

## **Family Care for Elders in Europe: Policies and Practices**

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### **Introduction**

Europeans themselves often have preconceptions about cultural features and other properties of European countries – their own and others - and how they differ. One such preconceived notion concerns differences between countries in the north and south of Europe. For example, many seem to assume that there is more autonomy but also more loneliness and lack of family care for elderly people in the north, whilst old people in the south can bask in the warm care but also control of their family network. At a distance in time or place, countries and cultures tend to be 'homogenized'. For example, social life and services in Portugal, Spain, Italy and Greece are by northern Europeans perceived as similar and welfare states up north may by Southerners also be seen as similar. If we can undermine some of these conceptions, our effort has not been in vain.

A seldom recognized fact is that there is much more variation than commonly thought in old-age care (and in many other respects) both between countries in the south and between countries in the north, but also within each country. This seems to be true of both public services and informal care, the relationship between these two being the subject of this chapter.

To a degree the perception of these issues depend on the vantage point taken: to a Japanese (Chinese etc.) observer, what Europeans consider significant variations may appear just marginal. We will yet try and clarify the real differences that do exist between these countries, and that are likely to persist even if old-age care in many European countries now is changing. There are some signs of convergence, but not to the extent that there is *a* European perspective in spite of official expectations by the European Union that member countries improve services for elderly people. Care in the community is in all of Europe official policy, which often implies that old people will be cared for by their families, with or without public support.

To assess family care itself and policies on them in European countries is a huge task and we can not pretend to cover all aspects of all countries, nor to disentangle all the intricacies of various national programs, legal complications and loop-holes, financial arrangements and private solutions. Fortunately a few recent research projects in OECD and another funded by the EU has undertaken to describe some of these aspects. There are country reports available for most European countries in the EUROFAMCARE project, the source when no special reference is given. The SHARE project, with national population sample surveys of middle-aged and older persons, covers several European countries and has some information on care and EUROSTAT (the European Union statistical agency) publishes useful information on social life in Europe. We will draw on these and other sources to try and clarify explicit and implicit policies on family care for old people and their rationales.

With family care we shall refer to help given by family with things that a person *can not do him/herself*, to distinguish it from services. Policies are laws, regulations, guidelines and practices of public administrations with obvious consequences for family care. Generally speaking, state interventions for old people may substitute for family care or complement it. The former is typically the case with institutional care, the latter may more often be the case with community services. Usually institutional care, that reaches relatively few people, get the major part of the budget. Community services that have the potential to support many families often receive meagre funding, although the balance may be better in countries with care insurance schemes (below). It is useful to distinguish between support for family care that is *direct*, aimed at the recipient and/or the giver of care, and support that is *indirect*. Typical cases of the former are tailored respite services and financial compensations; the most important indirect support is simply access to extensive public services that support families by alleviating some of their commitment. In the latter instance it is crucial to find out whether these services are rationed to mostly provide for old persons short of family ties.

Already now we want to point out that old people are far from always *receivers* of care, they also *provide* care and help. We think not only of minding of grand-children and other minors in the family, documented for example in SHARE. This is legio in all European countries that we have data for (Attias-Donfut, Ogg & Wolff 2005). It is also a fact that many old persons provide help and care for spouses and other family. For example, 21 % of elderly Swedes living in the community *give* care, often extensive, whilst 17 % *receive* informal care and 9 % use public Home Help. Much less often we meet with narratives about the positive aspects of more (old) people surviving into high age, their contributions and also the satisfaction that may be derived from helping an old family member. Importantly, old Europeans seem to increasingly transfer financial resources to children and grand-children and provide other support. Not considering these aspects distorts our perception of old people and tends to frame them up as passive consumers of care.

There are many indications that issues of family care receive increasing interest, both by professionals and by laymen. Many voice worry about the growing number of old people, their isolation, the waning number of (female) carers, rising (female) labour force participation assumed to hinder family care, the burden of care and so on. Informal care has come out of the closet. For example, a new French magazine explicitly deals with care-giving at home for both these categories of helpers (*Prendre Soins: le magazine d'information sur l'aide et le soin à domicile*). The status of family care can also be read as a commentary to the past and contemporary social and political history of European countries. We include Israel, but have less or no information on the Baltic countries, Portugal and most Eastern European countries. Voluntary work for old people will not be treated, but may well be important also in the Nordic countries, where it has received little government encouragement but recently seen growth.

The scope and complexity of European old age care prevents an exhaustive consideration of each nation in depth. Instead, we conclude this chapter with a myopic comparison of old age care in two countries that have historically been very different, namely Sweden and Spain. The former has been a front-runner in terms of

its long history of publicly funded community-based services for older adults and its emphasis on promoting and maintaining autonomy. The latter has traditionally emphasized family responsibility for old age care but has responded recently to its changing demographics and family structures by launching a comprehensive new law to provide for 'dependency' (2007). They are chosen for comparison precisely for their former diametral positions, now from each end of the spectre felt to be unsustainable. Because care is a function of both policies, demographics and family values, these countries demonstrate that there can be considerable change over even very short periods of time.

### **Family care: political and cultural aspects**

Family policies are politically sensitive and were even more so in the turbulent 20th century of European history. For example, when Spain became a republic in 1931, one of her first acts was to legalize divorces. In occupied France, the collaborationist Vichy regime immediately appointed a family minister (Dr. Serge Huard) who set out to promote nativity. The family in the 'new order' was to be 'honored, protected and supported'. The provocative motto about Liberté etc. on French money was shifted to Travail-Famille-Patrie, on coins made from a worthless light alloy. There were pronatalist policies before in France, but child allowances – paid to the father - were only for *married* parents; an unwed mother got nothing. Family allowances were set up after central agreements in 1932 for workers in industry and commerce, extended to agricultural workers in 1936, and became a universal benefit in 1946. When universal child allowances were introduced in Sweden in 1948, payable to mothers regardless of marital status, there was also a debate whether this might further 'immorality' and popular weeklies ran reportages about teen-age mothers.

Sweden had a 'bachelor tax' (higher tax rates for single men) in the 1930s and 1940s, later followed by joint taxes for married persons and family deductions that made it very unprofitable for women to work, abolished in 1971. France introduced a similar bachelor tax in 1920 (25 % higher tax for bachelors above 30 who did not support any family). Mussolini did likewise in Italy in 1927, for men above 25. Many countries still have marriage subsidies, nearly always as tax concessions (Montanari 2000). States have in various ways tried to monitor and influence family life, and this appears to have been more acceptable in the Nordic countries with their traditionally more 'state-friendly' culture. For example, in a joint effort, Denmark, Norway and Sweden all liberalized their family laws in the early 1900s, with no-fault divorces and other formal recognition of individual autonomy. In the Nordic countries family members in a sense were freed from the more intimate ties, but they were on the other hand tied more securely to the state, with child allowances, pensions and other control and support mechanisms.

Explicit family policies in most countries until recently concerned themselves almost entirely with young families and their off-spring, for example being the main focus of the UN 'Family Year' in 1994. Policies on the locus of old people in the family and their care are often in a developing state and it would of course be naive to expect full congruence between official policies and what is practiced by national and local administrations and by the public at large. We will therefore also delve into the

empirical living arrangements and help patterns of old people in a number of countries, how much public services that are available and how they are allocated.

Some of the programs examined in the next sections should probably be seen in the larger perspective of culture and norms of autonomy, traditionally strong especially in northern Europe, where for example few old persons live with their children, nor want to do so. In that vein one may also see contemporary emphasis on consumer choice and consumers as decision-makers (Payments for Care 1994). This is not deliberate policy, but rather an outcome of relatively more affluence among old people. For example, the remarkable growth of private retirement housing for the 55+ or so in several countries hints at an interest in self-direction amongst the elderly and their families. In Australia – to go outside of Europe - about 5 % of people 65+ live in retirement villages, about the same proportion as in institutional care. One significant aspect of choice is of course that public services or family care become alternatives. A recent OECD study provides international data and analyses on these aspects and is recommended for those especially interested in financial issues (Lundsgaard 2005).

Support to carers can be an attempt to incorporate carers in the paid labour-force. That was the explicit motive when family carers were employed as Home Helpers for the cared-for person in Sweden in the 1960s or in present France and Italy. At the same time the intention may be to safeguard fiscally sound old-age care. There is a general worry about the financial consequences of expanding public old-age care as ‘the main non-demographic driver of Long Term Care expenditure is related to the relative shares of informal and formal care’ (OECD 2006). Family carers, even when compensated financially for their commitment, typically ‘cost’ much less than professional care, although if kept outside the labour-force with a pittance of compensation, employment will be reduced. The proportion of the GDP spent on publicly financed long-term care in Europe varies from nearly nil to 3 % or more in the Nordic countries (OECD 2005). Clearly, there is a political, if not a financial limit to this. Historical figures on total spending on elderly people are hard to come by, if we want them to include pensions, housing subsidies (the two biggest parts of spending on old people in Sweden), and public services. For Sweden the proportion used for all these items was 5 % of the GDP in 1950 and culminated at about 14 % in the early 1990s.

We will cover themes of responsibility for care, public and family based and policies and various models of support for caring families. It is common to distinguish between the state and the private sphere, that is the family, the market and non-profit organizations, as alternative or supplementary providers of care. Market in the wider meaning as financial incentives will be touched upon, as they are important in many countries in continental Europe and tend to return in the Nordic countries, as the state has trouble to finance even constant service coverage. With the term state we mean public bodies: municipal, regional and national. In the Nordic countries municipalities have near monopoly in formal old-age care .

### **Policies of support for old people and their carers in contemporary Europe and the administrative context**

To establish a taxonomy of policies amounts to a similar categorization of countries. Well-known welfare theorist Esping-Andersen has suggested one influential way to

group European countries by ideological-political categories, but we will avoid the complex issue of finding a common rationale of this kind by simply grouping countries in Nordic, Northern and Southern (although this roughly corresponds to the Esping-Andersen taxonomy), following Iacovou (2002). This also happens to make reasonable sense for old-age care, formal and informal, because countries in these categories tend to differ visibly in how common it is for old people to live alone, to live with off-spring, to have access to public services and also the legal framework of care. The themes of policy, responsibility and finance are categorized in the matrix below.

Nordic countries are Denmark, Finland, Iceland, Norway and Sweden and Northern Europe here counted as Belgium, France, Germany, Luxemburg, The Netherlands and the UK. The Southern group includes Austria and Ireland, mostly for religious reasons (Iacovou 2002). Switzerland and Israel stand on their own. Another way to categorize countries is to group them according to tax levels and how much of the tax is spent on social protection, both as proportions of the GDP. This gives roughly the same ranking as the above, crude ordering of the countries (Statistics Sweden 1997). Again, we think it wise not to delve deeply into official documents and legal regulations, but rather to try and sum up the actual situation for old people and their carers.

Of course, no categorization will be perfect and it is hard to find countries that are 'typical' in every respect, though Sweden, Germany and Greece might be seen as typical of their respective groups. A statistical analysis of demographical aspects, patterns of care, public expenditures on old people and service levels disclose a rather more complex pattern (Glaser, Tomassini & Grundy 2004). Some countries are also changing their whole concept of care, which may in some years time invalidate these categories. For example The Netherlands is now 'municipalizing' her services and Spain differs in some important regards from the other Southern countries.

<i>Country groups</i>	<i>Policy of family care and support for carers</i>	<i>Level of Responsibility</i>	<i>Official Responsibility</i>	<i>How Financed*</i>
<i>Nordic</i>	<i>Yes, explicit</i>	<i>Municipality</i>	<i>State</i>	<i>Local tax</i>
<i>Northern</i>	<i>Yes, implicit</i>	<i>National</i>	<i>Shared</i>	<i>Insurance</i>
<i>Southern</i>	<i>No, implicit</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>

*\*User co-payment the rule in most countries*

Drawing on country reports in the EUROFAMCARE Project, which is the source when nothing else is indicated, we may distinguish between countries that have an official policy on family care and those that do not. Of course, there may still be an implicit policy, which can be deduced from administrative documents and routines. The Nordic countries and Britain have had a decentralized, local level approach to poor relief and welfare since medieval times. It appears to be a trend in many European countries to decentralize programs that used to be organized at the national or regional level. Now all countries except Greece, Luxembourg and Portugal have locally organized services for old people. They are more or less strictly regulated at the national level in the Nordic countries and in the Netherlands. Decentralization

sometimes occurs when central authorities wish to save money, but may also reflect attempts to make service provision more efficient. A valuable analysis of these issues was done in the OASIS-project (Lowenstein & Ogg 2003).

Yet, there are also cases of the opposite movement for the very same reason, for example when Denmark recently collapsed small municipalities into bigger ones and when Norway nationalized hospital care that was previously financed and run by regional bodies. Some countries, like the UK, have a confusing zig-zag of different local and regional bodies. Even the sheer number of local authorities can make the ambition difficult, like the 35 000 municipalities in France and the 8 000 in Spain. In the latter case, a national plan (Plan Gerontologico) and an energetic national drive to improve service coverage runs parallel with decentralization to regions and municipalities. These problems may be overcome by using national assessment schemes (for instance France, Germany, Israel and Spain).

Some countries with many small municipalities and/or in the absence of an independent municipal tax base and income equalization schemes, often can not muster resources for costly old-age care. In federal countries (Germany and Austria) still other problems of coordination and implementation may plague attempts to formulate national policies. Clearly, most everywhere large differences in service coverage and quality prevail. User co-payment is the rule in most countries, though Home Help has been free till now in Denmark (now about to change). This is frequently waived for low-income users and user-fees usually cover just a small fraction of the costs of public old-age care. British, French and Swedish studies indicate that informal care and/or services vary substantially between regions, at least partly to be explained by varying levels of need among the elderly (Young, Grundy & Kalogirou 2005, Wheller 2006, DREES 2005a, Davey et al. 2006). A British study found that service coverage was due more to local authority discretions and fees than to needs of old people (Evandrou et al. 1992), whilst a recent Swedish analysis found Home Help services to be quite equitable (Davey et al. 2006).

In some countries there is no family policy (usually countries where the family is seen as the 'natural' source of care), in one or two they even had trouble to come up with a domestic word for the concept family care in the EUROFAMCARE project. Even when established, the choice of words can be difficult. In France, the legislation on a dependency allowance (PSD, Prestation Spécifique Dépendence) introduced in 1997 chose to use the concept 'natural carer' instead of 'family carer'. In the case of Spain, the new agreement on a law of dependency to be phased in from 2007, and with financial provisions for carers, uses the concept 'familiares' (family member/relative), without any exact delimitation.

The public awareness about issues of family care varies a lot, from the rather intense discussion and extensive research underpinned by statistics and census-data in Britain and Germany to a near-total lack of a public agenda on family care in Bulgaria, Poland and Slovenia. (The Bulgarian country report even appears to misunderstand the concept and confuse it for public home help services.) Some countries may lack policy but have very active carers' associations and other pressure groups which keep the issue on the agenda (notably Ireland). At the time of writing, initiatives are taken to establish a pan-European organization, Eurocarers. These issues emerged later and more hesitantly in the Nordic countries, with the exception of Finland that in 2006

introduced a law on support for family carers (below). A typical formulation from an expansionist public welfare perspective was when a Swedish government commission stated that the 'family may supplement public services' (govt. bill 1987/88:176). More recently (1998), the Swedish social service act added a non-binding clause that municipalities 'ought to' support family carers.

Age-related expenditures are projected to increase radically in the coming decades in European countries, that have prepared more or less well for this. In several countries public debt may rise to impossible levels, if unchecked (European Union 2006). Family policies and practices are not fixed forever and already in 1992 a EU-sponsored expert meeting discussed emerging new 'welfare mixes' (*Eurosocial Report* 43/1992). In some quarters there are expectations that families are to shoulder more of the care in future. For example, a Council of Europe survey (about old-age care) to the national ministries of social affairs in 1998 referred to the need for increased reliance on family care to reduce government spending (Council of Europe 1998). Yet, a year later it resulted in a rather lame statement where the parliament of Europe wished to "reaffirm the importance of the family --- and argues in favour of it being restored to its rightful place", without clarifying what that place is (in Recommendation 1428, 1999). Another example is offered by a Norwegian econometric study that shows the vast impact on finances of varying assumptions about how much informal care is provided to old people (Statistics Norway 2006). The problem is aggravated by the official wish in the European Union to reconcile informal care with raised employment (of women) and gender equality, often captured in statements about a 'proper balance' between work and family life.

In Britain, carers in the 1990s got the right to have *their* needs assessed when the person cared-for was assessed for public services and recently a government 'Green Paper' proposed choice and prevention in future old age care, but also stated repeatedly with varying formulations that "when support from family and friends is not enough, it is supplemented by more formal models" (Department of Health 2005). (Scotland deviates slightly, for example with free Home Help services.) In a somewhat similar vein, a large part of continental Europe subscribes to subsidiarity, a concept established by the roman catholic church and used to describe a desirable social order: interventions shall be done where they 'belong'. Private family tasks and problems are not to be solved by the state or other higher entities. (Other denominations may endorse similar principles.) This should be seen in perspective. When pronounced by Pope Pius XI in an encyclical in 1931, his statement of the 'natural' rights of the family was directed against the strivings of expanding fascism to put individuals and families in service of the state. Without formally endorsing subsidiarity, similar results may emerge in the UK and the Nordic countries when the state primarily targets old people who need help with health care and personal care, whilst the family is expected to help the many more persons who primarily need help with household tasks of various kinds.

### **Informal care and legal filial duties**

It is readily understood that family and household patterns of old people has implications for who may provide care, or whom they may have to give it to. If old people live alone, with just their spouse (partner) and/or with others, this may also

affect their ‘risk’ of using public services, for example Home Help and institutional care. Therefore, an overview of these living arrangements is given in Table 1 for some European countries.

**Table 1. Household structure in selected European countries about 2004 for 65+ living in the community. Per cent**

	Living alone	With partner only	Other arrangements*
<i>Nordic</i>			
Denmark	41	55	4
Sweden	39	59	2
<i>Northern</i>			
Belgium/Flanders	27	63	10
Britain (1998)	36	51	13
France	36	55	10
Germany	39	53	8
Netherlands	42	54	5
<i>Southern</i>			
Austria	43	43	14
Greece	38	44	19
Italy	32	42	26
Spain	27	38	35
<i>Switzerland</i>	35	57	8
<i>Israel(2004)</i>	25	45	30

\*any kind of living arrangement: with partner+child, with child(ren) etc.

Source: our own computations on SHARE. Denmark and Sweden corrected for institutional population (8 % and 7 % respectively) by us, in the other European countries samples are of persons living in the community. Belgium: calculated from the LOVO-survey (2001), courtesy Benedicte de Koker. Israel: Brodsky, J, Shnoor, Y & Be'er, S (Eds.) The Elderly in Israel. Statistical Abstract 2005 /in Hebrew/ JDC Brookdale and ESHEL. Information kindly provided by Ariela Lowenstein. Britain: our own calculations on Glaser & Tomassini 2003.

The Nordic countries are characterized by their far-reaching household separation with many old people living alone, comprehensive services and no legal responsibility of the family, except spouses (‘individualism’). In the Northern countries solitary living is nearly as high, living with off-spring has declined but public services usually have lower coverage, especially the community-based ones, and filial obligations mostly apply. In the Southern countries solitary living is on the rise among old people (e.g. Spain 16 % in 1993, 22 % in 2003) but relatively low. Joint households are still common and have for example in Italy not declined at all. Legal family obligations, often elaborate, still apply.

Living alone is much more common in the Nordic countries than in the Southern ones, with the Northern ones close to the Nordic countries. The trend is the same for men and women, but levels are everywhere much higher for women (not shown), roughly corresponding to the 2-3 times higher risk for a marriage to end with the death of the husband than that of the wife. A widely preferred living arrangement, living just with one’s partner, is also more common in the Nordic countries, and everywhere much

more common among men. Other living arrangements, with off-spring, siblings, other relatives or unrelated people – live-in maids and others - is now rare indeed in the Nordic countries, but still frequent in the South.

It appears that ever more old people remain married into advanced age, with obvious consequences for chances to get – or have to give – informal care. Also cohabitation and LATs are increasing among old people, but more so in northern Europe than in the South. For example, in Sweden 56 % of the 65+ are married, 5 % live with a partner and 7 % are in LAT relationships (Socialstyrelsen 2006). In Britain unmarried cohabitation is also on the increase, but lower at about 2 % (ONS 2006). Family life has in some regards indeed improved, whilst other aspects may be more worrisome. One such feature is rising divorce rates. Due to divorces and widowhood over a tenth of married older persons are actually remarried (data for Britain and Sweden). Problematic is also delayed independence of the younger generations, who remain unmarried ever longer in their parents' household in the face of adverse housing and labour markets, particularly in Southern Europe. This may be a way to economize, for both generations: in Britain nearly a million households have three generations under the same roof (*Economic Lifestyles* Nov. 2005). The phenomenon has been studied for both the older and the younger generation in Italy (Menniti 2004).

The fact is that living alone has culminated in the Nordic countries. This is still less common but increasing in several continental and Southern countries. For example, 16 % of the Spanish elderly lived alone in 1993, but 22 % did so in 2003. The trend to live just with one's partner seems to be nearly universal. Solitary living as an important social fact is now recognized symbolically by the UN demographic fact chart on ageing, which provides data on this, for men and for women, where available (United Nations 2006). The reason is said to be their greater risk of social isolation and vulnerability in case of illness etc.

Do differences in living arrangements translate to variations in care-giving in European countries? It is well-known that old persons all over Europe depend primarily upon their families, but this does not necessarily imply that care is similar, seen from the providers' perspective. This aspect is assessed with recent data in Table 2. As women are often assumed to be the prime care-givers, they get separate entries.

Unexpectedly, care-giving in total – inside *and* outside of one's household - is more common among the 50+ in central European and in the Nordic countries Denmark and Sweden with their extensive welfare programs, than in Southern countries such as Spain and Italy, with their strong family traditions. Yet, 'external' care-giving may frequently be help with less demanding tasks than 'heavy' personal care inside the household. Care for someone in one's own household is two-three times more common in the Southern than in the Northern and Nordic countries, for example 10 % in Spain as against 4 % in Denmark-Sweden. In the latter countries in-household care is mostly spouse care, as it is rare for old persons to live with anyone else than their spouse. In the continental and Southern countries this will often be care for parents(in-law). When Danes and Swedes help parents, this will be help to another household, as co-residence with parents is very rare for this age-group in these countries (near zero), as against 4.1 % in Italy and 5.6 % in Spain (Attias-Donfut, Ogg & Wolff 2005). Needy Nordic elders mostly were helped from 'outside', Southern elderly mostly from 'inside' their households, but in total they received help about equally often. The

same pattern held for the *giving* of help and support by old people themselves (Socialstyrelsen 2006). It is also possible that ‘help’ is interpreted differently in northern and southern Europe, due to *i.a.* how common is co-residence (Ogg & Renault 2006).

**Table 2. Prevalence of care and employment in selected European countries for 50+ by gender, 2004. Per cent**

	Age 50+				Employed		Employed among	
	Gives care* in hhld All Women		Gives help** to other hhld All Women		All	Women	hhld carers All	Women
<i>Nordic</i>								
Denmark	4	4	47	37	52	47	35	25
Sweden	4	4	41	39	52	51	38	30
Netherlands	5	5	41	38	40	32	27	15
<i>Northern</i>								
Germany	6	7	32	29	46	33	18	15
France	6	8	31	31	33	30	17	16
<i>Southern</i>								
Austria	8	9	25	24	32	26	21	18
Greece	6	7	20	21	35	24	22	19
Italy	8	9	23	22	25	18	16	10
Spain	10	12	14	15	27	20	17	12
Switzerland	6	8	36	37	54	48	36	27

\* ‘regular care for sick or disabled adult in household last year’.

\*\* ‘help to family, friend or neighbour in other household’. Help can be with personal care, household and/or ‘paper work’

Source: SHARE, our own computations

In this context, it should also be observed that these cross-sectional rates of caregiving greatly underestimate the life-long risk of ever being a caregiver, which is roughly two-three times greater. Many stop, and many begin, a caregiving episod every year (Hirst 2002, Aeldre Sagen 2005). Data on this are very scarce, but in Sweden ca. 40 % of elderly women and 20 % of the men report having ever been carers, mostly for parents or spouses (Socialstyrelsen 2006). Who becomes a care-giver and who does not, is likely influenced by the density of one’s social network, among other things (Amirkhanyan & Wolff 2003, Socialstyrelsen 2006). For international comparisons of care-giving we have to make do with available time-point estimates.

Interestingly, there are hardly any gender differences in care inside the household in Denmark, Sweden and the Netherlands, but more visible ones in the Southern countries. These patterns are seen for example in national surveys of informal care in Spain and Sweden (IMSERSO 2005a, b, Socialstyrelsen 2006), in part possibly due to gender differences in care to parents-in-law. Evidence for partner-care indicate small differences between men caring for their wives and women caring for their husbands, in absolute and relative terms. At least the differences are smaller than stereotypically expected in northern European countries, with about equally many male and female spouse-carers in Sweden, England and Wales (Socialstyrelsen 2006, Young, Grundy

& Jitlal 2006). On the other hand, husbands have been found to less often be spouse-carers in Ireland and in Spain, even in spouse-only household constellations (National Council for the Aged 1988 and our own calculations on Spanish survey data).

The SHARE study asks whether one has helped someone in the household ‘daily or almost daily during at least three months --- during the last twelve months with personal care, such as washing, getting out of bed, or dressing’. In the total population sample 50+, this is affirmed by 2-3 % of European men and by 4-6 % of the women. The rates are naturally higher for married persons who live with their partner only. In this group men do this only slightly less often than women (5 % and 6 % respectively, European average). For both men and women, this is more common in Southern countries, possibly due to less adequate housing and/or poorer health (for example 3 % and 4 % respectively for married men and women in Denmark and Sweden, 7 % and 8- 9 % respectively in Italy and Spain).

Differences between men and women in the help they give to persons in other households are small, but less is known about the contents of this help: it may frequently concern practical tasks like house-repairs, car-maintenance etc that involve men as well. In general, then, informal care is common and when time-series exist (Norway, The Netherlands, Spain, Sweden, UK) there is no indication that informal care is on the decrease. It is for example estimated that in Sweden about 60 % of all old-age care, including institutional care, is provided informally (Szebehely 2005). German studies hint at weakening attitudinal support for family care, supposedly due to the new care insurance, but Swedish studies indicate a remarkable growth in actual informal care (EUROFAMCARE report on Germany; Johansson, Sundström & Hassing 2002). Research in Norway, The Netherlands, Poland, Spain, Sweden and the UK indicates that about 60-70 % or even more of informal care is directed from a younger generation to older persons, typically parents or parents-in-law. Also, as mentioned, care between ageing spouses is not negligible.

As seen in Table 2 employment rates are remarkably high in the Northern and Nordic countries, for both men and women 50 years or more (Sweden, Denmark, Netherlands, Germany and Switzerland) and very low for men *and* women in Italy and Spain. Among women employment has been on the rise for a long time in most countries, often in part-time jobs. (Finland is an exception with high rates in full-time positions.) Does care commitments then generally hinder carers from gainful work, as evidenced by Spanish surveys of informal carers? (IMSERSO 2005a). Evidence on this is ambiguous. An overview of the situation in Europe was cautious in its conclusions, as it is difficult to disentangle cause and effect of working and caring and the effects of care allowances on care-giving (Jenson & Jacobzone 2000). A major European survey also found little effect on labour supply of help provision to persons in other households, for men and for women 50+. (Analyses on SHARE, not shown here.) Those who give more demanding help *inside* their own household are everywhere less often in employment, though this tendency is more pronounced in the Southern countries.

A Swedish overview of population-based data on care concluded that carers were mostly of *better* health than the general population and there were no major effects on employment (Socialstyrelsen 2006). Yet, the British census of 2001 that included two questions on health and two on care-giving did find that carers both suffer poorer

health in general and are financially disadvantaged (Young, Grundy & Jitlal 2006), again hitting home the question of cause and effect. Importantly, many people both work and provide care. Thus, for Switzerland it is estimated that 12 % of women aged 50-54 are in paid work *and* have dependent parents; rates are lower before and after this age. In Sweden, the figure approaches 20 % (Perrig-Chiello & Höpflinger 2005, Socialstyrelsen 2006).

The UK didn't participate in SHARE, but we may draw on other evidence. In 2000 21 % of her adult population (16+) were 'carers' and 5 % gave 'heavy' care (at least 20 hours of care per week), proportions that have stayed stable since the first General Household Survey probing this in 1985 (ONS 2002). As indicated, British carers often suffer from poor health and stand outside of the labour market, with 'heavy' care frequently being a working-class prerogative (Young, Grundy & Jitlal 2006).

Heavy care commitments may be less common in the Nordic countries and mostly established rather late in life, when people may have stopped working for other reasons. Importantly, many dependent persons in the Northern countries receive *both* public services *and* family help, which may facilitate for carers to remain in the labour market or in other life roles. Informal care-giving seems to be expanding in a Nordic country as Sweden, in response to stagnating public services (Johansson, Sundström & Hassing 2002). In this context it should also be mentioned that in all European countries most old people have off-spring living in relative proximity, as evidenced in SHARE-data. In Sweden over half of old people have at least some adult child in the same municipality, and 6 out of 10 have *all* their children there (Statistics Sweden 2006).

It is possible that patterns of care partly reflect the demographics of a country. For example, there are more middle-aged persons, men and women, per thousand old people in Spain than in Sweden. Old Swedes hypothetically then have fewer family-ties (children) to rely on and the latter may then more often feel committed to be care-givers. This has been conceptualized as the caretaker pool, following seminal work by Moroney, here defined as women 45-69/65+ (Moroney 1976). In 1991 the care-giver pool ratio was 1.01 in Spain, as against 0.88 in Sweden, reflecting higher nativity in the 1920s and 1930s in Spain, when Sweden faced extremely low nativity. This is likely to change, as later cohorts of the Spanish had low fertility, when it was high in Sweden, but still in 2004 the average number of off-spring was higher in Spain. (In both countries, the majority of 50+ had 0,1 or 2 children.) Given the smaller care-giver pool, one would expect informal care-giving to be more common among middle-aged adults in Sweden than in Spain. Possibly this is reflected in generally more frequent help to persons in other households in Sweden than in Spain, but an analysis that pinpoints time transfers (help) to *parents* finds that to be more frequent in Spain, where 35 % of the 50+ give such help, higher than the 27 % in Sweden (Attias-Donfut, Ogg & Wolff 2005). We suspect that it is problematic to substitute demographical arithmetics for the complex dynamics of informal and formal care.

An obvious clue as to care policy is where the legal responsibility lies for financial support and/or for hands-on care (the distinction is not always legally clear) for dependent persons at large and for elderly people in this case. This, and state responsibility is categorized in the overview below, that should be seen as schematic only. Countries seem to vary in the extent that they enforce these obligations.

Sometimes they do so only when costly institutional care is the alternative. At least one country, Denmark, never had any legally prescribed family obligations for old people, whether in poor law or in the family code, yet there is nothing to indicate that Danish family care was any worse – or better – than elsewhere. Other Nordic countries had these obligations but abolished them in the 1950s or somewhat later (Iceland last, in 1991). On the continent most countries retain them, except Ireland, Luxembourg, UK and the Netherlands. This should be seen in a larger context. The Nordic countries thus jointly liberalized marriage clauses of their family laws in the 1920s, with for example no fault-divorce, that most continental countries did not accept till the 1970s. One interesting case is Israel, that applies both family obligations and clear state obligations – under specified conditions - in their care insurance law (Lowenstein 2006).

In the case of Spain, its civil law prescribes very clearly these obligations and in which order family members' obligations enter, corresponding to the order of inheritance. Italy has similar prescriptions, but with the amendment that family has to pay for care or itself take care of dependent persons. (Also in Spain families have this choice.) The EUROFAMCARE country report for Italy remarks that this is at times used by authorities to 'black-mail' families to provide care. Laws may also prescribe responsibility for step-parents (Slovenia) and aunt/uncles and nieces/nephews (Portugal). Italy and Spain include half siblings among the legally responsible, but Spain also makes a distinction between the extent of support, that is, spouses, children and grand-children carry a 'heavier' commitment than siblings and their ascendants and descendants. Obligations extend to grand-parents also in France and some other countries (and in Vorarlberg in federal Austria) and sometimes the locus of responsibility in the 'family' is not exactly defined (Bulgaria, Greece, Hungary). Services may be restricted to "persons who have no relatives to take care of them" (Bulgaria).

### **Overview of legal responsibility of family and/or state, selected European countries**

<i>Legal obligation for family</i>		<i>No obligation</i>	
<i>Extended family</i>	<i>Off-spring</i>	<i>No clear state obl.</i>	<i>Clear state obl.</i>
Italy	Austria	Ireland	Denmark
Portugal	Belgium	United Kingdom	Finland
Spain	France*a		Luxembourg
Bulgaria	Germany*		Netherlands
Hungary	Greece		Norway
	Slovenia		Sweden
	Luxembourg		Iceland
	Israel a		

\*may apply only when institutional care is the option

a. *Both* family obligations *and* clear state obligation

Source: after Millar and Warman 1996, adapted and expanded.

One may speculate that these obligations tend to go with legal prescriptions to keep inheritance within the family. Lack of obligations and testamentary freedom are 'natural' partners, as demonstrated in a comparison of France and England (Twigg & Grand 1998). In a traditional society ageing parents may indeed more often negotiate

inheritance against provision of care, as shown in a comparison of inheritance patterns in Japan and England (Izuhara 2002). Interestingly, in Spain a recent law (2003) prescribes that an irresponsible family member may inherit less or nothing, and conversely the cared-for person is legally entitled to favorise a carer in the family in the inheritance. (This is more difficult in the Nordic countries with legally fixed inheritance for off-spring.)

It should also be mentioned that in countries with filial obligations, the state may reclaim some of its costs for care from the old person's legacy, if any, which was the case also in the Nordic countries in the poor-law era. For example in France it was applied with the PSD but so far APA compensation is exempt from filial obligations, though this has been considered as a means to save costs. In the PSD (Prestation Spécifique Dépendence) from 1997, the state could recover costs from an old persons legacy, which discouraged elders from seeking this assistance (Morel 2006).

In practice, access to close family may often determine patterns of care at large including use of public support. For example, in contemporary Spain, only 17 % of institutionalized old people have children and 61 % report that they have no one to support them outside of their residence. The most common motive given for entering was solitude (our own computations on data for IMSERSO 2004). In France, 40 % of the residents have children, and in general their networks are small and many are socially isolated (Cribier 1998, Desesquelles & Brouard 2003). Obviously, then, children have rarely 'dumped' their parents in these countries. Institutional care in the Nordic countries is more 'democratic': in Sweden 19 % of old people in institutions lack off-spring, as against 14 % of their counterparts in the community (65+: our own computations on Statistics Sweden Level of Living Surveys 2002-03).

Another indication of the significance of family ties is the heavy overrepresentation of, for example, the never-married in institutional care. These patterns seem to gradually change, when institutional care shifts from being a place to live for the socially underprivileged to being a residence for the very old and frail at the end of life, visible for example in repeated French *enquetes* (DREES 2006c). This is compatible with higher proportions *eventually* entering an institution, but for a shorter period of time. For example, in Sweden in 1950, the large majority of institutionalized old people were never-married and childless, but frequently not frail at all. Some 15 % ended their life there, to compare with much higher figures today, contemporary residents being much frailer and less obviously socially under-privileged than in the past, but also staying shorter time in institutional care today. Yet, residents short on family ties are likely to always be over-represented, as the most important support is the partner, and married persons rarely are institutionalized. Incidentally, men seem no more likely than women to 'dump' their partner in an institution, judging from British and Swedish data, and French evidence even shows more married men than married women being institutionalized (ONS 2006, Socialstyrelsen 2006, DREES 2006c).

Family responsibility is sometimes only stipulated for financial maintenance of dependents, but this in practice tends to include care, as institutional care is usually scarce – and expensive – in countries with this type of legislation. In some countries, home care and/or care allowances may be explicitly excepted in assessments of filial responsibility, as is the case in France. Elsewhere "care services are rationed --

/depending on/ -- whether or not a family carer is (deemed to be) available” (Ireland). This criterion is also used by some Spanish municipalities when they allocate public home help. Even in countries with high coverage rates of community services a tendency of rationing makes itself felt, in The Netherlands for example through long waiting times (Social and Cultural Planning Office 2001). In Sweden access to family networks are increasingly considered in needs assessments, although this lacks legal underpinning (Johansson, Sundström & Hassing 2003).

State responsibility for care may or may not co-exist with family obligations. Thus France has both and Ireland has neither. Some countries, like Austria, has a clear state responsibility only in the realm of health care, whereas cases of primarily 'social' needs may fall between the chairs. Sometimes the degree of responsibility of the state is unclear or extended only to financial maintenance of (old) citizens. Countries may also be in transition, like presently Spain and The Netherlands (above). Officially Norway guarantees care in the community for old people regardless of how large their needs, whereas Sweden, perceived as also doing that, recently had a case in the administrative appeal courts that overturned this official corner-stone of elder-care (the municipality refused to provide unlimited Home Help and instead offered a room in an old-age home, accepted by the court). How far state responsibility extends may in practice depend on resources and political will, as in any other domain of public affairs.

Norms on responsibility for old people have been probed in a few international studies. In the OASIS-project, representative samples of old people in Norway, Germany, Britain, Spain and Israel varied somewhat in their definition of responsibility, but everywhere the large majority wanted responsibility to be shared between family and state, or what has been termed 'partnership' (Nolan 2001). Preferences vary, as may be expected, by actual availability of government support. Half or more was for 'mainly state' responsibility for financial support, domestic help and personal care in Israel and Norway. Much the same held for opinions on who should be responsible for increasing, future needs (Daatland & Herlofson 2004). Another international study found similar patterns, shown in Table 3.

In Sweden a quarter of carers endorse main responsibility for family, as against three quarters or more in the other countries. Yet, only in Poland (36 %) a large fraction accepts total family responsibility. (A couple of national studies confirm the pattern; see the concluding comparison of Spain and Sweden.) The OASIS-study is nearly exceptional in considering both family and state support simultaneously (Daatland & Lowenstein 2005). It is very unusual to find a conscious discourse on this in official publications. A rare exception is a French analysis of the APA, with systematic consideration of network configurations of old people at different levels of need and the interaction of family and public support (DREES 2006b). These aspects are likely to be more important in coming years.

A survey in Flanders (Belgium) found that most 55+ are negative towards legal filial responsibility for residential care (Vanden Boer & Vanderleyden 2003). Still, we rarely encounter discussions of the ambivalence and conflicts that may be inherent for both sides in obligatory care for a dependent old relative. Without entering a discussion of the complexities of these aspects, it appears that strict application of legal responsibility may not guarantee adequate care for dependent (old) persons. The

individual family history, with emotional ties but also conflicts, may make for abuse in situations of enforced care, documented both scientifically and in fiction.

**Table 3. Desired division of responsibility between family and state among carers of the elderly in selected European countries 2005. Per cent**

Desired responsibility	SWE-DEN	ENG-LAND	POLAND	GER-MANY	ITALY	GREECE
Family all	3	3	36	4	12	15
Mainly family, state contributes	22	65	57	71	77	78
Mainly state, family contributes	57	12	5	11	6	3
State all	6	2	1	0	1	0
Don't know, No answer	12	18	1	14	4	4
Sum	100	100	100	100	100	100
N	581	320	875	451	863	290

Source: EUROFAMCARE, by permission

### **Models of support to caring families. Payments or services?**

A significant difference is between countries that primarily support dependent elderly persons themselves and those which tend to support primarily (caring) family members. The former are the Nordic countries, Britain and the Netherlands, though the distinction is not always so clear-cut and also changing. Extensive public support to dependent old people can at the same time be seen as *indirect* support to caring families: they may be relieved from some of the tasks or are at least not standing alone. *Direct* support to carers is for example respite care, day care and other programs, but also financial support such as cash allowances and tax rebates.

Countries like the Nordic ones that upkeep relatively high levels of community services often have thought less about informal care and provided rather little direct support to family carers, be it financially or as services. It is illustrative that in Sweden, an ageing parent housed by a relative may face to pay more tax - if found out by the tax authorities – as he/she enjoys benefits in kind. In France and in Spain, in the same circumstances, a family may make a tax deduction. Payments done under these obligations are tax deductible for example in France and Israel. In France the recipient has to report them as income. If housing is provided, any rent forgone is also tax deductible.

Israel was the first (1988) country to introduce a Long Term Care Insurance, a means-tested program that only provides in-kind services to old people living in the community. Coverage is quite high but mostly functions as a complement to family care (Lowenstein 2006). Germany may be the best example of a country where

service levels are rather low, but where persons in need of care are recognized by a care insurance (introduced in 1995, for both institutional and community care) and many family carers are financially compensated. Austria, with comparatively high service-levels, only provides cash (from euros 148 to 1562), but in Germany the cared-for person can choose to either accept cash (from euros 205 to 665) – declining, but used by about 80 % - or to get services paid for, and then at a much higher rate (euros 384 to 1432). (A combination is also possible.) Luxembourg and The Netherlands (a limited version) also have programs akin to a care insurance. Some countries will introduce them in one version or another (Spain, Flemish part of Belgium, Hungary) and a few other countries (Ireland, Italy, Slovenia) consider them. The new Finnish program to contract family care may also be considered in this context (below). More often than not they guarantee services, but not financial compensations to carers (Luxembourg appears to have a hybrid of both). Care insurances have mostly been considered in countries with less extensive public old-age care and/or weak traditions of local responsibility for services to old people. Spain may be an exception, as it now expands services to dependent (old) people dramatically through their new legislation on dependency. Maybe unintentional, an important byproduct of these programs is the changing perception: when criteria of needs are established, assistance will be seen as a right.

Care insurances typically use standardized needs assessments, with simple and uniform criteria which provide rights and some choice to persons who are dependent on care, usually fixed in steps with corresponding compensations or services. This is for example the case with the Netherlands that began its Person Bound Budget modestly in 1995. It lets the clients decide on whom they will hire to provide the care; with its present c:a 75 000 cases it still covers very few elderly people. In comparison, the Austrian insurance scheme covers 15 %, the German one 6 % of the 65+, and the Israeli 16 %. The Israeli scheme has two levels (10 or 15 hours help/week, a few per cent only get day care or alarm systems), whilst the German scheme establishes three levels of need, much like the French APA and the new Spanish program. The obvious problem with a scheme based on legal rights is the cost aspect. Different measures can be used to curb costs, insurance or not. Sweden and several other European countries have sharpened their needs assessments and co-payments have been raised. Not unexpectedly it is found that Swedish families now provide more care than before and there is also a growth of other private, commercial services.

Most European countries have various schemes called Dependency or Carers Allowance etc, sometimes payable to the cared-for person, sometimes to the carer. Sometimes both types co-exist as in Belgium, Finland, France, Sweden and the UK. Compensations are frequently means-tested, that is, they are meant for persons on low income only (Ireland, Malta, UK). Italy is noteworthy for not means-tested and generous cash-benefits, which seem to enable many families to buy private help (below). Finland, France, Ireland and the UK have regular, nation-wide schemes. Usually the uptake is low for these programs, which may have many restrictions. For example, in the UK entitlement requires more than 35 hours attention/week. Sometimes bureaucratic procedures in practice make them next to unattainable (Slovenia). Low coverage also characterizes care allowances in Czechia and Hungary.

The exception is France, with its 2002 scheme APA (Allocation personnalisée d'autonomie à domicile) that covers nearly nine hundred thousand beneficiaries, 5 %

of the 60+, the eligible group. Dependency is assessed by teams of social workers and health care professionals and is graded with a scale (AGIR), with ensuing compensations from 500 to 1169 euros (minus co-payments) similar to Austria and Germany. The French APA pays for a needs assessed care plan and money can also be used to pay a carer chosen by the client, home adaptations etc., but also for institutional care (about 40 % of the beneficiaries). Frequently the beneficiaries live with their family, but spouses are not eligible. No compensation is paid when needs are only for household help, which has led to a decrease in public Home Help. With APA, 93 % of the users report that they are now able to use professional services, as against 65 % with the PSD (DREES 2006a). Interestingly, coverage rates of APA vary locally, with the highest levels in rural regions with higher poverty and working-class and farmer dominance (DREES 2005a). These are regions where many old people suffer health problems, entitling them to public support. Similar patterns are found – with the addition of lone householding – in an analysis of Swedish municipal Home Help (Davey et al. 2006). Large local variations in frailty among old people also in Britain emerge from an analysis of their 2001 census (Young, Grundy & Itlal 2006).

Unlike the Austrian and German care insurance schemes, the APA is a part of social assistance, and as compensations are reduced by applicants' income, it is primarily used by old people on small income. Dependent elders with higher income often prefer to pay a private helper, where they can make a tax deduction (DREES 2005b). Interestingly, when APA is used to compensate family (11 % do so), the clients receive more help at all levels of dependency than when relying on professional help (DREES 2004). It is noteworthy that it was not primarily the needs of the elderly and their carers but other political forces that helped create these two different responses, insurance in Germany and social assistance in France. Notwithstanding the economic recession of that era, conservative welfare states did extend their support to caring families (Morel 2005).

It is probably common that carers lose pension points because care-giving interferes with work, and especially for women (Evandrou & Glaser 2003). A few countries provide carers with 'points' towards their pension and two countries (Malta /259 cases/, Norway) have a special pension for a small minority of (ex)carers. Eligibility was always restricted in Norway and it is now being phased out.

Norway and Sweden also have traditional care allowances, decreasing in numbers, that compensate carers, used at the discretion of the municipality. Some municipalities remunerate many carers, but most few or none and there is no right for the carer or the cared-for person to get this allowance. For example Denmark never had it, but Finland in 2006 introduced an extensive system to compensate carers, with a contract between carer and municipality, a pension plan, accident insurance, regulated time off (then a professional carer will intervene) and a minimum compensation of 300 euro (taxable income). Sometimes, as in Denmark with needs for household help and in France with the program *accueil familial*, there is an administrative possibility to hire a family member to provide help, but this mostly remains a theoretical option. More or less experimental or ad hoc schemes exist in several countries. Thus some Spanish communities pay carers (nearly ten thousand in 2001) but only if they are long-term residents (and hence tax-payers, presumably) of the community, are on low income and caring for someone 65+. Some countries may give tax reliefs or deductions for

expenses for carers and/or for cared-for persons with various restrictions like being co-resident etc. (Belgium, France, Israel, Poland, Spain, UK), and it is nearly the only form of support to carers in Greece.

Care credits exist in some countries, implying a deferred gratification to carers, whereby their pensions may be somewhat enhanced. German and Italian co-resident carers may enjoy care credits, and some British carers also receive pension credits depending on program and amount of care. The few Norwegian and Swedish family members (in Sweden ca. 1 800, down from 19 000 in 1970) who are employed as *pro forma* Home Helpers receive pension credits, as with any other income, but the small wages paid translate to very marginal improvements.

Financial compensations to carers may be a mixed blessing. In many countries – less clear in the Nordic ones – family carers are often underprivileged and poor (and women). A compensation may then improve their situation, but may also ‘trap’ them in this situation. Outcomes should be assessed individually to make sure that the dependent person receives adequate care and the carer is not overtaxed. There may also be consequences such as an underdeveloped service sector: it is reported that the attendance allowance in Austria led to a price rise for social services (Evers, Leichsenring & Pruckner in Payments for care 1994). Risks such as ‘trapping’ especially female carers in the home should be considered and are indeed discussed by professionals in the field (for an example IMSERSO 2005a, b). One review concluded that payments that co-exist with reasonable coverage of other services may be the best, as they provide some measure of choice to both giver and receiver of care (Millar & Warman 1996). A thorough study of carers in England and Wales concluded that support for carers is also a way to support a socially and financially underprivileged group (Young, Grundy & Itlal 2006).

### **Private or ‘marketized’ solutions to needs for care**

Traditionally and still today, the family remains everywhere the most significant provider of care for the sick, frail and elderly. This does of course not always imply pure altruism and old people often want to balance their situation of dependence. The boundary between ‘pure’ family care and care that is in one way or another compensated is frequently somewhat blurred. In the past, in the Nordic countries and elsewhere, many old people used their property (if they had any) to safe-guard their subsistence and potential needs for care in old-age. Real estate, mostly, shifted hands at a price typically below market value against a legally binding, often very detailed contract about housing, food and heating that could also include ‘loving care and a decent burial’ and sometimes stated that the receiver was free to hire a private maid at the estate’s expense, should conflicts arise. This option, *undantag*, was of course not open to everybody in a semi-proletarized, rural society, but was used by about 10 % of the elderly into the 1950s in Sweden. In Finland and Norway remnants of this system still survive although considered obsolete. These arrangements border on the issue of inheritance and legal obligations discussed above.

Similar arrangements with owner-occupied apartments or other property, are known in Austria and seem to be frequent in Bulgaria (where it disqualifies for public services), Hungary, Poland, Slovenia and Spain and probably elsewhere as well. At

least Poland and Spain have recognized legal procedures for this. These arrangements are common also in Greece, but without any legal safeguards: old people then ominously have "no legal recourse if this care is not forthcoming" according to their EUROFAMCARE report. There are allegations that arrangements of this type can be misused and that dependent old people have been exploited, as in the Hungarian scheme of matching old people long on housing but short on care with young people who needed somewhere to live. The Bulgarian report indicates that transfer of property for financial support and/or care – which also precludes any social services – may worsen conflicts and indeed lead to premature institutionalization. Some of this was in the past also said in the Nordic countries about the *undantag*, a word still used metaphorically about someone marginalized or exploited.

A related problem is the weak financial position of old people in several European countries. Sometimes they possess property but are short on cash. Attempts to introduce equity conversion schemes have mostly been unsuccessful. Old people often refuse to convert their property to get additional social security or more care (Slovenia). In France the *rente viagère* is a legal arrangement to buy property from an unrelated person and pay him/her a life-long rent, getting access after the death of the seller. It is not known how common these arrangements are. Banks and other institutes of finance and insurance trade similar commercial products. This, of course, is an option for those elders who prefer to find a financial alternative outside of the family. Insurance companies in France and Germany have also attempted – with limited success – to sell private long-term care insurances, which would theoretically relieve families of some worry about their parents' old age., an argument also used in the marketing of these products.

In countries with little public services many families employ private live-in or other carers, mostly to help out with household tasks for elderly relatives. This is reportedly very common in Greece (estimated at 300 000), Italy, Portugal and Spain, but also frequent in Austria, Bulgaria and France. In Germany it is said to be common to use money from the care insurance for this purpose, it may just about cover the cost of a live-in maid, if hired 'black'. Hired help is also common in Spain, where they make up 9 % of the carers for old people. Frequently these carers are migrant workers, who may or may not be legally employed (IMSERSO 2005b, Hillman 2005).

The extent of a black market for these services sometimes causes concern. In Italy one can make deductions from taxable income (maximum 1550 euros) if help/care is provided by a legal private carer. An amnesty in 2002 tried to put an end to illegal immigration, but finally exempted one 'maid' per family, needed to help sick family members. France has a similar arrangement, to combat black market work and to raise employment. Germany has this option for persons who are 60+ or disabled (up to 924 euros tax deduction: non co-resident family members may be hired, but a legal employment must be established). The legal procedure is complicated for these 'household-near services'. At least Greece and Spain tend to look favorably upon the contributions by migrant workers as a means to provide care, but the system remains somewhat controversial. Spain has done a major study of these workers (IMSERSO 2005b). Israel is another country that hires many low-paid foreign carers, many of them Filipinos. The government tries to control the ca. 83 000 carers through a permit system, and in some rare cases an insight into the situation from the cared-for person's perspective is offered (*Haaretz* March 2 2006).

Similar arrangements were common in the not so distant historical past in the Nordic countries (and elsewhere). Maids were hired to provide the actual care of elderly relatives, well-off families hired nurses. The situation looked like 'family care' to the outside world and it often was, financially. Examples could be found in the advertisement section of Swedish ladies' journals up to the 1940s. In 1954, 3 % of older Swedes had their own live-in maid-servant and about 1 % used public Home Help.

### **Indirect support to carers**

Services provided by the market and/or the state are alternatives to or supplements to family care. This is clearly the case with institutional care, but also with Home Help and other services for persons living in the community, such as transportation services, meals-on-wheels, home adaptations etc. As indicated, these services can be seen as indirect support to caring families, at least when not rationed to only benefit old people short of family. If services are publicly financed, we consider them to be public.

The concept Home Help in some countries covers only 'home making' (such as in Denmark and Norway and several other countries) and there may be another Home Care program that provides personal care. In Finland and Sweden public Home Help is an integrated service that officially does 'everything' except purely medical treatments (but frequently also that), in other countries it may give very limited help with household chores. These and other administrative distinctions complicate any comparison, further worsened by a plethora of providers in some countries, where people may use more than one of them. In Britain, fewer than in the Nordic countries have Home Help, but a remarkable 8 % of older people report a home visit by a doctor in the last 3 months (25 % of the 80+). In Sweden that statistic, if it existed, would be very close to 0. Coverage statistics should also be supplemented with information on whether the service provides round-the-clock help including week-ends etc.

Statistics on these forms of support is mostly scarce and flawed, but levels of public services are generally higher in the northern parts of Europe, where many countries provide 5 - 10 % or more of older people (65+) with public Home Help; Denmark 15 % and Iceland 20 %. Many countries in southern Europe report rates around 1 % or less and some lack these services nearly altogether, though Spain appears to be an exception with 4 % of elderly people using Home Help and another 2 % or more using other community services (for example, 3 % have 'teleasistencia' and 0.5 % use day centres), but not Home Help. Other significant services, which often go unnoticed in the statistics, are intermediate types like day care and day centers for dementia sufferers, that may relieve carers.

Home Help users get on average 10 or 15 hours/week in Israel and for example 16 hours/month in Spain and 32 hours/month in Sweden, but the distributions are very skewed in both the latter countries, with a few 'heavy' clients using most hours. Medicalization of services is an issue in many countries. For example, the heat wave catastrophe in France in 2003 called forth changed financing of APA and services

became more medicalized. Geriatrics was recognized as a speciality and now play an important role in the local social welfare agencies (CLIC). The heat wave also made it clear that many old people in France live alone and lack a carer: many succumbed as no one monitored their situation (Crumley 2003).

As mentioned, all European countries have problems, sometimes big, with coordination between social services and health care and many countries are plagued by quality problems and staffing difficulties in these services. Coverage rates are generally considered unsatisfactory in country reports from southern Europe and also the number of hours provided to clients, accessibility of the service in evenings/nights and week-ends etc.

Simple coverage rates for individual countries are presented in Table 4. Targeting of Home Help and other services differs: in some countries these services are means-tested, in others they are for anyone in need, but with fees graded by income, for example in the Nordic countries (or free: Denmark, so far). Users are often old people who live alone (80 – 90 % of the users in Nordic countries), and it is not uncommon to focus services on people on low income and without a family to care for them. In southern Europe users sometimes live with or near family, who are busy in the daytime (Slovenia expressly mentions this). A criterion of very severe dependence may also apply. To disentangle the degree of 'overlap' between various forms of services is statistically tricky, and is reported systematically only in Britain. There 5 % use Home Help and 5 % some other service but not Home Help (2001). We estimate from survey data that these proportions are 9 % and 8 % respectively in Sweden (2004).

The degree of division of labour between family and Home Help is typically nebulous, though some countries report that there may indeed be agreements between family carers and the public services as to who does what, hence producing a significant overlap between these providers. In the Nordic countries the issue has surfaced in recent years of cutbacks in public services. A systematic comparison of care patterns for the 75+ in the international OASIS-project found that the overlap between formal and informal care was largest for frail persons in Norway and England and rather small in Germany, Israel and Spain, where more old people had help *either* from their family *or* from the state. In Israel and Spain proportionally many used private paid help (Daatland & Lowenstein 2005).

There are also individual studies that allow us to look closer into possible synergisms of the two spheres. In a German study of older persons with needs for care 55 % received help only from their family, 8 % only professional care and 28 % both (and 9 % privately financed help)(Infratest Sozialforschung 2005). The pattern of care is relatively similar in Sweden, with 58 %, 15 % and 23 % respectively; 5 % have neither, but may have other support (Socialstyrelsen 2005). For the UK, one study indicates 53 %, 9 % and 34 % respectively (Comas-Herrera et al. 2003, after OECD 2005). One French estimate arrives at 50 %, 21 % and 29 % respectively (EUROFAMCARE), another, for very frail old people, sets the proportions at 50 %, 17 % and 33 % respectively (Breuil-Genier 1999). Similar results are reported in a British study (Rands 1997).

**Table 4. Home Help use and institutionalisation rates of older (65+) people in selected European countries around year 2000.**

	Coverage rates (%) of Home Help <sup>a</sup>	Institutiona- nalization	Year
<i>Nordic</i>			
Denmark	15	8	2005
Finland	11	4	2002
Iceland	20	9	2001
Norway	13	6	2004
Sweden	9	6	2005
<i>Northern</i>			
Belgium/Flanders/	10	6	2004
Britain	5	5	2003
France	5	7	1998, 1996
Germany	7	4	2003
Luxembourg	5	7	2003
Netherlands	14	7	1999
<i>Southern</i>			
Austria	15	4	2000
Greece	<1	<1	'present'
Ireland	5	5	2000
Italy	c. 1	c. 1	'present'
Portugal	n.a. but low	4	2001
Spain	4	4	2005
<i>Non-Categ.</i>			
Bulgaria	n.a. but low	n.a.	no info.
Czechiya	n.a. but low	n.a.	no info.
Estonia	c:a 3	c:a 2	2005
Hungary	c:a 5	n.a.	2000
Poland	<1	n.a. but low	'present'
Slovenia	c. 1	4	'present'
Switzerland	5	7	2000
Israel	16	4	2004

a. Public(ly financed) services with household tasks and/or personal care.

Note: In spite of our attempt to cover the whole panorama of care and services in the community, variations may often reflect organisational as much as substantial differences. For example, Norwegian Home Help mostly provides household help and an independent organisation helps with personal care (and also more or less regular home health care etc.). This is likely to 'blow up' public services for the elderly in Norway, as compared to Sweden, where one single organization provides both household help and personal care. On the other hand, many old people in Sweden only use transportation services or some other service, but *not* Home Help. In Denmark, with more extensive Home Help, few old people seem to rely *only* on these 'other' services.

Sources for Table 4:

Denmark, Norway and Sweden: our own computations on national social service statistics\*

Finland: communication from professor Marja Vaarama, University of Lapland, Rovaniemi

Iceland: TemaNord 2005

Flanders: Benedicte de Koker, University of Antwerpen

Britain: personal communication from Care Equation, Britain

France: Home Help - DREES 2000 own computations; institutional care – Rostgaard & Fridberg 1998  
 Germany: OECD 2005  
 Luxembourg: Home Help - OECD 2005; institutional care - EUROFAMCARE  
 The Netherlands: Social and Cultural Planning Office 2001  
 Austria: OECD 2005  
 Greece: EUROFAMCARE  
 Ireland: OECD 2005  
 Italy: EUROFAMCARE  
 Portugal: C. Goncalvez INE  
 Spain: M. Sancho Castiello, IMSERSO  
 Bulgaria and Czechia: EUROFAMCARE  
 Estonia: Dr. Kai Saks, Tartu University, pers. comm.  
 Hungary: OECD 2005  
 Poland and Slovenia: EUROFAMCARE  
 Switzerland: OECD 2005  
 Israel: after Lowenstein 2006 and personal communication

A somewhat different panorama characterizes The Netherlands, where private help is common but public home care also has been high: in a group of dependent old people 28 % used informal care only, 30 % only formal care and 10 % both; another 32 % managed with private help (Social and Cultural Planning Office 2001).

A recent study of the introduction of the French APA importantly demonstrates that families continue their support as before the benefit: the two complement rather than substitute for each other and it is deemed that APA has in fact helped to increase the overlap ('mixité') between them. Three quarters of the beneficiaries have help from their families, and more help the greater the need (DREES 2006a). Similar results were reported in an earlier study (Le prix de la dépendance 1990).

It emerges then that family care is everywhere the most common source of care, and that between a quarter and a third of frail elderly persons get help both from their family and from the state in the countries we have evidence for, though they tend to be countries with relatively extensive public services. Other studies, from the perspective of the *carers*, in Norway, The Netherlands and Sweden also indicate that the persons they help frequently use public services as well. A Spanish study of carers indicates a much smaller overlap (7 %), and with many carers asking for more Home Help and other community services (IMSERSO 2005a). Danish and Swedish studies of carers report that half or more of the cared-for elders also use public services (AeldreSagen 2005, Socialstyrelsen 2006). This issue will be dealt with in more detail in our concluding comparison of Spain and Sweden.

There is thus a considerable overlap or *sharing* between families and the public services and especially when needs for care are high. In the German care insurance, combinations of cash (for family care) *and* services increase with the frailty of the person cared-for and there is increasing reliance on combined family and professional help in the French APA for the more dependent elderly. The same is the case in The Netherlands (Lundsgaard 2005, DREES 2004, 2006a, Social and Cultural Planning Office 2001). A Swedish study of elderly individuals followed over time found overlap to increase when needs increased (Socialstyrelsen 1999). In the Nordic countries all social classes use the public services and little in the way of private alternatives exist.

When we compare country rates of community services we must consider the social situation of elderly persons; how common is it for them to live alone and also whether these persons are of poorer health than average. As indicated, family patterns and

household constellations have consequences for public services, and this is particularly the case when old persons live alone.

Coverage rates of community services are generally higher than institutional care in northern Europe, though not uniformly so. In southern Europe, institutional care often has higher coverage rates than community care, in a way mirroring the situation in northern Europe some decades ago. It seems to take longer for community care to develop and get sustained financing. In Bulgaria, Italy, Poland and Greece about 1 % or less use residential care, in Portugal, Slovenia and Spain 3 % or a little more. Ireland has little Home Help and about 4 % of older people are institutionalized. The Netherlands, that used to have a vast number of various sheltered and unsheltered residences, is now down at 7 % institutionalization rate. The UK is steady at 5 % and Denmark and Iceland are remarkable for their high coverage of Home Help and a relatively low coverage of institutional care. As already mentioned, we often find big local variations in coverage rates for services although regular statistics on local/regional public old-age care exist, to the best of our knowledge, only in Britain, France, Spain and the Nordic countries.

In the Nordic countries old-age care beyond the family is mostly a public undertaking, on the continent there are usually both public and private (for profit and not) services and residences, frequently with clear distinctions between residences meant for (relatively) healthy persons and other institutions for dependent old people, implying forced moves when health deteriorates. In many countries these boundaries have begun to blur and complaints about the lack of coordination between social services and health care are universal. Several countries report that residents are increasingly very frail and dependent and tend to stay ever longer in their own home before doing a final move. Czechia retains the old system of rigid waiting lists, with many healthy older people moving into institutions.

Most European countries are in a process of adaptation to the changing profile of service users, with an increasing number of old persons who need much help with their ADL. For example, both France and Spain now face the same challenge: they have to turn 'social' institutions, often large, with residents who were there for socioeconomic reasons, into residences that provide much more care and health care and preferably small ones. Many obstacles make the transition difficult, like vested private interests in large-scale institutions. The countries in northern Europe have more or less successfully gone through this complicated process, that also requires a restructuring of the work force, training and other changes.

Except in the Nordic countries, Ireland, The Netherlands and the UK, residential care is often very expensive for the users, though a number of residents may be on welfare. Frequently there is a two-tiered system with public residences and private ones (for-profit and not). Many countries have programs for quality controls of Home Help and institutional care, but follow-up is frequently deemed as inconsistent and unsatisfactory, typically varying between providers etc. This has also been the case in the Nordic countries, with their extensive public services. Typically, Swedish authorities used to inspect only the few *private* nursing-homes. Controls may be more systematic and thorough when private providers are publicly financed to provide a service. Where private and public services co-exist comparisons are possible. In the Nordic countries private (very expensive and uncommon) institutional care may typically be of higher standing, whereas the picture is more varied in the southern

countries. In Spain public institutions for old people are reportedly of higher quality than many private ones.

Already Moroney (1976) pointed out that there is everywhere a tendency to spend most of the resources on institutional care, that is politically more “visible”. This is true also in the Nordic countries where cutbacks tend to hit home care harder and quicker than institutional care that substitutes for the family. Services that support families have been hard to establish and tend to be severed in periods of financial strictures.

### **Direct support to carers**

Several European countries have recently undertaken systematic studies of carers for elderly people and their potential problems and needs for support. As seen in Table 1 the frequency of care giving in the household varies between 4 – 10 % for the 50+. Between 13 % (Norway) and 29 % (The Netherlands) of the adult population report that they have care tasks, inside or outside their household. Caring is most common in the age span 45–64, where parent care is frequent. Country differences may be due to shifting ways to probe care and what is included in the concept. For example, many people in Spain and Sweden report that they ‘keep an eye on someone’: care can be anything – and everything – from little demanding monitoring to intense personal care.

It is commonly thought that many women are ‘squeezed’ in multiple roles: caring for frail parents, working and at the same time providing for family and small children (Moen & Chermak 2005). Slovenia reports that this is common, but data in SHARE indicates that this type of situation is (on average) unusual, affecting only some 2 % of adult subjects in their multi-country study. Similar results emerge from analysis of German studies (Künemund 2006), although this situation may become somewhat more common, with delayed ‘launching’ of the younger generation, as mentioned above (Attias-Donfut, Ogg & Wolff 2005). Also for Britain the evidence is that this is relatively rare, but becoming more common (Evandrou & Glaser 2004). In a somewhat looser sense, many women have competing obligations to their parents *and* off-spring, although it seems that most of them manage to fulfil both commitments (Grundy & Henretta 2006).

Rising female employment is often assumed to hinder family care, although the evidence for this is not strong, or at least not consistent. In Sweden, 9 % of persons 45+ with parents alive and in need of help say they can not do more for them, due to their work. Being hindered by distance is three times more common (Socialstyrelsen 2004). In Southern Europe employment is very low for men and women aged 50 and above, be they carers or not, as seen in Table 2. In the Nordic countries many people seem to both work and care. Employment may be difficult or impossible to combine with heavy care; thus an analysis of SHARE found that working women were as likely as other women to provide help, though less likely to give *regular* help (Ogg & Renault 2006). Still, care is often not ‘heavy’ and the family is a very flexible system. Hence the conflict may be smaller than frequently assumed, at least in countries with more extensive public services, as indicated in Table 2. Saying this, one should

consider the very real risk of over-burdening some carers now, and more in the long run.

The issue of work and care was explored in EUROFAMCARE, that also mapped various legal and other schemes to help carers combine paid work and family care. In a country like Sweden, with high employment rates for both men and women well into their late 50s (8 out of 10 aged 50-59 are still working), it is estimated that one employee in five is *also* a carer (Socialstyrelsen 2006). British studies report that between 14 % and 19 % of the workforce have caring duties (Rands 1997) and German estimates indicate even higher figures at about a third of the employees.

Several countries have programs meant to soften this predicament, for example a legal right to take a leave, unpaid or paid. The variations are impressive. In Austria a maximum of 1 week/year can be used for care, but there are many restrictions and compensation is low. (There is also a possibility of unpaid 'compassionate leave'.) Belgium allows a maximum of 10 days unpaid leave (any compelling reason), Czechia 9 paid days per diagnosis (!), Denmark, Norway and Germany have a certain right to paid leave at serious illness or death in the family. This also appears to be the case in Greece, but only for public employees and for a maximum of 6 days, whereas Italians can use three paid days per month all their life. Israeli carers have the right to six days of paid leave a year (deducted from their allotted sick days) to care for completely dependent parent(in-law). If they have to resign from their job, they are entitled to all dismissal benefits. Luxemburgians can use 3 weeks per year, paid by the national health insurance and Ireland has a little used program that offers up to 65 unpaid weeks leave per care recipient, with a prescribed minimum (!) of 13 weeks. In The Netherlands some unpaid leave is available in central labour agreements, but also the program Career Break could theoretically be used (employees expected to save days, that they may later use for care or other purposes). In Portugal public employees can have up to 15 unpaid days off per year to care for a sick family member over ten years old who lives in the same household (exceptionally it can be granted for a family member in another household if this person has no one else to rely upon). In Slovenia leave is granted for care of a spouse up to 7 paid days per year and up to 30 unpaid days. Spain has a program for workers of unpaid leave of 3-5 days when a family member has a disease, accident or is hospitalized and public employees in 2005 reached an agreement of up to a month of paid, reduced (up to 50 %) working hours a year to care for a 1<sup>st</sup> degree relative who is 'very seriously ill', with full salary. Yet, the evidence seems to be that few people use the option of reduced working time, as it is more advantageous to hire a (migrant) help to provide that care, which can be had for maybe 600 euro/month. Also, the above benefits don't apply to most employers (less than 250 employees), the outcome deemed to be that most care tasks still land on women, low-paid or not working at all.

Swedish employees only have a right to take a leave – certified by a doctor - when someone 'near' (unspecified) is deemed to be fatally ill or dying from an accident, providing up to 100 paid days altogether off from work per person cared for (can be shared by several carers). Neither in Spain nor in Sweden is personally provided care a necessary prerequisite. Spain also has a longer unpaid leave to care for close family, with right to maintain the same conditions of work within the first year (public employees two years). In the UK, employers have to give employees 'reasonable' time off (unpaid if nothing else agreed upon) under two different programs (Carers

Leave, Compassionate Leave). From 2007 carers can request flexible working arrangements under the new Carers' Equal Opportunities Act. Care leave is unheard of in Finland, France, Hungary, Malta and Poland. Together this illustrates the confusing variation and the limited attempts to facilitate caring *and* paid work. The programs mentioned here are reportedly often little used and certainly little used relative to the extent of care actually taking place.

A number of studies have compared carers and non-carers and for example in Spain carers frequently are non-employed or only work part time. Sometimes this seems to be due to other factors, carers being on average older, unemployed, already retired or for other reasons outside of the labour force, but many have also been forced to resign etc. due to their commitment of care (IMSERSO 2005a). In Norway and Sweden carers seem to differ little from non-carers, employment-wise or in socioeconomic terms: care is relatively egalitarian.

Notwithstanding the family obligations that apply in several European countries, there are programs in many of these countries that directly or indirectly remunerate carers for their efforts. Biggest in scope is undoubtedly the Austrian and German care insurance. The German program gives the user a choice between cash and services, the monetarized alternative frequently used to remunerate the carer (above). It has been criticized for some shortcomings, especially not considering needs due to cognitive decline, but meant a huge improvement relative to the situation before its introduction in 1997. Interesting is also the care payment recently introduced in Flanders, Belgium. Most users appreciate the program and more the larger their commitment, the higher the age of the carer and the longer the kin distance between provider and cared-for person (Jacobs 2003).

Attempts to probe attitudes to remuneration of carers come to diverging conclusions. Some studies have found that carers prefer services rather than cash, whilst a Norwegian survey found a greater interest in cash compensation (Lingsom in Payments for Care 1994). Caring is common in all social layers, but opinions on payments are diverging. Researchers seem mostly to conclude that financial compensations are unlikely to bring forth more informal care, but that they may still be a valuable support to carers who more often than not live with narrow financial margins (Payments for Care 1994).

Norway and Sweden remunerate a small and shrinking (5 000 in Sweden) number of carers. The Swedish program was introduced in the 1960s, when a government commission found that many women – often never-married - in their 50s and 60s were on welfare, after caring for their old parents for a long time. In this way one recruited personnel for the notoriously under-staffed Home Help service and could monitor the situation of the person cared for: being Home Help clients, their situation should be evaluated regularly. The intention, mostly failed, was to make these carers work also for other old people, at the same time or after the death of the person cared for. Implementation always differed drastically between municipalities. Finland has recently (2006) formalized an experimental program, to reimburse carers at a larger scale, now (2004) about 28 000 persons and set to grow. Carers, who must be family or “close”, conclude a contract with their municipality that regulates the compensation (from 300 to 600 euros/month), provides two days of relief per month, social security and insurance. The program is tailored for ‘heavy’ care, persons with smaller needs

for care and their carers are said to be better helped in other ways. Municipalities can reclaim 33 % of their expenses from the state.

The British special program called Direct Payment covers only about 1 in 10 000 of the 65+, corresponding to about 1 % of service users in this age group. The vision is to expand this considerably (Department of Health 2005, Davey 2006). The Swedish program covers 0.1 %, the Netherland's personal budget program 0.8 % and so on: these program are all quite restrictive, though support may reach more elders and/or their carers if the whole panorama of various allowances and programs are considered (OECD 2005). Still, the modest scope of these programs make little change in the over-all panorama of care, with the possible exception of Home-Care Grants in Ireland, due to the limited access to any other service in that country (Timonen, Convery & Cahill 2006). It should also be mentioned that many countries have respite care/day care to relieve family carers, though generally considered insufficient. There are also scattered initiatives such as training programs for carers.

Importantly, a thorough analysis of carers in England and Wales found that carers with heavy commitments are frequently over-represented in disadvantaged segments of the population; providing financial (or other) support for them may then be a way to address social inequalities (Young, Grundy & Itlal 2006).

### **A comparison of Spain and Sweden: carers and cared-for old people**

We have studied the variations in European household structure, family care, legal obligations and market alternatives that may or may not affect needs for state substitution for family and/or support to families, where institutional care and Home Help respectively are the two main types of state intervention. Community care is generally agreed upon to be the most important resource in an era when official policy is that old people are expected to remain at home as long as possible. To learn something about the forces that shape care - informal and formal - for old people we have singled out two European countries that are geographically distant and can be seen as opposites in most regards, Spain and Sweden. They differ in terms of religion and tradition, family and household structures, in their social services and naturally also in their social policy, family oriented in Spain and very individualistic in Sweden. In both countries many people believe the family to be decaying and no more able to fulfil its traditional tasks, including care for old family members.

Some recent shifts in both countries call both self images into question. Spain has found their services to be unsatisfactory and launched ambitious investigations to assess the situation of old people and their carers (1993 and 1994 respectively and again in 2003 and 2004 respectively). A comprehensive Plan Gerontologico set out to reform old age care already in 1993 and some notable progress has been achieved (Table 4). Sweden, on the other hand, seems to have reached the ceiling of her public service capacity, although a new national plan in 2006 will further investments in institutional care, raise competence of staff and support family carers, now timely found to be the back-bone of care.

From a comparison of Spain and Sweden we may gain insights into some unexpected similarities in seemingly different societies which, if present trends continue, are

bound to have converging service coverage in the future. In both Spain and Sweden recent large surveys permit us to paint a portrait in some detail of family members who give help to old persons and elderly people who receive informal care. It is instructive to compare these countries as Spain is trying hard to expand her services for old people and a new law to cover 'dependency' (for adults of any age) is launched successively from 2007, with ensuing big improvements in services and expanded programs to compensate carers financially. Sweden, on the other hand, has been on a trajectory of cutbacks and increasingly rationed services for elderly persons over the past 10-15 years and financial support to carers that was common still in the 1970s has nearly ceased. The implications for the Home Help services and their clients in Spain and Sweden have been studied (Sundström & Tortosa Chulía 1999). Recent data show that coverage rates increase rapidly in Spain, but has lower 'intensity' of care, whilst Sweden has had the opposite tendency: shrinking coverage rates but higher intensity of help (16 vs. 32 hrs help/month/client).

Relevant for this comparison is the fact that older people increasingly live alone in Spain (22 % 2003), in Sweden this culminated at about 40 % in the 1980s (Table 1). A large group of old Swedes are married/partnered only, a life-style that is increasing also in Spain but still less common. As shown in Table 5 it is noteworthy that old Swedes who live alone on average need help more often (28 %) than co-resident old people (17 %). In Spain, they need help about equally often (21 vs. 19 %). We may note that in Spain old people who live with 'others' are on average the single frailest group (analysis not shown here). This group is nearly non-existent in Sweden.

Given these socio-demographic differences, old people who need help often live with family (or others) in Spain, but frequently live alone in Sweden. It is estimated that five percent of Spanish households house one or more dependent old people. Earlier research has shown that older Swedes who live with family (for 96 % just a spouse) rarely use Home Help. The big bulk of Swedish services goes to persons who live alone and indeed the Social Service Act states that municipalities have to provide help when someone "has a need that can not be seen to otherwise". To assess how well services target old people in need it is therefore crucial to define 'need' in a reasonably comparable manner.

We here use old persons who *live alone and need help with their ADL* (activities of daily life) to compare targeting of Home Help services in Spain and Sweden in Table 5. Firstly we note that 3 % of all old persons in Spain use public Home Help as against 8 % in Sweden. In both countries those who live alone are more likely to be service users, 7 % and 15 % respectively in Spain and Sweden. Among co-resident old people only 2-3 % use Home Help in either country. Needs for help with ADL as measured here (as similarly as possible with our data) are about as common in Spain as in Sweden (20 % and 21 % respectively). Old persons who need help more often use Home Help, 9 % in Spain and 37 % in Sweden. Even among co-resident persons, their use rates are higher: 6 % and 19 % respectively. The service use of *frail persons who live alone* is as expected still higher: 18 % of old people in need of help and who live alone get Home Help in Spain, as against 54 % of a similar group in Sweden.

**Table 5. Use of public services (Home Help) among old people 65+ living in the community in Spain (2004) and Sweden (2002-03), by household structure and by need. Per cent**

	Living alone		Co-resident*		All	
	Spain	Sweden	Spain	Sweden	Spain	Sweden
All	22	39	78	61	100	100
Percent who use Home Help	7	15	2	3	3	8
Percent who need ADL** help	19	28	21	17	20	21
<i>Whereof use Home Help %</i>	<i>18</i>	<i>54</i>	<i>6</i>	<i>19</i>	<i>9</i>	<i>37</i>
<i>N</i>	<i>83</i>	<i>392</i>	<i>323</i>	<i>349</i>	<i>406</i>	<i>741</i>

\* any relationship

\*\*Ns refer to those who need help with ADL, defined as needs help with one or more of the following ADL-tasks:

Spain - shopping, cooking, bath/shower, outdoor mobility, (un)dressing, indoor mobility

Sweden - shopping, cooking, cleaning, laundry, bath/shower, (un)dressing, get into/out of bed.

Sources: our own computations on Encuesta de Condiciones de Vida de los Mayores 2004 for Spain, and on Statistics Sweden Level of Living Surveys 2002-03 for Sweden

In other words, after correcting for living arrangements and frailty, it emerges that public services target many more old people than we can deduce from the raw national averages, in both Spain and Sweden. Yet, for the most critical group, those who live alone and need help, the service still reaches out to just a minority in Spain and they often report that they need more help (analysis not shown). In Sweden public Home Help targets a little over half of the eligible recipients. This implies that most of them will need help from other sources both in Spain and Sweden. A special analysis of the data for Sweden verifies that most eligible persons who live alone but do not use Home Help, have rather small needs and usually get help from their families. Persons with big needs for help much more often use Home Help. Few report unmet needs (analyses not shown).

This takes us over to the important issue of the degree of interplay and overlap between what the family and the state is doing respectively for old people in need, in Spain and Sweden. This is described in Table 6. It should be observed that for Spain these tabulations had to use other items than in Table 5, which explains some discrepancies between the two tables. (The questionnaire enumerated who was the most important helper, next most important and so on; from this were deduced the configurations in Table 6.) It is likely that this has led to some underreporting of overlap of family help and public support, but it may not seriously distort the major patterns.

Once again we in Table 6 discern differences, but also some similarities. The family is the main resource for help both in Spain and - though somewhat less often - also in Sweden: 73 % and 58 % respectively of old people who need help rely on their family *only*. In Spain just one per cent rely on Home Help *only*, in Sweden a substantial minority of 15 %. To get help *both* from family *and* from Home Help is more

common than relying on Home Help only in both countries: 5 % in Spain and 23 % in Sweden benefit from overlapping care. Noteworthy is the large group (20 %) in Spain who use neither family care nor Home Help. Most of them (17 %) hire private help: there are an estimated 1 million care givers for old people in Spain and about 100 000 private helpers, often immigrants (IMSERSO 2005b). In total, help from family is forthcoming about equally often in Spain and Sweden: 78 % and 81 % respectively. The important difference is the degree of overlap with public services, which is much bigger in Sweden, and the use of private help, much bigger in Spain.

**Table 6. Home Help and family care among old people 65+ living in the community and who need help, Spain (2004) and Sweden (2002-03), by household structure. Per cent**

	Living alone		Co-resident		All	
	Spain	Sweden	Spain	Sweden	Spain	Sweden
Old people who need help* %	19	28	21	17	20	21
<i>Thereof helped by</i>						
Family only**	65	38	76	78	73	58
Home Help only	5	24	--	5	1	15
Both	6	30	3	15	5	23
Neither***	--	8	19	2	20	5
Sum	100	100	100	100	100	100
N	83	392	323	349	406	741

\*Need help with one or more ADL-tasks, help received refers to the same ADLs as in Table 5.

\*\*or other informal care

\*\*\*but may have other sources of support: in the Spanish case in total 3 % report having no one to help and 17 % "others" (mostly a private live-in helper or other private arrangement)

Sources: our own computations on Encuesta de Condiciones de Vida de los Mayores 2004 for Spain, and on Statistics Sweden Level of Living Surveys 2002-03 for Sweden

A closer look at Table 6 reveals that help uniquely from family is the biggest single provider even among old Swedes who live alone (38 %). For them off-spring – mostly daughters – are the main providers of help. Yet, this is more clearly the case in Spain, where family dominates the panorama absolutely with their 65 %. For co-resident old Swedes the carer is usually a partner, and there are in absolute numbers equally many male and female spouse carers in Sweden. In comparison, Spanish wives are about two times more likely than husbands to care for their partner. (Also in couples only households wives are more likely than husbands to be carers, when the partner needs care.) Other family than the spouse may be more active in these cases in Spain, reflecting that more old people there live with their off-spring or other family (above and analyses not shown).

In spite of the substantial differences in demographic structure, household arrangements and actual care patterns between Spain and Sweden, preferences for care in the general population are largely in favour of public responsibility *in principle*. Table 7 uses for Sweden a population sample 45+, where 32 % still had parents alive and 11 % had parents who needed help, but other surveys also show vast support for public involvement. Families don't want to abandon their elders, but they desire to share the task of providing for them with the state. Table 7 also indicates that families bear the main responsibility in Spain (84 %); in Sweden they mostly share it

with public services (38 % main responsible). Actual carers want the state to take on a much larger share of responsibility in both countries, but from different levels. Spanish carers (still) have rather modest wishes. There is a remarkable discrepancy in both countries between actual patterns of care and how carers would prefer them, but also a clear distinction between Spanish and Swedish patterns of care. They are, again, mostly family based in Spain, although a change appears to be under way: a national survey in 2004 found that 68 % wanted the state to provide all or most care of old people and only 5 % were for total family responsibility. In the same survey, 31 % said that they wanted more community services and 17 % financial support to family carers. For their own part, 73 % said that they in case of permanent needs for care wanted to remain in their own home rather than institutional care or other solutions (CIS 2004).

**Table 7. Division of labour, actual and preferred, among carers of old people\* in Spain and Sweden, 2003-2004. Per cent.**

<i>Care is</i>	SPAIN			SWEDEN			
	Carers*		Popu- lation	Parents need help		Family is carer**	
	Actual	Desired		Actual	Desired	Actual	Desired
Mostly or partly public	14	28	68	54	80	--	70
Mostly or partly family	84	72	31	38	16	100	28
Other, don't know etc.	3	--	--	6	4	--	3
Sum	100	100	100	100	100	100	100
<i>N</i>	1.504	1.504	2.496	117	117	68	68

\* in Spain carers of elderly persons, any relationship; in Sweden persons 45+ who have parents alive and care patterns for these parents.

\*\* Any person in the family that provides care to parent(s), alone or together with public services.

“Partly public” connotes principle responsibility for the public services, with the family contributing in the care; “partly family” the opposite constellation.

Sources: Spain – Encuesta de Apoyo Informal a los mayores en Espana 2004 and (population 18+ sample) CIS 2004.

Sweden – raw data for Socialstyrelsen 2004 (national, representative survey of the 45+ undertaken in 2003). Our own computations.

The remaining differences in preferences between Spain and Sweden probably reflect that families are indeed carrying a larger share in Spain, but preferences may also be affected by what is available of public services for old people. The Eurobarometer survey in 1998 found a much higher acceptance of institutionalization of frail old parents in Sweden than in Spain (and other southern countries), but also higher support of old Swedes staying put where they are, rather than moving in with family etc. The international OASIS-study found 61 % of the Spanish 75+ to want public services to cover increasing needs of old people in the future, as against 89 % in Norway (Daatland & Herlofson 2004). Sweden was not part of that study, but an explicit question on who should do more for ageing parents confirms that Swedes aged 45 and above with elderly parents in need of care want the state to take on more responsibility, not less (Table 7 and Socialstyrelsen 2004).

## Discussion

Family care for old people is the most common form of care in all European countries, in spite of widely varying household patterns: old people in the Nordic and Northern countries more often live alone and rarely co-reside with off-spring or other family than their spouses. The trend of solitary living has levelled off in the North, but is picking up speed in the South. The Nordic and Northern countries have more overlap of family care and public services, at least when needs for care are extensive. These countries have relatively high coverage rates of Home Help (and other types of community services) and institutional care, but struggle to upkeep them and in some countries, these rates have begun to decline.

Spain energetically expands her public services to old people, but as the comparison with Sweden shows even quite generous systems tend to provide help primarily to persons short of family ties. Countries that have less of public services frequently have more financial support for family carers than countries with high coverage rates. Hence, family carers are either supported indirectly – by availability of public services at large – or directly, by financial compensations, if at all. Under both regimes, many carers stand alone with their commitment.

The introductory overview tried to depict the confusing and ad hoc character of programs to support dependent old people and/or their families that have evolved in European countries. This was also the conclusion of an OECD study that covered several European and some non-European countries. Programs seem rarely to be the outcome of rational considerations, but may rather reflect more profound distinctions and many European countries strive to establish ‘images’ of the actual and desired relation between state and family in care for old people..

There are the relatively affluent and (benignly) paternalistic societies like the Nordic ones, the Netherlands and UK, that primarily provide in kind support to carers (services) and reasonably adequate pensions to most citizens. Another group is those countries where support is mainly financial, be it to carers and/or to cared-for persons, with Austria and Germany as prime examples. There is lastly a number of countries where many old people have very small or no (Poland) pensions. The predicament of small or no incomes frequently holds also for the carers, as witnessed by several studies.

Some form of care insurance may be an option when it is felt that taxes can not be raised further. This seems to have been a motivation in Japan, where only in-kind services can be purchased, for fear that families will else hoard the money (low consumption has plagued Japan for some time). Also in Sweden, with the world’s highest taxes, this has been an argument for an insurance: an ‘ear-marked’ tax is more palatable when there is a guarantee that it will benefit the payer (any public, compulsory deduction of income is technically a tax). An insurance and/or a general remuneration for carers has been brought up in Sweden but is politically not (yet) an attractive option, though discussed in some quarters as a future alternative.

A critique of the German care insurance, probably valid also elsewhere, is that it doesn’t cover care costs fully; hence many dependent elderly still have to rely on

social welfare. Another critique concerns elderly persons suffering from cognitive decline, where needs assessments do not always capture actual needs for supervision and care.

The concluding section relies on specific data for Spain and Sweden, which are interesting because service provision has shrunk in Sweden in the last decade, but expanded in Spain, where it is set to continue that way, after a decision on new legislation for a law of dependency. There shall also be financial support for about 300 000 carers (*El Pais* April 22 2006). It should be noted, in this context, that popular support for government ‘responsibility’ does not necessarily mean a desire for major state provision of defined volumes of care, but an expectation of a reliable presence of services *when they are needed*. This is obviously most critical for frail old persons living in the community. It was very helpful that the British census in 2001 asked about care-giving, hence all municipalities can provide information on this for family-carers and their support groups etc. and often do so on their websites.

A sizable ‘overlap’ between the family care and public services seem to be a workable road to safeguard care, formal and informal, and also implies support to carers. It emerges from international studies that *sharing* between families and the public services is often the preferred situation, both by the elderly and by their families. This may be especially true when needs for care are high. Yet, we may also ask whether the users of services and recipients of family care really want to be objects of planned coordination? In spite of all the aggregate statistics and a more near-sighted analysis for Spain and Sweden, it is worth remembering that each family is a microcosm of its own, with its own transactions and relations of power that influence exchanges of care and/or use of public services (Pyke 1999). Some important contributions have begun to assess the ‘overlap’ of family and state and possible synergisms between these providers for old people and more will be needed.

The specification of household arrangements and needs done in the Spanish-Swedish comparison provides for a better comparison of service coverage rates than can be done than by inspecting over-all rates of services in Table 4. Another, related aspect is that coverage rates - even when ‘adjusted’ for household structure and frailty - give a less than ideal representation of goal attainment. Ideally one would like to know also the ‘turnover’ of users and how many of those in need who eventually are reached by services. For example, coverage rates of Swedish services are shrinking, but a rising proportion is finally reached by public services: ca. 15 % were eventually institutionalised in 1950, 30 % in the 1970s and about 50 % or more today; before this residents normally use Home Help. By implication, this means more family (indirect) support, though on average of shorter duration. The lesson is that what matters is not just the resource allocation and coverage rates, but also how these resources are used.

Some data indicate a growth in informal care (Sweden) and it is noteworthy that old people who have off-spring typically often have them quite close. Of course, the major need is to support dependent elders living at home, not to risk premature institutionalization. In all European countries that we have evidence for, the preference of old people (and their families) is for independent living. This is of course influenced by actual living arrangements, but already in 1987 77 % of the French elderly said that they wanted to remain in their own residence and only 4 % wanted to live with off-spring if necessary (SOFRES 1987). Similar proportions are

reported in Spanish studies in 2004 and in the EUROBAROMETER surveys. In the OASIS-project it was found that 7 % in Israel and Norway, 10 % in Germany, 16 % in the UK and 38 % in Spain preferred to live with off-spring (Daatland & Lowenstein 2005).

Even in countries with extensive community services it is felt that targeting may be less than efficient and unnecessary institutionalisation occurs. It appears clear that no European country has as yet a perfect model of support to family carers, be it direct and/or indirect. This should not surprise us, as most countries still spend a small fraction of their GDP on dependency. The experience of the Nordic countries indicates that there is a ceiling to how much will be used for this purpose. Except for the UK, there is little in the way of citizen rights for carers; they are for example not covered by appeal rights in Sweden. Another lesson is that it is not only resources that count, but also how they are used. Institutional care is expensive and benefits few people (who may have little family support), whilst the same resources used for community care may help many dependent persons *and* their families.

From the comparisons it emerges that increased public responsibility may indeed help to maintain family solidarity, as seen in the Nordic countries. Yet, most countries suffer from poor coordination of social services and health care and there is a need for evaluations and quality controls. In many countries these services are fragmented on many providers and internal specialisation. Staff training will be a major issue, and the more developed providers now try to address quality rather than quantity. Quality, consumer choice and empowerment, new initiatives and normalization of care for the most dependent persons are bound to be important issues in the near future. Intermediate forms of care, home adaptations, day care, technical aids and other innovations will also be of greater significance, as they facilitate life for old people but also for their families. For the Nordic, Northern and Southern models of care to be sustainable, family, state, market and voluntaries all need to contribute.

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