



Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Work Package 5

The role of informal care in long-term care

National Report Greece

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1 Introduction and Background

Greece, or the Hellenic Republic as it is officially called, lies at the southernmost end of the Balkan Peninsula, covering an area of 131.957 km² and bordered to the northwest by Albania, to the north by the Former Yugoslav Republic of Macedonia and by Bulgaria, to the northeast by Turkey, to the east by the Aegean Sea, to the south by the Mediterranean Sea, and to the west by the Ionian Sea. Greece's topography is highly diverse. The numerous islands in the Aegean and Ionian Seas occupy about one-fifth of its territory and much of the land is mountainous and rugged, less than a fourth is lowland, and about one-fifth is forested.

Greece's population according to the 2001 census was 10,934,097, giving an overall population density of about 82,86 persons per km². The capital is Athens, with a population of about 3,894,573 documented citizens. During the 1990s there were substantial inflows from Albania (50% of all migrants), and other Eastern European countries e.g. Poland, Romania, Bulgaria and Russia. Other groups include Pakistani, Afghanistani, Bangladeshi etc., with total estimates being 200,000 for illegal migrants and approx 700,000 with some kind of legal residence permits and a further 150,000 in a grey area whose legal status is not clear.

According to law, any Greek citizen (as well as any citizen of an EU country) can receive services at any outpatient department of a National Health System (NHS) hospital, or at a rural health centre. In practice, any person from any country (including illegal immigrants) can receive care at these two provider settings. Entitlement on the basis of insurance contributions applies to all other provider settings. These include urban polyclinics owned by insurance funds, in-patient care provided by NHS hospitals, and private providers (whether private practices or diagnostic centres or hospitals) who are contracted with insurance funds. Coverage for these services is provided only for insurance fund members and their families and includes a wide variety of schemes for co-payment and/or reimbursement for services, investigations and treatment, involving complicated bureaucratic procedures. Pensioners continue to be covered by the fund they belonged to while working, and pay their own contribution. The unemployed belong to an unemployment fund financed by the budget, and are covered by IKA services for a period up to 12 months. Finally, there is also entitlement to services by virtue of being poor. The poor are entitled to free out- and in-patient care at public hospitals, following a protracted bureaucratic process to ensure entitlement, which gives the user the relevant documents.

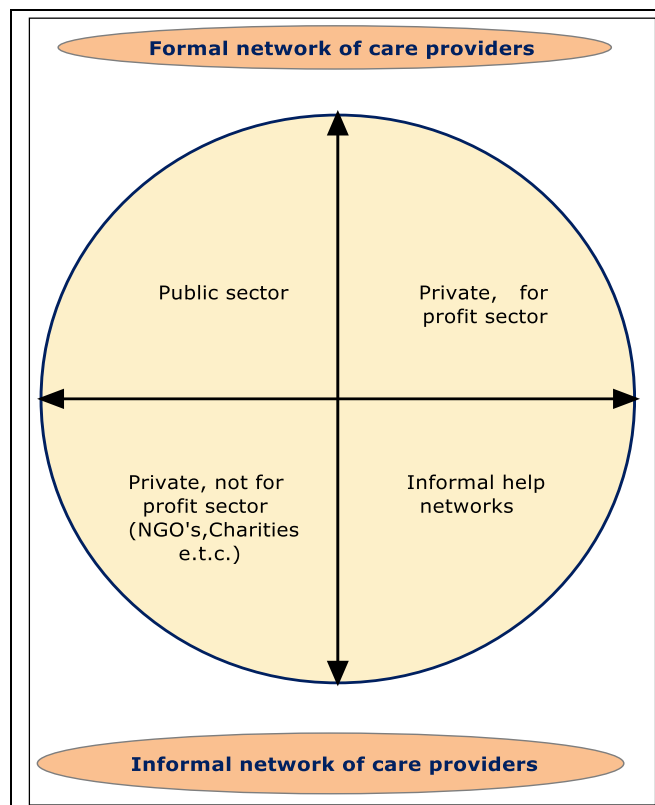
1.1 What is understood by “informal care” and “formal care” in your country? What are the main definitions used to distinguish between the informal and formal care sectors?

In Greece, the term “formal care” is understood to refer to any type of care service provided by the state or a private body or an NGO, but always by professionals. “Informal care” refers mostly to family care, or care being provided by relatives and friends in the home and by people who are not being paid for this kind of service, either by the patient or by the state or by their organization (in case of a N.G.O.).

The provision of paid but non-professional and often uninsured care by individuals such as migrant care workers, who are privately employed by older people with care needs and their families, currently constitutes an intermediate category of care whose characteristics fall between the formal and informal care sectors (see following paragraph and diagram).

Informal care is estimated to cover the biggest proportion of the needs of the Greek population, although there are no official data and in general it has to replace the weakness and inadequacies of the Greek health and social care system. This lack of formal support services, combined with greater longevity and increasing needs for care, smaller family size, geographical and social dispersion of families and women working increasingly outside the home, mean that Greek families are forced to find their own solutions to the provision of care; the main solution for those with adequate incomes, is the use of privately employed, live-in migrant care workers, the characteristics of whom are discussed in section 4 below. Their status for this report lies between the private for profit sector and Informal help networks in the diagram below.

Diagram 1 Sectors of care providers for dependent older people (Based on Pijl, 1994)



1.2 Cultural and current political context: attitudes to ageing/older people and their care needs. How are issues of informal/ family care and LTC services discussed?

The ageing of the population, both in absolute numbers and as a percentage, is a reality for Greece. Those aged 65 years and over constitute 19% of the population (895,384 men and 1,142,867 women) and those aged 80 years and over constitute 4.1% (2007 estimates). The increasing needs for care, especially of the oldest old, is already evident (Triantafillou et al, 2006) and the vast majority of older people in need of support from others in their everyday lives rely on the availability of the family, relatives or friends for help, following the Mediterranean model.

The issues of informal family carers and their interaction with LTC services are remarkably low on the public agenda in Greece. This is surprising considering the immediate involvement of most families for longer or shorter periods of time in the provision of informal care to dependent relatives. The issue focuses more on the “moral obligation” towards people in need, rather than on how to provide a sophisticated and well-organised alternative model of care. As a result the needs and the rights of both dependent older people and their carers are being neglected, as well as any kind of financial or other type of support to them.

1.3 Legal aspects of care – how are the relative responsibilities for the care and financial support of dependent older people shared between family and state? What is the estimated contribution of family care to the total provision of care for dependent older people?

The family under civil law is responsible for the care of its dependent members of all ages. Where the family cannot provide such care, then Social Protection policy operates, including both contribution-based social security cover and non-contribution-based social welfare provision. This legal primary responsibility of the family is specified in the Constitution of 1975, amended in 1986 and 2001, which includes the highest norms in the hierarchy of rules of law.

Although the constitution itself does not mention the concept of “social security”, two provisions in the revised text are particularly relevant for the recognition of the fundamental right to social protection: in Section 21 the following is stated (only the relevant parts are mentioned):

- *“The family, as the basis for the preservation and progress of the nation, as well as marriage, motherhood and childhood are under the protection of the State.*
- *Large families, war invalids and invalids of peacetime, victims of war, war widows and orphans, as well as the incurably physically and mentally sick, are entitled to special State care.*
- *The State will care for the health of citizens and will adopt special measures for the protection of young people, the elderly and invalids, as well as for assistance to the needy.*
- *For those without any or with insufficient accommodation, housing support is subject to special State care.*
- *Persons with special needs are entitled to take advantage of measures, which guarantee their personal autonomy, employment inclusion and participation in the social, economical and political framework of the country”.*

Despite responsibility being delegated to both the family and to the State, there is very great difficulty in enforcing these provisions since it requires action by the public legal service (legislator). Both in legal doctrine and in case law the legislator is given a wide discretion with regard to the concrete implementation of social rights. It should also be pointed out that in Greek law there is no legal remedy by which the legislator can be forced to act (see www.ggka.gr).

Psychosocial services are available in the community mental health centres, but there is no data on their use by family carers. In cases where family care is inadequate, the political authorities have the responsibility to intervene for the care and protection of the older person.

Until recently, there have been virtually no experts on family policy and although many lawyers handle family cases, there are no specialists in family law.

There is no national legal definition of old age, but the various Insurance and pension funds make rules defining the age or years of contribution, which confer pension rights. There were over 200 funds with a large variety of systems and rules; according to the recent law, their number has been limited to 13. Over 50 % of the population are insured by IKA (Social Insurance Fund covering mainly urban workers), which defines retirement in terms of a minimum of contribution payments completed, so workers in what are called dangerous or dirty / heavy occupations may obtain entitlements to a pension earlier than the current standard 65 years for men and 60 years for women. Individuals with inadequate numbers of years of contributions or no insurance coverage are granted the lowest level of pension entitlement (at about 500 €/month), which can be supplemented by applying for a special benefit – EKAS – currently received by low-level pensioners with a maximum income of 9.500 € or 14.000 €/month for families. Another major section of those on pension receive an entitlement to pension without necessarily having made any insurance contributions – OGA, the Agricultural Workers' Pension, awards pensions both to non-insured farmers and others not insured at the age of 67. Until recently, this was a non-contributory system, which was financed by contributions from other pension funds and the state. However, additional voluntary contributions can now be made to bring the amount up to the level of other basic pensions. Because of the wide disparities in both the amount of the pension and the age at which pensions can be granted (e.g. women with under age children in some insurance funds such as Civil Servants and Bank Employees, may be eligible to receive a pension after 15 years of work), current attempts are being made to reform these unsustainable systems in line with other EU countries, although these reforms are being met with fierce resistance by those negatively affected.

People aged 65+ may have access to subsidized public transport fares, and through the KAPIs may obtain Culture Cards for free or reduced tickets to museums, theatres, cinema etc.

1.4 Very brief description of main component services in national LTC systems (public, private, NGO); how are they organised and delivered; strengths and limitations, including coverage

The Ministry of Health and Social Solidarity is the leading institution in developing health policies and planning services. It is also responsible for the provision and financing of the National Health System as well as health and social services for the poor, the elderly and the disabled, many of which are provided and managed by municipal authorities; also a large part of health care services is provided by the private sector. The NHS, implemented in 1986, operates throughout Greece via the state hospital (secondary health care) sector, but the primary care sector is still characterized by fragmentation and inequities in both coverage and provision, due to the wide variety of different health insurance funds that offer primary care. Despite attempts to decentralize the governance of the NHS with horizontal integration of regional health and welfare services, it's main structure and orientation remains vertical, with a top-down approach and one central point for decision-making. Primary health care in the public sector is delivered through a dual system consisting of PHC centres and hospital ambulatory (outpatient) services that belong to the NHS, and 350 primary care units that belong to the largest social insurance fund (IKA) with 5.5 million beneficiaries (Lionis, et al. 2009). The rest of the funds provide health care services to their beneficiaries mainly through contracts with private physicians for the ambulatory sector, and public or private hospitals for secondary and tertiary health care services. As a result of the high ratio of physicians per 100.000 inhabitants, one of the highest in the EU, combined with one of the lowest ratios of nurses, there is a strong emphasis on curative services, rather than health promotion, disease prevention, rehabilitation and home care services (Lionis et al., 2009).

Secondary and tertiary care is provided by NHS hospitals, which are publicly owned and financed mainly by the state budget as well as by the insurance funds. Due to the lengthy bureaucracy and lack of coverage in parts of the primary health system, hospital out-patient departments, where appointments can be made directly by patients, are used heavily by older people, for example to obtain simple repeat prescriptions. Inpatient admissions are also frequently manipulated as the only form of respite care available to family carers, often with the tacit agreement of the hospital staff (Triantafillou and Mestheneos, 1994). Apart from the Ministry of Health and the social insurance funds, the private sector plays a significant role in health care provision, as well as the voluntary sector (NGO's, private not-for-profit sector) and other informal networks of help, apart from the family.

The Greek PROCARE report (Sissouras et al, 2002) gives a useful overview of systems of "integrated" care provision in Greece.

1.4.1 Public sector

In the public sector network are included services and programmes conducted by Ministries, State bodies and Municipalities. They are authorized bodies, and they offer health and social services, funded by taxation and obligatory social insurance contributions and are nominally without any charge to the user. They employ trained professional staff and the quality level of services reaches the minimum requirements of the law.

The main disadvantages in the public sector are the complicated bureaucracy and tardiness in the provision of services, whilst there are not enough incentives to public servants to evaluate and improve their professional role. Additionally, many publicly employed doctors also have a private practice, with

the obvious financial incentive to provide better care for their private patients. In most cases there is lack of efficiency and quality evaluation of services in the public sector and because of their huge dimension they don't have the flexibility to adapt to new methods and techniques.

Public services in the LTC system include:

“Help at Home”

A recent extensive study of the Home Care services, carried out by EETAA¹ (EURHOMAP, 2008) and involving questionnaire interviews with staff from a 27% sample of HC services and a 10% sample of 10,000 service users, reported the following main findings:

- 62% of services offered in the Help-at-Home services had a strong health dimension, despite the fact that older people lived within a 5 km range of primary health care services. However only a few of the latter (PHC) provide staff to support the Help-at-Home services and few provide outreach services.
- The law on eligibility for service use covers only those without adequate family support, who are dependent on the help of another person and poor. Others who have needs and could afford to pay a contribution to the service are not eligible to receive services from public bodies.
- There is no assessment of quality standards in the services, no common criteria for the assessment of needs and dependency levels for older people. Staff qualifications, though specified under the establishing Law, cannot always be met in some areas. The structure of the Help-at-Home service is currently changing, with the aim of giving all services a client budget and cost per unit of staff time.
- Funding remains a long-term problem. Some consequences are non-permanent work contracts for staff, non-payment of salaries and long-term insecurity.
- These findings and others are similar to those of a previous evaluation of the “HELP AT HOME” service, published by KEDKE² in 2002 (Amira et al, 2002), giving an indication of the difficulties encountered and obstacles to be overcome when running such an essential service in local areas

(See also INTERLINKS practice example EL_5.5.c,d,e,f <http://interlinks.euro.centre.org/project>).

KAPI (ΚΑΠΗ) - Open Care Centres for Older People

KAPIs are local community day centres for older people, existing as prototypes since 1979 and subsequently expanded into the present pan-Hellenic network of more than 1,000 centres, most of which have between 300-600 members; however, exact figures are difficult to obtain as many municipalities and large towns run several KAPI centres, but record overall numbers of members e.g. around 1000 members, not all of whom are active participants. The KAPIs offer socialization through social activities, primary health care including prevention and health promotion and social services. According to their regulations, their staff should consist of: a social worker, an occupational therapist, a physiotherapist, a nurse, a home helper and a part-time employed general practitioner, but many of them operate with the minimum staff of a social worker and a nurse, plus other part-time professionals when available. They do not offer protective day care for dependent older people, as their principal aim

¹ Hellenic Agency for Local Development and Local Government <http://www.eetaa.gr/>

² Central Union of the Municipalities of Greece <http://www.kedke.eu/index.asp>

is to maintain older people's autonomy by promoting their healthy, active participation in their communities, whilst living in their own homes for as long as possible. Older people must be able to attend the centre on their own in order to become members, for which they pay a symbolic amount (membership fee e.g. 1-10€ / year), which can be waived at the discretion of the social worker in charge. The KAPI funding is covered by the municipalities from central sources and depends to a large extent on the social policy priorities of the municipality. The popularity of the KAPIs has ensured their survival and expansion throughout successive political party governments as well as during times of financial crisis, although the increasing numbers of new centres being opened do not always provide a full spectrum of services, and financial cuts have also limited the programmes being offered by the longer established KAPIs. Administratively they belong to the municipalities and they are run by an Administrative Board, which includes at least one elected KAPI members' representative.

Despite their common aims and common basic structure, the KAPIs are not formally linked into a network, which, with a system of regular evaluation, would maximise their potential impact on the health and well-being of older Greeks. Finally, the KAPI centres together with their associated Help-at-home services provide a basic form of integrated care services to older people at the local level, the effectiveness of which is hampered however, by inadequate and insecure funding and lack of long-term planning and evaluation (Daniilidou et al 2003)

Public residential care homes for older people

Public residential care for the elderly is limited and mainly addressed to the poor and there is a long waiting list up to 3 years in many cases.

Day - Care Centres for Older People (KHΦH)

The development of Day-Care Centres for the Older People (KHΦH) by Municipal Enterprises, Inter-municipal Enterprises, Unions of Municipal Enterprises, Non- profit Private Law Entities, aim to provide day-care for dependent older people with no family or while their family carers are at work.

Centres for chronic diseases and rehabilitation

Centres for chronic diseases and rehabilitation - operate at about 10 centres around Greece, but with poor infrastructures and long waiting lists.

1.4.2 Private for-profit sector

This sector consists of private organizations and licensed individuals offering a variety of health and care related services for a negotiable fee, either through private hospitals, clinics, Residential Care Units for Older People (MFI) and employment agencies for home carers, or through private offices, and nominally monitored by a public body, e.g. the Nomarchia (prefecture). They function on market-based principals (for-profit) and their operational costs are covered by the clients. The personnel should have at least a minimum of trained professional personnel (e.g. for MFI, trained nurse and social worker), as well as usually untrained care staff. Their evolution and expansion is flexible enough to adapt to new needs and market demands for services. Moreover, they have the potential to offer incentives for achieving better quality of service and to operate using the latest management methods, although financial constraints may limit these potentially good practices.

Weak points in the private sector include firstly, their profit-maximising operation, which is an obstacle to access for social groups that do not have the ability to pay and which is in direct contradiction to the EU principles of equity in access to health and social care services. Secondly, the need to generate profit can lead to dangerous cost-cutting practices, which reduce both the quality and safety of the service, as well as the temptation to perform unnecessary investigations and prescribe expensive drugs that give more profit. Thirdly, the profits generated in the private sector encourage its unlimited expansion and the exploitation of ill health, rather than focusing on the less lucrative but more effective areas of disease prevention and health promotion. And finally the private sector may dominate and influence the policies of government in the area of health and social care provision in order to serve major vested interests (e.g. lack of regulation in the pharmaceutical sector, inadequate or difficult to access public health and care services forcing people to use the private sector, tax facilitations for private care services etc).

However, the lack of available data in the private care sector makes it impossible to reach any conclusions about the balance between positive and negative factors in practice.

Private for-profit sector's services in the LTC system include:

Residential care homes (MFI)

There is official data only on legally registered MFIs, which number 120 units from both the public, but mainly private sectors, and with a capacity of up to 10,000 beds. Additionally, many units are registered as hotels so as not to fulfil the official requirements for such institutions and there is no data available for them. The costs of residential care vary from 600€/month or more for unregistered facilities and from 900 to 3500 €/month (vat 9% included) for legally registered care homes, which are partially covered only by 2 of the smaller social insurance funds (health professionals and engineers). According to the law 1136/2007 the state designates the structural specification and staffing standards that the residential care unit should accomplish in order to get legal permission to operate. Some units have already adopted the ISO 9001:2001 which certifies the requirements for quality management systems, or the HACCP which assures safer food products.

(See also INTERLINKS practice example EL_2.3.e. <http://interlinks.euro.centre.org/project>)

Care workers at home

The majority are migrant women (especially those who must live in for a 24h/service), many working without work permits, without social insurance and without residence permits. Initially they are usually paid around the lowest basic salary of 740 euros gross/month or less where they do not know the language, but this amount may increase and the amount paid also relates to the dependency level of the older person and how much care is needed. There is no data about their total numbers in Greece; one estimate is that perhaps less than half are insured under IKA (see section 4.3), although carers of older people are recorded within the common category of "domestic workers", who pay a reduced contribution in an attempt to legitimise illegal workers. Figures from the EFC study of family carers showed a total of 7% of the sample using migrant care workers, but this figure does not include dependent older people without family carers, who might be expected to have a higher rate of use.

Medical care

Private medical care is available through private offices, clinics and hospitals and is offered at home within or without the official public health fund e.g. doctors registered with IKA polyclinics may offer services at home for an extra payment. For a large proportion of older people and the disabled, this kind of mixed public/private medical care arrangement constitutes their regular primary health care.

1.4.3 Private not-for-profit sector

This sector includes services and programmes run by NGO's, charity and philanthropic organisations, churches and their branches and privately funded foundations. They are private bodies, which work on a not-for-profit basis and where the voluntary element is usually quite high. They vary in size and in action while their activities may extend to the international level e.g. Hellenic Red Cross, Doctors without Frontiers etc. They are monitored and regulated by public bodies to assure both the legality and quality of services they provide and staff is composed of both paid employees in cooperation with volunteers. In Greece, as in many other countries, they cover the inadequacies of the welfare system and they are partners of the state in the provision of some social services.

These organizations can be particularly flexible, giving "voice" to socially excluded groups and defending their rights e.g. Alzheimer Associations. Their staff and volunteers are usually people with a deep knowledge of the problems in the field and can quickly develop new social programmes in response to changing needs. This "3rd sector" is said to be developing rapidly in the Western World by providing sometimes unique services in the field of social care and policy.

Their weak points are mainly related to finance; usually part of their income comes from State funding which immediately limits their autonomy. They also devote a lot of time to fundraising events and other actions to earn money, which can reduce the efforts to real action. The 3rd sector organizations have several times been accused of "commercialisation of philanthropy".

Private not for profit sectors services in the LTC system include:

- *NGO's for special groups*: NGO's which run support groups and day care services for special groups (e.g. Alzheimer's patients and their families)
- *NGO's of older people*: NGO's formed by older people themselves, such as 50plus Hellas, which aims to improve the quality of life of those over 50 years of age in Greece, within a more equal society and through actions and activities affecting all aspects of life, including work at advocacy level on promoting the rights of the elderly.
- *NGO's as service providers*: The Hellenic Red Cross operates "Help at Home" services since 1988 in less developed suburbs of Athens within the framework of their community social care programme. They offer a wide range of social services, psychological support, medical and nursing services and home-help services. Moreover, they operate a prototype KAPI (Daily Care Centre for the Elderly) in northern Athens and open services for psychosocial support for socially excluded people and families. The organization "Life Line Hellas" supports a system of tele-notification, through which older people in need who are subscribed to the programme can get rapid assistance (ambulance, relatives, police etc) by pressing a red button installed in their house or worn on the body.
- *NGO's combating social exclusion*: NGO's and other organizations (e.g. medical schools participating in EU funded projects), which run several health promotion and disease prevention programmes for

socially, excluded groups, which include older people (e.g. older homeless people, older ROMA populations, older migrants).

1.4.4 Informal and voluntary sector (family, friends, informal networks, etc)

When it comes to the need for care for loved ones, most Greeks choose to be involved either through a personal contribution or at least through close supervision of the care of their dependent relatives. Family networks are still essential in a society where welfare state provision is limited, and older people who have contributed throughout their lives to the practical and financial support of children and grandchildren, can expect to draw on the same network when they themselves need help. For Greek family carers, main motivations to care include emotional bonds, a sense of duty and a personal sense of obligation, whereas economic benefits were influential for only a tiny percentage of carers. However, there are no services for the carers (such as psychosocial support or respite care) and no recognition of their contribution or financial support for them, although they are sometimes forced to quit their jobs (about 10% - see 1.5.2. below for analysis) in order to assist their relatives.

Informal networks of help (e.g. in the neighbourhood) exist in some cases, but they are not well organized and they depend only on personal initiative. We do not have any official data for such efforts, as these networks are not supervised by any authority. However, data from the EFC NASURE showed that other informal carers contributed significantly to helping the main family carer to provide the care needed by the dependent relative, in contrast to the small input from formal care services and programmes (see Table 1 below).

Table 1 Who helps the older person to meet their needs?

Over 65 year olds relying partly or completely on others for help, by type of care needs and sources of help

Does the older person have a need for help in any of these areas (thus relying partially or completely on others to meet it)? ("YES" answers only)	Number in Sample: 1014	Source of help (% values)		
		<i>Needing help</i>	<i>The interviewed carer</i>	<i>Other informal carers</i>
<i>Type of help needed</i>				
Domestic Care	875	86.1	33.3	8.1
Emotional/Psychological/Social	912	95.8	48.8	8.1
Health Care	896	93.0	32.8	14.1
Mobility	728	92.9	35.7	6.9
Financial Management	803	90.9	25.3	1.7
Care Organisation & Management	741	88.0	25.8	5.3
Personal Care	667	92.2	8.1	6.9
Financial Support	532	87.6	26.9	2.4

Source: EUROFAMCARE National Survey Report for Greece (Triantafillou et al., 2006).- Note: *) more than one answer was possible, so percentage values (which are calculated on the total number of subjects who reported the specific need and answered this question) do not sum up to 100.

1.5 Data on Informal family carers and other informal, unpaid carers (volunteers, neighbours, friends, church etc.).

The European study “EUROFAMCARE: Services for Supporting Family Carers of Older Dependent people in Europe: Characteristics, Coverage and Usage” in its national survey report for Greece gives up-to-date and useful information about the profile of family carers in Greece, through data collected from a non-random sample of 1014 carers in Greece.

1.5.1 Socio-Demographic data

- Mean (average) age of Greek family carers: 51.7 years
- Women represented 80.9% of family carers.
- Marital status: 76.4% of the sample of family carers was married or cohabiting. 20.2% of the carer sample reported having no children. Of those who had children the mean number was two.
- Relationship of family carer to cared-for older person: 17.1% were spouse carers, and many of the men family carers were in this category and a further 1.8% were siblings, 55.4% of carers were children and 13.9% were daughters-in-law or sons-in-law, 4.4% were grandchildren, 4.2% were nephews/nieces and 3.2% fell into other categories e.g. other relatives, close friends, neighbors and volunteers.
- Of all family carers just 11 (1.1%) were of non-Greek origins. The situation concerning the family care of immigrants is unclear, as many migrants are younger and their older dependent relatives are still in their home country.
- Educational level: 37.4% had a low level of education, 40.6% an intermediate (typically those who had finished High School/Lykeio) and 22.1% had a high level of education.
- Religious beliefs: 36.3% reported that they were very religious and only 12.8% reported not being religious at all. Family carers belonging to a religious denomination were overwhelmingly (99.0%) of the Greek Orthodox faith.

1.5.2 Employment situation and care giving

- Mean hours of care provided/week for the dependent older person = 51 (the highest in the 6 survey countries), with an additional 31 hours/week of care given to others.
- Mean length of time for which care had been provided was 5 years at the time of the interview.
- Employment situation: 47.2% of family carers were still working. The high proportion of those who reported that they were self-employed (26.9%) is consistent with the norm in Greece. Greek carers worked, on average, longer hours – while the mean for the 6 countries was 35 hours, Greek working carers’ mean average working week was 40 hours, with a maximum of 140 hours a week! The numbers reflect the low participation rate of Greek older women in the formal labour market, although in reality a larger proportion of women work in the informal labour market e.g. as farmers’ wives in agricultural occupations and other forms of unpaid family labour; thus they are unlikely to state they are retired since they continue to work as housewives.
- Caring implications on working life: 126 carers (12,6% of sample) reported that caring had stopped them developing their career or studies; 122 (12,2%) had felt they could only work occasionally; while other forms of restriction were mentioned by 38 carers (3,8%). 91 (19,2%) had had to reduce the number of working hours by a mean number of 9 hours per week. This reduction had had a negative impact on their monthly income by up to 400 euros per month. Amongst non-working

carers 93 (17,7%) were unable to work at all because of their caring responsibilities, while 54 (10,3%) had given up working because of their caring duties.

- Income and financial issues
- House Sharing: family carers and the dependent older person shared the same household in 50.7% of the sample; a further 15.4% of carers lived in different households, but in the same building as the older person; thus in total 67.1% lived in the same block of flats or the same household. A further 15.6% of carers lived within walking distance of the older person while 18.3% had to drive or take a bus to get to the cared for person.
- Household income: the mean amount for a 3 person household including the older person was 1093 euros, a third less than Italy and almost a half of the mean income in German households. However there were huge variations from 40 euros per month to 10,000!
- Number of dependent people: Although the majority of family carers (80.9%) cared for just one dependent older person, 16.8% were caring for 2 older dependent persons while 2.3% were caring for 3 or more dependent older people.
- Financial difficulties caused by care giving were reported for only 27.8% of the carers. Despite this, it should be noted that 52.5% of older people were reported to need at least some financial support. Additionally, financial support was rated by the majority of family carers in Greece as the help they would most appreciate in caring for their older person.

2 What are the main links and interfaces between informal carers and the health and long-term care systems?

2.1 Policies for informal/ family carers of disabled people or dependent older people

There is some political rhetoric about supporting the family, but it is clear that family carers are viewed primarily as a resource and not considered to have their own needs for support. There is no type of benefits such as cash, pension credits/rights or allowances for the carers, although supporting a dependent older relative with an income below 500 euros a month may be claimed for income tax relief. The costs of caring are not only in terms of time but also direct costs, yet few carers receive any kind of financial support or benefit, with just 2.1% reporting receiving such help (Triantafillou et al, 2006).

The only supporting services for carers, mainly in Athens or other big cities, are self-help and support and training groups designed for family carers of patients with special care needs. For example, the Hellenic Gerontological and Geriatric Society and the NGO “Alzheimer Athens” organize supporting groups for carers of people with Alzheimer disease. A support group for family carers of dependent older members was run for a year at the KAPI Neos Kosmos as an initiative from the Carmen project (Nies and Berman 2004), but was subsequently abandoned due to lack of funding. The programme “Help at Home” being run by the municipalities, only covers some needs of older people - where it exists - and may be a “helping hand” to people who care for older relatives; although, the service addresses mainly isolated older people, it also aims to serve those who receive help from female relatives, who may thus be released to enter the labour market.

A recent small, unpublished study by students of the National School of Public Health, Athens, looking at how current services support family carers of older people, showed indications that some services are becoming more aware of carers’ needs and making informal modifications to their official service provision to accommodate certain aspects of care giving e.g. the needs of working carers for daytime supervision of the dependent older person (discussed above); including family carers in the activities of some Open Care Centres. So far, these activities operate in a pilot phase and their continuing function is under question due to lack of funding.

2.2 Links and /or gaps between informal carers of dependent older people and their use of formal care services in each country

2.2.1 Gaps in care provision

The EUROFAMCARE study provided information on family carers’ use of available services and also in what areas they needed more help.

Table 2 For which areas of need would family carers like to have more help for the cared for older person?

	No.	%*
Domestic Care	855	55.7
Emotional/Psychological/Social	896	63.8
Health Care	892	55.3
Mobility	716	60.1
Financial Management	795	36.9
Care Organisation & Management	733	62.5
Personal Care	660	55.3
Financial Support	528	74.2

Source: Triantafillou et al (2006). EUROFAMCARE The National Survey Report for Greece.- Note: *) Percentage values refer to the positive answers on the reported total number of valid answers to this question.

The need for financial support to meet the additional costs of care for Greek family carers is further illustrated by the responses in the following table.

Table 3: Has caring resulted in any additional financial costs?

Yes	Greece		Total EU sample	
	No.	%	No.	%
Special food	346	34.3	962	16.3
Medicines	739	73.3	2844	48.2
Other	136	13.5	731	12.4

Source: Triantafillou et al (2006). EUROFAMCARE The National Survey Report for Greece.

Thus, in contrast to the findings from the other country samples where there is often state coverage of essential drugs and special dietary requirements, these additional costs of care are of necessity met by Greek family carers, given the low incomes of the older people themselves.

2.3 Positive and negative aspects of care-giving: Carers' physical and mental health problems and estimated needs for their own care and support; Emotional aspects; Elder abuse etc.)

Data in the following sections is taken almost exclusively from the EUROFAMCARE (EFC) study (Triantafillou et al, 2006), except when stated otherwise.

2.3.1 Physical and mental health status of carers and quality of life

Carers health status: 31.8% reported their health as excellent, 25% as very good and 35.9% as good (Total GOOD = 67.7%), while 26.4% reported it as fair and 5.9% as poor. Although the figures are not strictly comparable both regarding the samples and the responses, in a study of health and use of health services in an adult Greek population (Kyriopoulos et al, 2003), 27.4% of the sample reported their health status as very good, 44.9% as good (Total GOOD =72.3%) 22.1% as moderate, 4.6% as bad and 0.9% as very bad (total BAD = 5.5%), indicating that carers report less good health than the general population.

Psychological well-being: only approximately 1/3 of the sample (22% - 39.9%) responded negatively (at no time or some of the time) to related questions (quality of life questionnaire) with the majority of responses (27.4% – 47.3%) being in the middle range and less than 1/3 in the higher range (most or all of the time, 18.9% - 34.4%).

Greek carers reported the lowest levels of “good” quality of life (50%) and the highest levels of “poor” QOL (10%) amongst the 6 country samples.

2.3.2 Evaluation of care giving role

With responses “often or always”, 90.7% of the EFC sample of family carers rated care giving worthwhile, 80.4% felt appreciated as caregivers, 83.2% estimated that they cope well as caregivers and 91.7% reported their relationship with the older person to be good, indicating some of the satisfactions from the caring role.

Regarding support in their role as caregivers, 53.3% felt well supported overall, with 75.1% supported by family, 50.5% by friends and neighbours, but only 36.3% being supported by services. However, 55.5% felt caregiving too demanding and 33.9% felt it had a negative effect on their emotional well-being, although only 27.6% felt it had a negative effect on their physical health. 30.7% felt trapped in their role as caregiver and 22.8% believed caregiving caused difficulties with relationships with friends, but only 13.4% reported that caregiving caused difficulties in their relationships with other family members.

Determinants of negative impact of caring on FCs was dependent on the health of the OP, the intensity of caring tasks, the carers’ support networks and the types of services used. In the Greek sample the percentages of those carers with higher negative impact (73.3 %) was clearly higher than in the other national samples. Further analyses showed that for Greek carers, the negative impact of caring was reduced by a good level of informal support, whereas in the countries with good service support the same effect was related to appropriate service use.

Main motives to care: Emotional bonds were the most commonly reported reason overall (96.8%) with 57.1% saying this was the primary reason. Duty (total 89.3%) and obligation (total 91.4%), in combination accounted for just over 30% of the primary reasons given for caring

Other studies also show some minor indications about motivation for caring situations, which could also help explain their satisfaction. Kabitsi & Powers (2002) indicate that Greek spouses reported being

significantly motivated by the desire to maintain family harmony. Family harmony reflects the Greek perception that people tend to understand themselves in a more relational than individual frame, and this understanding is largely interwoven within and dependent upon family relationships (Amira, 1986; Stathopoulos & Amira, 1991). In addition, older Greek women seek to fulfil their roles first as mothers, and then as wives, often displaying an attitude of tenderness, spontaneous self-denial, and self-sacrifice for their family (Harahousou, 1996).

The fact that Greek participants did not rate financial difficulties as a motivation to provide care themselves may reflect a cultural preference for informal care over institutionalized care (Kabitsi & Powers, 2002). Greek participants also indicated the avoidance of institutionalisation as a motivation for providing care, as well as the fact that “they provide the best possible care”. Both of these motivations are consonant with the valuing of the family in Greek culture.

2.4 Support for family carers. The existence and/or type and/or efficiency of all forms of support directed specifically to family carers

2.4.1 Training of informal/family carers

Family carers were asked in EUROFAMCARE research to report on both any specific services they used to support them in their work of caring as well as general support services, which could help. They were also asked about the frequency of use, their satisfaction with the service and the cost to them of using these services.

Only 21, 6% of Greek family carers reported using any specific or generic service at all. What specific services did family carers use to help them in their work? The very small percentages reflect the very tiny minority of family carers who had accessed any specific service. 0,1% used information services, 0,2% had used socio-emotional support; 0,3% used respite care to take a break from the care of the older person; none had received any training and there was no help in assessing the caring situation from professionals. Compared with the other countries in the research programme, Greek family carers are poorly supported.

Overall the frequency of specific support service use was very low and no-one used such a special service on a regular weekly basis. Thus there were no details on the costs of such services. In other countries the majority of such services, with the exception of respite services, were free.

However there were other more general services which Greek family carers resorted to, particularly health services. 17,8% (180 carers) visited a general doctor, 3,1% on a weekly basis, 92,8% of them were satisfied with the service (167 people) and 28,3% of those that visited a GP paid for the service (51 people). 13,3% used a specialist doctor in the 6 months prior to the research (135 carers), and 4,1% of these on a weekly basis. 91,1% of them were satisfied with the service (123 people) and 48,9% of them paid for the service (66 people). Nevertheless, these services apply to all citizens who have a valid social insurance.

Regardless of whether or not services were used, family carers were asked about the importance to them of different types of support for themselves and the older person, and whether they currently received such support.

Table 4 The importance of different types of support to family carers and if these types of support are currently received

Type of Support	Importance		Currently received	
	Number	%	Number	%
Information and advice about the type of help and support that is available and how to access it	1009	70,3	953	40,5
Information about the disease that the older person has	1009	74,4	944	68,0
Training to help family carers develop the skills they need to care	1009	41,6	901	28,5
Opportunities to enjoy activities outside of caring	1005	52,5	929	37,9
Opportunities to have a holiday or take a break from caring	1002	60,3	932	36,7
Opportunities for the older person's to undertake activities they enjoy	1005	60,9	937	28,8
Help with planning future care	1005	55,4	926	19,9
The possibility to combine care giving with paid employment**	809	49,3	700	19,6
The opportunity to talk over their problems as a carer	1006	44,2	921	27,3
Opportunities to attend a carer support group	1002	30,1	874	8,8
More money to help provide things they need to give good care	1007	64,2	916	16,3
Opportunities to spend more time with their family**	896	60,0	817	49,4
Help to deal with family disagreements**	764	32,5	665	34,7
Help to make the older person's environment more suitable for caring	999	50,2	889	34,8

The need for information, both about the older person's health problems (74.4%, currently available to 68.0%) and about the type of help and support that is available and how to access it (70.3%, currently available to only 40.5%), were ranked most important by family carers, with the latter response indicating the extent of unmet need in this area. Even more striking is the importance of financial support in the provision of good care, noted by 65.2% of carers, but currently received by only 16.3%.

2.5 The impact on the care process of different forms of family carer support

2.5.1 Carer outcomes e.g. reduction of carer burden/negative impact, improved carer satisfaction/positive value, improved health and/or QOL, improved carer/cared for relationship

As stated in 2.3.2, in the EFC study Greek carers with a good informal support network had less negative impact from caring, even for the most burdensome forms of caregiving.

Since formal support services for carers are very limited, there is no data on the outcomes for the carers using such services regarding the reduction of burden or their attitudes and satisfaction towards caring.

2.5.2 Older person outcomes e.g. better quality of care, satisfaction with care, improved carer/older person relationship

Similarly, the outcomes for the older persons are not measured, since support measures for their family carers scarcely exist. An important exception are the services provided by the Alzheimer Associations, which have as a stated aim the support of relatives of patients with this disease, who benefit from the programmes organised and run in different areas of Greece.

(See INTERLINKS example EL_1.2.a f <http://interlinks.euro.centre.org/project> for more details).

2.6 How do informal carers participate in health care

2.6.1 Promotion of their own and their older people's health

In the absence of specific services for the support of family carers, there exist more general services which Greek family carers resorted to, particularly health services. According to the EUROFAMCARE research, 17,8% (180 carers) visited a general doctor, 3,1% on a weekly basis, 92,8% of them were satisfied with the service (167 people) and 28,3% of those that visited a GP paid for the service (51 people). 13,3% used a specialist doctor in the 6 months prior to the research (135 carers), and 4,1% of these on a weekly basis. 91,1% of them were satisfied with the service (123 people) and 48,9% of them paid for the service (66 people). Nevertheless, these services apply to all citizens who have a valid social insurance.

2.6.2 Measures to reduce the development of higher levels of older people's dependency

Similarly, older people with a valid social insurance have access to public health facilities (hospitals, health centres) providing disease prevention programmes and can have screening and diagnostic tests and medicines from a pharmacy with a 10% - 25% contribution of their price.

Greece has no national data on disability and dependency rates in either the whole population or amongst older people, only estimates based on disability data from other countries (Mestheneou E and Triantafillou J, 2004). Thus, the following data provide an interesting insight into the reasons, physical, mental and social, why care provision was necessary.

In attempting to define the causes for and level of dependency of the older person, the family carers were first asked what they considered to be the main and supplementary reasons why the older person needed care and support.

Table 5 Main reasons for care

<i>REASON (%values)</i>	<i>1st Reason</i>	<i>2nd Reason</i>	<i>3rd Reason</i>	<i>4th Reason</i>	<i>TOTAL</i>
Physical illness/ disabilities	30.6	8.0	7.9	9.2	55.7
Mobility problems	24.4	14.7	10.4	8.1	57.6
Age related decline	15.9	4.4	4.4	4.6	29.3
Safety/feeling of insecurity	6.4	25.1	22.4	15.3	69.2
Social reasons, loneliness, need for company	5.7	8.2	2.8	4.3	21.0
Memory/cognitive problems/impairments	5.6	4.4	3.7	3.2	16.9
Non self caring	5.5	9.7	16.9	12.1	44.2
Sensory problems	3.2	18.3	24.3	35.4	81.2
Psychological/psychiatric illness/problems	1.9	3.0	2.7	2.3	9.9
Other reason	0.7				0.7

As might be expected, the main reason for care (1st reason) reported by the family carers was physical illness and disabilities (30.6%), followed by mobility problems (24.4%) and the rather non-specific category of age-related decline (15.9%), although when all reasons for care (2nd, 3rd and 4th reasons) are added, these figures rise to 55.7%, 57.6% and 29.3% respectively.

However, the frequency in the other reported supplementary reasons for care, especially safety/feelings of insecurity (69.2%) and sensory problems (81.2%), give an indication of the complexity of causes of dependency amongst older people and the need for comprehensive methods of needs assessment to cover all areas of support for dependent older people and their family carers, as well as giving credence to the increasing trend towards integrated care solutions (Nies & Berman, 2004). It also indicates potential areas for intervention to reduce the burden of need for care e.g. in-home and environmental modifications to maintain safety and all possible autonomy of dependent older people, as well as implementation of recent medical advances to improve common visual and hearing problems in older people e.g. cataract surgery, new types of hearing aids etc.

In view of the major age-related predicted increase in the incidence of Alzheimer types of dementia (DAT), questions were specifically asked about any memory and behaviour problems in the cared for person. Whilst these types of problem represented the main reason for care in 5.6% of the sample and

were contributory reasons in 16.9%, it should be noted that the following responses do not represent a systematic assessment of these problems, but simply reflect the opinion of the carers.

Moreover 35.8% of the cared for subjects were reported to have memory problems and in a further 23.8% behavioural problems were noted, giving an indication of the higher levels of stress likely to be experienced by carers dealing particularly with the latter type of problem and confirmed by further analysis of the total six-country sample.

Interestingly, psychological problems and psychiatric illness e.g. depression, were reported as the main reason for care in only 1.9% of the sample, although their total contribution to the need for care rose to 9.9%; these types of disorder are also a significant cause of behaviour problems and attempts to improve their recognition and treatment at an early stage should help to improve quality of life in both cared for older people and their family carers (Triantafillou & Mestheneos, 1994).

2.6.3 Rehabilitation following acute or chronic declines in health

Carers can be an invaluable source of help if the rehabilitation is being provided at home. In a study of older people's use of emergency hospital services, an orthopaedic consultant described how his staff took time to persuade and train relatives how to rehabilitate their older person after hip operations, as the results were superior to those of older people sent to residential care facilities (Triantafillou & Mestheneos, 1994). Carers can also help in other ways, including health protection, financial support, domestic care etc. If rehabilitation is being provided out of the home, e.g. in a specialized centre, carers cannot offer much, except psychological support and companionship.

As described earlier, rehabilitation can be provided in public and in private centres.

2.7 How are informal carers and older people themselves involved in issues of quality of services

2.7.1 Clinical outcomes and quality of life

The EFC study provides detailed data on family carers' use of services, both for the older people they care for as well as for themselves, but no data on outcomes of service use.

2.7.2 Clients' perceptions: satisfaction, knowledge and empowerment

Questions were also asked on reasons for not using or for stopping using needed services. In summary, the main reasons were related to costs, lack of information, poor quality and non-availability of services, as well as problems of access and mobility (including ineligibility for free service use).

There are no other relevant data for the situation in Greece.

3 Description of the “good practice discourse”

3.1 How and by whom is good practice defined? How are good practice criteria and models developed, disseminated, implemented? Illustrate with good practice models (useful approaches, positive interactions, innovative projects etc.).

One aim of the EUROFAMCARE project was to collect together examples of good and innovative practice in the support of family carers in Europe. The 23 national experts, when writing their background reports on the situation of family carers in their country (NABAREs), were requested, in the standardised protocol (STEP), to provide descriptions of examples of both good and innovative practices. The two examples provided below come from the Pan-European Background Report (PEUBARE) (Mestheneos, Triantafillou 2005) which provides an overview of the 23 national background reports (19 EU MS) written in 2003 - 2004.

3.1.1 Linking informal and formal long-term care policies and practices

- Example 1. GAARDA: The Greek Association of Alzheimer Disease and Related Disorders is an innovative attempt to help those with Alzheimer and their carers; it has become a ‘state of the art’ model for the integration of care services in Greece. Established in Thessaloniki in 1995, as a non-profit, nongovernmental organization, its purpose is to optimise the quality of care for AD people and their carers. The Greek organization was initiated by the International Alzheimer Association in conjunction with the current President of GAARDA, and Alzheimer Disease International (ADI) provided help in developing skills for setting up the Association, identifying aims, fundraising, recruiting volunteers, running support groups, raising awareness and providing information. In 1997 GAARDA became a member of Alzheimer Europe and in 1998 expanded and created branches in five other cities (Athens, Xanthi, Volos, Chania, Larissa). The core of the foundation is a large team of volunteers from various fields such as physicians (mostly neurologists), psychologists, physiotherapists, social workers and others. GAARDA promotes its fundamental aims through a wide range of activities including comprehensive and accurate information on all forms of dementia, on caring, legal and financial matters, social and health services and benefits; a network of carers groups, carers contacts and a telephone help-line; its own magazine; regular courses, meetings and conferences. It also delivers quality day care through 3 day-centres, offering discussion groups, seminars for caregivers and professionals, memory training for patients presenting with early-stage disease, music therapy for patients at all stages, speech therapy and physiotherapy. One of GAARDA’s objectives is to raise money in order to build a Clinic where patients in the late stages of AD will get the care they need and it recently obtained some financial support from the Ministry of Culture for this. GAARDA promotes research, education and training and a large number of AD patients and their carers take part in research activities (validation of neuropsychiatric scales, genetic research, and new pharmacotherapeutic trials, epidemiological aspects in Greece, prevalence, incidence, outcome and institutionalisation). <http://www.alzheimer-hellas.gr/> (See also INTERLINKS practice example EL_1.2.a <http://interlinks.euro.centre.org/project> for a more recent description of an Alzheimer Association’s programmes).

3.1.2 Identifying valid elements of good practice for supporting informal carers

- Example 2. First evaluation of the “HELP-AT-HOME” SERVICE: (Amira et al, 2002)
- Planning and evaluation: Local Authorities in Greece began home care services, mainly during the past decade. 97 of these were evaluated in a pilot programme covering their first 3 years’ of operation. Evaluation is rare in the Greek context, but the results from the 400 Municipalities currently operating Home Care Units (100 Help-at-Home and 300 Social Care Units) are to be used as a basis for funding and planning for the 1100 Municipalities in Greece. Financial evaluation indicated that one Help at Home programme with 3 employees, operating from a local Open Care Community Centre for Older people (KAPI) and providing full support at home for 60 dependent older people, cost 35216 euros per year in contrast to 17608 euros per year for institutional/residential care per older person i.e. the equivalent of supporting 30 dependent older people at home. The use of volunteers is important in these programmes, besides the professional staff, and help is needed in devising more efficient and effective strategies for the management of volunteer services. The development of additional methods of support to cover the needs of older people (Day Centres for social and nursing care, respite care, mobile care units, long-term social and nursing care centres and centres for the care of active dementia sufferers) are also needed and recommended. The long term funding of these programmes is insecure.
(See also INTERLINKS practice example EL_5.5.c,d,e,f <http://interlinks.euro.centre.org/project> for an updated description of this programme).

3.1.3 What mechanisms are being used to try to embed good practice in the support of informal carers into everyday practice (e.g. incentives, sanctions, legal frameworks, training etc)?

- How successful have these been?
- What are the main disincentives to good practice in this field?
- How do different systems try to ensure equity and effectiveness?
- How financially sustainable are the approaches being adopted?

No data in Greece at the time of writing this report; however, during Phase 2 of INTERLINKS, several of the Greek practice examples described contribute directly or indirectly towards the support of informal carers through these mechanisms and have been referred to in the relevant sections of the report.

4 Family carers' private solutions to care and their links with the formal health and long-term care systems

4.1 The focus is on the use of privately paid migrant care workers, although such solutions may include the use of privately paid family members and other directly privately paid carers e.g. friends, neighbours and other workers.

The flow of immigration towards Southern Europe (Greece, Italy, Spain, Portugal and Malta) is a developing phenomenon in recent years. In Greece, as in other countries of Southern Europe, there is a high percentage of women's immigration, with a predominance of women from Albania, Bulgaria, Ukraine, Georgia, Romania, Russia and the Philippines (Vassilikou, 2007). Women occupy a central position in these migration flows, both as 'dependent' and, more importantly, as 'independent' economic migrants, playing protagonist, active roles. At the same time, throughout southern Europe, policies aimed at reducing labour market rigidities and enhancing competitiveness have been introduced. This increases the eagerness of employers to hire undocumented workers, in a strongly gendered labour market that leaves few opportunities for women other than in the sex and 'entertainment' industries, and in feminised spheres of some services (tourism, nursing, domestic work) (Lazaridis, 2000). The employment rate for all female immigrants is higher than the rate for all Greek women. Thus, the 2001 census data reveal that employed female immigrants constitute 34.9% of all female immigrants, whereas the corresponding figure for Greek women of all ages amounts to 26.7% (Kapsalis, 2006). These research results confirm the comparative findings of Eurostat, according to which Greece constitutes an important exception in relation to the EU15 Member States – in the sense that immigrants' proportion of the unemployed population is smaller than their share in the labour force. More specifically, the country's female immigrants represent 6.3% of the female labour force, but only 5.8% of unemployed women.

Vassilikou (2007) suggests that immigrant women in Greece are usually domestic workers responding to the local population's needs for services connected mainly with children and older people. These immigrant women constitute an important part of the economic and family life of many Greek men and women. Unlike domestic workers in the upper class of Greek society in past times, these newcomers are for the most part employed by the middle class. Although they are present throughout Greece, especially in urban areas, their lives and destiny are not well known and social research has only begun to address them. This is due in particular to the complexity of their position and probably also to how recently the phenomenon has begun to occur. Their status is characterized by a lack of social recognition, and it reflects a multi-faceted problem concerning immigration, gender and human rights. These immigrant women find themselves in a vulnerable position: they live alone, away from their families, working for strangers in strangers' houses, often under very hard conditions; they are illegal or semi-legal residents and are fulfilling the urgent and heavy responsibility of supporting the families they have left behind. The recent association of the word "Philipina" with the domestic worker in the Greek language, which works both as a synonym and as metaphor, reflects the racist attitude towards Filipinas and the devaluation of domestic work (Hantzaroula 2008).

Neither the departure of the women from their home countries and their arrival in Greece nor the work offered to the immigrant women seem to depend on chance. Without any mechanism to expose in detail the existence of large-scale illegal networks of trafficking women destined to become domestic workers (though the existence of such networks is more than likely), as in the case of research on the sex trade, it is nonetheless obvious from the research of Vassilikou (2007) that structures connected with the transfer and reception of migrant women very much exist. The arrival and the work of these women constitute an important part of the informal sector not only of the Greek economy but also of the economy of the countries of the immigrant women and intermediary countries situated between their homeland and Greece (Vassilikou, 2007). Upon their arrival in Greece, the women approached certain employment agencies targeting immigrant workers, regardless of their residence status (legal or not).

4.2 Is there a debate in your country about the use of migrant workers in the field of LTC and specifically at home? Or is it hidden on the political agenda or not relevant and why?

The problem is well known, but it is rarely admitted and until recently has not been a topic with a high priority on the political agenda; however, during the last few days there has been a huge public media discussion about illegal immigration in Greece, following a much-publicised incident of racial intolerance by the police. There are no accurate data on the numbers of immigrants and their legal status and therefore there is no clarity in the discussions between politicians and the media.

4.3 If relevant can you give a rough estimate of the proportion of directly paid workers migrants represent?

According to a study by the Greek Institute of Migration Policy, the real number of foreigners who live and work in Greece is not known owing to the existence of illegal and uncontrolled immigration and the absence of data or the non-comparison of data issued from different programs of registration of migrants. However, it is estimated that Greece actually has over 1,000,000 foreign residents (Baldwin-Edwards, 2005), although more recent estimations give different figures e.g. <500,000 according to residence permits, but there are other legal statuses added to this figure and the estimate of illegal migrants (from several sources) is 200,000 for 2007/8 (Baldwin-Edwards, personal communication).

Cavounidis (2006) notes that about 25% of immigrants in Greece are occupied in domestic work (care and house-keeping); Markova & Sarris (1997) found that amongst Bulgarian immigrant women in Greece, 47 of the 75 females who participated in their research were working either caring for small children or for older people, 12 as housekeepers, and 6 as cleaning ladies.

Kapsalis (2006) estimates that 48.5% of female immigrants in Greece were employed in private households, according to LFS data for the second quarter of 2005.

Data from the EFC Greek National Survey reports the following: The past 10-15 years has seen a substantial expansion in the numbers of migrants who undertake caring work in the home of older dependent people. The EFC sample concerned 1014 older people who had a primary family carer (the respondent) and in this sample 30 respondents (3%) used cohabitant private carers with 86.7% of them being satisfied with the service (26 respondents) and all of them paying for the service. A further 36

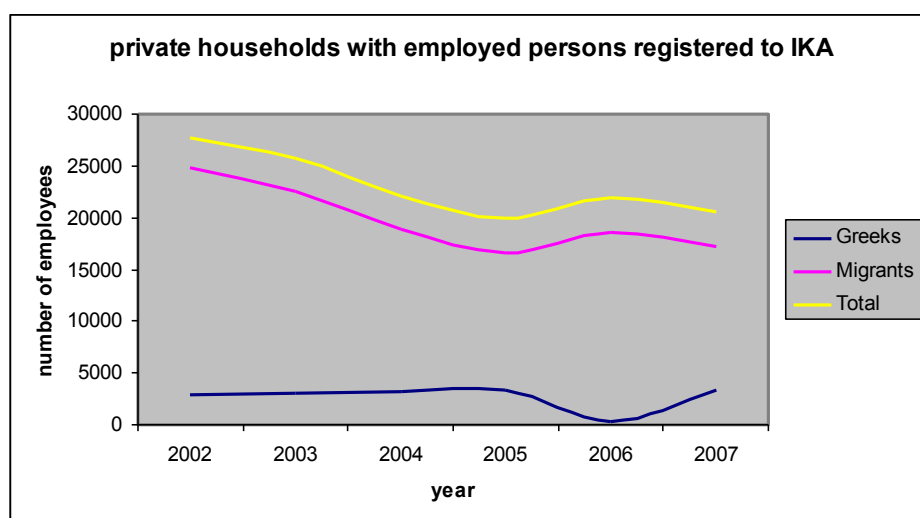
respondents (3.6%) used day-time private carers for their older person's personal care needs. 83.3% of the users were satisfied with the service (30 users) and all users paid for the service. While there would appear to be higher percentages of older people, many of whom have no regular family carers, being cared for by migrant care workers in the general population in Greece, the study focused on family carers, and this may explain why the percentage is lower than that estimated overall.

Data from IKA, the largest social security fund in Greece, reports that a mean number of employees, who work legally in private households and are registered to the organization, is about 20.000 people, the vast majority of whom (85%) are migrants. In the following table we see the number of employees per year and the distribution per sex. As expected, the greatest proportion is women. The following numbers apply to all domestic workers and not only to those who work in the care sector, as there are no specific data about people who care for older persons.

Table 6 Private households with employed persons registered with IKA

	<i>Greek citizens</i>			<i>Migrants</i>			<i>Total</i>		
	<i>Men</i>	<i>Women</i>	<i>Total</i>	<i>Men</i>	<i>Women</i>	<i>Total</i>	<i>Men</i>	<i>Women</i>	<i>Total</i>
2002	452	2,389	2,841	1,708	23,118	24,826	2,160	25,507	27,667
2003	456	2,633	3,089	1,471	21,137	22,608	1,927	23,770	25,697
2004	479	2,790	3,269	1,456	17,406	18,862	1,935	20,196	22,131
2005	518	2,858	3,376	1,421	15,140	16,562	1,939	17,999	19,938
2006	563	2,792	3,350	1,757	16,856	18,613	2,320	19,648	21,968
2007	544	2,792	3,336	1,835	15,376	17,211	2,379	18,168	20,547

Graph 2 Domestic workers per year



4.4 Profile of migrant care and domestic workers (legal and illegal). (Demographic and economic data, surveys, studies, documents, estimates, if available in the analysed national literature)

As a result of the overall conditions set by the statutory framework governing the issuance and renewal of immigrants' residence permits (GR0703019I), the majority of female immigrants are living in the country unofficially. This is mainly because, according to the current legal conditions, female immigrants must provide proof of 200 or 150 days of paid social insurance per year, depending on whether they are employed by one or more employers. However, it is the employer's rather than the employee's responsibility to declare the number of insurance days to the relevant insurer. Therefore, female immigrants who work in sectors where undeclared work is particularly widespread are not able to ensure that their employers meet their insurance obligations, and ultimately find it difficult or impossible to accumulate the required number of insurance days.

4.5 Intensity and type of tasks they provide

Domestic workers normally execute a wide range of tasks, which can include caring, personal hygiene, domestic work, cooking, socialisation, external work etc, depending on the employer and there is no norm or a well described job profile.

Live-in domestic work is excluded from the provisions concerning the length of the working day, additional payment for overtime work, prohibition of labour on Sundays or festivals, as well as payment for work on Sundays and night shifts. The arrangement of hours of work relies totally on the employer who is responsible, according to article 663 of the Civil Code, to regulate the hours of work and rest of live-in workers in order to secure the employee's health and the performance of religious and political duties. The only provisions from which live-in domestic workers are not excluded are holiday benefits (L. 1082/1980), annual leave (P.D. 376/961) and compensation for dismissal, which is covered by the articles 669-674 of the Civil Code (Court of Appeal of Piraeus 667/2001). Even though insurance against unemployment is meagre in Greece, all domestic workers are excluded from it, as well as from insurance against accidents at work (Hantzaroula 2008).

4.6 How many and which kind of families use this kind of assistance?

Immigrant women working in the care sector constitute an important part of the economic and family life of many Greek men and women. Unlike domestic workers in the upper class of Greek society in past times, these newcomers are for the most part employed by the middle class (Vassilikou, 2007).

4.7 Which kind of employment contract is used?

There is no official data on these workers, who may register with an employment agency, but are paid directly by the older person or their family, usually without a formal contract. They are mainly untrained middle-aged women with either legal, or more frequently illegal work or residence status. The contract does not always cover social security contributions, as most of the women who are illegal do not ask about it from fear that they may be deported.

As a motivation for reducing shadow employment in the field, IKA (the largest social insurance fund) applies reduced social security payments for domestic workers. In this way the state tries to encourage the registration of domestic workers.

4.8 Is there a policy or programs to promote the use of migrant workers such as developing public services providing support for families that intend to employ private migrant assistants?

4.8.1 Information

Being informed of the services offered, as well as for recruiting people is an absolutely private matter.

4.8.2 Recruitment of the assistant

There are private offices, which help the families in selecting and in hiring an assistant on payment.

Most of the assistants admit that upon arrival in Greece, women approached certain employment agencies targeting immigrant workers, regardless of their residence status (legal or not). Other women note that there are structures connected with the transfer and reception of migrant women in Greece; they describe the existence of large-scale illegal networks of trafficking women destined to become domestic workers, something like the sex industry, even though not in the same expansion (Vassilikou 2007). Migrant workers are also known sometimes to “sell” a good job to a replacement – and act as the go-between.

4.8.3 Contract

A written contract is not essential to work in a house, unless women cooperate with an employment agency.

4.9 Education and training programs for private assistance

4.9.1 Are there education/training courses for private assistants? Is training compulsory for registration (e.g. roll/register/list of private assistants)?

There are no public training courses for private assistants, although some have been run in the past. Training is not compulsory for registration in order to work as a carer, although EKEPIS (the National Centre for Professional qualifications) has a formal qualification for personal care assistants.

4.9.2 Is there recognition of educational/training qualification/diploma? Is there recognition of reciprocal competences? Is there recognition of work experience?

There is no recognition of formal qualifications, most of the people who are looking for an assistant rely more on her / his previous work experience and other skills, than to a relevant diploma.

Under the Leonardo programme an extensive theoretical and practical e-training course has been developed and should be implemented during 2009, using designated training centres and leading to a

recognized diploma in “Elderly Care Skill Building and Certification”. The aim of the ECV Leonardo Programme (see more at: <http://www.ecvleonardo.com>) “Elderly Care Vocational raining Program” is to promote academically and socially acceptable skills for elderly care taking workers through self-training electronic methods and means. The demand for qualified workers providing care and therapy in Care Homes for older people and private households all over Europe is expanding as a result of the ageing of the population and is augmented by the increasing trend of individuals to seek professional care in the place of the diminishing availability of the traditional child to parents assistance which was implicitly provided within the family.

(See also INTERLINKS practice example EL_4.2.d,e,f <http://interlinks.euro.centre.org/project>)

4.10 Guaranteeing the quality of the services

Apart from structural and staffing specifications for Residential Care homes, there are no legal regulations on quality related issues in these facilities. However, the Greek Care Homes Association, PEMFI, which represents all legally registered Care Homes in Greece, has adopted voluntary quality standards in an attempt to raise the standards of care and the image of these facilities.

(See also INTERLINKS practice example EL_2.3.a,b,e <http://interlinks.euro.centre.org/project>)

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