WORKING PAPER

11-03

The AGIR project: Ageing, Health and Retirement in Europe

Use of health care and nursing care by the elderly: Data for Belgium

Federal
Planning Bureau
Economic analyses and forecasts

Avenue des Arts 47-49
B-1000 Brussels
Tel.: (02)507.73.11
Fax: (02)507.73.73
E-mail: contact@plan.be
URL: http://www.plan.be

J. Mestdagh
M. Lambrecht

July 2003

The AGIR project: Ageing, Health and Retirement in Europe

Use of health care and nursing care by the elderly: Data for Belgium

J. Mestdagh
M. Lambrecht

July 2003

Federal Planning Bureau

The Belgian Federal Planning Bureau (FPB) is a public agency under the authority of the Prime Minister and the Minister of Economic Affairs. The FPB has a legal status that gives it an autonomy and intellectual independence within the Belgian federal public sector.

FPB's activities are primarily focused on macroeconomic forecasting, analyzing and assessing policies in economic, social and environmental fields.

Internet

URL: http://www.plan.be

E-mail: contact@plan.be

Publications

Publications:

The Economic Forecasts
The "Short Term Update"

Planning Papers (recent publications)

giving the results of policy analyses and assessments

92 *De administratieve lasten in België voor het jaar 2000 - Eindrapport*
Greet De Vil, Chantal Kegels - January 2002

93 *De Belgische Milieurekeningen - Les comptes environnementaux en Belgique*
Guy Vandille, Bruno Van Zeebroeck - June 2003

Working Papers (recent publications)

8-03 *ICT Diffusion and Firm-level Performance: Case Studies For Belgium*
C. Huveneers - June 2003

9-03 *The international transmission of shocks - Some selected simulations with the NIME model*
E. Meyermans - July 2003

10-03 *The AGIR project: Ageing, Health and Retirement in Europe - Bio-demographic aspects of ageing: Data for Belgium*
J. Mestdagh, M. Lambrecht - July 2003

Citations should refer to the publication, mentioning the author(s) and the date of publication.

Responsible Editor Henri Bogaert
Legal Depot: D/2003/7433/21

The AGIR project – acronym of Ageing, health and retirement in Europe – is a research project financed by the Fifth Research Framework Programme of the European Community for Research, technological development and demonstration (RTD) activities, "Quality of Life and Management of Living Resources" programme, key action 6 "The ageing population" (QOL-2001-6.1-3), proposal nr QLRT-2001-0517. It is worked out by eight members of the European network ENEPRI, created in 1999 at the initiative of CEPS, the Center for European Policy Studies in Brussels.

The participation of the Belgian Federal Planning Bureau, consisted essentially in a commented transfer of Belgian data for the first three Work packages of this research project. The most significant results are reflected in two Working Papers:

10-03 The AGIR project: Ageing, Health and Retirement in Europe. Bio-demographic aspects of ageing: Data for Belgium.

11-03 The AGIR project: Ageing, Health and Retirement in Europe. Use of health care and nursing care by the elderly: Data for Belgium.

Table of Contents

List of abbreviations:

ADL	Activity of Daily Living
FPB	Federal Planning Bureau
GP	General Practitioner
HH	Household
HIS	Health Interview Survey
IADL	Instrumental Activity of Daily Living
LFS	Labour Force Survey
LTC	Long-term care
NIS	National Institute for Statistics
NR	National Population Registry
PT	Part time employment
ROB	Elderly institution without nursing care
RVT	Elderly institution with nursing care

0 Foreword: the AGIR project

A. Overview of the AGIR project

The Belgian Federal Planning Bureau is one of the participating research institutes in the AGIR project (Ageing, Health and Retirement in Europe) co-financed by the European Union within the Fifth Research Framework Programme and carried out in collaboration with seven institutions of the ENEPRI network, to which the FPB is associated. The aim of the AGIR project is to study to what extent the health and the fitness of elderly have improved, how elderly people make use of health care and which effect ageing and the health status of the elderly can have on the decision to retire and on the future evolution of the public health care and pension expenditures.

B. The Fifth Research Framework Programme of the European Community

The Fifth Research Framework Programme, adopted on 22nd December 1998, defined the European Community activities in the field of research, technological development and demonstration for the period 1998-2002. It has been conceived to help solve problems and to respond to major socio-economic challenges facing the European Union.

Asides bursaries and various fellowships for young or experienced researchers or for hosts to sustain the organization of training activities, the Fifth Research Framework Programme developed various Specific Programmes aiming at financing researches lead by at least two legal entities from different EU-countries or associated states, under which the one named the "Quality of Life and Management of Living Resources" programme. This QOL programme is structured around six key actions:

1. Food, nutrition and health;
2. Control of infectious disease;
3. The 'cell' factory;
4. Environment and health;
5. Sustainable agriculture, fisheries and forestry, and integrated development of rural areas including mountain areas;
6. The ageing population and disabilities.

The AGIR project was introduced under the key action 6 "The ageing population" (QOL-2001-6.1-3), proposal nr QLRT-2001-0517.

C. ENEPRI

The European Network of Economic Policy Research Institutes (ENEPRI) was created in 1999 at the initiative of the Centre for European Policy Studies (CEPS) in Brussels, also financed during the first four years by the European Commission under the 5th Research Framework Programme. ENEPRI brings together leading national institutes from a number of EU member states and accession countries.

ENEPRI was initially formed by 8 partner institutes in EU member states and one institute in Poland and has now been expanded to 25 partner institutes, which include members from most of the EU-27 countries. The activities of the Network are coordinated and managed by CEPS.

The following institutes are (among others) members of the ENEPRI network:
Centre d'Etudes Prospectives et d'Informations Internationales (CEPII), Paris;
Centre for European Policy Studies (CEPS), Brussels;
Netherlands Bureau for Economic Policy Analysis (CPB), The Hague;
Deutsches Institut für Wirtschaftsforschung (DIW), Berlin;
Research Institute of the Finnish Economy (ETLA), Helsinki;
Fundacion de Estudios de Economia Aplicada (FEDEA), Madrid;
Belgian Federal Planning Bureau (FPB), Brussels;
Instituto di Studi e Analisi Economica (ISAE), Rome;
National Institute for Economic and Social Research (NIESR), London;
Niezalezny Osrodek Bana Economicznych (NOBE), Lodz, Poland.

The network aims to foster the international diffusion of existing research, to help to co-ordinate research plans, to conduct joint research and to increase public awareness of the European dimension of national economic policy issues.

The activities of ENEPRI include the organization of workshops and conferences, the publication of working papers and policy papers and the development of common research projects.

Currently ENEPRI members are conducting a major study on the health and demographic trends in the EU and its implications for health care, retirement and public finances: AGIR - Ageing, health and retirement in Europe. A joint project focusing on the analysis of demographic uncertainties and the sustainability of the social welfare systems, DEMWEL, started in January 2003. A Research Training Network on Health, Ageing and Retirement, called REVISER, started hiring trainees from spring 2003.

D. AGIR

The aim of the AGIR project is to study to what extent the fitness and health of the elderly have improved, and to use this information to estimate the future demand for health care by the elderly. The program will try to predict whether the trend in early retirement will continue along with the improvement of the fitness of the elderly. Ultimately, scenarios will be produced for the development of health and pension expenditure. Several options for social and budgetary policy will be analysed.

The first phase of the project consists of three work packages (WP) and concentrates on data gathering. Each WP is organized by a different member state institution and studies a different topic.

WP1 Bio-demographic aspects of ageing (FEDEA - Spain)

WP1 studies the bio-demographic aspects of population ageing. The aim is to get a better understanding of the nature of ageing. Not only is it important to analyse how fast a population gets older, it is also important to see what effect age has on the population's health and fitness, especially of the elderly. This WP concentrates on the health status of different age cohorts, by confronting purely demographic data with data on the health of the population and indicators concerning the quality of life. By doing so, **one** should get a better view on the past development, the current state and the potential future development of the health of the elderly.

WP2 Use of health care and nursing care by the elderly (DIW - Germany)

WP2 studies the use of health and nursing care by the elderly, by making a distinction between care in institutions and informal care. This distinction is necessary because there are indications that the demand of institutional care is increasing not only due to ageing, but also due to changes in family structure and labour market participation, especially of women.

WP3 Determinants of retirement (ETLA - Finland)

WP3 studies the determinants of retirement, going beyond the analysis of the well-known financial incentives. Its aim is to broaden the scope of these earlier studies by bringing in information on individuals' valuation of leisure and domestic work. A great deal of this information is gathered through national time use surveys. ETLA expects to find evidence to support the claim that, apart from the financial incentives and health status, the value of leisure time has important influence on the early retirement decisions.

The second phase of the project consists of another three work packages, which use the data gathered in phase one as input.

WP4 Alternative scenarios for health, life expectancy and social expenditure

Organized jointly by CPB (The Netherlands) and DIW (Germany), this WP aims at estimating the consequences of population ageing and the link between age and health on expenditure for health care and pensions.

WP5 Implications for social and financial policy (NIESR - UK)

The participating institutes in this WP will assess the implications of population ageing for public policy, notably with respect to the scope for influencing the development of social and budgetary policy.

WP6 Synthesis, final conference, publication and dissemination (CEPS)

The aim of this WP is to prepare a synthesis of findings of the preceding phases and to summarize the results. This WP will also be devoted to an assessment of the implications for the European Union's policies and actions with respect to ageing.

The FPB participated in the WPs of the first phase.

1 Introduction

Second work package of AGIR studies the use of health and nursing care by the elderly

This Working Paper reflects the contribution of the FPB to the second work package of the AGIR project, work package organized by the German DIW. It collects in a first attempt a lot of data to approach the volume and evolution of the use of health and nursing care by the elderly. Yet the authors are well aware of the limitations of the present study which can certainly be improved by more detailed data and refinement of the concepts.

The study makes a distinction between care provided by institutions and informal care. This distinction is necessary because there are indications that the demand for institutional care is increasing not only due to ageing, but also due to changes in family structure. This work package also studies how the provision of care for the elderly has changed over time, as well as the link between labour market developments and informal care.

The output of this work package will be used in the second phase of the program, in which scenarios will be produced and consequences for demand for health care and pension decisions will be studied.

II Results of data gathering process

A. Introduction

The results of the data gathering process are presented in four sections, in which respectively demand for health care, supply of health care, family structure and labour market developments are covered. The main conclusions are summarized at the end of the paper.

In the first section demand for health care is analysed by gender and age groups. How often do people contact a doctor or a specialist, how often are they admitted to hospital per year and how long do they stay there on average.

The second section examines the supply of health care, an important factor, too often forgotten. If supply doesn't reach demanded levels, some people who need health care can't get it. Data from the health insurance institute give the number of doctors, nurses, etc for recent years.

Since the provision of informal health care depends largely on household composition and the extent to which people can rely on family members to take care of them, the third section studies household composition. What is the average number of people in a household, how many people are single, married, divorced or widowed and how many elderly live in their children's family.

Lastly, the fourth section studies the labour market developments. Participation rates and the evolution of part-time employment shed light on the possible provision of informal care. As more women enter the labour market, they have less time to care for others and maybe therefore more elderly have to fall back on institutional care. Recent legislation has encouraged female labour market participation.

Most data collected for this working package come from the Health Interview Surveys (HIS) of 1997 and 2001, carried out by the Unit of Epidemiology of the Scientific Institute of Public Health in Brussels. Other data sources are the Ministry of Public Health and the Belgian Institute for Health Insurance. Most data on population were provided by the National Institute for the Statistics (NIS). Labour market participation rates stem from models used at the FPB.

B. Demand for health care

As the population is ageing, it is interesting to study how the demand for health care varies with age. If older age groups make use of health care services more of-

ten due to worse health conditions, the ageing of the population might have a significant effect on the demand and the cost of health care.

Demand or need for health care versus use of health care: not the same

Unfortunately, there are no data on *demand or need for* health care. Only data on the *use of* health care are available. There is an important difference between these two concepts though. It is very probable that some people lack resources to have access to health care (e.g. elderly people with small survivor pensions), so one can imagine that the need for health care exceeds the use of health care. This should be kept in mind while reading this paper.

In the following paragraphs, the demand for care by age group and gender is discussed to determine whether there is a relationship between age and demand for health care.

1. Number of hospital admissions per year

Increase in the number of hospital admissions

Data on hospital admissions are an important indicator of the number of health problems of a population. The Ministry of Public health provides data on the number of hospital admissions by gender and age group for 1991 to 2000. The results are shown in table 1. Between brackets is given the percentage of the admissions of the respective age group in total admissions. Data for years in between can be found in appendix.

TABLE 1 - Number of hospital admissions by age group and gender, 1991-2000

	Men		Women	
	1991	2000	1991	2000
0	36,662 (5.2)	86,170 (10.5)*	28,867 (3.3)	76,790 (7.8)*
1-4	36,622 (5.2)	29,796 (3.6)	25,473 (2.9)	23,310 (2.4)
5-14	43,830 (6.2)	36,691 (4.5)	33,000 (3.8)	28,892 (2.9)
15-24	58,511 (8.3)	42,631 (5.2)	95,117 (10.9)	67,517 (6.9)
25-34	69,621 (9.9)	54,936 (6.7)	171,218 (19.7)	150,860 (15.4)
35-44	73,108 (10.4)	76,461 (9.4)	94,143 (10.8)	101,476 (10.4)
45-54	74,318 (10.6)	99,269 (12.1)	76,115 (8.8)	93,447 (9.6)
55-64	104,321 (14.9)	107,657 (13.2)	88,748 (10.2)	91,519 (9.4)
65-74	109,995 (15.6)	147,450 (18.0)	102,459 (11.8)	134,239 (13.7)
75+	95,100 (13.5)	136,598 (16.7)	152,599 (17.6)	210,653 (21.5)
Total	702,088 (100.0)	817,659 (100.0)	867,739 (100.0)	978,703 (100.0)

Source: Ministry of Public Health, 1991-2000.

* The increase in number of admissions in the youngest age group is partly due to the obligation of hospitals to register births for MKG since 2000.

Most admissions at age 0 and in highest age groups

Table 1 induces following conclusions regarding hospital admissions:

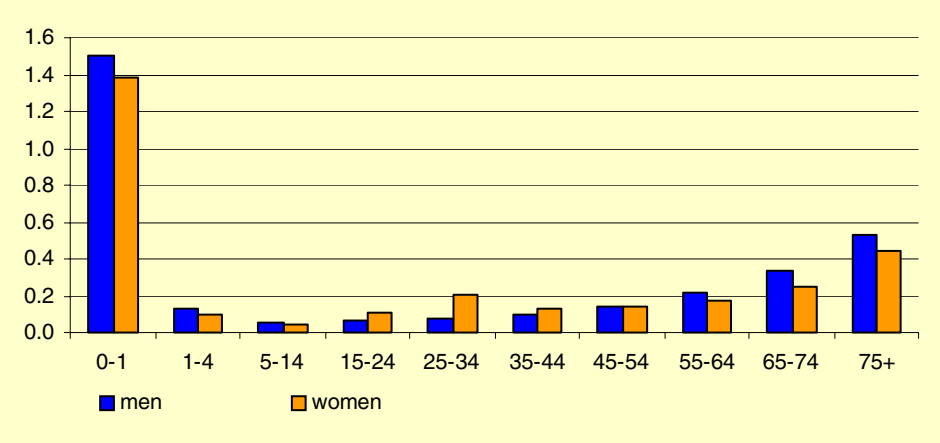
- The total number of hospital admissions has increased between 1991 and 2000. For men this was a rise from 702,088 admissions to 817,659 (an increase of 16.5%), for women, the number rose from 867,739 to 978,703 (an increase of 12.8%).

- This increase is the result of, on one hand an increase in the number of admissions in the youngest age group and in older age groups (starting at age 35); and on the other hand a decrease in the number of admissions for people between age 1 and 34. This holds for both men and women.
- The number of admissions is higher for women than for men, after the age of 15. In younger age groups, the number of admissions is higher for men than for women.
- Looking at percentages of admissions by age group, for both men and women, the highest proportion of admissions can again be found in older age groups. There seems to be a positive relation between age and number of hospital admissions.

These pure numbers, however, don't say much. The increase in hospital admissions could be purely the result of an increase in the size of the population, and not an increase in use of health care. Therefore, these data have to be compared with the evolution of the population to see whether the average number of admissions per person in every age group has increased as well.

The average number of admissions in percentage of population in 2000 is shown in figure 1.

FIGURE 1 - Average number of hospital admissions by age group and gender, 2000



Source: Ministry of Public Health, 2000.

Positive relation between age and admissions; men are admitted more often

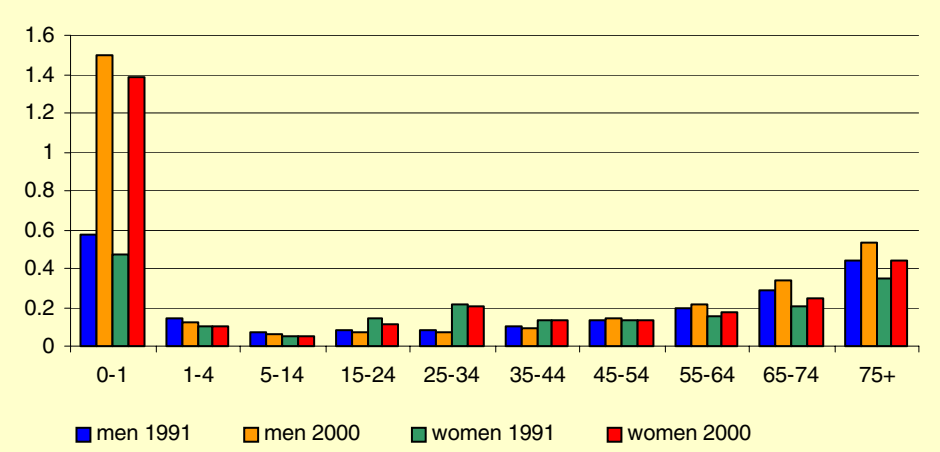
This graph leads to the following conclusions:

- The age group with the *highest average number* of admissions is, both for men and women, the *youngest age group*. Boys under the age of one are admitted on average 1.5 times a year, newborn baby girls on average 1.4 times a year.
- After the age of one, the average number of admissions drops significantly to approximately 0.1 for both men and women, and from then on a *clear positive relation with age* exists. As people get older, the average number of admission increases to finally reach 0.5 for men and 0.4 for women for people older than 75.
- In all age groups, except between ages 15-34, *women are less frequently admitted* to hospital than men. The higher number of admissions between the ages 15-34 is due to the fact that these are ages at which women mostly give birth. The higher number of admissions in this age group might not be a good indicator for health status for women.

Average number of admissions increased in younger and older age groups

Comparing the average number of hospital admissions for men and women in 1991 and 2000 leads to the observation that it hasn't changed much between 1991 and 2000: it increased from 0.14 to 0.16 for men, from 0.17 to 0.18 for women. But there may have been underlying shifts between age groups, as is shown in figure 2.

FIGURE 2 - Average number of hospital admissions by age group and gender, 1991 and 2000



Source: Ministry of Public Health, 1991-2000.

The rather stable number of total admissions between 1991 and 2000 is the result of following underlying evolutions:

- For both men and women, the average number of hospital admissions has increased significantly for newborn babies: for boys it rose from 0.6 to 1.5, for girls it increased from 0.4 to 1.5. This is partly due to the new obligation of hospitals to register births.
- The average number of admissions has also increased, though to a lesser extent, in older age groups, starting at age 45 for men and 55 for women.
- For the age groups between ages 1 and 45, the average number of admissions dropped between 1991 and 2000.

Thus, though the total average number of admissions hasn't changed much, there has been an increase in frequency of admissions for newborn babies and older people.

Thus, there is a clear positive relationship between age and frequency of admission: as people get older, they are admitted to hospital more often. And this average number of admissions has increased between 1991 and 2000 for older people.

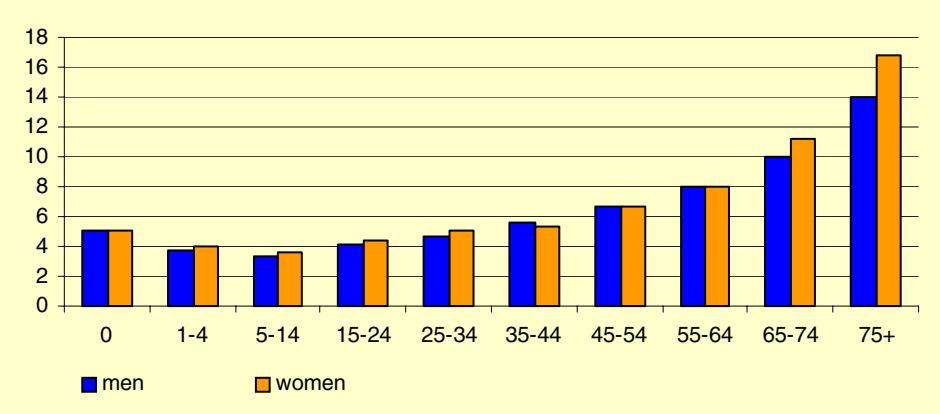
2. Average length of hospital stay

How long do people stay in hospital?

The Ministry of Public Health has also gathered data on the number of nights spent in hospital. The average length of hospital stay is calculated by dividing the number of nights spent in hospital by the number of admissions to hospital.

The results for 2000 by age group and gender are shown in figure 3. Data can be consulted in the appendix.

FIGURE 3 - Average number of nights spent in hospital by age group and gender, 2000



Source: Ministry of Public Health, 2000.

Number of nights increases with age and women stay longer

Two conclusions can be drawn:

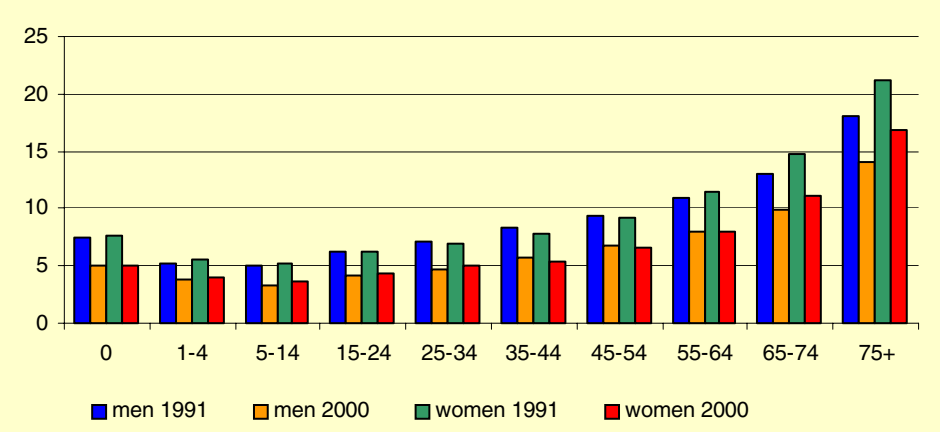
- There is a *positive relation between age and length of hospital stay.* At age 0, on average 5.1 nights are spent in hospital. This drops to 4 nights when the children reach the age of 1, and 3 nights for 5-9-year olds. Then the average length of stay rises with age. For women, the number of nights spent in hospital increases to almost 17 nights in the oldest age group. For men, the number of nights increases to 14 for men older than 75.
- Women spend more nights in hospital than men do, especially in the oldest age group. Women might be admitted to hospital less frequently than men are (see above, figure 2), but they stay there longer.

Number of nights spent in hospital has increased

The comparison of the average length of hospital stay for men and women in 1991 and 2000 is shown in figure 4 below.

The graph clearly shows that for all age groups, and both for men and women, the average number of nights spent in hospital decreased between 1991 and 2000, the biggest decrease even taking place in the oldest age groups. For example, in the oldest age group, men spent 18 nights in hospital in 1991 compared to 14 in 2000. For women, the average length of hospital stay in that age group dropped from 21 to 17 nights.

FIGURE 4 - Average number of nights spent in hospital, by age group and gender, 1991-2000



Source: Ministry of Public Health, 1991-2000.

So, as people get older, a higher percentage of the population is admitted to hospital and the average number of nights spent in hospital increases. This leads to the conclusion that *there is a positive relationship between age and demand for care in hospital, for both men and women.*

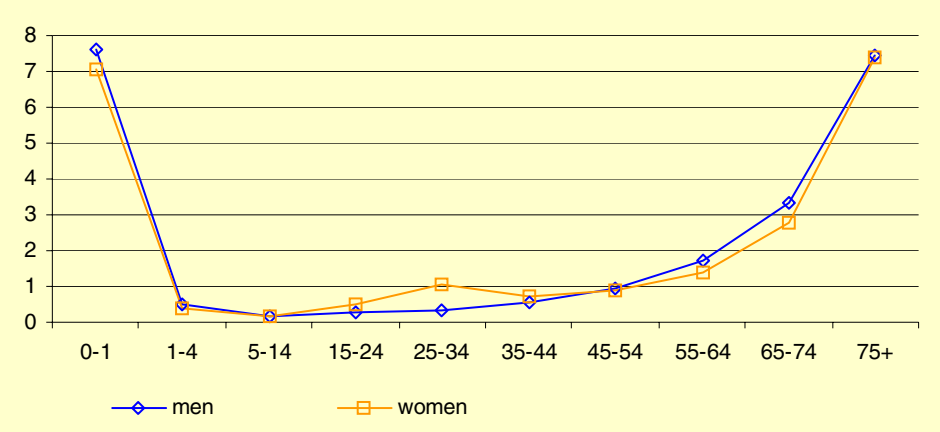
3. Volume of hospital stay

Putting the frequency of hospital admissions (average number of hospital admissions per year) and the average length of each hospital stay together, gives the *average volume of hospital stay,* or the average total number of nights spent in hospital per person in a year.

average volume of hospital stay = average number of admissions × average lenght of stay

Figure 5 shows the average volume of hospital stay in 2000 by gender and age group.

FIGURE 5 - Average volume of hospital stay, by age group and gender, 2000



Source: Ministry of Public Health, FPB calculations.

Volume of hospital stay is high in youngest and older age groups

The following picture emerges from this measure:

- *A clear age-related profile exists.* Excluding the youngest age group (newborn babies), the volume increases with age. Until the age of 54, less than 1 night – on average – is spent in hospital per year. Then it increases to 2 nights for people between 55 and 64, to 3 nights in the next age group and finally 6 nights for people older than 75.

Men are admitted more frequently but stay fewer nights than women do: the volume of hospital stay is equal for men and women

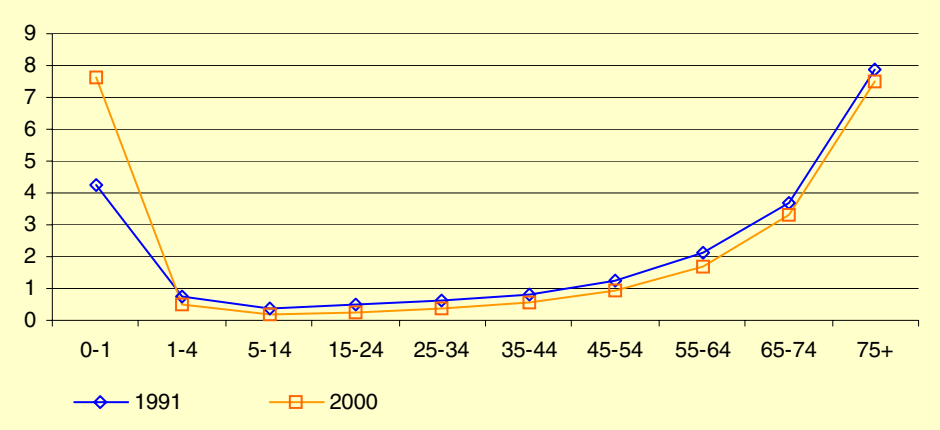
- *No big differences occur between men and women: they spend on average the same amount of nights in hospital per year* (except women between 25-34, who have a higher average volume of hospital stay due to childbearing). Previous sections indicated that men are admitted to hospital more often than women, but that women spend on average more nights in hospital than men. These two developments seem to cancel each other out, since the volume for men and women is the same.

Important is that the *volume of hospital stays, or the average total number of nights spent in hospital each year increases with age*, especially in the oldest age group.

Decrease in the volume of hospital stay between 1991 and 2000

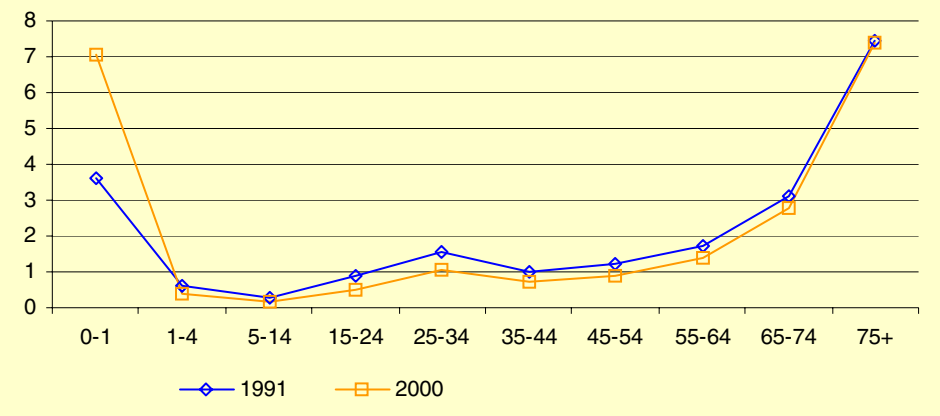
Figures 6 and 7 show the evolution of the volume of hospital stay between 1991 and 2000, by age group, respectively for men and women.

FIGURE 6 - Volume hospital stay, by age group, men, 1991-2000



Source: Ministry of Public Health, 1991-2000.

FIGURE 7 - Volume hospital stay, by age group, women, 1991-2000



Source: Ministry of Public Health, 1991-2000.

There has been a slight decrease, both for men and women, in the volume of hospital stay between 1991 and 2000, in all age groups except for newborn babies. As already mentioned, this increase in the youngest age group is due to the fact that as of 2000, hospitals had to register births. The age-related profiles haven't changed in other age groups; the volume still increases with age.

4. Contacts with general practitioner (GP)

The GP plays an important role in health care. In 1997, 93% of the Belgians had a fixed GP, in 2001, 94%. The role of the GP is constantly developing and is becoming more important as the government is taking measures[1] to encourage people to consult a fixed practitioner and to see the GP before consulting specialists or emergency rooms.

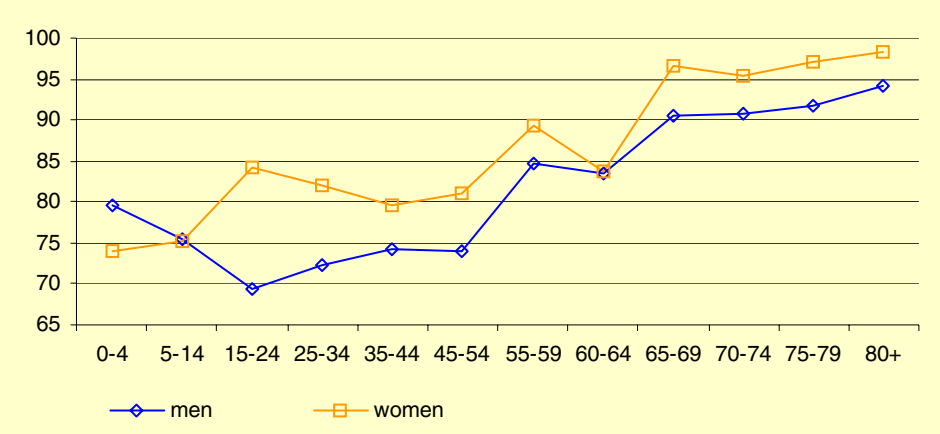
1. For example, elderly people who consult a fixed general practitioner and have their GP keep a medical file of them get more money back from health insurance than people who don't.

The Health Interview Surveys carried out by the Scientific Institute of Public Health in 1997 and 2001 questioned respondents about their medical consumption. They were asked whether and how often they contacted their doctor during the past year.

The proportion of people to contact doctor increases with age….

In 1997, 74.4% of all men and 82.7% of all women saw their doctor at least once that year. In 2001, this percentage was slightly higher: 77.4% for men and 84.1% for women. Figure 8 shows the proportion of the population that had contact with their doctor at least once during the past year, by age group and gender in 2001. Detailed data can be found in appendix.

FIGURE 8 - Percentage of population with contact with GP during past year, by age group and gender, 2001



Source: OECD.

... and more women than men contact their doctor

This figure leads to following conclusions:

a) There is a *positive relationship between age and the proportion of the population having had contact with their doctor*: as people become older, a higher percentage of the population visits their doctor at least once a year. In the youngest age groups, this is 75% for women and 80% for men. In the oldest age group (80 and older), 95% of all men contacted their doctor at least once and 97% of women did.

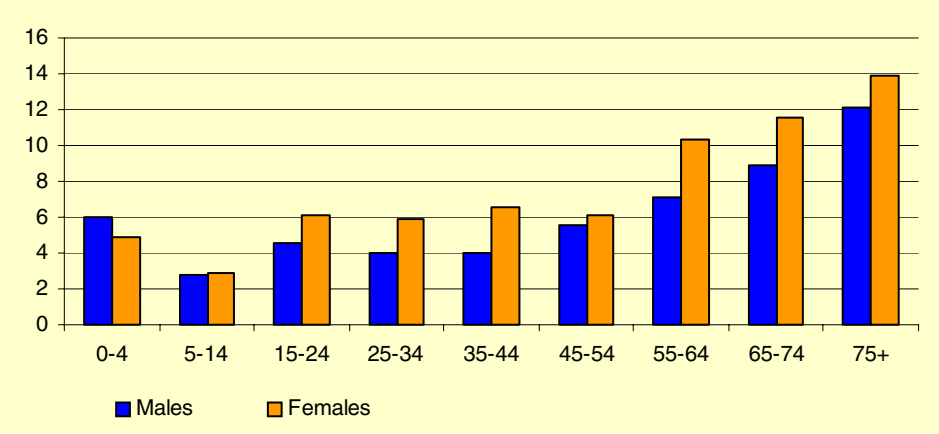
b) In all age groups (except 0-4), *more women contact their GP than men do*. For example, between age 25 and 34, about 72% of men contacted their doctor, compared to 82% of all women. The gap between men and women differs between age groups and there is no clear relation between age and the gap between men and women.

A look at the percentages in 1997 and 2001 does not imply a significant evolution between those years. For both men and women, there has been a small increase in some age groups, while in other age groups there has been a small decrease. Therefore, this graph is not presented here. Data for 1997 can be consulted in appendix.

Elderly people see their doctor more often and ***women more so than men***

Figure 9 shows the average number of contacts with a GP in 2001, by age group and gender. Detailed data can be found in appendix.

FIGURE 9 - Average number of contacts with GP by age group and gender, 2001



Source: Health Interview Survey, 2001.

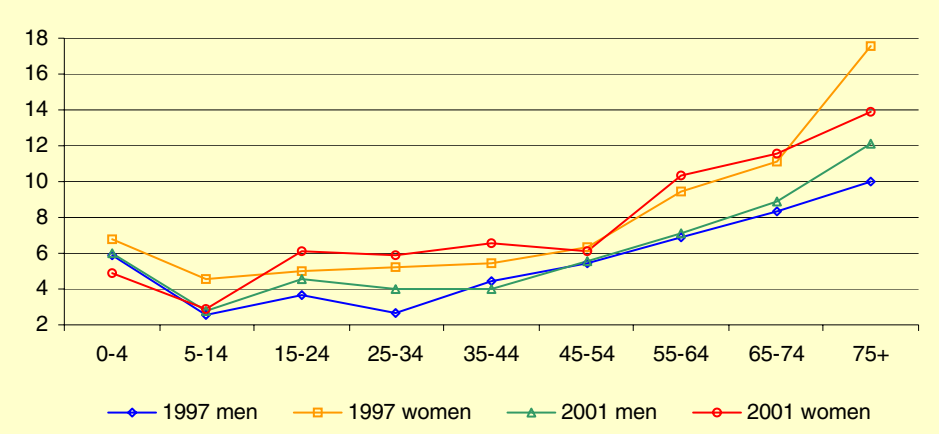
Two main conclusions can be drawn:

- A *positive relation between age and number of contacts exists*. As people get older, they see their GP more often. People aged 5-14 see their doctor about twice a year; people over 74 do so 12 to 14 times. Exception is the youngest age group, which contacts the doctor a little more often, namely 5-6 times a year.
- Except for the youngest age group, *men have fewer contacts with their GP than women* do. The biggest difference between genders occurs at the age of 55-64, when men contact their GP 7 times a year and women 10 times.

Slight increase in the number of contacts between 1997 and 2001…

Figure 10 shows the number of contacts with a doctor in 1997 and 2001, by age group and gender. This allows to study the evolution over time of frequency of contact.

FIGURE 10 - Number of contacts with doctor by age group and gender, 1997 and 2001



Source: Health Interview Survey, 1997-2001.

This picture clearly shows the *positive relation between age and number of contacts with the doctor*, for both men and women, in both 1997 and 2001.

For men, the number of contacts with a doctor in 2001 was slightly more elevated than in 1997, especially between ages 5-14, 25-34 and in the oldest age groups. Women also consulted their doctor more often in 2001 than in 1997, except in the youngest and oldest age group. This is a remarkable evolution: for women in the oldest age group, the average number of consultations with a doctor has dropped since 1997, whereas one would expect it to rise.

The main conclusions about the consultation of a general practitioner are: as people get older, they contact their doctor more often. Moreover, the number of contacts with a doctor tends to rise over time, except for women in the oldest age group. Women contact the doctor more often than men do.

5. Contacts with specialist

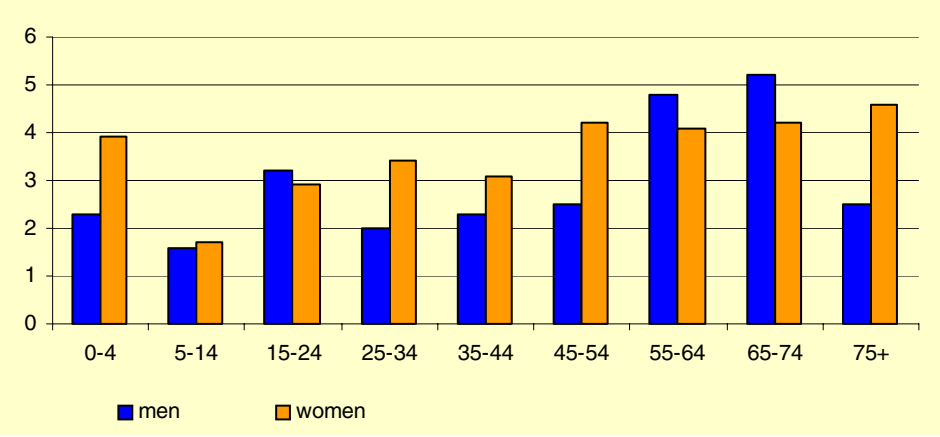
Contacts with specialized doctors account for an important part of medical consumption, especially because until now, patients can consult specialists without first seeing a general practitioner. The government is however taking measures to discourage patients to contact specialists immediately and to try to enforce them to see a GP first.

This section studies the demand for specialized doctors. Data come from the HIS in 1997 and 2001 and include all contacts with specialists, whether they took place in private or in hospital. Consultations in emergency rooms and contacts on the phone are also taken into consideration. Contacts with specialists while admitted in hospital are however excluded.

In 1997, 38.9% of all men had seen a specialist at least once during the past year and 13% of men had never seen a specialist before. Of all women, 57% had seen a specialist during the past year and 8% never had. In 2001, 44% of all men and 56.6% of all women had at least once seen a doctor, and respectively 14 and 9.5% of men and women had never done so.

Figure 11 shows the average number of contacts with a specialist, by age group and gender in 2001. Data on which this graph is based can be found in appendix.

FIGURE 11 - Average number of contacts with specialist, by age group and gender, 2001



Source: Health Interview Survey, 2001.

It is very hard to draw conclusions based on these data:

- A relationship between age and contacts with specialists is hard to detect, especially for men. The average number of contacts varies with age. For women, excluding the youngest age group, one could say the number of contacts tends to increase with age, but data aren't very convincing.
- Secondly, data do not allow to make a distinction between men and women. In some age groups, men see a specialist more often, in others, women do.

Since no clear conclusions can be drawn, medical consumption provided by specialists will not be analysed in detail.

Clear positive relationship between age and the use of health care

Except for contacts with specialists, previous sections lead to firm conclusions on the *relation between use of health care and age*. Data show that as people get older, the frequency of hospital admission increases, as well as the length of hospital stay and the number of contacts with a doctor. Based on these results, one can assume that population ageing will lead to an increase in demand for health care. Usually, use of health care is higher among women then among men.

The next section analyses the demand for (use of) a different kind of care: long-term care.

6. Long-term care

What is long-term care?

The WHO defines long-term care (LTC) as "the system of activities undertaken by informal caregivers and/or professionals to ensure that a person who is not fully capable of self care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity". (WHO, 1999b, p.1)

LTC is in fact the umbrella term for the array of supportive services used by persons who need assistance to function in their daily lives because a chronic condition, trauma, or illness limits their ability to carry out basic self-care tasks, often called activities of daily living (ADLs), or household chores, known as instrumental activities of daily living (IADLs).

The need for LTC is influenced by changing physical, mental and/or cognitive functional capabilities that are in turn, over the course of an individual's life influenced by the environment (WHO, 1999b, p. 1). Conditions that may lead to a need for LTC include physical frailty or disability, development disabilities, mental illness, AIDS, Alzheimer's disease or stroke.

The results of research in WP1 indicate that there is a negative relation between age and health, which means that an ageing population would lead to an increasing demand for LTC.

LTC services include nursing care, home health care, personal care, rehabilitation, adult day care, case management, social services, assistive technology and assisted living services. LTC often involves the most intimate aspects of people's lives-what and when they eat, personal hygiene, getting dressed, using the bathroom.

Other less severe long-term care needs may involve household tasks such as preparing meals or using the telephone.

A lot of people still believe that most LTC is provided in nursing homes. The reality is that most LTC is provided in community settings and involves a wide range of services, such as personal care and adult day services, needed to help people function independently for as long as possible. LTC services may be provided by formal service providers or informal, unpaid caregivers, such as family and friends.

a. Number of people in need of long-term care at home

Informal LTC is provided in the home by family members, friends

First a word about informal long-term care. Informal long-term care is provided exclusively in the home or combined with care in the community. It includes care provided by members of nuclear and extended families, neighbours, friends and individual volunteers, as well as assistance organized through voluntary organizations such as religious bodies (WHO, 1999b, p. 5).

Long-term care includes a wide range of possible services

What is included in long-term home based care? There is no unique definition of LTC or the activities it involves. The WHO has drawn up a list of minimum or core services, which include (among others):

- Assessment, monitoring and reassessment;
- Health promotion, health protection, disease prevention and postponement of disability;
- Facilitation of self-care, self-help, mutual aid and advocacy;
- Health care, including medical and nursing care;
- Personal care, e.g. grooming, bathing, meals;
- Household assistance, e.g. cleaning, laundry, shopping;
- Physical adaptation of the home to meet the needs of disabled individuals;
- Community-based rehabilitation;
- Provision of supplies, assistive devices and equipment (e.g. hearing aid) and drugs;
- Alternative therapies and traditional healing;
- Palliative care, e.g. management of pain and other symptoms;
- Provision of information to patient, family and social network;
- Counselling and emotional support;
- Facilitation of social interaction and development of informal networks;
- Development of voluntary work and provision of volunteer opportunities to clients;
- Productive activities and recreation;
- Opportunities for physical activities;
- Education and training of clients and of informal and formal caregivers;
- Support for caregivers before, during and after periods of care giving.

(WHO, 1999b, p. 6)

i. Long-term care at home

Institutional care provided at home

The Belgian Institute for Health Insurance collects data on the number of people who receive nursing care at home, by age group and by degree of dependence, but without distinction by gender.

Four degrees of dependence of people in need for LTC at home

The degree of dependence depends on the extent to which elderly people can manage activities of daily living. This leads to the following categories:

Bathroom: person needs help to go to the bathroom
Category A: person has problems with washing, getting dressed, moving about or going to the bathroom (score 3)
Category B: same as category A + dependence to eat or due to incontinence
Category C: same as category B but with score 4 for activities of daily living.

LTC at home increases with age

Table 2 shows the percentage of the population receiving LTC at home, by age group for 1998 until 2001. Again, informal care provided at home is not included, only formal care. Tables with complete data can be found in appendix.

TABLE 2 - Percentage of population receiving LTC at home, by age group, 1998-2001

	1998	1999	2000	2001
0-59	0.12	0.14	0.13	0.14
60-74	1.76	1.95	1.65	1.68
75-79	7.08	6.93	5.92	6.07
80-84	12.20	13.66	12.95	13.09
85-89	20.34	18.82	18.48	18.49
90-94	25.85	21.42	25.16	25.68
95+	27.73	19.98	29.08	29.51
Total	1.19	1.22	0.56	1.20

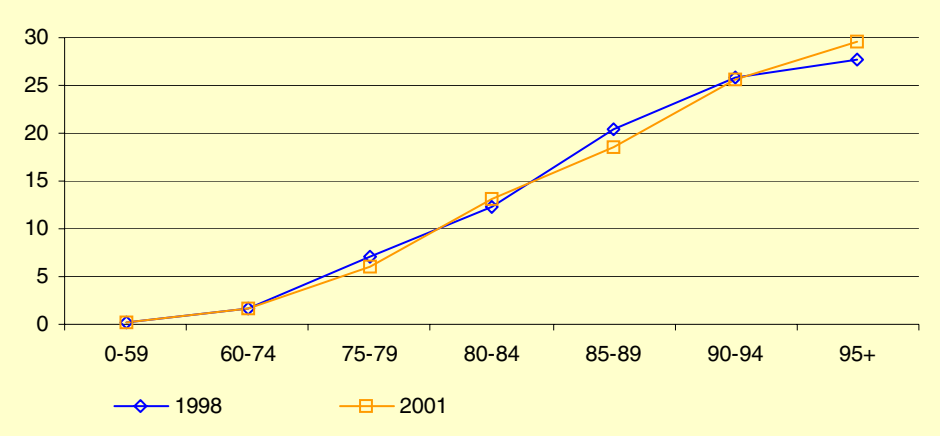
Source: Belgian Institute for Health Insurance, FPB calculations.

This table leads to following conclusions:

- There is a *positive relation between age and the percentage of the population receiving LTC at home*: as people get older, a higher proportion uses nursing care at home. For example, in 2001, 6% of people between age 75 and 79 received care, compared to 18.5% of people aged 85-89 and almost 30% of people older than 95.
- *No clear evolution over time can be detected*. In some age groups, especially the younger ones, the percentage has remained stable between 1998 and 2001. For people aged 75-79 and 85-89, the percentage decreased, for older age groups, it increased.

The positive relation between age and nursing care at home is shown in figure 12, for 1998 and 2001. *The percentage of people receiving nursing care at home increases with age*, from almost 0% in the youngest age group (0-59) to almost 30% for people older than 95. The figure also shows that little has changed in the age-pattern across time.

FIGURE 12 - Percentage of population receiving LTC at home, by age group, 1998 and 2001

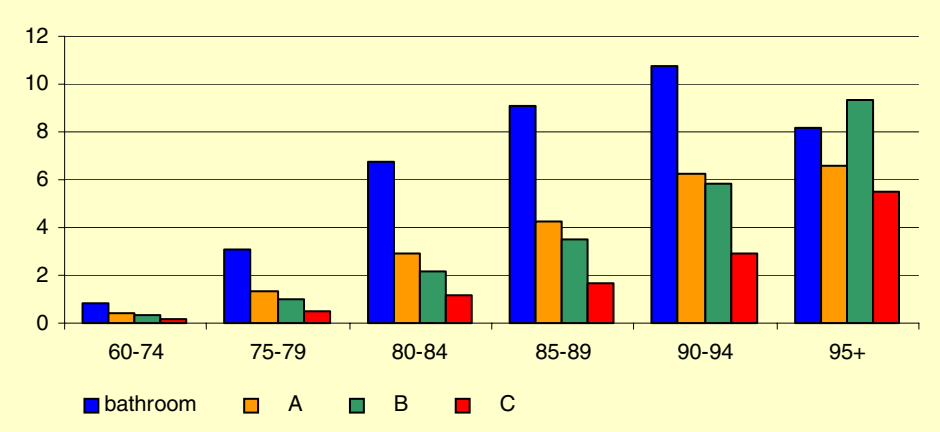


Source: Belgian Institute for Health Insurance, FPB calculations.

The degree of dependence increases with age …

Data in 2001 also describe the degree of dependence of the patients receiving nursing care at home. Figure 13 shows for each age group, the percentage of people in each category of dependence. The youngest age group (0-59) is excluded due to low percentages.

FIGURE 13 - Percentage of population receiving care at home by age group and category, 2001



Source:Belgian Institute for Health Insurance, FPB calculations.

… and category A is most important at all ages

Several conclusions can be drawn:

- For all categories of dependence, the *percentage of the population receiving care increases with age*. Only for the category 'bathroom' there is a decrease in the oldest age group. Thus, the degree of dependence increases with age.
- The majority of people receiving care at home are people who have difficulties with going to the bathroom by themselves (10% of total population). Other categories of degree of dependence are less important (less than 8% of total population).
- Category 'A' is second most important (except in oldest age group), category 'B' is third most important and last comes category 'C'. This can easily be explained by the fact that, as the degree of dependence increases,

for example to category C, it becomes more difficult to live independently. People are thus less likely to receive care at home, and more likely to receive care in institutions. The pattern of formal care will be the opposite: the higher the degree of dependence, the higher the percentage of people receiving care in institutions (see next section on formal care).

Other services include home delivered meals and home care

ii. Other services that support elderly people

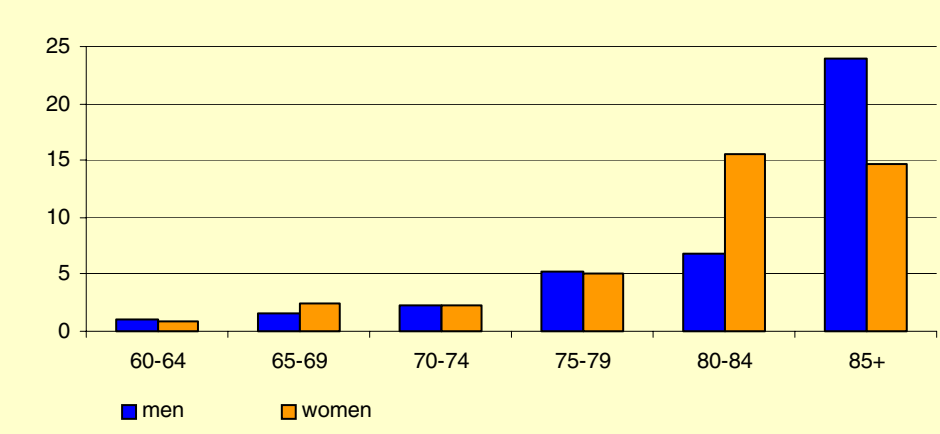
Other services exist to support people during their older days, to make life more comfortable for them or to help them with some daily activities. Some of these services were questioned in the Health Interview Surveys, which allows to report on these briefly in this paper.

Home delivered meals

Home delivered meals can be a solution for elderly people who are still healthy and fit enough to live by themselves, but who sometimes have difficulties with certain household tasks, such as preparing meals.

Figure 14 shows the proportion of people receiving home delivered meals, by age group and gender in 2001. Detailed data can be found in appendix.

FIGURE 14 - Proportion of people having meals delivered, by age group and gender, 2001



Source: Health Interview Survey, 2001.

The percentage of people receiving meals at home increases with age

People younger than 75 make (almost) no use of meal services. Only at the age of 75, people start using these services. There's a *clear positive relation between age and the use of delivered meals*. At 65, about 1% of the people use the services. This number increases as people get older, to reach 2.3% at age 70-74, 5% at age 75-79 and finally between 15% of women over 85 and 24% of men over 85. Thus, as people get older, they make use of home delivered meals more often.

Interesting is the *difference between gender*. Except in the oldest age group, women make more (or to the same extent) use of home delivered meals than men do. This is surprising, since it is mostly women who prepare meals during the active life, so one would expect men to have a higher demand than women. The difference is especially clear in the age group 80-84, where 6% of men use home delivered

meals, as opposed to 15% of all women. In the oldest age group however, 24% of men uses delivered meals and 'only' 15% of women.

The data from 1997 show a similar pattern of use of meals. Since the percentages don't differ much from these in 2001 (no significant increase or decrease in use), they are not included in the paper.

Home Care

Home care services exist that provide care in the household, especially for families with children or for elderly people. Home care can have three objectives:

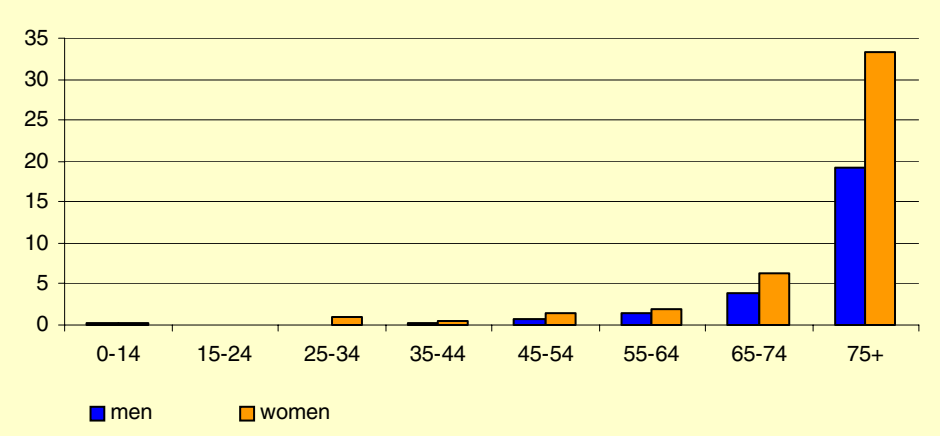
- To substitute for acute care hospitalization;
- To substitute for long-term care institutionalization;
- To prevent the need for institutionalization and to maintain individuals in their own home and community.

Overall, the goal is to provide high quality, appropriate and cost-effective care to individuals in order to enable them to maintain their independence and the highest quality of life (WHO, 1999, p. 1).

The percentage of people receiving home care increases with age and women receive more home care than men

Figure 15 shows the proportion of the population receiving home care, by age group and gender in 2001. Detailed data can be found in appendix.

FIGURE 15 - Proportion of population receiving home care, by age group and gender, 2001



Source: Health Interview Survey, 2001.

Two main conclusions can be drawn:

- There is a *positive relation* between age and the proportion of the population that receives home care. Until the age of 65, less than 5% of the people use home care. About 4% of men between 65 and 74 and 6% of women that age received home care. Only in the oldest age groups, the percentage increases significantly, to 19.3% for men and 33.2% for women.
- Women more often receive home care than men do, in all age groups. The biggest difference can be found in the oldest age group.

Since these data do not differ much from those in 1997 - no significant increases or decreases have taken place between 1997 and 2001 and the same age pattern occurs - they are not reported here. Data for 1997 are in appendix.

These are two examples of other services and sorts of care that exist to make life easier for older people. In both cases, both for home delivered meals and home care, one can detect a positive relation between age and the extent to which people make use of these services. Usually, women make use more often of these services than men do.

b. Number of people in need for long-term care in institutions: Formal care

Formal care is provided in institutions by professional caregivers

Institutional or residential long-term care is defined as the provision of care to three or more unrelated people in the same place (WHO, 1999b, p. 4) It may be publicly financed and organized, but the services may be provided by governmental organizations, NGOs or by the private sector. Formal care is usually provided by professionals (doctors, nurses, social workers) and auxiliaries, such as personal care workers. (WHO, 1999b, p. 5)

Two types of institutions exist….

In Belgium two different kinds of institutions for elderly exist:

- Homes for elderly provide housing and help with daily tasks to elderly people with varying degree of dependence (Categories O, A, B and C). Homes for elderly want to give elderly people a home-replacing environment when possibilities for LTC at home are not sufficient any more.
- Nursing homes for elderly provide housing and nursing care to elderly people with varying degrees of dependence (Categories B and C). These are institutions in between homes for elderly on one side and hospitals on the other side.

… and four categories of dependence

The categories of dependence are the same as for long-term care at home (Categories A, B and C), but the category 'bathroom' disappears and is replaced by category O including persons totally independent and managing activities of daily living.

The Belgian Institute for Health Insurance has gathered data on the number of people residing in homes for elderly and nursing homes for elderly by age group and degree of dependence from 1995 to 2001. These data are shown in appendix.

The analysis starts with a look at the total number of people in institutions by age group, without distinction by degree of dependence. This is shown in table 3. It is to be noted that hospital beds for long-term care are not included in this analysis.

TABLE 3 - Percentage of people living in institutions, by age group, 1995-2001

	1995	1996	1997	1998	1999	2001
0-59	0.02	0.03	0.03	0.03	0.03	0.03
60-74	0.53	1.00	0.82	0.91	0.94	0.92
75-79	4.54	4.66	4.85	4.73	4.67	4.26
80-84	10.72	12.14	10.70	10.84	11.55	11.82
85-89	23.45	24.02	25.01	25.08	25.85	25.06
90-94	-	38.19	46.13	43.25	44.15	49.68
95+	-	-	70.78	62.50	65.35	79.99
Total	0.95	1.02	1.05	1.06	1.11	1.16

Source: Belgian Institute for Health Insurance and FPB Population data, proper calculations.

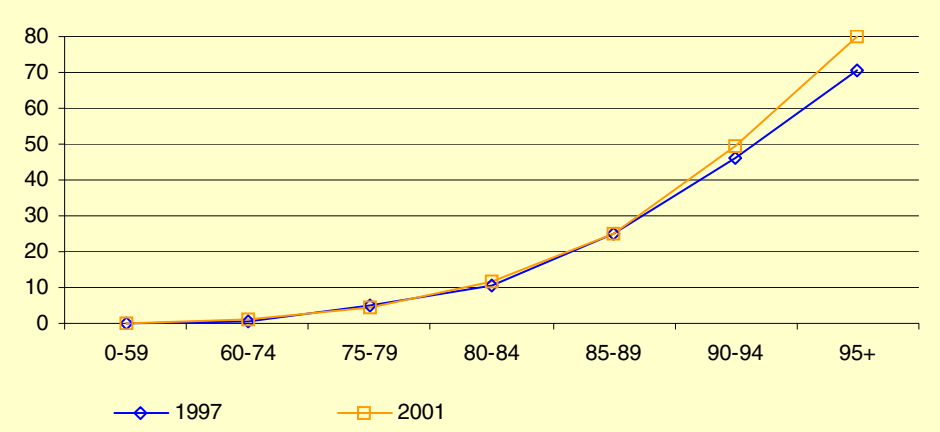
The number of people in institutions increases with age and over time

A firm conclusion can be drawn from this table:

- A *positive relation exists between age and the proportion of the population in institutions*. Less than 1% of people younger than 75 resides in homes for elderly or nursing homes for elderly. As people get older, the proportion increases: it reaches 10% in the 80-84 age group; 20% in the 85-89 age group and between 40 and 80% in the oldest age groups. From 1997 onwards, two thirds of all people older than 95 resided in an elderly institution.
- The proportion of the population in institutions *increases over time*. Excluding 1995 from this analysis (lack of data), one can see that, for example in 1995 9.7% of 80-84-year olds stayed in an institution, compared to 11.8% in 2001. In older age groups, the increase is even bigger: 48.4% of 95 year-olds lived in a home for elderly or nursing homes for elderly in 1995, whereas in 2001 this was almost 80%.

These conclusions become very clear in figure 16, which shows the percentage of people living in institutions by age group for 1996 and 2001. This figure shows the positive relation between the proportions of people living in institutions and age, as well as the increase in this proportion over time, especially in the older age groups.

FIGURE 16 - Percentage of people living in institutions by age group, 1997 and 2001



Source:Belgian Institute for Health Insurance, FPB calculations.

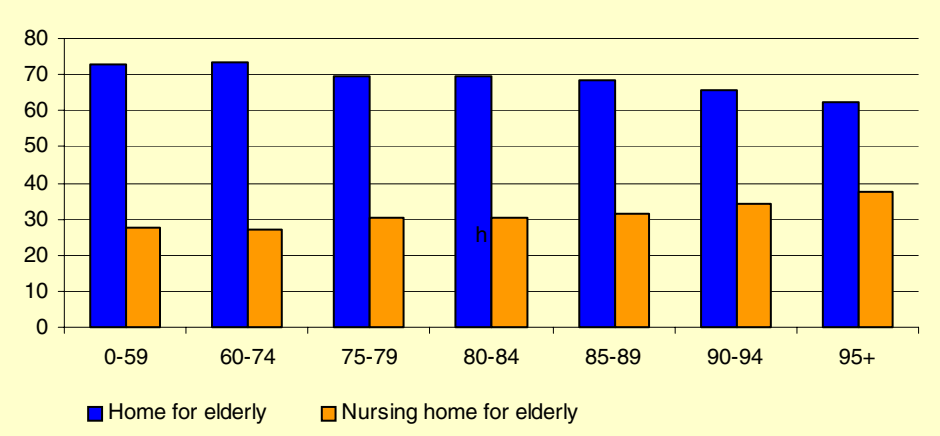
What follows concentrates on the situation in 2001.

The majority of institutionalized people lives in a home for elderly

As mentioned before, there are two types of institutions. The homes for elderly are accessible to people with all degrees of dependence. The nursing homes for elderly, on the contrary, are only accessible to people with degree of dependence B or C. Therefore, the more dependent one becomes, the more likely **is he or she** to reside in a nursing home for elderly instead of a home for elderly.

Figure 17 shows the percentage of all institutionalized people, living either in a home for elderly or a nursing homes for elderly by age group, for 2001.

FIGURE 17 - Percentage of institutionalized people by age group and type of institution, 2001



Source: Belgian Institute for Health Insurance.

In 2001, the majority (between 60 and 70%) of institutionalized people lived in a home for elderly, and between 30 and 40% of institutionalized people lived in a nursing home for elderly The proportion living in a nursing home for elderly (with higher dependence) does increase with age, which indicates that as people get older, their dependency increases and a higher proportion lives in nursing homes for elderly.

Keeping in mind that more people live in a home for elderly rather than in a nursing home for elderly table 4 takes a look at the percentage of the population living in a home for elderly and a nursing home for elderly, by age group and by degree of dependence.

TABLE 4 - Percentage of people living in a home for elderly - a nursing home for elderly, by age group and degree of dependence, 2001

	0-59	60-74	75-79	80-84	85-89	90-94	95+
O	0.01	0.27	1.06	2.85	5.57	9.78	14.58
A	0.01	0.16	0.65	1.82	3.85	7.30	9.51
B	0.01	0.19	0.93	2.62	5.42	10.58	15.07
C	0.01	0.30	1.61	4.53	10.22	22.02	40.83
Total	0.03	0.92	4.26	11.82	25.06	49.68	79.99

Source: Belgian Institute for Health Insurance, FPB calculations.

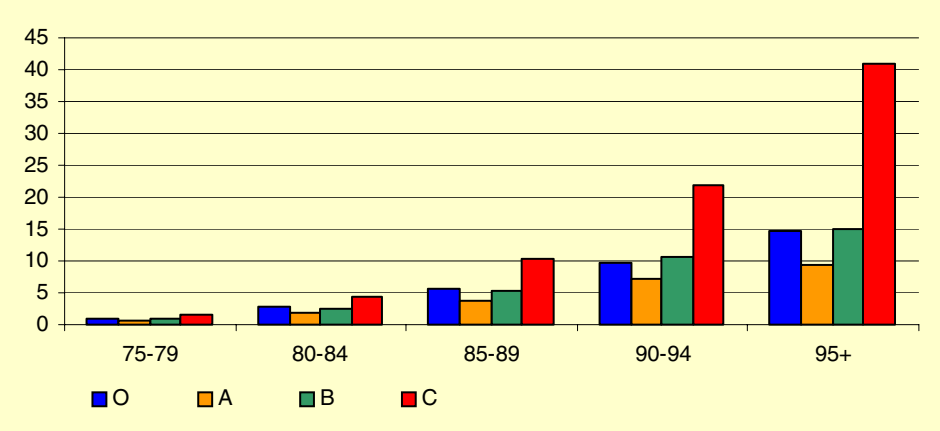
These data lead to the following conclusions:

- There is a *positive relation between age and the percentage of people receiving care in institutions, in all categories*. For example, for category A, 0.01% of the population younger than 60 resides in an institution, compared to 9.5% of people older than 95.
- For people in institutions, category 'C' is dominant. That is, the biggest proportion of people in institutions belongs to category C. Category B comes second, then O and then A. This is logical, since the lower the dependence, the lower the need to be institutionalized. Informal care might be a better solution for people with a lower degree of dependence.

In institutions, category C is most important

These results become clearer with figure 18, which gives the percentage of the population receiving formal long-term care by age group and degree of dependence in 2001. The two youngest age groups are excluded due to low percentages.

FIGURE 18 - Percentage of population living in a home for elderly -nursing home for elderly by age group and degree of dependence, 2001



Source: Belgian Institute for Health Insurance, FPB calculations.

Figure 18 confirms the earlier conclusions drawn from table 4, namely that there is a positive relation between age and the percentage of the population residing in a home for elderly - a nursing home for elderly, and that among people residing in institutions, category C is most important.

This analysis only includes long-term care provided in specialized institutions. As already mentioned, long-term care provided in regular hospitals is not included in this analysis.

7. A small forecasting exercise…

How will hospital admission and LTC at home and in institutions evolve over time?

Hospital admissions

On the basis of the data of the Ministry of Public Health and the population data, rates of hospital admissions have been calculated by age group and gender (see 'average number of admissions'). Table 5 shows the rates of hospital admission calculated for 1998 on which the forecasts are based, by age group and by gender. Since this study focuses on the demand for care by elderly people, people until the age of 65 are globalised in one category.

TABLE 5 - Rates of hospital admission, by age group and gender, 1998

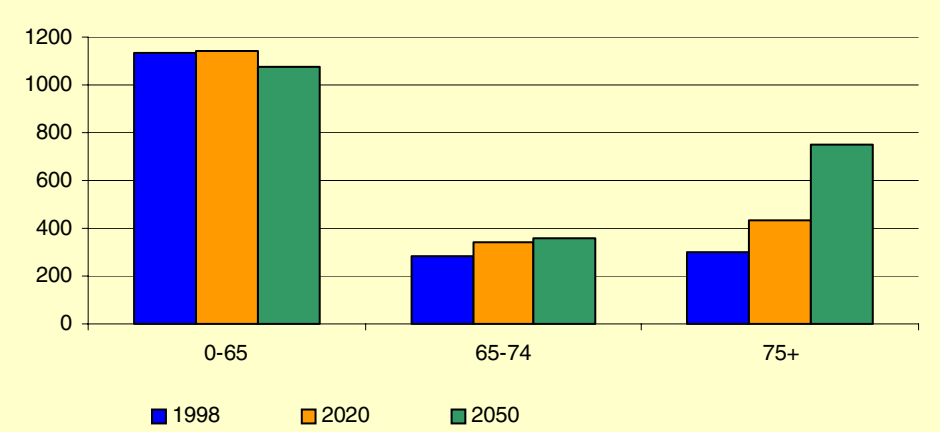
	Men	Women
0-65	0.12	0.15
65-74	0.34	0.25
75+	0.49	0.41
Total	0.16	0.18

Source: Ministry of Public Health, 1998, FPB population data.

Number of inpatient cases is expected to increase by 2050….

Assuming that these rates would remain constant until 2050 in the lack for now of more information, they have been combined with population forecasts to estimate the number of inpatient cases in the future, without making a distinction between genders. Figure 19 shows the estimated evolution of the number of inpatient cases per age category in 1998, 2020 and 2050.

FIGURE 19 - Estimated evolution of inpatient cases by age group (in 1,000), total population, 1998-2050



Source: NIS - FPB population projections, FPB calculations.

This figure 19 clearly shows the consequences of the ageing of the population on demand for health care: the number of people older than 65 admitted to hospital will have almost doubled by the year 2050. The number of patients admitted to hospital younger than 65 years old will decrease a little by 2050 (1,073,954 patients compared to 1,135,710 in 1998). This decrease will be on average 0.1% per year.

The increase in inpatient cases is especially clear in the two other age groups: the number of people between 65 and 74 admitted to hospital will increase from 281,970 in 1998 to 355,153 in 2050, which is an increase of 25.9%. The number of inpatient cases in the oldest age group will increase from 300,837 in 1998 to 746,076 in 2050, which is an increase of 148%, or more than a doubling.

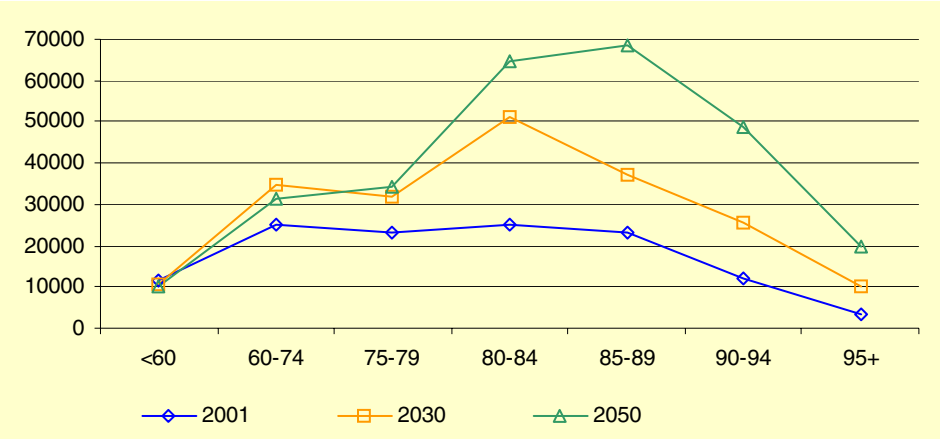
Long-term care at home

The forecast of the future demand for LTC at home is based on the most recent percentages of population receiving long- term care at home, namely data in 2001, assuming that these percentages won't change in the future. These are combined with the projected number of population in each age group in 2030 and 2050.

The number of people receiving LTC at home will increase by 2050

The results of this forecasting exercise are shown in figure 20, which emphasizes the increase of people who should be receiving LTC at home in the future.

FIGURE 20 - Forecasted number of people receiving LTC at home, by age group, 2001-2050



Source: Belgian Institute for Health Insurance, NIS - FPB population projections, FPB calculations.

The total number of people receiving LTC at home is expected to increase from 123,566 people in 2001, to 200,542 people in 2030 and finally 277,432 people by the year 2050. This is an increase of 124%, or, in other words, between now and 2050, if current rates of use of LTC at home don't drop, the number of people receiving long-term care will more than double. This increase would be due to an increase in the older age groups. Figure 20 shows that in the younger age groups, the extra number of people is rather small. The biggest increase can be found in age groups 80-84 and 85-89, and even 90-94.

Keeping in mind that the society is changing and that people nowadays attach great importance to living independently, one can safely assume that the percentages of people receiving LTC at home are not likely to fall. On the contrary, people will put off going to long-term care institutions and will therefore depend more on informal LTC. The percentages used might therefore be an underestimate of the future percentages, and thus, the number of people receiving LTC at home in the future might be even higher.

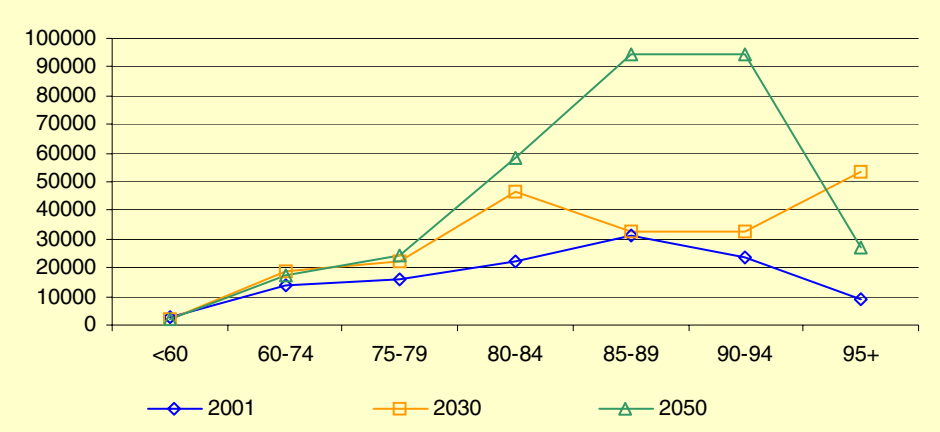
Long-term care in institutions

Similarly, one can attempt to forecast the future number of patients receiving LTC in institutions, by combining population projections with the most recent data on formal long-term care. More specifically, for 2030 and 2050, the projected numbers of people in each age group are multiplied with the percentages of the population of those age groups receiving LTC in institutions in 2001. Again these percentages might change over time. The outcome of this simple exercise is shown in figure 21.

The number of people living in institutions will increase as well.

Again the number of people receiving long-term care, but this time in institutions, is expected to increase in the future.

FIGURE 21 - Forecasted people receiving LTC in institutions, by age group, 2001-2050



Source: Belgian Institute for Health Insurance, NIS - FPB population projections, FPB calculations.

With constant rates of institutionalisation, the total number of people receiving long-term care in institutions is expected to increase from 119,254 people in 2001 to 209,009 people in 2030 and finally reach 317,979 people in 2050. This is an increase of 166.6%, or, in other words, by 2050, the number of people residing in institutions providing long-term care is expected to more than double over the period. Again, the increase is bigger in oldest age groups, as also noticed with the projections of LTC at home.

This small forecasting exercise, though based on some very simplifying assumptions, sheds light on the problems that might rise as the population sensibly grows in the older ages in the coming decades. The demand for health care, whether it is regular care in hospital, or long-term care at home or in institutions, will increase steadily, and serious investments in health care supply will be needed to meet the demand. This will of course imply serious costs for the government, and the patients.

C. Supply of health care

Confronting demand and supply….

After having studied the demand side of health care, it is important to have a look at the supply side as well. An increase in demand for health care combined with a decreasing or stable supply of health care can lead to soaring health care prices and inaccessible health care for many people. That is why this section analyses the evolution of the number of caregivers in the country as well as the number of hospital beds, as indication for supply of health care.

1. Number of caregivers

a. Caregivers in general

Increase in the number and density of caregivers

The Belgian Institute for Health Insurance collects data on the number of caregivers. Table 6 shows the evolution of the number of caregivers in several categories between 1993 and 2000. These numbers have been associated to the FPB popula-

tion data to get the number of caregivers per 1,000 inhabitants (density); this is shown between brackets.

TABLE 6 - Number of caregivers and density per 1,000 inhabitants, 1993-2000

	1993	1994	1995	1996	1997	1998	1999	2000
General practitioner	16,281 (1.62)	N/A	19,824 (1.96)	20,254 (2.00)	20,605 (2.03)	20,851 (2.05)	21,130 (2.07)	21,415 (2.09)
Specialists	15,142 (1.50)	N/A	16,046 (1.58)	16,390 (1.62)	16,846 (1.66)	17,258 (1.69)	17,639 (1.73)	18,104 (1.77)
Pharmacists	N/A	N/A	9,499 (0.94)	9,692 (0.96)	9,879 (0.97)	10,087 (0.99)	10,437 (1.02)	10,724 (1.05)
Dentists	7,616 (0.75)	7,727 (0.76)	7,852 (0.78)	7,992 (0.79)	8,095 (0.80)	8,240 (0.81)	8,326 (0.82)	8,465 (0.83)
Midwives	3,737 (0.37)	3,866 (0.38)	4,026 (0.40)	4,146 (0.41)	4,311 (0.42)	4,376 (0.43)	4,351 (0.43)	4,508 (0.44)
Nurses	45,719 (4.54)	N/A	48,639 (4.80)	50,428 (4.97)	51,958 (5.11)	52,332 (5.13)	53,819 (5.27)	55,406 (5.41)
Physical therapists	21,514 (2.14)	22,438 (2.22)	23,347 (2.30)	24,331 (2.40)	24,286 (2.39)	25,009 (2.45)	26,050 (2.55)	27,053 (2.64)
Speech therapists	5,701 (0.56)	N/A	6,198 (0.61)	6,504 (0.64)	5,104 (0.50)	5,443 (0.53)	2,891 (0.28)	2,983 (0.29)
Opticians	2,969 (0.29)	2,992 (0.30)	3052 (0.30)	3095 (0.31)	3169 (0.31)	3200 (0.31)	3239 (0.32)	3280 (0.32)

Source: Belgian Institute for Health Insurance, FPB population data, FPB calculations.

During the 1993-2000 period, the number of caregivers in every category increased, except for the speech therapists, whose number decreased by more than 50%. It is however more important to look at the density, or, the number of caregivers per 1,000 inhabitants, because an increase in caregivers does not mean anything if the increase in the population is even bigger.

The density of caregivers leads to the same conclusion: there has been an increase in density for every category of caregivers, except for speech therapists, whose density dropped from 0.6 to 0.3. The density of opticians and midwives remained more or less the same. The biggest density is found in the nursing category: in 2000, there were 5.4 nurses per 1,000 inhabitants. In 1993, this was only 4.5. In 2000, there are about 2.6 physical therapists and 2.09 general practitioners per 1,000 patients. Next are specialized physicians: about 1.7 per 1,000 people. The increase in density in most caregivers' categories is a positive evolution, considering the expected increase in demand for health care due to ageing.

Increase in the number of physicians per 1,000 inhabitants as from 1960

The OECD has collected data on the number of practising physicians in the country, going back further in time. Table 7 shows the density of practising physicians per 1,000 inhabitants from 1960 until 2000.

TABLE 7 - Density of practising physicians per 1,000 inhabitants, 1960-2000

1960	1969	1980	1990	1995	1996	1997	1998	1999	2000
1.3	1.6	2.3	3.3	3.5	3.6	3.7	3.7	3.8	3.9

Source: OECD.

In a period of 40 years, the number of practising physicians per 1,000 inhabitants has tripled. In 1960, there were 1.3 physicians for 1,000 people. By 1980, this had increased to 2.3 per 1,000 inhabitants and the number has increased since then. In 2000, there were almost 4 physicians for 1,000 inhabitants. About 45% of these physicians are general practitioners; the other 55% are specialists.

There has been an increase in the number of physicians and thus in the supply of health care. Whether this increase is enough to cover an increase in demand for health care caused by population ageing, is a question yet unanswered.

b. Caregivers in institutions for long-term care

Increase in the number of caregivers in institutions, but decrease in the density

Table 8 shows the caregivers working in elderly institutions, by type of care and for 1993-1999. It also includes the density of caregivers per 1000 residents of nursing homes for elderly - homes for elderly (between brackets) for years when data on number of residents are available (1995-1999).

TABLE 8 - Caregivers in homes for elderly and nursing homes for elderly, numbers and density by type of care, 1993-1999

	1993	1994	1995	1996	1997	1998	1999
Carers	15,323	15,816	16,218 (168.7)	16,313 (180.1)	16,366 (153.4)	16,620 (154.2)	17,318 (153.4)
Nurses	9,594	10,395	10,971 (114.2)	11,051 (122.0)	11,634 (109.1)	11,933 (110.7)	12,479 (110.6)
Physical / speech therapist	*	*	*	1,301 (14.4)	1,367 (12.8)	1,539 (14.3)	1,764 (15.6)
Paramedic Staff	1,169	1,294	1,356 (14.11)	293 (3.3)	313 (2.9)	305 (2.8)	326 (2.9)

Source: Belgian Institute for Health Insurance, FPB calculations.

There has been an increase in the number of caregivers in homes for elderly and nursing homes for elderly between 1993 and 1999, except for paramedical staff. This increase, however, did not compensate the increase in number of patients. Therefore the density of caregivers per 1000 residents of institutions has decreased, except for physical and speech therapists. This means that fewer caregivers are taking care of more elderly people. If the demand for long-term care in institutions keeps rising, this tendency might cause problems.

2. Hospital beds

a. Hospital beds (in general)

Decrease in the density of hospital beds in general….

Another important component of supply of health care is the number of hospital beds that are available for patients. The OECD has gathered data on the number of hospital beds per 1,000 inhabitants for the 1970-1997 period. Results are shown in table 9.

TABLE 9 - Hospital beds per 1,000 inhabitants, 1970-1997

1970	1980	1990	1995	1996	1997
8.3	9.4	8.0	7.4	7.3	7.3

Source: OECD.

Whereas between 1970 and 1980 the number of hospital beds per 1,000 inhabitants increased from 8.3 to 9.4, the density of hospital beds has since then decreased. By 1997, the number of hospital beds had dropped to 7.3 beds per 1,000 inhabitants. This is the consequence of the rationalisation of the health policies, older people needing care being after a while transferred to nursing homes for elderly. Yet, given the ageing foreseeable in a next future, more older people will need a hospitalization and this could lead to an enormous gap between the number of hospital beds needed and the number of hospital beds available.

b. Hospital beds for long-term care

… and decrease in the density of hospital beds for long-term care

In the analysis of LTC in institutions, LTC in hospitals was not included. OCDE provides data on the number of hospital beds specific for long-term care between 1990 and 1994, as well as the number of beds per 1,000 persons aged 65 or older. The data are shown in table 10 below.

TABLE 10 - Hospital beds for long-term care, 1990-1994

	1990	1991	1992	1993	1994
Number of beds for LTC	12,203	11,603	11,625	11,559	11,507
Number of beds / 1000 people age 65+	8.27	7.73	7.62	7.46	7.32

Source: OECD.

The number of hospital beds for LTC decreased from 12,203 in 1990 to 11,507 in 1994, because of the rationalisation politcies just mentioned above. This decrease in number of hospital beds, combined with an increasing population, leads to a decrease in the number of hospital beds per thousand inhabitants. In 1990, there were 8.27 hospital beds for long-term care per 1,000 people age 65 or older. By 1994, this had dropped to 7.32 per 1,000 people.

c. Acknowledged beds in homes for elderly and nursing homes for elderly

Density of beds in homes for elderly decreases while it increases significantly in nursing homes for elderly

Homes for elderly and nursing homes for elderly are specialized institutions, which give residence and care to elderly people. Table 11 shows the number of acknowledged beds between 1996 and 2000 for each type of institution, as well as the number of beds per 1,000 inhabitants older than 65 (between brackets). The age of 65 has been taken as the lower age limit since few people under the age of 65 live in those institutions.

TABLE 11 - Beds in homes for elderly - nursing homes for elderly + density per 1000 inhabitants > 65, by type of institution, 1996-2000

	1996	1997	1998	1999	2000
Homes for elderly	96.755 (59.52)	100.656 (60.88)	98.658 (58.77)	94.302 (55.55)	90.433 (52.72)
Nursing homes for elderly	19.020 (11.70)	19.316 (11.68)	23.231 (13.84)	28.980 (17.07)	33.953 (19.79)
Homes for elderly + Nursing homes for elderly	115.775 (71.22)	119.972 (72.56)	121.889 (72.61)	123.282 (72.62)	124.386 (72.51)

Source: Belgian Institute for Health Insurance, FPB calculations.

The total number of acknowledged beds in homes for elderly and nursing homes for elderly has increased, from 115,775 in 1996 to 124,386 in 2001. The density of beds in the population older than 65 has increased as well, from 71.2 beds per 1,000 people in 1996 to 72.51 in 2001. This is the result of two opposite evolutions:

- The number and density of acknowledged beds in homes for elderly have decreased, attesting a disinterest for an institutionalization when not needed for health reasons. The number of beds dropped from 96,755 in 1996 to 90,433 in 2000, meaning a decrease of 6.5%. The density of beds in homes for elderly dropped from 59.5 beds per 1,000 people older than 65 in 1996 to 52.7 beds in 2000.
- The number and density of acknowledged beds in nursing homes for elderly have increased, being the counterpart of the rationalisation of the hospital beds for LTC mentioned above. The number of beds increased from 19,020 in 1996 to 33,953 in 2001, which is an increase of 78%. The density increased from 11.7 beds per 1000 inhabitants older than 65 in 1996 to 19.8 beds in 2000.

3. Availability of informal care

The provision of informal care depends mainly on two factors…

An important part of care is provided by informal caregivers, such as partners, children or other social network members of the person. The 'supply' or 'availability' of informal care depends on several factors (Jacobzone, Cambois, Chaplain, Robine, 1998, p. 7), two of these are:

a. Participation rates of women in paid work

….women's participation on the labour market...

This section will discuss on labour market evolutions. Women are the first caregivers for the elderly. Since they participate more on the labour market, they get less time to care for elderly.

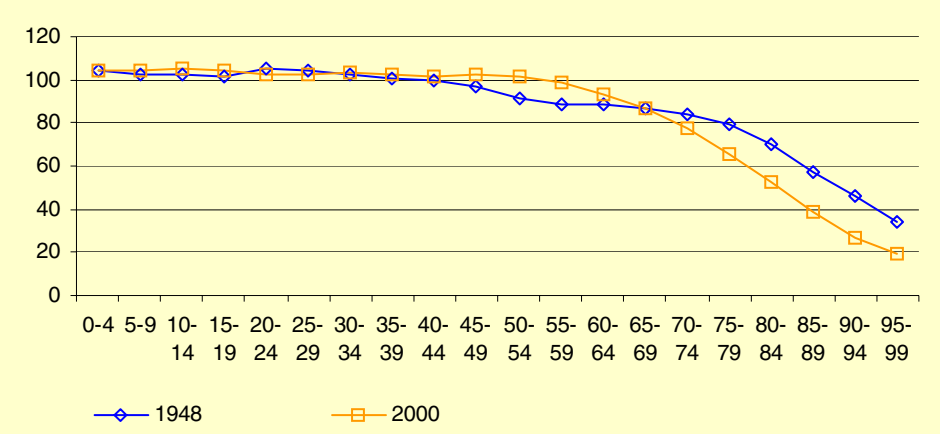
b. The male/female ratio

…and the male/female ratio

Since a lot of ill people are taken care of, informally, by their partner, the 'availability' of informal care is higher when people have a partner. When male/female ratios are highly unbalanced, in other words, when there are many more men than women, or vice versa, more people live without partner and are left without this potential source of informal care.

The masculinity index of the population is the ratio of men to women by age group. This index is shown in figure 22 from 1948 to 2000. Data can be found in appendix.

FIGURE 22 - Masculinity Index, by age group, 1948 and 2000



Source: NIS.

Until the age of 55, the index remains stable around 100, there is a balanced male/female ratio: there are about as many men as women. At older ages, the index drops, reaching low numbers as 20 in the oldest age group in 2000. This means that, in the oldest age group in 2000, there were 5 women for every man. This also means that the probability not to have a partner, and thus to be without this potential source of informal care, is higher. In 1948 the same pattern emerged, though the index remained somewhat higher (less imbalanced) than in 2000

D. Household composition

Household composition is important for informal care

Evidence suggests that families and informal network members want to continue to care for ill-health family members. In turn, persons who do require care want to remain in their own homes and communities. (WHO, 1999, p. 1)

Therefore, it is interesting to study the living situation of the elderly. This section analyses the household composition to attempt a measure of the extent to which family members and network members are available to care for elderly. How many (elderly) people are single, married, widowed or divorced? How many elderly people live within their children's family? And what is the average number of people living in one household?

1. Average household size and number of people in the household

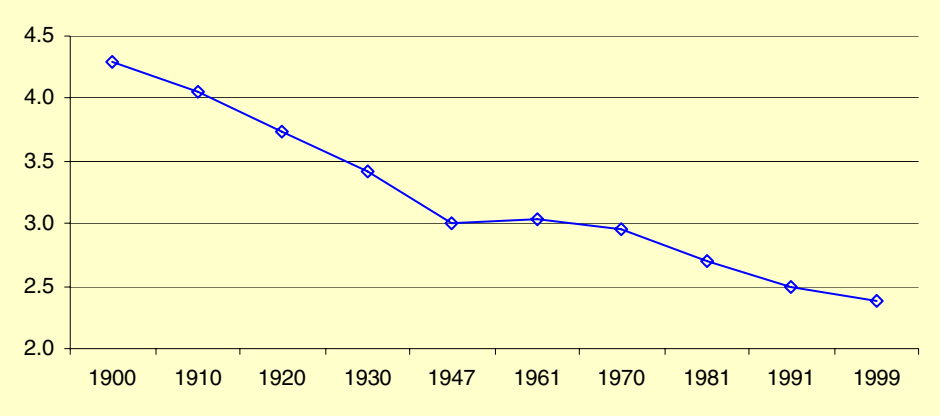
The National Institute for Statistics regularly publishes data on the average size of the household (HH) and the number of people that live in each household. The more people live in one household, the bigger the probability that one of the HH members can take care of someone in the household, and no formal care is needed.

The data on number of people in the household by gender and age-group give a good idea of how many elderly people can rely on family members for care.

The average household size in the beginning of last century was twice the size it is now

The analysis starts with a look at the evolution of the average size of the household. Figure 23 shows the results from 1900 to 1999.

FIGURE 23 - Average household size, 1900-1999



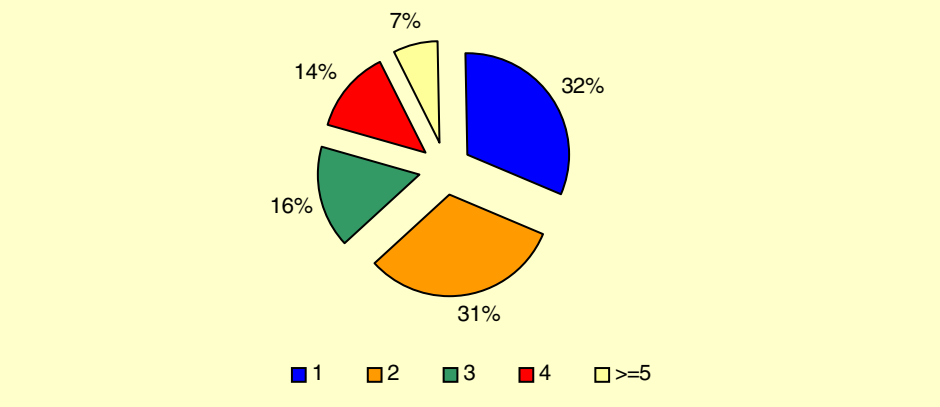
Source: NIS.

In the beginning of the previous century, every HH counted on average 4.3 people. The average HH size has known a downward evolution since then, reaching 3.7 in 1920 and 3.0 right after the Second World War. Between 1947 and 1970, the average HH size remained more or less stable, to decrease again after 1970. In 1999, most HH consisted of, on average, 2.4 people. Figure 23 clearly shows that households were much smaller in 1999 than in 1900.

Composition of households by number of household members

The evolution of the proportion of single households, two-person households, three-person households, etc. in the total number of households is given in figure 24 for the year 2001. Distinction is made between single households, and households consisting of 2, 3, 4 or 5 or more people.

FIGURE 24 - Proportion of households by size in total number of households, 2001



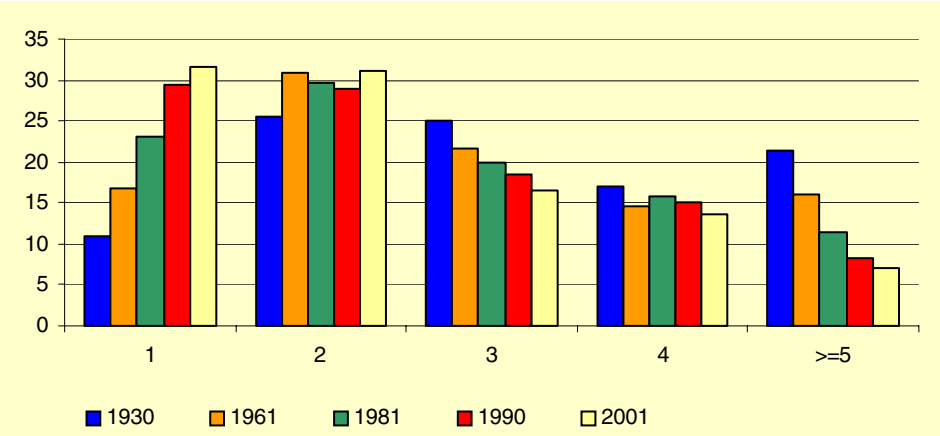
Source: NIS.

In 2001, the majority of the households consisted of less than 3 people: about 32% of all households were single HH, and 31% of all households counted 2 members. The proportion drops as HH size increases: three-person HH accounting for 16% of all households and four- people HH for 14%. Only 7% of all families consisted of five or more people.

…and the number of smaller households has increased since 1930

Have single and two-person households always made up the majority of all households? And has the proportion of large families always been so small? To answer this question, graph 25 gives the evolution of the proportion of HH of each size between 1930 and 2001.

FIGURE 25 - Proportion of households by size in total number of households, 1930-2001



Source: NIS.

In 1930, only 10% of all households were single households, and the majority of people lived in two- or three-person families (25% each). About 21% of all families counted 5 people or more and 16% of the households consisted of four members.

The proportion of single households has thus increased significantly between 1930, and 2001: from 10% to 32%. The proportion of two-person HH increased as well, though to a lesser extent: from 25% to 31%. The proportion of all other HH types decreased over the period, the sharpest decrease having taken place for households counting 5 or more people. It dropped from 21% in 1930 to only 7% in 2001.

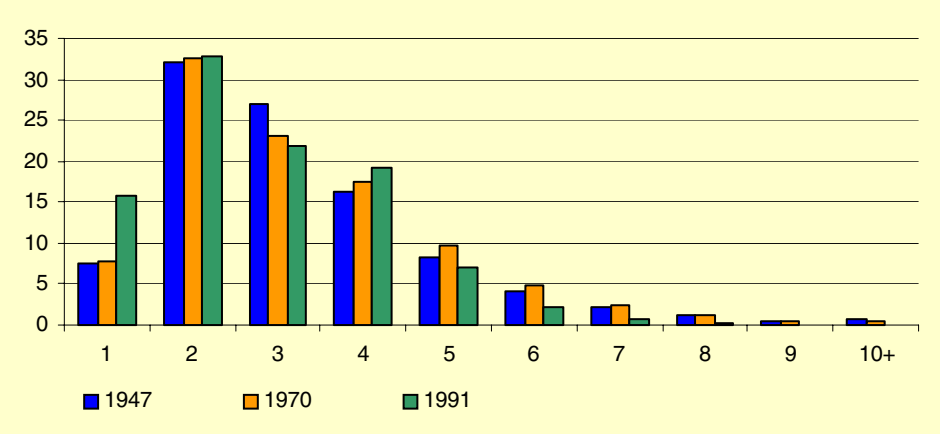
Household composition with distinction between gender

The population censuses deliver data on number of household members by gender of the reference person. Many more men are reference person of a household than women. When women are reference person, they are usually single, since in married couples, men usually are reference person. This explains why the proportion of female reference persons in bigger families is so small compared to men.

Men live mainly in 2- or 3-person households…

Figure 26 shows the distribution of male reference person by household size in 1947, 1970 and 1991. Detailed data can be found in appendix.

FIGURE 26 - Distribution of male reference persons by household composition, 1947-1991



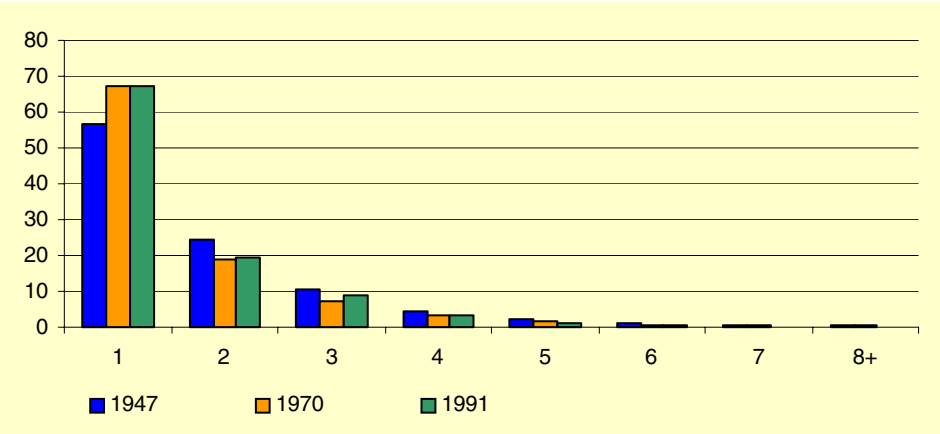
Source: NIS, Population censuses.

In 1947, about 7% of all male reference persons were single, the majority lived in households counting 2, 3 or 4 people. Between 1947 and 1991 there has been quite a shift in the household composition. The proportion of male reference persons living single has doubled to more than 15%, the proportion living in 2- and 4-people HH has increased a little bit, the proportion in other household compositions has decreased. Often, the biggest changes took place between 1970 and 1991 and didn't change all that much in the 1947-1970 period.

…while women live mainly in single households.

Figure 27 shows the same results for female reference persons in 1947, 1970 and 1991.

FIGURE 27 - Distribution of female reference persons by household composition, 1947-1991



Source: NIS, population census.

In 1947, about 57% of all female reference persons were single, 25% lived in a household with 2 people, 10% in a household of 3 people and a small minority in bigger households. By 1991, the proportion of women living single increased even more to almost 70%, while the proportion of other categories dropped.

These figures confirm earlier conclusions, namely that there has been a significant change in HH composition. Smaller households become more important as the number of bigger families (counting 4 or more people) drops.

To appreciate the situation of the elderly, this paragraph ends with a look at data on HH composition by gender and age group for the older age groups. Detailed data can be found in appendix.

As people get older, the proportion living in single households increases

Table 12 shows the percentage of male or female reference persons by age group and household composition in 1991 and 2001.

TABLE 12 - Household composition by age group and gender, 1991-2001

	Men				Women			
	1991		2001		1991		2001	
	Single	2 or more	Single	2 or more	Single	2 or more	Single	2 or more
65-69	14.1	85.9	14.8	85.2	79.5	20.5	78.5	21.5
70-74	16.7	83.3	16.7	83.3	84.0	16.0	82.3	17.7
75-79	23.2	76.8	20.3	79.7	87.0	13.0	84.7	15.3
80-84	33.4	66.6	25.9	74.1	88.0	12.0	86.3	13.7
85-89	44.8	55.2	38.6	61.4	88.1	11.9	87.4	12.6
>90	58.6	41.4	53.0	47.0	87.3	12.7	86.2	13.8

Source: NIS.

This table leads to the following conclusions:

- For men and women, *the proportion of people living alone increases with age*, which means older people tend to have fewer household members to rely on for care.
- At all ages, *women find themselves more often in a single household than men do*. But this could be due to the fact that when women live together with other people (a man), they are not the reference person.
- For both men and women and at all ages, the proportion of single HH is smaller in 2001 than in 1991, which could mean an improvement in the living situation for elderly.

The decrease in the average family size and in the proportion of large households, together with the fact that the majority of people live in single or two-person households, lead to believe that fewer people now can rely on family members to take care of them than a century ago. On top of that, elderly people seem to live in single households more often than younger people do, while these are the age group that requires most care. This might have an increasing effect in the demand of any kind of formal care.

2. Household composition by marital status

Population by marital status: can people rely on a partner for care?

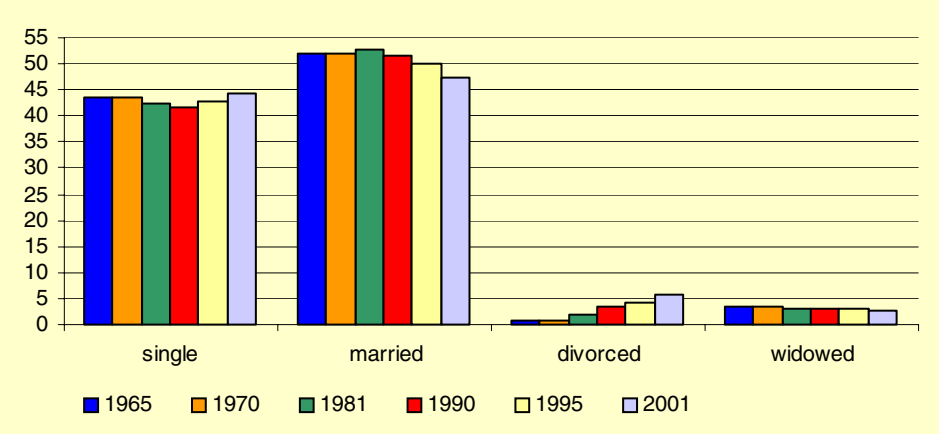
Older people are often taken care of by their husband or wife. Therefore, it is important to know how many elderly people are single, married, divorced or widowed. An older person living alone is more dependent on formal care than a person who has his or her husband or wife to take care of them.

One drawback of the NIS data is that there is no separate category for people living together without being married. Divorced people, for example, might live together with a new partner without being married. Those people can rely on their partner to care for them, however, in this analysis, divorced people are considered to be living by themselves. This might lead to an over-estimation of the number of people who have to rely on formal care.

Majority of men is either single or married, only few are widowed or divorced…

To begin with the marital status, figure 28 shows the proportion of men being either single, married, divorced or widowed, from 1965 to 2001. Data can be found in detail in appendix.

FIGURE 28 - Marital status of men, in % of all men, 1965-2001



Source: NIS.

… but the proportion of single and divorced men has increased since 1965

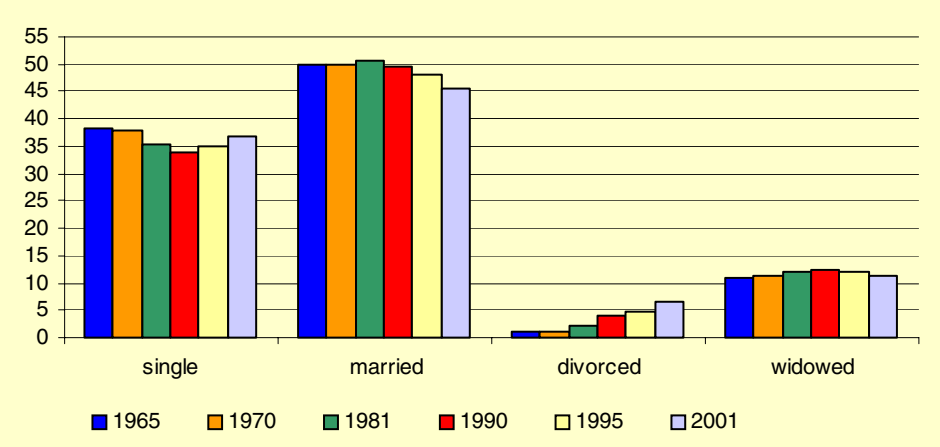
In 1965, 52% of all men were married and 43.5% were single. Only a very small fraction of the male population was widowed, namely 3.6%. Divorced men were almost non-existent in 1965: only 0.9% of all men were divorced. Between 1965 and 2001, the proportion of married men and widowed men has decreased, while the proportion of men living single and divorced men increased. In 2000, 46% of the men were married, 45% were single. The number of divorced men had increased to 5%, and the number of widowed men decreased a little bit to 2.8%.

Although the majority of men in 2001 were still married, namely 46%, more men live by themselves now than 35 years ago. Since these men cannot rely on their partner to care for them, this might have an increasing effect on the demand for formal care.

Majority of women is single or married ….

Figure 29 shows the evolution of the marital status of women between 1965 and 2001.

FIGURE 29 - Marital status of women, in % of all women, 1965-2001



Source: NIS.

In 1965, about half of all women were married and 38% were single. The proportion of widowed women (10%) is a lot higher than for men. This is due to the fact that women often live longer and outlive their partner. Similar to men, there were almost no divorced women in 1965 (1%).

…but the proportion of single and divorced women has increased since 1965

Between 1965 and 2001, the proportion of married women decreased from 50% to 45%, the proportion of widowed women increased slightly until 1990 (from 11% to 14%), to remain stable after that. The proportion of women living single first decreased until 1990, to then increase to reach almost the same level as in 1965. Interesting to note is the spectacular increase in the number of divorced women: it increased from 1% in 1965 to 6% in 2001.

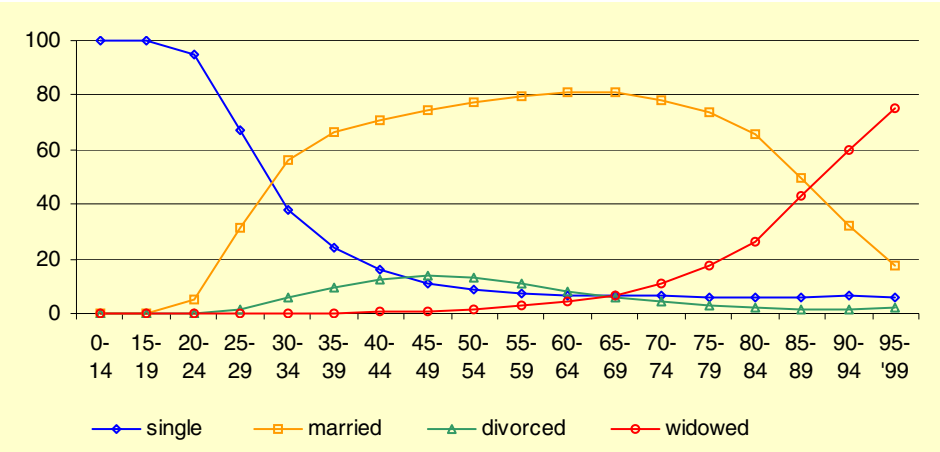
In 2001, still most women (45%) were married and 37% were single. About 11% of all women were widowed and 6% was divorced. This increase in divorced women and decrease in married women, makes it again possible that fewer women can rely on a partner to take care of them and therefore need formal care.

Marital status by age

To appreciate the situation of the elderly, figures 30 and 31 focus on the marital status by age group in 2001, for men and women.

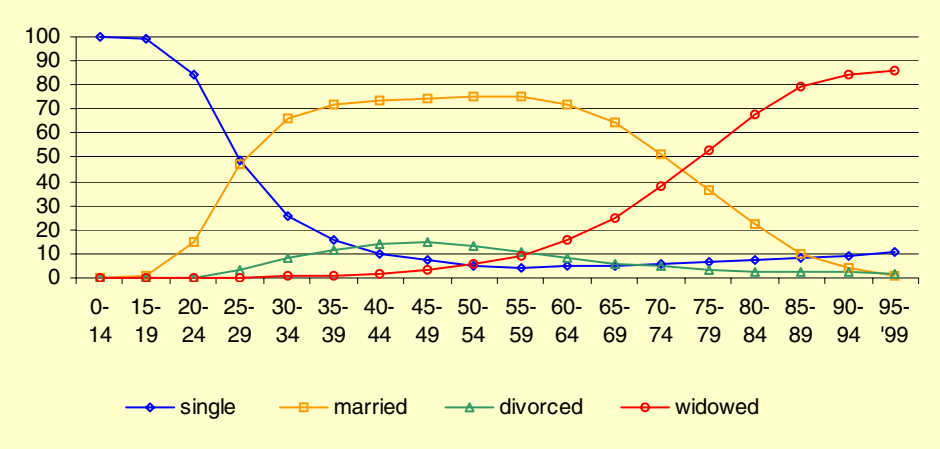
Proportion of widowed people increases with age…

FIGURE 30 - Marital status by age group (in %), men, 2001



Source: NIS.

FIGURE 31 - Marital status by age group (in %), women, 2001



Source: NIS.

Similar age-patterns can be detected for men and women. Until the age of 25, the majority of men and women are single and this percentage drops with age starting at age 20, to reach less than 10% in the oldest age groups. As people get older, the proportion of married people gradually increases to reach its peak at age 70 for men (80% of men are married) and at age 60 for women (75% of women). After the age of 75, the proportion of married people decreases again. This goes together with an increase in the proportion of widowed people. Almost no-one is widowed until the age of 70, then the proportion sharply increases with age to reach 70-80% in highest age groups. Women become widowed at younger ages than men do. A small proportion of people (less than 10-15%) were divorced. The majority of divorced people can be found in age groups 40-60; at older ages the proportion drops.

… which leaves many elderly without partner to take care of them

Among elderly people, the proportion of married people is low, and the proportion of widowed people (and thus people living alone) is high (80%). This might indicate that many elderly people will have to rely on care by children or others or formal care, since no husband or wife is around to take care of them.

3. Household composition by relationship with other members

How are family members related?

Previous paragraphs covered the average size of households as well as the marital status of people. This section will conclude the analysis on household situation and composition by looking at the relationship between household members.

The population censuses, carried out every ten years, provide information on the relationship between HH members. In the framework of this research, it would have been very interesting to dispose of data by age (group). Unfortunately, data are only available for the total population, without distinction by age.

Four types of households

For every census-year, the proportion of certain types of households in total households has been calculated by making a distinction between the following categories, characterized by the reference person of the household:

- Single without children;
- Single with children;

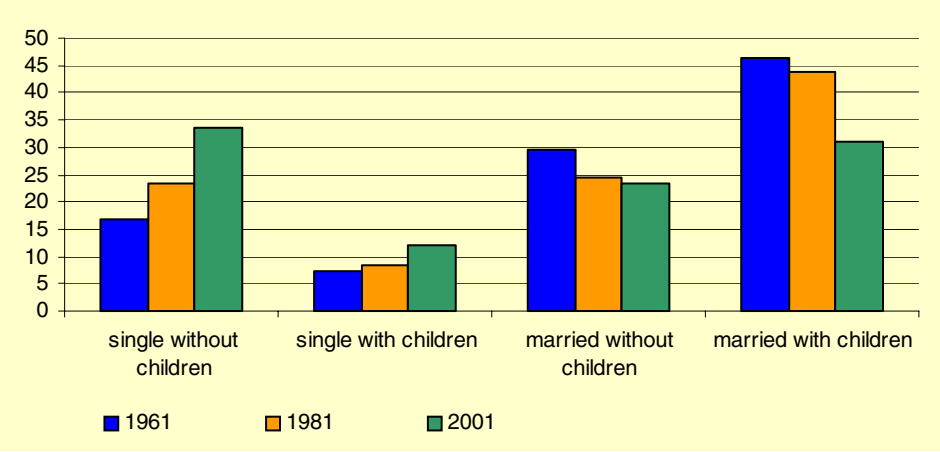
- Married without children;
- Married with children.

Of course, other types of households exist, for example, people cohabiting without being married, but these are not taken into consideration in this analysis.

Majority of people still live in married households….

The proportion of each type of household in the total numbers of households between 1961 and 2001 is shown in figure 32.

FIGURE 32 - Household composition by relation between members, total population, 1961-2001



Source: NIS.

…but the proportion of single households increases over time

In 1961, the majority of the households (46%) consisted of married people with children. About 30% of all households were married couples without children. 17% of households were people living single and less than 10% were single people with children. There has been a clear change over time. The proportion of married couples with children decreased, to reach 31% in 2001. The proportion of married couples without children remained fairly stable. The two other categories have increased, the proportion of single people to 34% in 2001, and they now make up the majority of the households. The proportion of single parents has increased to 12%.

Since more people tend to live alone – with or without children – and fewer people are married, this could influence the demand for health care by older people. Non-married people cannot rely on their husband or wife to take care of them, and the absence of children could fasten the switch from informal to formal care.

How many elderly live with their children?

Another calculation based on NIS data gives the proportion of households of which the reference person declares an elderly person lives with them in the total number of households. Elderly living with their children usually make less use of formal care than others do.

In 1970, 4% of all households had an elderly person staying with them; in 1981 this was 2.67% and by 1991, the figure dropped to 1.63%. This decreasing trend in the number of elderly people who live with their children has continued since then: in 1998, only 1.33% of all households had an elderly living with them and in 2001 this was 1.21%. This indicates that elderly people can rely less on family

or children to take care of them when they're older, and that the ageing of the population might lead to an increase in demand for formal care.

Conclusions on household composition

This chapter carried out a thorough analysis of household structure, size and composition based on NIS data. This analysis has lead to following conclusions:

a) The average size of households has decreased during the past century. What's more, the majority of all households are single and two-person ones. Households with more members become scarce. This conclusion holds even when looking separately at male and female reference persons.
b) As people get older, the proportion of married people drops and the proportion of widowed people increases significantly. This means that at older ages, more people are left living alone, without someone to depend on.
c) The number of married couples and families with children decreases in favour of people living single without children.
d) Fewer families take in an elderly person to live with them.

Unfortunately, this analysis didn't include many data on the living situation of elderly people. Therefore, the next section tries to elaborate more on that.

4. Elderly people

To face this scarcity of the NIS data on elderly people living with children or other family members, the demographic department at the Flemish University of Brussels,. provided some more detailed information on the living situation of some elderly in 1991.

Two groups of elderly people living with family members

The data are based on the Population census itself lying on the National Population Register (NR), and thus on the legal place of residency. In the NR, elderly living with their (grand) children can be found in two groups:

- Elderly HH members, who aren't the reference person or their partner, but are (grand) mother, (grand) father or father- or mother in law of the reference person.
- Older reference person with (grown-up) children (in-law) living with them.

Category one: elderly HH members who are (grand) mother or father (in-law)

This group consists of (grand) parents who have moved in with their (grand) children who aren't financially or otherwise dependent from them. In 1991, this group counted approximately 65,000 people, among which 51,000 women. Results are shown in table 13.

TABLE 13 - (Grand) parents (in law) living with (grand) children (in law), by age group, 1991

	Father (in law)	Mother (in law)	Grandfather	Grandmother
50-59	775	1828	0	1
60-69	2260	6248	3	27
70-79	3641	13749	45	214
80-89	5087	22357	91	485
90-99	1553	6254	31	203
100+	42	111	1	6
Total	13358	50547	171	936

Source: VUB, NR.

Category 2: Older reference person with children (in law) living with him/her

This is a very heterogeneous group. Grandchildren are not included. Data can concern children who never left their parents' house, children who returned after a divorce, sick children, disabled children or children who move in to take care of their parents. In other words, it can concern an arrangement of care in both directions: from parent to children or from children to parent. Distinction by age group can more or less clarify the sort of relation, but one has to interpret these data with caution. Data are shown in table 14.

TABLE 14 - Older reference people with children living with them, by age group, 1991

	Total number of reference persons	Reference persons with children (in law) living with them	% of reference persons that have children (in law) living with them
50-59	652.200	298.349	45.75%
60-69	684.925	144.617	21.11%
70-79	452.258	48.702	10.77%
80-89	246.426	19.190	7.78%
90+	29.741	2.173	7.31%

Source: VUB, NR.

In the two youngest age categories, the high percentage of reference persons having children living with them is the normal outcome of postponed parenthood, especially since reference persons are usually men. These data are only included here as they don't say anything about provision of care by children to their parents, on the contrary.

After the age of 70, it occurs less frequently that subsequent generations live together, and it is only from that age on, that the percentages can be an indication of provision of care by children to their parents. 10.7% of all older reference persons between ages 70-79 had children living with them, in the two oldest age groups this was between 8 and 7%.

Keeping in mind that the data shown here include only part of all elderly people (for example, elderly people living with children and the children are reference person), the conclusion can be that only a very small part of elderly people lives with their children.

Elderly people can rely less on family members for care than before

All of these developments are to the detriment of older people, who can rely less on husband or wife, or on children to take care of them in their old days. The rising individualism in the lifestyle could result in an increased need for formal assistance. Family relationships still exist, but parents as well as children are demanding more independence. The percentage of elderly people living alone is increasing steadily.

Therefore, as population increases and informal care becomes less available, the demand for formal care to elderly will increase in the future. This trend becomes even stronger when looking at the developments that have taken place in the labour market. This is analysed in the next chapter.

E. Labour market developments

(Female) Labour market participation influences provision of informal care

Since a lot of care for elderly people is provided at home, informally by the husband, wife or children, it is important to have a look at labour market developments. Increasing participation rates, the steadily growing proportion of women participating in labour market, as well as the growing number of people working part-time, have lead to more people being at work now than some 50 years ago. This might be interesting from an economical point of view, but this also means that fewer people (especially women) have time to take care of older people.

This section describes the evolution of labour market participation rates and the development of part-time employment. Also it gives reasons for which people opt to work part-time instead of full-time and informs on the labour market legislation, which has facilitated women to enter the labour market.

1. Labour market participation rates

The global labour market participation rates indicate the proportion of the active population (aged 18-64) that are willing to participate in the labour market, whether they are currently working or not. These are the people currently at work plus the number of people currently unemployed actively looking for work, but also unemployed people older than 50 who are no more looking for a job as well as people having temporarily interrupted their career and early retirees. In what follows, participation rates refer to this broad concept.

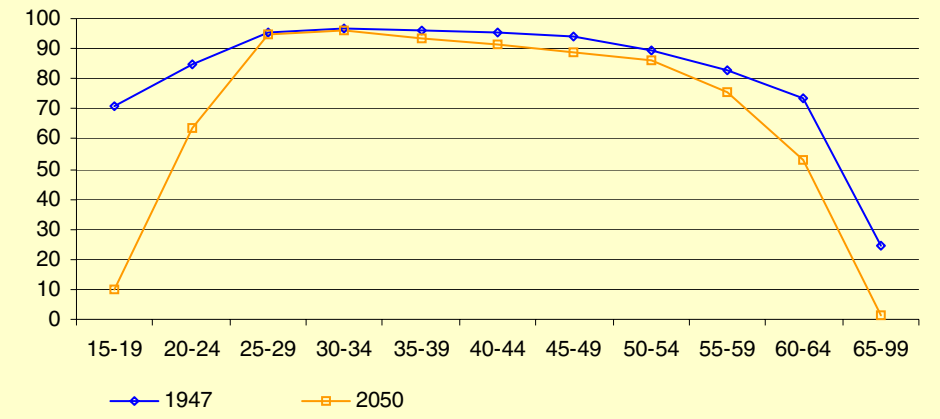
Higher participation potentially means less time for informal care

The evolution of labour market participation rates is important for the provision of informal care for elderly. As more people participate in the labour market, they have less time left to take care of other people. Therefore, as labour market participation rates increase, more elderly people will have to rely on formal long-term care.

Decrease in labour market participation of men since 1947

The evolution of the participation rates between 1947 and 2050 is first examined. Figure 33 shows the labour market participation rates for *men*, by age group, in 1947 and 2050. Detailed data can be found in appendix.

FIGURE 33 - Labour market participation rates, by age group, men, 1947-2050



Source: FPB data.

The labour market participation rate–curve by age for men has the typical reversed U-shape. The rates are lower in younger and older age groups, and higher in middle age groups. This goes for 1947 as well as 2050, though the U-shape is much stronger in 2050. The lower participation rates in younger age groups can be explained by the fact that people receive education longer. In higher age groups it is due to people retiring sooner from the labour market.

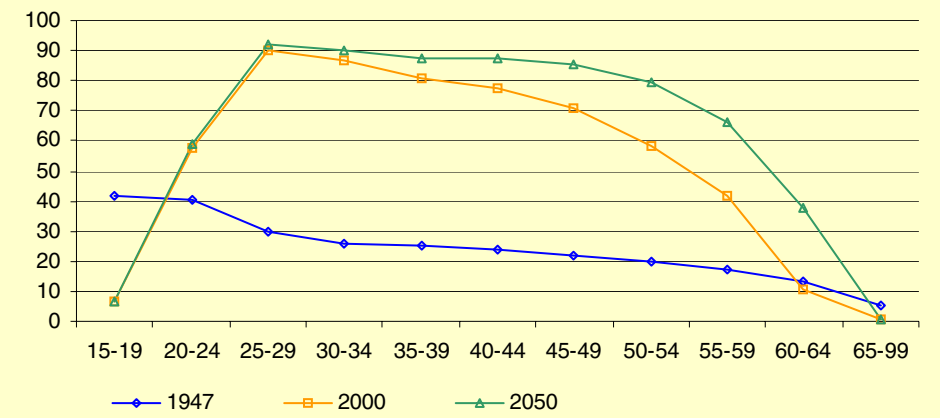
The 2050-curve lies totally beneath the 1947-curve, which means that at all ages the labour force participation of men will be lower in 2050 than it was in 1947. The difference is biggest in youngest and oldest age groups, which can be explained by the increase in the statutory learning age from 14 to 18 and the increasing popularity of early retirement. In the middle age groups, the difference is almost non-existent.

In 2050, only 9.8% of the men between 15 and 19 would participate in the labour force. As men get older, this rate would increases, to reach 96% at the age of 30. It then would remain rather stable until the age of 50-54. Then, men would gradually start to retire and withdraw from the labour market. Of all men between 60 and 65, less than 60% would participate, in the oldest age group, this would be even less (1%).

Significant increase in labour market participation of women

Figure 34 shows the participation rates for women, by age group, in 1947 and 2050.

FIGURE 34 - Labour market participation rates, by age group, women, 1947-2050



Source: FPB Data.

Whereas the participation-curve by age for women in 1947 sloped downward, in 2050 it would be shaped totally differently and come close to the reverse U-shaped pattern as encountered for the male population. This is an enormous evolution.

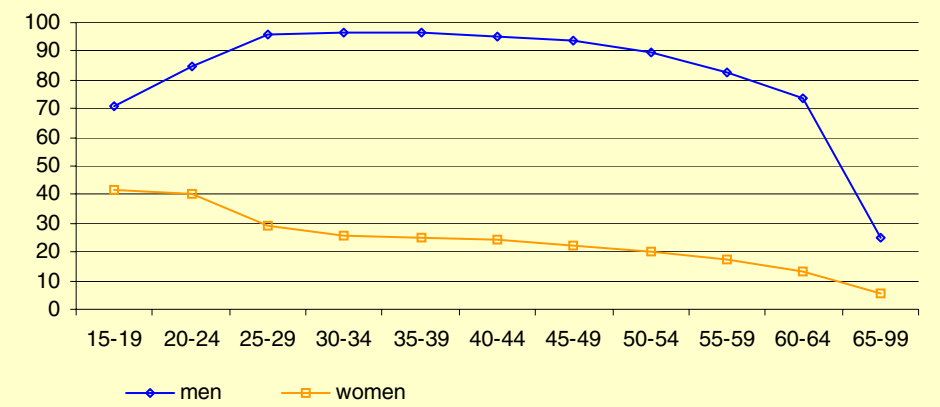
Interesting to note is that the 2000 and 2050 curves lay above the 1947 curve, except for younger and older age groups (due to statutory learning age and early retirement). This means that women between the age of 20 and 60 participate more in the labour market than before. What's more is that women don't seem to withdraw from the labour market when they have children. They continue to participate. In 1947, this was certainly not the case: the highest rates were found in the youngest age groups and then, as soon as women became mothers, dropped. This evolution over time is due to the enormous amount of measures taken by the government to encourage women to work and to facilitate the combination of motherhood and work (for example, the right to maternal leave).

In 2050, less than 7% of women between 15 and 19 would participate in the labour force. This percentage would then increase with age, to reach its peak at age 25-29 (about 90% participation). Then the rates gradually would decrease again, to reach 87% at the age of 40-44, 85% at the age of 50-54 and finally less than 40% for women older than 60.

Women caught up on men on the labour market

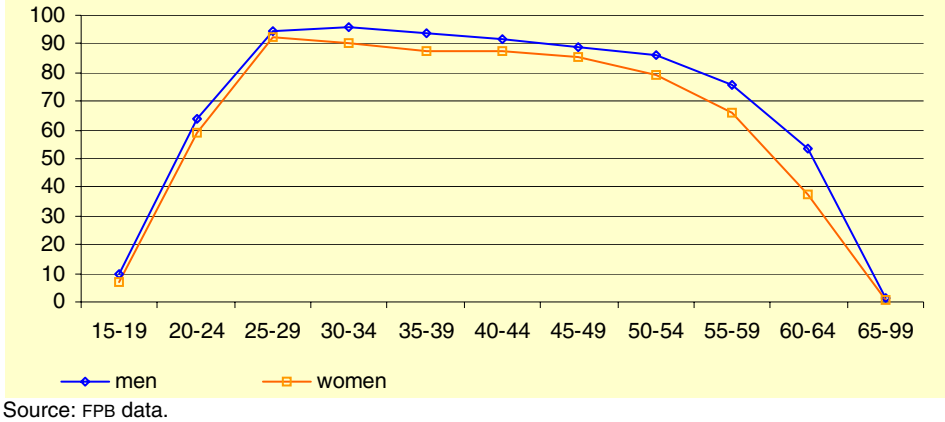
The next step is to look at the difference between men and women. Figure 35 shows the participation curve by age for men and women in 1947, figure 36 does so for 2050 based on projections. The picture for the year 2001 is comparable to the situation in 2050.

FIGURE 35 - Labour market participation rates, by age group and gender, 1947



Source: FPB data.

FIGURE 36 - Labour market participation rates by age group and gender, 2050



Source: FPB data.

These figures show the evolution of the labour market participation rates, as well as the catch-up women are doing relative to men. In 1947, the male curve had the reverse U-shape, whereas the female curve was rather flat and decreasing. The female curve lay significantly lower than the male curve, implying that fewer women participated in the labour market than men.

In 2050, the situation is expected to be totally different. First of all, the female curve will also have the reverse U-shape. Women will no longer withdraw from the labour market once they have children, but will combine work and childcare. Secondly, the female curve will lay close to the male curve, both genders reaching almost the same participation rates.

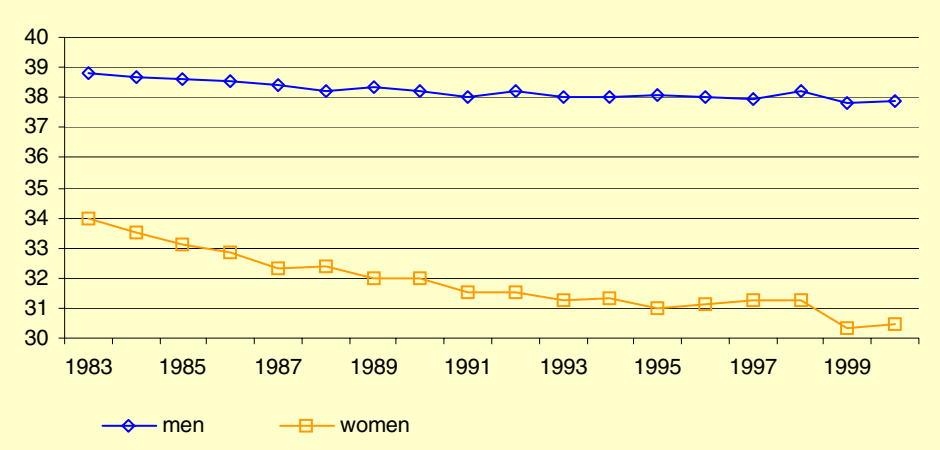
Women now, compared to some 50 years ago, participate more in the labour market, and do so for a longer time. This can have serious consequences for the provision of informal care. As more women enter the labour market, fewer women have time to care for elderly people. These now have to rely more on formal care, possibly in institutions.

2. Weekly working hours

How many hours do people work?

Not only is it important to know what percentage of the population participates on the labour market, another interesting issue is how many hours people work per week. An increase in the average weekly working hours would imply that people have, in general, less time for other activities, such as caring for older people. Therefore, figure 37 gives the evolution of average weekly working hours. Data come from the NIS Labour Force Survey (LFS), 1983-2000.

FIGURE 37 - Average number of weekly working hours, by gender, 1983-2000



Source: NIS Labour Force Survey, 1983-2000 and proper calculations.

Men work more hours a week than women

From this graph, two conclusions can be drawn:

a) *Women work, on average, fewer hours a week than men*, and the difference seems to have increased over time. In 1983, the difference between average working hours of men and women was 4.9 hours. In 2000, this difference had increased to 7.4 hours.

b) *For both men and women, the average number of hours worked per week has decreased since 1983*. This trend was stronger for women. The number of

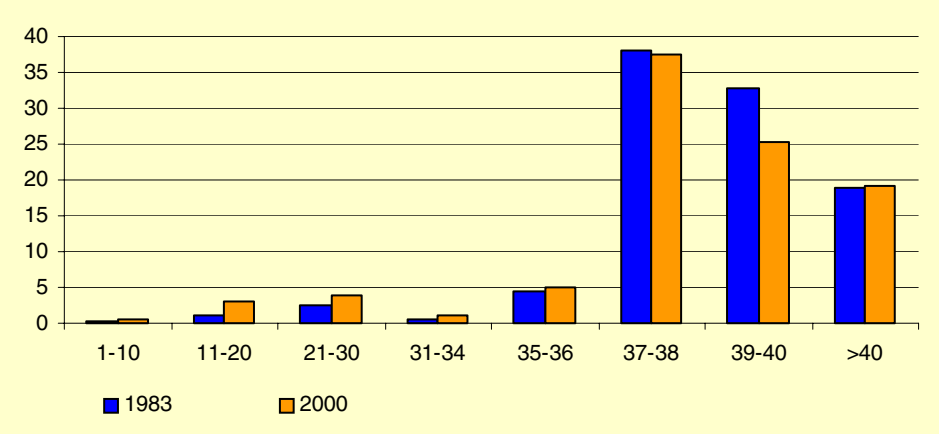
hours worked per week by men dropped from 38.8 in 1983 to 37.8 in 2000. For women, the number dropped from 33.9 to 30.4.

From these data, it would be easy to conclude that, since people work fewer hours per week, on average, they have more time for other activities than before. However, it is important to know whether the decrease in working hours is due to a great number of people working 1 or 2 hours less, or due to a maybe smaller number of people working 10 hours less. Working one or two hours less a week might not have that big an influence on the provision of informal care.

Majority of men works 37 hours a week or more

Therefore the working population has been broken down into categories according to number of hours worked per week. This, and the importance of each category, is shown in figure 38, for men, and in figure 39 for women, for 1983 on one hand, and 2000 on the other hand.

FIGURE 38 - Number of hours worked per week by men, in% of working population, 1983-2000



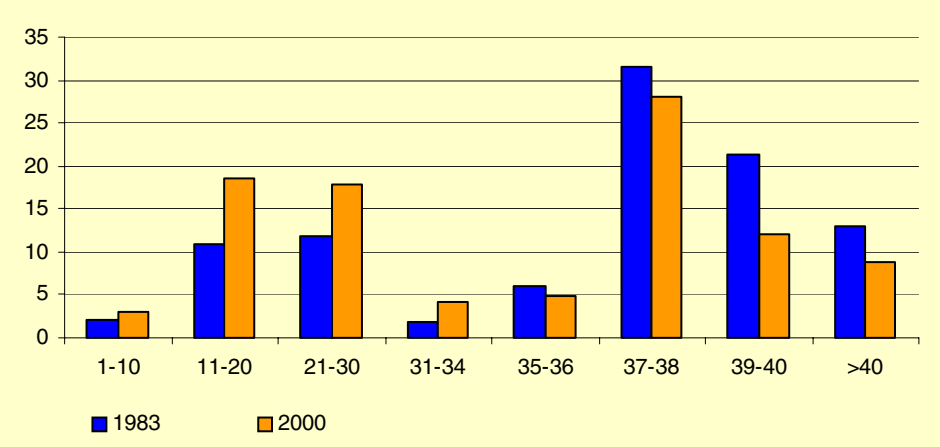
Source: NIS Labour Force Survey.

Most men (38%) work 37-38 hours per week, the second biggest group works 39-40 hours per week and the third group (20%) works more than 40 hours per week. The proportion of men working less than 37 hours per week is **extremely** small, less than 15% of the men in 2000.

Looking at the evolution over time, the proportion of men working 37-38 hours and 40 hours or more has remained quite stable. There was a drop in the percentage of men working 39-40 hours, from 32% in 1983 to 25% in 2000. This was then compensated by a small increase in the percentage of men working 11-20 hours (from 1 to 3%) and 21-30 hours (2.6 to 3.9%).

Group of women works 11-30 hours a week, other group works 37 hours a week or more

FIGURE 39 - Number of hours worked per week by women, in% of working population, 1983-2000



Source: NIS Labour Force Survey.

The picture for women has another profile. In 1983, most women (32%) worked 37-38 hours, 21% of the women worked 39-40 hours and 13% worked 40 hours or more. The importance of categories with less working hours was significantly smaller.

In 2000, again, the biggest part of women (28%) worked 37-38 hours per week. However, the number of women working 39-40 hours and 40 hours or more had decreased significantly. These two categories now account respectively for 'only' 11 and 8 per cent of female working population. On the other hand, the number of women working between 11 and 30 hours increased to almost 18%.

From these data the conclusion can be that the rather small decrease in average working hours for men was due to a smaller proportion of men working 39-40 hours, and more men working 11-30 hours. However, this evolution is not that important since it involves only a few men.

More women work fewer hours a week

The evolution for women is far more important. The increasing popularity of part-time work has caused more women to work 11-30 hours, and fewer women to work 38 hours or more. It would be wrong to conclude that women have more time for informal care since they work less. This information has to be combined with data on labour market participation. A bigger proportion of women might work fewer hours a week, but more women work. Thus, it might very well be that women, who used to be unemployed, now work, which has a negative influence on the provision of informal care.

3. Part-time employment

Part-time employment can be described as any type of employment during which people work less hours per week than average. Thus, it includes people working 1/3 as well as 1/2 or 4/5 of the total normal weekly working hours.

Part-time employment allows finding a balance between work and family

The evolution of part-time (PT) employment is important because it allows people who have responsibilities at home (care of children, elderly…) to combine this task with labour participation. The impact of PT employment on the provision of informal LTC is unclear. On one hand, PT employment allows people who used to

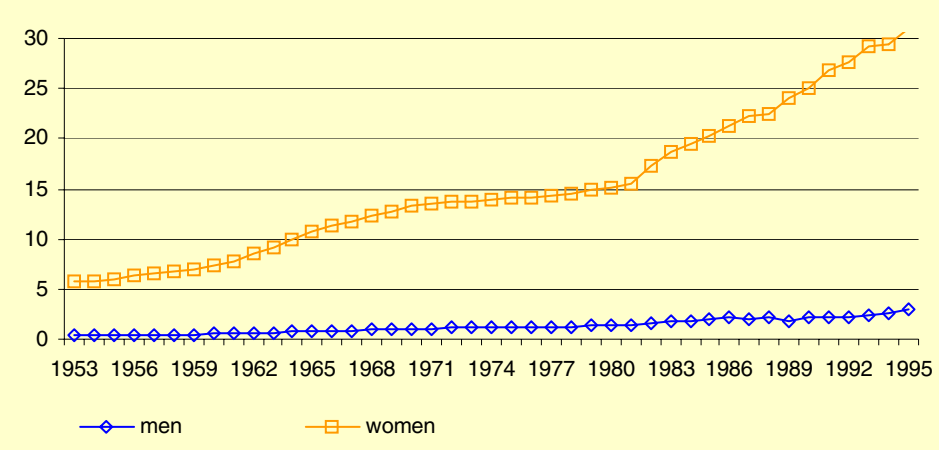
work full-time to take care of other people without losing all their income. On the other hand, working PT entices people previously not working to enter the labour market, leaving them with less time to take care of other people.

a. Data and graphs

Incredible increase in PT employment for women

The evolution of part-time employment as percentage of full employment by gender between 1953 and 1995 is shown in figure 40.

FIGURE 40 - Part-time as% of total employment, by gender, 1953-1995



Source: FPB calculations.

Two conclusions can be drawn:

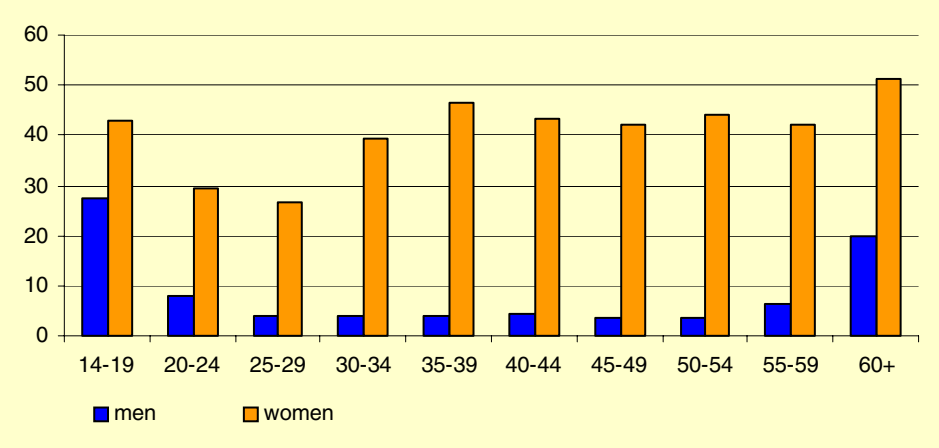
a) *The importance of PT work has steadily increased since 1953,* especially for women. For men, it increased from 0.3% of total employment in 1953 to 2.9% in 1995. For women, the percentage has soared since 1953, rising from 5% to 30% in 1995.

b) There's a difference between genders in PT employment. Even though the percentage for men has risen over time, no more than 5% of all men works part-time. *PT work seems to be a feminine phenomenon*: in 1953 about 5% of working women worked PT, in 1983 this had risen to 15%, and in 1995 it reached 30%.

The next step in the analysis is to look at the PT employment rates by age group and gender. This is shown in figure 41 for 1999, based on the NIS LFS.

PT employment as transition to and from labour market for men …

FIGURE 41 - Percentage of part-time in total employment, by gender and age group, 1999



Source: NIS Labour Force Survey.

Although in 1999, only 5% of all working men did so PT, there are two age groups in which this percentage is higher. In the youngest age group (14-19), about 27% of all men worked PT. This could be the result of men combining their job with education or training. Once the age of 20 is reached, PT employment drops to 3-4%, only to increase again in the oldest age group (60+). This can be explained by the decision of some men to retire gradually, and work PT for a while before leaving the labour market.

… while it is a common phenomenon for women at all ages.

For women, the situation is different. In 1999, 39% of working women worked PT. The variation across age is a lot smaller than for men. Again, the percentage is rather high in the youngest group (41%), and then drops slightly to 26% for women aged 25-29. Then it starts to increase again, to reach levels around 40%, and a peak again in the highest age group (50%). As for men, education and gradual retirement might explain the higher percentages in the youngest and oldest age groups. However, the elevated percentages in the other age groups indicate that women might have other responsibilities besides work (housekeeping, child care, taking care of elderly….).

The conclusions of point a can be:
Working PT is mostly a feminine thing. Almost 30% of women work PT, compared to 5% of men. The higher percentages in younger and older age groups can be explained by education and gradual retirement, both for men and women. The higher percentages for women in the middle-age groups, however, indicate that there might be another reason for women to work PT than for men. This is analysed in the following section.

b. Reasons for part-time employment

The previous section made obvious that a significant bigger proportion of women works PT than of men. This section analyses the reasons for which people choose to work PT instead of full-time. This is checked because one can suspect that taking care of elderly people (and children) is mostly a feminine task, and that women decide to work PT to have time to care for others. The reasons for men to work part-time might be completely different. Data for this analysis come from the NIS LFS, and include only people who were working part-time at the time.

The possible reasons for part-time employment are:

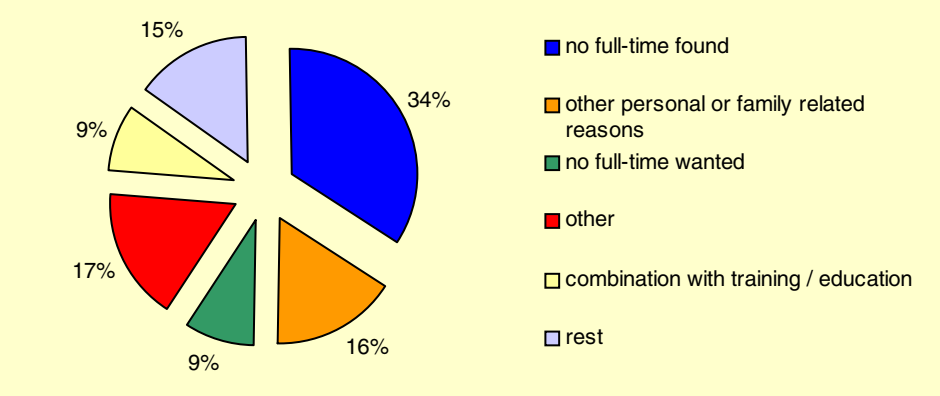
a) No full-time employment found/wanted;
b) Other part-time employment completes this job;
c) Combination of job and education/training;
d) Not able to work due to handicap;
e) Child care;
f) Other personal or family related reasons;
g) Other reason.

The following analysis only withdraws the most important reasons given by the respondents; the other categories are put together as ‘rest’.

Men work part-time because no full-time was found or combination with education

Figure 42 shows the reasons for part-time employment for men in 2000.

FIGURE 42 - Reasons for PT employment, men, 2000



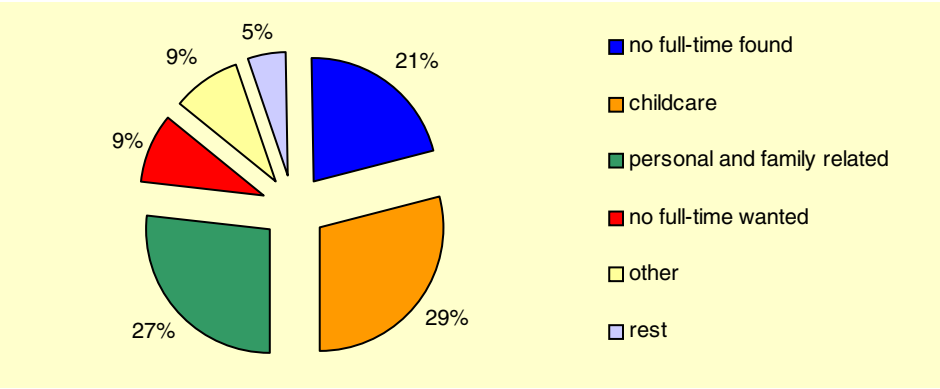
Source: NIS Labour Force Survey.

Of all men working PT in 2000, 34% did so because full-time employment was not found. About 17% of the men had other reasons, of which 16% personal or family related reasons. Nine per cent of PT working men did so to combine their job with training or education, or because they don't wish to work full-time. Other reasons mentioned in the list above account for 15%. Only 2% of PT working men did so to take care of children.

Women work part-time due to personal and family related issues

Figure 43 shows the reasons for working part-time for women in 2000.

FIGURE 43 - Reasons for part-time employment, women, 2000



Source: NIS Labour Force Survey.

Almost a third of all women working PT did so to take care of children. Ranked second are personal and family related reasons, which account for 27%. One fifth (21%) of the women couldn't find a full-time job. Those were the three main reasons for working PT. No full-time wanted and other reasons each account for 9%.

Thus, the reasons for men and women to work part-time are very different. Men work mostly part-time because they can't find or don't want a full-time job or for family or other personal reasons. Women work part-time mainly to take care of children, for other personal or family reasons or because they couldn't find a full-time job.

While 34% of men work PT because they couldn't find a full-time job, only 21% of the women do so for this reason. On the other hand, 27% of the women work PT to take care of children, as opposed to 2% of men. The same difference, though smaller, goes for personal and other family related reasons. For women, this accounts for 26% as main reason, for men only 15%. For both men and women, about 9% chose PT work because full-time work wasn't wanted.

These data lead to believe that women mostly take care of family (elderly people) and children. Therefore the evolution of the female labour force participation rates as well as the legislation on equal opportunities for men and women on the labour market might have a negative effect on the provision of informal care. More women participate on the labour market today, so they have less time to take care of elderly (and children). The elderly people depend therefore more on formal care now than some 50 years ago.

c. Legislation

Legislation to support female labour participation

The increase in popularity of part-time work can partly be due to the measures taken by the government to make part-time work attractive to people, by giving them better rights. These are some examples of what **can** play in favour of PT work.

Part-time workers have the same rights as full-time workers do, in correspondence with the hours of work they perform.

Labour legislation is applicable on both part-time and full-time work.

No special statute exists for part-time workers, but new modalities have been incorporated.

The labour contract signed for part-time employment, should be drawn up separately for every part-time worker, at the latest at the moment at which the employee starts to work. This document should mention what part-time arrangement and working hours were agreed upon. These working hours may be flexible.

For unemployment benefits, it is important to know whether a person works full-time or part-time, as well as the category of part-time work. To benefit from unemployment benefits, one has to work at least 12 hours a week or 1/3 of the normal average weekly working hours.

Ideally, in the future, a comprehensive legal framework should be established to make sure part-time workers enjoy the same rights as full-time workers. But recent improvements have already proven to have an increasing effect on part-time work.

4. Conclusions

In the past decades, remarkable developments have taken place on the labour market, which may have consequences for the provision of informal care, and thus for the demand of formal care.

On one hand, the proportion of women participating on the labour market has known a significant increase. The participation pattern of women now approaches the pattern of men, which means less women stop working when they get married and have children, and women continue to work until higher ages than before.

On the other hand, data show that women, on average, work fewer hours during the week. This is confirmed by the fact that part-time work is a feminine thing. Many women work part-time, but only few men do. Thus, women participate more than half a century ago, but the number of hours they work is less than that of men.

The increase in part-time work can have a dual effect on the supply of informal care by women:

- It allows women who used to work full-time, to switch to part-time work to take care of elderly people, what causes an increase in supply of informal care.
- It could entice some women who until now didn't work at all, to start working part-time and combine labour and care activities, what causes a decrease in supply of informal care.

On average, it is safe to say that the increasing labour participation of women reduces the time they have left to care for others and therefore has a negative effect on informal care.

III Concluding remarks

This paper studied the use of and need for health care by elderly people, the supply of health care, the living and family situation of elderly people as well as labour market evolutions. As mentioned in the introduction, the authors are well aware that the information collected can certainly be improved by more detailed data and refinement of the concepts. Yet, this paper already leads to interesting conclusions on the impact of population ageing and other developments in society on demand for health care.

Expected increase in demand for health care due to population ageing…

Concerning *demand for health care*, an important finding is that there is a positive relation between age and the demand for and use of health care. The number of hospital admissions, as well as the length of hospital stays increase with age. Similarly, people contact their doctor more often as they get older. Only for contacts with specialists, the relationship is less clear. These findings show that as the population ages, the demand for health care will increase.

Looking specifically at long-term care, our results confirm the positive relationship between age and the use of health care. Demand for long-term care at home increases with age and increases with the degree of dependence. No clear evolution in time could be detected. Other services provided to the elderly at home exist. For example, home delivered meals and help in the household for elderly people. Data show that the demand for both services increases with age.

Formal long-term care is provided in two types of institutions. The homes for elderly are places where elderly people live together and receive help in household and daily activities. In nursing homes for elderly, nursing care is also provided. Of all institutionalized people, 60-70% live in homes for elderly. The percentage of population living in either institution increases with age as well and increases with degree of dependence. Also, the percentage has risen between 1996 and 2001.

All these findings lead to conclude that as people get older, demand for health care increases, whether it be contacts with a GP, hospital admissions or long-term care. Therefore, with the prospect of a population ageing, one can expect an increase in demand for and use of health care.

…but decrease in the provision of formal care, especially in elderly institutions

Is there enough supply to deliver the demanded health care? The second chapter covers several components of *health care supply*. The density of most caregivers per 1,000 inhabitants has increased between 1993 and 2000, indicating an increase in supply of health care. However, the density of caregivers in homes for elderly and nursing homes for elderly decreased significantly, meaning fewer people have to take care of an increasing population living in institutions. What's more, the density of hospital beds and beds in LTC institutions has decreased as well. All this

seems to indicate that, specifically for elderly people, the supply of health care might not be sufficient to cover the future increase in demand.

Can informal care compensate the shortage of formal care?

Fortunately, there is still informal care, provided by partners, children or other people. The availability of this kind of care depends on several factors, the first being the *household situation* of the elderly people. The more household members there are, the more elderly people can rely on them to be taken care of without having to resort to formal care.

Evolution in household composition leaves many elderly to fend for themselves

Data show however, that the average household size has decreased, meaning fewer family members can be relied on to provide care. The proportion of people living in households that count more than 3 people has decreased significantly, while the number of elderly people living single or being divorced has increased. On top of all that, the percentage of households that have an elderly person living with them decreased too. All these developments mean that elderly people can less depend on others to provide care, what makes them rely more on formal care.

Increased female labour participation decreases provision of informal care

Lastly, l*abour market developments* that have taken place the last decennia have a double influence on the provision of informal care. On one hand, the labour force participation rates of women increased significantly, which means they have less time to care for others. On the other hand, the proportion of women working part-time increased, which means they actually might have some time left to care for others. Especially since most women working part-time indicate they do so to provide care in some way, either to children or to elderly.

In short, this research paper shows that, given the fact that population is ageing and people are getting older, an increase in demand for health care can be expected. The question remains how this demand can be met. The provision of informal care might not be sufficient and even decrease in the future due to household and labour market developments. This means formal care will have to increase to meet the demand. More effort should be put in developing services to the elderly at home, but also developing the homes for elderly and nursing homes for elderly, making sure enough caregivers are available and all sorts of care are accessible to people. Only then will elderly people be able to be sure to be taken care off in their old days.

This working paper collects in a first attempt a lot of data to approach the volume and evolution of the use of health and nursing care by the elderly. Yet the authors are well aware of the limitations of the present study which can certainly be improved by more detailed data and refinement of the concepts.

IV Bibliography

Health Interview Survey, Belgium, 1997 and 2001, Unit of Epidemiology, Scientific Institute of Public Health, Brussels.

Jacobzone S, Cambois E, Chaplain E, Robine JM, 1998, "Long-term care services to older people, a perspective on future needs: the impact of an improving health of older persons', 24p, OECD, Working paper APW 4.2, Paris.

World Health Organisation, 1999, "Home-based and Long-term Care – Home care issues and Evidence", 40p. WHO/HSC/LTH/99.2, prepared by Betty Havens, University of Manitoba, Winnipeg, Canada.

World Health Organisation, 1999b "Home based Long-term care", Report of a WHO Study Group; WHO Technical Report Series 898; 41p., Geneva.

V Appendix

A. Number of hospital admissions

TABLE 15 - Number of hospital admissions for MEN, by age group, 1991-2000

	1991	1992	1993	1995	1996	1997	1998	1999	2000
0	36,662	40,750	41,757	39,928	40,095	69,697	69,800	65,744	86,170
1-4	36,622	37,601	38,754	37,949	35,195	34,193	33,626	30,330	29,796
5-14	43,830	45,055	42,361	41,040	38,913	38,620	35,572	37,573	36,691
15-24	58,511	58,278	53,906	51,068	47,905	46,017	43,880	43,964	42,631
25-34	69,621	70,330	64,586	63,377	61,050	59,121	57,920	57,173	54,936
35-44	73,108	75,567	71,278	74,633	73,745	74,314	74,594	77,300	76,461
45-54	74,318	78,904	77,420	84,026	87,443	89,490	93,555	97,125	99,269
55-64	104,321	107,819	107,482	108,255	107,991	105,345	105,296	106,844	107,657
65-74	109,995	120,434	127,210	138,896	142,927	143,597	147,056	148,832	147,450
75+	95,100	96,116	94,261	99,226	106,465	109,699	116,513	132,254	136,598
Total	702,088	730,854	719,015	738,398	741,729	770,093	777,812	797,139	731,489

Source: Ministry of Public Health, MKG.

TABLE 16 - Number of hospital admissions for WOMEN, by age group, 1991-2000

	1991	1992	1993	1995	1996	1997	1998	1999	2000
0	28,867	32,256	33,255	32,437	33,115	60,548	60,416	58,613	76,790
1-4	25,473	25,931	27,675	27,460	25,927	25,456	25,794	23,345	23,310
5-14	33,000	33,972	31,850	31,950	30,076	30,025	28,934	29,349	28,892
15-24	95,117	93,953	87,756	82,264	78,166	75,089	72,479	68,985	67,517
25-34	171,218	173,716	167,549	162,359	160,933	158,425	155,902	154,746	150,860
35-44	94,143	98,237	96,007	97,602	97,304	97,041	98,019	103,134	101,476
45-54	76,115	79,761	78,347	82,368	85,156	85,948	89,529	93,842	93,447
55-64	88,748	90,650	89,734	92,783	92,051	89,313	90,394	91,915	91,519
65-74	102,459	111,589	118,202	129,890	133,562	132,591	134,914	135,836	134,239
75+	152,599	155,126	155,571	162,895	173,173	177,896	184,324	206,914	210,653
Total	867,739	895,191	885,946	902,008	909,463	932,332	940,705	966,679	901,913

Source: Ministry of Public Health, MKG.

B. Average length of hospital stay

TABLE 17 - Average length of hospital stay – MEN, by age group, 1991-2000

	1991	1992	1993	1995	1996	1997	1998	1999	2000
0	7.5	7.2	6.3	5.9	5.7	5.6	5.6	5.1	5.1
1-4	5.2	5.2	4.0	3.7	3.8	3.8	3.9	3.8	3.8
5-14	5.0	4.9	3.5	3.3	3.3	3.3	3.2	3.3	3.3
15-24	6.2	6.1	4.5	4.3	4.2	4.1	4.0	4.1	4.1
25-34	7.2	7.0	5.2	4.9	4.8	4.7	4.5	4.8	4.7
35-44	8.4	8.1	6.2	6.0	5.8	5.6	5.4	5.6	5.7
45-54	9.4	9.0	7.3	7.0	6.8	6.6	6.5	6.9	6.7
55-64	11.0	10.6	9.1	8.6	8.3	8.2	7.9	8.3	8.1
65-74	13.1	12.6	11.1	10.7	10.3	10.1	9.8	10.2	10.0
75+	18.0	17.5	16.0	15.1	14.5	14.0	13.3	14.4	14.1
Total	10.2	9.9	8.4	8.1	8.0	7.8	7.6	8.1	7.9

Source: Ministry of Public Health, MKG.

TABLE 18 - Average length of hospital stay – WOMEN, by age group, 1991- 2000

	1991	1992	1993	1995	1996	1997	1998	1999	2000
0	7.7	7.4	6.4	5.9	5.9	5.7	5.7	5.2	5.1
1-4	5.5	5.4	4.2	4.0	4.0	4.0	4.1	4.1	4.0
5-14	5.2	5.1	3.8	3.6	3.6	3.6	3.7	3.7	3.6
15-24	6.3	6.2	4.8	4.6	4.5	4.5	4.4	4.4	4.4
25-34	7.0	6.8	5.4	5.3	5.3	5.2	5.2	5.1	5.1
35-44	7.8	7.6	5.8	5.7	5.6	5.5	5.4	5.5	5.4
45-54	9.2	8.9	7.1	6.8	6.8	6.7	6.5	6.7	6.7
55-64	11.4	11.0	9.1	8.7	8.3	8.1	7.9	8.2	8.0
65-74	14.8	14.2	12.4	12.0	11.5	11.1	10.7	11.3	11.2
75+	21.1	20.5	18.7	17.5	16.9	16.2	15.6	17.2	16.8
Total	11.0	10.7	9.1	8.9	8.7	8.5	8.3	8.9	8.8

Source: Ministry of Public Health, MKG.

C. Contacts with general practitioner

TABLE 19 - Percentage of the population having had contact with doctor at least once in the past year

	1997		2001	
	Men	Women	Men	Women
0-4	81.70	82.90	79.50	74.10
5-14	76.80	75.30	75.40	75.30
15-24	67.70	85.20	69.40	84.20
25-34	69.70	79.80	72.20	81.90
35-44	69.30	81.20	74.30	79.50
45-54	75.40	79.20	74.10	81.10
55-59	78.20	83.10	84.80	89.40
60-64	83.30	87.20	83.40	83.60
65-69	79.80	90.40	90.60	96.50
70-74	91.20	92.60	90.70	95.50
75-79	83.20	90.60	91.70	97.10
80+	94.00	98.80	94.20	98.20
Total	74.40	82.70	77.40	84.10

Source: Health Interview Survey, 1997 and 2001.

TABLE 20 - Average number of contacts with general practitioner during the past year

	1997		2001	
	Men	Women	Men	Women
0-4	5.90	6.80	6.00	4.90
5-14	2.60	4.60	2.80	2.90
15-24	3.70	5.00	4.60	6.10
25-34	2.70	5.20	4.00	5.90
35-44	4.50	5.50	4.00	6.60
45-54	5.40	6.30	5.60	6.10
55-64	6.90	9.40	7.10	10.30
65-74	8.30	11.10	8.90	11.60
75+	10.00	17.60	12.10	13.90
Total	4.80	7.00	5.50	7.50

Source: Health Interview Survey, 1997 and 2001.

D. Average number of contacts with specialist

TABLE 21 - Average number of contacts with specialist

	1997		2001	
	Men	Women	Men	Women
0-4	3.5	2.9	2.3	3.9
5-14	1.5	1.7	1.6	1.7
15-24	1.4	2.6	3.2	2.9
25-34	1.4	4.4	2.0	3.4
35-44	1.4	3.1	2.3	3.1
45-54	1.7	4.2	2.5	4.2
55-64	2.3	2.8	4.8	4.1
65-74	2.9	3.5	5.2	4.2
75+	3.6	1.4	2.5	4.6
Total	1.8	3.2	2.9	3.5

Source: Health Interview Survey, 1997 and 2001.

E. People in need for long term care at home

TABLE 22 - Number of people receiving long term care at home, by age group and degree of dependence. Total number and percentage in population, 1998-2001

	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
1998																
Bathroom	3,986	0.05	14,925	1.0	13,890	4.3	14,054	7.5	14,763	11.9	5,759	13.1	935	10.0	68,312	0.67
A	2,065	0.03	5,686	0.4	4,828	1.5	4,596	2.5	5,129	4.2	2,505	5.7	569	6.1	25,378	0.25
B	2,341	0.03	4,262	0.3	3,263	1.0	3,195	1.7	3,870	3.1	2,214	5.0	708	7.6	19,853	0.19
C	1,517	0.02	1,781	0.1	1,146	0.4	1,078	0.6	1,384	1.1	906	2.1	380	4.1	8,192	0.08
Total	9,909	0.12	26,654	1.8	23,127	7.1	22,923	12.2	25,146	20.3	11,384	25.9	2,592	27.7	121,735	1.19
1999																
Bathroom	4,388	0.05	16,475	1.1	15,069	4.1	14,005	8.2	13,466	10.7	4,694	10.2	670	6.7	68,767	0.7
A	2,372	0.03	6,153	0.4	5,020	1.4	4,837	2.8	4,901	3.9	2,233	4.9	428	4.3	25,944	0.3
B	2,547	0.03	4,924	0.3	3,647	1.0	3,395	2.0	3,923	3.1	2,095	4.6	565	5.7	21,096	0.2
C	1,715	0.02	1,906	0.1	1,285	0.4	1,162	0.7	1,481	1.2	829	1.8	331	3.3	8,709	0.1
Total	11,022	0.14	29,458	1.9	25,021	6.9	23,399	13.7	23,771	18.8	9,851	21.4	1,994	19.9	124,516	1.2
2000																
Bathroom	3,624	0.05	12,225	0.8	11,959	3.1	11,745	6.9	12,209	9.5	5,034	10.8	867	8.3	57,663	0.6
A	2,335	0.03	5,810	0.4	5,069	1.3	5,020	2.9	5,558	4.3	2,895	6.2	750	7.2	27,437	0.3
B	2,572	0.03	4,655	0.3	3,730	1.0	3,608	2.1	4,317	3.3	2,635	5.6	945	9.0	22,462	0.2
C	1,983	0.02	2,142	0.1	1,686	0.4	1,651	1.0	1,801	1.4	1,185	2.5	489	4.7	10,937	0.1
Total	10,514	0.13	24,832	1.7	22,444	5.9	22,024	13.0	23,885	18.5	11,749	25.2	3,051	29.08	118,499	1.2
2001																
Bathroom	3,776	0.05	12,182	0.8	11,922	3.1	12,942	6.8	11,430	9.1	5,132	10.8	896	8.2	58,280	0.6
A	2,583	0.03	5,789	0.4	5,245	1.4	5,595	2.9	5,358	4.3	2,977	6.2	722	6.6	28,269	0.3
B	2,874	0.04	4,762	0.3	3,951	1.0	4,164	2.2	4,381	3.5	2,775	5.8	1,025	9.3	23,932	0.2
C	2,304	0.03	2,349	0.2	2,066	0.5	2,258	1.2	2,110	1.7	1,396	2.9	602	5.5	13,085	0.1
Total	11,537	0.14	25,082	1.7	23,184	6.1	24,959	13.1	23,279	18.5	12,280	25.7	3,245	29.5	123,566	1.2

Source: Belgian Institute for Health Insurance

F. Home delivered meals

TABLE 23 - Percentage of population making use of home-delivered meals, by age group and gender

	1997		2001	
	Men	Women	Men	Women
0-14			0.0	
15-24				
25-34				
35-44			0.1	0.2
45-54			0.3	
55-64			0.8	0.5
65-74	1.1	1.05	1.9	2.4
75-79	5.37	6.11	5.3	5.0
80-84	5.80	11.57	6.8	15.6
85+	17.78	16.0	23.9	14.6

Source: Health Interview Survey, 1997 and 2001.

G. Home care

TABLE 24 - Percentage of population receiving home care, by age group and gender

	1997		2001	
	Men	Women	Men	Women
0-14	0.1	0.1	0.3	0.2
15-24		1.3	0.1	
25-34	0.3	0.5	0.1	1.0
35-44	0.4	0.7	0.3	0.6
45-54		0.7	0.7	1.4
55-64	0.4	0.8	1.4	2.0
65-74	1.6	4.4	4.0	6.3
75+	4.5	12.2	19.3	33.2

Source: Health Interview Survey, 1997 and 2001.

H. People in need for long term care in institutions

TABLE 25 - Number of people living in homes for elderly (ROB) or nursing home for elderly (RVT), by age group and degree of dependence. Total number and percentage in population, 1995-2001

	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
1995																
RVT																
B	43	0.0	355	0.02	264	0.1	600	0.3	694	0.6					2,452	0.02
C	162	0.0	1,675	0.11	1,531	0.7	3,445	1.5	4,077	3.5					14,502	0.14
Total	205	0.0	2,030	0.13	1,795	0.8	4,045	1.8	4,771	4.1					16,954	0.17
ROB																
O	602	0.01	4,865	0.19	3,272	1.4	6,805	3.0	6,733	5.8					25,993	0.26
A	273	0.00	2,316	0.09	1,905	0.8	4,344	1.9	5,004	4.3					17,001	0.17
B	330	0.00	2,298	0.09	1,792	0.8	4,048	1.8	4,805	4.2					16,580	0.16
C	220	0.00	2,016	0.08	1,932	0.8	4,712	2.1	5,844	5.1					19,566	0.19
Total	1,425	0.02	11,495	0.45	8,901	3.8	19,909	8.9	22,386	19.3					79,140	0.78
RVT+ROB																
O	602	0.01	4,865	0.19	3,272	1.4	6,805	3.0	6,733	5.8					25,993	0.26
A	273	0.00	2,316	0.09	1,905	0.8	4,344	1.9	5,004	4.3					17,001	0.17
B	373	0.00	2,653	0.10	2,056	0.9	4,648	2.1	5,499	4.8					19,032	0.19
C	382	0.00	3,691	0.15	3,463	1.5	8,157	3.6	9,921	8.6					34,068	0.34
Total	1,630	0.02	13,525	0.53	10,696	4.5	23,954	10.8	27,157	23.5					96,094	0.95
1996																
RVT																
B	71	0.00	398	0.03	315	0.12	661	0.30	743	0.63	485	0.99			2,673	0.03
C	320	0.00	2,032	0.13	1,826	0.70	3,941	1.80	4,425	3.73	3,653	7.43			16,197	0.16
Total	391	0.00	2,430	0.16	2,141	0.82	4,602	2.11	5,168	4.35	4,138	8.41			18,870	0.19
ROB																
O	766	0.01	4,752	0.31	3,314	1.27	6,694	3.07	6,295	5.30	3,161	6.43			24,982	0.25
A	475	0.01	2,760	0.18	2,187	0.84	4,842	2.22	5,342	4.50	3,135	6.37			18,741	0.18
B	538	0.01	2,709	0.18	2,138	0.82	4,758	2.18	5,117	4.31	3,241	6.59			18,501	0.18
C	406	0.01	2,545	0.17	2,340	0.90	5,618	2.57	6,597	5.56	5,106	10.38			22,612	0.22
Total	2,185	0.03	12,766	0.84	9,979	3.84	21,912	10.03	23,351	19.67	14,643	29.77			84,836	0.84
RVT+ROB																
O	766	0.01	4,752	0.31	3,314	1.27	6,694	3.07	6,295	5.30	3,161	6.43			24,982	0.25
A	475	0.01	2,760	0.18	2,187	0.84	4,842	2.22	5,342	4.50	3,135	6.37			18,741	0.18
B	609	0.01	3,107	0.20	2,453	0.94	5,419	2.48	5,860	4.94	3,726	7.58			21,174	0.21
C	726	0.01	4,577	0.30	4,166	1.60	9,559	4.38	11,022	9.28	8,759	17.81			38,809	0.38
Total	2,576	0.03	15,196	1.00	12,120	4.66	26,514	12.14	28,519	24.02	18,781	38.19			103,706	1.02

	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
1997																
RVT																
B	103	0.00	357	0.02	373	0.13	552	0.27	732	0.61	453	1.07	123	1.40	2,693	0.03
C	288	0.00	1,814	0.12	1,936	0.66	3,265	1.59	4,601	3.82	3,188	7.54	1,153	13.11	16,245	0.16
Total	391	0.00	2,171	0.14	2,309	0.79	3,817	1.85	5,333	4.42	3,641	8.62	1,276	14.51	18,938	0.19
ROB																
O	503	0.01	2,880	0.19	4,237	1.45	5,045	2.45	6,484	5.38	4,797	11.35	1,669	18.98	25,615	0.25
A	394	0.00	2,629	0.17	2,471	0.84	4,269	2.07	5,851	4.85	3,278	7.76	841	9.57	19,733	0.19
B	487	0.01	2,343	0.15	2,330	0.80	3,991	1.94	5,343	4.43	3,060	7.24	801	9.11	18,355	0.18
C	395	0.00	2,371	0.16	2,850	0.97	4,915	2.39	7,139	5.92	4,719	11.17	1,636	18.61	24,025	0.24
Total	1,779	0.02	10,223	0.67	11,888	4.06	18,220	8.85	24,817	20.59	15,854	37.52	4,947	56.27	87,728	0.86
RVT+ROB																
O	503	0.01	2,880	0.19	4,237	1.45	5,045	2.45	6,484	5.38	4,797	11.35	1,669	18.98	25,615	0.25
A	394	0.00	2,629	0.17	2,471	0.84	4,269	2.07	5,851	4.85	3,278	7.76	841	9.57	19,733	0.19
B	590	0.01	2,700	0.18	2,703	0.92	4,543	2.21	6,075	5.04	3,513	8.31	924	10.51	21,048	0.21
C	683	0.01	4,185	0.28	4,786	1.64	8,180	3.97	11,740	9.74	7,907	18.71	2,789	31.72	40,270	0.40
Total	2,170	0.03	12,394	0.82	14,197	4.85	22,037	10.70	30,150	25.01	19,495	46.13	6,223	70.78	106,666	1.05
1998																
RVT																
B	113	0.00	467	0.03	510	0.16	581	0.31	939	0.76	570	1.29	153	1.64	3,333	0.03
C	340	0.00	2,117	0.14	2,570	0.79	3,604	1.92	5,684	4.60	3,897	8.85	1,479	15.82	19,691	0.19
Total	453	0.01	2,584	0.17	3,080	0.94	4,185	2.23	6,623	5.36	4,467	10.15	1,632	17.46	23,024	0.23
ROB																
O	668	0.01	4,150	0.27	4,068	1.25	5,059	2.69	6,992	5.66	3,558	8.08	903	9.66	25,398	0.25
A	377	0.00	2,403	0.16	2,582	0.79	3,503	1.86	5,189	4.20	3,231	7.34	798	8.54	18,083	0.18
B	500	0.01	2,414	0.16	2,709	0.83	3,631	1.93	5,539	4.48	3,316	7.53	960	10.27	19,069	0.19
C	359	0.00	2,194	0.14	3,011	0.92	3,997	2.13	6,655	5.38	4,473	10.16	1,549	16.57	22,238	0.22
Total	1,904	0.02	11,161	0.74	12,370	3.79	16,190	8.62	24,375	19.72	14,578	33.11	4,210	45.04	84,788	0.83
RVT+ROB																
O	668	0.01	4,150	0.27	4,068	1.25	5,059	2.69	6,992	5.66	3,558	8.08	903	9.66	25,398	0.25
A	377	0.00	2,403	0.16	2,582	0.79	3,503	1.86	5,189	4.20	3,231	7.34	798	8.54	18,083	0.18
B	613	0.01	2,881	0.19	3,219	0.99	4,212	2.24	6,478	5.24	3,886	8.83	1,113	11.91	22,402	0.22
C	699	0.01	4,311	0.28	5,581	1.71	7,601	4.05	12,339	9.98	8,370	19.01	3,028	32.40	41,929	0.41
Total	2,357	0.03	13,745	0.91	15,450	4.73	20,375	10.84	30,998	25.08	19,045	43.25	5,842	62.50	107,812	1.06

	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
1999																
RVT																
B	112	0.00	613	0.04	717	0.20	763	0.45	1,278	1.01	825	1.79	237	2.37	4,545	0.04
C	436	0.01	2,540	0.17	3,271	0.91	4,105	2.40	6,969	5.52	4,969	10.81	1,835	18.38	24,125	0.24
Total	548	0.01	3,153	0.21	3,988	1.11	4,868	2.84	8,247	6.53	5,794	12.60	2,072	20.76	28,670	0.28
ROB																
O	692	0.01	4,121	0.27	4,319	1.20	4,693	2.74	7,381	5.84	3,809	8.28	1,045	10.47	26,060	0.26
A	432	0.01	2,436	0.16	2,763	0.77	3,289	1.92	5,237	4.15	3,196	6.95	877	8.79	18,230	0.18
B	517	0.01	2,381	0.16	2,863	0.79	3,478	2.03	5,789	4.58	3,477	7.50	999	10.01	19,483	0.19
C	365	0.01	2,114	0.14	2,929	0.81	3,446	2.01	5,981	4.74	4,055	8.82	1,530	15.33	20,420	0.20
Total	2,006	0.03	11,052	0.73	12,874	3.57	14,906	8.70	24,397	19.32	14,507	31.55	4,451	44.59	84,193	0.82
RVT+ROB																
O	692	0.01	4,121	0.27	4,319	1.20	4,693	2.74	7,381	5.84	3,809	8.28	1,045	10.47	26,060	0.26
A	432	0.01	2,436	0.16	2,763	0.77	3,289	1.92	5,237	4.15	3,196	6.95	877	8.79	18,230	0.18
B	629	0.01	2,994	0.20	3,580	0.99	4,241	2.48	7,067	5.60	4,272	9.29	1,236	12.38	24,028	0.24
C	801	0.01	4,654	0.31	6,200	1.72	7,551	4.41	12,950	10.25	9,024	19.62	3,365	33.71	44,545	0.44
Total	2,554	0.03	14,205	0.94	16,862	4.67	19,774	11.55	32,644	25.85	20,301	44.15	6,523	65.35	112,863	1.11
2001																
RVT																
B	171	0.00	858	0.06	1,102	0.29	1,426	0.75	2,001	1.59	1,478	3.09	476	4.33	7,512	0.07
C	554	0.01	2,826	0.19	3,839	1.01	5,392	2.83	7,994	6.35	6,682	13.97	2,816	25.61	30,103	0.29
Total	725	0.01	3,684	0.25	4,941	1.29	6,818	3.58	9,995	7.94	8,160	17.07	3,292	29.94	37,615	0.37
ROB																
O	705	0.01	3,967	0.27	4,062	1.06	5,426	2.85	7,014	5.57	4,677	9.78	1,603	14.58	27,454	0.27
A	407	0.01	2,313	0.16	2,482	0.65	3,479	1.82	4,849	3.85	3,491	7.30	1,046	9.51	18,067	0.18
B	477	0.01	2,045	0.14	2,464	0.65	3,565	1.87	4,818	3.83	3,580	7.49	1,181	10.74	18,130	0.18
C	334	0.00	1,718	0.12	2,305	0.60	3,247	1.70	4,866	3.87	3,845	8.04	1,673	15.22	17,988	0.18
Total	1,923	0.02	10,043	0.67	11,313	2.96	15,717	8.24	21,547	17.12	15,593	32.61	5,503	50.05	81,639	0.80
RVT+ROB																
O	705	0.01	3,967	0.27	4,062	1.06	5,426	2.85	7,014	5.57	4,677	9.78	1,603	14.58	27,454	0.27
A	407	0.01	2,313	0.16	2,482	0.65	3,479	1.82	4,849	3.85	3,491	7.30	1,046	9.51	18,067	0.18
B	648	0.01	2,903	0.19	3,566	0.93	4,991	2.62	6,819	5.42	5,058	10.58	1,657	15.07	25,642	0.25
C	888	0.01	4,544	0.30	6,144	1.61	8,639	4.53	12,860	10.22	10,527	22.02	4,489	40.83	48,091	0.47
Total	2,648	0.03	13,727	0.92	16,254	4.26	22,535	11.82	31,542	25.06	23,753	49.68	8,795	77.99	119,254	1.16

Source: Belgian institute for health insurance and proper calculations.

I. Masculinity index

TABLE 26 - Masculinity index in 1948, 1975 and 2000 by age group

	1948	1975	2000
0-4	104.01	105.29	104.34
5-9	102.20	104.57	104.69
10-14	102.09	104.42	105.18
15-19	101.48	104.26	104.16
20-24	104.85	105.50	102.21
25-29	104.10	105.54	102.49
30-34	102.37	103.81	103.27
35-39	100.88	101.31	102.68
40-44	99.77	99.98	101.80
45-49	97.24	98.33	102.09
50-54	91.19	96.39	101.41
55-59	88.81	92.94	98.32
60-64	88.74	87.43	93.49
65-69	87.08	79.10	86.94
70-74	84.26	70.15	77.32
75-79	79.08	60.82	65.92
80-84	69.97	53.11	52.23
85-89	57.48	51.41	38.96
90-94	46.29	46.24	27.12
95-99	34.44	41.35	19.73

Source: FPB - NIS population data and proper calculations.

J. Household composition

TABLE 27 - Households counting 1, 2, 3, 4 or 5 and more people, 1930-2001, men and women in percent

	1	2	3	4	>=5	Total
1930	11.00	25.60	25.00	17.10	21.30	100.00
1947	15.90	30.80	24.10	14.30	14.90	100.00
1961	16.83	30.95	21.56	14.61	16.05	100.00
1970	18.78	30.16	20.13	14.80	16.12	100.00
1981	23.20	29.71	19.98	15.72	11.38	100.00
1990	29.33	28.98	18.50	14.99	8.20	100.00
1991	29.48	29.21	18.35	14.93	8.03	100.00
1992	29.50	29.44	18.25	14.88	7.93	100.00
1993	29.61	29.65	18.10	14.80	7.85	100.00
1994	29.58	29.92	17.96	14.75	7.80	100.00
1995	29.65	30.20	17.79	14.65	7.71	100.00
1996	29.87	30.41	17.59	14.52	7.62	100.00
1997	30.20	30.56	17.35	14.36	7.53	100.00
1998	30.56	30.75	17.11	14.15	7.44	100.00
1999	30.90	30.92	16.87	13.96	7.35	100.00
2000	31.19	31.10	16.64	13.81	7.27	100.00
2001	31.63	31.17	16.43	13.60	7.16	100.00

Source: NIS.

TABLE 28 - Households counting 1, 2, 3 , 4, 5, 6, 7, 8, 9 or 10 and more people, by gender of reference person, 1947-1991, in percent

	1947		1961		1970		1981		1991	
HH members	Reference person Men	Reference person Women	Reference person Men	Reference person Women	Reference person Men	Reference person Women	Reference person Men	Reference person Women	Reference person Men	Reference person Women
1	7.53	56.68	7.03	63.66	7.80	67.27	10.73	68.79	15.69	66.98
2	32.11	24.21	32.96	21.31	32.66	19.16	32.78	18.48	32.85	19.70
3	26.94	10.32	24.34	8.26	23.03	7.33	23.39	7.54	21.88	8.79
4	16.35	4.51	16.91	3.65	17.41	3.30	19.17	3.11	19.17	3.07
5	8.24	2.10	9.19	1.70	9.64	1.57	8.40	1.26	7.16	0.99
6	4.19	0.99	4.81	0.75	4.98	0.72	3.39	0.48	2.16	0.32
7	2.18	0.46	2.37	0.36	2.36	0.34	1.27	0.20	0.65	0.10
8	1.17	0.25	1.22	0.18	1.10	0.16	0.50	0.08	0.25	0.04
9	0.59	0.12	0.57	0.07	0.53	0.08	0.21	0.03	0.11	0.01
10+	0.71	0.36	0.61	0.06	0.50	0.08	0.15	0.03	0.09	0.01

Source: NIS, population census data.

TABLE 29 - Households counting 1, 2, 3, 4 or 5 and more people, by gender and age group of reference person , in 1991 and 2001 in percent

	Single HH	2-person HH	3-person HH	4-person HH	5+ person HH
1991					
Men					
<20	83.65	10.60	5.00	0.66	0.09
20-24	36.70	42.57	15.96	3.89	0.88
25-29	21.86	31.54	27.74	14.96	3.90
30-34	16.50	13.63	25.28	31.66	12.93
35-39	14.22	9.52	22.15	34.57	19.53
40-44	12.87	10.47	23.23	33.29	20.15
45-49	12.49	16.43	25.70	27.49	17.90
50-54	12.11	28.58	27.05	19.23	13.03
55-59	12.01	43.83	25.02	11.88	7.27
60-64	12.97	56.27	20.12	6.77	3.87
65-69	14.12	65.35	14.59	3.81	2.13
70-74	16.67	68.26	11.13	2.48	1.46
75-79	23.25	65.78	8.24	1.66	1.06
80-84	33.43	58.18	6.26	1.24	0.89
85-89	44.86	47.86	5.21	1.28	0.78
>90	58.62	34.88	4.72	1.03	0.76
Total	16.31	32.66	21.72	19.00	10.32
Women					
<20	88.73	9.71	1.25	0.23	0.08
20-24	74.80	18.99	4.88	1.07	0.25
25-29	63.01	23.08	9.98	2.96	0.97
30-34	45.45	26.87	18.37	6.61	2.70
35-39	35.89	28.63	23.12	8.47	3.90
40-44	34.82	30.20	23.15	8.32	3.50
45-49	42.87	29.62	18.11	6.54	2.85
50-54	54.33	27.04	12.26	4.22	2.15
55-59	64.32	23.52	7.89	2.68	1.59
60-64	72.86	19.46	5.07	1.63	0.97
65-69	79.51	15.31	3.22	1.13	0.82
70-74	83.99	12.23	2.33	0.80	0.64
75-79	87.03	10.23	1.71	0.59	0.45
80-84	88.03	9.44	1.68	0.52	0.32
85-89	88.08	9.41	1.77	0.44	0.30
>90	87.26	9.86	2.13	0.45	0.29
Total	68.36	18.94	8.42	2.90	1.39

	Single HH	2-person HH	3-person HH	4-person HH	5+ person HH
2001					
Men					
<20	86.01	10.85	2.86	0.23	0.05
20-24	52.05	34.83	10.13	2.37	0.62
25-29	32.61	35.24	20.50	9.16	2.49
30-34	23.30	18.35	23.72	25.74	8.89
35-39	19.12	11.11	18.63	33.47	17.66
40-44	17.44	10.84	18.56	32.47	20.69
45-49	16.35	15.99	23.21	27.71	16.74
50-54	15.69	30.08	26.34	18.37	9.51
55-59	15.26	46.87	22.95	9.86	5.06
60-64	14.77	59.61	17.34	5.20	3.08
65-69	14.83	67.13	13.13	3.06	1.84
70-74	16.75	69.66	10.34	2.04	1.22
75-79	20.32	69.02	8.25	1.48	0.94
80-84	25.92	65.20	6.96	1.21	0.71
85-89	38.63	54.16	5.63	1.01	0.58
>90	53.06	41.29	4.21	0.96	0.48
Total	19.73	35.10	18.79	17.25	9.14
Women					
<20	80.86	15.95	2.70	0.44	0.05
20-24	62.41	25.90	8.74	2.35	0.60
25-29	54.26	26.24	12.76	4.80	1.93
30-34	40.26	26.14	19.66	9.43	4.52
35-39	31.18	25.85	24.16	12.41	6.41
40-44	30.56	28.20	24.53	11.23	5.49
45-49	39.48	30.73	19.71	7.06	3.01
50-54	53.51	29.74	11.90	3.45	1.40
55-59	66.82	24.04	6.40	1.78	0.95
60-64	74.23	19.65	4.13	1.22	0.78
65-69	78.57	16.60	3.12	0.96	0.76
70-74	82.29	13.90	2.43	0.79	0.59
75-79	84.70	12.07	2.05	0.69	0.50
80-84	86.30	10.84	1.89	0.55	0.42
85-89	87.41	10.03	1.80	0.45	0.30
>90	86.23	10.92	2.10	0.42	0.33
Total	62.30	21.06	10.36	4.22	2.07

Source: NIS, population census data.

K. Marital status

TABLE 30 - Marital status by gender, without distinction by age

	Single	Married	Divorced	Widowed	Total
Men					
1947	44.44	50.57	0.72	4.28	100.00
1962	43.05	52.43	0.79	3.74	100.00
1963	43.19	52.31	0.81	3.69	100.00
1964	43.38	52.19	0.80	3.64	100.00
1965	43.50	52.11	0.81	3.59	100.00
1966	43.61	52.02	0.81	3.56	100.00
1967	43.69	51.95	0.83	3.53	100.00
1968	43.72	51.93	0.85	3.50	100.00
1969	43.70	51.95	0.87	3.48	100.00
1970	43.62	52.04	0.89	3.46	100.00
1971	43.49	52.16	0.91	3.44	100.00
1972	43.40	52.23	0.95	3.41	100.00
1973	43.27	52.34	1.00	3.38	100.00
1981	42.22	52.77	1.87	3.13	100.00
1989	41.77	51.75	3.34	3.13	100.00
1990	41.72	51.69	3.49	3.10	100.00
1991	41.71	51.60	3.62	3.06	100.00
1992	41.81	51.40	3.76	3.04	100.00
1993	42.18	50.90	3.92	3.00	100.00
1994	42.42	50.54	4.08	2.96	100.00
1995	42.69	50.13	4.25	2.93	100.00
1996	42.98	49.45	4.66	2.91	100.00
1997	43.15	49.29	4.82	2.74	100.00
1998	43.62	48.42	5.12	2.85	100.00
1999	44.00	47.82	5.34	2.84	100.00
2000	44.36	47.26	5.56	2.83	100.00
2001	44.29	47.28	5.73	2.70	100.00
Women					
1947	40.03	49.04	0.93	10.00	100.00
1962	38.03	50.20	1.04	10.74	100.00
1963	38.09	50.08	1.04	10.79	100.00
1964	38.19	49.92	1.05	10.84	100.00
1965	38.24	49.81	1.06	10.89	100.00
1966	38.25	49.74	1.07	10.94	100.00
1967	38.19	49.72	1.09	11.00	100.00
1968	38.09	49.73	1.11	11.07	100.00
1969	38.07	49.67	1.13	11.14	100.00
1970	37.78	49.84	1.15	11.24	100.00
1971	37.55	49.96	1.17	11.32	100.00
1972	37.34	50.06	1.22	11.38	100.00
1973	37.11	50.17	1.27	11.46	100.00
1981	35.36	50.50	2.21	11.93	100.00
1989	34.09	49.62	3.78	12.50	100.00
1990	34.00	49.54	3.95	12.50	100.00
1991	33.99	49.46	4.10	12.45	100.00
1992	34.08	49.27	4.27	12.39	100.00
1993	34.45	48.82	4.44	12.29	100.00
1994	34.66	48.49	4.63	12.21	100.00
1995	34.90	48.13	4.83	12.14	100.00
1996	35.18	47.49	5.26	12.08	100.00
1997	35.78	47.26	5.38	11.59	100.00
1998	35.79	46.49	5.80	11.92	100.00
1999	36.18	45.92	6.06	11.84	100.00
2000	36.55	45.38	6.31	11.75	100.00
2001	36.89	45.37	6.42	11.33	100.00

Source: NIS.

TABLE 31 - Marital Status – MEN – by age group

	Single	Married	Divorced	Widowed	Total
1947					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	100.00	0.00	0.00	0.00	100.00
15-19	99.29	0.71	0.00	0.00	100.00
20-24	78.07	21.83	0.04	0.06	100.00
25-29	38.72	60.54	0.47	0.27	100.00
30-34	20.17	78.10	1.09	0.64	100.00
35-39	14.93	82.57	1.49	1.02	100.00
40-44	11.90	84.80	1.67	1.68	100.00
45-49	9.11	86.72	1.51	2.66	100.00
50-54	7.75	86.96	1.27	4.01	100.00
55-59	7.69	84.96	1.12	6.24	100.00
60-64	8.42	80.19	0.98	10.41	100.00
65-69	9.01	73.35	0.85	16.79	100.00
70-74	9.25	63.61	0.69	26.46	100.00
75-79	9.43	51.04	0.55	38.98	100.00
80-84	8.77	37.95	0.35	52.92	100.00
85+	9.31	23.82	0.26	66.61	100.00
Total	44.44	50.57	0.72	4.28	100.00
1961					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	100.00	0.00	0.00	0.00	100.00
15-19	99.36	0.63	0.00	0.00	100.00
20-24	70.74	29.20	0.04	0.02	100.00
25-29	26.55	72.94	0.40	0.10	100.00
30-34	14.70	84.11	0.98	0.21	100.00
35-39	10.95	87.28	1.32	0.45	100.00
40-44	9.03	88.59	1.63	0.74	100.00
45-49	9.04	87.74	1.77	1.45	100.00
50-54	9.19	86.50	1.83	2.48	100.00
55-59	8.41	85.50	1.64	4.45	100.00
60-64	7.19	83.68	1.41	7.72	100.00
65-69	6.54	79.54	1.04	12.87	100.00
70-74	6.90	70.83	0.84	21.43	100.00
75-79	7.42	57.87	0.68	34.02	100.00
80-84	7.94	42.46	0.57	49.03	100.00
85+	7.61	25.78	0.37	66.24	100.00
Total	43.05	52.43	0.79	3.73	100.00

	Single	Married	Divorced	Widowed	Total
1970					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	100.00	0.00	0.00	0.00	100.00
15-19	98.97	1.02	0.00	0.01	100.00
20-24	64.54	35.34	0.08	0.04	100.00
25-29	21.98	77.23	0.66	0.12	100.00
30-34	12.52	85.88	1.36	0.23	100.00
35-39	10.08	87.75	1.74	0.43	100.00
40-44	9.28	88.04	1.96	0.72	100.00
45-49	8.28	88.50	1.90	1.32	100.00
50-54	7.64	88.33	1.83	2.20	100.00
55-59	8.03	86.26	1.80	3.91	100.00
60-64	8.32	83.21	1.65	6.82	100.00
65-69	7.53	79.35	1.41	11.71	100.00
70-74	6.62	72.24	1.13	20.01	100.00
75-79	6.15	62.48	0.78	30.59	100.00
80-84	6.57	47.60	0.57	45.26	100.00
85+	7.22	29.04	0.56	63.18	100.00
Total	43.49	52.16	0.91	3.44	100.00
1981					
0-14	100.00	0.00	0.00	0.00	100.00
15-19	99.31	0.69	0.00	0.00	100.00
20-24	71.37	28.45	0.16	0.02	100.00
25-29	26.82	71.48	1.61	0.10	100.00
30-34	13.41	82.97	3.40	0.21	100.00
35-39	9.57	85.74	4.32	0.37	100.00
40-44	8.62	86.40	4.30	0.69	100.00
45-49	8.18	86.75	3.85	1.21	100.00
50-54	8.04	86.45	3.38	2.13	100.00
55-59	7.41	86.21	2.83	3.55	100.00
60-64	6.96	84.94	2.52	5.58	100.00
65-69	7.31	80.83	2.20	9.70	100.04
70-74	7.66	74.23	1.94	16.16	100.00
75-79	6.99	65.00	1.55	26.46	100.00
80-84	6.36	51.25	1.18	41.20	100.00
85-89	5.88	37.45	0.78	55.88	100.00
90-94	6.59	22.84	0.65	69.91	100.00
95-99	6.62	14.16	0.52	78.70	100.00
100+	7.41	12.96	4.19	75.44	100.00
Total	42.22	52.77	1.87	3.13	100.00

	Single	Married	Divorced	Widowed	Total
1990					
0-14	100.00	0.00	0.00	0.00	100.00
15-19	99.84	0.16	0.00	0.00	100.00
20-24	85.47	14.46	0.07	0.01	100.00
25-29	43.07	55.29	1.59	0.05	100.00
30-34	21.22	73.41	5.21	0.17	100.00
35-39	12.83	78.75	8.07	0.35	100.00
40-44	9.43	81.17	8.76	0.65	100.00
45-49	7.94	82.66	8.28	1.13	100.00
50-54	7.68	83.64	6.69	1.99	100.00
55-59	7.51	84.00	5.16	3.34	100.00
60-64	7.21	83.43	3.93	5.43	100.00
65-69	6.56	81.77	3.09	8.58	100.00
70-74	6.31	77.60	2.56	13.53	100.00
75-79	6.61	69.13	2.09	22.16	100.00
80-84	6.96	56.54	1.65	34.85	100.00
85-89	6.45	40.96	1.36	51.23	100.00
90-94	5.75	24.59	1.00	68.66	100.00
95-99	6.67	15.56	0.39	77.39	100.00
100+	6.73	6.73	0.00	86.54	100.00
Total	41.72	51.69	3.49	3.10	100.00
2001					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	99.99	0.01	0.00	0.00	100.00
15-19	95.39	4.59	0.01	0.01	100.00
20-24	56.31	43.26	0.21	0.22	100.00
25-29	24.53	73.49	1.05	0.93	100.00
30-34	14.46	81.76	1.76	2.02	100.00
35-39	11.63	83.54	1.88	2.94	100.00
40-44	10.61	82.95	1.84	4.59	100.00
45-49	10.35	80.48	1.63	7.54	100.00
50-54	10.91	76.31	1.35	11.43	100.00
55-59	11.75	69.62	1.27	17.36	100.00
60-64	11.97	61.91	1.23	24.88	100.00
65-69	12.29	51.78	1.09	34.84	100.00
70-74	12.60	39.47	0.90	47.03	100.00
75-79	13.21	26.35	0.72	59.72	100.00
80-84	13.59	14.81	0.62	70.99	100.00
85+	13.78	6.68	0.45	79.09	100.00
Total	40.03	49.04	0.93	10.00	100.00

Source: NIS.

TABLE 32 - Marital Status – WOMEN – by age group

	Single	Married	Divorced	Widowed	Total
1947					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	99.99	0.01	0.00	0.00	100.00
15-19	95.39	4.59	0.01	0.01	100.00
20-24	56.31	43.26	0.21	0.22	100.00
25-29	24.53	73.49	1.05	0.93	100.00
30-34	14.46	81.76	1.76	2.02	100.00
35-39	11.63	83.54	1.88	2.94	100.00
40-44	10.61	82.95	1.84	4.59	100.00
45-49	10.35	80.48	1.63	7.54	100.00
50-54	10.91	76.31	1.35	11.43	100.00
55-59	11.75	69.62	1.27	17.36	100.00
60-64	11.97	61.91	1.23	24.88	100.00
65-69	12.29	51.78	1.09	34.84	100.00
70-74	12.60	39.47	0.90	47.03	100.00
75-79	13.21	26.35	0.72	59.72	100.00
80-84	13.59	14.81	0.62	70.99	100.00
85+	13.78	6.68	0.45	79.09	100.00
Total	40.03	49.04	0.93	10.00	100.00
1961					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	100.00	0.00	0.00	0.00	100.00
15-19	94.17	5.81	0.01	0.01	100.00
20-24	43.53	56.15	0.20	0.12	100.00
25-29	14.52	84.32	0.82	0.38	100.04
30-34	9.91	87.95	1.39	0.75	100.00
35-39	9.45	87.29	1.76	1.50	100.00
40-44	8.97	85.88	2.11	3.03	100.00
45-49	9.17	82.76	2.27	5.80	100.00
50-54	9.12	79.18	2.10	9.59	100.00
55-59	9.14	73.19	1.81	15.85	100.00
60-64	9.48	64.02	1.45	25.05	100.00
65-69	10.47	53.04	1.22	35.30	100.00
70-74	11.63	40.09	1.14	47.14	100.00
75-79	11.79	27.60	1.08	59.53	100.00
80-84	12.30	16.23	1.00	70.47	100.00
85+	13.02	7.23	0.79	78.96	100.00
Total	38.02	50.20	1.04	10.74	100.00

	Single	Married	Divorced	Widowed	Total
1970					
0-4	100.00	0.00	0.00	0.00	100.00
5-9	100.00	0.00	0.00	0.00	100.00
10-14	100.00	0.00	0.00	0.00	100.00
15-19	93.15	6.82	0.01	0.02	100.00
20-24	40.08	59.44	0.32	0.16	100.00
25-29	11.66	86.64	1.25	0.46	100.00
30-34	7.25	90.03	1.91	0.82	100.00
35-39	6.62	89.80	2.15	1.43	100.00
40-44	7.07	87.85	2.28	2.80	100.00
45-49	7.67	84.81	2.33	5.19	100.00
50-54	7.93	80.54	2.18	9.35	100.00
55-59	8.21	74.40	2.03	15.36	100.00
60-64	8.56	65.44	1.85	24.14	100.00
65-69	8.92	53.68	1.53	35.87	100.00
70-74	9.46	40.19	1.27	49.04	99.96
75-79	10.76	27.62	1.05	60.57	100.00
80-84	12.01	16.07	1.03	70.90	100.00
85+	12.64	7.22	0.98	79.16	100.00
Total	37.55	49.96	11.32	1.18	100.00
1981					
0-14	99.997	0.003	0.000	0.000	100.00
15-19	94.673	5.291	0.018	0.018	100.00
20-24	47.239	52.042	0.584	0.136	100.00
25-29	15.269	81.563	2.755	0.413	100.00
30-34	7.768	87.050	4.383	0.798	100.00
35-39	5.765	87.709	5.041	1.486	100.00
40-44	5.356	87.507	4.633	2.503	100.00
45-49	5.591	85.858	4.017	4.533	100.00
50-54	6.320	81.958	3.472	8.250	100.00
55-59	7.152	75.485	2.980	14.383	100.00
60-64	7.547	66.832	2.732	22.890	100.00
65-69	8.092	55.303	2.475	34.130	100.00
70-74	8.599	41.653	2.212	47.535	100.00
75-79	9.07	27.79	1.78	61.36	100.00
80-84	9.89	16.02	1.46	72.64	100.00
85-89	11.07	8.45	1.25	79.23	100.00
90-94	13.30	3.72	1.27	81.71	100.00
95-99	12.61	1.99	1.44	83.96	100.00
100+	10.75	0.54	2.15	86.56	100.00
Total	35.36	50.50	2.21	11.93	100.00

	Single	Married	Divorced	Widowed	Total
1990					
0-14	100.00	0.00	0.00	0.00	100.00
15-19	98.32	1.68	0.00	0.00	100.00
20-24	66.98	32.60	0.35	0.06	100.00
25-29	26.53	70.05	3.10	0.32	100.00
30-34	12.75	79.59	6.90	0.76	100.00
35-39	7.69	81.70	9.22	1.38	100.00
40-44	5.47	82.53	9.67	2.33	100.00
45-49	4.78	82.45	8.66	4.11	100.00
50-54	4.90	81.61	6.60	6.89	100.00
55-59	5.34	77.64	5.00	12.03	100.00
60-64	6.33	69.46	4.07	20.14	100.00
65-69	6.96	58.06	3.47	31.52	100.00
70-74	7.62	44.30	2.77	45.31	100.00
75-79	7.97	30.71	2.61	58.71	100.00
80-84	8.62	17.57	2.23	71.58	100.00
85-89	9.44	8.30	1.79	80.47	100.00
90-94	10.47	3.42	1.57	84.54	100.00
95-'99	13.06	1.40	1.54	84.00	100.00
100+	19.12	0.98	0.74	79.17	100.00
Total	34.00	49.54	3.95	12.50	100.00
2001					
0-14	100.00	0.00	0.00	0.00	100.00
15-19	98.88	1.11	0.00	0.00	100.00
20-24	84.31	15.26	0.41	0.02	100.00
25-29	48.91	47.51	3.40	0.18	100.00
30-34	25.46	66.17	7.89	0.48	100.00
35-39	15.64	72.10	11.25	1.01	100.00
40-44	10.28	73.83	13.94	1.96	100.00
45-49	7.18	74.62	14.84	3.35	100.00
50-54	5.28	75.48	13.58	5.66	100.00
55-59	4.52	74.90	11.10	9.48	100.00
60-64	4.57	71.72	8.35	15.37	100.00
65-69	5.01	64.17	6.11	24.72	100.00
70-74	5.89	51.64	4.66	37.81	100.00
75-79	6.74	36.62	3.57	53.06	100.00
80-84	7.32	22.29	2.87	67.52	100.00
85-89	8.10	10.21	2.48	79.21	100.00
90-94	9.10	3.83	2.44	84.63	100.00
95-'99	10.63	1.24	1.88	86.26	100.00
Total	36.89	45.37	6.42	11.33	100.00

Source: NIS.

L. Family situation

TABLE 33 - Men and women

	Number of house-holds	Single without children	Single with children	Married without children	Married with children	Single without children %	Single with children %	Married without children %	Married with children %	Total	Number of house-holds with elderly	In % of all house-holds
Men and women												
1961	2,997,448	508,607	217,034	885,275	1,386,532	16.97	7.24	29.53	46.26	100.00		
1970	3,199,155	607,381	228,479	903,913	1,459,382	18.99	7.14	28.25	45.62	100.00	128,901	4.03
1981	3,608,178	837,268	301,457	882,666	1,586,787	23.20	8.35	24.46	43.98	100.00	111,191	3.08
1991	3,799,068	1,123,671	361,850	903,616	1,409,931	29.58	9.52	23.79	37.11	100.00		
1998	3,976,716	1,276,907	438,813	941,467	1,319,529	32.11	11.03	23.67	33.18	100.00	45,398	1.14
1999	3,996,006	1,300,520	454,470	942,008	1,299,008	32.55	11.37	23.57	32.51	100.00	43,984	1.10
2001	4,042,375	1,353,013	489,100	944,051	1,256,211	33.47	12.10	23.35	31.08	100.00	41,642	1.03

Source: NIS.

M. Labour force participation rates

TABLE 34 - Men – by age group

	1947	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2001	2050
15-19	71.1	66.0	58.3	51.6	46.1	41.3	33.5	29.3	15.9	9.5	8.6	10.5	10.9	9.8
20-24	84.9	85.5	86.4	87.4	85.7	83.3	80.6	79.6	70.5	60.0	60.3	61.7	62.5	63.8
25-29	95.6	96.1	96.6	97.1	96.8	96.0	96.5	96.0	95.4	94.1	93.1	92.4	91.6	94.7
30-34	96.6	96.9	97.4	97.8	97.6	97.4	97.9	97.5	97.5	96.2	94.9	95.9	96.0	96.2
35-39	96.3	96.4	96.5	96.6	96.6	96.7	97.0	96.5	97.0	95.2	95.4	94.5	94.6	93.5
40-44	95.4	95.4	95.5	95.6	95.2	94.8	95.2	94.7	96.0	94.7	93.3	92.6	92.5	91.6
45-49	93.8	93.8	93.9	94.0	93.2	92.2	92.3	91.6	93.1	92.0	91.0	90.4	90.4	88.8
50-54	89.6	89.9	90.4	90.9	90.3	89.2	88.2	86.7	85.0	76.7	82.3	80.8	81.3	86.2
55-59	82.9	83.4	84.1	84.9	83.9	82.3	80.2	72.5	62.7	50.2	53.1	51.5	51.8	75.6
60-64	73.4	72.8	71.8	70.9	67.6	63.8	48.3	35.4	27.1	19.4	18.5	17.0	17.2	53.3
65+	24.7	21.5	16.2	10.9	8.2	6.8	4.8	4.0	2.5	1.9	2.3	1.7	1.7	1.3

Source: FPB.

TABLE 35 - Women – by age group

	1947	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2001	2050
15-19	41.8	41.5	41.1	40.7	37.8	34.5	27.3	23.4	14.9	8.1	5.0	6.6	7.3	6.8
20-24	40.5	42.8	46.8	51.3	55.9	60.9	66.0	71.5	66.8	58.4	54.9	50.9	51.4	58.9
25-29	29.5	31.0	33.5	36.0	42.3	49.7	60.2	71.8	78.6	79.4	81.8	83.0	82.6	92.4
30-34	25.6	26.8	28.8	30.8	34.8	39.3	49.4	60.0	71.0	70.8	77.6	80.2	80.7	90.2
35-39	25.1	26.2	27.9	29.7	32.4	35.3	42.3	52.2	62.3	67.9	74.1	76.7	77.5	87.7
40-44	24.0	25.5	27.5	29.6	31.6	33.4	36.9	44.5	52.1	58.6	67.7	72.4	73.1	87.4
45-49	22.0	23.4	25.6	27.8	29.4	30.8	32.4	37.1	42.8	48.0	57.1	63.4	64.4	85.3
50-54	19.8	21.0	23.0	25.0	26.3	27.6	27.4	29.2	29.7	30.8	42.0	47.2	48.4	79.4
55-59	17.3	17.9	18.9	19.9	20.0	20.0	19.0	17.7	16.7	15.7	21.5	26.7	28.0	66.0
60-64	13.3	12.4	10.9	9.6	8.6	7.6	6.4	5.9	5.4	4.0	5.4	5.8	6.4	37.5
65+	5.4	5.1	4.6	3.9	2.9	2.2	1.4	1.5	0.9	0.6	1.0	0.6	0.6	0.6

Source: FPB.

N. Weekly working hours

TABLE 36 - Average number of hours worked per week, 1983-2000, men + women, men, women

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Men + women	37.16	36.87	36.69	36.49	36.21	36.04	35.96	35.84	35.49	35.55	35.23	36.03	35.36	35.19	35.10	35.30	34.60	34.68
Men	38.84	38.67	38.63	38.53	38.42	38.21	38.34	38.22	38.05	38.23	37.99	38.04	38.08	38.02	37.97	38.21	37.84	37.89
Women	33.97	33.50	33.11	32.83	32.30	32.38	32.00	31.99	31.53	31.54	31.26	31.33	30.97	31.15	31.25	31.25	30.30	30.45

Source: Labour Force Survey, NIS.

TABLE 37 - Number of people working certain hours – MEN – in thousands + in % of total working hours (in brackets)

Hours	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
1-10	5,2	5,7	6,0	8,3	7,7	9,1	5,9	4,7	5,5	4,1	5,2	4,6	5,6	6,3	7,1	8,6	16,4	14,5
	(0.2)	(0.2)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.3)	(0.4)	(0.79)	(0.65)
11-20	23,6	33,7	33,2	34,3	33,0	33,6	32,0	40,3	46,9	36,8	39,2	47,5	45,4	46,9	47,8	50,0	64,5	69,7
	(1.0)	(1.5)	(1.4)	(1.5)	(1.5)	(1.5)	(1.4)	(1.8)	(2.0)	(1.6)	(1.7)	(2.1)	(2.0)	(2.1)	(2.1)	(2.2)	(3.12)	(3.14)
21-30	58,2	57,4	67,3	62,8	66,9	75,1	67,6	68,9	73,9	65,5	66,4	60,7	64,8	61,9	62,5	64,7	85,3	86,6
	(2.6)	(2.5)	(2.9)	(2.8)	(3.0)	(3.4)	(3.0)	(3.0)	(3.2)	(2.9)	(3.0)	(2.7)	(2.8)	(2.7)	(2.7)	(2.8)	(4.13)	(3.9)
31-32	9,9	8,1	10,1	10,3	11,3	7,8	9,4	10,6	8,6	8,3	8,8	10,1	12,2	11,8	14,2	16,1	19,4	21,1
	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.3)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.6)	(0.7)	(0.94)	(0.95)
33-34	3,9	3,1	2,9	3,0	2,0	3,5	1,4	1,4	3,5	4,4	2,1	3,1	4,7	4,6	3,7	4,1	6,5	6,3
	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.31)	(0.29)
35-36	101,2	88,8	107,1	107,3	93,0	81,0	66,2	76,4	76,3	84,0	94,0	90,4	92,6	94,9	97,9	113,8	111,8	113,7
	(4.5)	(3.9)	(4.7)	(4.7)	(4.2)	(3.7)	(2.9)	(3.4)	(3.3)	(3.7)	(4.2)	(4.0)	(4.1)	(4.2)	(4.3)	(5.0)	(5.41)	(5.12)
37-38	856,9	944,2	947,0	885,7	954,0	972,4	1020,6	1079,4	1067,7	1056,1	1027,7	1019,7	1019,8	974,5	1026,8	927,5	800,3	834,9
	(38.1)	(41.8)	(41.5)	(39.0)	(42.7)	(43.9)	(44.9)	(47.5)	(46.5)	(46.2)	(45.7)	(45.2)	(44.8)	(42.9)	(45.1)	(40.9)	(38.72)	(37.59)
39-40	735,2	673,3	623,5	689,5	617,4	586,6	573,8	484,8	521,4	527,5	491,4	495,6	499,6	516,8	486,2	542,0	554,3	560,7
	(32.7)	(29.8)	(27.3)	(30.3)	(27.6)	(26.5)	(25.3)	(21.3)	(22.7)	(23.0)	(21.9)	(22.0)	(22.0)	(22.8)	(21.4)	(23.9)	(26.82)	(25.25)
>40	428,3	423,4	446,2	401,1	380,9	337,9	345,4	359,5	333,3	335,3	284,6	311,6	332,1	312,5	317,6	397,3	400,8	428,4
	(19.0)	(18.8)	(19.5)	(17.6)	(17.0)	(15.3)	(15.2)	(15.8)	(14.5)	(14.6)	(12.7)	(13.8)	(14.6)	(13.8)	(13.9)	(17.5)	(13.39)	(19.29)
Total	22224	22377	22433	22023	21662	21070	21223	21260	21371	21220	20194	20433	20768	20302	20638	21241	20593	21359

Source: Labour Force Survey, NIS.

TABLE 38 - Number of people working certain hours – WOMEN – in thousands and in % of total working hours (in brackets)

Hours	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
1-10	25,8	31,2	33,5	34,3	38,1	33,4	34,4	25,0	31,6	28,2	27,7	28,3	33,3	29,6	34,0	35,4	56,1	51,9
	(2.2)	(2.6)	(2.7)	(2.7)	(3.0)	(2.6)	(2.6)	(1.8)	(2.2)	(1.9)	(1.9)	(1.9)	(1.8)	(1.9)	(2.2)	(2.2)	(3.6)	(3.13)
11-20	130,6	145,1	161,7	176,4	191,2	196,6	222,3	240,2	264,4	270,5	274,0	272,3	320,0	279,1	268,2	284,0	302,4	309,3
	(11.0)	(12.0)	(13.1)	(14.1)	(15.3)	(15.3)	(16.8)	(17.6)	(18.4)	(18.2)	(18.3)	(18.2)	(18.1)	(18.3)	(18.3)	(17.9)	(19.4)	(18.64)
21-30	139,0	154,3	152,7	148,6	146,0	152,2	153,5	164,3	179,9	196,9	198,7	195,2	172,9	210,7	216,0	244,0	276,6	297,3
	(11.8)	(12.7)	(12.4)	(11.9)	(11.7)	(11.9)	(11.6)	(12.0)	(12.5)	(13.3)	(13.3)	(13.0)	(13.7)	(13.8)	(13.8)	(15.4)	(17.75)	(17.92)
31-32	17,5	17,9	21,6	25,3	25,6	24,1	23,4	26,0	25,0	27,2	33,7	34,3	44,5	40,2	47,7	45,8	51,6	54,4
	(1.5)	(1.5)	(1.7)	(2.0)	(2.0)	(1.9)	(1.8)	(1.9)	(1.7)	(1.8)	(2.3)	(2.3)	(2.1)	(2.6)	(3.1)	(2.9)	(3.31)	(3.28)
33-34	4,7	6,2	5,6	6,9	3,6	4,3	5,8	4,4	4,8	8,2	7,1	6,8	14,1	10,0	7,7	10,2	14,7	15,3
	(0.4)	(0.5)	(0.4)	(0.5)	(0.3)	(0.3)	(0.4)	(0.3)	(0.3)	(0.5)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.94)	(0.92)
35-36	72,0	69,3	72,8	74,2	70,0	62,2	52,1	57,2	58,1	65,4	69,6	77,0	70,0	74,6	70,3	90,2	80,2	80,7
	(6.1)	(5.7)	(5.9)	(5.9)	(5.6)	(4.8)	(3.9)	(4.2)	(4.1)	(4.4)	(4.6)	(5.10)	(4.6)	(4.9)	(4.5)	(5.7)	(5.15)	(4.87)
37-38	372,6	381,3	392,8	390,5	411,3	447,7	459,8	485,8	501,3	493,6	508,0	515,0	501,3	481,5	499,7	462,4	433,1	464,1
	(31.5)	(31.5)	(31.9)	(31.2)	(33.0)	(34.8)	(34.7)	(35.6)	(34.9)	(33.2)	(33.9)	(34.4)	(33.0)	(31.6)	(32.0)	(29.1)	(27.79)	(27.98)
39-40	253,0	231,7	212,4	216,9	216,3	203,7	201,0	173,2	198,1	204,7	180,2	174,4	185,5	180,0	185,4	200,0	200,2	199,4
	(21.4)	(19.2)	(17.2)	(17.3)	(17.4)	(15.8)	(15.9)	(12.7)	(13.8)	(13.8)	(12.0)	(11.7)	(12.2)	(11.8)	(11.9)	(12.6)	(12.85)	(12.02)
>40	153,3	162,7	158,1	149,4	118,7	121,1	120,2	133,5	116,6	124,2	105,5	108,9	127,0	119,6	177,8	153,3	137,9	145,9
	(13.0)	(13.4)	(12.8)	(11.9)	(9.5)	(9.4)	(9.1)	(9.8)	(8.1)	(8.40)	(7.1)	(7.3)	(8.4)	(7.9)	(7.5)	(9.7)	(8.85)	(8.8)
Total	11685	11997	12112	12225	12208	12453	12725	13096	13798	14189	14045	14152	14686	14253	14468	15253	15529	16182

Source: Labour Force Survey, NIS.

O. Part time employment

TABLE 39 - Part time employment as % of total employment, by gender, 1955-1995

	1955	1960	1965	1970	1975	1980	1985	1990	1995
Men	0.4	0.52	0.76	1.05	1.17	1.35	2.0	2.13	2.92
Women	6.02	7.38	10.73	13.37	14.03	15.10	20.25	24.94	30.90

Source: FPB.

TABLE 40 - Part time employment as % of total employment – MEN – by age group

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
14-19	9.6	6.9	11.5	13.8	15.8	15.3	18.7	19.6	23.3	26.2	25.9	25.2	27.9	30.2	30.1	24.0
20-24	2.1	3.1	4.0	3.8	3.6	3.6	2.6	3.9	3.3	3.9	4.2	4.1	5.8	6.2	6.6	7.5
25-29	1.7	0.8	1.4	1.9	2.0	2.2	1.7	1.9	2.1	2.0	2.1	2.7	2.9	3.4	3.7	4.4
30-34	1.2	0.5	1.0	1.6	1.0	1.8	1.3	1.8	1.3	1.2	1.8	1.9	2.4	2.3	2.5	2.8
35-39	1.4	0.7	0.5	1.2	1.3	0.8	0.8	1.3	1.2	1.4	1.5	2.0	2.1	1.6	2.5	2.4
40-44	1.2	0.5	0.8	0.9	0.4	0.8	0.7	0.6	1.0	1.4	1.6	1.6	1.5	1.6	2.0	2.5
45-49	1.7	0.8	1.0	0.9	0.9	0.8	0.7	1.0	0.8	0.9	1.5	1.6	1.4	1.6	1.7	2.1
50-54	1.2	1.3	1.0	0.8	1.0	1.0	1.0	1.9	1.8	1.8	1.4	2.2	2.2	1.8	2.1	2.3
55-59	2.5	1.5	1.7	1.7	2.5	2.3	2.0	1.6	1.9	2.3	2.8	2.7	2.8	3.5	3.5	3.6
60-64	4.9	3.7	4.5	5.6	4.6	4.7	3.3	2.9	4.0	4.6	3.4	7.1	5.9	5.6	7.6	7.5
65+	19.7	24.7	32.2	20.9	16.9	21.4	21.4	11.6	20.9	17.5	14.9	11.4	22.0	25.1	27.2	12.8
Total	2.0	1.4	1.8	2.0	1.9	2.0	1.6	2.0	2.0	2.1	2.2	2.6	2.8	3.0	3.3	3.5

Source: FPB.

TABLE 41 - Part time employment as % of total employment – WOMEN – by age group

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
14-19	16.6	13.8	23.1	26.9	25.0	24.4	25.1	29.8	31.6	31.0	32.6	29.8	28.9	43.3	36.2	40.8
20-24	14.5	18.8	16.9	19.8	22.2	20.2	21.9	21.4	21.3	22.6	22.0	21.1	22.3	23.2	25.8	28.1
25-29	14.3	16.7	17.8	20.9	22.9	23.5	24.2	25.3	26.4	25.2	24.7	24.9	23.4	23.8	23.0	23.9
30-34	21.9	21.0	22.2	22.8	25.0	25.9	27.8	29.3	30.4	32.0	33.7	32.9	34.2	33.9	33.4	34.8
35-39	22.9	23.3	24.5	23.1	24.7	24.2	25.8	28.3	30.4	31.2	31.4	31.6	35.1	34.7	36.8	37.8
40-44	21.9	21.6	22.6	24.8	25.6	20.6	23.5	25.3	28.1	28.7	31.9	30.9	31.6	33.5	35.6	36.7
45-49	23.6	20.5	22.7	24.5	24.9	22.0	24.3	26.2	24.2	27.1	26.3	26.7	30.8	29.5	32.1	35.1
50-54	23.0	22.2	24.0	25.0	24.9	26.3	26.0	20.3	29.5	29.3	26.6	26.6	27.5	32.2	29.6	31.9
55-59	21.0	23.5	21.8	19.9	22.0	20.3	25.7	23.9	25.7	29.8	24.8	29.4	31.3	30.1	30.2	35.4
60-64	25.2	22.4	19.8	22.7	19.4	24.0	19.3	30.0	22.8	24.4	23.2	16.7	18.7	28.9	29.5	34.8
65+	35.3	27.4	18.1	34.1	28.8	33.6	31.5	25.3	9.2	17.0	22.9	22.7	22.8	28.9	31.2	33.7
Total	19.6	20.2	21.1	22.5	24.0	23.2	24.9	25.8	27.3	28.1	28.5	28.3	29.8	30.5	31.4	33.2

Source: FPB.