



Social welfare systems across Europe

Introduction

The SensAge project is addressing the rapid ageing of the population and the consecutive raise of sensory impairments. The project put the foundations of a network of stakeholders, involved in the care and support of this target group. The main objective of the partnership is to setup a platform which to become the reference point within Europe for information and knowledge related to these interweaved topics and thus contribute to the high quality of services for the support users and their opportunities for lifelong learning and better quality of life.

Next to developing a knowledge base with information related to ageing and sensory impairments, the project also aims to investigate what is influencing the life of this population. Through a series of reports we first attempted to identify some of the key stakeholders and policies having an impact at EU and national level. Then we collected views on main challenges and recommendations for their overcoming, from various actors from across Europe.

In the process of gathering and analysing this information it became evident that that the same groups of stakeholders are relevant for the different countries and are influenced by the same general policy frameworks at European level. However the realities in which these actors work and the EU policies need to be implemented vary significantly from country to country.

In order to deepen our understanding of the situation of the ageing people with sensory impairments in this third paper, we will examine some main similarities and differences existing across Europe. The goal is not to provide an in depth analysis of the situation of EU countries, but to gain a better overview the different social care and health systems and realities in which the various stakeholders live and operate. The paper will attempt to outline key challenges that need to be overcome respecting this diversity, in order to create a more social and inclusive Europe for all.

The information provided in this paper is obtained through desk research; the surveys done by EASPD within the SensAge project and collected by the partners for the SensAge conferences and Knowledge base.

Overview of the situation across Europe

As shown from the previous SensAge reports, the main challenges that elderly persons with sensory impairments face are related to the options they have for tackling the social and health implications of their situation. Key domains that directly correspond to these issues are the social welfare and the health systems in place in their countries.

The differences that can be observed in these areas across Europe are often significant. The reason for this can be found in historical, political, economic, cultural, and other specificities of each country. The division is also illustrated by the literature which groups the social welfare systems across Europe in five provisional models:

- Continental (Bismarckian)
- Anglo-Saxon
- Nordic
- Mediterranean (Southern European)
- Central/Eastern European

The characteristics of each will be described later in the paper. Regardless their differences the models are designed to protect people against the risks related to unemployment, parental responsibilities, health care, old age, housing and social exclusion. The Member states are responsible for organising and financing their social protection systems, while the role of the Union is to ensure the sufficient protection of those moving across borders as well as to coordinate the efforts to combat poverty and social exclusion through mutual learning.

Looking at the social protection systems, we see noticeable gaps between the living standards across the Union. This is clearly shown by the latest available Eurostat data in regard to the social protection expenditure per inhabitant in Euros (Table 1). While the average for the EU 28 for 2012 is €7.279, 45, the expenditure per capita is in Luxemburg is €18.136, 02, followed by Norway, Denmark, Sweden, the lowest expenditure is in Bulgaria with only €927, 43. This indicates a difference of nearly 20 times between the highest and the lowest mark. Indeed the economic differences between these two countries are significant and the GDP of Bulgaria for the same year is nearly 14 times lower than that of Luxemburg, but this again just comes to show what a vast gap is existing between the countries in the Union.

GEO/TIME	2011
European Union (28 countries)	7.279,45
Belgium	10.146,25
Bulgaria	927,43
Czech Republic	3.025,44
Denmark	14.785,09
Germany (until 1990 former territory of the FRG)	9.389,88
Estonia	1.962,82
Ireland	10.516,59
Greece	5.662,80
Spain	5.842,41
France	10.331,72
Croatia	2.137,78
Italy	7.900,12
Cyprus	4.782,80

Latvia	1.039,27
Lithuania	1.742,18
Luxembourg	18.136,02
Hungary	2.281,16
Malta	3.009,68
Netherlands	11.578,16
Austria	10.608,79
Poland	1.847,61
Portugal	4.298,59
Romania	1.061,87
Slovenia	4.409,55
Slovakia	2.327,62
Finland	10.522,02
Sweden	12.070,93
United Kingdom	7.641,28
Iceland	7.905,78
Norway	17.919,60
Switzerland	15.944,37
Serbia	1.010,89

Table 1: Euro per inhabitant total social protection expenditure as for 2012, Eurostat 2014

Serious differences are observed also in regard to health care provision. According to the available data in Eurostat (Table 2), the difference in the percentage of GDP expenditure for all kinds of health care provision between the countries with most and least spending is double- while in 2011 the Netherlands has spent 11, 14% of its GDP for health care, in Romania this percentage is 5.51%.

GEO/TIME	2009	2010	2011	2012
Belgium	10,60	10,51	10,53	:
Bulgaria	:	:	:	:
Czech Republic	7,98	7,23	:	:
Denmark	11,04	10,67	:	:
Germany (until 1990 former territory of the FRG)	11,32	11,15	10,89	:
Estonia	6,65	6,27	5,75	:
Greece	10,03	9,34	9,67	9,14
Spain	9,36	9,40	9,26	:
France	11,17	11,13	11,07	11,16
Croatia	:	:	7,05	:
Cyprus	:	:	:	:
Latvia	6,23	:	:	:
Lithuania	7,43	6,89	6,56	:
Luxembourg	:	:	:	:
Hungary	7,57	7,83	7,73	:
Netherlands	11,01	11,20	11,14	:
Austria	10,54	10,47	10,26	:
Poland	6,72	6,55	6,39	:

Portugal	10,24	10,15	9,66	:
Romania	5,59	5,82	5,51	:
Slovenia	8,59	8,58	8,55	:
Slovakia	8,61	8,48	7,60	:
Finland	8,68	8,56	8,62	:
Sweden	9,48	8,97	8,96	9,07
Iceland	9,64	9,29	:	:
Norway	9,25	9,07	8,94	:
Switzerland	11,00	10,91	11,05	:

Table 1: Percentage of GDP spent on Health care for all health care providers, Eurostat 2014

A very important indicator for the ageing population with sensory impairments is the public expenditure on long-term care in percentage of GDP, by care setting. It refers to the benefits provision of public and private institutions to individuals due to chronic impairments and a reduced degree of independence for aged and disabled persons. For the provided below date (Fig. 1), whenever an age breakdown has been available, the figures refer to older people aged 65 +. Figure 1 clearly illustrates the vast difference across the EU. Clearly, Sweden and the Netherlands stand out in comparison with the rest of the researched countries, with 3.5% of their GDP spent on long-term care. The report of the European Centre for Social Welfare Policy and Research (Rodrigues, Huber, & Lamura, Facts and Figures on Healthy Ageing and Long-term Care, 2012) underlines that even though the majority of beneficiaries are cared for in their homes, a large share of public expenditure is spent on institutional care in most of the countries.

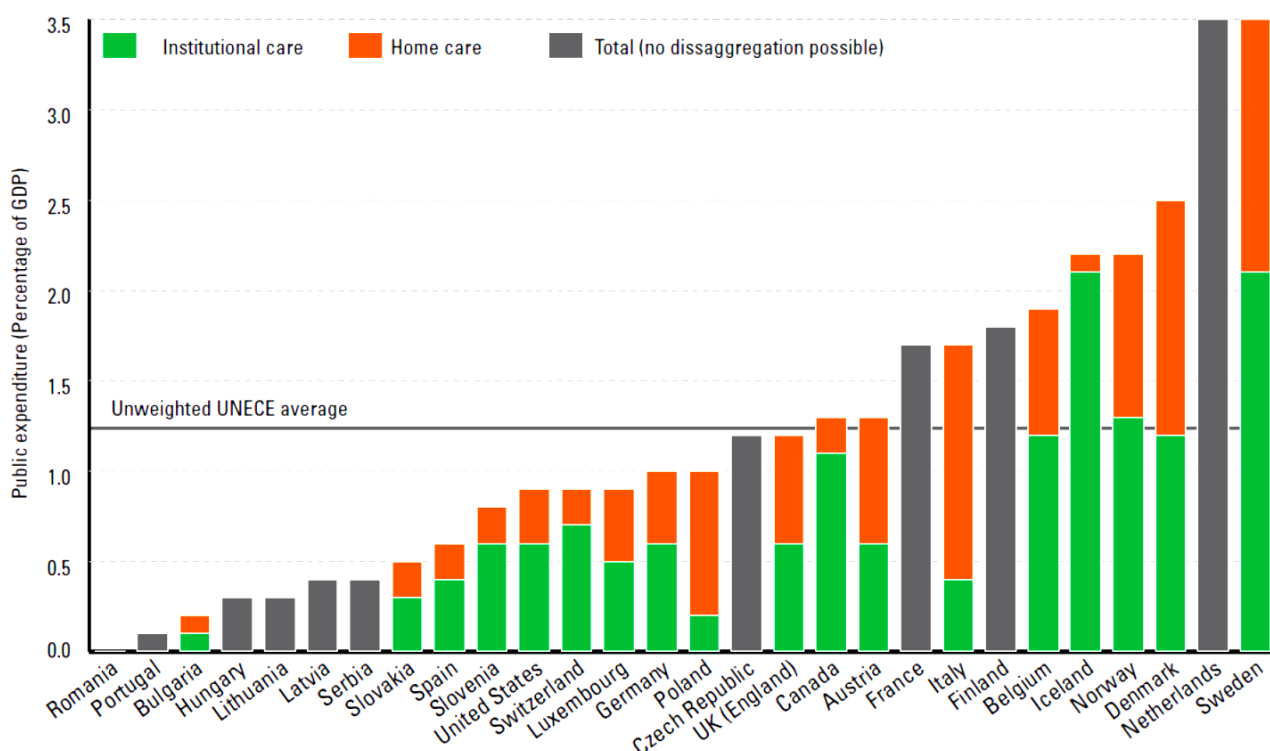


Figure 1: Public expenditure on long-term care by care setting- 2009 or latest available year

Source: Facts and Figures on Healthy Ageing and Long-term Care (Rodrigues, Huber, & Lamura, Facts and Figures on Healthy Ageing and Long-term Care, 2012)

Note: the grey bars represent data for which no reliable information by care setting is available

The wide gap between the European countries is further illustrated by the communicated by Eurostat in December 2013 information that quarter of the EU population as for 2012 is of risk of poverty with a range in the percentages from country to country from 49% at risk (in Bulgaria), 42% (in Romania) to 3 times less- 15% at such risk in the Netherlands and Czech Republic.

All these data plainly demonstrate the wide-range of realities in which persons with sensory impairments live and age. The difference of systems, policies, and economics does not change the needs of people. As noted in the SensAge stakeholders' perspective paper, regardless where they live, elderly with sensory impairments share common types of needs and according to their condition, require comparable levels of quality support, in order to enjoy their human rights. These needs clearly can't be met in the same way across Europe when differences in social expenditure of up to 20 times exist.

Evidently, this extreme variance makes the achievement of the priorities set for the whole of EU by the Europe 2020 strategy for smart, sustainable, and inclusive growth, very challenging. Therefore it is important how EU policies are being translated into the national and local legislations and plans. They need to be adapted to each country's specificity and implemented in a correct way without losing the focus on quality of life and equality of human rights. For this to happen in regard to the relevant for the elderly persons with sensory impairments measures, it is crucial for decision-makers to work in close cooperation with all stakeholders, including the service providers and the representatives of the users themselves.

Social welfare and Healthcare Models in Europe

Buhigas Schubert and Martens (2005) argue that the social and welfare models applied in the European countries have common characteristics but, as also Sapir (2006) claims the concept of the 'European social model' is deceptive and doesn't apply everywhere in Europe. Nevertheless the social systems in EU are highly developed and are deemed the have the following similarities:

- Emphasis on social protection
- Ex-post benefits for traditional risks/needs
- Large role for 'passive' transfers during non-employment (pensions, unemployment, disability, sickness, maternity, family dependants etc.)
- Residual safety nets (against poverty)
- Target: households with various family members (female carers)
- Education & training: outside social protection

These aspects are represented in the different countries in specific ways; however, they can be clustered in five different social models. The models are divergent in the sense of features, performance, in terms of efficiency and equity (Ferrera, 2013).

Most academics agree that rather than a single European model of social policy, there are four social policy models in Europe, defined as – Continental (Bismarckian); Anglo-Saxon; Nordic; Southern European (Mediterranean) (Sapir, 2006, p. 375; Ferrera, 2013; Sengoku, Emerging Eastern European Welfare States: A Variant of the "European" Welfare Model?, 2003; Casalegno, 2006). While till the beginning of the new millennium, based on lack empirical data (Sengoku, Emerging Eastern European Welfare States: A Variant of the "European" Welfare Model?, 2003, S. 231; Casalegno, 2006), it has been presumed that the post-communist countries will adopt one of the existing models. Nowadays it is recognised the existence of a new, fifth model - the Central/Eastern European Model (Sengoku, 2003; Ferrera, 2013; Beblavý, 2008).

(Mato, 2014) explains, that regardless these different models, in the European Union, countries essentially offer universal coverage of health expenses. Some of the models in place are contributory or ‘Bismarck-model’ systems, in which the State guarantees health benefits through mandatory contributions. Such is the case in Germany, Austria, Belgium, Luxembourg, the Netherlands, and France. Others are the so called ‘Beveridge-model’ system, applied for instance, in the UK, Scandinavia, Italy, Portugal, and Spain. They are tax-based schemes in which the public health service is funded from general taxation and is provided universally and free of charge.

Historically, the Bismarck model has been usually applied in Central Europe, while the Beveridge model- in Northern. Nowadays these systems are converging and tax the tax funding approach gains more importance in France, while the volume of contributions has increased in some of the state-based systems, such as that in Slovakia.

Such types are very important due to the compliance with the European policies for ensuring patients’ rights in high quality safe healthcare across the EU countries.

Figure 2 shows a detailed overview on the characteristics of the five Social Models introduced above. It is essential to emphasise on the heterogeneity of the CEE Model where five subgroups can be distinguished (Beblavý, 2008, S. 17). For the purpose of briefness of this paper Fig.2 shows this diversity only in its part “Expenses on social support”.

In the next paragraphs we will overview each of them in a bit more detail.

	Nordic/ Scandinavian	Anglo-Saxon Model	Continental/ Bismarck	Mediterranean /Southern	Central/Eastern European
Expenses on social support	High	High, the taxpayers ask the decrease in taxation burden	High	High	Low – Baltic states Moderate – Bulgaria, Romania, Slovakia High – Visegrád States, Slovenia
Employment	High, stimulated by the government	High	High, the part-time employment is widely spread	Low, the majority of women do not work	Low
Principle source of financing	Government and local authorities; taxation re-distributing	Government for unemployed taxes re-distribution), while the social insurance for employed people	Market; the social insurance	Market; local authorities; family support; self-support.	Government; taxation re-distributing; family support; self-support
Level of poverty	Low	Moderate	Moderate	High	High
Re-distribution	High	High	Moderate	Low	High
Private provision of social support	Yes	Yes	Yes	Yes	Yes

Figure 2. Characteristics of Social Models.

Source: (Popova & Kozhevnikova, 2013, S. 567; Beblavý, 2008, S. 17)

Nordic Model

The Nordic model includes the northern European countries: Norway, Sweden, Finland, Denmark, and the Netherlands (Norden; Casalegno, 2006; Ferrera, 2013). These countries might not provide welfare in precisely identical manner but they are similar enough to constitute a “Nordic welfare model” (Norden).

The ‘egalitarianism’ is the fundamental principle of the Nordic model (Popova & Kozhevnikova, 2013). According to it, the social benefits are distributed between all the members of society on the base of equality. (Ferrera 2013) defines the following main characteristics of the model:

- Strong universalism
- Service rich (including Active Labour Market Policies) already a Social Investment element
- Dual earner model (DEM): female employment, gender equality
- Strong but limited safety nets, low poverty, high inclusion

This model is a combination of free market economy - where the forces of supply and demand are free of interference by the state, price-setting monopolies or other authority - with a welfare state. The state is the key player in the protection and promotion of economic and social welfare of its civilians (Sanandaji, 2012). The Nordic welfare states share the same political aim of promoting social cohesion (Norden). Their social model is known for the universal aspect of its welfare supply, drawn on the principles of equality (such as equal access to social and health services, education and culture), solidarity (so that there is special consideration to the needs of those who have less chance than others of making their voices heard or exercising their rights (Holm, Liss, & Norheim, 1999; Ferrera, 2013)) and security for everyone including social outcasts and vulnerable groups (Norden, 2013).

The health care systems in the Nordic countries are also very similar. The healthcare is almost completely publicly, financed by taxation – which is quite high - and nearly all hospitals are publicly owned and managed. The primary care sector is fairly important and people need to see a general practitioner (GP) before being able to see a specialist. In Denmark, almost all visits to the GP and all visits to hospitals are free. In Norway and Sweden, there has been an upper limit price set for consultations and no charge for children at GPs. Citizens of Scandinavian welfare states expect excellent health services for all for equality and solidarity are basic ideologies of this model.

The countries under the Nordic welfare model support free trade, a stabilized economy, and a Universalist welfare – which promotes individual autonomy, social mobility and human rights (2013). The Nordic countries have the highest index of quality of life, welfare and equality. In general, these countries manage to have justice and equality along with a good economy, proving that money and justice can coexist.

In the questionnaire developed by the EASPD and given to SensAge partners, Royal Dutch Visio explained that in the Netherlands, health and social care of elderly people with sensory disabilities is threatened by the stepping back of the government and health insurance companies. This is leading to a growing number of small “caring communities”, less expensive but also less specialized. Health and social care systems are also weakened by the poor awareness of visually and hearing impaired individuals in the population. According to Royal Dutch Visio, the health care system could improve if knowledge and solutions were brought to the immediate environment (professional and non-professional) of elderly people

with sensory impairments. On a more positive note, the social care system benefits from an emphasis on the clients' self-government.

Strengths

- Seen by many as the best social policy model
- Highest index of quality of life, welfare and equality
- Same political aim of promoting social cohesion (Norden).
- Excellent health services for all as equality and solidarity are basic ideologies of this model
- Security for everyone including social outcasts and vulnerable groups and therefore elderly people with sensory impairments
- Social care system benefits from an emphasis on the clients' self-government (Netherlands) (questionnaire - Visio)

Weaknesses

- Health and social care systems are weakened by the poor awareness of visually and hearing impaired individuals in the population (in the Netherlands, questionnaire - Visio)
- Lack of data on the outcome of the provided services and support
- Lack of data on the effect and influence on quality of life (questionnaire – Visio)
- Elderly people with sensory disabilities have a lack of knowledge and accessibility of specialised care (questionnaire-Visio)
- Lack of staff training on types of visual and hearing impairments and on possible solutions: aids, technology, etc. (questionnaire -Visio)
- The model might prove hard to implement in less wealthy countries

Anglo-Saxon model

The Anglo-Saxon, is implemented in the United Kingdom and Ireland. It is identified by the provision of social benefits to all who are in need by the state welfare system, while the social funds are accumulated mainly by the citizens themselves (Popova & Kozhevnikova, 2013). (Ferrera 2013) outlines as key traits of the model:

- Its Beveridgean “encompassing” schemes, weak universalism
- The Occupational/fiscal welfare for the middle classes and
- The means-tested benefits for the poor (including working poor): poverty & exclusion

The model is also known as ‘liberal’ for its attitude to markets. The attitude to markets is quite liberal. The main characteristic of this model is its social assistance of last resort. Bigger portion of the funds is used for the working-age population, and less towards pensioners. Previous employment defines the access to benefits, which means that those who haven't been employed would not be admitted to such. This constitutes a particular problem for family members who have stayed home to take care of disabled relative, for example.

In the countries under the Anglo-Saxon model, the employment rate is higher than to average for the EU and the welfare system seems to be sustainable from economical point of view. On the downside, trade unions are not very powerful; there is higher income dispersion and more low-wage employments, hinting at a non-negligible probability of falling into poverty (Casalegno 2006).

The health system in the UK and Ireland is a national health service, mainly funded from general taxation. The National Healthcare Services (NHS) in UK have grown to become the world's largest publicly funded health services and it deems to be among the most efficient, egalitarian and comprehensive ones. The Health Services in Ireland (HSE) provides all of Ireland's public health services, in hospitals and communities across the country.

The literature along with the contribution of the Fife Society for the Blind (UK) to the SensAge surveys outlines some of the main strength and weaknesses of the Anglo-Saxon health and social care systems.

Strengths

- Sets general standards of care
- Popular and universal
- Few social cleavages
- Relatively cost effective to maintain
- Has public employment effects
- Intermediate taxes
- Less sensitive to labour market pressures
- Free national health services
- Social care system integrated with health care
- There are clear Central Government guidelines for delivery of health and social care
- Services are legislated to be provided on a coordinated basis
- Government strategy is for joint delivery of services to Deaf and Blind
- Organisations including health and social care, voluntary and statutory all collaborate.

Weaknesses

- Expenditure are mostly directly towards the working age population and much less towards the older population, putting elderly people with sensory disabilities at disadvantage
- Health and social care systems suffer from funding shortages, long waiting times and are threatened by further funding cuts
- Need of more non-invasive health care in to the community
- Lack of evidence based research on interventions and their outcomes

Continental Model

The continental welfare social model includes Austria, France, Germany, Belgium, and Luxembourg. The Continental (Bismarck) model assumes that the social support is given to those who have already been represented on the Labour Market, and it fully depends on the social accumulation of this exact person (Popova & Kozhevnikova, 2013). (Ferrera, 2013) identifies its characteristics as follows:

- Bismarckian insurance schemes (BIS) insider/outsider divide
- Transfer heavy, lean on services
- Male breadwinner model (MBM)

This system is seen as middle ground between the Nordic and the Anglo-Saxon model. It is very much based on the principle of "security" and is identified by the numerous laws on employment protection and an important amount of regulation in the industry. The labour

market tends to be rigid and slow to react to globalisation. In this model governments provide generous unemployment benefits. A well-funded welfare state allows poverty reduction, high quality health care and disability pensions. However, often these allowances are linked to conditions which put barriers to the employment at the open labour market of persons with disabilities, as they may be cut if the person is working. Although the membership fees are low, trade-unions do have power of decision in collective agreements. Health care in these countries is funded by public or private compulsory insurance funds (OECD, 2013). Sometimes, health care is partly funded with general taxation. In Belgium, for instance, the state subsidy is significant while in Germany only 21% of the funds come from general taxation (OECD, 2013).

Strengths

- A well-funded welfare state allows poverty reduction, high quality health care and disability pensions
- High level of public support
- Allows benefit recipients to maintain their level of income
- Allows for private service system without rationing (e.g., in health care)
- Benefits increase with rise in contributions
- Intermediate tax burden

Weaknesses

- Maintains and reinforces social cleavages
- Sensitive to employment conditions and demographics, which might be with a particular effect on persons with sensory disabilities facing employment barriers
- Drives up labour cost (payroll taxes) and low wage unemployment (in/out groups)
- Tends to penalize those in unstable, non-traditional or part-time job situations
- Often provides few benefits for those outside the insurance model (new poverty)

Southern (Mediterranean) Model

The Mediterranean model is used by Italy, Spain, Greece, Portugal, and Turkey. The model is based on the principle that the family has the main role in supporting its socially unprotected members (Popova & Kozhevnikova, 2013). It is similar to the Continental model, yet the labour market is not very flexible due to employment protectionism. However this model is not very efficient at decreasing poverty. Welfare is mainly directed towards generous state-pensions and early retirements as a means to better work conditions. As a consequence the level of social assistance is much lower than in the other countries.

Countries whose social policy system falls under the Mediterranean model have more segmentation of status and rights and therefore the access to social provisions is very much conditioned. Trade unions in those countries generally have large membership which could be an explanation of lower income dispersion (Kluzer, Redecker, & Centeno, 2010).

In terms of care at home, the Mediterranean countries offer less possibility to receive formal care and therefore, most elderly people who need assistance such as those with sensory impairment, are taken care of by informal carers such as family, friends, volunteers or caregivers employed by the elderly person or his/her family. This situation is further motivated by the cultural specificities of these countries. Traditionally, often the households are multigenerational where the elderly is supported by their children. In general the senior

benefit from being very well respected in the society and be involved through the strong connection and interaction with their family and friends.

The SensAge partner Bolu Mili, shared some examples of the advantages and issues of the social policy in Turkey. Central role there is played by the government. It generally supports the active participation of elderly people with sensory disabilities in the society by offering, for instance, public transport services at a discount or free of charge, by providing housing to elderly citizens. Nevertheless the services for elderly and persons with disabilities are not yet sufficient enough to effectively enable their full involvement.

Bolu further reports that the health system in Turkey has greatly improved in the last decades. There is an established strong public hospital system, medical care at home and efficient new staff training provided by universities for this field. However there is a prominent need of funding for creation of more hospitals and community based care services in order make them available to all in need, which is not the case at the moment. In fact, the availability of quality services in smaller towns and in rural areas is reported by the partners as a prominent problem across Europe.

An important aspect for ensuring the quality of services is the coordination between the various actors. The example of Turkey, shows that when different services are provided by different ministries, their coordination often is not optimal. For instance, home care for the elderly people is not always integrated with rehabilitation and training and this is problematic for those with sensory impairment as they have a greater need of them. Home care givers also suffer from a lot of stress during the care of a senior with sensory problems because there is a lack of mobile units. . Bolu confirms that there is a great need for training of professionals both from the social and the health care systems, on how to correct address the needs of elderly persons with sensory impairments. Similar issues and needs are also shared from other SensAge partners from Western Europe

Strengths

- Generous state-pensions and options for early retirement, ensuring the for the security and material comfort of the seniors
- Active interpersonal and intergenerational communications and support, mostly thanks to family members
- Benefits for the seniors when using public services
- Public health care

Weaknesses

- High dependency on the support from the family
- Insufficient coverage of services in the rural areas and smaller towns
- Insufficient community-based services
- High dependency on the political priorities and actions at governmental level

Central/Eastern European Model

The assumption that Eastern and Central European (CEE) countries would adopt existing social models after the political shifts in the '90s has proven to be wrong. It is important to underline that the CEE countries are "united" in a CEE welfare model rather based on their common history and political governing before 1990. Since there are major differences among the countries, there are also diverse instruments applied, while perceiving their new welfare system (ref. to Fig.2).

Beblavý (2008) states that the post socialist welfare systems that of the old member states of the European Union and they doesn't resemble any of the four existing models as present in Europe. In the middle of the '90s, many CEE governments have undertaken social-policy reforms. The main common characteristics of these reforms are summarised by Sengoku (2002, S. 232 f) as follows:

- Withdrawal of the state from the (public) welfare sector: various kinds of subsidies on many goods and services have been abolished or suspended; some privatisation and marketization of health and social-care services are introduced; and activities of the "third sector" such as the voluntary sector and non-governmental organisations are encouraged.
- Introduction of an institutionally pluralised welfare system: social security funds are separated from the state budget; pension funds are separated from health care insurance; social security is implemented by a number of independent institutions; and the power and responsibilities of the regional and local governments have been enlarged.

The approaches of reforming the welfare systems have differed from country to country in the CEE and Former Soviet Union (FSU) states. Poland has increased its welfare effort (Cook 2007b), Bulgaria have chosen to decrease expenditures, while Ukraine have maintained previous levels. Also, the policies which have been used to respond to the downward economic pressures have varied: Poland and Hungary have increased early retirement benefits, Bulgaria and Romania have reduced unemployment benefit levels and expanded the coverage of disability benefits, while FSU countries have avoided massive unemployment through reliance on wage arrears.

The health systems of Eastern European countries are contribution- and employment-based social insurance systems. They cover employed persons and family members of the insured (Sengoku, 2003, p. 235). There is a sharp contrast in regard to the pension systems between Hungary and Poland on the one hand, and the Czech Republic and Slovenia on the other hand (Sengoku, 2003, p. 235).

The Baltic States are considered to belong to the CEE group. Their welfare systems are characterised by high inequalities, low social expenditure and low social inclusiveness. They rely on resource intensive or unskilled-labour intensive traditional industries. In contrast, the Visegrad states (Czech Republic, Poland, Slovakia and Hungary) are performing fairly well in terms of addressing inequalities and promoting social inclusiveness while relying on capital and skill intensive industries. (Bohle & Greskovits, 2007, S. 30).

Hungary and Poland have introduced a multi-pillar system with a mandatory, privately-funded, second-pillar pension in accordance with the recommendation of the World Bank. Bulgaria has adopted the same scheme, yet with a voluntary privately-funded second pillar. In contrast, the Czech Republic and Slovenia have basically rejected any kind of radical reform and retain the traditional Pay-as-you-go (PAYG) system for old-age pensions without shifting to funding at the expense of the public pension tier.

Strengths

- Stronger emphasis on redistribution to prevent poverty
- Traditional strong involvement and support from the family
- Ongoing transition process from institutional to community-based care
- Developed non-discriminative legislation, strategies and plans for supporting elderly and persons with disabilities

Weaknesses

- Low state budgets due to poor tax collection, which reflects negatively on the social protection expenditure
- Low pensions
- High risk of poverty and material deprivation among the elderly people
- Lack of basic necessities
- Poorer housing and living conditions, especially for the elderly people
- Insufficient implementation and monitoring of the developed legislation, plans and strategies concerning the wellbeing of persons with disabilities
- Still very high percentage of institutionalisation of elderly and persons with disabilities

Conclusions

Evidently there is a wide diversity in the way different European countries address the social and health needs of their citizens. The economic, political, historic and cultural background of each state to a big extent determines the way it develops its social welfare system.

In terms of care provision, for instance, it can be concluded that although European countries' social and health systems have witnessed a growing public support to long-term care of elderly people at home – informal care, mostly provided by family members, friends, volunteers or other caregivers employed by the family – is still much more used than state care (Kluzer, Redecker, & Centeno, 2010, p. 11).

In some parts of Europe the social support is highly dependent on the involvement of family members. Eastern European countries have the highest share of people aged 65 and older living in households with at least two younger generations of their family. At the same time however the family is often not sufficiently, if at all, supported by the state for providing such services, which puts a heavy burden on the younger generation. The emphasis of informal care also poses serious questions in regard to the quality of the services the users receive and the negative consequences unqualified care might have on the wellbeing of the elderly with sensory impairments.

On the other hand, multigenerational households seem to be much less common in Northern European countries such as Norway, Sweden, the Netherlands, Finland, as well as Germany (Rodrigues, Huber, & Lamura, Facts and Figures on Healthy Ageing and Long-term Care. Europe and North America, 2012).

A number of similar prominent differences can be found in other aspects of the welfare systems in Europe. Nevertheless, the description and the outlined strengths and weaknesses of the welfare models across the continent, speak not only for the diversity of the realities in which the users live, but also for the challenge of defining comparable characteristics on which to base draw definite conclusions on the similarities and gaps between countries and base actions.

The borderline variety of living standards, system approaches, political, cultural inheritance, all pose a huge challenge for ensuring the desired full integration and involvement of the ageing population with sensory disabilities across Europe. The task of the European Unions for ensuring the full implementation of the UN Convention on the Rights of Persons with Disabilities (UN CRPD) and the achievement of the EU 2020 strategy targets is extremely

difficult but also of great importance as the EU should guarantee the quality of life and the respect of rights of all its citizens.

In order to create the inclusive and social Europe we wish to live in therefore, all stakeholders need to work together. The role of networking, sharing experiences and models of good practice, cross-border and cross-sectorial cooperation therefore is crucial. To guarantee that the policies and measures implemented by European, national and local decision-makers are really addressing the needs of the elderly people with sensory disabilities, those who know and understand these needs best- the users themselves, the services providers and the families, should actively participate in the discussions on developing and implementing these actions.

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