to inhibited spontaneity in relation to the partner, even spreading to more reserved interaction with other members of the social net work. Depression and reduced self confidence are part of the picture. There exists a broad international literature on caregiver strains, and some literature on gains as well. A conclusion is that sufficient practical and psychological help to family caregivers is of uttermost importance (Ingebretsen and Solem 2002).

Abuse of elderly is generally estimated to range between 3 % and 6 % (Hydle and Johns 1992, Daatland and Solem 2000). According to studies in the Nordic countries abuse of elderly varies from 1 % to 8 % (Hydle 1994). Definitions of abuse vary. According to the 1997 level of living survey (Statistics Norway 1999, p. 65-66), older people are less often than younger people subject to violence and threats. Among older people, both men and women, 3 % at the most have been subject to violence last year, while many more express fear of being subject to violence and threats. In the 1997 level of living survey data, 80 % of women aged 80+ were anxious of violence, but none had actually experienced violence or threats, either in their homes or outside. There are geographical variations. Middle aged and older women in cities are more often subject to violence or threats (5 %) than women of the same age elsewhere in the country.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

The number of migrant care and domestic workers in Norway is unknown. The number of workers with a non-Norwegian ethnic background in formal care for elderly is noticeable and increasing, in particular in cities and among the unskilled care workers. This is legal labour by people with permanent or long-term residence in Norway.

Inviting non-Norwegian young girls as child-minders on a (legal) au-pair contract is quite popular. To some extent, immigrants will do domestic work in private homes, often on the black market.

Demand for domestic work in Norway has been restricted since World War II, but has been increasing in recent years. The amount of such work done by immigrants is unknown, but most probably increasing, as is the proportion that is illegal. This will mainly be housework and to a very small extent care work for the elderly.

Illegal migrants doing housework and child-minding on a short-term basis (on a tourist visa, and possibly returning again on a new tourist via) is reported now and then in the press, but is most probably of little significance for domestic care for the elderly.

A considerable number of elderly Norwegians migrate permanently or for longer periods to the south of Europe, but maintaining strong links with Norway (Helset, Lauvli and Sandli 2004). Spain in particular is popular. Most of these are in rather good health, and will return to Norway when their health fails: "For the time being the majority appear to opt to return to Norway in late old age rather than spend a life-phase of growing infirmity and care dependence in Spain (p. 132). Care will be supplied locally, partly by Norwegians care workers established in conjunction with housing complexes. Two Norwegian mu-

nicipalities have organized old age care in institutions built in Spain, as part of their regular old age care services.

1.13 Other relevant data or information

Services and other form of support

Lingsom (1997) has drawn the following general conclusion on formal vs. informal care, also referred to as the substitution issue: There has been a stability over the years in family care vs. formal care, both in the period 1965-85, when the welfare state expanded, as well as in the following period of contraction in welfare state services. Therefore, public and private care complements rather than substitutes each other. Family care is more robust and independent of care policies than often supposed. For example, old parents receiving public home services also receive more help from their children than do parents who do not receive home services, also when needs for help and access to help from children are controlled for (see also Gautun 1999, p. 19-20). Further, the family gives less help when the old parent lives in an institution. If the parent moves out and into his / her home again, family help / care increases. Family care has not been reduced, but has rather increased, in the last 30 years (ibid.).

Some information is already given above in the table under 1.1.8 Residence pattern, on formal and informal care given to one-person and more-person households. Kitterød (1993, p. 409) summarizes as follows: Apart from informal care to people in own household, formal care and (privately) hired care for older people are more directed towards the most needy than is informal care. Only 5 % of older people with fair functional ability and people living at home received public help with practical tasks in 1987. In contrast, half of the frail old received such help.

Further, there is a division of labour between private and public agencies. Data from the 1987 Level of living survey show that public help concentrates on housecleaning, while help from family, neighbours and friends is far more important than public agencies when it comes to shopping, transportation and house maintenance (Kitterød 1993, p. 409).

Kitterød's conclusion regarding formal vs. informal help is confirmed by later data (Lowenstein & Ogg, 2003):

Table 28: Receipt of help among 75+, at least one kind of help. Others include neighbours, friends, volunteers and privately paid helpers. N = 411. Per cent

Family help	29 %
at risk	43 %
not at risk	19 %
Services	42 %
at risk	73 %
not at risk	21 %
Help from others	7 %
at risk	11 %
not at risk	2 %

Source: Kitterød 1993

Comparing 5 nations and the relationship between formal and informal help, the Oasis data do not "support the idea that a substitution of family help in instrumental domains is a response to - or producing - a breakdown in other aspects of family solidarity such as affection and consensus." … It is much more likely a response to the availability of alternative resources of help. The majority of the urban population in all countries except Spain has a preference for services over family care, and older people even more than the younger (Lowenstein & Ogg, 2003).

The following table (Vigran 2002, p. 114) presents various public and private services available in Norwegian municipalities, relevant for older people (but not specified according to age of recipients).

Table 29: Availablility of services, according to source

Service	Public service	Private service	Both	Service not available
Janitor help	79.4	1.5	0.4	19.7
Security alarm	90.2	2.6	6.8	0.4
Ambulant food service	93.6	1.5	2.3	2.6
Pedicure	20.6	64.7	4.9	9.8
“Safe-places”*	21.7	0.4	0.2	77.7
Old age social centre	63.6	4.9	3.2	28.3
Day centre for persons with dementia	28.3	0.2	0	71.5
Say centre fort multiuse	40.0	1.7	0	58.3

* "Safe-places", short-term recidens for older people when they feel insecure.
Source: Vigran 2002

Table 30: Sources of care for parents of the 46 years' old

Source of care	Caregiver		No. of months	
	To father	To mother	To father	To mother
Son / daughter	15	30	3	14
Spouse	40	26	44	6
Other daughter	15	14	26	29
Other son	12	10	34	30
Other family	6	7	37	35
Neighbours / friends	5	2	4	3
Home nurse	40	32	29	22
Home helper	47	72	23	20
Father / mother in inst.	46	54	29	34

Source: acc. to Gautun 1999

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

Care and services to the frail elderly in Norway are a mixture of public and private initiatives and efforts. The public sector is the dominant part while close family functions as an important supplement.

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

Public agencies are the most dominant both in financing and providing services within the Norwegian welfare system. The national government plays a direct role on all administrative levels, including government regulating and financing services and also providing cash transfers for pensions etc. It runs the main hospitals and has the responsibility for specialised services, organised throughout the 19 counties. Other health and social services both for the elderly and for the rest of the population are the responsibility of the 435 municipalities. Services are regulated by health and social service legislation. Both health and social services are financed through taxes and moderate user fees. "Service provision has traditionally been a local government (mainly municipal) responsibility within the laws and financial limits regulated by the state" (Daatland 1997, p. 24). Due to a decentralisation policy and local priority decisions, there is substantial variation in volume and profile of services among municipalities.

Traditionally, "care for the aged" includes services like institutional care, special housing and home based services (home help, home nursing). The trend has been towards integration of these services. During the last years a national plan," The Action Plan for the Elderly" with the aim of individualised, need- and user-oriented services, has been implemented. (St.meld.50, 1996-97, Elster & Gran 2000) As regards services, the goals are to strengthen home based care, expand sheltered housing and modernise nursing homes. At the national level, this goal attainment is exceptionally high, according to Romøren and Svorken (2003). Local discussions and decisions demonstrate great variations with municipality size as a decisive variable.

As regards family care, "The Action Plan for the Elderly" does not announce signals about enhanced expectations, but underlines the importance of taking care of and supporting the caregiving abilities in families. Voluntary organisa-

tions also play an important role in this respect, for example by support groups for family caregivers, transport services etc. (Thorsen 1999).

Another political debate concerns service delivery from public vs. private care agencies. Service delivery from private firms has been tried out in some municipalities. The caretaker's option of choice between different care suppliers, is one argument. The possible gain in cost effectiveness is another argument. On the other hand, risks of reduced services, more administration and fewer opportunities for controls of standards have been emphasised. Across arguments, it is a common goal to maintain the primary responsibility of the welfare state for the wellbeing of older people.

As regards formal vs. family caregiving, a comparative study of urban populations in Norway, England, Germany, Spain and Israel (OASIS) documents the north / south devide of the countries. Support for filial norms was highest in the South, but still substantial in the northern countries including Norway (Daatland and Herlofson 2003b). Filial solidarity is not incompatible with generous welfare state arrangements, however. Solidarity or felt obligations towards parents are highly alive, but their manifestations have changed in recent years, according to the authors (p. 540). In this study, Norway, together with Israel, are categorised as high-service countries. With a wider range of community services, such as home help and home nursing care, the OASIS study shows that the family provides somewhat less instrumental and personal care in Norway compared to other countries. The total level of help (family and formal services) in Norway is higher than in countries with more family dominated model found in countries like Spain and England. (Lowenstein & Ogg, 2003)

Table 31: Per cent of the 75+ at risk (with disability) who received help, and from what help sources

Nation	Family only	Family and welfare state	Welfare state only	Other sources
England	26,9	13	8,7	22,5
Germany	30	3,3	11,9	17,8
Israel	12,7	7,5	19,3	33,4
Norway	9,9	29	35,2	12,3
Spain	39,5	3,6	3,6	16,3

Source: Daatland & Herlofson, 2004

In Norway, there are no legal obligations of caring between adult generations. Social policies are based on individual needs and rights. 'Welfare state orientation' refers to expectations about the relative responsibilities of the welfare state and the family on the three domains of social policies and services for older people: financial support, instrumental help and personal care. A person's 'preferences for care' are a compromise between normative considerations and personal preferences (Daatland and Herlofson, 2003b). The majority of the respondents in all the five countries in the OASIS study believed more

or less strongly that adult children have responsibilities towards their old parents.

In the Oasis survey, residential proximity between adult children and their parents was found to be lowest in Norway. Even though Norwegians were as affirmative as the Spanish on the proposition that older people should be able to depend upon their children for help, most Norwegians preferred residential care to living with a child. Nine out of ten older Norwegian parents prefer a residential setting if they can no longer live by themselves (Lowenstein & Ogg, 2003). In other words, even though children express a rather positive attitude to helping, elderly Norwegians themselves are mostly inclined to seek formal help when they foresee substantial needs of care. Most Norwegians held the opinion that the welfare state should be the prime source of care, with the family in a supporting role (Daatland and Herlofson 2003b). In the Oasis study one in three of elderly 75+ received formal home help services in Norway and Israel compared to one in 15 in Germany and Spain. It is worth noticing that elderly Norwegians themselves are among the most eager exponents for the development of formal care (Daatland and Herlofson 2003a).

The population of elderly immigrants and refugees in Norway is increasing. One of the main minority groups comes from Pakistan. Many work-emigrants that arrived in the 1970s remain in Norway. Some elderly immigrants arrive to reunite with their families. Research in the 1990s revealed that these groups of elderly utilised few of the public care services for the elderly. They expected their children to take care of them (Moen 1993). The impression of high expectations of family care was further strengthened in interviews with elderly Pakistanis (Moen 2002). Even though some of them had strong needs of care, most of them prefer and get most of their help from their families. The willingness and the possibility of family members to take care seem to be of uttermost importance for the life quality of elderly Norwegians of Pakistan origin. Children and children-in-law seem to a great extent to share these family norms. It is a realistic expectation, however, that the needs for formal care for elderly in minority groups will increase due to changes in family structures in the years to come, as it will for other minority groups.

An action plan for health and social services to the Sami people in Norway, points to the responsibility of the municipalities to provide services that are tailored to the traditions, needs and customs of the Sami people. A permanent contact-person in the service system is one of the proporsals. When deciding on applications for care wage (for family caregivers) from Sami people, municipalities are recommended to observe their potential problems with the Norwegian language and cultural knowledge of the formal service system (Sosial- og helsedepartementet 2001).

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

The Municipal Health Service Act (1982, 2003) states that all municipalities have the responsibility to provide necessary health services for all persons resident or temporarily resident in the municipality". The responsibility of the municipal health service includes 1) promotion of health and prevention of illness, injuries, and physical defects. 2) Diagnosis and treatment of illness, injuries and infirmities, 3) Rehabilitation, 4) Nursing and care.

The legal right to necessary health services is also underlined in the Patients' Rights Act (1999) ("Pasientrettighetsloven").

According to the Social Services Act (paragraph 4), people who are not able to look after themselves (due to illness, disability or old age) are entitled help from the municipal social service office. This "legal" definition of dependency is somewhat more worked out by the Ministry for social affairs in its specifications of the social services act, and by local practice.

The Social Services Act (1991) specifies different forms of relevant services (§ 4.2): a) practical assistance and training, included personal assistance, for those who are in special need of help owing to illness, disability, old age or for other reasons. b) respite care for persons and families doing especially burdensome caring work, c) support contacts for persons and families, d) places in institutions or accommodation with 24-hour caring services, e) pay (care wage) to persons performing especially burdensome caring at home work for members of own family.

The dependent person and / or the person giving care is entitled to help, but the kind and amount of help are decided by municipal authorities. Such municipal decisions can be appealed to the County governor.

This legislation is not age specific.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

According to the Social services act, providing help to dependent elderly in daily living is a local or municipal responsibility. Services are managed, organised and financed by local government. Some forms of financial support to individuals (due to disability in old age) are paid by the national social security system.

Health care, like home nursing and home help, is provided locally under the Act of municipal health service.

The social services act specifies that persons who are unable to care for themselves due to illness or disability, or who are completely dependent on

practical or personal help to manage their daily tasks, are entitled to help (§ 4-3). Family caregivers with "especially burdensome caring work" may be paid a municipal care wage (§ 4-4.) The act gives only a weak entitlement to this arrangement. The "right" is restricted to a right to have a decision on care wage, and the municipality may chose to help the dependent old in other ways than allowing a care wage to the family member giving the care. This legislation is presently (March 2004) under consideration in the Norwegian parliament.

A universal old age pension is provided by the National social insurance scheme, from the age of 67 or under an early retirement scheme from the age of 62. Some professions retire at an earlier age. A considerable proportion is allowed disability pension from the national social insurance scheme prior to retirement.

The national government is responsible for specialised health service including mental health services regardless of age, ethnic and social background and geographical context.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

As mentioned above, the Social services act allows for respite services as well as care wage for persons having "extraordinarily heavy care burdens" at home for own family members. These rights are not age specific. The social services act gives a weak entitlement for the caregiver, however, since the municipality has the right to decide on the kind of help it will give to the dependent family member.

It is not a strong tradition in Norway to have welfare right decided by the courts. Two cases are relevant, however, even though they do not concern elderly people.

In 1997, the Norwegian, supreme court ruled that the income of the family is irrelevant when an application for care wage is considered. In another court case (Kjønstad 1990), it was ruled that a disabled person has the right to live in his / her own home, i.e. the municipality is obliged to supply enough services to make this possible (in stead of providing institutional care.

In Norway there are no legal obligations of caring between adult generations. The Marriage Act (1991) (Ekteskapsloven) § 38 states the joint responsibilities of spouses to support the family by partners being jointly responsible for the expenses and the work required to maintain the household and to cover other joint needs, the upbringing of their children and the particular needs of each spouse.

The Patients' Rights Act (1999) (Pasientrettighetsloven) endows close family (or otherwise closely related) with certain tasks / rights: Consent to medical help for people without own competence to consent themselves. In such

cases, close kin has a right to be informed of the health condition of the patient and of the help that is given.

Under the National Social Insurance Act (Folketrygdloven), there is a provision for full pay compensation when nursing terminally ill family members (Pleiepenger). This act also allows for short-term care leave with full pay compensation.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

The legal definition of old age in Norway is 67 years, the retirement age (with rights to pensions) according to the National social insurance scheme. The Negotiated Early retirement Scheme (AFP) is available from the age of 62. Some jobs have special rules for early retirement. Disability pension before ordinary retirement age is quite common.

Most health and social services are defined by needs, regardless of age.

2.2 Currently existing national policies

2.2.1 Family carers?

The "Action plan for care of the elderly: Security - respect - quality 1998-2001" sets out concrete objectives for the development of local authorities regarding nursing and care services. The core aims were: 1) to provide nursing and care to ensure the elderly a secure and, to the maximum possible extent, a worthy and independent life, 2) to ensure elderly persons the ability to live in their own home for as long as possible, and 3) to provide sufficient capacity to ensure that services are available when and where needed.

In St. meld. nr. 45 (2002-03) "Better quality of the services of care in the community" the focus is on national strategies for the development of formal services. This Govermental paper also underlines the importance of strengthening the interplay between formal and family care (p. 23). Family caregivers are mentioned in connection with arrangements like municipal care wage and national assistance pension. Services are mostly organised from the perspective of individual needs but respite and cash payment due to especially burdensome caring work are included in the above mentioned "Act of social services".

Over the last years the development of formal services are pinpointed both in government policies and in public discussions. Elderly themselves are strong exponents of formal services in political discussions. These views are confirmed in survey research. Both the younger and the older generations seem to hold the view that family care represents a supplement to formal services. Some family caregivers with heavy care burdens stand up in public to focus on the need for more respite care, economic assistance and support. Organisa-

tions, for example for caregivers to persons with dementia, are exponents for more and better formal care, for the patients and the caregivers as well.

It has been questioned whether or not family support to the elderly will be reduced due to changes in gender roles, patterns of work and mobility. As has been shown earlier, children represent an important supplement of care to their elderly parents. The new welfare system gives the family new tasks, like helping the elderly to demand their rights for formal help and services. This comes in addition to direct care and nursing (Lingsom 1997). Gautun (1999) found that otherwise active women and men are also active in their roles of helping their elderly parents to get what they need of formal care and to provide family assistance (p. 50).

2.2.2 Disabled and / or dependent older people in need of care / support?

A main principle is that everyone in need of health care or unable to take care of themselves have the right to get municipal help and care. For the last decades the rights of elderly to get municipal help in their own home has been underlined. "The Action Plan for the Elderly" had as its primary goals to strengthen home based care, expand sheltered housing and modernise nursing homes. Single rooms for all elderly living in institutions have been a major objective.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

The arrangement of municipal care wage (in the Social Services Act) may serve as a financial compensation for loss of income when family members are unable to keep their jobs (partly or fully) due to care work for own family members. The care wage is normally fairly low (on average NOK 55,000 a year in 2002, equals Euro 675), and compensate for some of the care work done but not for loss in income.

There is a right to leave with full pay compensation (according to the National social insurance act) when nursing terminally ill family members. The arrangement is primarily directed towards parents nursing own children. The same act allows limited and short-term leave (with pay) for caring.

There is no right to job sharing or part-time work. There is a strong tradition for part-time work in certain occupations and among women (teachers, nurses, home helpers, etc.).

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

Legislation and policies for health and social services are national, but supplied by municipalities (except specialised health services). There are some local variations in amount and availability of services.

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

The variations between municipalities as regards services have consequences for family members as well. This is clearly illustrated in dementia care. In 2000 / 2001, 80 % of the municipalities in Norway had special units with sheltered living for persons with dementia, compared to 70 % four years earlier. Most of the municipalities without such units are small (with less than 2500 inhabitants) (Eek and Nygård 2003).

In 1996 / 97, 55 % of municipalities in Norway had special respite arrangements for persons with dementia. Only 13 % of the municipalities had established support groups for caregivers and even fewer had special courses, training or consultation services for caregivers. (Eek & Nygård 1999) It is, however, expected that this proportion has increased during the last years.

Since municipal care wage has a weak position as an individual right, there is great variation between Norwegian municipalities in the use of care wage - how frequently care wage applications are accepted, on what terms it is allowed and what amount is paid (Eriksen, Andersen and Askheim 2003).

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)		X[1]		X[1]				
Counselling and Advice (e.g. in filling in forms for help		X[2]		X[2]				
Self-help support groups		X[3]				X[3]	X[3]	
"Granny-sitting"		X					X	
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X					X	
Weekend breaks		X						
Respite care services		X						
Monetary transfers		X						
Management of crises		X						
Integrated planning of care for elderly and families (in hospital or at home)		X						
Special services for family carers of different ethnic groups		X[4]						
Other								

1 Need assessment is always done on application for services. The patient in need is the main focus. The situation of the carer is more or less taken into account. There is no systematic evaluation of needs of family carers who try to manage on their own (in these cases the services are partially available).

2 In principle, all carers are free to seek advice from the formal help system (statutory). More specific counselling services are sometimes organised from "senior centres", day care centres, centres for voluntary help or organisations like "Organisations for caregivers of persons with dementia" (partly available). Elderly caregivers have the opportunity to seek help for psychiatric policlinics and Centres for family counselling, and special competence centre and Memory Clinics, but these services are not fully developed throughout the country (partly available).

3 Self-help support groups are partly organised from volunteer centres, partly from organisations, especially "Organisations for caregivers of persons with dementia" and partly in co-operation with the formal help system in the municipality.

4 Some senior centres has tried out special services for elderly of different ethnic groups. In addition some voluntary work is done, but to a modest degree.

3.1 Examples

3.1.1 Good practices

- Examples of organisations, centres and services of special relevance for families with persons with dementia:
  - The Norwegian Health Association, a national voluntary organisation, has dementia as one of its main issues, with a "Dementia Federation" and a "Dementia forum".
  - "Schools for caregivers" have been established in Oslo and some other places in Norway. They operate in co-operation with the local organisations for caregivers of persons with dementia and other organisations.
  - The Norwegian Centre for Dementia Research Oslo / Sem is a national "Centre of Competence" for research and development projects to give better services to persons with dementia and their relatives.
  - GERIA, a Resource Centre for Dementia and Psychiatric Care of the elderly, is a service under the Department of Primary Health Care and Social Affairs, City of Oslo.
  - "The Memory Clinic" at Ullevål University Hospital, Oslo is an example of a policlinic for diagnosis of dementia and follow-up of both the persons with dementia and their close relatives.
  - The Rosenborg centre (Oslo) is a unit for diagnostic considerations and treatment for persons with failing cognitive functions. The psychosocial aspect is emphasised.
  - Gerontopsychiatric / psychological policlinics.
- Terminal care
  - The "Fransiscus-help" (Fransiskushjelpen) located in Oslo, is a free service offering consultation on pain relief, care and nursing to terminal patients who want to stay at home.
  - Hospice Lovisenberg, Oslo is an example of a unit for terminal care.
  - The Norwegian association of Palliative Care has been active in pointing to the needs of palliative care for elderly and their families.

3.1.2 Innovative practices

- Projects related to caregivers in families with dementia
  - New technology. Together with partners from England, Ireland, Finland, and Lithuania, The Norwegian Centre for Dementia Research participates in the ENABLE project.

- Another example of ICT for caregivers is the "Action project" in Nøtterøy, Vestfold county.
- "The Project on Caregiver" (GERIA) focuses on the relationship between staff and family caregivers after the persons with dementia receive formal care from institutions or day centres.
- "Visiting service" to persons with dementia. The Norwegian Red Cross organises a service of visits to elderly in need of social contact.

- Agencies for central and local influence on politics for the elderly
  - The National Council for Senior Citizens is an advisory board for public authorities and national institutions.
  - Local "Councils for Senior Citizens" have a similar function.
- Senior- and volunteer centres

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

Municipal health care and social services in Norway include nursing homes, sheltered and assisted housing, home nursing, practical help at home and respite care. Giving care and help to elderly, who are not able to manage by themselves, is a public responsibility. However, family caregivers are involved to different degrees in the planning of the services and may find that the services offered are more or less available or sufficient and thus (more or less) a relief of their own burdens of caregiving. As from 2001 each citizen is referred to a specific physician as his / her permanent GP to secure continuity in health care both for patients and their families.

According to a recent reform, the national government is now responsible for the specialist health services including psychiatry, while dental services are a county responsibility. Long distances and insufficient resources for the service system may cause problems for the elderly and their families.

4.1.1 Health services

4.1.1.1 Primary health care

Home services are usually organised in teams. Services are available locally. Their quality and extent vary and may represent barriers to users. Further, in small and remote municipalities distance and temporary vacancies represent barriers to use. There are no or small economic hindrances to use. Not all transport is free, and the family may be called upon for transportation purposes.

Dental care services at home generally are not available; neither is home chiropody.

Home lab tests are included in standard fees collected on treatment.

4.1.1.2 Acute hospital and Tertiary care

Generally available at regional- or sub-regional level, for free. No specific barriers. Shortage of beds should not apply in case of acute care. Needs are evaluated by medical personnel prior to admission.

Rehabilitation facilities are statutory and available at local level. More specialized services are provided by regional hospitals and specialized institutions. No economic barriers, but shortage of beds occurs. Distance can be seen as a hindrance to users.

Few hospitals operate own geriatric wards, but geriatric services are available in most counties, normally as policlinics. These services are not well developed in Norway.

It should be born in mind that the public - and not the family - is responsible for the care of elderly people in Norway.

There are special assessment units for elderly with memory problems.

There are ca 25 units / teams / policlinics of gerontopsychiatry in Norway. The goal of having one in each county has not yet been reached.

Help to elderly people with psychological problems has not been given sufficient attention, resulting in problems also for their families. The psychiatric / psychological services to the elderly are best developed in the capital of Oslo and in other central areas. Compared to the situation 20 years ago, when most elderly psychiatric patients were found in long term hospitals, more patients are now treated policlinically and by short term interventions.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Nursing homes and medical facilities are available at local level, mostly public, without economic hindrance. Shortage of beds occurs. There are few private clinics.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Hospice Lovisenberg, Oslo, offers palliative and symptoms relief treatment, terminal care to cancer patients and to patients with other terminal diseases. Hospice Lovisenberg offers day care as well. The service is open for non-Oslo citizens, including free overnight stays at the patient hotel. Both treatment and transport are free.

As an example of an NGO institution, but a publically financed service, Hospice Lovisenberg serves the health region of Eastern Norway.

In Bergen the nursing home of the Red Cross Hospital offers terminal care.

4.1.1.5 Are family carers expected to play an active role in any form of inpatient health care?

In nursing homes the closest family career are expected to keep in contact with staff as regards important decisions for persons not in a position to take decisions for themselves.

There is considerable variation in informal norms for family carers, in that carers are rather free to develop their "caregiver careers" in the institutional setting. Some, especially spouses, include visits to their partners as a part of their daily routines. They often give personal care and assist at meals. This practice may lead to enhanced expectations from staff in terms of help given by close

relatives. As an ideal, staff and family caregivers have initial and follow-up meetings to clarify expectations and consider / reconsider the involvement of the family-caregiver. In principle, it is up to the family caregiver to decide how much care they want to give and the extent to which they keep on to the relationship. Some prefer to take the laundry home, accompany on trips outside the institution, and in general to administer care. Others define their roles more in terms of visiting, keeping in contact and doing "the little extras".

4.1.2 Social services

4.1.2.1 Residential care (long-term, respite)

Respite stays in day centers or nursing homes are often used for a period prior to long-term care.

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes).

Table 32: The older population in sheltered housing and nursing homes, 2000. Percentage

	67 y+	67-79 y	80-84 y	85-89 y	90 y+
Sheltered housing	5.2	3.0	7.6	12.1	15.1
Institutions / nursing homes	6.6	2.2	9.0	19.4	38.5

Source: Vigran 2002

Corresponding figures for 1994 were: 3.3 % of the population aged 67 years of age and more lived in sheltered housing and 6.7 % in institutions, mostly nursing homes. As seen, there has been an increase in sheltered housing, while the proportion of older people living in residential homes (nursing homes) has been stable.

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

Admission criterium is degree of dependency. Income is not a criterium. Shortage of facilities is reported, as are waiting lists.

Number of beds has been expanded in recent years. According to research (Romøren & Svorken 2003) there is now little shortage of beds. Number of beds in institution is not stable, but a large number of sheltered housing (special housing for elderly and disabled with limited services) have been built in recent years (The 1998-2001 Governmental action plan).

There are different opinions about the appropriate balance between traditional institutions (nursing homes) and sheltered (assisted) housing.

4.1.2.1.3 Public / private / NGO status

Social services are generally both provided and financed by the municipality, with varying fees paid by user. Some services are operated by NGOs, but paid for over public budgets. In some municipalities services are outsourced to commercial companies, but otherwise financed in the same way as public services. Services operated on market principles and fully paid by the user are supplementary and rare.

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

At admission staff usually will have meeting with close relatives. The intensity and follow-up vary both between institutions and family caregivers.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Again, it should be noted that care of (frail) elderly people in Norway is not the responsibility of the family. Community care services are consequently directed toward all older people needing such services, living alone or with a spouse / family. Thus, need is defined by the person's condition and not by the availability or ability of the family to meet caring needs. In practice, however, priority may be given to older persons without close family.

Frail elderly living alone may be evaluated as more "at risk" and therefore get more help than elderly living with or close to their families. Support to family carers in special need is statutory.

4.1.2.2.1 Home-help

Statutory (The social services act), for all people in need, young or old.

4.1.2.2.2 Personal care

As for home help, considerable needs in connection with personal care will qualify for residential care.

4.1.2.2.3 Meals service

Not statutory and varies between municipalities.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Free transport based on needs assessment is mandatory for municipalities. Help with laundry generally not available. Help with shopping not statutory, but home helpers may shop.

4.1.2.2.5 Community care centres

Not statutory; available to all older people in many municipalities.

4.1.2.2.6 Day care ("protective" care)

Not statutory, but available in some municipalities, based on needs and most often as day care in nursing homes.

Community care services mentioned above are given both to elderly living alone and as support to family carers.

4.1.2.3 Other social care services

Technical aids are statutory and available free of charge. Counseling agencies are not a generally established service. Home adaptation not an established service, but may be financed for older disabled people through the National housing bank (based on needs assessment). Training family carers is not general service, although occasionally done, i.a. by NGOs.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modeling of both home and other support care services

4.2.1 Who manages and supervises home care services?

Municipalities supervise and usually manage home care services.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

Municipalities are responsible for quality and standards of primary health and social services, regardless of who carries out the services, cpr. Supervision legislation. Control and supervision are shared between the offices of the County governor and the County physician. Care services have, since the mid-1990s, worked to assure the quality of their service provision. In accordance with the WHO strategy "Health for all 2000", the aim is to develop "effective systems to supervise and guarantee the quality in the system of health care" (Statens helsetilsyn 2002, Vabø 2002). The act of Governmental supervision of health services emphasizes the systems and the administrative procedures of intern control. In addition, staff is requested to establish comprehensive and effective quality systems.

The idea of "total quality management" and fixed routines and care assignments may, however, be ambiguous in relation to people with changing and

unstable needs. In her report on home service, Vabø (2002) stresses that management documents need to be formulated and applied cautiously to make room for necessary adjustments to individuals and situations.

There is a tension between different interpretations of what is appropriate. While administrators strive to create clearer boundaries for public care responsibility, care staff is striving to give flexible care. "A sense of dividedness and institutional confusion arises that renders the service impenetrable and difficult to comprehend" (p. 159). This tension will influence the family caregivers as well. As "care administrators" and caregivers the family will be interested in more general aims of care, but they are also closely related to the practical everyday realities of the person in need of help.

The perspectives of family caregivers will depend upon their roles and their priorities may change over time. The importance of flexible solutions and consideration of individual wishes and needs are, however, often mentioned by caregivers (Ingebretsen and Solem 2002). Family caregivers are more or less involved in the development of quality control and individual plans in nursing homes. A project on the cooperation between family caregivers and staff approach this problem (Geria 2003).

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

To be a registered nurse a professional certificate is required (obtained through four years post secondary training). To be an assistant nurse, one year of post secondary training is required. Home helpers may have courses, but both home helpers and assistants in institutions may be without formal education.

4.2.4 Is training compulsory?

For nurses and assistant nurses to be certified, training is compulsory. Due to lack of available trained personnel is untrained personnel often hired. Leaders and other persons in positions with certain responsibilities have to be certified.

4.2.5 Are there problems in the recruitment and retention of care workers?

There is a general shortage of certified / qualified care workers and many positions held by untrained personnel working part-time. Stability of staff is high in rural areas, lower in urban areas.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

4.3.1 Are family carers ' opinions actively sought by health and social care professionals usually?

The various municipal home services are generally well integrated, compared with other nations.

In the initial home visits to evaluate the needs of the elderly in question, family careers and other sources of care are registered as well. Family care is taken into account when sparse resources are to be considered. Family caregivers are more or less involved in the evaluation of needs and cooperation partners during the process. Spouses are usually involved, as far as their own health and competence are decisive for the tasks they are in need of help to perform. As regards family careers living in another household, their involvement varies depending on the character of the relationship, how able care respondents are to express their own needs and whether or not the family caregiver takes an active role as a care administrator. How actively the health and social care professionals cooperate with the family caregivers depend upon these relational factors as well as on local traditions and routines.

Routines and cooperation between family carers and staff vary to a great extent at the institutions for the elderly as well (see 4.1.1.5).

5 The Cost – Benefits of Caring

The GDP for the country?[1]

5.1 What percentage of public spending is given to pensions, social welfare and health?

According to Statistical yearbook 2003 (Statistics Norway 2003, p. 448, COFOG classification of public expenditure):

- Health: 16.6 % of total public expenditure
- Social care: 39.2 % of total public expenditure
- Pensions: 20.5 % of total public spending
- Social security transfers (2000): 13.9 % of GDP2

Social expenditure as percentage of GDP (Eurostat method), Nososco 2003 (web.nom-nos.dk): 25.8 % in 2001, 29.4 % of which was used on old age (70 % per cent on cash benefits and 30 % on services).

The above figures are not restricted to older people.

5.2 How much - private and public - is spent on long term care (LTC)?

In sources we have come across (public expenses and consumer surveys) it is not possible to identify costs for care (or long-term care).

Public care is a municipal responsibility. In 2002, Norwegian municipalities spent 50 mia NOK (Euro 600 mill) on social care services (long- and short-term, irrespective of age of the the receiver of the service; Statistical yearbook 2003, p. 448). This makes up 15.3 % of total municipal expenditures, and 7.6 % of total public expenditures. Municipal health (which includes nursery homes) made up 33 billion NOK (388 mill Euro), or 16.7 % of total municipal expenditures (5.0 % of total public expenditures).

According to consumption surveys (Statistical yearbook 2003, p. 204-5) social care expenditures made up 1.3 % of total consumption in Norwegian households in 2000, 0.2 % was spent on hospitals.

[1] This will be obtained from OECD/ centrally.
[2] Source: OECD Historical statistics 1970-2000 (p. 67)

5.3 Are there additional costs to users associated with using any public health and social services?

Health and social services in Norway are public (with minor exceptions) and mainly paid for through taxes.

- Health. Medical treatment by doctors and in hospitals is covered by the national health insurance system, with standard fees paid by the patient when seeing a doctor, including specialists.
- Medical expenses for each patient (including direct payment by the patient to doctors) are restricted to NOK 1,350 (approx. Euro 165) per year (2003). Exempted is certain medication (expensive medicines and / or medicines needed for long term / permanent use); such medication is covered by health insurance), transport to / from doctor (except emergencies), some accessories and basic fees for medical tests (when seeing a doctor), most treatment by physiotherapists and most dental treatment. As for psychotherapy, psychological treatment / counselling some are private with high fees, while some services are covered by the national health insurance. Also, other health services are to a certain degree organized from private clinics where patients cover all costs.
- Social services are provided by municipal welfare agencies. The receiver of home services will pay a fee for each visit. The fee varies with income. The fee varies between municipalities and is not intended to cover actual costs. Fees have been rising and may approach costs for buying services in an open / grey market.

5.4 What is the estimated public / private mix in health and social care?

Health services are public (minor exceptions being a few private clinics), in the sense that medical expenses are paid by the national health insurance system, which is finances by taxes.

Hospitals are public, while most GPs and also medicals specialists (outside hospitals) run their own business, but are paid by the national health insurance system (except for patient fees (see above).

Social services are (public) municipal responsibilities, except of course for informal care. Social services supplied directly to the care receiver on a commercial basis are so far of minor importance. However, some municipalities buy (part) of their social services from commercial organisations, in stead of running the services themselves, as has been - and is still - the traditional pattern.

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

In nursing homes, payment is regulated according to the resident's income. Each resident pays an amount equivalent to 75 % of the so-called baseline amount of the National social insurance arrangement (at present (March 2004) NOK 54,170, or Euro 6,600), supplemented with maximum 85 % of other forms of income (if any), after taxes. There is a basic exemption of NOK 6,000 (Euro 730). On average, users pay about one third of the total costs for staying in a nursing home. As indicated, low income residents pay less than high income residents.

Total costs vary between municipalities. On average it has been estimated to kr. 400,000 a year (Sosial- og helsedepartementet 1999b). It is typically estimated to about NOK 450,000 (Euro 54,900) in 2004. Irrespective of income and costs, every resident is guaranteed a minimum amount at own, free disposal, at present about NOK 2,000 (Euro 250) a month.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

Residential care is funded by public local authorities, but partly paid for by the resident (see 5.3).

Home care will partly be funded by local authorities by care wage to the carer (a strongly limited arrangement; see 1.1.1) and by the similar (but more short-term) arrangement of "nursing allowance" to close relatives when nursing terminating ill people, paid by the state (The national social insurance board) and by local public services, which are paid for by the recipient (but generally not at full cost), in addition to informal care.

The local expenses for cash transfer and services (and the limited arrangement of nursing allowance) are funded by taxes (although the part for the National social insurance system is specified on the tax return).

Health services are public (minor exceptions being a few private clinics), in the sense that medical expenses are paid by the national health insurance system, which is finances by taxes.

Hospitals are public, while most GPs and also medicals specialists (outside hospitals) run their own business, but are paid by the national health insurance system (except for patient fees (see above).

Social services are (public) municipal responsibilities, except of course for informal care. Social services supplied directly to the care receiver on a commercial basis are so far of minor importance. However, some municipalities buy (part) of their social services from commercial organisations, in stead of

running the services themselves, as has been - and is still - the traditional pattern.

5.7 Funding of family carers

As seen from 5.6 above family carers for older people are funded by municipalities (care wage, less than 2,000 carers a year, approx. 100 mill NOK - Euro 120) and by the National social security board through "assistance pension and through "an allowance for nursing terminating ill family members. Total costs are not specified in the annual statistics from the board (Rikstrygdeverket, 2003), but is most probably not a substantial arrangement in our context (mostly used for caring for children and middle aged people). Also, employed carers may take out sick leave for a limited period. The extent is not known. Both care wage and nursing allowance (and paid sick leave) are funded through taxes.

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

Cash - municipal care wage; see above.
Pension / credit rights - all carers are given pension points - 3 a year (corresponding to a wage clearly below average).
Arrangements are not means tested.

The terminology in the following table is understood as follows:

- Attendance allowance - cash payment to the person who needs care. Assistance pension is paid by the National social security board, typically on a long-term basis.
- Carers' allowance - cash payment to carer (care wage).
- Care leave, may be granted by employer; if paid costs are shared between employer and the National social security board. Will normally be short-term.

	Attendance allowance	Carers´ allowance	Care leave
Restrictions	Need for special nursing and care due to illness / injury	Extraordinarily Heavy care duties	Formally allowed for ten days per year
Who is paid?	Care receiver	Carer	Carer
Taxable	No	Yes	Yes (as reg. wage)
Who pays?	National social security	Municipality	Employer / Nat soc sec (dep on length)
Pension credits	No	Yes	Yes
Levels of payment / month	Depend on needs, max NOK 5,862 a month	Depend on care load, av. NOK 4,600 per month	Full wage
Number of recipients in 2002	30,124 (79 % women)	Approx. 1,850	Unknown

5.7.2 Is there any information on the take up of benefits or services?

For carers' allowance an indication is the number compared to recipients of attendance allowance. The two allowances are said to cover more or less the same purpose, and a take-up of 6.1 % is certainly low. However, both arrangements are granted more according to evaluation than they are rights based on specified and clear criteria. Also services are granted according to judgement of needs, and also restricted by available resources. A yardstick that would enable us to calculate the number of eligible recipients, be it of cash transfers or services, hardly exists, and take-ups then cannot be estimated.

The general notion that transfers and services are short in supply, or rationed for other reasons would be correct in varying degrees, depending on municipality and / or transfer / service.

5.7.3 Are there tax benefits and allowances for family carers?

Tax benefits / allowance generally not for carers (but some for the care recipient).

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

Bequest rights are restricted in Norway, favouring spouses and children (blood-relatives in a direct downward vertical line). Property and capital exceeding a rather high minimum can be bequeathed according to testator's wishes.

There is considerable transfer from the older to younger generation, as inheritance, pre-inheritance and gifts (Langsether and Hellevik 2002). Gautun (1999;

see above) has shown that help (incl. economic transfers) does not influence the amount of care giver to older parents by children - generally. If parents are in need of nursing, however, previous help from parents to children result in more nursing by children, and most so for fathers (Gautun 1999, p. 49).

There is also in Norway the traditional arrangement of "kår"-contract of sustenance for old people, when the farm is transferred from parents to the oldest child (Gulbrandsen and Langsether 2003). On farms, parents are entitled to housing quarters on the farm until they die. Formally the arrangement does not entail any caring responsibilities when the child takes over the farm. In practice, however, the old couple living on the farm on a "kår"-contract would also expect to be helped and cared for by the young couple, albeit to varying extent. In today's society, with less farms and more mobility, kår-contracts are less important, as is caregiving associated with "kår"-contracts.

5.7.5 Carers' or Users' contribution to elderly care costs (check list of services and costs to user)

The welfare system for elderly in Norway is public and universal and based on needs (and not means tested). It is basically paid for through taxes. Contributions on use for medical services are limited to NOK 1 550 per year (Euro 189). Payment for use of services varies and is highest for long term institutions (maximum 85 % of running income with no consideration for property / assets). Services are delivered by local welfare authorities (the municipality), except for general hospitals (which are a regional responsibility).

"Not avail." - in the text below means that there is no specialized service for the elderly.
(X) - means may be available, but not systematically organized.

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner		Max E 189				
Specialist doctor		- ″ -				
Psychologist		- ″ -				
Acute Hospital	X					X
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)		Max 85 % of income				X
Day hospital						X
Home care for terminal patients	Home nurse	Home help				X
Rehabilitation at home		Physi ot.				X
Nursing care at home (Day / Night)	X					X
Laboratory tests or other diagnostic tests at home	X					
Telemedicine for monitoring						
Other, specify						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X				X
Temporary admission into residential care / old people's home in order to relieve the family carer		X				X
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		X				X
Laundry service						
Special transport services		X				X
Hairdresser at home						
Meals at home		X				X
Chiropodist / Podologist						
Telerescue / Tele-alarm (connection with the central first-aid station)		X				X
Care aids		X				X
Home modifications						
Company for the elderly		X				X
Social worker	X					
Day care (public or private) in community center or old people's home		X				X
Night care (public or private) at home or old people's home		X				X
Private cohabitant assistant ("paid carer")						
Daily private home care for hygiene and personal care	X					X
Social home care for help and cleaning services / "Home help"		X				X
Social home care for hygiene and personal care						X
Telephone service offered by associations for the elderly (friend-phone, etc.)						
Counseling and advice services for the elderly	X					
Social recreational centre	X					
Other, specify						

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring		(X)				
Telephone service offered by associations for family members	(X)					
Internet Services	(X)					
Support or self-help groups for family members	(X)					
Counseling services for family carers		(X)				
Regular relief home service (supervision of the elderly for a few hours a day during the week)		(X)				
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)		X				
Assessment of the needs[3]						
Monetary transfers	(X)					
Management of crises	(X)					
Integrated planning of care for the elderly and families at home or in hospital	X					
Services for family carers of different ethnic groups	(X)					
Other, specify						

[3] There is no assessment service as such. (Most) services are universal and based on needs. Needs are assessed before admittance to residential care, before home nursing and home help are organized, etc.

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

The carers' point of view may be exemplified by The "Dementia Federation" in the Norwegian Health Association (a nationwide organisation). This federation has as its aim to work for the best possible conditions for persons with dementia and their relatives. The 10-point program of principles includes four points especially concerned with the needs of family caregivers. It is claiming formal help and service system in the municipalities, intervention and follow up the families of persons with dementia, and that information and training are available. It is emphasized that the family caregivers' willingness to care do not free public authorities of their responsibilities from cooperation with and support to families. To be able to adapt to the real needs of each family the municipalities have to supply adequate and flexible services. The principles state that the families of persons with dementia should be given economic compensations to be able to maintain their earlier standard of living.

The Norwegian Pensioners' Association (Norsk Pensjonistforbund) emphasises the major role of family carers and the support needed for these careers. The association underlines the need for better access to care wages and flexible services for elderly and their families in home services, respite care, rehabilitation, nursing homes and terminal care.

As regards abuse, experience indicates that elderly victims often have problems of getting the help they need from the ordinary service system. In Oslo, 'Protection of the elderly' ('Vern for eldre') is part of the municipal program to improve safety. This service offers counselling to elderly, coordinates services and gives advice to the service system as well.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

In Norway, expectations toward the formal service system are high. St. meld 45 (2002-03) underline the national strategies for development of formal services, but also the interplay between formal and family care. In general, the formal welfare services to the elderly are extensive. The relationship between the family and the formal welfare service system can be characterized by complementarity rather than substitution. Many family caregivers are, however, under pressure due to insufficient formal care. From time to time, there is a call for more voluntary and family care. Costs as well as performance of the

highly developed welfare system are under debate. With an increased pressure on the service systems, the interplay between the formal service system and family care will be of great importance in the future.

Cash support will hardly replace services, but the introduction of competition among service providers may imply that clients may - in the future, be awarded a certain volume of services that they may trade from different service providers - i.e. a modified voucher system - in kind, not in cash.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

The National Council for Senior Citizens (Statens seniorråd) is an advisory board for public authorities and national institutions. The council has its attention also on politics concerning senior citizens with special needs for nursing and care. On a local level the "Councils for Senior Citizens" are by law established in all municipalities as advisory bodies for local authorities.

The Norwegian Pensioners Association has direct consultations with the National Government, and act also as a pressure group centrally and through local branches.

The Norwegian Senior Citizen Association (Seniorsaken) is recently established as an interest group for the 50+. The organisation has as its aim to develop the quality of life in the third and fourth age of life, both for active and well off elderly and elderly who are dependent of help and care. The organisation wants to have the role of a 'watch dog' in the political debate and a spokesman for elderly towards the government and welfare agencies.

As regards the "Dementia Federation" in the Norwegian Health Association, (see 6.1 above), local associations for dementia caregivers around the country organize groups of caregivers and act as pressure groups on the local political level.

There are also a number of NGOs like The Norwegian Women's Public Health Association and Lions Club international who are working to give support and improve the quality of life in their local communities.

6.4 Are there any tensions between carers' interests and those of older people?

In general, elderly people in Norway have a preference for welfare state services over services from their families / relatives. Due to insufficient public services, however, families are to some extent called on to supply more care than they find reasonable. Some spouses and close family members give care at the cost of their own health and welfare.

For immigrants from other ethnic groups, the tension between the generations as regards family care needs to be taken into due consideration. A flexible and cultural sensitive service system is needed to meet the individual- and family needs.

As to care wage, there is a possible contradiction between supporting family care and gender equality policies in general and / or the interest of the career. Care wage is overwhelmingly paid to women, and thus may result in income loss as well as loss in social rights (like pensions). More generally, a care wage contributes to keeping women out of the regular labour market, partly or fully, for shorter or longer periods of time.

In general there is a common interest among both older people and their families in the support of generous public services; hardly any conflict between them in these matters. Conflict is now more likely between those in support for public service provision and those in favour of privatisation and competition in the care market.

When a person moves to a nursing home the payment is regulated according to his / her income. Thus institutionalisation will affect the total economic situation of families, couples and cohabiting partners.

6.5 State of research and future research needs (neglected issues and innovations)

Further studies on collaboration between the formal care and service system and family care are highly relevant, both for elderly in home care and in institution. This is a natural follow up of the Norwegian action plan for care of the elderly. The focus has been on the elderly persons' ability to live in their own home as long as possible and to provide sufficient services for a worthy and independent life in assisted housing units and institutions. It is worth asking how this is related to family perspectives and the aims, strains and services of family caregivers. This is highly relevant regarding families with elderly with mental health problems.

The organisation and economy of service provision, in particular the balance between public and private provision; also the question of financing, is another relevant research topic.

An evaluation of the role of New Public Management in the organising care of elderly people in Norway and especially the perspectives of elderly and family caregivers, would be useful.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

Two examples referred to in appendix, are projects on products to promote well-being for persons with dementia and their caregivers. ENABLE project (Holthe et al. 2003, www.enableproject.org) and Action (www.action.bb.se).

The National Office of Social Insurance (Trygdeetaten) reports that the number of users and the expenses to technical aids have increased. A more active service have led to more aids per user and information technology is often built into the aids. (Trygdeetaten, 2000). There are Offices for Assistive Aids in every County. Safety alarms and other equipment are widely used by elderly and their carees. Studies of elderly with combined sight and hearing problems clearly illustratrate the importance of services to this group (Lyng 2001).

6.7 Comments and recommendations from the authors

As a conclusion, we want to underline the importance of considering care for the elderly both from the perspective of individual needs and from a family- and caregiver perspective. This is relevant both for economic services and offers of care and support.

7 Appendix to the National Background Report for Norway

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 33: Life expectancy at birth (male / female) and at age 65 years

2002	At birth	At 60 years
Male	76.45	20.23
Female	81.52	24.06

Life expectancy at 65 years is estimated in 2001, for males – 16,2 years and females 19,8 years (at birth 76,2 and 81,5 respectively).
Source: Statistical yearbook 2003

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 34: % of > 65 year-olds in total population by 5 or 10 year age groups

	Per cent of total population
65-69	3.6
70-74	3.5
75-79	3.2
0-84	2.5
85-89	1.4
90+	0.6

1.1.2003; Source: www.ssb.no/statistikkbanken

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 35: Marital status of > 65 year-olds. Per cent

Gender / Age	Married	Widow(er)	Divorced / separated	Never married	Total
Male					
65-69	74.6	5.6	11.7	8.0	99.9
70-74	73.7	9.3	8.4	8.6	100.0
75-79	70.4	15.5	5.5	8.6	100.0
80-84	63.9	24.2	3.7	7.2	100.0
85-89	51.9	37.6	2.7	7.9	100.0
90+	34.1	55.5	1.8	8.7	100.1
Female					
65-69	61.8	22.4	11.3	4.5	100.0
70-74	51.9	35.1	7.9	5.1	100.0
75-79	38.1	50.0	5.6	6.3	100.0
80-84	23.7	64.5	4.3	7.5	100.0
85-89	11.3	76.0	3.7	9.1	100.1
90+	3.9	81.4	2.8	11.9	100.0

1.1.2003

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

Table 36: Living alone and co-residence of > 65 year-olds

Age	Percentage living alone		Percentage married / cohabiting	
	Men	Women	Men	Women
65-69	23.0	36.7	77.0	63.3
70-74	25.0	47.9	75.0	52.1
75-79	29.1	62.2	70.9	37.8
80-84	36.7	76.9	63.3	23.1
85-89	50.6	89.4	49.4	10.6
90+	69.6	96.8	30.4	3.2

Source: 2001, Statistics Norway (Census 2000)

7.1.1.5 Urban / rural distribution by age

Table 37: Urban / rural distribution by age

Age	Percentage in urban areas	Percentage in rural areas	Unspecified	N
67-69	73.3	25.7	1.0	97,188
70-79	73.5	25.5	1.0	312,969
80+	74.0	24.5	1.5	205,416

Source: Statistics Norway (Census 2000)

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

Table 38: Disability rates, by age, 1996. N=65.219

Age	Rate in %
60-64	32.1
65-69	32.9
70-74	33.8
75-79	39.7
80-84	46.9
85+	54.9
18+	20.5

Source: Eriksen & Næss 2004

According to the Health Surveys in Nord-Trøndelag county (Eriksen & Næss 2004), which surveyed the entire adult population in the county, disability rates varied as follows by age. Disability is here based on self-reports: Do you have a long-term illness or injury that reduce your functions in daily life (long-term meaning at least one year; "slightly" reduced excluded; only "medium and much reduced functions" included.

1985 figures were on the same level. For older people, disability rates are probably underestimated due to low response, and most so among the long-term ill or disabled.

Other methods of measuring disability rates would give other figures. According to the 2002-level of living survey (Statistics Norway 2002), around 80 % of respondents 67 years and more reported to have a long-term illness. Still, around 62 % reported to be in "very good or good health", while about 15 % reported their health condition to be "poor / very poor. More women than men report poor health. In terms of reported disability, however, there are negligible differences between men and women in the health surveys of Nord-Trøndelag county (average 20.5 and 20.4 respectively; slightly higher disability rates among women aged 45-54 and 80+, compared to men).

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

Table 39: Average household income (after direct taxes), according age of main income provider. In NOK*

Age	All Households	Single persons	Couples with-out children
55-66	334,400	179,900	383,900
67-79	203,200	144,800	271,400
80+	147,500	128,300	215,400

* One Euro equals NOK 8.20 in March 2004.
Source: Statistical yearbook 2003

7.1.1.8 % > 65 year-olds in different ethnic groups

Table 40: Immigrant population aged 60+, by country of origin. 1.1.2002

Country of origin	Aged 60+
Total	28,520
Denmark	5,617
Sweden	2,850
USA	2,291
Germany	2,269
Great Britain	2,087
Bosnia-Hercegovina	1,557
Finland	832
Vietnam	780
Pakistan	776
Poland	644
Hungary	610
The Netherlands	577
Yugoslavia	493
Iran	410
China	392
India	376

Source: Østby 2002

7.1.1.9 % Home ownership (urban / rural areas) by age group

Table 41: % Home ownership

Age (of oldest household members)	Percentage owning own home
85.8	85.8
83.8	83.8
70.6	70.6
77.0	77.0

Source: Statistics Norway (2000 Census)

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Table 42: Percentages with / without indoor plumbing

Age	Both bathroom and water toilet	Either bathroom or water toilet	Neither bathroom nor water toilet
50-66	98.0	1.5	0.5
67-79	96.9	2.2	0.9
80+	95.5	3.3	1.2

Source: Statistics Norway (2000 Census)

Living in homes three floors and more, percentages with a lift

Age	Living alone	Not living alone
67-79	37.1	32.9
80+	45.0	36.6

Close to 100 % of Norwegian homes will have electricity, TV and telephone(s).

7.2 Examples of good or innovative practices in support services

7.2.1 Examples of good practices

7.2.1.1 Work related to caregivers in families with dementia

Below are presented a selection of examples of organisations, centres and services of special relevance for families with persons with dementia.

7.2.1.2 The Norwegian Health Association

For the Norwegian Health Association, a national voluntary organisation, dementia is one of its main issues. The aim is to work for the best life conditions possible for persons with dementia and their relatives. The organisation has established special "dementia contacts" in all of the 19 counties and 119 local associations for dementia caregivers throughout the country are registered

(November 2003). Among other objectives, the organisation works to inform about dementia, put the caregivers' stress and need of support in focus and start support groups. The organisation operates a special journal and a free telephone service for everyone needing advice or someone to talk to with respect to dementia. The "Dementia forum" offers information and opportunities to exchange experience on Internet and by E-mail. The "Dementia Federation" within the organisation co-ordinates the central and the local work. This federation operates under a 10 points program of principles. Four of the points are especially concerned with the needs of family caregivers, claiming i.a. a formal help and service system in the municipalities to give early intervention and follow-up of the families of persons with dementia and to have available information and training for everyone. It is emphasised that the family caregivers' willingness to care does not free public authorities from their responsibilities to co-operate with and support the families. To attend to the real needs of each family the municipalities have to offer adequate and flexible services. The principles state that the families of persons with dementia should be given economic compensations to be able to keep their earlier standard of living (http://www.nasjonalforeningen.no/).

7.2.1.3 "Schools for caregivers"

"Schools for caregivers" have been established in Oslo and some other places in Norway, they operate in co-operation with the local organisations for caregivers of persons with dementia as well as with other organisations. They arrange courses for caregivers with lectures and group discussions on dementia, on the situation of the caregivers and on other relevant issues (Hotvedt 1999, Nasjonalforeningen 2002).

7.2.1.4 The Norwegian Centre for Dementia Research

The Norwegian Centre for Dementia Research in Oslo / Sem was established in 1997 as a national "Centre of competence" for research and development projects to give better services to persons with dementia and their relatives. Main tasks are to develop and give information on dementia, to offer counselling and consultation to the municipal and specialised health services, to develop new models of services and care for persons with dementia. The Norwegian Centre for Dementia Research organises courses all over the country and has widespread publication and information services. Projects includes one on dementia in persons younger than 60 years of age (http://www.nordemens.no/).

Also other research centres operate relevant projects for family caregivers, like one conducted by NOVA – Norwegian Social Research, on dementia from a couple perspective (http://www.nova.no/). (Ingebretsen and Solem 2002, 2003)

As an example on the local level, is GERIA, a Resource Centre for Dementia and Psychiatric Care of the elderly, a service under the Department of Primary Health Care and Social Affairs, City of Oslo. Help to family caregivers are especially mentioned as an objective. A project on collaboration between staff and relatives of persons with dementia in institutions is in process (http://www.geria.no/).

In Oslo, "The Memory Clinic" at Ullevål University Hospital is a policlinic for diagnosis of dementia and follow-up of both the persons with dementia and their close relatives (Øksengård et al.1997). The Rosenborg centre (Oslo) is a unit for diagnostic considerations and treatment for persons with failing cognitive functions, with an emphasis on psychosocial aspects.

Gerontopsychiatric / psychological policlinics and units for elderly and their families are not fully developed in Norway. There are great variations in availability and the differentiation of the services offered varies between different parts of the country. Most "Family clinics" do not give special attention to the problems of elderly families. It is a national goal that everyone should be guaranteed the necessary health services regardless of age, ethnic or social background, or economic and geographical circumstances. (St. meld nr 25, 1996-97 and St. prp nr 63, 1997-98). "The plan for Stepping up of Mental Health services" (Sosial- og helsedepartementet 1999a.)

7.2.1.5 Terminal care

The "Fransiscus-help" (Fransiskushjelpen) located in Oslo, offers free service consultation on pain relief, care and nursing to terminal patients who want to spend their last days at home. Included in the service is consultation and support to family caregivers of the terminal patients as well as respite care. Caregivers with long lasting care tasks and persons in grief are other target groups for this well-regarded service.

Hospice Lovisenberg (Oslo) is an example of a unit for terminal care. It is based on the hospice ideology with holistic care both for patients and families. The unit accepts patients from the eastern part of Norway for day or day and night care.

The Norwegian Association of Palliative Care has been active in pointing to the needs of palliative care for elderly and their families.

7.2.2 Examples of innovative practices

7.2.2.1 Projects related to caregivers in families with dementia

7.2.2.1.1 New technology: Enable

Together with partners from England, Ireland, Finland, and Lithuania, The Norwegian Centre for Dementia Research participates in the ENABLE project.

The project is funded under the EC Programme "Quality of Life and Living Resources", and lasts for three years. The project aims at facilitating independent living for people with early dementia and to promote their wellbeing through access to enabling systems and products. In Norway, 25 persons with dementia and 25 family carers are involved in the ENABLE trial assessment. Products tested are: night and day calendars, picture telephones, locators (of lost objects), and medicine reminders (programmed with an automatic sound). Most respondents are satisfied with the products, they find them useful and they use them. The products that are most popular in Norway are the night and day calendar and the medicine reminder (Holthe et al. 2003, www.enableproject.org).

7.2.2.1.2 Action

'Action' stands for: Assisting Carers using Telematic Interventions to meet Older persons' Needs. The 'Action project' in Nøtterøy, Vestfold county is organised in co-operation with the College of Borås, Sweden, based on an EU-project. The main aim is to support frail older people and their families to maintain or enhance their quality of life via the use of user-friendly information and communication technology in their own homes (www.action.hb.se/).

7.2.2.1.3 "Project on Caregivers"

"The Project on Caregivers" (GERIA) focuses on the relationship between staff and family caregivers after the persons with dementia receive formal care from institutions or day centres. The project includes staff and family carers in four institutions and use a variety of methods: questionnaires, lectures, group discussions and one-to-one-collaboration between staff and family carers. An earlier project from GERIA focused on collaboration contracts between staff and family carers (http://www.geria.no/).

7.2.2.1.4 "Visiting service" to persons with dementia

The Norwegian Red Cross (www.redcross.no) has an organised service of visits to elderly in need of social contact. In collaboration with GERIA, the organisation of caregivers and the "Fransiscus help", the "Red Cross Visiting Services in Oslo" offer special courses for volunteers who want to be visitors of persons with dementia.

7.2.2.2 Agencies for central and local influence on politics for the elderly

The National Council for Senior Citizens is an advisory board for public authorities and national institutions. The council focuses on issues concerning living conditions of senior citizens, and their opportunities to take part in working life and society at large. In particular, the council has its attention on politics concerning senior citizens with special needs for nursing and care. The council has existed since 1970 and functions as a useful channel of influence

directly to Government organs for family caregivers as well as other interest groups.

On a local level the "Councils for Senior Citizens" in the municipalities have a similar function.

7.2.3 Norwegian senior centres and volunteer centres

Senior centres have a history of more than 50 years in Norway, with ca. 330 centres and 130 000 elderly users (Daatland et al 2000). In addition Norwegian volunteer centres has been established from 1991. In 2001 more than 200 volunteer centres are registered. Voluntary initiatives on health and social affairs have been, and still are, central in the work of these centres. Elderly persons (60+) are the largest group of both users and volunteers. Examples of help include: bringing meals, transport and accompany service, visits, gardening, etc. This is useful both to the person in need of help and as an assistance to the formal service system and to family caregivers. A recent report emphasises a shift in the profiles of the volunteer centres over the years, where the care-perspective has become somewhat downplayed. Three activity profiles are mentioned: The "care centres" with a relatively narrow orientation towards social and practical tasks. "Community centres" sees the centres as a driving force in building social neighbourhoods in the community as a whole. According to Kloster et al. (2003) the most common activity profile is the "meeting-place centre" which has a broad repertory of social care activities as well as recreational and community activities. Self-help groups and groups for caregivers are often organised in connection to or in collaboration with voluntary centres.

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