Long-Term Care for the elderly

Provisions and providers in 33 European countries

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Table of contents

Country Abbreviations

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
FYROM	Former Yugoslav Republic of Macedonia
HR	Croatia
HU	Hungary
IE	Ireland
IS	Iceland
IT	Italy
LI	Liechtenstein
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	The Netherlands
NO	Norway
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
TK	Turkey
UK	United Kingdom

List of Figures

List of Tables

Appendix of Figures

Appendix of Tables

Executive summary

Aims and scope. The core objective of this report is to analyze long-term care for the elderly in Europe (LTC or long-term care henceforth) from the twin perspectives of female employment and gender equality. The focus is on provisioning rather than financing and expenditure, provisions in kind such as institutionalization or personal care delivered at home, monetary provisions such as care or attendance allowances, and time-related provisions such as leave off-work or the right to flexible hours. Based on the reports of the national experts of the EGGE network, a comparative analysis is conducted on 33 European countries including the 27 EU Member States, the 4 candidate countries - Croatia, the Former Yugoslav Republic of Macedonia (FYROM), Iceland and Turkey – and 2 EFTA countries, Norway and Liechtenstein.

Women are the main stakeholders in the provision of long-term care. On the demand side they account for the majority of beneficiaries: on the supply side they are still largely overrepresented among caregivers, paid or unpaid. Availability, affordability, and quality of provisions affect women, and men, in their role as potential beneficiaries. On the supply side, persisting over-representation of women among informal care givers compounds the extreme feminization of care workers and professionals. Whilst the pronounced feminization of long-term care work opens up employment opportunities for women in a rapidly expanding sector, it raises important concerns about gender equity in the labour market, as well as within households.

The analysis conducted in this report focuses on issues concerning availability, affordability, and gender equity. Besides the national reports from the 33 experts in the network, five main sources of information are used in the compilation of statistics: the 2009 Ageing Report from the European Commission, the EU-SILC survey, the Survey of Health, Ageing and Retirement in Europe (SHARE henceforth), OECD Health Data, and the recent collection of facts and figures on long-term care by Huber et. al (2009).

Background trends. According to the European Commission's 2009 Ageing Report, the scale of the expansion in future demand for long-term care is impressive even under moderately conservative assumptions (**Chapter 1**). With people older than 79 expected to triple in numbers by 2060, the long-term care segment will be one of the drivers of this expansion over the next fifty years or so. Future demand for long-term care services is subject to some uncertainty

because of contrasting evidence on disability trends, compounded by a lack of agreement on what exactly constitutes disability in old age. As found by a 2007 OECD study by Lafortune and others, in some countries the prevalence of disability has been increasing over time, while in other countries the opposite has been the case. In view of this contrasting evidence, the so-called 'demographic scenario' in the EC Ageing Report is prudent and assumes no change in the current prevalence of disability. Adopting the further assumption of no change in the probability of receiving formal care at home or in institutions, this scenario predicts that persons older than 65 suffering from at least one disability in activities of daily living will more than double between 2007 and 2060, reaching 44.4 million by 2060. Dependent older people receiving care in institutions would almost triple, reaching 8.3 million; those receiving formal care at home would more than double, from 5.5 to 13.9 million; and those receiving informal or no care would increase from 12.2 to 22.3 million. In a more 'optimistic' scenario, disability rates are assumed to diminish as life expectancy further improves; but even in this scenario the total number of older people suffering from disability is expected to almost double.

Women will continue to form the majority of beneficiaries according to all projections, but this gender imbalance will probably lessen in the future. Based on the latest statistics on coverage rates of formal provisions, the current probability of a woman being a beneficiary of institutional care is between 1.1 and 2.8 times that of a man in all the countries except Latvia and Poland, while her probability of being a beneficiary of formal home care is between 1.5 and 2.8 times higher than that of a man in all the countries except Poland (**section 2.2**). This disproportionate representation of women among care recipients reflects higher longevity together with the steep rise in disability after the age of 70-75 years. However, this overrepresentation will lessen in the next fifty years or so if life expectancy continues to rise more rapidly for men, as anticipated by demographic research.

Informal care givers, i.e. family and friends, remain the most important group of providers. Of the expected 20.7 million dependent elderly estimated for the whole of the EU in 2007, 8.4 million are estimated to have benefited from formal care in 2007, while 12.3 million received informal or no care (EC, Ageing Report, p. 148). An encouraging finding of the present report is that men take part in informal long-term care much more than in (informal) childcare and their contribution may be on the rise. Among informal, mostly family, caregivers, men account for a

good 39% in the 13 countries included in the SHARE datasets. The main reason for this is that, in practically all countries, spouses and partners are the main care givers for co-residing older people, and men very often assume care responsibility for their spouse or partner (**section 4.1**). In fact, spouses/partners are equally likely to care for each other, independently of sex, in half of the countries for which detailed information is available (Austria, Belgium, Italy, the Netherlands, Spain and Poland). And men's participation is explicitly reported to be increasing in some countries (e.g. the UK and Norway).

Growing participation by male partners in informal care may thus represent a source of additional care-giving, and it may offset expected losses of female care-giving potential. Such losses are expected to result from the ongoing postponement of the pensionable age, or from smaller and more geographically dispersed families. By contrast, there is no evidence that gender rebalancing is likely in the near future among care workers and professionals. According to European Labour Force Survey data, in 2007 women accounted for about 90% of all care workers and nurses (plus midwives) in EU27, and there is no reason to believe that the proportion is much lower in the long-term care segment, for which no such data are available.

Availability of provisions. Given fast-rising demand and persisting gender imbalances in supply, progress from a gender perspective depends on a concomitant expansion of formal care provisions. Conditional on quality-of-health outcomes, such expansion ought, moreover, to prioritize home care and semi-residential facilities where feasible, given the evidence that men and women assign a second-order preference to institutional care. Progress from a gender perspective is also dependent on greater participation by men in informal care-giving and greater outsourcing to formal care providers in the private or public sector.

There has been visible progress in the supply of formal provisions in long-term care, in-kind, in-cash, or in time off-work **(Chapters 2, 4 and 5**). Following the literature, coverage rates are used in the present report as indicators of the overall level of formal provisions.[1] They are reported and discussed for residential and home care and, whenever available, for semi-residential care. Residential care is typified by nursing homes and old-age homes, home care includes home help,

[1] Coverage rates are defined as the share of beneficiaries of long-term care provisions in the population of elderly people (more than 65 years old).

personal care and nursing care at home, and semi-residential services are typified by day care centres and respite care facilities. The accurate assessment of formal long-term care supplies is hindered by problems of data comparability across countries and sources which this report could not overcome. Nevertheless, the information collected here is broader in its scope than alternative sources for Europe, such as the OECD or recent compilations by experts (Huber et al. 2009). Information supplied by the national experts of the EGGE network are cross-checked and complemented with selected data from these sources.

Coverage rates for residential care converge on relatively modest values among West, Nordic and South European countries. This is indirect evidence of progress towards a re-balancing of provisions away from institutional care and towards home care. The highest and lowest values are recorded by Iceland and FYROM with 8.3% and 0.2%, respectively. Towards the top of the ranking, France, Belgium and the Netherlands have rates just above 6%. Immediately below, Sweden, Norway, Slovenia and Luxembourg record values between 5% and 6%, followed by Austria, the Czech Republic, Cyprus, Germany, Denmark, Spain, Finland, Hungary, Ireland, Italy, Malta, Portugal, Slovakia, and the UK with values between 2.5% and 5%. At the bottom of the ranking, Turkey and Greece join a group of 7 East European countries – Estonia, Croatia, Latvia, Poland, Lithuania, Romania and FYROM – all of which record rates below 2%.

Signs of progress towards more adequate supplies of formal LTC services also include a certain catching-up by Mediterranean countries with respect to home and semi-residential care. By contrast, in only a handful of East European countries can the elderly count on significant home care infrastructures. The dominant feature of home and semi-residential care coverage, however, is a great dispersion across countries. Some of this dispersion may reflect differential needs due e.g. to the age structure or the pattern of disability, but any attempt to estimate the coverage of actual needs is problematic given that disability is often understood differently across countries. Differences in actual needs, however, are unlikely to be a major component of the current inter-country differentials in conventional coverage rates. Home care coverage of (in-kind only) services, for example, is almost double in Sweden with respect to Italy despite the fact that in 2009 the latter was the oldest country in Europe after Germany.

For the 27 countries for which data are available, the coverage rate for home care ranges from 0.3% for Romania to between 20% and 21% for the Netherlands, Iceland and Denmark. Nordic countries all stand at or near the top of the ranking, with the exception of Finland, but there is a considerable distance between Sweden with 9.4% and the top three scorers.

Five East European countries stand at the bottom of the ordering with less than 2% coverage – Romania, Lithuania, Latvia, Poland and Slovenia – while Estonia and Slovakia do slightly better with a 2.3% coverage. South European (member) countries are all ranked above those from Eastern Europe, with the exception of the Czech Republic and Hungary. In fact, Greece, Italy and Spain are now at around the 5% mark, while Portugal and Malta are only 1 percentage point away from it. The four countries that have implemented mandatory long-term care insurance all do better than the Southern group, but differences among them are very marked: from 21% for the Netherlands and the considerable 14% for Austria down to 7% for Luxembourg and 6.6% for Germany.

Only a minority of countries account for semi-residential services separately, and coverage rates are above 2% in Greece, Estonia, Portugal, Iceland, Denmark and Finland. Estonia and Greece are the prominent examples of fast growth in the recent past.

High coverage rates for formal provisions do not necessarily correspond to greater care outsourcing on the part of families, i.e. to a more balanced distribution of care-giving between formal and informal care providers. For example, coverage rates may include cash benefits that are not spent to purchase care services. In reality, the balance between formal and informal care-giving continues to show marked differences that only partially correspond to differences in coverage rates. Investigation of SHARE data for 13 European countries - Austria, Belgium, the Czech Republic, Germany, Denmark, Greece, Spain, France, Ireland, Italy, the Netherlands, Poland and Sweden - has revealed that informal family carers (and some friends) retain a pervasive role in all the countries when care is ‘spaced out’, i.e. given less than daily. And in all these 13 countries except France and Belgium, 80% or more of the elderly receiving care rely exclusively on the family, while only 20% resort to formal, hence paid, care services (on an exclusive basis or in combination with family care). Important differences among countries emerge only when care-giving intensifies and becomes daily or almost daily. In France, Belgium,

the Netherlands and Denmark, exclusive reliance on the family concerns less than 30% of elderly beneficiaries when care-giving is intense, while the corresponding figures for Italy, Spain, Greece, Germany, the Czech Republic and Poland do not fall below 60%.

In each country, the division of labour between the state, the market and the family in their roles as care providers can be seen to give rise to a 'viable' equilibrium when complementarities between these institutions are sufficiently exploited. 'Viable' does not imply 'optimal' or even 'good', but when this happens a model or regime is created. This is the rationale that underlies the attempts made to identify welfare or care regimes (models) in the literature. Current cross-country differences in the level and mix of home versus institutional care or in the degree of outsourcing to private and public providers indicate that the taxonomies received from the literature may need updating. The use of clustering techniques on the subset of 13 countries included in the SHARE survey identifies four clusters of countries where membership of a given cluster indicates closer overall 'similarity' with other members than with any non-member. The clusters are (i) Denmark and the Netherlands, (ii) Greece and Poland, (iii) Belgium, France and Sweden, and (iv) the Czech Republic, Germany, Ireland, Italy and Spain. Austria stands apart. There is some continuity between this clustering and the taxonomies of long-term-care regimes that previous work by the EGGE network has contributed to popularizing. But there are also clear signs of change reflecting major developments in the European long-term care sector since the early 1990s.

Enlargement has brought into the Union several East European countries where formal long-term care for the elderly is still rather underdeveloped. A bloc of East European countries has thus replaced Mediterranean countries at the bottom of the ranking for the development of formal long-term care provisions and at the top of the ranking for informal, family care. Prior to transition, assistance to the elderly in former planned economies consisted primarily in financial support, such as pensions for retired persons or workers who had become disabled, subsidization of goods and (general) services, as well as access to housing, summer cottages, and land. Family carers, mainly women, and informal community networks provided the elderly with long-term assistance while long-term residential institutions (mainly social care housing) were the fall-back option when families or friends could not provide care. Even before transition began to deplete

the stock of facilities, however, coverage rates for institutional care stood below 2% in most former Eastern planned economies, including Russia, and they were close to zero in several small former Soviet Union Republics.

The financial crisis of the 1990s and the ensuing budgetary restrictions compelled greater reliance on informal, family care in countries such as Sweden. Partially sheltered from that earlier financial crisis, some Mediterranean countries went the opposite way. In Spain the recent *Ley de Dependencia* (2006) has laid the foundations for the much larger involvement of public and market providers in the LTC sector, although assessment of actual accomplishments still invites caution, and the severe budget cuts made necessary by the current financial crisis may be hindering progress. But even where no such reform has been implemented – as in Italy, Greece or Portugal – a significant share of families have taken advantage of massive female migration and of increased cash transfers from the state to hire care workers and professionals from other EU countries or from outside the EU – women in particular. From primary care providers, families in these countries have quickly turned into care managers.

The overall outcome is some blurring of the previous divide between South-West Europe, where the LTC sector overwhelmingly relied on the family, and the rest of Western Europe, where the mix of services was more diversified. While South European countries have become more similar to (some) West European ones, perhaps the largest difference to emerge with the EU's enlargement to the East opposes (most) new member and candidate countries against the old members.

Affordability of services. One of the drivers of change in care systems is the search for new solutions to the problem of affordability of long-term care services. As to be expected, new solutions have been sought primarily for rapidly expanding services, namely home and community care. **Chapter 3** reviews evidence on service fees or market prices, drawing primarily on the national reports of the EGGE network.

An overall and expected finding in this chapter is that residential care tends to be less affordable than home care for families. Moreover, care in private nursing homes or equivalent private institutions – all of which price services on the basis of full costs – is generally the most expensive type of long-term care in all countries. Somewhat surprisingly, however, the countries offering

affordable residential services may not be in a minority. If the criterion is adopted that fees absorbing at most 85% of the income are 'affordable', (given that care in an institution covers all basic needs), then out of the 21 countries for which fees for publicly subsidized services are broadly comparable, 12 satisfy this affordability criterion: Austria, Bulgaria, Denmark, Estonia, Finland, Greece, Hungary, Ireland, Norway, Poland, Romania and Sweden. Countries where the criterion is not fulfilled include the Czech Republic, France, Slovenia, Germany, Italy, and the UK. For the remaining countries – Iceland, Luxembourg, Latvia and Malta – the evidence is not conclusive. In the Nordic bloc, affordability is simply a facet of a country's universalistic care aspirations. In countries with poor provisions affordability is often the other side of rationing: limited provisions are put in place as 'last resort' solutions targeted on the elderly who cannot count on, or pay for, any other alternative, including family care.

Assessing the affordability of home care services is problematic, if only because of the variety of care packages within each country. However, *typical costs* can be observed for a selection of four distinctive organizational profiles of home care provisions. The four profiles are respectively called 'comprehensive care but rationalized face time', 'migrant-in-the-family', 'service voucher', and 'minimal reliance on care outsourcing'.

The first type is illustrated by Sweden, but it broadly applies to the Nordic group of countries and the Netherlands. In all these countries, formal home care services in kind are comprehensive as well as affordable, but affordability rests on a marked rationalization of hours of care.
The migrant-in-the-family type is typified by Italy and Greece, where this solution has assumed large proportions, but it is rather popular also in Spain and Cyprus. Three main 'resources' are typically combined in these countries: limited but cheap public services that complement family care, selective rather than universal cash allowances, and a large, mostly irregular market for mobile and migrant care workers and professionals. Thanks to this combination, a 24-hour care solution or relatively extended hours of care are *de facto* affordable for a large minority of families. Variants of this basic model are also to be found in Austria and Turkey, although they do not reach the same proportions as in Italy, Greece or Spain.

The role of service vouchers is well illustrated by the French system, which can be regarded as offering an answer to the problem of affordability which is intermediate between those of Nordic

countries, on the one hand, and of Mediterranean countries on the other. This answer features near universal rather than selective cash transfers, strong reliance on private as well as public providers via service vouchers, and less rationalized hours of care compared to those in Denmark or Sweden, although hours of care are shorter than those that migrant-in-the family arrangements may offer.

Poland exemplifies the case where the outsourcing of family care is minimal not only because publicly subsidized alternatives are very scarce, but also because private options can be quite expensive. Whilst a small proportion of the elderly in the country have access to public services provided free of charge, the majority must rely on the market or on fee-based home services. Per hour or per item fees are generally low, but a person with significant and frequent care needs faces potentially high costs. Other East European countries share with Poland the paucity of formal home care services, as well as expensive market alternatives to informal family care. Examples are Hungary and Slovenia.

Comparison among these four organizational and pricing profiles reveals two intertwined trade-offs. The first trade-off is between hours of care, on the one hand, and distributional equity on the other: the most universally affordable solution typified by Nordic countries rationalizes hours of care in order to ensure the widest coverage at affordable prices to clients. In Iceland and Sweden, for example, average hours of care are, in fact, less than 3 per week, whilst in Denmark they range between 4 and 6 hours per week. Extended hours of care tend, in contrast, to be expensive in the remaining countries and therefore affordable for a minority of families. Only where poorly trained workers are employed and wages are kept low by immigration and large irregular markets does this minority become sizeable, as illustrated by the 'migrant in-the-family' arrangement in Italy. French-style service vouchers seem to provide a compromise solution for this trade-off because the scheme does not compel the extreme rationalization of hours, although it does not make extensive hours of care equally affordable for all.

The second trade-off is between job-creation potential and quality of employment. When extensive hours of care are provided, a large portion of the care time involves social and emotional rather than professional skills (i.e. for minding or providing companionship to the older person). Rationalized hours of care demand a comparatively smaller but more skilled

workforce, because medical and nursing tasks are less easily compressed or neglected than social skills. Hence extensive hours of care are likely to promote more employment than are rationalized hours, but a comparatively less skilled regular workforce.

Gender Equity. Issues of work and care are addressed in some detail in **Chapter 4.** For informal carers the main issue is the risk of a potential conflict between caring and working. For formal long-term care workers and professionals, the main issue is pay and working conditions. For future care receivers the critical issue is the risk of shortages of care personnel. The findings discussed in the chapter are somewhat reassuring with respect to the first of these risks, but not the other two.

In principle, the potential conflict between working and caring is not solely a woman's issue, given the considerable participation of men in informal care. In practice, however, there is some uncertainty as to how (un)equally this risk is actually distributed. On the one hand, the conflict concerns employed informal carers, and the probability of employment is still lower for women. On the other hand, employed men are less likely than employed women to take on responsibility for long-term care. In any event, extensive reviews of national research by the experts of the EGGE network suggest that having to care for an older person is less consequential on choices about work than childcare is. Women in employment with LTC responsibility quit their jobs in order to care more often than do men in a similar position. However, the estimated incidence of employment loss is generally below 10% (or just above this figure) even in countries that rely heavily on the family, such as Poland, Italy or Spain. Some countries report more than 10% of caregivers who reduce their hours of work or take leave rather than quitting employment: a case in point is France, where it has been estimated that 15% of the caregivers in employment resort to part-time in order to meet their care commitment towards the elderly. Comparative econometric research confirms, in fact, that the impact of informal long-term care on the probability of exiting employment or of reducing hours of work is generally positive and statistically significant, albeit limited.

However, if ongoing efforts to boost the employment rate of people aged over 55 are successful, these estimates may under-rate the magnitude of the conflict to come. There is some evidence, specifically for France, that older women currently in employment may be a rather self-selected

sample characterized by a strong determination to hold on to the job even when the need to care for family members intensifies. If so, the additional women in employment in the future may show a higher propensity to quit or to reduce working hours than is found at present.

Well-designed working time policies may help mitigate this conflict. The detailed review of leave and other time-related provisions conducted in **Chapter 4** shows that, in some countries, provisions are simply underdeveloped. In (some) other countries, however, the problem is not so much a lack of provisions as poor design and poor coordination with the other long-term care services in place.

In particular, the Czech Republic, Croatia, Cyprus, Estonia, Greece, Slovenia, Poland, Norway and Portugal offer only short-duration leaves ranging from 6 to 30 days per year, while the majority of the remaining countries feature both short- and medium-to-long duration leaves. Short leaves are often paid (but not everywhere, e.g. not in Cyprus or Croatia), and they are not made conditional on the employer's consent. The prevalent motivation is care-giving to family members, and only in about one-third of cases are provisions explicitly or *de facto* targeted on older people, e.g. in Austria, Greece and Romania. One or more medium- and long-duration leave schemes are reported for 14 countries: Austria, Bulgaria, Belgium, Germany, Denmark, Spain, Finland, France, Ireland, Iceland, Italy, Malta, the Netherlands, Romania and Sweden. In the majority of cases the maximum duration does not exceed one year, but there are numerous exceptions: Spain and Italy with two years, Ireland with five, Malta with eight, and Belgium with one leave scheme targeted on older workers, which can be extended until retirement. The general rule is that these leaves are unpaid, but in a non- negligible number of cases some compensation is offered, although restrictions apply.

The experience of countries that have implemented or attempted to implement leave schemes specifically targeted on long-term care – Austria in particular – indicates that there may still be insufficient knowledge about the optimal design of a long-term care leave. Since the time horizon in long-term care is more uncertain, and the evolution of needs over time more unpredictable, parental or childcare schemes do not offer valid templates. Also, other working time arrangements may efficiently meet the needs of care givers in employment. In particular, flexible working hours are popular among European care givers, men or women, as they often suffice to

satisfy care demands when disability is light, while effectively serving to complement formal care when disability is severe. Finland, Latvia, Norway, Romania, Slovenia and the UK currently operate flexible hours programmes for the purposes of long-term care.

The evidence gathered for this report is less reassuring with regard to pay and working conditions for care workers and professionals than it is for the employment-care conflict. With all the caution warranted by inevitable problems of comparability, analysis of standardized national figures for full-time monthly wages (i.e. values taken in ratio of the OECD average wage level for the country) indicate that:

- Only in Denmark and Iceland – 2 out of the 17 cases for which sufficiently comparable data are reported – workers in residential care with basic skills earn at least as much as the average worker in the economy, despite the fact that several such cases refer to the public sector, where wages for care workers tend to compare favourably with those in the private sector. In almost half of the cases, wages reach at most two-thirds of the average OECD figure. The comparison with the average employee in the economy is even less favorable for public sector or all-sectors workers in home care.
- Professionals (typically nurses) do better than their less qualified colleagues, but not as well as their level of schooling and skill would warrant. Only in 6 out of the 16 reporting countries does a nurse or worker of equivalent qualification in home care earn as much or more than the OECD average figure, but there are also 6 cases where s/he receives two-thirds of the OECD average figure at most. Professionals in residential care do marginally better.
- There are insufficient data for the private, irregular sector. Fragmentary evidence indicates that earnings for home care workers and professionals hired on the grey market are available at a considerable 'discount'.
- Despite very high feminization, female care workers and professionals are further penalized by the gender pay gap. Actual values for this gap differ considerably across countries and skill levels, and the figures reported are too few to warrant generalizations.

Relatively low levels of pay are compounded by poor working conditions. On reviewing working conditions, the evidence from the national reports buttresses medical evidence on the many occupational hazards facing long-term carers. National reports emphasize physically wearing

work conditions compounded by mental fatigue and stress, to which must be added exposure to infections from close body contacts and to road accidents while travelling to the client's home.

In response to poor pay and working conditions, turnover is reported to be very high in countries as different as Austria, Belgium, Bulgaria, Iceland, Italy, the Netherlands, Poland and the UK. Moreover, shortages of care workers and professionals – nurses in particular, but also intermediate skill workers – are being experienced or are anticipated in the long-term care sector of a large number of countries, both in Western and Southern Europe (Austria, Belgium, Cyprus, Germany, Finland, Italy, the Netherlands, Malta and the UK) and in several Central and East European countries (Bulgaria, Latvia, Poland and Hungary).

Policies. According to some national experts (e.g. from Austria, Greece, France, Iceland and Latvia), long-term care has not been as high on the political agenda of Member States as childcare was until the financial crisis set in. A lack of clear targets like those set for child-care in the Lisbon strategy may have lessened the pressure to address the issue publicly. However, there are signs that the topic is gaining prominence in the public arena, notably in Norway and the UK. **Chapter 5** offers a short overview of selected policy developments in recent years.

The past decade has not witnessed major reforms of the architecture of the long-term care system in the Member States, but government representatives of at least five countries have publicly discussed or advocated the introduction of mandatory long-term care insurance (France, Hungary, Poland, Romania and Slovenia). As highlighted by the national reports of the network experts, the current financial crisis may forestall reforms. Yet there are instances of major reforms that have been enacted in the past also in an attempt to curb the rapid rise in expenditure on long-term care. A case in point is Germany, where, in the view of some scholars, long-term care insurance was introduced also with the intent of curbing the rise in expenditure on social assistance, i.e. the main source of public funding for formal LTC expenses prior to the reform.

Most policy developments over the past decade have followed trends that had set in earlier and that can be summarized as progressive shifts (i) away from institutionalized care and towards home care; (ii) away from public provisions and towards private or mixed services backed up by cash transfers; (iii) in favour of services that complement rather than replace informal care.

The shift towards home-based LTC is documented in the review of coverage rates in chapter 2, and it reflects the need to contain the costs of services while also seconding widespread preferences among the elderly for being cared for in one's own home. Risks inherent in this move include lower health standards and the development of an untrained and underequipped workforce. To avoid the former, health outcomes in home care ought to be carefully compared with those in institutional care: for example, are the chances of rehabilitation from a stroke higher in a specialized unit or in home care? As to the quality of employment in LTC, this has been affected by the practically universal preference for cash-for-care transfers, rather than by the move towards home care *per se*.

Cash transfers have been distributed primarily via two types of allowances. The first is paid to the older person in need in order for her/him to purchase care services, and it is often – although not consistently - called 'attendance allowance'. The second allowance is paid to the family carer or the older person as compensation for the (family) carer's services, and it is often called 'care allowance'. Examples of cash transfers other than allowances include tax refunds and tax credits, disability pensions, subsidies to buy medical equipment or to carry out house adaptations, the waiving of social security contributions for care workers and professionals (especially if hired by the family), and yet others.

Attendance allowances are more widespread than care allowances (25 countries against 20), and tend to be higher in amount. In order to ensure standardization across countries, the reported amounts are taken in ratio to the average income for a 65-year-old in the country. In 7 countries (Austria, the Czech Republic, France, Germany, the Netherlands, Portugal and Slovakia), maximum amounts for the attendance allowance are at least 90% of the reference income, whilst in the case of the care allowance this holds true only for Hungary. Moreover, in about half of the countries reported to operate a care allowance scheme, the fixed or maximum amount is below 50% of the reference income (Bulgaria, Iceland, Italy, the Netherlands, Poland and the UK).

Distributional and efficiency issues are involved in the design of allowances. One important issue is that, in LTC insurance countries, top payments tend to be significantly higher than elsewhere (in ratio to the reference income). This suggests that LTC insurance schemes tend to guarantee

higher income protection at severe and very severe disability stages, to the clear advantage of the 'grand elderly', i.e. people older than 80, among whom women predominate. From a gender equity perspective, however, an even more important issue is whether cash transfers are tied or free. 'Free to spend' allowances encourage the expansion of irregular employment as well as tax evasion, as witnessed by all the countries where the migrant-in-the-family model is prospering. Service vouchers are an example of tied transfers. Depending on the implementation of the scheme, service vouchers can encourage the emergence of irregular labour, ensure at least some skill upgrading for the workers involved, and some uniformity of care quality – all at feasible costs for public budgets. In the assessment of the national experts, however, they also created segments of (female) employment that often do not ensure 'decent' pay and working conditions.

Cash transfer policy in long-term care can thus have and has had major repercussions on actual labour markets. Paradoxically, labour-market policies appear to have often addressed the symptoms of the labour market's malaise in the long-term care sector – i.e. shortages and turnover – rather than the root causes, i.e. low wages, poor working conditions or segregation.

Actual or expected shortages of care workers and professionals are an important concern for governments. The most articulated policy responses from European countries have attempted to provide fresh training while also redefining educational or vocational requirements or redesigning career paths – all with a view to improving recruitment and retention of personnel in the sector. Examples are Austria and Belgium, where a semi-skilled occupation in nursing (respectively 'assistant nurse' and 'nursing carer') has been introduced in an attempt to lengthen the career ladder and attract more candidates to the occupation. Initiatives in other countries have been geared to encouraging attendance on training courses, increasing the number of training positions within firms (Estonia, Germany, Norway, Portugal and Spain) or the level of vocational training or formal education required for carers at each skill level (Germany, Latvia, Norway, the UK), and certifying the training received by home care workers (Romania). In Spain and France, initiatives to boost training have extended to home care workers hired via service vouchers.

Unattractive pay levels are at the root of shortages, but very few countries have directly addressed factors other than training that contribute to low wages in LTC: for instance, irregular

employment, a low capacity to pay on the part of families, poor recognition of care as a profession, and disproportionate feminization. Exceptions are Austria, where social security contributions have been abated in order to encourage the emergence of irregular migrant care workers and professionals, Germany, where the minimum wage has been introduced in the care sector, and Romania, where care-giving in LTC has recently been recognized as a 'profession' with a separate entry in the occupational code. In practically no country have concrete efforts to encourage more men to enter this sector made it on to the policy agenda. Whilst the importance of further education or training for meeting shortages is not under discussion, practically exclusive reliance on these measures may prejudice effectiveness.

Perhaps the most serious challenge that lies ahead for the majority of the 33 countries reviewed here is the effect of the current crisis on future provisions. It would, however, be a great loss of opportunity for the economy, and not only for gender equality, if the prevalent response to the financial crisis were confined to rationalizing provisions and putting pressure on the family to insource rather than outsource care. Rather, the challenge lies in reversing this perspective and turning a rapidly expanding sector like long-term care into an employment growth engine. At the same time, employment expansion could also be used to turn this employment segment into a port of entry for men into the larger care sector.

Résumé

Objet et champ d'application. Le présent rapport a pour principal objet d'analyser les soins de longue durée aux personnes âgées en Europe (ci-après SLD ou soins de longue durée) de la double perspective de l'emploi des femmes et de l'égalité des genres. Cette analyse porte sur la fourniture des prestations plutôt que sur leur financement et les dépenses, sur les prestations en nature comme l'institutionnalisation des soins à domicile, les prestations monétaires comme les allocations de présence ou de soins, et les dispositifs d'aménagement du temps de travail comme les congés ou le droit à des horaires flexibles. À partir des rapports des experts nationaux du réseau EGGE, une analyse comparative est actuellement menée sur 33 pays européens comprenant les 27 États membres, les 4 pays candidats (Croatie, Macédoine, Islande, Turquie) et 2 pays AELE (Norvège et Liechtenstein).

Les femmes sont les principales protagonistes dans les services de soins de longue durée. En matière de demande de soins, elles représentent la majorité des bénéficiaires. Quant à la fourniture de soins, elles comptent toujours pour une large majorité des aidants, qu'ils soient ou non rémunérés. La disponibilité, l'abordabilité et la qualité des prestations ont une incidence sur les femmes et les hommes en leur qualité de bénéficiaires potentiels. S'agissant de la fourniture de soins, la sur-représentation récurrente des femmes parmi les aidants non professionnels aboutit à un niveau de féminisation extrême des travailleurs et professionnels des soins. Si le niveau de féminisation élevé des soins de longue durée crée des opportunités d'emploi pour les femmes dans un secteur en expansion rapide, cela ne va pas sans quelques interrogations majeures en matière d'égalité des genres sur le marché du travail et dans le foyer.

L'analyse menée dans ce rapport porte sur les aspects de disponibilité, d'abordabilité et d'égalité des genres. Outre les rapports nationaux des 33 experts du réseau, cinq sources d'information principales ont été utilisées pour la compilation de statistiques. Il s'agit du Rapport 2009 sur le vieillissement démographique de la Commission européenne, de l'enquête SILC de l'UE, de l'enquête SHARE (santé, vieillissement et retraite en Europe), des données de l'OCDE en matière de santé et de récents recueils de données factuelles et chiffrées sur les soins de longue durée par Huber et al. (2009).

Tendances de fond. Selon le Rapport 2009 sur le vieillissement démographique, l'ampleur de l'expansion de la demande future des soins de longue durée est impressionnante, même d'après des scénarios assez conservateurs (**chapitre 1**). Si l'on considère que le nombre de personnes de plus de 79 ans triplera d'ici 2060, le segment des soins de longue durée sera l'un des moteurs de cette expansion au cours des cinquante prochaines années environ. L'ampleur de la demande future des services de soins de longue durée fait naître quelques incertitudes du fait d'éléments contradictoires sur les tendances liées à l'invalidité, qui dérivent de l'absence de consensus sur ce qu'est l'invalidité à un âge avancé. Comme le révèle une étude de l'OCDE de 2007 (Lafortune et al.), la prévalence de l'invalidité a augmenté au fil du temps dans certains pays, alors qu'elle a diminué dans d'autres pays. Au vu de ces éléments contradictoires, le « scénario démographique » présenté dans le Rapport de la Commission européenne sur le vieillissement démographique est assorti d'une certaine prudence et reprend les données actuelles en matière de prévalence de l'invalidité. En adoptant l'hypothèse selon laquelle la probabilité de recevoir des soins professionnels à domicile ou en établissement restera inchangée, ce scénario prédit que les personnes de plus de 65 ans atteintes d'au moins une forme d'invalidité dans leurs activités quotidiennes feront plus que doubler entre 2007 et 2060, pour atteindre 44,4 millions d'ici 2060. Le nombre de personnes âgées dépendantes recevant des soins en établissement sera au moins multiplié par trois et atteindra 8,3 millions, le nombre de celles recevant des soins professionnels à domicile fera plus que doubler, passant de 5,5 à 13,9 millions, et le nombre de celles recevant des soins non professionnels ou ne recevant pas de soins augmentera de 12,2 à 22,3 millions. Un scénario « optimiste » prévoit une diminution des taux d'invalidité à mesure que l'espérance de vie s'allonge. Même dans ce scénario, cependant, le total des personnes âgées atteintes d'une invalidité fera plus que doubler.

Dans toutes les projections, les femmes continueront à constituer la majorité des bénéficiaires de soins, même si ce déséquilibre est appelé à s'atténuer. Selon les dernières statistiques en matière de taux de couverture des prestations professionnelles, la probabilité pour une femme de bénéficier actuellement de soins en établissement est de 1,1 à 2,8 fois celle des hommes dans tous les pays à l'exception de la Lettonie et de la Pologne, tandis que la probabilité de bénéficier de soins professionnels à domicile est de 1,5 à 2,8 fois celle des hommes dans tous les pays à l'exception de la Pologne (**section 2.2**). La représentation disproportionnée des femmes parmi les

bénéficiaires des soins s'explique par leur plus grande longévité et par la forte hausse de l'invalidité après 70-75 ans. Néanmoins, cette sur-représentation est appelée à diminuer dans les cinquante prochaines années environ si l'espérance de vie des hommes continue à progresser plus rapidement, comme le prévoient certaines recherches démographiques.

Les aidants non professionnels, à savoir les familles et les proches, demeurent le groupe de prestataires le plus fourni. Sur les 20,7 millions de personnes âgées dépendantes estimées dans toute l'UE en 2007, on estime que 8,4 millions ont bénéficié de soins professionnels en 2007 et que 12,3 millions ont reçu des soins non professionnels ou n'ont pas reçu de soins (CE, Rapport sur le vieillissement démographique, p. 148). Une conclusion encourageante du présent rapport fait état d'une contribution des hommes en matière de soins non professionnels de longue durée beaucoup plus élevée qu'en matière de soins (non professionnels) aux enfants, cette contribution étant même susceptible d'augmenter. Les hommes comptent ainsi pour 39 % des aidants non professionnels (principalement la famille) dans les 13 pays de l'enquête SHARE. Cela tient principalement au fait que, dans presque tous les pays, les époux et partenaires sont les principaux pourvoyeurs de soins aux personnes âgées vivant sous le même toit, les hommes s'occupant alors souvent de leur épouse ou partenaire (**section 4.1**). De fait, les époux/partenaires sont susceptibles dans une mesure égale de s'occuper d'une autre personne, indépendamment de son sexe, dans la moitié des pays pour lesquels des données détaillées existent (Autriche, Belgique, Italie, Pays-Bas, Espagne, Pologne). Et la participation des hommes est manifestement en hausse dans plusieurs pays (Royaume-Uni et Norvège par exemple).

La participation croissante des partenaires masculins aux soins non professionnels est donc susceptible de représenter une source complémentaire de prestations de soins, de même qu'une compensation pour les pertes attendues de potentiel de prestations par les femmes. Ces pertes font suite aux reports en cours de l'âge de la retraite ou s'expliquent par l'existence de familles réduites et dispersées géographiquement. Rien ne présage cependant d'un rééquilibrage prochain entre les deux sexes parmi les travailleurs et professionnels des soins. Selon des données de l'Enquête européenne sur les forces de travail, les femmes comptaient en 2007 pour environ 90 % des soignants et des infirmières (plus les sages-femmes) dans les 27 pays membres de l'UE, et rien ne porte à croire que cette proportion soit plus basse dans le secteur des soins de longue durée, pour lequel de telles données sont absentes.

Disponibilité des prestations. Étant donné la progression rapide de la demande et la persistance des déséquilibres entre les sexes dans la fourniture de soins, les progrès dans une perspective de genre sont subordonnés à une expansion équivalente des prestations de soins professionnelles. En fonction de la qualité des résultats en matière de santé, cette expansion devrait autant que possible donner la priorité aux soins à domicile et à l'hébergement partiel en centre, dans la mesure où les femmes et les hommes les préfèrent aux soins en établissement. Les avancées dans une perspective de genre dépendent d'une participation accrue des hommes aux soins professionnels et à un plus grand recours aux prestataires professionnels du secteur privé ou public.

Il y a des progrès manifestes dans la fourniture de services professionnels de soins de longue durée, en nature, en espèces ou en temps hors du travail (**chapitres 2, 4 et 5**). Conformément à la littérature, les taux de couverture utilisés dans ce rapport font office d'indicateurs du niveau global des prestations professionnelles.[2] Ils sont reportés et traités en lien avec les soins en établissement et à domicile et, quand ils sont disponibles, pour les prestations avec hébergement partiel en centre. Les soins en établissement sont habituellement donnés en centres de soins infirmiers et foyers pour personnes âgées. Les soins à domicile comprennent quant à eux l'aide familiale, les soins personnels et les soins infirmiers à domicile. Les services avec hébergement partiel en centre sont habituellement donnés en centres de jour et en centres de soins de suppléance. L'évaluation précise des prestations professionnelles de soins de longue durée se heurte à des problèmes de comparabilité des données entre pays et sources, problèmes que ce rapport n'a pas été en mesure de surmonter. Les informations recueillies ici ont néanmoins un champ d'application plus vaste que les autres sources existantes pour l'Europe, comme celles de l'OCDE ou les récents recueils d'experts (Huber et al. 2009). Les données tirées de ces sources sont enrichies dans le présent rapport par les informations des experts nationaux du réseau EGGE.

Les taux de couverture des prestations en établissement de soins ont convergé vers des valeurs relativement modestes dans les pays d'Europe de l'Ouest, du Nord et du Sud. C'est la confirmation indirecte d'une tendance au rééquilibrage des prestations, des soins institutionnels

[2] Les taux de couverture sont définis comme la part des bénéficiaires de prestations de soins de longue durée chez les personnes âgées (plus de 65 ans).

vers les soins à domicile. L'Islande et la Macédoine présentent les valeurs les plus élevées et les plus basses, avec respectivement 8,3 % et 0,2 %. La France, la Belgique et les Pays-Bas occupent le haut de ce classement avec des taux supérieurs à 6 %. Viennent ensuite la Suède, la Norvège, la Slovénie et le Luxembourg avec des valeurs comprises entre 5 et 6 %, puis l'Autriche, la République tchèque, Chypre, l'Allemagne, le Danemark, l'Espagne, la Finlande, la Hongrie, l'Irlande, l'Italie, Malte, le Portugal, la Slovaquie et le Royaume-Uni avec des valeurs entre 2,5 et 5 %. Au bas de l'échelle se trouvent la Turquie et la Grèce, qui rejoignent un groupe de 7 pays d'Europe de l'Est (Croatie, Estonie, Lettonie, Pologne, Lituanie, Roumanie, Macédoine) dont les taux de couverture sont inférieurs à 2 %.

Autre signe de glissement vers des prestations professionnelles adéquates de soins de longue durée, le rattrapage relatif des pays méditerranéens concernant les soins à domicile et en hébergement partiel en centre. À l'inverse, seule une poignée de pays d'Europe de l'Est offrent aux personnes âgées des infrastructures solides en matière de soins à domicile. Il convient néanmoins, pour la couverture des soins à domicile et en hébergement partiel en centre, de souligner la grande dispersion des valeurs d'un pays à l'autre. Si cette dispersion s'explique en partie par des besoins différenciés, du fait par exemple de la structure par âge ou du modèle d'invalidité, toute tentative d'estimation de la couverture des besoins réels est problématique dans la mesure où l'invalidité revêt souvent une acception différente d'un pays à l'autre. Il reste néanmoins peu probable que la disparité des besoins réels soit une cause majeure des différences actuelles entre les pays en matière de taux de couverture conventionnels. La couverture des services de soins à domicile (en nature uniquement), par exemple, est au moins deux fois plus importante en Suède qu'en Italie, même si ce dernier pays était en 2009 le plus vieux d'Europe après l'Allemagne.

Concernant les 27 pays pour lesquels des données sont disponibles, le taux de couverture des soins à domicile varie de 0,3 % en Roumanie à 20-21 % aux Pays-Bas, en Islande et au Danemark. Les pays nordiques sont parmi les mieux placés, à l'exception de la Finlande. La Suède, avec 9,4 %, se détache nettement des trois pays de tête.

Cinq pays d'Europe de l'Est (Roumanie, Lituanie, Lettonie, Pologne, Slovénie) se trouvent en bas de l'échelle avec un taux de couverture inférieur à 2 %, alors que l'Estonie et la Slovaquie font à

peine mieux avec 2,3 %. Les pays (membres) d'Europe du Sud se situent tous au-dessus des pays d'Europe de l'Est, à l'exception de la République tchèque et de la Hongrie. La Grèce, l'Italie et l'Espagne se situent ainsi autour de 5 %, alors que le Portugal et Malte ne sont qu'à 1 point pourcentage de ces pays. Les quatre pays ayant introduit une assurance de soins longue durée obligatoire font tous mieux que les pays d'Europe du Sud, en dépit de différences marquées : de 21 % aux Pays-Bas à 14 % pour l'Autriche, à 7 % pour le Luxembourg et 6,6 % pour l'Allemagne.

Seule une minorité de pays considère séparément les services avec hébergement partiel en centre, mais les taux de couverture sont supérieurs à 2 % en Grèce, en Estonie, au Portugal, en Islande, au Danemark et en Finlande. L'Estonie et la Grèce sont les meilleurs exemples d'une croissance rapide dans un passé récent.

Des taux de couverture élevés pour les prestations professionnelles n'impliquent pas nécessairement une externalisation plus élevée des soins de la part des familles, c'est-à-dire une répartition plus équilibrée de la fourniture de soins entre aidants professionnels et non professionnels. Par exemple, les taux de couverture peuvent inclure des prestations en espèces qui ne sont pas dépensées pour des services de soins. En réalité, le solde entre soins professionnels et non professionnels continue à faire apparaître des différences marquées qui correspondent en partie seulement aux différences des taux de couverture. L'étude des données SHARE relatives à 13 pays européens (Allemagne, Autriche, Belgique, Danemark, Espagne, France, Grèce, Irlande, Italie, Pays-Bas, Pologne, République tchèque, Suède) révèle que les aidants familiaux non professionnels (et quelques proches) restent omniprésents dans tous les pays où les soins sont espacés, autrement dit lorsqu'ils ne sont pas donnés quotidiennement. Dans ces 13 pays, France et Belgique exceptées, 80 % ou plus des personnes âgées bénéficiant de soins se reposent exclusivement sur la famille, alors que 20 % seulement recourent à des services de soins professionnels, donc rémunérés (sur une base exclusive ou combinés aux soins prodigués par la famille). Des différences importantes n'apparaissent entre les pays que lorsque les prestations de soins s'intensifient et ont lieu sur une base quotidienne ou presque. En France, en Belgique, aux Pays-Bas et au Danemark, le recours exclusif à la famille concerne moins de 30 % des personnes âgées bénéficiaires lorsque les prestations sont délivrées fréquemment, contre au moins 60 % pour l'Italie, l'Espagne, la Grèce, l'Allemagne, la République tchèque et la Pologne.

Dans chaque pays, on peut considérer que la division du travail entre l'état, le marché et la famille en leur qualité de pourvoyeurs de soins, crée un équilibre « viable » lorsque les complémentarités entre ces institutions sont suffisamment exploitées. Notons que si « viable » ne signifie pas « optimal » ou « bon », la naissance d'un équilibre viable porte à la création d'un modèle ou d'un régime. Voilà le postulat sur lequel reposent les tentatives d'identifier les régimes (modèles) de prévoyance ou de soin dans la littérature. Les différences actuelles entre les pays concernant le niveau et la répartition des soins à domicile et en établissement ou concernant le degré d'externalisation à des prestataires privés et publics indiquent que les classifications héritées de la littérature peuvent nécessiter une actualisation. À l'aide de techniques multi-échelles sur le sous-ensemble des 13 pays de l'enquête SHARE, quatre groupes de pays ont été identifiés. L'appartenance à un groupe donné indique une « similitude » globale avec d'autres membres plutôt qu'avec tout autre pays non membre. Ces groupes sont (i) Danemark et Pays-Bas, (ii) Grèce et Pologne, (iii) Belgique, France et Suède, (iv) République tchèque, Allemagne, Irlande, Italie et Espagne. L'Autriche est à considérer séparément. On note une certaine continuité entre ces regroupements et les classifications des régimes de soins de longue durée que les précédents travaux du réseau EGGE ont contribué à populariser. Des signes manifestes de changement apparaissent néanmoins, reflétant d'importantes mutations du secteur des soins de longue durée en Europe depuis le début des années 1990.

L'élargissement a fait entrer dans l'Union européenne plusieurs pays d'Europe de l'Est dans lesquels les soins professionnels de longue durée sont encore très peu développés. Un ensemble de pays d'Europe de l'Est a donc remplacé les pays méditerranéens au bas de l'échelle en matière de développement des prestations professionnelles de soins de longue durée, et en haut de la classification en matière de soins familiaux non professionnels. Avant cette transition, l'aide aux personnes âgées dans les pays autrefois à économie planifiée consistait surtout à apporter un soutien financier comme les retraites pour les personnes à la retraite ou les travailleurs devenus invalides, à subventionner les biens et services (généraux) et à assurer un accès au logement, aux résidences d'été et à la terre. Les aidants familiaux, principalement les femmes, et les réseaux communautaires informels, assuraient aux personnes âgées une aide de longue durée, avec des institutions de long séjour (principalement les foyers d'aide sociale) comme solution de repli en cas d'impossibilité pour la famille ou les proches de fournir ces soins. Avant

même que la transition ne commence à entamer les infrastructures existantes, les taux de couverture des soins en établissement étaient inférieurs à 2 % dans la plupart des anciennes économies planifiées de l'Est, Russie comprise, et proches de zéro dans plusieurs des petites Républiques de l'ancienne Union soviétique.

La crise financière des années 1990 et les restrictions budgétaires qui en ont découlé ont amené des pays comme la Suède à recourir davantage aux soins familiaux non professionnels. En partie protégés de cette crise financière, plusieurs pays méditerranéens prirent une direction opposée. En Espagne, la récente *Ley de Dependencia* (2006) a posé les fondements d'un engagement largement accru du secteur public et du marché dans les soins de longue durée – une évaluation des avancées actuelles invite néanmoins à la prudence –, même si les sévères coupes budgétaires entraînées par la crise financière actuelle peuvent en freiner la progression. Cependant, même lorsque de telles réformes n'ont pas été mises en œuvre, comme en Italie, en Grèce ou au Portugal, une part importante des familles a tiré profit de l'immigration féminine massive et de la hausse des transferts en espèces de l'état pour embaucher des travailleurs et des professionnels des soins – surtout des femmes – d'autres pays de l'UE ou de pays hors UE. Dans ces pays, les familles sont rapidement passées du statut de pourvoyeurs de soins primaires à celui de superviseurs.

Cette situation a dans l'ensemble rendu moins visible la séparation entre l'Europe du sud-ouest, où le secteur des soins de longue durée reposait essentiellement sur la famille, et le reste de l'Europe disposant d'une gamme de services plus diversifiée. Alors que les pays d'Europe du Sud se sont rapprochés de (certains) pays d'Europe de l'Ouest, l'élargissement à l'est oppose peut-être désormais (la plupart) des nouveaux États membres et des pays candidats aux anciens États membres.

Abordabilité des services. Un des moteurs de l'évolution des systèmes de soin réside dans la recherche de nouvelles solutions au problème de l'abordabilité des services de soins de longue durée. Comme on pouvait s'y attendre, de nouvelles solutions ont tout d'abord été recherchées pour les services en expansion rapide, à savoir les soins à domicile et de proximité. **Le chapitre 3** examine le coût des prestations ou les prix du marché en se reportant principalement aux rapports nationaux du réseau EGGE.

Ce chapitre dresse une conclusion globale prévisible, à savoir que les soins en établissement tendent à être moins abordables pour les familles que les soins à domicile. De même, les soins en centres infirmiers privés ou dans des institutions privées équivalentes, où les services sont facturés sur la base des coûts totaux, sont d'une manière générale et dans tous les pays le type de soins de longue durée le plus cher. De façon quelque peu surprenante, cependant, les pays offrant des services de soins en établissement abordables semblent ne pas être qu'une minorité. Si le critère retenu est que les coûts absorbant un maximum de 85 % du revenu sont « abordables » (en considérant que les soins en institution couvrent tous les besoins fondamentaux), 12 pays satisfont ce critère d'abordabilité sur les 21 pays dont les coûts des services financés par l'état peuvent globalement être comparés, à savoir l'Autriche, la Bulgarie, le Danemark, l'Estonie, la Finlande, la Grèce, la Hongrie, l'Irlande, la Norvège, la Pologne, la Roumanie et la Suède. Les pays dans lesquels ce critère n'est pas satisfait sont la République tchèque, la France, la Slovénie, l'Allemagne, l'Italie et le Royaume-Uni. Pour les pays restants, c'est-à-dire l'Islande, le Luxembourg, la Lettonie et Malte, cet élément n'est pas représentatif. Dans les pays nordiques, l'abordabilité est une simple facette des mesures nationales universalistes adoptées en matière de soins. Dans les pays où le niveau des prestations est faible, l'abordabilité constitue souvent une autre facette du rationnement : des prestations limitées sont mises en place comme solutions de « dernier recours » pour les personnes âgées qui n'ont pas d'autres choix, soins familiaux compris, ni de moyens de payer.

L'évaluation de l'abordabilité des services de soins à domicile est problématique, ne serait-ce que du fait de la diversité de l'offre de soins de chaque pays. Cependant, il est possible d'examiner les coûts habituels pour quatre modèles organisationnels distincts de prestations de soins à domicile : « Les soins intégrés avec temps de rencontre physique rationnalisé », « le travailleur immigré dans la famille », « le chèque-service » et « le recours minimum à l'externalisation ».

Le premier modèle, illustré par la Suède, s'applique d'une manière générale aux pays nordiques et aux Pays-Bas. Dans ces pays, les prestations de soins à domicile en nature sont intégrées et abordables, mais l'abordabilité repose sur une nette rationalisation des heures de soin.
Le modèle du « travailleur immigré dans la famille » est typique de l'Italie et de la Grèce où il a été largement adopté, mais il est également assez populaire en Espagne et à Chypre. Ces pays combinent généralement trois « ressources » principales : des services publics limités mais

abordables en complément des soins familiaux, des prestations en espèces sélectives plutôt qu'universelles, et un vaste marché, principalement irrégulier, pour les travailleurs et professionnels des soins itinérants et immigrés. Grâce à cette combinaison, une solution couvrant les 24 heures de la journée ou impliquant des horaires de soin relativement larges est de fait abordable pour une large minorité de familles. L'Autriche et la Turquie proposent des variantes à ce modèle de base, sans pour autant atteindre les proportions de l'Italie, de la Grèce ou de l'Espagne.

Le système français illustre bien le modèle du chèque-service, dans lequel on peut voir une solution intermédiaire à la question de l'abordabilité, à mi-chemin entre les pays nordiques et les pays méditerranéens. Cette solution se caractérise par des transferts en espèces universels plutôt que sélectifs, par un recours élevé tant aux prestataires publics que privés à travers les chèques-service, et par une moindre rationalisation des heures de soin en comparaison du Danemark et de la Suède, malgré un nombre d'heures de soins plus faible que dans le modèle du « travailleur immigré dans la famille ».

La Pologne est quant à elle représentative du modèle de l'externalisation minimale des soins familiaux. Les dispositifs financés par l'état y sont non seulement très limités, mais les solutions proposées par le secteur privé peuvent aussi être très chères. Alors qu'une faible proportion de personnes âgées dans le pays peut accéder à la fourniture publique de services gratuits, la majorité d'entre elles doit recourir au marché ou à des services à domicile tarifés. Si le coût horaire ou à l'acte reste généralement faible, une personne nécessitant des soins fréquents et lourds affronte des coûts potentiellement élevés. D'autres pays d'Europe de l'Est ont en commun avec la Pologne ce manque de services professionnels de soins à domicile et la cherté des alternatives du marché aux soins familiaux non professionnels. La Hongrie et la Slovénie en sont de bons exemples.

De la comparaison de ces quatre modèles organisationnels et tarifaires, il ressort deux compromis intimement liés. Le premier entre les heures de soin et l'équité de répartition : les solutions universalistes les plus abordables typiques des pays nordiques rationalisent les heures de soin pour donner aux clients une couverture la plus large possible aux prix les plus abordables.

En Islande et en Suède, par exemple, moins de 3 heures de soin hebdomadaires sont en moyenne prodiguées, contre de 4 à 6 heures hebdomadaires au Danemark. Les heures de soin prolongées ayant en revanche tendance à être chères dans les autres pays, elles ne sont donc accessibles qu'à une minorité de familles. Ce n'est que lorsque des aidants sans formation adéquate sont employés et que le niveau de rémunération reste faible du fait du large recours au travail irrégulier et à l'immigration que cette minorité acquiert une certaine taille, comme l'illustre le modèle italien du « travailleur immigré dans la famille ». Les chèques-service utilisés en France semblent une solution équitable concernant ce compromis. Ce dispositif évite l'extrême rationalisation des heures, même si tous n'ont pas accès de manière équitable aux heures de soin prolongées.

Le second compromis se situe entre le potentiel de création d'emploi et la qualité de l'emploi. Lorsque des heures de soin prolongées sont prodiguées, une partie importante du temps de soin fait appel à des compétences d'ordre social et émotionnel plutôt que professionnelles (comme rassurer une personne âgée ou lui tenir compagnie). Les heures de soin rationalisées exigent une force de travail plus réduite mais aussi plus qualifiée, les actes médicaux et infirmiers étant moins aisément compressibles ou éludés que les tâches sociales. À l'inverse, si les heures de soin prolongées sont susceptibles de créer plus d'emplois que les heures rationalisées, la force de travail sera en comparaison moins qualifiée et régulière.

Égalité des genres. Les questions relatives à l'emploi et aux soins sont traitées de manière assez détaillée dans le **chapitre 4**. Pour les aidants non professionnels, le problème tient principalement au conflit potentiel entre les soins et l'emploi. Pour les travailleurs et les professionnels des soins de longue durée, le principal problème tient aux conditions de travail et de rémunération. Pour les futurs bénéficiaires de soins, le risque de pénurie de personnel soignant est le problème qui se pose avec le plus d'acuité. Les conclusions discutées dans ce chapitre sont d'une certaine façon rassurantes dans la perspective du premier de ces problèmes, mais pas dans celle des deux autres.

En théorie, étant donné la contribution importante des hommes aux soins professionnels, les femmes ne sont pas les seules à être touchées par le conflit potentiel entre emploi et soins. Mais dans la pratique, savoir dans quelle mesure la répartition actuelle de ce risque est (in)équitable

ne va pas sans quelques incertitudes. D'un côté, ce conflit concerne les aidants non professionnels salariés, la probabilité d'emploi étant toujours plus faible pour les femmes. De l'autre, la probabilité pour les hommes salariés de prodiguer des soins de longue durée est moins élevée que pour les femmes salariées. Dans tous les cas, un examen approfondi des recherches des experts nationaux du réseau EGGE amène à la conclusion que s'occuper d'une personne âgée a moins de répercussions sur les choix en matière d'emploi que s'occuper d'un enfant. Les femmes abandonnent cependant leur emploi plus souvent que les hommes dans une situation similaire pour prodiguer des soins de longue durée. On estime généralement la perte d'emploi à moins de 10 % (ou légèrement plus), même dans des pays comme la Pologne, l'Italie ou l'Espagne, qui se reposent largement sur la famille. Dans certains pays, plus de 10 % des aidants réduisent leurs heures de travail ou prennent un congé plutôt que de quitter leur emploi : c'est le cas en France, par exemple, où l'on estime que 15 % des aidants possédant un emploi recourent au temps partiel pour s'occuper de personnes âgées. Des recherches économétriques comparatives confirment de fait l'impact des soins professionnels de longue durée sur la probabilité d'abandonner son emploi ou de réduire ses heures de travail. Cet impact, jugé statistiquement significatif, reste néanmoins limité.

Cependant, si les efforts actuels pour stimuler l'emploi des plus de 55 ans aboutissent, ces estimations pourraient ne pas rendre l'ampleur du conflit à venir. Certains éléments montrent, en France notamment, que les femmes âgées possédant un emploi pourraient être un échantillon caractérisé par un désir personnel et une forte volonté de garder son emploi même lorsque la nécessité de s'occuper de membres de la famille s'intensifie. Dans ce cas, ces femmes supplémentaires possédant un emploi pourraient à l'avenir avoir une plus grande propension à abandonner leur travail ou à réduire leurs heures de travail que dans les estimations actuelles.

Des politiques adaptées en matière de temps de travail peuvent contribuer à désamorcer ce conflit. L'examen approfondi des congés et autres dispositifs d'aménagement du temps de travail mené au **chapitre 4** montre simplement un sous-développement des prestations dans certains pays. Dans d'autres pays, le problème tient tant à la faiblesse des prestations qu'au manque de coordination avec les services existants de soins de longue durée et à une élaboration inadaptée.

En particulier, la République tchèque, la Croatie, Chypre, l'Estonie, la Grèce, la Slovénie, la Pologne, la Norvège et le Portugal ne prévoient que des congés de courte durée allant de 6 à 30 jours par an, contre des congés de courte, moyenne ou longue durée dans la majorité des autres pays. Les congés de courte durée sont souvent payés (pas partout cependant, comme à Chypre et en Croatie) et ne sont pas subordonnés à l'accord de l'employeur. La motivation principale est de prodiguer des soins aux membres de la famille, les prestations étant, dans un tiers des cas seulement, explicitement ou de fait destinées aux personnes âgées, comme en Autriche, en Grèce et en Roumanie. On relève pour 15 pays un ou plusieurs dispositifs de congés de moyenne ou longue durée. Il s'agit de l'Autriche, la Bulgarie, la Belgique, l'Allemagne, le Danemark, l'Espagne, la Finlande, la France, l'Irlande, l'Islande, l'Italie, Malte, les Pays-Bas, la Roumanie et la Suède. Dans la majorité des cas, la durée maximale des congés ne dépasse pas un an, mais les exceptions ne manquent pas : deux ans en Espagne et en Italie, cinq en Irlande, huit à Malte, tandis que la Belgique possède une mesure spécifiquement destinée aux personnes âgées qui permet de prolonger un congé jusqu'à la retraite. Si ces congés ne sont en règle générale pas rémunérés, des compensations sont prévues dans un nombre non négligeable de cas, avec quelques restrictions.

L'expérience des pays qui ont introduit ou tenté d'introduire des mesures en matière de congés ciblant les soins de longue durée – en particulier l'Autriche – fait peut-être ressortir une méconnaissance de la forme optimale à donner aux congés pour soins de longue durée. L'horizon temporel dans les soins de longue durée étant très incertain et l'évolution des besoins dans le temps assez imprévisible, les dispositifs existants en matière de congés parentaux ou de garde d'enfants ne représentent pas un modèle viable. D'autres dispositifs en matière de temps de travail peuvent apporter une réponse valide aux aidants possédant un emploi. En particulier, les horaires de travail flexibles sont populaires en Europe auprès des aidants, tant des femmes que des hommes, dans la mesure où ils suffisent souvent à satisfaire la demande de soins en cas d'invalidité légère ou complètent efficacement les soins professionnels en cas de lourde invalidité. La Finlande, la Lettonie, la Norvège, la Roumanie, la Slovénie et le Royaume-Uni ont actuellement recours à des horaires de travail flexibles pour prodiguer des soins de longue durée.

Les éléments rassemblés aux fins du présent rapport sont moins rassurants concernant les conditions de rémunération et de travail des aidants que concernant le conflit entre soins et emploi. Avec les réserves d'usage du fait d'inévitables problèmes de comparabilité, l'analyse des valeurs nationales standardisées pour les salaires mensuels à plein temps (en rapport du niveau de rémunération moyen, par l'OCDE) indique que :

- Dans 2 pays seulement sur les 17 pour lesquels des données comparables suffisantes existent (Danemark et Islande), les travailleurs possédant une qualification de base dans les soins en établissement gagnent au moins autant qu'un travailleur moyen dans les autres secteurs de l'économie, bien que plusieurs de ces cas soient à relier au secteur public où les salaires tendent à être plus favorables que dans le secteur privé. Dans près de la moitié des cas, les salaires atteignent tout au plus deux tiers des valeurs moyennes de l'OCDE. La comparaison avec l'employé moyen dans le reste de l'économie est encore moins favorable pour le travailleur du secteur public (ou de tout secteur) qui prodigue des soins à domicile.
- Les professionnels (infirmières, le plus souvent) font mieux que leurs collègues moins qualifiés, sans atteindre pour autant ce que leur niveau de formation et leurs compétences devraient leur valoir. Dans seulement 6 des 16 pays concernés, une infirmière ou un travailleur possédant une qualification équivalente dans les soins à domicile gagne autant ou plus que la valeur moyenne de l'OCDE, mais dans 6 cas également il/elle gagne tout au plus deux tiers de la valeur moyenne de l'OCDE. Les pourvoyeurs professionnels de soins en établissement sont très légèrement mieux lotis.
- Les données pour le secteur privé et irrégulier sont insuffisantes. Selon des données fragmentaires, la rémunération des professionnels et des travailleurs dans les soins à domicile sur le marché gris est nettement plus basse.
- En dépit d'un niveau de féminisation très élevé, les pourvoyeuses de soins et les prestataires professionnelles sont un peu plus pénalisées par l'écart de rémunération entre les femmes et les hommes. Les valeurs actuelles relatives à cet écart diffèrent largement selon le pays et le niveau de qualification, mais les chiffres existants sont trop peu nombreux pour autoriser des généralisations.

Les niveaux de rémunération relativement bas sont aggravés par de mauvaises conditions de travail. En analysant les conditions de travail, les rapports nationaux étayent les éléments

médicaux faisant état, pour les aidants de longue durée, de nombreux risques pour leur travail. Ces rapports mettent l'accent sur des conditions de travail entraînant une usure physique comme la lassitude mentale et le stress, auxquels il convient d'ajouter une exposition aux infections du fait du contact rapproché avec les corps et une exposition aux accidents de la route lors des déplacements au domicile du client.

Conséquence des mauvaises conditions de rémunération et de travail, le renouvellement de personnel est très élevé dans des pays aussi différents que l'Autriche, la Belgique, la Bulgarie, l'Islande, l'Italie, les Pays-Bas, la Pologne et le Royaume-Uni. De plus, un grand nombre de pays constate ou anticipe actuellement un renouvellement et surtout une pénurie de travailleurs ou de professionnels (infirmières par exemple) dans le secteur des soins de longue durée. C'est le cas en Europe de l'Ouest et du Sud (Autriche, Belgique, Chypre, Allemagne, Finlande, Italie, Pays-Bas, Malte, Royaume-Uni) et dans plusieurs pays d'Europe centrale et de l'Est (Bulgarie, Lettonie, Pologne, Hongrie).

Mesures politiques. Selon des experts nationaux (d'Autriche, de Grèce, de France, d'Islande et de Lettonie par exemple), depuis le début de la crise financière, les soins de longue durée ne figurent plus en aussi bonne place dans l'agenda politique des États membres que les soins aux enfants. Le manque d'objectifs ciblés comme ceux définis pour les soins aux enfants dans la stratégie de Lisbonne peut avoir fait diminuer la nécessité de traiter publiquement cette question. Certains signes laissent néanmoins penser que cette question occupe une place croissante dans le débat public, notamment en Norvège et au Royaume-Uni. Le **chapitre 5** donne un court aperçu de certains développements politiques des dernières années.

La décennie passée n'a pas été marquée par des réformes importantes de l'architecture du système de soins de longue durée dans les États membres. Cependant, les représentants d'au moins cinq gouvernements nationaux (France, Hongrie, Pologne, Roumanie, Slovénie) ont récemment évoqué ou préconisé l'introduction d'une assurance obligatoire de soins de longue durée. Comme le soulignent les rapports nationaux des experts du réseau, la crise financière actuelle pourrait être un obstacle aux réformes. Il existe pourtant des exemples de réformes majeures mises en œuvre par le passé dans le but notamment de limiter l'inflation des dépenses dans le secteur des soins de longue durée. L'Allemagne fait à ce titre figure d'exemple : selon certains experts, l'assurance de soins longue durée a été introduite dans le but notamment de

contenir la hausse des dépenses dans l'aide sociale, principale source de financement public pour les soins professionnels de longue durée avant la réforme.

Une grande partie des développements politiques de la décennie écoulée se situe dans le prolongement de tendances passées et peut être résumée à un glissement progressif (i) des soins institutionnalisés vers les soins à domicile ; (ii) des prestations publiques vers les services privés ou mixtes avec transferts en espèces ; (iii) en faveur de services qui complètent les soins non professionnels plutôt qu'ils ne les remplacent.

Le glissement vers les soins de longue durée à domicile est confirmé par l'analyse des taux de couverture faite au chapitre 2, et reflète la nécessité de contenir le coût des services tout en allant dans le sens de la préférence largement exprimée par les personnes âgées de recevoir des soins à domicile. Les risques inhérents à ce changement sont de diminuer le niveau des soins de santé et de développer une force de travail sous-équipée et ne possédant pas la formation requise. Pour éviter cela, les résultats des soins à domicile doivent être attentivement comparés à ceux des soins institutionnels : par exemple, la probabilité de reprise après un AVC est-elle plus élevée avec des soins en unité spécialisée qu'avec des soins à domicile ? Quant à la qualité de l'emploi dans les soins de longue durée, elle a été affectée par la préférence quasi-universelle pour les transferts en espèce plutôt que par un penchant pour les soins eux-mêmes.

Les transferts en espèces s'opèrent principalement à travers deux types d'allocations : la première, versée à une personne âgée nécessitant des services de soins, est souvent appelée (de manière non systématique) « allocation de présence ». La seconde, versée à l'aidant familial ou à la personne âgée en compensation des services de l'aidant (familial), est souvent appelée « allocation de soins ». Entre autres exemples de transferts en espèces distincts des allocations, on trouve les remboursements d'impôt et les crédits d'impôt, les pensions d'invalidité, les primes pour l'achat de matériel médical ou pour la réalisation d'aménagements dans la maison, l'allègement des contributions de sécurité sociale pour les travailleurs et les professionnels des soins (notamment s'ils sont embauchés par la famille).

Les allocations de présence sont plus répandues que les allocations de soins (25 pays contre 20), et les sommes concernées généralement plus élevées. Pour assurer une standardisation entre les pays, les montants reportés sont exprimés en rapport du revenu moyen d'une personne de plus

de 65 ans. Dans 7 pays (Autriche, République tchèque, France, Allemagne, Pays-Bas, Portugal, Slovaquie), les montants maximum de l'allocation de présence représentent au moins 90 % du revenu de référence, cela ne restant valable que pour la Hongrie dans le cas de l'allocation de soins. De plus, dans la moitié environ des pays ayant adopté un dispositif d'allocations de soins (Bulgarie, Islande, Italie, Pays-Bas, Pologne, Royaume-Uni), le montant maximum ou fixe est inférieur à 50 % du revenu de référence.

Les questions liées à la répartition et à l'efficacité sont du domaine de la configuration même des allocations. Il importe de constater que, dans les pays ayant introduit une assurance de soins longue durée, les plafonds de paiement tendent à être beaucoup plus élevés que partout ailleurs (en rapport du revenu de référence). Ce qui fait dire que les dispositifs d'assurance de soins longue durée tendent à garantir une meilleure protection du revenu en cas de niveaux d'invalidité élevés et très élevés, clairement au bénéfice des personnes d'un âge très avancé (plus de 80 ans), parmi lesquelles les femmes sont les plus nombreuses. Dans une perspective d'égalité des genres, cependant, la question consistant à savoir si les transferts en espèces sont libres ou conditionnés se révèle encore plus importante. Les allocations « libres d'utilisation » encouragent l'expansion de l'emploi irrégulier et l'évasion fiscale, comme l'illustrent tous les pays dans lesquels prospère le modèle du « travailleur immigré dans la famille ». Les chèques-service sont un exemple de transferts conditionnés. Selon ses modalités de mise en place, le chèque-service peut encourager l'émergence d'emplois irréguliers, assurer au moins une certaine amélioration des compétences des travailleurs et introduire une certaine uniformité en matière de qualité des soins, le tout à des coûts raisonnables pour les budgets publics. Dans l'évaluation des experts nationaux, cependant, des segments d'emploi (féminin) ont aussi été créés, qui, bien souvent, ne garantissent pas une rémunération et des conditions de travail « décentes ».

Les mesures relatives aux transferts en espèces dans le domaine des soins de longue durée peuvent donc avoir – et ont eu – des répercussions importantes sur les marchés du travail. Paradoxalement, il apparaît que les mesures touchant le marché du travail se sont souvent attaquées aux symptômes du malaise sur le marché du travail dans le domaine des soins de longue durée – c'est-à-dire les pénuries et le renouvellement de personnel – plutôt qu'aux

causes fondamentales comme la faible rémunération, les mauvaises conditions de travail ou la ségrégation.

La pénurie actuelle ou attendue de travailleurs et de professionnels des soins est une grande préoccupation des gouvernements. Les réponses politiques les plus structurées des pays européens ont souvent visé à proposer de nouvelles formations tout en redéfinissant les besoins professionnels et d'éducation ou en réélaborant les parcours de carrière, en vue d'améliorer le recrutement et d'inciter le personnel à rester dans le secteur. Les cas de l'Autriche et de la Belgique l'illustrent : l'emploi semi-spécialisé dans les soins infirmiers (aide-soignants et infirmiers) y a été introduit afin d'allonger le cheminement professionnel et d'attirer plus de candidats. Dans d'autres pays, les initiatives sont moins novatrices et visent à accroître la participation aux cursus de formation, le nombre de postes de formation dans les entreprises (Estonie, Allemagne, Norvège, Portugal, Espagne) ou le niveau d'études ou de formation professionnelle requis pour les préposés aux soins à chaque niveau de qualification (Allemagne, Lettonie, Norvège, Royaume-Uni), et à certifier la formation reçue par les prestataires de soins à domicile (Roumanie). En Espagne et en France, les initiatives visant à encourager la formation ont été étendues aux travailleurs embauchés par le biais de chèques-service dans le domaine des soins à domicile.

Les niveaux de rémunération peu attrayants sont une cause fondamentale des pénuries de personnel. Pourtant, un nombre restreint de pays s'est directement attaqué à autre chose qu'à la formation pour revaloriser les salaires dans les SLD : par exemple, les emplois irréguliers, la faible capacité à payer des familles, la mauvaise reconnaissance des soins en tant que profession, la sur-représentation des femmes. On trouve cependant quelques exceptions : en Autriche, où les contributions de sécurité sociale ont été réduites pour permettre l'émergence de travailleurs et de professionnels des soins immigrés irréguliers, en Allemagne où un salaire minimum a été introduit dans le secteur des soins, en Roumanie où les prestataires de soins de longue durée ont récemment été reconnus comme appartenant à une « profession » distincte dans le code de l'emploi. Presque aucun pays n'a inscrit à son agenda politique de mesures visant à faire entrer davantage d'hommes dans ce secteur. Si l'importance d'études ou de formations supplémentaires pour remédier aux pénuries ne fait aucun doute, se reposer presque exclusivement sur ce type de mesures pourrait compromettre leur efficacité.

Le défi sans doute le plus important pour la majorité des 33 pays examinés tient à l'impact de la crise actuelle sur les prestations futures. Se limiter en réponse à la crise financière à rationaliser les prestations et à exercer une pression sur les familles pour qu'elles internalisent les soins au lieu de les externaliser serait pourtant une belle occasion de ratée, tant du point de vue économique que de l'égalité des genres. Il conviendrait bien plutôt d'inverser cette perspective et de faire du secteur en expansion rapide des soins de longue durée un moteur de croissance en matière d'emploi. En parallèle, les répercussions positives en matière d'emploi pourraient faire de ce segment une porte d'entrée pour les hommes dans le secteur des soins au sens large.

Kurzfassung

Zweck und Ziele. Hauptziel des vorliegenden Berichtes ist die Analyse des Angebots im Bereich der Langzeitpflege in Europa (im Folgenden LZP oder Langzeitpflege) aus der Doppelperspektive der Beschäftigungssituation der weiblichen Bevölkerung und der Gleichstellung der Geschlechter. Der Schwerpunkt wird auf die Leistungen gelegt und weniger auf die Finanzierung und Ausgaben, den Naturalunterhalt durch Versorgung in Pflegeeinrichtungen oder die private, häusliche Pflege, finanzielle Zuwendungen wie Pflege- oder Beaufsichtigungszuschüsse sowie zeitlich gebundene Unterstützungsmaßnahmen in Form von Ausgleichszahlungen für Arbeitsausfallzeiten oder das Recht auf flexible Arbeitszeiten. Auf Grundlage der Berichte der Länderexperten des EGGE-Netzwerkes erfolgt eine vergleichende Analyse der Situation in 33 europäischen Ländern, zu denen die 27 EU-Mitgliedsstaaten, die 4 Beitrittskandidaten Kroatien, die ehemalige Jugoslawische Republik Mazedonien, Island und die Türkei sowie die 2 EFTA-Staaten Norwegen und Liechtenstein gehören.

Frauen sind überdurchschnittlich stark in das Erbringen von Langzeitpflegeleistungen involviert. Auf der Nachfrageseite machen sie den Hauptteil der Leistungsempfänger aus: Auf der Angebotsseite sind sie als bezahlt oder unbezahlt Pflegeleistende nach wie vor deutlich überrepräsentiert. Verfügbarkeit, Bezahlbarkeit und die Qualität der Leistungen beeinflussen Frauen wie Männer in ihrer Rolle als potentielle Leistungsempfänger. Auf der Angebotsseite verstärkt die anhaltende Überrepräsentation der Frauen als Pflegeleistende im Rahmen der nicht institutionalisierten Pflege die bestehende extreme Gewichtung hin zu weiblichen Pflegeleistenden auch im professionellen Bereich. Während die deutliche Feminisierung der Langzeitpflege Frauen Beschäftigungsmöglichkeiten in einem sich schnell entwickelnden Sektor eröffnet, wirft sie zugleich wichtige Fragen hinsichtlich der Gleichstellung der Geschlechter sowohl auf dem Arbeitsmarkt als auch in den familiären Haushalten auf.

Die Analyse in diesem Bericht konzentriert sich auf Fragen zur Verfügbarkeit und Erschwinglichkeit der Leistungen sowie zur Gleichstellung der Geschlechter. Neben den Länderberichten der 33 Experten des EGGE-Netzwerks werden als Grundlage für die Statistiken vier Hauptquellen verwendet: der Altersbericht 2009 der Europäischen Kommission, die EU-SILC-Erhebung, der *Survey of Health, Ageing and Retirement in Europe* (im Folgenden SHARE),

Gesundheitsstatistiken der OECD sowie die jüngste Datenzusammenstellung zur Langzeitpflege von Huber et al. aus dem Jahre 2009.

Entwicklungstrends im Hintergrund. Nach dem „2009 Ageing Report“ der Europäischen Kommission ist die zu erwartende Ausweitung der Nachfrage nach Langzeitpflege selbst unter moderat konservativen Annahmen eklatant (**Kapitel 1**). Angesichts der Erwartung, dass sich die Anzahl der über 79-Jährigen bis zum Jahr 2060 verdreifachen wird, wird das Segment der Langzeitpflege in den kommenden rund 50 Jahren eine der Triebfedern dieser Ausweitung sein. Das zukünftige Ausmaß der Nachfrage nach Leistungen in der Langzeitpflege ist nicht genau abzusehen, da zu einer mangelnden Übereinstimmung hinsichtlich der Definition einer Behinderung im hohen Alter auch widersprüchliche Daten zur Entwicklung der Behindertenstruktur treten. 2007 wurde im Rahmen einer OECD-Studie von Lafortune und anderen festgestellt, dass im Laufe der Zeit die Verbreitung von Behinderungen in einigen Ländern gestiegen war, während in anderen Ländern das Gegenteil der Fall war. Angesichts dieser gegensätzlichen Daten geht das sogenannte demographische Szenario des „Ageing Report“ der Europäischen Kommission vorsichtiger Weise von keiner Änderung der derzeitigen Verbreitung von Behinderungen aus. Des weiteren davon ausgehend, dass die Wahrscheinlichkeit, häusliche oder institutionalisierte Pflege in Anspruch zu nehmen unverändert bleibt, ergibt sich im Rahmen dieses Szenarios, dass die Zahl der über 65-Jährigen, die unter mindestens einer Einschränkung bei der Ausführung der lebenspraktischen Fertigkeiten leiden, zwischen 2007 und 2060 auf einen Wert von 44,4 Millionen steigen und sich damit bis Ende 2060 mehr als verdoppeln wird. Die Zahl älterer Menschen, die in Pflegeeinrichtungen betreut werden, wird sich demnach mit einem Wert von 8,3 Millionen nahezu verdreifachen. Die häusliche Pflege würde mit 13,9 Millionen Empfängern von mehr als doppelt so vielen Menschen wie zuvor (5,5 Millionen) in Anspruch genommen. 22,3 Millionen gegenüber 12,2 Millionen Menschen im Jahr 2007 könnten lediglich informelle oder gar keine Pflege in Anspruch nehmen. In einem ‚optimistischeren’ Szenario wird angesichts einer fortgesetzten Verbesserung der Lebenserwartung von einer Verringerung der Behindertenzahlen ausgegangen. Doch selbst in diesem Szenario ist nahezu eine Verdopplung der Zahl älterer Menschen mit Behinderung zu erwarten.

Nach allen Prognosen werden Frauen auch weiterhin den Hauptteil der Leistungsempfänger darstellen, doch dieses Ungleichgewicht wird sich in Zukunft wahrscheinlich verringern. Auf Grundlage der jüngsten Statistiken zur Versorgung mit formellen Pflegeleistungen ist die derzeitige Wahrscheinlichkeit für eine Frau, institutionalisierte Pflege in Anspruch zu nehmen, in allen Ländern außer in Lettland und Polen zwischen 1,1 und 2,8 Mal höher als für Männer. Die Wahrscheinlichkeit, dass Frauen Empfänger formeller häuslicher Pflege werden, liegt in allen Ländern außer in Polen zwischen 1,5 und 2,8 Mal höher als für Männer (**Abschnitt 2.2**). Die unverhältnismäßige Repräsentation der Frauen unter den Empfängern von Pflegeleistungen spiegelt die höhere Lebenserwartung und den starken Anstieg der Behinderungsrate ab einem Alter von 70 bis 75 Jahren wider. Diese Überrepräsentation wird sich jedoch in den kommenden rund fünfzig Jahren verringern, wenn, wie demographische Studien vorwegnehmen, die Lebenserwartung von Männern schneller steigen wird.

Wichtigste Gruppe sind nach wie vor die Erbringer informeller Pflegeleistungen, insbesondere Familienmitglieder und Freunde. Von den 20,7 Millionen älteren Pflegebedürftigen, die Schätzungen zufolge 2007 in der Europäischen Union lebten, sollen wiederum schätzungsweise 8,4 Millionen Empfänger formeller Pflege gewesen sein, 12,3 Millionen empfingen hingegen informelle oder gar keine Pflege (Europäische Kommission, Ageing Report, S. 148). Ein vielversprechendes Ergebnis des vorliegenden Berichts ist, dass Männer sehr viel stärker in die informelle Pflege Älterer einbezogen sind, als in die (informelle) Kinderbetreuung und dass ihr sich Beitrag in der Langzeitpflege positiv entwickeln könnte. Unter den informellen Pflegeleistenden, im Allgemeinen Familienangehörige, machen Männer in den 13 Ländern, die in die SHARE-Datenbögen aufgenommen wurden, einen Anteil von gut 39% aus. Hauptgrund ist, dass in praktisch allen Ländern Ehepartner und Partner die größte Gruppe der Pflegeleistenden für gemeinsam lebende, ältere Menschen darstellen. Dabei übernehmen Männer sehr häufig Pflegeverantwortung für ihre Frau oder ihre/n Partner/in. (**Abschnitt 4.1**). In der Hälfte der Länder, für die detaillierte Informationen vorliegen (Österreich, Belgien, Italien, Niederlande, Spanien und Polen), übernehmen Ehepartner/Partner geschlechtsunabhängig mit gleicher Wahrscheinlichkeit Pflegeverantwortung füreinander. Zudem wird von einigen Ländern explizit ein Anstieg der Beteiligung von Männern erwähnt, darunter das Vereinigte Königreich und Norwegen.

Eine zunehmende Beteiligung der männlichen Partner an der informellen Pflege könnte so eine Quelle zusätzlicher Pflegeleistungen und einen Ausgleich für den zu erwartenden Rückgang des weiblichen Pflegepotentials darstellen. Dieser Rückgang wird im Zuge der fortlaufenden Heraufsetzung des Rentenalters oder auch aufgrund kleinerer Familien und einer stärkeren geographischen Vereinzelung der Familienmitglieder erwartet. Im Gegensatz dazu gibt es keinerlei Anzeichen für einen Ausgleich des geschlechtsspezifischen Ungleichgewichts zwischen professionellen Pflegern und Pflegedienstleistenden. Laut den Ergebnissen der Europäischen Arbeitskräfteerhebung aus dem Jahr 2007 stellten Frauen in der EU der 27 rund 90% der Pflegekräfte und des Krankenpflegepersonals (einschließlich Hebammen), und es gibt keinen Grund zu der Annahme, dass dieser Anteil im Segment der Langzeitpflege, für das keine vergleichbaren Daten vorliegen, deutlich geringer wäre.

Verfügbarkeit von Angeboten. Angesichts der schnell wachsenden Nachfrage und eines fortwährenden geschlechtsspezifischen Ungleichgewichts unter den Anbietern von Pflegeleistungen, hängt ein Fortschritt hinsichtlich der Gleichstellungsfrage von einer Ausweitung des formellen Pflegeangebots in einem dementsprechenden Umfang ab. Darüber hinaus sollte eine solche Ausweitung wo möglich vorrangig die häusliche und teilstationäre Pflege fördern, denn es zeigt sich, dass sowohl Männer als auch Frauen diese der institutionellen Pflege vorziehen. Aus Sicht der Gleichstellung der Geschlechter hängt ein Fortschritt ebenso von einer umfangreicheren Beteiligung der Männer an der Erbringung informeller Pflegedienste sowie von einer vermehrten Nutzung von Anbietern formaler Pflegeleistungen im privaten oder öffentlichen Sektor ab.

Sichtbare Fortschritte wurden in der Langzeitpflege beim Angebot formeller Leistungen in Form von Sachgütern, finanziellen Leistungen oder Pflegeangeboten außerhalb der regulären Arbeitszeiten gemacht **(Kapitel 2, 4 und 5)**. Wie auch in der Fachliteratur werden die Deckungsraten im vorliegenden Bericht als Indikatoren für die allgemeine Versorgung mit Pflegeleistungen verwendet.[3] Sie werden für die Bereiche häusliche und stationäre Pflege und sofern diesbezügliche Daten zugänglich sind auch für den Bereich der teilstationären Pflege wiedergegeben und ausgewertet. Stationäre Pflege ist durch Pflege- und Altersheime

[3] Deckungsraten sind als Anteil der Empfänger von Langzeitpflegeleistungen an der Gesamtanzahl älterer Menschen (65 Jahre und älter) definiert.

gekennzeichnet, während häusliche Pflege eine Hilfe im Haushalt, persönliche Pflege und häusliche Krankenpflegedienste umfasst. Teilstationäre Leistungen stehen in Tagesstätten und in Form von Pflegeentlastungen zur Verfügung. Der genauen Bewertung von Leistungen im Bereich der Langzeitpflege stehen Probleme mit der länder- und quellenübergreifenden Kompatibilität der Daten im Wege, die dieser Bericht nicht überwinden konnte Nichtsdestotrotz sind die hier zusammengestellten Informationen auf ein breiteres Ziel hin ausgerichtet, als in anderen Quellen für den europäischen Raum, wie zum Beispiel der OECD oder jüngerer Zusammenstellungen von Experten (Huber et al. 2009). Die Angaben der Länderexperten des EGGE-Netzwerkes werden anhand von Gegenproben überprüft und durch ausgewählte Daten aus diesen Quellen ergänzt.

Die Deckungsraten der stationären Pflege tendieren in west-, nord- und südeuropäischen Ländern zu vergleichsweise verhaltenen Werten. Dies ist ein indirektes Anzeichen für eine ausgleichende Entwicklung bei der Versorgung, die sich von der institutionellen hin zur häuslichen Pflege verschiebt. Der Höchstwert dieser Raten findet sich Island (8,3%), der Tiefstwert in der ehemals Jugoslawischen Republik Mazedonien (0,2%). An der Spitze rangieren zudem Frankreich, Belgien und die Niederlande mit Deckungsraten von knapp über 6%. Es folgen Schweden, Norwegen, Slowenien und Luxemburg mit Werten zwischen 5 und 6% sowie Österreich, die Tschechische Republik, Zypern, Deutschland, Dänemark, Spanien, Finnland, Ungarn, Irland, Italien, Malta, Portugal, die Slowakei und das Vereinigte Königreich mit Werten zwischen 2,5 und 5%. Am unteren Ende rangiert die Türkei und Griechenland gemeinsam mit den 7 osteuropäischen Ländern Kroatien, Estland, Lettland, Polen, Litauen, Rumänien und der ehemals Jugoslawischen Republik Mazedonien, die sämtlich Deckungsraten von unter 2% verzeichnen.

Zeichen für eine Entwicklung hin zu einer besseren Versorgung mit formeller LZP ist auch das Aufholen der Mittelmeerländer im Bereich der häuslichen und teilstationären Pflege. Nur in einer Handvoll osteuropäischer Länder können ältere Menschen hingegen auf eine wirkungsvolle Infrastruktur zur häuslichen Pflege bauen. Dominierendes Kennzeichen der häuslichen und teilstationären Pflege ist jedoch ihre Verbreitung über zahlreiche Länder hinweg. In den einzelnen geographischen Gebieten können sich in dieser Verteilung durchaus unterschiedliche Bedürfnisse widerspiegeln, so aufgrund der Alters- oder Behinderungsstruktur, doch jeder Versuch, die Deckung des tatsächlichen Bedarfs zu beurteilen, gestaltet angesichts der Tatsache,

dass Behinderung in verschiedenen Ländern verschieden verstanden wird, durchaus problematisch. Es ist jedoch unwahrscheinlich, dass Unterschiede in den tatsächlichen Bedürfnissen einen Hauptteil der derzeitigen Abweichungen zwischen den konventionellen Deckungsraten der einzelnen Länder verantwortlich darstellen. So ist die Deckung mit häuslicher Pflege (nur in Form von Sachleistungen) in Schweden beinahe doppelt so hoch wie in Italien, obgleich das Mittelmeerland im Jahr 2009 nach Deutschland den höchsten Altersdurchschnitt Europas aufwies.

In den 27 Ländern, für die Daten vorliegen, liegt die Deckungsrate der häuslichen Pflege zwischen 0,3% in Rumänien und 20-21% in den Niederlanden, Island und Dänemark. Mit Ausnahme Finnlands sind die nordischen Länder im obersten Bereich der Klassifizierung zu finden, es besteht jedoch ein deutlicher Abstand zwischen den drei höchstbewerteten Ländern und Schweden mit 9,4%.

Am unteren Ende der Liste stehen mit Deckungsraten von unter 2% fünf osteuropäische Länder: Rumänien, Litauen, Lettland, Polen und Slowenien. Estland und die Slowakei liegen mit einer Deckungsrate von 2,3% knapp darüber. Die südeuropäischen Länder (EU-Mitgliedsstaaten) liegen sämtlich über den Ländern Osteuropas, eine Ausnahme bilden nur die Tschechische Republik und Ungarn. Griechenland, Italien und Spanien liegen derzeit bei rund 5%, Portugal und Malta lediglich einen Prozentpunkt darunter. Die vier Länder, die eine obligatorische, langfristige Pflegeversicherung eingeführt haben, schneiden durchwegs besser ab, als die Gruppe südeuropäischer Länder, doch bestehen auch zwischen ihnen deutliche Unterschiede: von 21% in den Niederlanden und beachtlichen 14% in Österreich bis hin zu 7% in Luxemburg und 6,6% in Deutschland.

Nur eine Minderheit der Länder macht separate Angaben zur teilstationären Pflege. In Griechenland, Estland, Portugal, Island, Dänemark und Finnland liegen die Deckungsraten über 2%. Estland und Griechenland sind in jüngerer Zeit herausragende Beispiele eines schnellen Wachstums.

Hohe Deckungsraten formeller Leistungen entsprechen nicht zwangsläufig einer größeren Fremdbeschaffung seitens der Familien, also einer gleichmäßigeren Verteilung der Pflegeaufgaben zwischen formellen und informellen Pflegeleistenden. Deckungsraten können

beispielsweise auch finanzielle Zuwendungen umfassen, die nicht für den Erwerb von Pflegeleistungen verwendet werden. Tatsächlich weist das Verhältnis zwischen formeller und informeller Pflege nach wie vor deutliche Unterschiede auf, die nur teilweise mit den Unterschieden in den Deckungsraten übereinstimmen. Eine Untersuchung der SHARE-Daten aus 13 europäischen Ländern (Österreich, Belgien, Tschechische Republik, Deutschland, Dänemark, Griechenland, Spanien, Frankreich, Irland, Italien, Niederlande, Polen und Schweden) hat ergeben, dass informell pflegeleistende Familienangehörige (und einige Freunde) nach wie vor in allen Ländern vorrangig im Einsatz sind, wenn Pflege in relativ weiten Abständen, also seltener als einmal täglich geleistet wird. Mit Ausnahme Frankreichs und Belgiens verlassen sich in jedem dieser 13 Länder mindestens 80% der älteren Menschen, die Empfänger von Pflegeleistungen sind, ausschließlich auf die Familie, nur 20% nehmen professionelle und somit bezahlte Pflegeleistungen (ausschließlich oder in Verbindung mit Pflege durch Familienangehörige) in Anspruch. Bedeutende Unterschiede zwischen den Ländern zeigen sich erst dann, wenn die Pflegeanforderungen intensiver und täglich oder beinahe täglich erforderlich werden. In Frankreich, Belgien, den Niederlanden und Dänemark verlassen sich bei intensiven Pflegeanforderungen weniger als 30% der älteren Leistungsempfänger ausschließlich auf die Familie, in Italien, Spanien, Griechenland, Deutschland, der Tschechischen Republik und Polen fällt dieser Wert hingegen nicht unter 60%.

In jedem Land entwickelt sich durch die Aufgabenteilung zwischen Staat, Markt und Familie in ihren jeweiligen Rollen als Pflegeleistende ein ‚praktikables' Gleichgewicht, sobald Komplementaritäten zwischen diesen Institutionen in ausreichendem Maße genutzt werden. ‚Praktikabel' impliziert nicht ‚optimal', nicht einmal ‚gut', doch ist der Vorgang einmal in Gang gebracht, wird ein Modell oder System geschaffen. Eben dieses Grundprinzip unterliegt den Versuchen einer Ausarbeitung von Wohlfahrts- oder Pflegesystemen (Modelle) in der vorhandenen Literatur. Derzeitige Unterschiede zwischen den Ländern hinsichtlich des Umfangs und der Strukturierung der häuslichen gegenüber der stationären Pflege oder auch hinsichtlich des Umfangs der Nutzung privater oder öffentlicher Anbieter weisen darauf hin, dass die in der Literatur einst herausgearbeiteten Klassifizierungen möglicherweise einer Aktualisierung bedürfen. Bei Anwendung von Multiskalen-Techniken auf die 13 an der SHARE-Studie beteiligten Länder ließen sich vier Gruppen erkennen. Die Zugehörigkeit zu einer bestimmten Gruppe zeigt

hierbei eine engere allgemeine ‚Ähnlichkeit' mit anderen Mitgliedsstaaten als mit jedem beliebigen Nicht-Mitgliedsstaat. Die Gruppen sind (i) Dänemark und die Niederlande, (ii) Griechenland und Polen, (iii) Belgien, Frankreich und Schweden sowie (iv) die Tschechische Republik, Deutschland, Irland, Italien und Spanien. Österreich steht an isolierter Stelle. Es zeigt sich eine gewisse Kontinuität zwischen dieser Gruppierung und den in der jüngsten Arbeit des EGGE-Netzwerks zur allgemeinen Bekanntmachung herausgearbeiteten Klassifizierungen von Langzeitpflegesystemen. Es gibt jedoch auch deutliche Zeichen der Veränderung, die auf dem Sektor der Langzeitpflege in Europa seit Beginn der 1990er Jahre herausragende Entwicklungen widerspiegeln.

Die EU-Erweiterungen haben mehrere osteuropäische Länder in die Gemeinschaft gebracht, in denen die formelle Pflege älterer Menschen noch recht unterentwickelt ist. So hat ein Block osteuropäischer Länder die Länder des Mittelmeerraums am unteren Ende der Rangliste für den Ausbau der Leistungen in der formellen Langzeitpflege sowie von den Spitzenpositionen bei der informellen Pflege durch Familienangehörige abgelöst. Vor dem politischen und wirtschaftlichen Systemwechsel bestand die Unterstützung älterer Menschen in den ehemaligen Planwirtschaften vornehmlich aus finanziellen Unterstützungen wie Renten für Ruheständler oder Arbeitskräfte, die eine Behinderung erlitten hatten, Bezuschussung von Gütern und (allgemeinen) Dienstleistungen sowie Zugang zu Wohnraum, Ferienhäusern und Grund und Boden. Pflegeleistende Familienangehörige, vorrangig Frauen und informelle Gemeinschaftsnetzwerke, sorgten für eine langfristige Pflege der älteren Menschen. Auf Langfristigkeit angelegte stationäre Einrichtungen (in erster Linie betreutes Wohnen) waren hingegen eine Ausweichlösung für den Fall, dass Familienangehörige oder Freunde zur Pflege nicht imstande waren. Bereits bevor der politische Wandel die vorhandenen Einrichtungen zu dezimieren begann, lag der Anteil der institutionellen Pflege in den meisten Planwirtschaften des Ostens einschließlich Russland bei unter 2% und bewegte sich in einigen kleineren ehemaligen Sowjetrepubliken um 0%.

Die Finanzkrise der 1990er Jahre und die darauffolgenden Budgetrestriktionen zwangen Länder wie Schweden dazu, stärker auf die informelle Pflege durch Familienangehörige zurückzugreifen. Einige Mittelmeerländer, die zum Teil von dieser frühen Finanzkrise verschont wurden, entwickelten sich in eine entgegengesetzte Richtung.

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Im Gesamtergebnis verschwimmt die ursprüngliche Trennung zwischen Südwesteuropa, wo sich der Sektor der Langzeitpflege übermäßig stark auf die Familie stützte und dem übrigen Westeuropa, wo die Art der Erbringung der Pflegeleistungen breiter gefächert war. Während sich die Länder Südeuropas (einigen) westeuropäischen Ländern stärker angeglichen haben, offenbart sich der wahrscheinlich größte Unterschied mit der EU-Osterweiterung, durch die nun die (meisten) neuen Mitgliedsstaaten und Beitrittskandidaten den derzeitigen Mitgliedern gegenüber stehen.

Finanzierbarkeit der Leistungen. Eine der Triebfedern für Veränderungen in Pflegesystemen ist die Suche nach neuen Lösungen für das Problem der Finanzierbarkeit von Langzeitpflegediensten. Erwartungsgemäß wurden neue Lösungen vorrangig für die sich schnell entwickelnden Bereiche der häuslichen Pflege und Community Care gesucht. **Kapitel 3** befasst sich mit den Kosten oder Marktpreisen für Pflegeleistungen und geht dabei in erster Linie von den Länderberichten des EGGE-Netzwerks aus.

Eine generelle Schlussfolgerung aus diesem Kapitel ist erwartungsgemäß die Tatsache, dass die stationäre Pflege für Familien tendenziell weniger erschwinglich ist als die häusliche Pflege. Die Pflege in privaten Pflegeheimen oder vergleichbaren Einrichtungen, die sämtlich ihre Leistungen

auf Vollkostenbasis abrechnen, ist generell in allen Ländern die teuerste Art der Langzeitpflege. Es überrascht jedoch, dass Länder, die erschwingliche stationäre Pflege anbieten, möglicherweise nicht in der Unterzahl sind. Wird ausgehend davon, dass die stationäre Pflege alle Grundbedürfnisse befriedigt, als Kriterium festgelegt, dass Aufwendungen für die Pflege in Höhe von bis zu 85% des Einkommens als ‚erschwinglich' eingestuft werden können, erfüllen 12 der 21 Länder, mit deren Aufwendungen für staatlich gestützte Pflegeleistungen in groben Zügen vergleichbar sind, dieses Erschwinglichkeitskriterium: Österreich, Bulgarien, Dänemark, Estland, Finnland, Griechenland, Ungarn, Irland Norwegen, Polen, Rumänien und Schweden. Zu den Ländern, in denen das Kriterium nicht erfüllt wird, zählen die Tschechische Republik, Frankreich, Slowenien, Deutschland, Italien und das Vereinigte Königreich. Für die übrigen Länder (Island, Luxemburg, Lettland und Malta) liegen keine aussagekräftigen Daten vor. Im nordeuropäischen Block ist die Erschwinglichkeit ein Teilaspekt der universalistischen Strategien in der Pflegepolitik. In Ländern mit einer schlechten Versorgung ist die Erschwinglichkeit häufig eine Kehrseite von Rationierungen: Ein begrenztes Angebot wird als eine Art letzter Ausweg für Ältere genutzt, denen - einschließlich der familiären Pflege . keine zuverlässige oder erschwingliche Alternative zur Verfügung steht.

Eine Beurteilung der Erschwinglichkeit häuslicher Pflegedienste gestaltet sich schon allein aufgrund der Vielfalt der Maßnahmenpakete in den verschiedenen Ländern schwierig. In einer Auswahl von vier individuell ausgeprägten Organisationsprofilen können dennoch *typische Kosten* für die häusliche Pflege beobachtet werden. Die vier Profile sind die ‚Umfassende Pflege bei begrenzter Zeit für das persönliche Gespräch', ein ‚Migrant in der Familie', die Nutzung von ‚Pflegegutscheinen' und ‚minimales Vertrauen in die Fremdvergabe von Pflegeleistungen'.

Beispiel für ein Profil des ersten Typs ist Schweden. In seinen Grundzügen findet sich jenes Profil jedoch in allen skandinavischen Ländern sowie in den Niederlanden. In diesen Ländern sind formelle häusliche Pflegedienste in Form von Sachleistungen sowohl umfassend als auch erschwinglich. Diese Erschwinglichkeit beruht jedoch auf einer klaren Rationalisierung der Pflegestunden.

Das Profil ‚Migrant in der Familie' wird in Italien und Griechenland in großem Umfang genutzt, ist aber auch in Spanien und Zypern beliebt. In diesen Ländern findet sich typischerweise eine Kombination aus drei ‚Hauptressourcen': begrenzte doch kostengünstige öffentliche Dienste in

Ergänzung zur Pflege durch Familienangehörige, keine universelle sondern eine selektive Vergabe von Barzuschüssen und ein großer, weitgehend ungeregelter Markt für Pflegekräfte mit Migrationshintergrund. Dank dieser Kombination ist eine 24-stündige oder doch täglich mehrstündige Pflegebetreuung für eine große Minderheit der Familien *de facto* erschwinglich. Varianten dieses Grundmodells finden sich auch in Österreich und in der Türkei, obgleich sie dort nicht in demselben Umfang wie in Italien, Griechenland oder Spanien auftreten.

Für die Funktion des Pflegegutscheins ist das französische System ein besonders gutes Beispiel. Für das Problem der Erschwinglichkeit bietet es eine Lösung, die zwischen denen der nordischen Länder und denen der Mittelmeerländer angesiedelt ist. Anstelle selektiver Leistungen werden hier nahezu universelle Finanzleistungen gewährt, beim Einsatz der Pflegegutscheine verlässt sich das System stark auf private und öffentliche Pflegeanbieter. Gegenüber Dänemark oder Schweden sind die Pflegezeiten weniger stark rationalisiert, obgleich sie kürzer sind als dies im Modell ‚Migrant in der Familie' möglich ist.

Polen ist ein Beispiel für die minimale Fremdvergabe familiärer Pflegeleistungen, nicht nur aufgrund äußerst geringer staatlich bezuschusster Alternativen, sondern auch deshalb, weil private Angebote recht kostspielig sein können. Während ein kleiner Teil der älteren Menschen im Land kostenlosen Zugang zu staatlichen Pflegeleistungen hat, muss sich die Mehrheit auf den Markt oder auf kostenpflichtige häusliche Dienste verlassen. Die Stunden- oder Stückkosten sind im Allgemeinen gering, doch eine Person mit umfangreichem und häufigem Pflegeanspruch sieht sich potentiell mit hohen Kosten konfrontiert. Andere osteuropäische Länder teilen Polens Mangel an formellen häuslichen Pflegeangeboten und das Angebot kostspieliger kommerzieller Alternativen zur familiären Pflege. Beispiele hierfür sind Ungarn und Slowenien.

Bei einem Vergleich dieser vier Organisations- und Preisprofile werden zwei miteinander verknüpfte Kompromisslösungen erkennbar. Die erste besteht zwischen der Anzahl der Pflegestunden auf der einen und einer ausgewogenen Verteilung auf der anderen Seite: Die grundsätzlich erschwinglichste Lösung, die sich in den nordeuropäischen Ländern findet, rationalisiert die Pflegestunden, um so eine bestmögliche Abdeckung zu erschwinglichen Preisen zu ermöglichen. In Island und Schweden liegt die durchschnittliche Anzahl der Pflegestunden

beispielsweise bei unter 3 Stunden pro Woche, in Dänemark hingegen bewegt sie sich zwischen 4 und 6 Stunden wöchentlich. Im Gegensatz dazu sind lange Pflegezeiten in den übrigen Ländern tendenziell kostspielig und daher nur für eine Minderheit der Familien erschwinglich Nur dort, wo keine fachlich geschulten Pflegeleistenden beschäftigt werden und die Löhne durch Zuwanderung und große informelle Märkte niedrig gehalten werden, wächst diese Minderheit zu einer messbaren Größe an, wie das Modell ‚Migrant in der Familie' in Italien zeigt. Pflegegutscheine wie sie in Frankreich üblich sind, scheinen eine Kompromisslösung zu sein, da dieses System nicht zwangsläufig zu einer drastischen Rationalisierung der Pflegestunden führt, zugleich jedoch lange wöchentliche Pflegezeiten nicht für alle gleichermaßen erschwinglich macht.

Die zweite Kompromisslösung besteht zwischen dem Potential zur Schaffung von Arbeitsplätzen und der Beschäftigungsqualität. Bei einem Angebot ausgedehnter Pflegezeiten sind für einen Großteil der Pflegezeit eher soziale und emotionale Fähigkeiten als berufliche Professionalität gefragt, wenn sich beispielsweise mit der älteren Person befasst und ihr Gesellschaft geleistet wird. Rationalisierte Pflegezeiten erfordern im Vergleich dazu weniger, aber fachlich besser geschulte Pflegekräfte, da medizinische Aufgaben und Krankenpflege weniger leicht zusammengefasst oder weggelassen werden können als soziale Fähigkeiten. Daher ist es wahrscheinlich, dass ausgedehnte Pflegezeiten zwar für mehr Beschäftigung sorgen, als rationalisierte Pflegezeiten, die Beschäftigten jedoch fachlich geringer geschult sind und die Arbeitssituation unsicherer ist.

Gleichstellung der Geschlechter. Probleme im Zusammenhang mit Beruf und Pflegeaufgaben werden in **Kapitel 4** detaillierter betrachtet. Für Erbringer informeller Pflegeleistungen besteht das Hauptproblem in dem Risiko eines potentiellen Konflikts zwischen der Pflegeleistung und dem Beruf. Für fest angestellte, professionelle Pflegeleistende stellen sich Bezahlung und Arbeitsbedingungen als zwei Hauptprobleme dar. Für zukünftige Empfänger von Pflegeleistungen stellt die Kürzung des Pflegepersonals die größte Schwierigkeit dar. Die in diesem Kapitel besprochenen Ergebnisse sind nur hinsichtlich des ersten Risikos in gewisser Weise beruhigend, nicht aber hinsichtlich der zwei verbleibenden Risiken.

Angesichts des beachtlichen Anteils der Männer an der informellen Pflege ist der Konflikt um die Vereinbarkeit von Beruf und Pflegeaufgaben prinzipiell nicht nur eine Angelegenheit der Frauen. Konkret besteht einige Ungewissheit darüber, wie (un)gleichmäßig das Risiko tatsächlich verteilt ist. Einerseits betrifft der Konflikt berufstätige Erbringer informeller Pflegeleistungen, und die Beschäftigungswahrscheinlichkeit für Frauen ist nach wie vor geringer. Andererseits ist es für berufstätige Männer unwahrscheinlicher, Langzeitpflegeaufgaben zu übernehmen als für berufstätige Frauen. In jedem Fall deuten die eingehenden, landesweiten Untersuchungen der Experten des EGGE-Netzwerks darauf hin, dass die Pflege eines älteren Menschen weniger Konsequenzen auf berufliche Entscheidungen hat, als die Kinderbetreuung. Berufstätige Frauen, die eine Pflegeverantwortung übernommen haben, verlassen häufiger als Männer in einer vergleichbaren Situation ihren Beruf, um den Pflegeaufgaben nachzukommen. Der geschätzte Beschäftigungsverlust liegt jedoch allgemein bei unter 10% (oder knapp darüber) und dies selbst in Ländern wie Polen, Italien oder Spanien, die sich in großem Umfang auf die Pflege durch Familienangehörige verlassen. Einige Länder berichten von mehr als 10% Pflegeleistenden, die ihre Arbeitszeit verkürzen oder eine Freistellung beantragen, den Beruf jedoch nicht vollständig verlassen. Ein Beispiel hierfür ist Frankreich, wo schätzungsweise 15% der berufstätigen Pflegeleistenden ihren Beruf in Teilzeit ausüben, um ihrer Pflegeverantwortung gegenüber den Älteren nachzukommen. Vergleichbare ökonometrische Untersuchungen bestätigen denn auch, dass die Wahrscheinlichkeit, aufgrund informeller Langzeitpflegeverpflichtungen den Arbeitsplatz aufzugeben oder die Arbeitszeit zu verkürzen zwar besteht, aber dennoch moderat ist.

Sollten jedoch die derzeitigen Bemühungen um eine Steigerung der Beschäftigungsrate der über 55-Jährigen erfolgreich sein, könnten diese Schätzungen das Potential des zu erwartenden Konfliktes unterbewerten. Insbesondere in Frankreich gibt es einige Hinweise darauf, dass die Stichprobe der gegenwärtig im Berufsleben stehenden älteren Frauen dem Fehler der Selbstselektion unterliegen könnte, da diese Gruppe durch eine starke Entschlossenheit gekennzeichnet ist, das Berufsleben nicht zu verlassen, selbst wenn sich der Bedarf an Pflegeleistungen durch Familienangehörige intensivieren sollte. Liegt eine Selbstselektion vor, dann könnten berufstätige Frauen in der Zukunft eine größere Neigung zur Aufgabe des Arbeitsplatzes oder zur Reduzierung der Arbeitsstunden zeigen, als bisher angenommen.

Umsichtig gestaltete Arbeitszeitstrategien könnten helfen, diesen Konflikt zu entschärfen. Die detaillierte Untersuchung der Freistellungszeiten und anderer zeitgebundener Leistungen in **Kapitel 4** zeigt, dass die Angebotslage in einigen Ländern schlicht unterentwickelt ist. In (einigen) anderen Ländern besteht das Problem jedoch weniger in einem Mangel an Angeboten als vielmehr in einer unzulänglichen Gestaltung und schlechten Koordination mit anderen vorhandenen Angeboten zur Altenpflege.

Insbesondere in der Tschechischen Republik, in Kroatien, Zypern, Estland, Griechenland, Slowenien, Polen, Norwegen und Portugal besteht lediglich die Möglichkeit für einen kurzen Freistellungszeitraum von 6 bis 30 Tagen im Jahr, wohingegen die Mehrheit der übrigen Länder sowohl kurz- als auch mittel- und langfristige Freistellungszeiträume bietet. Freistellungen von kurzer Dauer sind häufig bezahlt (jedoch nicht immer, z. B. nicht in Zypern oder Kroatien) und nicht von der Zustimmung des Arbeitgebers abhängig. Die vorrangige Begründung ist die Pflege von Familienangehörigen und nur in rund einem Drittel der Fälle ist das Angebot ausdrücklich oder *de facto* auf die Altenpflege hin ausgerichtet, so in Österreich, Griechenland und Rumänien. Ein oder mehr mittel- und langfristige Freistellungsmodelle werden aus 15 Ländern berichtet: Österreich, Bulgarien, Belgien, Deutschland, Dänemark, Spanien, Finnland, Frankreich, Irland, Island, Italien, Malta, den Niederlanden, Rumänien und Schweden. In der Mehrzahl der Fälle überschreitet die maximale Freistellungsdauer nicht den Zeitraum eines Jahres, doch gibt es zahlreiche Ausnahmen: Spanien und Italien mit zwei Jahren, Irland mit fünf und Malta mit acht Jahren sowie Belgien mit einem Freistellungsmodell speziell für ältere Arbeitnehmer, das bis zum Ruhestand hin ausgeweitet werden kann. Allgemein gilt, dass diese Freistellungen unbezahlt sind, in einer nicht zu vernachlässigenden Anzahl von Fällen jedoch ein Ausgleich angeboten wird, wenngleich mit einigen Einschränkungen.

Die Erfahrungen von Ländern, in denen speziell auf die Langzeitpflege ausgerichtete Freistellungsmodelle eingeführt oder der Versuch einer Einführung unternommen wurde, insbesondere in Österreich, deutet darauf hin, dass für die optimale Gestaltung eines Freistellungsmodells zur Altenpflege noch zu geringe Kenntnisse vorliegen. Da der zeitliche Horizont bei der Altenpflege schwerer abzuschätzen und die Bedürfnisentwicklung weniger vorhersehbar ist, können Modelle für Erziehungszeiten oder zur Kinderbetreuung nicht zur Orientierung herbeigezogen werden. Zudem könnten andere Arbeitszeitregelungen den

Bedürfnissen berufstätiger Pflegeleistender mit Effizienz entgegenkommen. Insbesondere flexible Arbeitszeiten sind unter europäischen Pflegeleistenden, Männern wie Frauen, beliebt, da sie oft schon ausreichen, um im Falle leichter Einschränkungen die Anforderungen des Pflegeempfängers zu erfüllen und zugleich im Falle schwererer Behinderungen die professionelle Pflege effizient ergänzen. Finnland, Lettland, Norwegen, Rumänien, Slowenien und das Vereinigte Königreich arbeiten derzeit im Rahmen der Angebote für die Altenpflege mit flexiblen Arbeitszeitmodellen.

Weniger beruhigend als für den Konflikt zwischen Beruf und Pflege sind die für diesen Bericht erhobenen Daten hinsichtlich der Bezahlung und der Arbeitsbedingungen von professionellen Pflegeleistenden. Bei aller durch die unvermeidlichen Probleme der Vergleichbarkeit gebotenen Vorsicht ergibt die Analyse der standardisierten Zahlen für Einkommen aus Vollzeitbeschäftigung der einzelnen Länder (also an den von der OECD für die einzelnen Länder zugrundegelegten Durchschnittslohn angelehnte Beträge) Folgendes:

- Lediglich in Dänemark und Island, also in 2 von 17 Fällen, für die ausreichend vergleichbare Daten vorliegen, erhalten Beschäftigte mit Grundausbildung in der stationären Pflege mindestens den Durchschnittslohn eines Arbeiters im nationalen Wirtschaftsraum, und das obwohl die Erhebung bei vielen der untersuchten Fälle den öffentlichen Sektor betraf, auf dem die Löhne für Pflegekräfte tendenziell in einem guten Verhältnis zu denen auf dem privaten Sektor stehen. In beinahe der Hälfte dieser Fälle erreichen die Einkünfte bestenfalls zwei Drittel des OECD-Durchschnittswertes. Der Vergleich mit dem durchschnittlichen Angestellten ist für Beschäftigte mit Grundausbildung in der staatlichen und sektorübergreifenden häuslichen Pflege noch unvorteilhafter.
- Fachlich geschulte Pflegekräfte (typischerweise Krankenpfleger/innen) schneiden besser ab als geringer qualifizierte Kolleginnen und Kollegen, jedoch nicht so gut, wie es Fachwissen und Können rechtfertigten. In nur 6 der 16 Länder, die berichtet haben, verdienen Krankenpfleger/innen oder Arbeiter/innen mit gleichwertiger Qualifikation in der häuslichen Pflege gleichviel oder mehr als den OECD-Durchschnittswert; in 6 Fällen erhalten sie jedoch höchstens zwei Drittel des OECD-Durchschnitts. Fachlich geschulte Pflegekräfte in der stationären Pflege schneiden geringfügig besser ab.

- Für den ungeregelten Privatsektor liegen keine ausreichenden Daten vor. Bruchstückhafte Angaben deuten darauf hin, dass Pflegekräfte und geschulte Fachkräfte, die über den unorganisierten Markt Beschäftigung finden, dort zu sehr günstigen Preisen zur Verfügung stehen.
- Trotz der überaus starken Feminisierung sind weibliche Pflege- und Fachkräfte durch das geschlechtsspezifische Lohngefälle zusätzlich benachteiligt. Die Zahlen, die dieses Gefälle beschreiben, weichen in den einzelnen Ländern und je nach Qualifikationsgrad stark voneinander ab, und es liegen zu wenig Angaben vor, um Verallgemeinerungen zuzulassen.

Eine vergleichsweise Bezahlung ist mit schlechten Arbeitsbedingungen verknüpft.

Bei einer Auseinandersetzung mit den Arbeitsbedingungen stützen die Beschreibungen in den Länderberichten die medizinischen Befunde hinsichtlich der zahlreichen Berufsgefahren in der Langzeitpflege. Länderberichte weisen vorrangig auf die Mischung körperlich erschöpfender Arbeit und mentaler Ermüdung und Stress hin. Dem ist das durch den engen Körperkontakt erhöhte Infektionsrisiko sowie das Unfallrisiko durch die Fahrten zum Wohnsitz der Kunden hinzuzusetzen.

Als Reaktion auf schlechte Bezahlung und Arbeitsbedingungen wird in so verschiedenen Ländern wie Österreich, Belgien, Bulgarien, Island, Italien, den Niederlanden, Polen und dem Vereinigten Königreich von einer sehr starken Mitarbeiterfluktuation berichtet. Darüber hinaus sind im Bereich der Langzeitpflege in einer Vielzahl von Ländern Engpässe bei angelernten und Fachkräften und insbesondere bei Krankenpfleger/innen zu spüren oder zu erwarten. Dazu gehören west- und südeuropäische Länder (Belgien, Deutschland, Finnland, Italien, die Niederlande, Malta, Österreich, das Vereinigte Königreich und Zypern) sowie mehrere mittel- und osteuropäische Länder (Bulgarien, Lettland, Polen und Ungarn).

Politische Strategien. Einige Länderexperten berichten (beispielsweise aus Österreich, Griechenland, Frankreich, Island und Lettland), dass der Langzeitpflege in den Mitgliedsstaaten keine solche Priorität eingeräumt wurde wie sie vor der Finanzkrise der Kinderbetreuung zukam. Das Fehlen eindeutiger Ziele, wie sie in der Lissabon-Strategie für die Kinderbetreuung festgelegt wurden, könnte den Druck verringert haben, das Problem öffentlich anzusprechen. Es gibt jedoch Anzeichen, dass das Thema im öffentlichen Bewusstsein an Bedeutung gewinnt. Besonders stark

ist dies in Norwegen und im Vereinigten Königreich zu spüren. **Kapitel 5** bietet einen kurzen Überblick über ausgewählte politische Maßnahmen der vergangenen Jahre.

Im letzten Jahrzehnt gab es keine größeren Reformen in den Langzeitpflegesystemen der einzelnen Mitgliedsstaaten, doch Regierungsvertreter aus mindestens fünf Ländern (Frankreich, Polen, Rumänien, Slowenien und Ungarn) haben jüngst öffentlich die Einführung einer obligatorischen Langzeitpflegeversicherung diskutiert oder sich dafür ausgesprochen. Wie in den Länderberichten von den Experten des Netzwerks betont, könnte die derzeitige Finanzkrise Reformen ausbremsen. Es gibt jedoch Beispiele umfassender Reformen, die in der Vergangenheit nicht zuletzt mit dem Vorhaben durchgeführt wurden, den raschen Anstieg der Ausgaben für die Langzeitpflege zu drosseln. Ein Beispiel hierfür ist Deutschland, wo nach Ansicht einiger Wissenschaftler die Langzeitpflegeversicherung nicht zuletzt mit der Absicht eingeführt wurde, den Kostenanstieg im sozialen Bereich zu deckeln, der vor dieser Reform die Hauptfinanzierungsquelle der formellen Langzeitpflege war.

Die meisten politischen Entwicklungen der vergangenen zehn Jahre verliefen in bereits zuvor festgelegten Bahnen, die zusammenfassend als schrittweise Abkehr (i) von der institutionalisierten hin zur häuslichen Pflege und (ii) von staatlichen Angeboten hin zu privaten und gemischten, von Transferzahlungen gestützten Angeboten beschrieben werden kann, sowie (iii) als eine Entwicklung hin zu Leistungen, die die informelle Pflege eher ergänzen, als sie zu ersetzen.

Die Verschiebung hin zur häuslichen Langzeitpflege zeigt sich in der Analyse der Deckungsraten in Kapitel 2 und spiegelt den Versuch wider, Kosten einzudämmen und zugleich der weitverbreiteten Vorliebe älterer Menschen entgegenzukommen, in den eigenen vier Wänden gepflegt zu werden. Zu den mit dieser Maßnahme verbundenen Risiken gehören geringere Gesundheitsstandards und der allmähliche Aufbau einer nicht fachlich geschulten, unzureichend ausgestatteten Mitarbeiterschaft. Um letzteres zu verhindern, sollten die im Rahmen der häuslichen Pflege erzielten Ergebnisse sorgfältig mit den Ergebnissen der institutionellen Pflege verglichen werden. Sind beispielsweise die Rehabilitationsmöglichkeiten nach einem Schlaganfall in einer spezialisierten Einrichtung besser als in der häuslichen Pflege? Hinsichtlich der Beschäftigungsqualität in der Langzeitpflege wurde dies durch die praktisch überall

anzutreffende Vorliebe für Barzuschüsse in stärkerem Maße beeinflusst, als durch den Übergang in die häusliche Pflege an sich.

Transferzahlungen wurden in erster Linie über zwei Arten von Beihilfen verteilt. Die erste wird dem bedürftigen älteren Menschen ausgezahlt, so dass sie/er Pflegeleistungen erwerben kann. Häufig, wenn auch nicht durchgängig, wird dies als „Pflegegeld" (*„attendance allowance"*) bezeichnet. Die zweite Beihilfe wird an das pflegende Familienmitglied oder die pflegebedürftige Person selbst als Ausgleich für die (familiären) Pflegeleistungen gezahlt. Häufig wird sie „Pflegezuschuss" (*„care allowance"*) genannt. Zu den Transferzahlungen, die keine direkten Beihilfen sind, zählen Steuererstattungen und -anrechnungen, Behindertenrenten, Bezuschussung von medizinischen Geräten oder für erforderliche Umbauten im Haus, Übernahme der Sozialabgaben für Pflegekräfte (vor allem, wenn sie von der Familie beschäftigt wurden) und anderes.

Pflegegeldzahlungen sind weiter verbreitet als die Zahlung von Pflegezuschüssen (25 Länder gegenüber 20) und bieten tendenziell höhere Beträge. Um eine länderübergreifende Standardisierung zu ermöglichen, werden die berichteten Werte ins Verhältnis zum mittleren Einkommen eines 65-jährigen Einwohners des Landes gesetzt. In sieben Ländern (Frankreich, Deutschland, Niederlande, Österreich, Portugal, Slowakei und Tschechische Republik) liegen die Höchstbeträge für das Pflegegeld bei mindestens 90% des Referenzeinkommens, und nur in Ungarn trifft das gleiche auf den Pflegezuschuss zu. In rund der Hälfte der Länder, die laut Bericht mit einem Beihilfesystem arbeiten, liegt zudem der festgelegte oder der Höchstbetrag unter 50% des Referenzeinkommens (Bulgarien, Island, Italien, Niederlande, Polen und Vereinigtes Königreich).

Bei der Gestaltung der Beihilfemodelle spielen Fragen der Verteilung und der Effizienz eine Rolle. Ein wichtiges Thema sind die Höchstbeträge in Ländern mit einer Langzeit-Pflegeversicherung, die (bezogen auf das Referenzeinkommen) deutlich über denen anderer Länder liegen. Systeme mit einer Langzeit-Pflegeversicherung scheinen also eine bessere Einkommenssicherung in Fällen von schweren und sehr schweren Graden der Behinderung zu garantieren. Dies kommt der Generation der Ältesten, also der über 80-jährigen besonders deutlich zu Gute, in der die Frauen in der Überzahl sind. Aus Sicht der Gleichstellung der Geschlechter ist jedoch die Frage, inwiefern

Transferzahlungen gebunden oder unabhängig sind, weitaus wichtiger. Nicht an klar definierte Ausgaben gebundene Beihilfen begünstigen eine Ausweitung der ungeregelten Beschäftigung wie auch der Steuerumgehung. Dies wurde in allen Ländern beobachtet, in denen das Modell ‚Migrant in der Familie' genutzt wird. Pflegegutscheine sind ein Beispiel für gebundene Transferleistungen. In Abhängigkeit von der Ausgestaltung und Umsetzung des Modells können Pflegegutscheine die Entwicklung ungeregelter Arbeit begünstigen, zumindest einen geringen Zugewinn an Fähigkeiten für die betroffenen Arbeiter sichern und zur Vereinheitlichung der Pflegequalität beitragen. All das mit einem Kostenaufwand, den öffentliche Haushalte durchaus zu tragen in der Lage sind. Nach Einschätzung durch die Länderexperten führten sie jedoch auch zur Entstehung von (weiblichen) Beschäftigungssegmenten, die häufig keine „angemessenen" Einkommen und Arbeitsbedingungen sichern.

Die Strategie der Transferzahlungen kann auf diese Weise große Auswirkungen auf die derzeitigen Arbeitsmärkte im Bereich der Langzeitpflege haben und hat sie auch bereits gehabt. Paradoxerweise haben arbeitsmarktpolitische Strategien häufig die Symptome der Arbeitsmarktschwäche im Bereich der Langzeitpflege ins Auge gefasst, also Engpässe und Fluktuation, nicht aber deren Ursachen, also geringe Löhne, schlechte Arbeitsbedingungen oder Segregation.

Aktuelle oder zu erwartende Engpässe bei Pflegeleistenden und Fachkräften stellen für Regierungen eine große Herausforderung dar. Im Rahmen der detailliertesten Ansätze im europäischen Raum wurde der Versuch unternommen, neue Schulungen anzubieten und zugleich die Anforderungen an die schulische und berufliche Bildung neu zu definieren oder Karrierewege umzugestalten. All dies mit dem Ziel, die Einstellungssituation zu verbessern und Arbeitskräfte im Sektor zu halten. Beispiele sind Belgien und Österreich, wo der Beruf des angelernten Pflegers (Hilfsschwester oder Hilfskrankenpfleger) geschaffen wurde, um einen Ausbau der Karriereleiter zu ermöglichen und mehr Bewerber für den Beruf zu interessieren. Initiativen in anderen Ländern waren darauf ausgerichtet, die Beteiligung an Schulungen zu verbessern, die Anzahl der Schulungsplätze in Unternehmen zu erhöhen (Deutschland, Estland, Norwegen, Portugal und Spanien), die Anforderungen an den Grad der Schul- oder Berufsausbildung für Pflegekräfte auf allen Ebenen anzuheben oder für die absolvierte Schulung im Bereich der häuslichen Pflege ein Zeugnis zu erhalten (Rumänien). In Spanien und Frankreich

wurden die Maßnahmen zur Verbesserung der Ausbildung auf Pflegeleistende ausgeweitet, die über einen Pflegegutschein in der häuslichen Pflege tätig sind.

Ein unattraktives Lohnniveau ist die Wurzel des Pflegekräftemangels, doch nur sehr wenige Länder haben zur Beseitigung des Problems der geringen Löhne in der Langzeitpflege andere Faktoren als lediglich die Schulung direkt in Angriff genommen. Als da wären nicht regulierte Beschäftigung, eine geringe Zahlungskapazität seitens der Familien, geringe Anerkennung der Pflege als Beruf und ein überproportioneller Frauenanteil. Ausnahmen bilden Österreich, wo die Beiträge zur sozialen Sicherung gesenkt wurden, um die Beschäftigung nicht-professioneller Pflegekräfte mit Migrationshintergrund zu fördern, Deutschland, wo im Pflegesektor ein Mindestlohn eingeführt wurde, sowie Rumänien, wo die Pflege im Rahmen der Langzeitpflege kürzlich als ‚Beruf' anerkannt wurde und eine eigene Erwähnung im Beschäftigungsgesetz erhielt. Bemühungen, mehr männliche Arbeitskräfte für die Pflegebranche zu interessieren, haben es in praktisch keinem Land auf die politische Tagesordnung geschafft. Während die Bedeutung von Aus- und Weiterbildung als Antwort auf Engpässe nicht in Frage gestellt wird, kann die ausschließliche Nutzung dieser Maßnahmen deren Effizienz einschränken.

Die vielleicht größte Herausforderung für die Mehrzahl der 33 hier untersuchten Länder sind die Auswirkungen der derzeitigen Krise auf das zukünftige Leistungsangebot. Man gäbe jedoch nicht nur wirtschaftlich sondern auch im Hinblick auf die Gleichstellung der Geschlechter eine hervorragende Gelegenheit verloren, wenn die vorherrschende Antwort auf die Krise in der Rationalisierung von Angeboten und dem Druck auf die Familien läge, Pflege intern zu leisten, statt sie zu übertragen. Die Herausforderung liegt vielmehr in der Umkehrung dieser Perspektive und darin, eine schnell wachsende Branche wie die Langzeitpflege zu einem Motor für Beschäftigungszuwachs zu machen. Gleichzeitig könnte eine Ausweitung der Beschäftigung genutzt werden, um diesen Beschäftigungsbereich für Männer als Eintrittsmöglichkeit in den umfangreichen Sektor der Pflegedienstleistungen zu etablieren.

Introduction

The core objective of this report is to analyze existing provisions of long-term care in Europe from the twin perspectives of female employment and gender equality. It complements the earlier report from this network on child care and, in the same spirit, prioritizes the supply of provisions and their employment repercussions, rather than the expenditure and financial side.

Women are still the largest consumers, as well as the main producers, of long-term care. Shorter life expectancy lowers men's consumption of LTC services; traditional gender roles tend to shelter them from care obligations; and occupational segregation still keeps male workers out of a large number of care occupations.

One positive aspect of ageing is that it may help reduce these gender asymmetries. In some European countries, life expectancy is increasing more rapidly among men than among women (EC 2008a, p.16). This is expected to re-balance the overrepresentation of women among dependent elderly and to increase the likelihood of there being a male partner to take care of his companion. Male participation in informal care is also likely to be enhanced by the pressure on Member States to equalize the pensionable age of women with that of men. Finally, whilst the vast majority of migrant care workers and professionals are women, the very fact that the care sector is among those that will generate substantial employment opportunities in the near future may attract more men.

To date, however, evidence of such re-balancing is both meagre and uncertain, whilst gender differences remain important among the providers and recipients of long-term care. This poses four main policy issues concerning, respectively, the mix of provisions, acceptability and affordability of care services, gender equity in the distribution and the quality of care work, and labour-market sustainability of current care arrangements.

Availability and affordability. A large body of literature on long-term care has classified available provisions using different and partially overlapping criteria, such as the nature of provisions (time, e.g. for leave from work; money, e.g. from cash transfers; services in kind), types of provider (the state, the market, the family) or of hosting institution (hospital, nursing

home, sheltered flat or other residential arrangement), and the labour status of the provider (formal versus informal, skilled versus basic care).

Each of these distinctions has been shown to matter in diversifying care and employment outcomes. For example, cash transfers to families provided as an alternative to services in kind allegedly encourage informal and irregular employment. In turn, formal care services are generally associated with a more structured, regular, and therefore skilled labour market (Simonazzi 2009, Ungerson and Yeandle 2007, Huber et al. 2009). Another example concerns access to institutional care, which is of special interest to women who live longer. Higher longevity for women in combination with lower retirement income raises the issue that, in some countries, good institutional care is rather costly and may therefore be less affordable for the average woman facing the prospect of institutionalization in her last years of life. The relevant question, therefore, is what mix of provisions and delivery conditions should be favoured in order to pursue employment, gender equality, and quality-of-care goals that are consistent with national and European objectives.

Gender equity. Comparatively more men contribute to long-term care than to child care (Bettio and Verashchagina 2009, Del Bono et al. 2009, Fagan 2010, Glendinning et al. 2009). However, the traditional division of labour within the family compounds the role of occupational segregation in perpetuating a strong gender imbalance among care givers. The implications are familiar: it is largely up to working women to make the effort to reconcile work and care; and if they happen to be employed in long-term care they face prospects of low wages and other unattractive working conditions (Bettio and Verashchagina 2009, EUROCARERS 2007).

Labour market sustainability. Growing demands for long-term care services are multiplying employment opportunities. Health and social services created almost 3.3 million jobs between 2000 and 2007 in the EU-27, boosting their share of the total EU workforce from 8.7% to 9.6%. In 2007, the two sectors together employed 20.6 million workers in Europe (Employment in Europe 2009: Box 4). Given occupational segregation, these opportunities have so far gone primarily to women. However, poor pay and/or working conditions have generated shortages of local carers at various skill levels, from nurses in the UK or Austria to live-in home care workers in Mediterranean countries. Female workers from within and outside Europe have

filled the gap, but mere reliance on spontaneous immigration flows may not be enough to ensure a match between supply and demand in the future (Bettio et al. 2006, Lyberaki 2008, Leon 2010, Piperno 2008, 2009).

Future labour market sustainability can be improved by reducing the attrition between employment, on the one hand, and informal care for the elderly on the other. More working women than working men currently reduce their hours of work, quit employment or simply curtail leisure activities in order to informally care for relatives or friends (Lamura et al. 2007, Bolin et al. 2008, Bonsang 2009). Leave and flexible work hours specifically targeted at providers of long-term care are relatively infrequent within Europe (Plantenga and Remery 2005, EC 2009b). The pressure to counter future shortages in the care sector may provide an opportunity to design leave and flexible schemes that are able to attract men, and not just women.

The report will be organized around the issues of the availability and affordability of provisions, gender equity, and labour market sustainability. The quality of services would require a separate report, since the relevant literature and information is rather specialized and not readily available for all countries. It will therefore be given secondary consideration, mainly in connection with, and partly as a result of, the organization and conditions of care work.

An introductory part sets the background with a brief overview of demographic and health projections. The next three chapters of the report focus on current patterns of long-term care provisions and on employment patterns. A short glossary of key terms as they are used in this report is given in Box 1.

Box 1. Use of key terms

Older people with disability are generally referred to as '**dependent elderly**'. With reference to specific provisions or statistical data, however, the term 'disabled' may be used instead of 'dependent' because it refers to certified or ascertained disability. Disability is usually measured in terms of the inability to perform one or more Activities of Daily Living (ADL).

Throughout the report, '**long-term care'** (LTC) strictly refers to the older population. Definitions of long-term care vary within the EU. For the OECD, it 'brings together a range of services for persons who are dependent on help with basic Activities of Daily Living over an extended period of time' (EC 2008b, p. 3). Basic medical treatment,

home nursing, social care, housing, transport, meals, occupational assistance and help with managing one's daily life, are all included. 'Long-term care' is meant here as a broad synonym for 'elderly care' but it is preferred to the latter because the focus is primarily on the functional dimensions of care while 'elderly care' does not necessarily imply ADL dependency.

The term '**formal care givers'** stands for persons who work for pay in the LTC occupations. They are also referred to as **care workers and professionals** and include all levels of skill, from home helpers, to personal and social care workers, assistant nurses, therapists and nurses. Formal care givers may work for pay without a contract, in which case they are called '**irregular**'. '**Informal care givers'** are family and friends who are not paid for the services that they provide.

'**Care provider'** may refer to persons and organizations (firms, governmental agencies, third-sector organizations) or persons that provide care services.

For the sake of simplicity and consistency with the current literature, the term '**migrant**' is meant to encompass both mobile people from within the EU (i.e. people working in a EU country other than their own) and immigrants from outside the Union.

1. Future demand for Long-Term Care

Health and Care services represent one of the fastest expanding sectors in the EU, if only in terms of employment creation. Long-term care is a driver of this expansion, and it is fuelled in its turn by the evolution of the age structure in combination with disability rates. The number of elderly of any age is certain to grow and can be estimated with a fair degree of accuracy. According to the EUROPOP2008 population projections (EC 2009a, p. 141), people older than 79 are expected to triple in number by 2060, and since long-term care begins to rise exponentially at around 75 to 85 years of age, a rapid growth of demand is inevitable for the next fifty years or so.

There is less certainty about future trends in disability. According to the latest Ageing Report (EC 2009, p. 139) "Trends in ADL-dependency rates have decreased in the United States (Crimmins 2004), and some European countries, but they have increased in several other European countries and Japan and have remained stable in Australia (OECD 2007)". In the 2007

OECD study, Lafortune et al. found "clear evidence of a decline in disability among elderly people in only five of the twelve countries (Denmark, Finland, Italy, the Netherlands and the United States), even though in the case of Denmark the findings are based on a less severe measure of disability (only having functional limitations). Three countries (Belgium, Japan and Sweden) report an increasing rate of severe disability among people aged 65 and over during the past five to ten years, and 2 countries (Australia, Canada) report a stable rate. In France and the United Kingdom, data from different surveys show different trends in ADL disability rates among elderly people, making it impossible to reach any definitive conclusion on the direction of the trend" (Lafortune et al. 2007, p.48).

In the most conservative European scenario for the next fifty years, the prevalence of disability for each age group and sex is not assumed to change (EC 2009a, p. 145). If, in line with conservative forecasting, it is also assumed that the probability of receiving formal care at home and formal care in an institution remains constant, then the size and composition of care recipients will only depend on the (projected) demographic structure of the population – the 'purely demographic scenario' in the wording of the above quoted Ageing Report. The figures in this scenario are striking. Between 2007 and 2060 it is estimated that persons older than 65 suffering from at least one ADL disability will more than double, reaching 44.4 million by 2060. Those receiving care in institutions will almost triple, reaching 8.3 million, and those receiving informal or no care will increase from 12.2 to 22.3 million. The figures differ by country, with several East European countries experiencing the lowest increase in demand for formal care (at home or in institutions), while Spain, Luxembourg or Ireland are projected to experience massive increases in demand for both home and institutional care. Perhaps the most significant finding, however, is that even the countries facing comparatively slow growth in demand should expect it to almost double. Box 2 gives the figures and some more details.

Given the uncertainty about trends in disability, a less conservative scenario for future projections is the 'constant disability scenario'. If the current disability rate of an elderly person (65 years old or more) is 20%, and if the estimated increase in life expectancy for this age group is 5 years, this scenario assumes that in the future people older than 70 years will record 20% disability (EC 2009a: p.149). In line with this assumption, disability rates among the elderly are

projected to consistently diminish across Member States. This notwithstanding, in the next fifty years the actual number of people aged 65 years or more with at least one ADL

Box 2. Projections of older dependent people by type of care received.

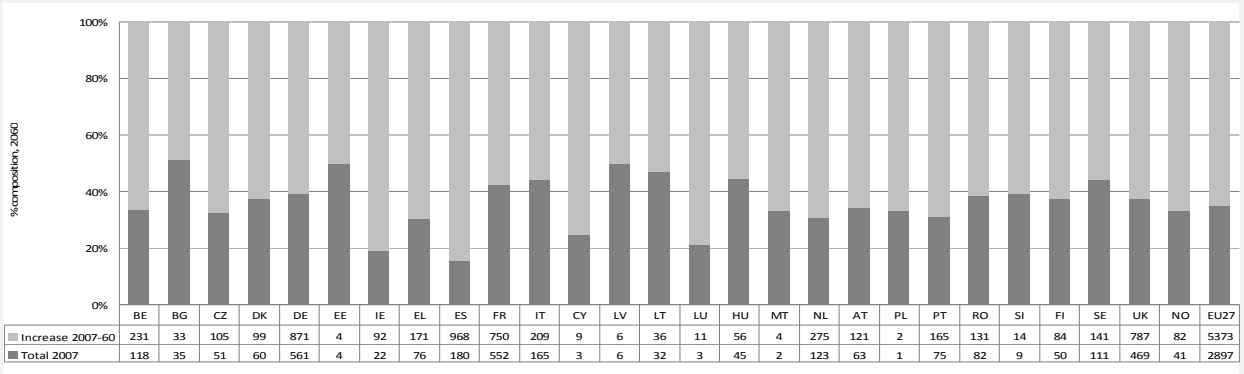
Assume that neither disability rates nor current LTC policies change with respect to 2007 – the base year used for projections in the Ageing Report (EC 2009a) – and let pure demographic projections drive future patterns. No policy change means, in particular, that the probability of receiving formal care at home and formal care in an institution remains constant at the 2007 level. Under these assumptions the cited report (ibid.: Table. 34, p. 148) estimates that by 2060 in the EU27 as a whole:

- dependent older persons will have more than doubled: from about 20.7 to 44.4 million (+115%);
- dependent older persons receiving care in institutions will have almost tripled: from 2.9 to 8.3 million (+185%);
- dependent older persons receiving formal care at home will have more than doubled: from 5.5 to 13.9 million (+151%);
- dependent older persons receiving informal or no care will have less than doubled: from 12.3 to 22.3 million (+84%).

Estimates differ by country, as shown in Figure 1, but the order of magnitude of the projected increases for institutional and formal home care remains high in all countries. Spain leads the projected growth in the number of older persons in institutional care with a more than fivefold increase, followed by Luxembourg and Poland, neither of which is projected to experience less than a threefold increase; and only in three East European countries (Bulgaria, Estonia and Latvia) will the increase be less than 100%. As to persons receiving formal care at home, Spain and Ireland are expected to lead the change with rates of growth above 300% while other countries are projected to at least double their numbers, with the exception of Bulgaria and Latvia (EC 2009a: Table. 34, p. 148).

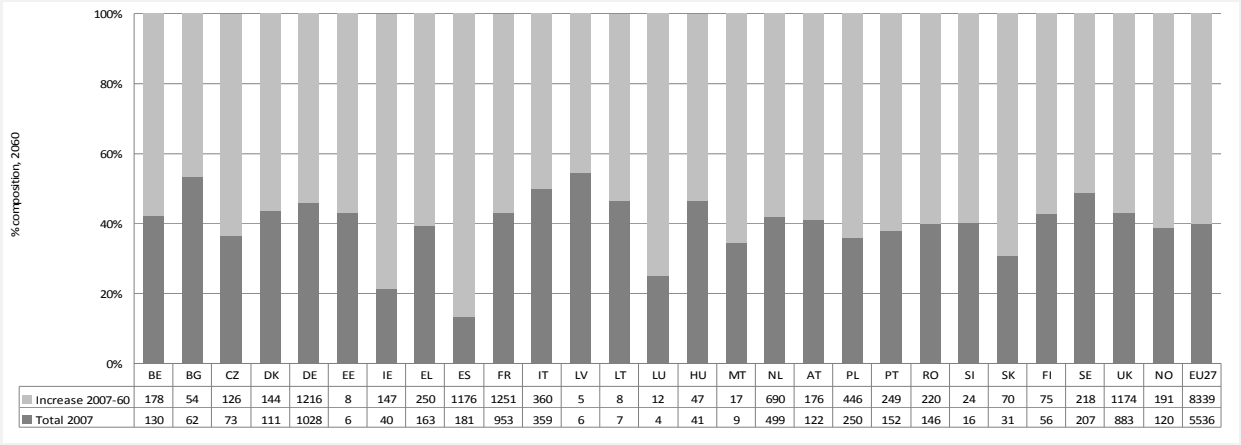
Figure 1. Dependent elderly, pure demographic scenario: initial values and increases, 2007-2060

a) receiving care in institutions



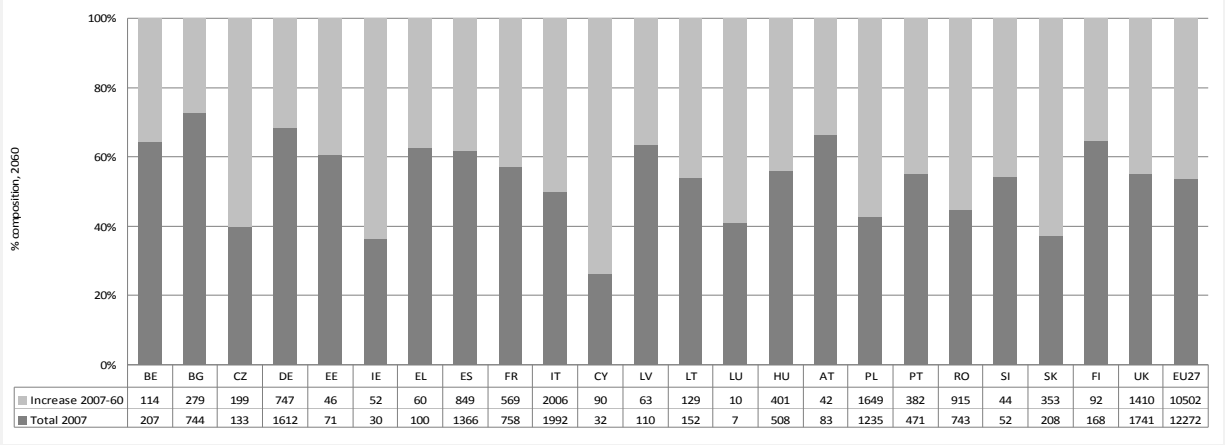
	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	FI	SE	UK	NO	EU27
Increase 2007-60	231	33	105	99	871	4	92	171	968	750	209	9	6	36	11	56	4	275	121	2	165	131	14	84	141	787	82	5373
Total 2007	118	35	51	60	561	4	22	76	180	552	165	3	6	32	3	45	2	123	63	1	75	82	9	50	111	469	41	2897

b) receiving formal care at home



	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK	NO	EU27
Increase 2007-60	178	54	126	144	1216	8	147	250	1176	1251	360	5	8	12	47	17	690	176	446	249	220	24	70	75	218	1174	191	8339
Total 2007	130	62	73	111	1028	6	40	163	181	953	359	6	7	4	41	9	499	122	250	152	146	16	31	56	207	883	120	5536

c) receiving informal or no care



	BE	BG	CZ	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	AT	PL	PT	RO	SI	SK	FI	UK	EU27
Increase 2007-60	114	279	199	747	46	52	60	849	569	2006	90	63	129	10	401	42	1649	382	915	44	353	92	1410	10502
Total 2007	207	744	133	1612	71	30	100	1366	758	1992	32	110	152	7	508	83	1235	471	743	52	208	168	1741	12272

Source: own elaboration using data from the Ageing Report (EC 2009a: Table 34, p. 148).

disability is predicted to nearly double in the EU27: from 20.7 million to 39.9 million (EC 2009a: Table. 35, p. 150). Even less prudent assumptions about disability trends, therefore, yield very large increases in demand.

Gender plays contrasting roles in the expected upsurge of care demand, and it is especially important for shifting demand from informal to formal care, and hence for policy action. Shrinking family size and more dispersed living arrangements are likely to increase the demand for formal care in the stead of informal, family arrangements even if we disregard the tendency towards postponement of the retirement age. On the other hand, differential growth of life

expectancy may ease the demand pressure by making more husbands or brothers available to care for their relatives informally[4].

Current disability rates tend to be higher for women, although this is not consistently the case (EC 2009a: Table. 71, p. 248). Moreover, the gap with respect to men increases with age, partly because of compositional effects, e.g. women in the 85-90 age group tend to be older because fewer men reach age 90. This is shown in Figure 2 (Box 3), where the age profile of disability is depicted separately for 5 of the 6 largest countries in Europe by population (the UK, France, Germany, Italy and Poland), as well as for women and men. At the same time, life expectancy is projected to increase more among older men than women: respectively by 5.4 and 5.2 years in 2060 for those aged 65 (EC 2008a, p. 16). A partial convergence of life expectancy may therefore mitigate the current gender imbalance in the supply of informal care givers, since, as noted, more husbands or brothers will be available to care for their spouses or sisters informally.

Given that the available evidence on past national trends in levels of disability yields contrasting results, sex-disaggregated forecasting can be especially problematic (Box 3). This partly explains the reluctance of the specialized literature to break down projections of future demand for care in the EU by sex.

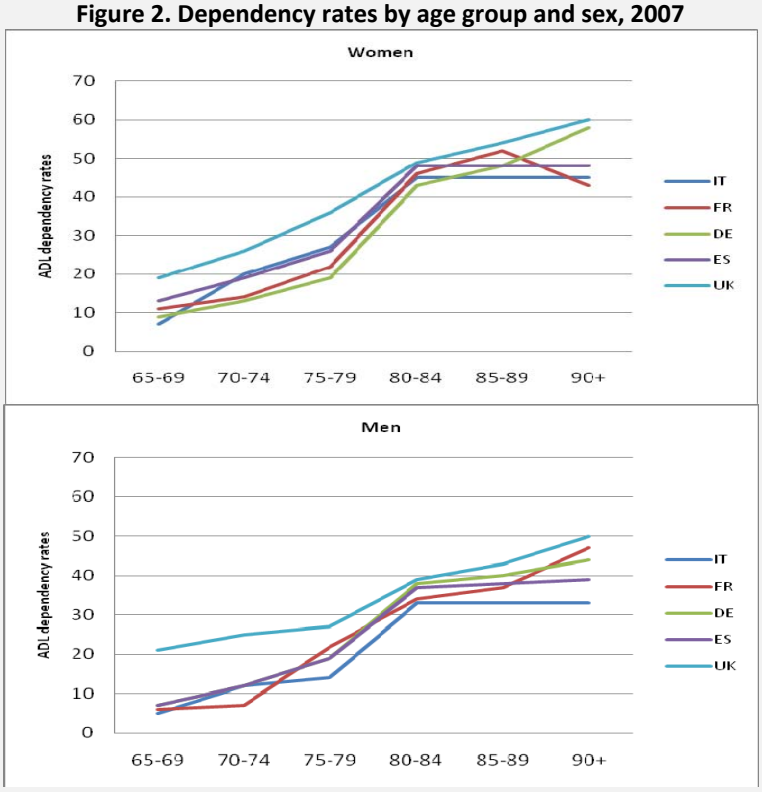
Box 3. What we know about current disability rates

There is no common definition of disability in old age, but it is often measured by the inability to perform one or more ADL, which include eating, moving, cooking, bathing, and so on. Nor is there a reference and comprehensive data source for Europe. In fact, at least three comparative sources can be used to derive rates of disability: the SHARE survey (Survey of Health, Ageing and Retirement in Europe), the EU-SILC (the EU Survey of Income and Living Conditions) panel, and ELSA (English Longitudinal Study of Ageing for England). However definitions do not necessarily coincide. The SHARE database affords information on the percentage of people with *'the prevalence of 1+ limitations with activities of daily living among men and women over 50 years of age'*. The data from SILC survey concern the percentage of people in a given age group who *'are severely restricted in activities they usually do because of health problems for at least the last 6 months'*. In the case of the UK, ELSA produces figures that are fully comparable with the SHARE methodology. Figures drawn from these three surveys are used for the projections of care demand in the above mentioned Ageing Report (EC 2008a; 2009a).

Below, we compare the typical age profile of disability for men and for women in the five largest European countries. The figures for all these countries are drawn from the SHARE and EU-SILC surveys, and they document how the prevalence of disability is slightly higher for women even in the youngest age group, although the gender gap systematically widens with age.

[4] See for example Pickard et al. (2007) for the UK.

Figure 2. Dependency rates by age group and sex, 2007



Source: own elaboration using data from the Ageing Report (EC 2009a: Table. 71, p .248)

2. Availability of long-term care provisions for the elderly

The 'no policy change' assumption underlying the projections in Box 2 for the number of informal and formal care givers (in private or public employment) is a useful heuristic device, but it should not be taken to indicate that current policies will not change in the future. The first report from this network to focus on care of elderly people (together with care of children) dates back to 1998, only twelve years ago (Bettio and Prechal 1998). Yet today's picture has changed in important respects. This section maps formal and informal provisions of care for the elderly today, tracks change over the last fifteen years, and asks how the division of labour among the three main providers – the family, the state and the market – varies alongside disability in the different countries. Four main types of sources are used in the attempt to overcome well-known gaps in the data for Europe: the national reports of the EGGE network,

the SHARE survey, OECD Health Data 2009, and the recent collection of facts and figures on long-term care by Huber et al. (2009) (see Box 4 for further details).

Building on national, administrative sources, both the OECD Health Data and Huber et al. furnish updated information on formal care in a subset of 24 European countries.[5] Since the two sources overlap only partially in terms of the countries that they cover and the figures that they provide, both are used in this report. The value added that the SHARE survey brings to this report is updated and comparable information on informal care givers, i.e. (unpaid) family members and friends, as well as on formal, home-based care givers working for the family. One limitation of the SHARE source is that data are currently available for a subset of 13 countries.[6] By combining these three sources with national level information provided by the EGGE experts, we aim to offer the most comprehensive mapping available to date, although we cannot resolve numerous inconsistencies among sources or fill all the existing gaps in the information.

With this caveat in mind, we begin with analysis of formal LTC provisions. These are defined as services supplied by market or public concerns against a fee that may or may not cover the full (social) costs and may even be zero. One key difference with respect to informal provisions is that the latter are supplied outside any formal arrangement with private or public providers. Data on formal provisions are generally, but not consistently, derived from administrative sources that record the beneficiaries of public expenditure on different welfare programmes, and they are sometimes referred to as 'publicly subsidized' provisions.

2.1. Institutional care

Box 4 sets out the conventional classification of formal, publicly subsidized, provisions into residential, semi-residential and home care services. In the LTC literature, residential services are sometimes called ‘institutional’, a term that the OECD uses to include nursing homes and

[5] Austria, Belgium, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, Slovenia, Slovakia, Spain, Sweden and the United Kingdom.

[6] Austria, Belgium, Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, Netherlands, Poland, Spain and Sweden.

other residential facilities for the elderly. While we shall use the two terms interchangeably, in this section we will often prefer 'residential' because it affords a clearer distinction with respect

Box 4. Data sources and definitions for care services

SHARE (Survey of Health, Ageing and Retirement in Europe [7]). The survey has been conducted since 2004 and is repeated every two years. In this study we use data from the second wave, 2006-2007, which covers 22255 households or 32442 individuals. 14 countries take part in the project: Austria, Belgium, Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, Netherlands, Poland, Spain and Sweden, plus Switzerland. Eligible for the survey are all household members aged 50 and over, plus their spouses, independently of their age. The SHARE survey closely follows those for long conducted in England, ELSA[8] (English Longitudinal Study of Ageing), and the USA, HRS (Health and Retirement Study). Börsch-Supan et al. (2008) compare the three datasets. Börsch-Supan et al. (2011) set out and analyse key results from the third wave, not yet available for download at the time of writing this report.

Facts and Figures on Long-Term Care. The most comprehensive and up-to-date compilation of statistics on long-term care in Europe is provided in Huber et al. (2009). Some similarities and differences in the use of terms between this source and the present report deserve attention. Huber et al. distinguish between *institutional and home care,* only. In the wording of the authors:

'*Institutional care* [also called *residential care* in this report] includes long-term care services that are supplied or available 24 hours a day in institutions that also serve as places of residency for those receiving care. Therefore 'institutional care' stands for institutions and living arrangements where care and accommodation are provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms. This does not include, however, temporary or short-term stays, such as respite care'.

'Home care refers to long-term care services provided to care recipients who live in their own houses or apartments. This also includes day care, respite care, and direct support to individuals who provide care, such as care allowances and care leaves. Care provided in home-like environments (sometimes referred to as assisted living), where it is only available for a certain period of time and individuals live in their own homes, not sharing living space with other beneficiaries with the exception of relatives or partners, is also considered home care (Huber et al. 2009)'.[9]

OECD Health Data[10] is the source of comparable statistics on health and health systems across the OECD countries that offers up-to date information on the recipients of LTC, both in institutions and at home. Differences with respect to Huber et al. (2009) concern not so much the broad definition of LTC as service coverage in specific countries. For example, home help, if not combined with personal care, is not counted as home care in Denmark and the Netherlands. This contributes to explaining why coverage rates in these two countries exceed 20% according to Huber et al., but are considerably less than 20% in the OECD source. As we are interested in the widest service coverage, preference has been given to the former source when the reported statistics differed for the same country and age range.

This report adopts a tri-partite classification of care provisions into *residential, semi-residential, and home-based formal care* where temporary services such as respite and day care are included in the separate category of semi-residential services whenever sources allow for it.

to the growing typology of semi-residential services (such as respite care or day care centres) for which separate figures will be given whenever this is made possible by national statistics.

[7] http://www.share-project.org/t3/share/index.php?id=98

[8] We do not use ELSA data for this project because the separate retrieval and processing of data for a single country was outside the scope of this report.

[9] Note, however, that this may not be consistently the case in the national data that we used.

[10] We further checked both sources against OECD Health Data:
http://www.ecosante.org/index2.php?base=OCDE&langh=ENG&langs=ENG&sessionid=

The indicator of choice for the availability of care services is the coverage rate, conventionally defined as the percentage share of the actual beneficiaries 65 years of age or older in the population in the same group[11]. Coverage rates are calculated using administrative sources that record beneficiaries of public expenditure on different welfare programmes. They should, therefore, be taken for what they are, namely indicators of publicly subsidized provisions, rather than of total LTC provisions available to care for the elderly.

The national experts of the EGGE network have been asked to retrieve data on coverage rates from national sources, check the figures against those provided by OECD (2009) or Huber et al. (2009) where applicable, and explain possible differences. The final compilation from this cross-checking procedure is shown in Figures 3 and 4 and in Table 1, all of which are based on Table A1 in the Appendix, where additional details are provided. Figure 3 and Table 1 display, respectively, coverage rates for residential and semi-residential care received by the population older than 65, while Figure 4 reports coverage rates for formal, home-based long-term care (see also Table A1 in the Appendix). In both figures countries are listed in decreasing order of coverage rates.

It is important to read these figures and the table bearing in mind the many and different reasons why coverage rates may not be strictly comparable across countries. The principal reason is that similar services may be allocated to a different care category or they may go unrecorded. For example, semi-residential services may be included in home care or separated out depending on the country, and in some cases they go unrecorded. Moreover, formal home care services counted for coverage rates ought, in principle, to include beneficiaries of leave off-work and recipients of services delivered in kind or as cash transfers. In many countries, however, only in-kind services are counted as (formal) home care, e.g. Estonia, Finland, Latvia, Malta, Italy, Greece, Poland, Romania, Slovenia, with a potentially large underestimation of the coverage rate where cash transfers are important (see the notes to Table A1).

Despite such limitations, the patterns that emerge are consistent with the widely-held view that in most European countries LTC expenditure has re-balanced in favour of home care over

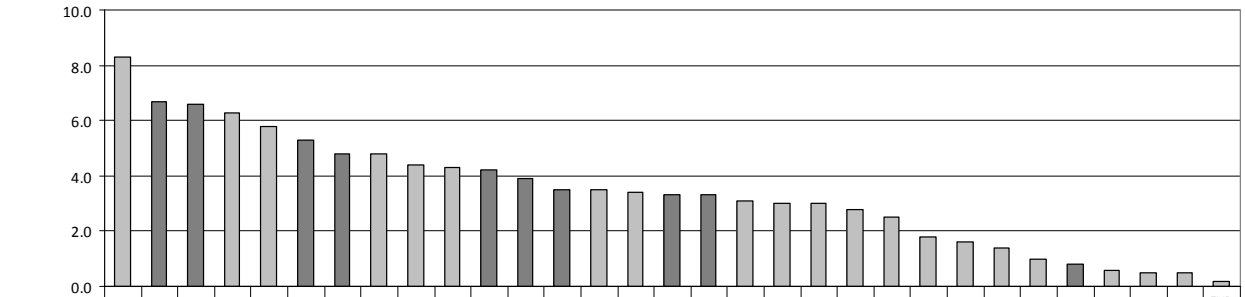
[11] There is limited variation across countries in the reference age group, and differences will be commented on in the tables and in the text where applicable (see Table A1 for details).

the past two decades (Lundsgaard 2005, Marin et al. 2009). This rebalancing may account for convergence towards relatively low levels of care in institutions and the clustering of most West, South and Nord European countries within a relatively narrow range of values for residential care coverage.

Most West European countries now cluster within a relatively narrow range of values for residential care coverage. With the exception of Iceland – an outlier with a more than 8% coverage rate – three countries at the top of the ranking display rates just above 6% – France, Belgium and the Netherlands. Sweden, Norway, Slovenia and Luxembourg follow with values of around 5% to 6%. At the bottom of the ranking, FYROM, Turkey and Greece join a group of three East European countries – Romania, Lithuania and Poland – all of which record rates below or close to 1% (Figure 3).

The largest divide in residential care coverage does no longer follow the familiar North/South line but sees the majority of East European countries at one end of the spectrum and the vast majority of North, West and South European countries at the other end. With the exception of Greece, no North, West or South European country falls below a 2.5% coverage rate. By contrast, 6 out of 10 Central and East European countries record lower values, often much lower than 2% (Estonia, Croatia, Latvia, Poland, Lithuania and Romania); the exceptions are Slovenia, the Czech Republic, the Slovak Republic and Hungary.

Figure 3. Coverage rates for residential care, people aged 65 years and over, latest year available



	IS	FR	BE	NL	SE	NO	LU	SI	ES	MT	UK	IE	CZ	DE	PT	AT	SK	FI	CY	IT	HU	DK	EE	HR	LV	PL	LT	EL	RO	TK	FYR OM
Residential	8.3	6.7	6.6	6.3	5.8	5.3	4.8	4.8	4.4	4.3	4.2	3.9	3.5	3.5	3.4	3.3	3.3	3.1	3.0	3.0	2.8	2.5	1.8	1.6	1.4	1.0	0.8	0.6	0.5	0.5	0.2

Note: Dark grey bars indicate that the displayed values coincide with those reported by Huber et al. (2009) or the on-going OECD project using Health Data 2009 [http://www.oecd.org/dataoecd/23/61/45408422.xls]. Light grey bars indicate alternative values derived from national sources and deemed more accurate, more recent or simply new.
Source: own elaboration using the national reports of the EGGE network (for details see Table A1 in the Appendix).

2.2. Home and semi-residential care: formal provisions

In comparison with residential care, the dispersion of values is much larger for home care coverage. Some of this dispersion may reflect differential needs due, for example, to the age structure or the pattern of disability, but any attempt to estimate the coverage of actual needs is problematic given that disability is often understood differently across countries. Differences in actual needs, however, are unlikely to be a major component of the current inter-country differentials in conventional coverage rates.

For the 27 countries for which this indicator is available, values range from between 0.2% and 0.3% for FYROM and Romania to between 20% and 21% for the Netherlands, Iceland and Denmark. Nordic countries – with the exception of Finland – all stand at or near the top of the ranking, but there is a considerable distance between Sweden with 9.4% and the top three scorers. Five East European countries are placed at the bottom of the ordering with less than 2% coverage – Romania, Lithuania, Latvia, Poland and Slovenia – while Estonia and Slovakia do slightly better with 2.3% coverage. South European (member) countries form the second largest group from the bottom – all of them placed above East European countries with the exception of the Czech Republic and Hungary. In fact, all Mediterranean countries except Malta and Portugal are now close to the 5% mark, and even these are only 1 percentage point away. Finally, the four countries that have implemented mandatory Long-Term Care Insurance[12] do better than the South European group, but differences among them are very marked: from 21% for the Netherlands and the considerable 14% for Austria down to 7% for Luxembourg and 6.6% for Germany (Figure 4).

If we disregard for a moment the fact that the entry of East European countries has produced a generalized 'promotion' up the ranking of all 'old' North, West and South European countries and concentrate on the latter groups, the mapping of home care provisions appears broadly to match the typical clustering of care regimes that has emerged from the earlier reports by this

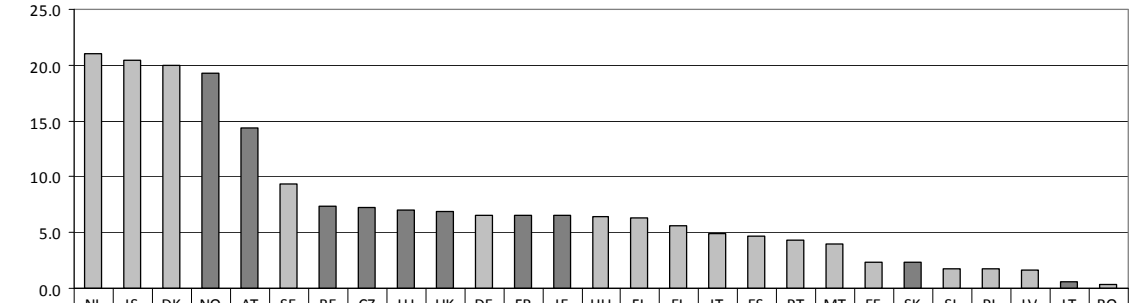
[12] Long-term care insurance is a type of insurance developed specifically to cover the costs of long-term care services, most of which are not covered by traditional health insurance. These include services at home such as assistance with Activities of Daily Living as well as care in a variety of facility and community settings [http://www.longtermcare.gov]. For example, in Germany LTC insurance is a separate "pillar" of social insurance, which is financed and regulated independently from health insurance and managed by existing sickness funds. It is

network, and is still rather popular in the literature (Bettio and Prechal 1998; Bettio and Plantenga 2004). This clustering featured Mediterranean countries at the bottom, Nordic countries at the top, France and Belgium and Germany and Austria in distinctive, intermediate subclusters, the Netherlands and the UK in top clusters.

On closer inspection, however, there are important signs of change. A number of continental countries – France, Germany, Belgium – as well as the UK, report values much closer to those of Mediterranean countries, such as Italy, Spain and even Greece, primarily thanks to progress made by the latter. Also, Finland and Sweden are now placed at considerable distance from other Nothern countries, including the Netherlands, and at some distance even from Austria, where home care appears to have grown apace in the past decades.

Some of this change is real, as we shall also document later, but some is purely statistical and stems from the noted lack of homogenity of definitions and sources. For instance, home care coverage is overestimated in the Netherlands or Austria compared to, say, Finland. It is overestimated in Austria because beneficiaries of (extensive) cash-for-care schemes are included, unlike in Finland, and cash services are of overwhelming importance; and in the Netherlands because some care provisions to beneficiaries younger than 65 are included.[13]

Figure 4. Coverage rates for formal home care, people aged 65 years and over, latest year available



	NL	IS	DK	NO	AT	SE	BE	CZ	LU	UK	DE	FR	IE	HU	FI	EL	IT	ES	PT	MT	EE	SK	SI	PL	LV	LT	RO
Home	21.0	20.5	20.0	19.3	14.4	9.4	7.4	7.2	7.0	6.9	6.6	6.5	6.5	6.4	6.3	5.6	4.9	4.7	4.3	4.0	2.3	2.3	1.8	1.7	1.6	0.6	0.3

Note: see the note to the previous Figure.

funded by insurance contributions which are collected on top of the health insurance premium (OECD 2005, p. 118).

[13] The coverage rate for home care in the Netherlands is drawn from Statistics Netherlands. In this report, long-term care is defined as production of care provided by home-care organisations and nursing and care homes. The majority of care is provided to persons aged 65+, a small part is however also provided to persons aged under 65 (5% of the care provided by nursing and care homes and 15% of the care provided by home-care organizations). (From our correspondence with the Dutch experts J. Plantenga and C. Remery, October 2010).

Source: own elaboration using the national reports of the EGGE network (for details see Table A1 in the Appendix).

Several countries report semi-residential services separately (Table 1 below). The list comprises Denmark, Estonia, Greece, Spain, Finland, FYROM, Hungary, Iceland, Poland, Portugal, Romania, Sweden, Slovenia and Turkey (Table 1). Reported coverage rates vary considerably between a minimum of almost zero (0.02%) for Turkey and a maximum of 9% in Greece. Frequency of use probably accounts for part of the variability, since recreational facilities may be expected to exhibit higher turnover than medical facilities.[14]

Table 1. Coverage rate for semi-residential care. People aged 65 years and over, latest year available

	DK	EE	EL	ES	FI	FYROM	HU	IS	PL	PT	RO	SE	SI	TK
Semi-residential	2.4	7.5	9	0.8	3.4	1	1.6	3	≈0.3	3.3	1	0.7	0.2	0.02

Source: own elaboration using the national reports of the EGGE network (for details see Table A1 in the Appendix).

Accounting for semi-residential services significantly boosts the overall availability of formal provisions in a minority of countries, viz. Greece, Estonia, Portugal, Iceland, Denmark and Finland. Greece and Estonia are the most striking cases. In Greece, in particular, formal care was practically non-existent until the early eighties. Having to make a choice as to where to invest at a time when most European nations were re-directing investment away from traditional residential care, Greece prioritized semi-residential, community care facilities (KIFI: Karamessini 2010, p. 4). In Iceland, Denmark, Finland and Portugal, semi-residential care is comparatively less important than in Greece or Estonia, but it is nevertheless sizeable, with coverage rates of around 3%.

If we were to sum the rates for semi-residential and home care, Iceland and Denmark would be promoted to the best scorers in home care services, and the positions of Finland and Portugal would also noticeably improve. However, in view of the noted problems with recording and counting the beneficiaries of semi-residential care, summing rates across these two care categories would be rather problematic.

[14] While this in no way detracts from the importance of semi-residential services in increasing the well-being of older people, the failure to standardize for regularity of use across countries adds to the reasons for caution in drawing comparisons.

2.3. Provisions, age and gender

There is a certain division of labour among providers of formal LTC services: that is, residential providers cater more to people with severe disability, while providers of home-based care are less specialized. The dividing line is not sharp, however: in Italy for example, old-age homes still host people with no physical or mental dependency. A simple, but adequate indicator to capture this degree of 'specialization' is the age index, i.e. the ratio of the coverage rate of the 'great elderly' (80 years +) to that of the younger elderly (65 to 79 years). The higher this ratio, the more specialized the provider is in clients with severe disability. Using OECD Health Data, Huber et al. (2009) calculate this ratio for home and residential care in a sample of countries comprising 18 of those considered in the present report. The values range between about 1 to 6 for home care and 3 to 13 for institutional care (*Ibid.*: Figure. 6.6, p. 95).[15] Subjective assessments by the experts in the network confirm that in most of the Member Countries residential care caters mainly to people suffering from severe disability, often in the last period of their life: 21 out of the 33 countries considered for this report give explicit indications that old-age institutions are typically entered at very old age in the presence of serious disability (see Grid 1 in the national reports).

Mapping the coverage of formal care provisions is of equal importance to older men and women in need of care, but at the same time it is of especial importance to women, who are more at risk of disability in old age. However, not all countries break down statistics on formal provisions by age or by sex. In analogy to the age index, a relatively simple but effective indicator of the distribution of provisions between men and women is the gender index, i.e. the ratio of the female rate to the male one. The available information on the gender index is displayed in Figures 5 and 6 below for beneficiaries of institutional and home care, respectively.

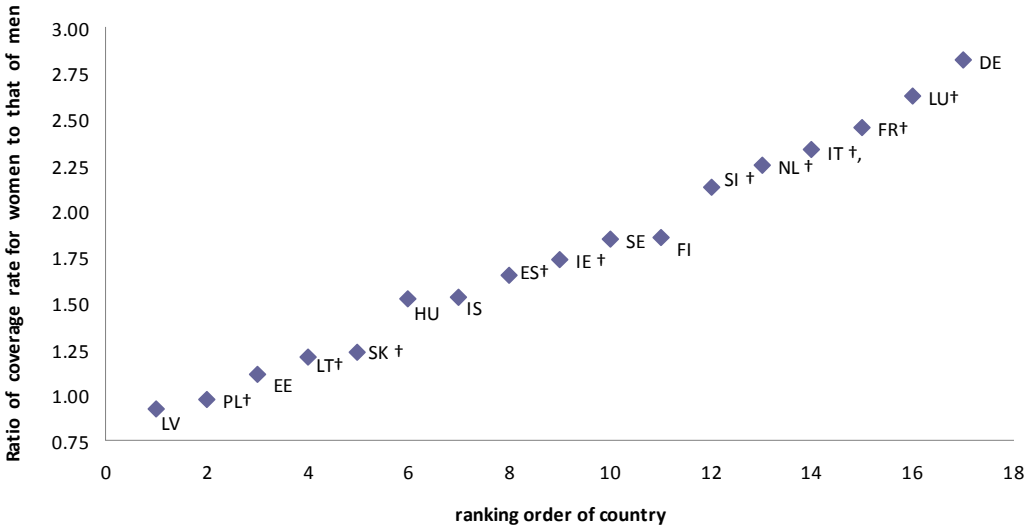
The index has a straightforward interpretation: value 1 indicates an equal probability of men and women being among the beneficiaries, while values above 1 indicate a higher probability for women, and vice versa for values below 1. Actual country values range between 0.92 and

[15] The value of 13% for residential care in France identifies the country as an 'outlier', i.e. it is an exceptional, extreme value. However, this is a statistical rather than 'real' outcome because the age interval available for France goes from 58 to 85 instead of 65 to 80. The index is pushed upwards by a consequent decrease of the coverage rate at the denominator and an increase at the numerator.

2.82 for residential care and between and 1 and 2.82 for home care. Only in Latvia does the index fall below 1 for residential care, but this is partly accounted for by the fact that the age threshold is lower, 62 instead of 65[16] (see Table A.1 in the Appendix). The (simple) average for the countries included in the respective figures is 1.8 for residential care and 1.9 for home care, implying that, typically, women are nearly twice as likely to receive formal care of some type.[17]

No clear pattern emerges from comparative analysis of the gender index in Figures 5 and 6 other than a greater feminization of recipients. For example, it might be hypothesized that low coverage rate countries exhibit higher values for the index where priority is given to needs because women predominate among the oldest and most dependent persons. However, no consistent pattern is apparent in the data. Lithuania, Latvia and Estonia are cases in point, as their coverage rates are consistently low but the gender index is among the highest for home care and the lowest for residential care.

Figure 5. Gender Index for residential care coverage

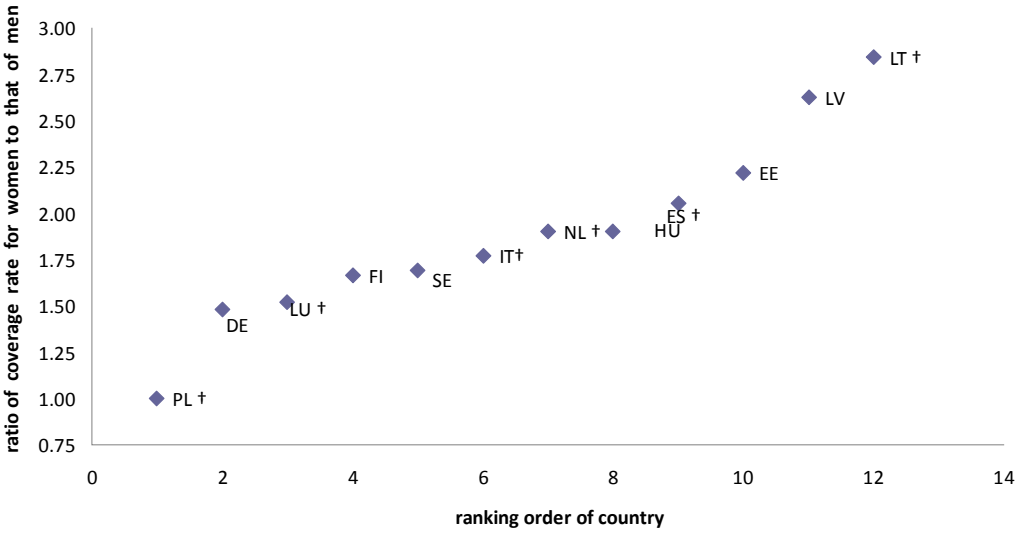


Note: Year 2007 or most recent date.
Source: National reports of the EGGE network (for details see Table. A1 in the Appendix); †Huber et al. (2009: Figure. 6.2, p. 92).

[16] When the index is calculated for people aged 65+ instead of 62+, the number of female survivors increases in comparison with men because of higher life expectancy. But survivors often suffer from disability; hence the number of dependent women versus that of dependent men tends to increase.
[17] This statement holds true if the number of men and women in the same age group is more or less equal. Women will be favoured even more if they represent a higher share in the same age group.

One should therefore take the information afforded by the index with the customary pinch of salt, since much depends on the selection of countries reporting a breakdown by sex, the age distribution of beneficiaries in each country, as well as the specific typology of services.

Figure 6. Gender Index for home care coverage



Note: Year 2007 or most recent date.
Source: National reports of the EGGE network (for details see Table. A1 in the Appendix); †Huber et al. (2009: Figure. 5.7, p. 85). Year 2007 or most recent date.

2.4. Home care: informal providers

Of the 20.7 million dependent elderly in the whole of the EU in 2007, 8.4 million are estimated to have benefited from formal care in 2007, while 12.3 million received informal or no care (EC 2009a: Table. 34, p. 148). Thus informal care givers – family and friends – remain the most important group of providers.

Simple statistics cannot convey the complex division of labour that exists between different care providers. The same beneficiary of, say, formal, publicly subsidized home care may at the same time receive informal care from the family. Moreover, formal care, as measured in the preceding section, is largely publicly subsidized, but the family also buys care services from formal carers at full cost. Salient questions are therefore the extent to which care from the family replaces market or public services or is flanked by them, and the extent to which this

varies across European countries. A related question of interest is how the mix of family and market or public services changes as old age disability progresses. The underlying issue is transition from unpaid care services to paid care work, both of which are highly feminized but carry different implications for gender equality.

There is limited comparative evidence in the literature about the division of labour among providers, but the SHARE survey throws some light on the issue in regard to home care.[18] Overall, the results of the survey can be analyzed along three crucial dimensions: type of home care provider, intensity of care, and level of disability of the care recipient. SHARE interviewees are asked whether or not they are receiving help with their daily activities from (i) family members within or outside the home, (ii) friends, (iii) formal care providers, or (iv) some combination of these.[19] [20] Respondents are also asked whether they receive (give) care almost daily, weekly, monthly or non-regularly, and for how many hours. Finally, based on a large number of questions about personal health and ability to carry out ADL, SHARE respondents are classified according to a three-level index of disability as not being ADL limited (not disabled), being limited but not severely (mild disability), and being severely limited (severe disability) .

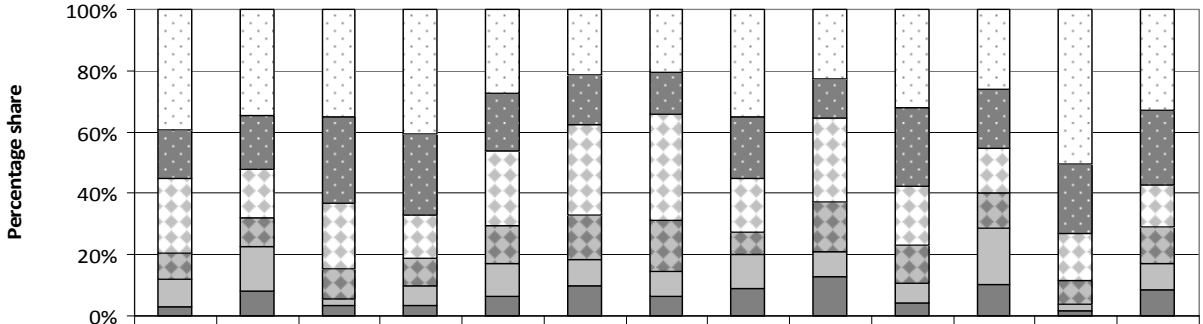
The typical profile of the care recipient in this source broadly conforms with what is already known. Taking the simple average for the 13 countries in the survey, two-thirds of the respondents older than 65 years who receive care on a regular basis are great elderly, and the remaining third belong to the 65- to 79-year-old group. Across countries, a minority of care recipients are classified as people with no disability (15%), while mild disability accounts for 33%, and severe disability for the remaining 52% (see Table A2 in the Appendix). As expected, women form the majority of care receivers (62%), the lowest disproportion with men being

[18] The recent paper by Bonsang (2009), which draws on the first wave of the SHARE for 2004, provides evidence for 9 European countries on how informal care from adult children may affect the choice of LTC services among the elderly. The list includes Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, Spain and Sweden.
[19] Suppliers of 'Meals on Wheels' are included among the providers alongside workers and care professionals. 'Meals on Wheels' is a programme that delivers meals to the homes of those who cannot buy or prepare their own meals.
[20] Interviewees are also asked whether or not they have resorted to private medical or paramedical services, hospitals or other residential services when they could not access public facilities. Since we are interested in regular provisions of LTC rather than occasional medical or other services from private providers, we have not used this information.

found among the elderly with no disability (1 man for every 1.32 women), the highest among those with mild or severe disability (1 man for every 1.89/1.58 women, respectively.: Figure 7).

We use the data to answer two main questions: what is the balance between care from family and friends versus formal services?; and how does this balance respond to changes in the frequency of care-giving and degree of disability? In order to answer these questions, we

Figure 7. Male and female care recipients by level of disability



	AT	BE	CZ	DE	DK	EL	ES	FR	IE	IT	NL	PL	SE
F_III	42	72	62	58	38	47	47	60	14	71	31	105	27
M_III	17	37	50	38	26	36	31	34	8	58	23	48	20
F_II	26	33	38	20	34	65	79	30	17	43	17	32	11
M_II	9	20	17	13	17	32	38	13	10	27	14	16	10
F_I	10	30	4	9	15	19	18	19	5	14	22	4	7
M_I	3	17	6	5	9	22	15	15	8	10	12	4	7

Note: M, F stand for men, women, respectively; I/II/III stand for not limited/limited but not severely/ severely limited in ADL.
Source: own elaboration using SHARE 2006/2007 data (see also Table A2 in the Appendix).

distinguish between *intensive* and *spaced-out* care, where *intensive* stands for care given almost daily by family and friends or at least 12 weeks per year if it is provided by formal carers; and *spaced-out* stands for care received regularly but less than 'intensively'. Like Bonsang (2009), we find that, as care needs intensify, informal care by family and friends is increasingly outsourced because of growing demands on the care givers' time or skill, or both. In addition, we find that frequency of care-giving (intensive versus spaced-out care) is more closely associated with outsourcing than is the degree of disability.

In Figure 8 countries are ranked in reverse order with respect to exclusive reliance on family and friends (versus formal care givers) when care is spaced out. The dark grey portion of each

bar identifies the share of recipients cared for exclusively by family or friends, while a lighter shade of grey distinguishes the share accruing to formal providers (in combination with family and friends or on an exclusive basis). Thus, for example, 96.8% of all the elderly receive spaced-out care from family and friends in the Czech Republic, with only 3.2% of them being cared for by formal providers. The overall indication offered by the figure is the pervasiveness of the role of family (and friends): in 11 out of 13 countries included in the chart, 80% or more of the recipients of regular care rely exclusively on the latter. It is also worth noting that the three countries that rely most on informal care comprise the two East European countries in the survey, Poland and the Czech Republic, together with Greece. At the opposite extreme, France and Belgium are the countries with the lowest reliance on informal carers, whilst traditionally familistic countries, such as Italy or Spain, are positioned in the middle, closer to a country like Sweden than would be expected. This latter finding is qualified by the fact that, in Sweden, friends are a larger component of the 'family and friends' aggregate than in any other SHARE country with the exception of Denmark (see Figure 12 in section 4.1.1.).

When care needs become 'intensive', the comparative contribution of informal care-giving diminishes substantially, and a more familiar clustering of countries emerges. Superimposed on the bars in Figure 8 is a black line which re-designs the division of labour between family and friends, on the one hand, and care workers and professionals on the other, when 'intensive' care is provided. Thus, for example, the share of the elderly who receive care daily and exclusively from family and friends falls by 18.3 percentage points in the Czech Republic (down to 78.5%). In France, Belgium, the Netherlands, Denmark, Sweden, Austria and Germany, the fall amounts to at least 20 percentage points, whereas the drop is much more contained in Italy, Spain, Greece, Poland, and the Czech Republic. A notable finding is that, while France, Belgium, the Netherlands and Denmark rely exclusively on family and friends in less than 30% of the cases when care is given daily, the corresponding figure is as high as 71.3% in Germany and 54.9% in Sweden, practically on a par with Austria at 55.1% (Table A2 in the Appendix).

Of course, care needs intensify as disability progresses, so that the extent of the shift from informal to formal care in Figure 8 can be interpreted as the combined effect of disability and frequency of care. It is, however, of some interest to investigate to what extent disability progression influences outsourcing *per se*, e.g. because the elderly with higher disability need

skills and equipment that families cannot offer, not because care is given more often. In order to separate out the influence of disability, Figure 9 retains only care recipients who are looked after daily or almost daily and tracks the extent to which they resort to care workers and professionals when disability moves from moderate to severe. As in Figure 8, shades of colour separate the elderly exclusively cared for by family and friends from those relying on formal care workers when disability is moderate; and a black line separates the two groups when disability is severe. The results confirm that disability progression to the severe stage reduces the share of care recipients who rely exclusively on family and friends. However, the extent of the reduction is below 10%, and often well below, with Germany as the only exception (-17.2%).

Comparison between the two figures thus suggests that the combined effect of the frequencies of care and disability on the decision to outsource is much greater than the effect of disability progression alone. Frequency of care-giving is therefore a better indicator of the extent of outsourcing than is the degree of disability.

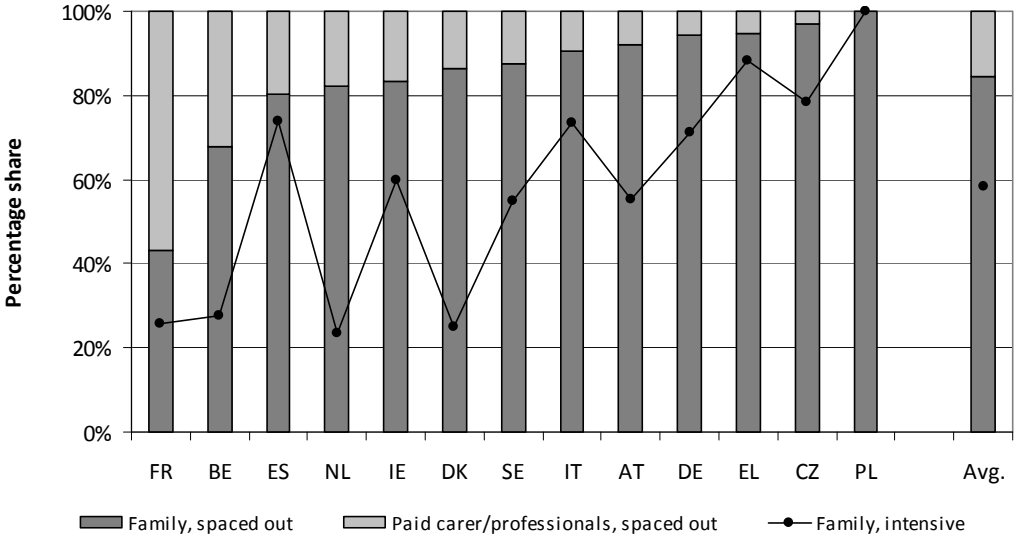
Several qualifications apply. Perhaps the most important of them is that, since the 13 national samples are generally small, national differences may be exaggerated as the analysis grows more refined because of the limited number of observations. Moreover, the survey may not fully account for two types of professional services, namely publicly subsidized home care and care from waged workers 'irregularly' hired by the family.[21] A specific qualification concerns Poland for which no formal providers are reported (i.e., zero). This may depend on the fact that public care services are very underdeveloped in this country (see Figure 4 above) and may thus have failed to show up altogether in a relatively small sample like that of the SHARE survey.

Despite these qualifications, the findings are rather suggestive. To summarize, the outsourcing of (home) care to formal providers is associated with both the frequency of care-giving and the severity of disability, but the strength of the association is greater for the former. If services

[21] Underestimation of the amount of publicly provided services may explain why the share of families giving intensive care does not fall below 30% even in Denmark, where the coverage rate for home care is 25%. If, moreover, irregular wage workers were fully accounted for this would boost the role of informal care in all the countries where families employ migrant workers as carers (Mediterranean countries, but also Austria and some East European countries, e.g. Hungary). Another caveat is that the number of observations available for analysis is generally small, so that percentages become sensitive to small changes in absolute numbers.

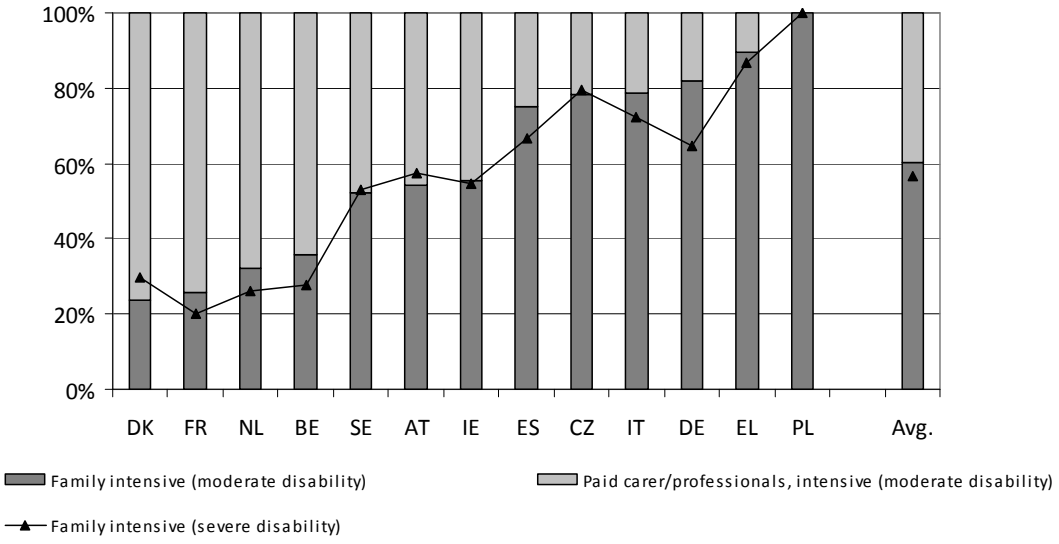
involve little more than, say, shopping weekly for one's parents or taking them to the doctor when they are in need, family involvement may be very high even in countries with developed LTC infrastructures. Clear examples are the Netherlands and Denmark, where family and friends make up more than 80% of providers when care is spaced out, but only between 25 and 30% when intensive care is needed.

Figure 8. Long-term care recipients by type of provider and intensity of care



Source: own calculations using SHARE 2006-2007 data.

Figure 9. Recipients of intensive long-term care by type of provider and level of disability



Source: own calculations using SHARE 2006-2007 data.

Two final indications arise from consideration of specific countries. Compare France and Belgium with Germany. France and Belgium appear to rely exclusively on family and friends for less than one-third of recipients of intensive care, against about two-thirds for Germany. This is consistent with the possibility that voucher schemes, such as the *chèque services* programme operating in France and Belgium (see section 3.2.3 below), may be more effective for outsourcing family care than the introduction of mandatory universal long-term insurance like that enforced in Germany. However, there may be additional factors involved, as indicated by the case of Austria. Like Germany, Austria has introduced mandatory LTC insurance, but progress in care outsourcing appears to have been much faster, although the noted statistical problems may exaggerate the extent of the progress.

The specific story told by Sweden concerns the changing role of the family. The results for this country indicate that more than half of the elderly rely on family and friends even when care is needed daily. This is qualified by evidence about a larger role played by friends in comparison to other countries, but it is also consistent with the possibility that the financial crisis of the 1990s has compelled greater reliance on the family (Nyberg 2010).

2.5. Summary view: change in existing taxonomies?

In each country the division of labour among the state, the market, and the family in their roles as care providers may be seen to give rise to a viable equilibrium when complementarities among these institutions are sufficiently exploited. 'Viable' does not imply 'optimal' or even 'good', but when this happens, a model or regime is created. This is the rationale that underlies the attempts to identify welfare or care regimes (models) made in the literature (Bettio and Prechal 1998, Bettio and Plantenga 2004, Simonazzi 2009).

One way to summarize the analytical review of the different service provisions carried out in the preceding sections is to ask how countries cluster in relation to the typology of care regimes received from the literature. This goes beyond purely academic interest because models are important for guiding policy action.

The principal component analysis in combination with the Kmeans clustering analysis can be used to group countries in a bi-dimensional space based on the similarities/differences that the

chosen set of indicators reveals (for more details on the methodology see e.g. Hamilton, 2006, and an application in Employment in Europe 2006). The technique is particularly well suited to small samples of observations like the one used here.

Given the limitations inherent in this clustering exercise – primarily the fact that it only considers long-term care and is confined to a small set of indicators and countries – *it cannot be viewed as an attempt to update taxonomies of care regimes*[22]. Rather, it offers an opportunity to synthesize the findings on the availability of care services and complementarities among providers while also capturing some of the changes that care regimes are undergoing.

Figure 10 sets out the results. The 13 countries are positioned in the box according to the four indicators of service provisions just reviewed[23]; to repeat:

- coverage rate of residential care;
- coverage rate of home care;
- share of recipients relying exclusively on family and friends when care is provided intensively (recall that, by construction, this share is the complement to 1 of the share of recipients resorting to formal providers);
- share of recipients relying on care workers and professionals when the recipient suffers from severe disability.

The four indicators are condensed into two components, 1 and 2, laid out along the horizontal and the vertical axes, respectively. Component 1 can be interpreted as strength of outsourcing towards home care provided by paid/professional carers: it correlates positively with the coverage rate for home care, and with the share of families relying on paid care and professionals at severe stages of disability; negatively with the share of families relying on friends and family members when care is provided intensively. Component 2 can be interpreted as strength of outsourcing towards residential care or paid/professional services at home: it

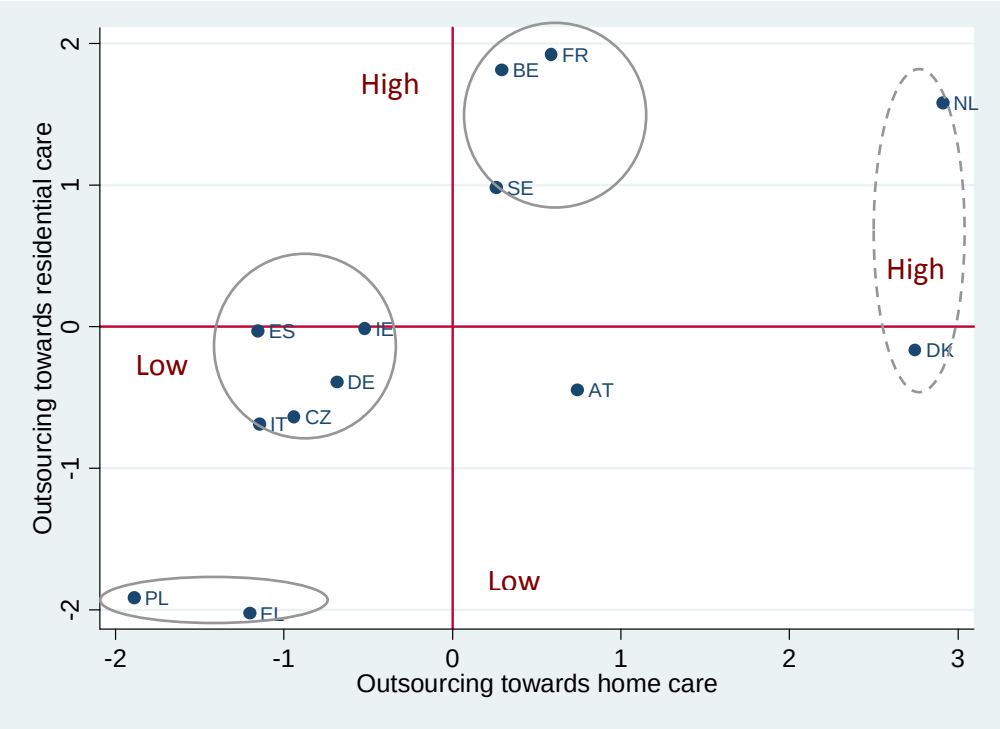
[22] To mention the most obvious reasons, the focus here is exclusively on long-term care, whilst care regimes consider all types of care. Moreover, the number of countries considered is small and arbitrarily limited by one of the data sources being used. Finally, the data on coverage rates do not systematically account for all care resources, as repeatedly noted, and especially for cash transfers or leave provisions, and such shortcomings are only partly offset by the indicators based on SHARE data.

[23] The dissimilarity measure (Euclidean distance) reflects the difference between the two observations across a specified set of variables. The countries are then plotted on a two-dimensional diagram, so that clusters of countries can be identified visually. The closer countries are to one another, the more similar they are on all the indicators used.

correlates positively with the coverage rate for residential care and with the share of families relying on paid care and professionals at severe stages of disability, and negatively with the share of families relying on friends and family members when care is provided intensively.

Four clusters can be identified: (i) Denmark and the Netherlands, (ii) Greece and Poland, (iii) Belgium, France and Sweden, (iv) a large subgroup including the Czech Republic, Germany, Ireland, Italy and Spain. Austria stands apart, being positioned somewhere between this latter group and that of Denmark and the Netherlands. It is not surprising that the Netherlands and Denmark should be close: according to the indicators used for the exercise, they are among the three most generous providers of subsidized formal care (home-based and institutional care combined) and outsource a considerable amount of informal care as soon as care needs intensify. The earlier report on care provisions (Bettio and Prechal 1998) had already indicated that in the Netherlands, as in the UK, long-term care has been traditionally viewed as the responsibility of the state, unlike childcare.

Figure 10. Clustering of countries by type of care provisions and extent of outsourcing



Source: own calculation.

The novelty with respect to the past clustering are Sweden and Austria. Austria appears to have moved towards top performing countries primarily by virtue of generous home care coverage. Sweden is now positioned at some distance from Denmark and the Netherlands and closer to Belgium and France because of middle-to-high, rather than top, levels of formal, subsidized care; also its balance between informal and formal providers is more similar to that of Austria than of Denmark. Belgium and France are closer to each other than to any other country because of the shared combination of middle–to–low levels of subsidized (public) services, on the one hand, and the lowest reliance on family carers on the other. Poland and Greece both have low levels of formal provisions 'compensated for' by a high involvement of family caregivers. With the exception of Greece, the two other Mediterranean countries considered for the exercise – Italy and Spain – fall in the largest cluster, with sufficient proximity to Germany, Ireland and the Czech Republic. In all these countries, the family retains an overwhelmingly important role, although it is flanked to different degrees by subsidized formal services. Yet Germany is not usually thought of as a familistic country!

It is worth reiterating that some of the apparent novelties revealed by this clustering exercise may be exaggerated by the poor comparability of the indicators being used. Recall, in particular, that the figures for home care in Austria may be overestimated in comparison with those for the other countries in the exercise, for example Finland. Moreover, the proximity between Greece and Poland in the diagram may be exaggerated by the fact that semi-residential services are not accounted for in this exercise although they are important in Greece.[24]

Overall, however, the new clusters tell a story that is consistent with some key developments in the national LTC sectors since the (early) 1990s. Specifically, enlargement has brought into the Union many East European countries where formal care for the elderly is still rather underdeveloped. A majority bloc of East European countries has thus replaced Mediterranean countries at the bottom of the ranking for the development of formal LTC provisions and at the top of the ranking for informal, family care. Note that the case is different from that of child care. The previous planned economies aimed at achieving practically full coverage of child care

[24] As noted earlier, only a few countries distinguish between residential and semi-residential care, making it impossible to include any such indicator in the present calculations.

in the name of substantive gender equality in the labour market, and it was mainly during the transition that the child-care infrastructure was depleted (Plantenga and Remery 2009a, p. 35). Prior to transition, assistance to the elderly in the former East European planned economies consisted primarily in financial support, such as pensions for retired persons or workers who had become disabled, subsidization of goods and (general) services, as well as access to housing, summer cottages, and land. Family carers, mainly women and informal community networks, provided the elderly with long-term assistance, while long-term residential institutions (mainly social care housing) were the main fall-back option. However coverage rates for institutional care stood at around 2 percent in large countries such as Hungary, Poland and Russia (2.6%, 1.5% and 1.8%, respectively) in 1990, i.e. before transition eroded the stock of facilities.[25]

In the meantime, some West European countries, where long-term care was and is still viewed as primarily the responsibility of the state, such as Sweden, have moved back towards informal care in the aftermath of the financial crisis of the 1990s and the ensuing budgetary restrictions (Nyberg 2010), although the move is of limited proportions. Some Mediterranean countries went the opposite way. In Spain the recent *Ley de Dependencia* (2006) has laid the foundations for a much larger involvement of public and market providers in the LTC sector Assessment of current progress towards outsourcing still invites caution according to some commentators (section 3.3 and Box 12 below). Rather, the law may have reinforced trends that Spain shares with other Mediterranean countries: Italy, Greece or Portugal. In all these countries, an increasing share of families have taken advantage of massive female migration and of increased cash transfers from the state to hire migrant workers as home-based carers, women in particular. And this has boosted coverage.

The combined outcome is some blurring of the previous divide between South-West Europe, where the LTC sector overwhelmingly relied on the family, and the rest of Western Europe, where the mix of services was more diversified. While South European countries have become

[25] For an overview report see Tobis (2000: 9-10 especially). According to this report coverage rates stood at 2.6% in Hungary, 1.8% in Russia and Belarus and 1. 5% in Poland, down to 0.2% in Azerbaijan and 0.3% in Georgia, with some of the rates referring to persons aged 60+. According to the reports, long queues were frequent. Beleva 2010 for Bulgaria, Karu 2010 for Estonia, Plomien 2010 for Poland, Albu 2010 for Romania confirm that formal long-term care services in pre-transition and transition times were very scarce.

more similar to (other) West European countries, with the EU enlargement to the East perhaps the largest difference to emerge opposes (most) new member and candidate countries to most old members.

3. Affordability of provisions

Costs are of paramount importance in the LTC sector. Because of a large medical component, full costs may be high for equipment or professional services. Moreover, there is limited scope for exploiting economies of scale because individual needs differ among elderly patients with disability, and they can only be met by giving sufficient 'face time'.[26] Fees may therefore be high even where services are considerably subsidized.

Affordability matters especially for women, given that the average level of pensions is lower for them, sometimes considerably lower (Zaidi 2007, Ivoševic 2009). Bequests or a more equal sharing of assets in old age may compensate for this gap, but only in part. According to the comparative GALCA research project carried out in 2003 in Denmark, Ireland and Italy, the gender gap in median income for people over 65 was 9.9% in Denmark, 40% in Ireland, and 38.7% in Italy. The gap is defined as the difference in median net income between men and women in ratio to men's median income. Measuring wealth as the sum of all real estate and financial assets that the person possesses, the study also found that the gender gap in wealth for people older than 65 and living on their own was positive in all the three countries, and of considerable magnitude in Italy and Denmark, where it reached respectively 28.7% and 32.8%. In Ireland it stood at 8.3%.[27]

This section uses information from the national reports of the EGGE network to document the affordability of publicly subsidized and market services in the different European countries. As to be expected, information is patchy. Statistics are not available for all countries, or they are not always fully comparable, and gaps are more frequent for home care services, especially those that families tend to buy on the market.[28] Nevertheless, some clear patterns emerge. In

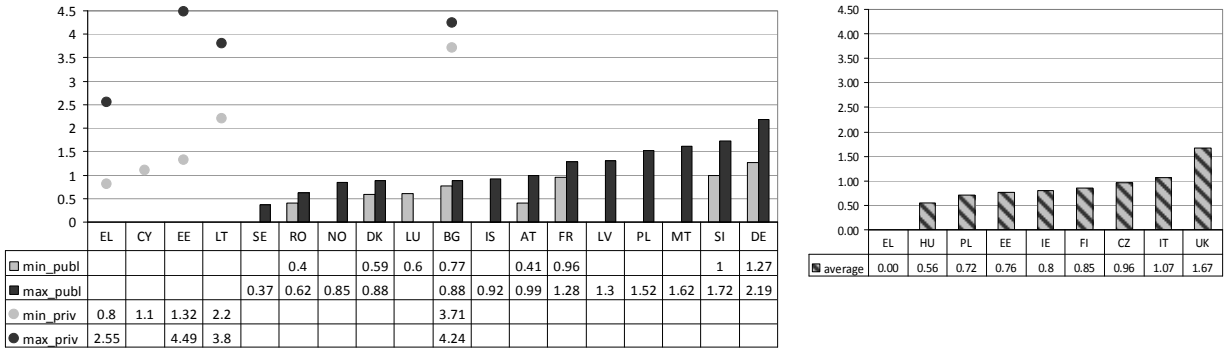
[26] Direct personal interaction or contact between two or more people at the same time and place.
[27] See Bettio (2004: Tables 5 and 10).
[28] Data on informal care are often available from time-use surveys or more general household use surveys, and administrative records can be used to document publicly subsidized provisions.

order to carry out meaningful comparison, values are taken in ratio to the median net income for a single, older person (65+) living on her/his own[29] – henceforth the *reference income*.

3.1. Residential care services

Figure 11 shows fees for publicly subsidized care in institutions (nursing homes whenever possible) in ratio to reference income for older people in each country. Dots indicate fees for private institutions, bars stand for publicly subsidized facilities. Bars and dots in the left chart measure minimum and maximum fees in ratio to the reference income, while bars in the chart to the right measure average fees. The statistics in the chart are the very latest available: the majority refers to 2009 and the oldest to 2003. As in the preceding sections, absolute values and further details are reported in Table A3, the source table for Figure 11.

Figure 11. Fees for residential care in ratio to the reference income of 65-year-olds and over, latest year available



Source: national reports of the EGGE network for fees and Eurostat for income data (for details see Table A3 in the Appendix).

Following a principle that is used in several countries to cap individual fees for institutional care, one possible criterion with which to assess comparative affordability is to set the

[29] Alternative standards of reference, such as the average level of income/pension for older women, are more problematic. First, taking fees in ratio to pensions may exaggerate actual problems of affordability, because in several instances additional sources of income are available to the elderly. Given that women are the majority of care recipients , taking female rather than average income as the standard of reference seems to be appropriate but it is likely to introduce a systematic bias in the comparison because differences in the income gap between men and women across countries would confound differences in fees, which are the main object of interest.

threshold at 85% of the reference income, although the criterion is fairly restrictive.[30] Out of the 21 countries for which fees for publicly subsidized services can be meaningfully compared, 12 satisfy this affordability criterion[31] – Austria, Bulgaria, Denmark, Estonia, Finland, Greece, Hungary, Ireland, Romania, Poland, Sweden and Norway.[32] Countries where the criterion is not fulfilled include the Czech Republic, France, Slovenia, Germany, Italy and the UK, where either the minimum or the actual (reported) average is higher than the threshold. For the remaining countries – Iceland, Luxembourg, Latvia and Malta – the evidence is not conclusive: in the case of Malta, for example, only maximum fees are reported and they well exceed 85% of the reference income.

Private residential services are much more expensive. There is limited information on fees for non-subsidized residential care, but whatever data exist they indicate that this option is the privilege of a few. Bulgaria and Greece are striking examples: in the former country, minimum fees for private institutions are almost four times higher than the reference income of an older person; in Greece the cheapest private facilities are just affordable (80% of income), but nevertheless more expensive than institutionalization in public facilities, which is provided free of charge; also quality standards are reported to be rather low for these facilities, while minimum fees for 'decent' private residences are reportedly above the average income (Karamessini 2010, p.7). Finally, in Cyprus, Estonia and Lithuania monthly expenses for the cheapest private residential services are at least 10% higher than the country's reference income.

[30] To give just a few examples, this is the case of Finland (Sutela 2010, p.7) as well as Norway (Ellingsæter 2010, p.6). A slightly lower threshold is set in Ireland (by the recently approved Nursing Home Support Scheme (80%: Barry 2010, p.11), in Bulgaria (up to 80%: Beleva 2010, p.9) and in Romania (60%: Albu 2010, p. 8).

[31] Excluded from the list are countries reporting no information, those for which the reference income is not available, or those raising problems of comparability in some important respects.

[32] Among them there are two countries reporting maximum values below 85% of the income threshold– Sweden and Norway – and four more countries reporting minimum and maximum values that yield a simple average below this threshold – Austria, Bulgaria, Denmark and Romania. The weighted average may be higher in some of these four countries but probably not high enough to exceed the threshold since maximum fees are consistently below or just above the latter. Six more countries report below-the-threshold average values rather than (or in addition to) maximum and minimum values – Greece, Hungary, Poland, Estonia, Ireland and Finland.

3.2. Home care services

Home care is, on average, less costly to the community than residential care, i.e. the full social cost is lower although there are exceptions, for example this may not be true at all levels of disability or for all the countries (Hughes et al. 2004, Bettio and Solinas 2009). The evidence discussed below also indicates that home care tends to be comparatively more affordable for families. This buttresses the view that a shift in favour of home care is desirable because it meets families' preferences, as well as being cost-effective.

However, cross-country comparisons of service affordability for the final users are fraught with difficulties. These difficulties have several facets and a common root cause – low standardization of services across providers, countries and regions. One facet, transversal to all countries, concerns cash transfers. When services are bought using cash transfers, the latter should be factored in as a subsidy and discounted from the fee or the price of the service. In order to assess affordability, therefore, detailed knowledge about cash transfers should be combined with data on fees or on the price paid by the final user. Given the variety of existing cash transfers and limited information on fees, this is not an easy task.[33]

An additional difficulty is the extreme variability of care packages. Hours of care and the content itself of the care package differ across countries for comparable levels of disability. By way of an example, consider the two groups of elderly classified at the top of the assistance scale in the Netherlands, respectively those in need of 'nursing care' and those also in need of daily 'guidance'. The former receive on average, some 8 hours of care p.w. from the municipalities (2.4 hrs for housework, 2.1 for personal care, and 3.2 for nursing).[34] The latter receive some 15 hours per week. Both groups top up municipal services with informal care services, and with services bought on the market for a weekly average of about 3 hours. Thus the elderly in need of nursing care receive, in total, about 10 hours p.w. and those in need of 'guidance' 20 hours p.w. For the purpose of comparison take an older person living on her/his own and suffering from Parkinson's disease or disabled by rheumatoid arthritis; in the Netherlands, s/he is likely to be included among those in need of 'nursing care' or of 'guidance',

[33] Note that this difficulty is less severe for residential care, since in most countries cash allowances are not available when residential fees are subsidized.

depending on the severity of the syndrome; in a Mediterranean country, s/he has good chances of being entrusted to a live-in care worker if the family can afford it, and, in this case s/he receives care on a 24-hour basis. The skill level of the carers involved would also differ between the Dutch and the Mediterranean solutions, and so would the use of assistive technology. Mere comparison of the average fee/price per hour paid by the family would therefore be misleading as an indicator of affordability.

Furthermore, any attempt to carry out cross-country comparisons based on equivalent care packages cannot overcome the problem that the content of the package (quality of care) is likely to differ. For example, a bed-ridden old patient cared for by an untrained live-in worker may suffer from *decubitus ulcers* (bedsores) if the carer is not skilled enough to handle him/her as required. However, s/he is less likely to suffer from loneliness than an older person cared for by municipal services in a typical Nordic country, where hours of care are highly rationalized (see below).

Rather than assembling information of dubious comparability across several countries, therefore, we present below a selection of *typical cost types,* each corresponding to a distinctive organizational setting for home care provisions. The selection encompasses (i) comprehensive, publicly subsidized and administered home care packages typified by Sweden, (ii) employment of live-in untrained and mostly foreign workers typified by Italy (the migrant-in-the-family model), (iii) use of *chèque services* exemplified by France, and (iv) predominant reliance on family carers as in Poland. Each of these types can be considered broadly representative of a larger group of countries. In order to facilitate comparison, the outline of each type includes essential information about the architecture of LTC in the reference country.

3.2.1 Cost type 1: comprehensive care but rationalized 'face time' in Nordic countries

In Sweden, public service provisions still account for the overwhelming majority of all formal provisions, despite some downsizing of public service provisions. In quality, if no longer in scope, therefore, publicly delivered and subsidized services retain the typical feature of what is known as the Nordic care regime. The hallmark of the 'cost type' exemplified by Sweden is

[34] Woittiez et al. 2009: p. 29, quoted in Plantenga and Remery (2010).

home care for all in need (or for most), with affordability for users and financial sustainability made (more) compatible by the pronounced rationalization of care hours. Rationalization typically hinges on a comparatively skilled workforce as well as on assistive technology.

Since the Social Services Act was passed in 1982, the elderly in Sweden have had the right to receive public service and assistance at all stages of life. Responsibility for the welfare of the elderly is divided among three governmental levels – the central government, regional authorities, and the municipalities – that are legally obliged to deliver social services and that currently provide about 90% of all formal care (i.e. excluding friends and family). Taxes and general allowances finance the bulk of expenditure on long-term care, while fees finance only around 4 percent. Home carers, in particular, provide assistance with shopping, cleaning, cooking, washing and personal care to elderly persons living in ordinary housing who cannot cope on their own and may be offered assistance around the clock, if needed (Nyberg 2010).

On 1 July 2002, a new system of fees was introduced for the long-term care of the elderly and the disabled. The purpose of the system was to protect individuals against excessively high costs for municipal care, and to ensure that all citizens retain a minimum sum for living expenses after all fees have been paid. This minimum is known as 'reserve sum' (förbehållsbelopp) (Socialstyrelsen 2002). Currently (2010) the reserve sum amounts to 4787 Swedish crowns (SEK, around €475) per month for single people and 4045 SEK (around € 400) per person for married or common-law spouses living together (*ibid.*).

The reserve sum should cover household expenses for food, clothes and shoes, leisure activities, hygiene, consumable goods, daily newspapers, telephone costs, television licenses, furniture and home appliances, home insurance, household electricity, travel, dental care, outpatient medical and health care, and medicines. It does not cover expenses for care services and support from the municipalities, or rent. Regular additional expenses incurred on account of functional disability may be added to the reserve sum, which, however, may be reduced if the fee for home help services includes food at a day care centre, or if the fee for accommodation also includes other costs that should be covered by the reserve sum. At any rate, the maximum fee that the municipal authorities may charge for home care services is SEK 1,696 (around 170 Euro) per month in 2010 (*ibid.*).

Measured in proportion to the reference income of an older person, the maximum monthly fee for home care in Sweden is therefore around 15% (see Table A3 in the Appendix). Other Nordic countries, as well as the Netherlands, report rather affordable home care services for the user. The details are summarized in Box 5. It should be stressed that in all these countries home care is made affordable not only because it is highly subsidized by general taxation but also because face time is extremely rationalized. In Sweden, the average number of hours was 2.9 per week (Nyberg, p. 16). In Denmark, average referral hours per week ranged between 4 to 6 p.w. (Sjørup 2010, p. 5). And, as just noted, in the Netherlands a person in need of nursing care received about 8 hours at home every week, plus almost three hours of informal or privately purchased care.[35]

Box 5: Home care costs for the Nordic option in Denmark, Finland, Iceland and the Netherlands

In **Denmark** home help is free, but meals on wheels are charged €7 per day; on a monthly basis an elderly receiving care plus meals on wheels would pay 14% of the reference income for older people; less than what s/he would spend for residential care (Sjørup 2010: Grid 4 and Table A3 in the Appendix).

In **Finland** home care can be free. Paying users are charged about €170 per month, i.e. about 16% of the reference income plus auxiliary services (Sutela 2010[36]: Grid 4 and Table A3 in the Appendix).

In **Iceland** the per hour fee for home care was approximately €3 in 2009, and the average number of home care hours per user was 2.5 per week (Hrafnista, Reykjavík, Tryggingastofnun ríkisins, quoted in Johannesson 2010: Grid 4).

In the **Netherlands** the fee for home care services for an 'average family' was estimated at €48 per week in 2003, corresponding to 15% of the reference income (Eggink et al. 2009, quoted in Plantenga ad Remery 2010: Grid 4, and Table A3 in the Appendix)[37].

3.2.2 Cost type 2: migrants-in-the-family in Mediterranean countries and Austria

At the opposite extreme of publicly organized and highly rationalized home care services lies the 24-hour live-in carer arrangement to be found in countries as different as Austria, Cyprus, Turkey and Portugal, but typified by Greece, Spain and Italy. In these countries, the home care

[35] Differences between these countries are likely to reflect differences in the composition of care recipients (younger recipients tend to lower the average), as well as in the care basket (e.g. home help as opposed to nursing care).

[36] Figures obtained via personal consultation with special advisor Anne-Mari Raassina from the Ministry of Social Affairs and Health (March 2010).

[37] There is no uniform maximum fee for care in the Netherlands. Instead, persons in a nursing or care home or using home care have to pay part of the costs. These are income prices, implying that the higher the (household) income, the higher the contribution. As a result of the different costs of different forms of care, it is rather complicated to calculate an average user fee. The €48 per week quoted in the text is an estimate for an 'average' family (Plantenga and Remery 2010: Grid 4).

segment has grown in parallel with the supply of migrant workers hired by the family: primarily female migrants from Central and Eastern Europe to Italy, Greece, Austria and Turkey, from the Philippines and Sri Lanka, to Cyprus and from Eastern Europe or Latin America to Spain. Key feature of this 'cost type' are extensive hours of care and selective affordability based on an abundant supply of foreign workers from within or outside the EU. The vast majority of such workers are poorly trained, and a sizeable number do not have regular employment contracts.

The phenomenon has been studied in some detail in Italy, where it has assumed large proportions. It is estimated that about 700-800 thousand foreign carers work in childcare or long-term care, primarily the latter (Censis 2008: p. 16, quoted in Bettio and Verashchagina 2010). Different sources of evidence concur that these workers supply the bulk of all formal, home-based long-term care in the country.[38]

By law and tradition, long-term care in Italy is the responsibility of the family. Home care services are jointly delivered by regional health authorities and by the municipalities under a loose regulatory framework enacted by the central government. The modest expansion of these services over the past decade has been intended to complement rather than substitute for services provided or bought by families. Caught between the strong rise in demand and sluggish public provisions, Italian families have taken advantage of cash transfers to hire cheap (female) immigrants from Eastern Europe soon after the fall of the Berlin Wall. Live-in, all-purpose long-term care workers known as 'minders' (*badante*) have become popular, and the market has extended to per-hour or per-day minders, which now represent the growing segment. Migrant care workers often also perform basic nursing tasks, relieving families from the need to hire skilled carers, at least to some extent.

[38] According to the SHARE data reviewed earlier (Fig. 8), between 21% and 28% of families caring for elderly dependents on a daily basis rely on care workers. Estimates of the share of families that hire care workers directly (among those who care for an older persons on a regular basis) vary, but several indicators suggest that it may be close to one quarter for either live-in or per-hour workers (Bettio and Verashchagina 2010, p. 8). The vast majority of the care workers directly hired by families are foreigners: the latest estimate, recently endorsed by the Ministry of Labour and Social Security puts the share of foreigners around 90% (Pasquinelli and Rusmini 2008). All this implies that the bulk of formal home-based LTC in Italy is supplied by foreign workers hired directly by families.

Services delivered by the municipality or National Health Service agencies are generally free of charge, while two main allowances are made available to families so that they can buy services on the market or (partially) to compensate informal care givers: the attendance allowance, and the care allowance. The former is tax-financed, and it is granted upon certification of severe disability. The current (2010) amount stands at €480.47 per month, the allowance covers 8.9% of over 65-year-olds (mid-2000s) and, in practice, it can be spent freely.[39] The second allowance – care allowance – may be paid by regional or municipal authorities, but since it is not mandatory, coverage rates and amounts vary greatly across regions and towns, with a general tendency to be much lower than the attendance allowance[40].

Based on the specifications of the latest national pay agreement for 'domestic' workers (2007-2011), the minimum cost to the family of a regularly employed live-in carer can be estimated at around €1100 a month for 2007, including social security contributions.[41] The figure exceeds by 10% the reference income for older people in the same year. However, if the older person were granted the attendance allowance, the ratio between the cost of a regular live-in carer and total income (i.e. reference income + the allowance) would diminish to 74%. In plain words, regular round-the-clock care is affordable, but only just, in the presence of the most generous allowance. 'Only just', because one care worker per older person does not suffice for a full 24-hour service because the labour contract grants at least one and a half days off per week; also the additional expenses, including food, lodging and supplementary services, for the carer must be factored in when assessing overall affordability. It is therefore not surprising that families often hire in the black market or on a per hour basis, or both. The black market discount may be fully 40%-50% in the poorer regions of the country (the South) and for the weakest segment of migrants, those without work permits. Hiring on a per-hour basis, and according to the

[39] INPS (Istituto Nazionale per la Previdenza Sociale): http://www.inps.it/newportal/default.aspx?sID=%3b0%3b5614%3b&lastMenu=5630&iMenu=1&itemDir=6143

[40] For recent overviews of LTC services in Italy see Gori C. and Lamura G. (2009) and Chiatti et al. (2010)

[41] Calculations for regularly employed care workers are based on minimum pay rates for a worker graded CS (the grade that should be assigned to experienced 'minders', specified in the latest contractual agreement, 2007), plus current social security contributions due from the employer and the worker. For live-in carers, a food and lodging allowance as well as severance pay are also factored into the calculation. It is assumed that the contract for the live-in carer specifies 25 hours per week irrespective of actual hours, in order to avoid payment of higher contributions (The minimum contractual amount of hours for a live-in domestic worker Contratto Nazionale per il lavoro domestico 2007-2011: http://www.filcams.cgil.it).

specifications of the latest national pay agreement, would have cost the user around €7.2 per hour in 2007 (including social security payments), but significantly less in the black market.[42]

Overall, the combination of the black market and a sufficiently wide coverage of the attendance allowance makes the live-in carer option affordable for a sizeable minority of families, and definitely more affordable than subsidized residential care. The live-in carer option is popular in other countries that are destination venues for migrant workers: Mediterranean countries such as Spain and Greece, but also Turkey and Cyprus, and non-Mediterranean countries such as Austria. Box 6 sets out the details.

Box 6. Home care costs for the migrant-in-in the family option in Austria, Cyprus, Greece, Spain, and Turkey

Unlike in Italy, Greece and, to date, Spain, home care services in **Austria** have grown considerably since implementation of the long-term care insurance scheme in 1993. However, geographical proximity to East European countries has boosted immigration in the LTC sector, especially from Slovakia. Experts estimate that approximately 40,000 illegal care workers supported people in need of long-term care and their families in around the mid-2000s (see Rudda and Marschitz 2006, and Schneider and Trukeschitz 2010, quoted in Mairhuber 2010). Foreign care workers are often qualified nurses who commonly choose to commute between their home country and Austria every other week or every two weeks, staying with a care client for a full week or fortnight. Since the estimated cost to the user of regular nursing home care on a full 24-hour basis was between €3000 and €4000/month in around the mid-2000s (Schneider/Trukeschitz 2008, quoted in Mairhuber 2010), i.e. between 2.5 and 3.3 of the reference income for older people, as in Table A3 in the Appendix, most foreign workers were hired illegally. In response to these developments, a new scheme offering financial support of between €500 and €1000 per month was enacted in 2007. It was intended to offset the considerable burden of social security contributions for families hiring carers and thus favour the emergence of irregular employment in this sector. Furthermore, legislation was passed one year later to 'ease' contractual duties on families. To date, however, no assessment has been made of these new provisions (Mairhuber 2010, p. 22).

Cyprus has joined other Southern Mediterranean countries in moving long-term care towards the 'migrant-in-the-family' model. Home care is largely provided either by informal, unpaid carers within the family or paid, live-in female migrant workers mostly from Asian countries. In Cyprus, like elsewhere in the Mediterranean, migrant care workers are more affordable than local workers, and they are plentiful. Standard contracts set by the government contribute to keeping the wages of these workers very low (Ellina 2010).

The case of **Greece** is similar to that of Italy in important respects. Public home care services cover a modest share of the older population in the country (5.6%, close to the 4.9% in Italy, see Table A1 in the Appendix). A non-negligible proportion of the existing demand, however, is met by hiring migrant care workers, mostly from the Balkans and Eastern Europe (Lyberaki 2008). The cost of a live-in worker to the family ranged from €450 to €900/month in 2006 (Karamessini 2010), or between 0.72 and 1.44 of the reference income for an older person in the same year.

In **Spain**, the purpose of the recently implemented LTC reform (Ley de Dependencia 2006) is to gradually build a universal system of care provisions for people of all ages suffering from disability. In practice, it is targeted on older people with disabilities. The text of the law prioritizes services over cash transfers, with subsidized fees for services ranging from €0 to €2.8 per hour. However, the current rationing of services as well as the level of fees are inducing families to opt in favour of cash transfers and to buy services from migrant, all-purpose, care workers. For

[42] See previous note.

between €700 and €800 per month, a live-in care worker can be hired on a schedule of 24 hours a day, 6 days a week (León 2010, p. 15). The reference income for older people in Spain in 2008 was €700/month.

Turkish-speaking female workers migrating from countries such as Bulgaria, Moldova, Romania and Ukraine are involved in long-term care in Turkey. Families who can afford to pay a monthly wage of 500-1500 euros (depending on the severity of the client's disability and on the carer's level of qualification) usually prefer to employ migrant carers because, for the same level of qualification, the latter are available on a 24-hour base, unlike their Turkish colleagues.[43] They are often 'illegal' employees, i.e. without any work and residence permit, and they must travel abroad regularly in order to renew their tourist visas. Intermediary firms that match migrant workers and households/jobs perform their activities without any restriction and openly post advertisements on public websites, although, strictly speaking, the employment offer is illegal (Ozar 2010).

3.2.3 Cost type 3: service vouchers in France and Belgium

The organization of home care for the elderly in France can be viewed as offering a solution intermediate between that of Nordic countries and that of Mediterranean countries. Belgium operates a system inspired by France. The key features of the French system are strong reliance on private as well as public providers, less rationalized hours of care compared to Nordic countries or the Netherlands, but hours much shorter than those that a migrant-in-the-family arrangement may offer. In principle, the system encourages the emergence and regularization of foreign labour. It has also the potential of ensuring a fairly well-trained workforce, although this may not have materialized in the case of France or Belgium (see also section 5.3.3).

The French National Health Service offers medical and nursing services to the elderly at home, mostly for free, whilst personal care and home help increasingly pivot on service vouchers. Vouchers can be used to buy home help and personal care from accredited care providers, the cost to the families being subsidized by a combination of cash for care and tax allowance (rebates on social security contributions). For this combination of home services, affordability can be viewed as intermediate between the Nordic and the Mediterranean solutions.

In France, service vouchers for long-term care are now subsidized via the Allocation Personnalisée à l'Autonomie or APA (Personalised Autonomy Allowance)". The APA is a universal programme enacted in 2002 in order to replace existing, selective, schemes. It is granted to older people cared for at home or in institutions according to the level of dependency. Assessment of disability distinguishes six levels of dependency, with the APA being allocated up to the fourth level. In order to guarantee access to the same services across the

[43] Expert's own estimate.

country, care packages (*Plan d'aide*) are defined according to the level of dependency – the so-called 'GIR' – and give rights to a certain amount of benefit. The benefit is paid to finance individualized care plans drawn up by a professional team and can only finance the services identified as necessary by the team. Families can use a so-called 'universal voucher' to buy personal care and home help. The CESU or *Chèque Emploi-Service Universel* is the latest version of the voucher scheme introduced in 1994 with the aim of fighting unemployment. According to the French government, 100 thousand jobs were created each year between 2006 and 2008, and this positive trend is expected to continue. Below the income threshold of €669.89 recipients are not expected to contribute with co-payment. Above this threshold, a 'user fee' is due. Moreover, there is a tax reduction for employing care workers at home (for personal care or home help). With reference to 2003, and for the bracket comprising the reference income, it was estimated that, after accounting for tax reduction, the co-payment ranged from 25% of income for people with mild disability to 55% for those with severe disability. The corresponding number of hours of service was 44 and 105 per month, i.e. between 10 and 30 hours per week, respectively (Cour des Comptes 2005, quoted in Silvera 2010). Note, however, that the tax reduction mechanism favours high-income families while very low-income families benefit from exemption from co-payments, leaving middle-income families to shoulder a comparatively larger share of the financial burden of the incumbent system.

The voucher system also operates in Belgium, but with a less central role than in France and within a different LTC architecture (Box 7). In both countries, the scheme has been credited with considerable job creation.

Box 7: Home care costs in Belgium under the service voucher programme

In **Belgium**, the institutional architecture of long-term care is more complex and fragmented than in France (Willemé 2010). Service vouchers are a recent addition to the system: they were introduced in January 2004 as part of the fight against undeclared work, as well as in order to help finance the social security system, and to respond to the demand for reasonably priced household services.

The net price of a voucher in Belgium equals the market price in the underground economy for an hour's work. The remainder is subsidized. For private households, the vouchers cost €7.5. Part of this cost is tax deductible (low earners who do not pay taxes receive a tax credit), so that the final cost is below €5. The vouchers can be used to purchase services by the hour from certified enterprises (which function as middlemen between workers and households). On top of this amount, the latter receive an hourly subsidy of approximately €13.3 in order to make this kind of labour affordable (Meulders 2010).

The exact amount spent by Belgian families on services for the elderly via the voucher scheme is not known, but the available evidence suggests that the order of magnitude is not negligible.[44] The scheme has provided many women previously active in the shadow economy with official employment status. Since its introduction, the voucher system has been modified a number of times. By 2006, it had already generated 25000 new jobs, and in 2007 the number of jobs further increased by 40%. In 2008, the number of workers operating via vouchers was estimated at between 90000 and 120000 for a total of 62 million vouchers bought. Almost half of all the workers employed through this scheme were formerly (long-term) unemployed (46%), 39% were low-qualified, and 14% did not have Belgian nationality (Meulders, 2010: Grid 1).

3.2.4 Cost type 4: minimal reliance on care outsourcing in East European countries

Formal home care services are least developed in Eastern and Central Europe, with the scarce public supplies being rationed by quantity and treated as last resort options by families and private supplies because they are strongly rationed by price. Like elsewhere, family care givers, still the vast majority, are typically untrained but tend to offer long hours of care. Poland is an example of this cost-type but other East European countries show variations on the Polish type.

The provision of care for the elderly in Poland is divided among the private sector (family and the market), public sector (social and health sectors, at central and local levels), and the third sector (NGOs and church-based organisations). The model of care is firmly family-based, home care is preferred to institutional care, and women account for the largest share of long-term care recipients, care givers and care workers, both informal and formal (Plomien 2010).

According to the Eurofamcare survey (2006), 99.8% of cared-for elderly people live at home, and 80.1% live with others – the majority resides with children (70.4%), grandchildren (44.9%), partner (38.8%), or children-in-law (35.7%). Opinion polls reflect this, in that the vast majority of respondents favour family-based care.[45]

[44] Total expenditure on home care by the state or by families was 881.3 million euros (Weillemè, 2010: Table 1), excluding purchase of service vouchers. In 2008 the service voucher scheme cost the public finances 1.3 billion euros (Ibid.: 6). The proportion accounted for by LTC services is unknown and is probably much lower than that spent on childcare. However, even if it were assumed that only twenty percent of the entire cost went towards subsidizing long-term care services, the share of the scheme in overall expenditure for home care would be about 23% (Willemé 2010).

[45] The Eurofamcare survey was conducted in 2003 in 6 European countries (Germany, Greece, Italy, Poland, Sweden and the United Kingdom) with the principal aim of collecting detailed and comparable information on family care workers. The details of the survey, as well as the main results, are available at the dedicated website: http://www.uke.de/extern/eurofamcare/. The specific figures quoted in the text above are drawn from (Lamura et al. 2008)

Eligibility for public long-term care support is based on health and income criteria as well as on the family situation of the elderly person. The Social Assistance Act (2004: Dz.U. nr 64. poz. 593) stipulates eligibility for social assistance benefits and services free of charge based on an income test, which since 2006 has been set at a monthly level of 477 PLN (€121) for one-person households, and of 351 PLN (€89) per person in households of more than two people.[46] Given that in 2008 the average per capita income in households was 1046 PLN[47], both income test thresholds are rather stringent. The immediate family (spouse, children, parents) is responsible in the first instance for persons who, due to age, illness or other reasons, require nursing or specialist care. Lone persons or those whose family cannot provide care are entitled to care and specialist services from local authorities on a residential, semi-residential, or home basis. Thus, the state provision of care services to the elderly is a matter of last resort, when family and financial resources (set at a very low level) are deficient. In the context of this potentially stigmatising regulatory framework, attitudes to formal care tend to be negative (Plomien 2010).

While a small proportion of the elderly in Poland have access to public provision of services free of charge, the majority have to rely on the market for an alternative to family care. Currently (2010), the hourly rates charged by a care assistant are in the range of 10 - 16 PLN (€2.5 - €4) depending on the level of dependency and time of service; the corresponding figures for a nurse or physiotherapist range from 12 to 45 PLN (€3 - €11). There are also itemised health practitioner charges based on the type of service provided, e.g. an injection costs 30 PLN (€7.4) and dressing replacement 50 PLN (€12.4). While these individual charges are relatively low, a person with significant and frequent care needs faces potentially high costs, which can also exceed their monthly income (Plomien 2010).

Other East European countries share with Poland a paucity of formal home care services and not inexpensive market alternatives to family care. Examples are Hungary and Slovenia (Box 8).

Box 8: Home care costs in Hungary and Slovenia

According to the **Hungarian** Institute for Social Policy and Labour (2009), in Hungary about 80% of formal home care recipients contribute with co-payments. User fees are decided by the local government and range from 0 to 1200 HUF per hour or up to €5/hour (Frey 2010). At the top rate, the 'average' elderly person living on

[46] MPiPS website: www.mpips.gov.pl
[47] GUS website: http://www.stat.gov.pl

€321/month would be able to buy little more than 2 hours per day, provided s/he could pay rent, food, clothing and bills out of the remaining 25% of her/his income.

In accordance with the Social Security Act, municipalities in **Slovenia** subsidize at least 50% of the costs of home care services offered to the families. In the first half of 2007, the average fee was €4.3/hour while the full, average cost of the service was €13.9 (SORS, 2008). Despite considerable subsidization, fees are not low for the average elderly person, whose income stood at approximately €500/month in 2007 (Kanjuo-Mrcela 2010).

3.3. Summary view: open issues in affordability

Comparative evidence on the affordability of long-term care indicates that outcomes may differ considerably between and within countries depending on whether the analysis focuses on institutional or home care.

One general and rather expected finding from the evidence gathered by the experts is that residential care not only entails higher full costs but tends also to be less affordable for families than home care. Care in private nursing homes or equivalent private institutions – all of which price services on the basis of full costs – is generally the most expensive type of long-term care in all countries.

Adopting the criterion that fees absorbing at most 85% of the reference income are 'affordable' (given that care in an institution covers all basic needs), it was found that publicly subsidized residential care is affordable in the majority of the countries, that is, 12 out of the 21 for which a meaningful comparison could be instituted. Interestingly, the cases of positive affordability include Nordic countries, many of which, however, are no longer the most generous providers having re-directed some services towards semi-residential facilities or home care. But cases of positive affordability also include many of the poor providers, i.e. a large number of Eastern and Central European countries together with Greece. The countries that do not satisfy the affordability criterion are the Czech Republic, France, Germany, Italy, Slovenia and the UK.

For the Nordic bloc, affordability is simply a facet of the country's universalistic care aspirations. For the countries with poor provisions affordability is often the other side of rationing. Limited provisions are put in place as 'last resort' solutions targeted on the elderly who cannot count on, or pay for, any other alternative, including family care.

Cross-country comparisons on the affordability of home care services are especially problematic since fees vary greatly within the same country conditionally on the level of dependency, thus adding to the diversification among countries. However, some broad patterns are discernible. In countries where formal home care services in kind are generously supplied, they are also affordable, and the list of generous home care providers includes the Nordic countries and the Netherlands, as usual. By contrast, in countries where the supply of such services is rather poor – i.e. in Central and Eastern Europe – publicly subsidized services are not only rationed, but in some cases they are also expensive.

Middle-level providers – the Mediterranean countries, Germany, Belgium and France – have found different answers to the problem of home care affordability. Germany, France and Belgium have moved towards universal cash schemes, either by running long-term care insurance schemes or by granting allowances sufficiently generous in their coverage. The key difference between France and Belgium, on the one hand, and Germany on the other, is that the former ensure affordability for a large segment of families primarily by subsidizing outsourced and regulated private services, whereas the latter subsidizes family budget and leaves families to decide how much to outsource and to whom. Austria has adopted the German solution to the problem of affordability. However, short commuting time with ex-socialist countries ready to provide skilled as well as basic care workers (Slovakia and Hungary in particular) has further expanded the 'care menu' accessible to families, including a round-the- clock , live-in option.

The recipe of Mediterranean countries like Italy or Greece combines three main ingredients: limited but free or very cheap public services that complement private supplies, selective cash allowances, and a large irregular market for migrant care workers. Thanks to this combination, a round-the-clock solution or relatively extended hours of care are *de facto* affordable for a significant share of families, one key ingredient of affordability being irregular and thus cheap labour.

Spain is in transition between ambitions to gradually achieve universal coverage of services and an underdeveloped care infrastructure that is pushing families back towards traditional alternatives, i.e. migrant care workers subsidized by cash transfers. The following excerpt from

a recent study reporting interviews administered in Spain to people involved in the implementation of long-term care policies clarifies the issues involved.

> *"For 700 or 800 Euros a month you can have a personal carer in your home 24 hours a day, 6 days a week. But if you choose service instead of cash you might be offered assistance only for a few hours a day. Some of these services, for instance day centres, have rigid timetables and are not easy to combine. So it is not surprising really that people opt for cash. We should not demonise individuals who make that decision because the truth is that the law has been badly planned. It says services should be prioritized but it does not effectively make it more beneficial for consumers to choose services over cash". (Leon 2010, p. 15)*

If a hypothetical policy-maker had to choose among the different solutions to the affordability problem adopted by member countries, s/he would be confronted with two manifest trade-offs. The first is between hours of care, on the one hand, and horizontal equity on the other; the second is between job-creation potential and quality of employment. This chapter has mainly looked at the former trade-off, while the latter will be subject to discussion in the next chapter.

Nordic countries have long been aware of the tension between generosity with care time and universal affordability. The most affordable solution for home care typified by these countries must rationalize hours of care in order to ensure the widest coverage. At the other extreme lies the round-the-clock, live-in carer arrangement of Mediterranean countries, which is made affordable for a significant minority of families by large supplies of migrants working in the irregular segment of the market. Such extended care hours, however, become expensive as soon as migrant labour is regularly employed. The clearest example in this regard is Austria, where the government is subsidizing social security contributions in order to encourage the emergence of irregularly hired migrant workers.

Finally, there is the French and Belgian solution. With the *chèque services* system that abates the cost to families (and to the state) of supplying sufficiently long hours of work, France – and to a lesser extent Belgium – appear to have found a more balanced response to the trade-off between hours of service and equity.

4. Gender Equity

For care receivers or care givers, the LTC sector is still largely the province of women. This chapter looks at some of the main implications for equality in labour-market outcomes of women's overrepresentation among formal and informal care givers. In addition, work and pay conditions for (formal) care givers are reviewed and briefly assessed in regard to their implications for the future of employment in this sector.

The first section is devoted to informal care givers and the potential conflict between work and care. After sketching the current profile of care givers in the various countries, the section discusses available evidence on the potential conflict between working and caring for an older person. It then goes on to review the time-related provisions made available by member states to mitigate this conflict, focusing primarily on leaves off-work.

The second section looks at the formal segment of care givers. It offers some systematic evidence on pay levels among skilled care workers (nurses) and other waged care workers, as well as selected qualitative evidence on working conditions. The related discussion touches upon some of the topical issues concerning employment in long-term care, including turnover rates and staff shortages, and the use of migrant workers to remedy such shortages. Given the scope of the present report, analysis of each of these issues cannot be comprehensive but will nevertheless attempt to (briefly) cover the most prominent concerns.

4.1. Informal care givers

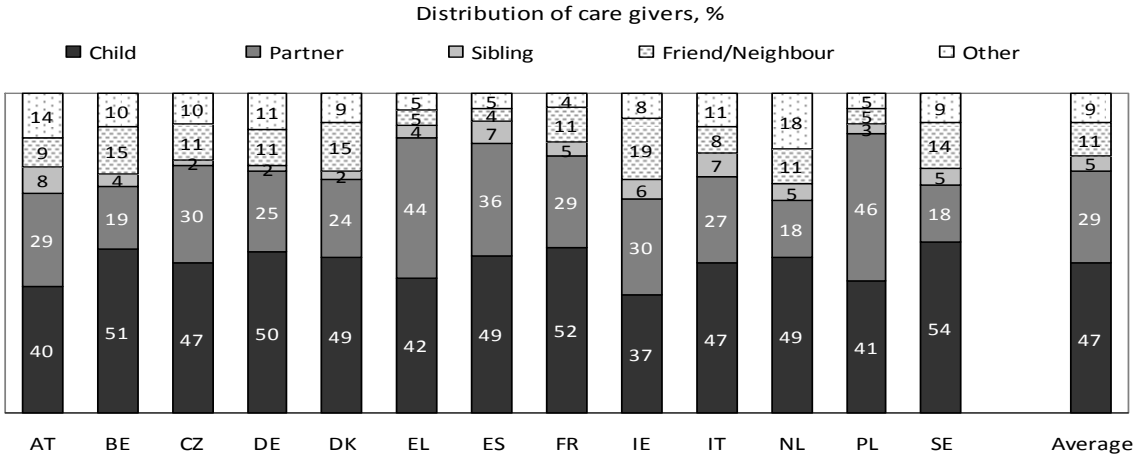
4.1.1 Uneven progress in gender balance

Within families (or among friends), men assume care responsibility for older people more than for their children, but women still shoulder the larger part of the burden. For the 13 countries covered by the SHARE survey, Figures 12 and 13 below illustrate the relationship between informal care givers and care receivers, as well as the proportion of women among the former. Given the design of the survey, the vast majority of informal care givers are more than fifty years old (see Box 4). Those included in the two Figures comprise live-in care givers, as well as

those living outside the older person's household, all of whom furnish care on an almost daily basis ('intensive' caregiving in our categorization).

Taken together, children and partners (including spouses) account, on average, for three-fourths of all informal care givers in the 13 countries considered, with the highest value accruing to Poland (87%) and the lowest to Ireland (67%). On average, children outnumber partners by a ratio of 1.6 to 1 when both co-residing and non co-residing care givers are considered (as is done here). But in practically all the countries spouses is the largest group of co-residing care givers. Siblings, friends and other care givers account for just one-fourth of the total, with friends and neighbours performing a more than marginal role in a few countries only (Ireland, Sweden and Belgium in particular) (see Figure 12).

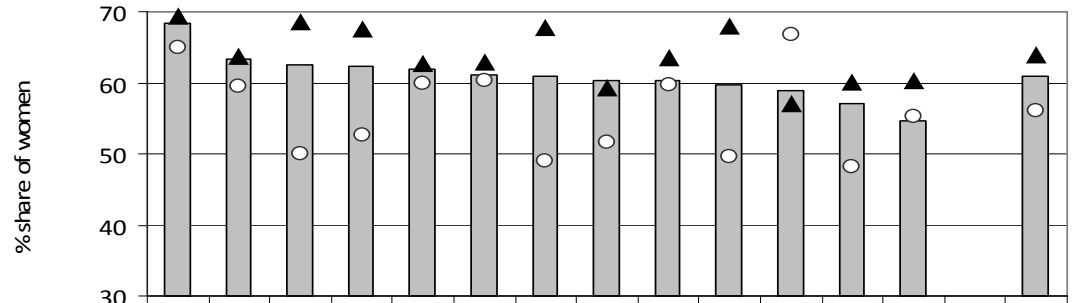
Figure 12. Relation of care givers to care receivers, intensive care



Note: The last column to the right reports (simple) average values across the 13 countries.
Source: own calculations on SHARE data, 2006-2007.

With 61% of the total, women form the majority of informal care givers, but not the vast majority (Figure 13). As a general rule, men still represent 'second instance' informal care providers, and their caregiving is much more conditional on employment status than it is for women. They are also more ready to pay to outsource at least part of the services (Box 9 below). Children are the largest and most feminized subgroup, as shown by the black pointers in Figure 13. The second largest group, that of spouses and partners, is the least feminized (the small circles in the same Figure), and the relatively large presence of men among spouses (44%, on average) is worth emphasizing: in 6 out of 13 SHARE countries, male and female partners

Figure 13. Proportion of women among informal care givers



	EL	FR	ES	IT	CZ	DE	AT	NL	DK	PL	SE	BE	IE		Avg.
All care givers	68.4	63.3	62.5	62.3	62	61.1	61	60.4	60.3	59.6	58.9	57.1	54.7		60.9
Partner	65	59.5	50	52.7	60	60.4	48.9	51.7	59.6	49.6	66.7	48.1	55.3		56.0
Child	69.4	63.8	68.5	67.6	62.8	62.9	67.7	59.3	63.5	67.9	57	60.2	60.3		63.9

Source: own calculations on SHARE data, 2006-2007.

appear to be involved in caring for the spouse on a more or less equal basis (Austria, Belgium, Italy, the Netherlands, Spain and Poland). According to the national evidence surveyed in Box 9, Norway and the UK are also witnessing the equal involvement of male and female partners in caring for their spouses.

The general picture is one of ongoing de-segregation. However, progress is uneven by age, labour-market status, and position in the family. National and comparative information concurs that the likelihood of men becoming informal care givers is highest among older, retired male spouses (to the benefit of their partners) and lowest among younger, employed sons (to the benefit of their parents). Because informal care givers for older people are themselves relatively old and only a minority is still in employment, the overall gender imbalance is now rather small for this group. This contrasts with the strong and persistent imbalance among formal care givers (workers or professionals) discussed in later sections.

Box 9. Men in family care

Estonia. In a recent study, Laidmäe et al. (2009) showed that 96% of women and 83% of men were ready to assist their elderly parents. Helping was seen to involve different activities, from nursing to financial help. However, only women stated that they would help with household chores (doing the laundry, preparing food, cleaning the house, washing and nursing an elderly person in bed). The study also finds that middle-aged women are more willing to nurse a parent than men. Men are more ready to pay for nursing or for a place in a nursing home. (Karu 2010)

Norway. Current estimates on informal care are not easily available. By adding care for dependent persons in the household to regular help outside the household, Langset (2006) estimates that family carers work 80,000 man-labour years. Moreover, figures from 1995 suggest that 17% of the adult population provided regular help to sick,

disabled or elderly persons outside their own households, with one-third of the help being given to parents. Men and women provided this kind of help equally (17% among men, 16% among women). (Ellingsæter 2010)

Poland. Based on a random sample of women aged 50-65 and men aged 55-70, research by Kotowska and Woycicka (2008) suggests that 31% of women and 20% of men care for others (including children). The majority of this sample of men and women provide care to adults. There are no differences between employed and unemployed women in providing care, whilst among men, those not in employment are more likely to care than those who are employed (20% versus 17%). Moreover, women report difficulties in combining work with care more often (37%) than men (23%), whilst the reverse is the case when reconciliation comes easily (30% women versus 38% men). Furthermore, care is provided in the first instance by women, and men become involved only thereafter. (Plomien 2010)

Spain. The Law on Dependency explicitly gives preference to vouchers over cash transfers in order to promote formal care over family care. Cash transfers, in fact, are considered the last resort when there are no services available for the dependent elder. If effective, this regulation would have the side-effect of reducing the imbalance between male and female carers, since 94.2% of family carers are women and, even though females also form the majority of skilled carers, there is a larger number of men working in long-term care than in family care (figures from Official statistics as of March 1st, 2010). (González Gago 2010)

Sweden. A number of studies claim that when publicly financed long-term care decreases, unpaid informal care increases. For example, a study by Socialstyrelsen (2004) shows that the share of elderly persons (75+) living at home who received help from municipalities declined from 22% in 1988 to 17% in 2000, and those who only received informal help increased from 55% to 67%. Additional calculations concerning the same category of elderly show that public assistance contributed 40% of the total volume of assistance in 1994 and that this share declined to 30% in 2000, implying an increase in informal assistance from 60% to 70% (Socialstyrelsen 2004a p. 14). The discussion on gender equality has largely focused on families with small children, whilst families that help elderly persons in their everyday lives have been largely omitted, and this in spite of the fact that the supply of publicly financed child care has increased, while that of long-term care has decreased – with, moreover, a shift of long-term care from the public sector to the family. Female relatives, mainly elderly wives and middle-aged daughters, have increased their unpaid care work. Caregiving by male relatives has not increased to the same extent. A government inquiry concerning gender equality policy points out that it is important from a gender perspective to monitor these developments (SOU 2005:66. p. 23). (Nyberg 2010)

UK. Analysis of the 2001 UK census has revealed that 10% of the adult population are informal carers for sick, disabled or elderly people: 11.3% of women and 8.6% of men. Among those aged 70 and over the incidence and time commitment to informal care is higher for men than women (Dahlberg et al. 2008). These are likely to be men caring for a spouse, while in this age group, women's informal care responsibilities for a spouse may have stopped because of widowhood (*ibid.*). There is some evidence that the contribution made by men to informal care is increasing, primarily when there is no female relative available to provide care. This applies particularly to older men caring for their spouses. This means that the gender gap in informal care is decreasing among older people, while it persists among those of working age (Himmelweit and Land 2008). (Fagan 2010)

4.1.2 Employment and caring

Informal care givers with jobs represent a minority of all informal care givers in LTC, as just noted, but they may face difficult choices with regard to employment. The available evidence suggests that the negative impact of care time on employment is non-negligible, but nevertheless modest in comparison with childcare.

Eurofamcare is the largest European survey to have focused on family carers (see section 3.2.4). According to the results of this survey for Greece, Italy, the UK, Poland and Sweden, family

carers in employment made up between 34% and 47% of all carers in around 2004 (in Sweden and Greece, respectively). Depending on country, between 7% and 21% of all employed care givers in the survey had reduced their hours of work, and between 3% and 18% of all non-employed care givers had previously had to quit work (Lamura et al. 2008).

The national-level research summarized in Box 10 suggests that the trade-off between caring and working may be less substantial than has been found by the Eurofamcare survey. Informal female care givers with jobs tend to quit employment more often than employed male carers, but the estimated incidence of quits is generally below 10% and only occasionally just above this figure. This holds even for countries relying heavily on the family, such as Poland, Italy or Spain. A larger share of employed carers who reduce their hours of work or take leave is reported for France, where it has been estimated that 15% of women in employment resort to part-time in order to meet their care commitments. Comparative econometric research confirms that the impact of informal care on the probability of exiting employment or of reducing hours of work is positive and statistically significant, but perhaps lower than the figures from the Eurofamcare survey imply (Box 10).

Box 10. The tension between employment and care for the elderly

National evidence

Austria. Pochobradsky et al. (2005) looked at the situation of family carers assisting relatives in receipt of the LTC allowance. They showed that 56% of carers had been in paid employment prior to caring. At the time of the survey, however, only 32% of the respondents receiving lower levels of the allowance were still working, compared with only 26% of beneficiaries of higher levels of the allowance. (Mairhuber 2010)

France. In 1999 the HID (*Handicap, invalidité, dependence)* survey identified 1521 women carers, half of whom were partners, and 600 were daughters or daughter-in-laws. Two hundred and fifty of the daughters worked (i.e. almost 42%). Only 38 of them, *i.e. 15%, had rearranged their occupational activity because of their caring role* (changes in their work schedules or reduction in working time (Le Bihan and Martin 2006). At the same time, only 15% of these women indicated that the role of carer had changed their leisure activities, although for 53% of them holidays posed the problem of finding a replacement. For the large majority of them (87%), having to care in addition to working had little impact on their life with their partner. (Silvera 2010)

Italy. According to the GALCA survey conducted towards the end of 2003 in Modena (a high employment area), 10.5% of the female family carers had had to give up work, while the share of those having to reduce working hours or having asked for leave off work was negligible (1% and 0.5%, respectively). The corresponding figures for men were 9.4% for quitting work and zero for reduced working time. According to an official survey carried out in 2002/3, 4.3% of all women who had quit employment for reasons other than retirement or old age had done so in order to care for older or sick relatives; by contrast, about a quarter (24.7%) had quit following marriage or the birth of a child (ISTAT 2008, Figure. 9.3). Moreover, of all non-employed women of working age, 10.5% had not sought employment because they were taking care of older relatives, as opposed to 33.5% not seeking work because they were caring for children. Finally, a recent paper by Marenzi and Pagani (2008, Table. 4) finds that the probability of participating in the labour market decreases by some 13.9 percentage points when care is provided to older parents. (Bettio and Verashchagina 2010)

Norway. Multivariate analysis indicates that there is no significant correlation between experiencing problems of combining work and care, on the one hand, and gender, age, educational level, working hours or sector on the other. However, problems may arise among those working short or long hours, especially with regard to care of the elderly. The most frequently reported effect of long-term care on one's job is irregular attendance, and thereafter concentration problems. Men handle this more often by working flexible hours, reaching work late and leaving early, while women more often experience concentration problems. Both sons and daughters feel that they are hindered in social activities and in advancing their careers (Gautun 2008). (Ellingsæter 2010)

Poland. The Eurofamcare survey found that 60.3% of family carers are not in employment, while 6.1% of working carers had to reduce their working hours, which resulted in a negative income effect in all cases. Among family carers not working due to care for the elderly, 8.1% stated that they could not work at all, and 4.7% stated that they had had to give up work (Eurofamcare 2006). Among non-employed respondents, 32% of women with care responsibilities would have liked to take up employment, and care responsibilities were seen as a barrier by 15% of women and 10% of men (Kotowska and Woycicka 2008). (Plomien 2010)

Spain. Moya Martínez (2009) shows that performing informal care activities for more than 20 hours a week reduces the likelihood of working by 10-12%. However, the effect is much larger (-17.5%) for younger care givers, those more likely to take care of children. (Gonzalez Gago 2010).

Sweden. There is very little research on the relationship between employment and informal, unpaid long-term care. Sundström and Malmberg (2006) suggest that reconciliation is feasible, except when the care burden is "heavy". Reportedly, limited informal care does not influence employment, whereas women who give help daily are more often outside the labour market than other women. This is not the case among men. Around 60 000 women and 20 000 men declared that they worked part-time or had stopped working in order to take care of elderly or ill relatives. Ulmanen (2008) suggests that, in the same way as there is a right to be absent from work to take care of sick children, so there should be a right to be absent from work to take care of elderly family members. (Nyberg 2010)

United Kingdom. Smeaton et al. (2009) found that care responsibilities have a modest negative effect on employment rates for working-age women. However, the incidence of informal caring among the working age population is higher for the economically inactive than the employed (20% in 2000). Women of working age who have care responsibilities are less likely to be full-time employed and much more likely to be part-timers, and co-resident carers are the least likely to be in paid employment (Vickerstaff et al. 2009). Working-age women providing intense levels of care have lower participation rates than other women (Glendinning et al. 2009). A qualitative study of employed carers in receipt of the Carer's Allowance found that they reduced their hours or stopped employment as the care responsibilities on them increased (Loretto et al. 2008). (Fagan 2010)

Comparative econometric evidence

For 10 countries - Denmark, Sweden, the Netherlands, Austria, Germany, France, Switzerland, Greece, Italy and Spain - Bolin finds that the probability of being in employment drops by at least 3.2% among male carers and by 2.8% among female carers in response to a 10% increase in weekly hours of informal care (Bolin 2008: 728-731).

Using ECHP data for EU-12 between 1994 and 1996, Spiess and Sneider (2003) specifically test the trade-off between hours of informal long-term caregiving and hours of work for Northern and Southern European countries. They find that, in the latter, both the start of caregiving and an intensification of care due to the worsening of the patient's conditions entail a significant reduction in work hours, while in Northern countries hours decrease only when the individual starts to care. (Spiess and Sneider 2003).

Crespo (2006) uses SHARE data to estimate the trade-off between work and long-term care for informal caregivers. She finds that being an intensive caregiver in Southern countries (Greece, Italy and Spain) reduces the probability of participating in the labour market by between 4 and 42 percentage points, depending on the methodology and the sample being used (Crespo 2006, Table. 11).

4.1.3 Leave time and flexible time for informal care givers

The conflict between working and caring for older people is not of the same order of magnitude as that entailed by caring for children (or other people suffering from disability), but the on-going postponement of the retirement age will may exacerbate the tension between work and long-term care, especially for women, and thus alter this order of magnitude. Since time off-work is the basic resource that employed carers use to solve this conflict, it is important to verify the extent to which existing time-off provisions are adequate, particularly in view of future demographic trends.

The policy debate on provisions for time off-work is still dominated by the pressure to ensure enough parental time for children. Out of the limelight, however, ageing is pushing towards the introduction of targeted time-off-schemes to care for the elderly, or the updating of existing schemes in order to include care for the elderly. The following concise review focuses on those characteristics of time-off provisions most likely to influence take-up rates, but also to negatively affect subsequent working conditions. They include whether or not access to the leave scheme is given as a right as opposed to being made conditional on approval by the employer; whether compensation is offered and how much; what eligibility restrictions apply, and the terms of statutory duration. Table 2 below summarizes information on these counts from the national reports of the EGGE network, based on Table A4 in the Appendix where additional details can be found. Unfortunately, such details do not include take-up rates, on which information is generally lacking.

Typically, (informal) care givers in employment can take short-duration leaves in order to deal with health-related emergencies or unexpected care needs. In addition to leave schemes, some countries, but only a few, offer care givers the option of reducing working time while needs persist, or guarantee the right to switch to flexible working time. The majority of countries, but not all of them, also offer long-duration leaves, but the conditions are more restrictive. Short-duration leaves are generally granted as a right and are paid, provided that health or care needs are certified. Longer leaves are often unpaid and not infrequently conditional on approval by the employer, especially in the private sector.

Table 2. Leave and flexible time provisions

Country	Motivation / type of provision	Leaves off work				
		Duration	**Paid (replacement rate or amount)**	**Deemed contribu-tions#**	**Conditional on approval by employer**	**Restrictions**
AT	Family hospice leave	Max 3 months, can be extended to 6 months			Y	
BE	Medical assist.	1-3 months/year	Y (€741/month) ¥		D	m, s
	Palliative care	1(+1) month/year	Y (€741/month) ¥			m
	Compelling reasons	10 days/year				
	Unspecified	Upon agreement			Y	
	Time credits/career interruption	3 months-1 year †	Partially‡		D / Y §	a, s
BG	Care leave	Up to 40 working days	Na	na	Y	m
CY	*Force majeur*	Max 7 days/year				
CZ	Care of family member	Max 9 days, renewable (there is no yearly max)	Y for 6 days			
DE	Short care leave	Max 10 days/year	Y/N *			
	Long care leave	Max 6 months/year		Y	Y*	s
DK	Care leave	Max 6 months/year	Y (€2566/month)		¥	
EE	Care leave	Max 7 days/year	Y (80% of the wage)			
EL	Sickness of elderly dependents	Max 6 days/year				f
ES	Care leave	Max 2 years		Y (first year)	D ¥	e
FI	Job alternation leave)	Max 12 months	Y (70-80% of unempl. benefit)		Y	a, e
	Urgent family reasons	Upon agreement	D (mostly unpaid)			
FR	Family Solidarity Leave	3 months/year	An allowance can be used for 3 weeks. The amount of €47/day.		Y	e
HR	Short-term leave	Up to 7 days		Na		
HU	Care leave	No limit	¥	Y		m
IE	Care Leave	13-65 weeks/year	Partially		Y	
	Career Breaks	Max 5 years			Y	e
IS	Care leave	Max 3 months				
IT	Short license	3 days/year	Y(for certified disability)	Y (if paid)		m
	Compelling personal reasons	2 years all together	D	D	Y	m
LV	Short care leave	Upon agreement	Y	Na	Y	e
MT	Responsibility	1 year			Y	a, m

	leave	Max 8 years during the working life				
NL	Short duration leave	Max 10 days/year	Y	D*	Y	f
	Long duration leave	6 times working hours per week		D*	Y	f, m
NO	Care leave	Max 10 days (up to 60 days in the terminal stage of life of the cared–for person)				m
PL	Care leave	Max 2 weeks	Y (80%)			
PT	Leave to assist spouse	Max 30 days/year	Y (100% in public sector; varies in private sector)	Y	D	e
	Leave to assist family members	Max 15 days/year	Y (100% in public sector; varies in private sector)	D	D	e
RO	Care leave (part-time leave, 50%)	No limit specified by the law §	Y (initial gross wage of a social worker)	Y	Y	f
SE	Care leave	Max 100 days	Y (partially)		N	
SI	Care leave	Max 7 days/year	Y (100%)	Y		

Notes: Y - Yes, D - Depends, NA - Not Applicable, na - not available; # deemed contributions are granted for periods of inactivity , e.g. during maternity, and are counted towards benefits, for example towards the pension amount..
Types of restrictions: a - seniority, e - sector or type of employment, f - family characteristics, m - medical conditions of the care recipient, s - size of the firm.
BE. **¥:** for full-time employees this amount is proportionally reduced according to working hours. 1/2 leave: below 50 y.o. - €371/month; 50+ y.o. - €629/month. 1/5 leave: below 50 y.o. - €126/month, below 50 y.o. and single parent - €169/month, 50+ y.o. - €252/month; **† :** sector-level collective agreements can extend this full-time credit to a maximum of 5 years (until retirement in large firms); **‡ :** *Time credit.* 2-5 years of seniority - €407/month (net), more than 5 years of seniority - €543/month (net). *Career interruption*. €341-407/month (net), plus supplements according to the number of dependent children; **§ :** *Time credit* is a right in the private sector, but no more than 5% of the employees of a company can use it at the same time. Only in companies with fewer than 11 employees is the employer's approval necessary. For a career interruption the employer's approval is necessary; it is not a right.
DE. *: the short care leave is paid only if this is envisaged by the work contract or a collective agreement which includes the right to paid short leave. Hence it is often not paid. Long care leave is a right, but the employer may have cogent reasons to postpone the beginning of a leave.
DK: the care leave is not conditional on the employer's approval, but there must be a 6-week warning concerning both the date to start the care leave and to end it.
ES: the care leave is conditional on approval by employer for workers in the private sector if two or more workers of the same company apply for it at the same time and if there are organizational reasons that can be cited. In the case of public servants, there is no such a condition.
HU: the care leave is unpaid, but the period of care leave is compensated by a nursing allowance. In the case of persons with severe disabilities, the amount of the nursing allowance is 100% of the minimum old age pension, whilst in the case of persons with severe disabilities in need of intensive care it is 130%.
NL - depending on collective agreements, participation in a pension fund is allowed for.
RO - Even if the maximum duration of the care leave is not specified, a certain limit is imposed by the availability of local budget funds, severely restricted in 2009 and 2010 because of the economic downturn.

Source: national reports of the EGGE network (for more details see Table A4 in the Appendix).

Short-duration leaves. Of the 26 countries included in Table 2, nine – the Czech Republic, Cyprus, Croatia, Estonia, Greece, Slovenia, Poland, Norway and Portugal – offer only short-

duration leaves ranging from 6-7 days to 30 days per year, while the majority of the remaining countries provide both short- and medium-to-long duration leaves. Short leaves are often paid (but not everywhere, e.g. not in Cyprus or Croatia), and they are not made conditional on the employer's consent. The main motivation is caregiving to family members; but only in about one-third of the cases are provisions explicitly or *de facto* targeted on older people, e.g. in Austria, Greece and Romania (see Table 2 and Table A4 in the Appendix).

One or more medium- and long-duration leave schemes are reported for 14 countries: Austria, Bulgaria, Belgium, Germany, Denmark, Spain, Finland, France, Ireland, Iceland, Italy, Malta, the Netherlands, Romania, and Sweden. In the majority of cases, the maximum duration does not exceed 1 year, but there are numerous exceptions: Spain and Italy with two years, Ireland with 5, Malta with 8, and Belgium with one leave scheme targeted on older workers, which can be extended until retirement. In about half of cases, the statutory motivation is caring for family members in general, the remaining half being divided between schemes devoted to caring for older relatives or parents, and multi-purpose leave schemes like the career interruption scheme in Belgium. The general rule is that these leaves are unpaid, but in a non- negligible number of cases some compensation is offered, although restrictions apply: cases in point are the palliative care leave in Belgium, as well as the time credits and the career interruption schemes, the job alternation leave in Finland, the leave for compelling personal reasons in Italy, the part-time leave in Romania, and the 100 days care leave in Sweden. Belgium is one of the most 'generous' countries in terms of both number and variety of leave schemes, 5 in all, generally entailing some compensation (Table 2 and Table A4).

Flexitime or reduction of working time may represent an alternative to leave, and, in some countries, long-term care features among the reasons for entitlement. Examples are Spain[48], Finland, the Netherlands, Norway and the UK for reduced working time; Finland, Latvia, Norway, Romania, Slovenia as well as the UK[49] for flexitime (for details see Table A4). In the Netherlands, entitlement to reduced working time is not conditional on specific reasons, such

[48] The reduction is limited to a minimum of 1/8 and a maximum of 1/2 in the private sector. In the case of civil servants, the limit varies across administrations (González Gago 2010).

[49] There are certain application restrictions, however, such as only being able to apply annually, and any alteration constitutes a permanent change of contract. This limits the usefulness of the scheme for long-term care

as care needs, but is granted as a universal right. The general rule is that shorter working hours must be agreed upon with the employer and entail a reduction in pay proportional to that in hours.[50]

Restrictions on eligibility, duration, or pay are much more frequent for long leaves and for working time reductions than for short leaves. Many such restrictions are country-specific, but two distinctions are commonly observed. The first is between small and large firms, and the second between private and public concerns. Across countries, conditions of access, replacement rate, or the maximum statutory length are all much more restrictive in small, private firms than in the public sector and large firms.

This compilation of time off-work provisions suggests in general that, while in some countries provisions are simply underdeveloped, in others the problem is not so much a lack of provisions as an unequal distribution across firms and sectors, poor design, and poor coordination with other provisions.

Consider leave schemes. The widely-held view that parental time has few valid substitutes during the first six or twelve months of a child's life is often cited in support of granting sufficiently long periods of parental leave. When the beneficiary is an older person, however, family care givers are more readily replaced by formal care workers for cultural reasons (the emotional bond with the child is highly valued) or because skills are required that the typical family carer does not have. Moreover, care needs progress over time, but the pattern is often difficult to predict. At early stages of disability, hours of care can be given sparsely and flexibly, and, as several experts suggest, flexible time significantly helps in coping with care obligations (Sutela 2010, Ellingsæter 2010, Silvera 2010, Fagan 2010). At later stages, the need for formal professional care and medical services may be sufficiently high to make informal care a very poor substitute (Bonsang 2010). Hence, at these stages, full-time or extended leave provisions enabling informal carers to give care on a 24-hour basis may not represent the most effective use of available (human) resources for society.

responsibilities, since the onset and duration of adult care needs are less predictable than those of children, as we shall remark later in the text.

[50] In Romania, the care leave scheme is itself a half-time working scheme with fixed compensation for the hours lost equivalent to that of a social worker (Table 2).

An additional specificity of long-term care is uncertainty. Parents wanting to care for their children can plan time-off according to their desires and opportunity costs, and they can do so with a reasonable degree of certainty, fitting leaves of defined length into their plans. In the case of long-term care, however, even a generous one-year leave may not suffice, and the beneficiary may still be faced with the difficult option of reducing or quitting work at the end of the leave, with the added complication that this is far less predictable (Himmelweit and Land 2008).

Generosity with leave time, moreover, does not always work to the advantage of care-givers. In her recent summary of the long-standing debate about the repercussions of leaves off-work on labour-market outcomes for women, Lewis (2009) notes that the literature is divided between those who claim that leaves longer than six months have a negative impact and those who find or believe that the critical threshold is one year. Concerns about the negative repercussions of extended leave schemes have also been raised with regard to schemes explicitly devoted to caring for the elderly, e.g. in Germany (Box 11).

Leave schemes for care of the elderly should therefore be flexible and designed to cater to the specific needs of caregiving in this sector. Currently, available leaves are not always sufficiently flexible, e.g. they may not grant the option of part-time or of use over a sufficiently flexible horizon (for details see Table A4 in the Appendix). An example of a targeted but poorly designed scheme is the 'family hospice leave' recently introduced in Austria and illustrated in Box 11, whereas the right for employees to request flexible working hours introduced in the UK in 2007 is an example of a successful time-related provision (and is also reported in Box 11).

In fact, leave schemes need not be prioritized over other provisions. Depending on the intensity of care needs, flexible hours may be a better alternative, because they represent a relatively effective option that can be used over extended periods of mild disability at relatively low social costs for workers and firms. In their comparative review of working time schedules in Europe, Plantenga and Remery (2009, Table. 1) report that, as a general rule, slightly more men than women work flexible hours. In nearly one-third of the European countries, however, less than 10% of all employed women work flexible hours. Only in Denmark, Germany, Norway, Austria and Finland are one-third or more of working women on flexible hours. With the exception of

Box 11. Developments in time off-work and flexible time schemes

Austria. In 2002 the **'family hospice leave'** was introduced in Austria to allow relatives to accompany dying family members or to care for severely ill children. The leave is unpaid, lasts a maximum of three months, but with the possibility of extension up to six months. Protection against dismissal begins with the application and stops four weeks after the end of family hospice leave. Owing to the gendered division of labour, a negative impact on women's labour-market participation may be expected. In addition, there is apparently a high risk of losing the job after the 4 weeks of protection against dismissal. However, the take-up rate is apparently low (e.g. in 2006 only 481 women and 93 men took the option). The reasons are both scarce knowledge about the leave, but also the financial insecurity associated with the scheme (see Stelzer-Orthofer/Jenner 2004: 104f; Streissler 2004: 13). (Mairhuber 2010)

Germany. The Federal Ministry for Family, Seniors, Women and Youth recently proposed the introduction of a care leave period of two years, during which the caring person would be allowed to reduce his/her working time to 50% while receiving 75% of the previous wage. After 24 months, the person would have to return to full-time work but would receive 75% of the wage until the "wage balance" was reached. The proposal was only preliminary, but the immediate reactions were negative, both on the part of the employers' organizations, which do not want employers to bear the financial risks of the proposal, and of feminist health and care researchers. The latter pointed out that the majority of family carers are past employment age and do not work in full-time employment before taking on care. (Maier and Carl 2010)

Italy. A judicial ruling has extended the leave for serious and certified personal reasons previously granted to parents of disabled children to selected family members of older people in need. The ruling allows for up to two years off-work during a person's entire working life. It can also be used in parts. Some beneficiaries of the two-year leave are also entitled to full pay. According to the amendment to the respective Law required by the ruling, the list of the close relatives of disabled people who are entitled to pay now includes live-in children if there are no suitable care givers to replace them. (Bettio and Verashchagina 2010)

Norway. The government has proposed 10 days of unpaid leave to care for elderly parents. This parallels a right to leave off-work in order to care for sick children, although the latter is paid.

Slovenia. The 2007 law on labour relations introduced some changes concerning gender equality and working time arrangements as well as the balance between work and family life. The maximum number of overtime hours a year has been reduced from 180 to 170 hours. And a new provision stipulates that, when a worker asks her/his employer for a change in the distribution of his/her working time in order to improve the balance between work and family life, the employer must justify his/her decision in writing based on production needs. (Kanjuo-Mrcela 2010)

United Kingdom. The Flexible Working Regulations extension in the UK (2007) extended the right for employees to request flexible or reduced working hours to include employees who have, or expect to have, care responsibilities for dependent adults, which encompasses most relatives[51] or someone else living at the same address as the employee. This was an extension to the right which had been introduced for parents, first implemented through the Employment Act 2002. Employers are legally obliged to consider requests seriously, although they can be refused. When the right was introduced for parents, the impact was broadly positive (see Fagan 2009 for a review), and recent research shows that the business community generally accepts the need to provide flexibility for workers with care responsibilities: in a 2007 CBI survey (Confederation of British Industries) over 95% of employers felt the Right to Request (RTR) legislation had a positive or neutral impact on productivity, recruitment, retention, employee relations and absence rates (Employment Task Force 2008: 4). Research on older workers with long-term care responsibilities revealed a high latent demand for flexible working hours (Smeaton et al 2009). However, the RTR may have more limited use for carers of adults because the needs are less predictable than those of children; in particular, applications can only be made once a year and any alteration to hours constitutes a permanent change of contract. And there is still no statutory carers' leave equivalent to that for parental leave (Himmelweitand Land 2008; Smeaton et al 2009). (Fagan 2010)

[51] It includes the spouse, same sex civil partner or cohabiting partner (heterosexual or same sex), other primary relatives (parents, grandparents, siblings, adult children, aunts and uncles, adopter, guardian) and their equivalent through marriage ('in-laws'), re-marriage (step-relatives and half-blood relatives) and adoption (adoptive relationships).

Germany, these countries have extensive public home care provisions, but many offer relatively short face time, making flexible working time a precious resource with which to top up the social and emotional component of formal care services (see section 3.2 above). The implied lesson from these countries is that designing time-related provisions in such a way that they effectively complement other services is often an effective alternative to granting time-off.

4.2. Care workers and professionals: wages and working conditions

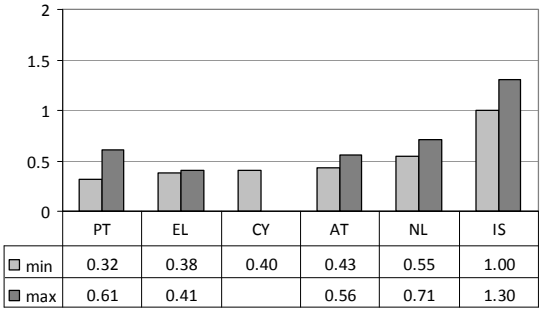
Care workers (and, to a lesser extent, professionals) provide a textbook example of a feminized occupation with poor pay and working conditions, and LTC workers are no exception. In several countries, shortages of health care professionals and the increasing presence of migrant workers in care occupations are spreading awareness about some of the implications of poor pay and working conditions. However, this increasing awareness has not yet translated into systematic knowledge, and detailed, comparable information across countries is still lacking.

The finest occupational breakdown available at European level separately classifies (i) care workers and (ii) nurses and midwives. The former category comprises three subgroups: home helpers in long-term care, personal care workers, and teachers in pre-primary services. Nurses and midwives belong to all sectors of activity, healthcare, childcare and long-term care. Neither of these groups, therefore, exactly identifies employees in the formal LTC sector, but both are highly feminized. In 2007 women accounted for 89.6% or more of total care workers in EU27, with no country falling below 78.6%, except Malta. Nurses and midwives are equally feminized, with women accounting for 90% of all workers (EU27, 2007), and no country registering less than 75%, except Cyprus and Luxembourg (Figure A1 in the Appendix). Women's share in both groups is sufficiently high to rule out any great variation across care sectors.

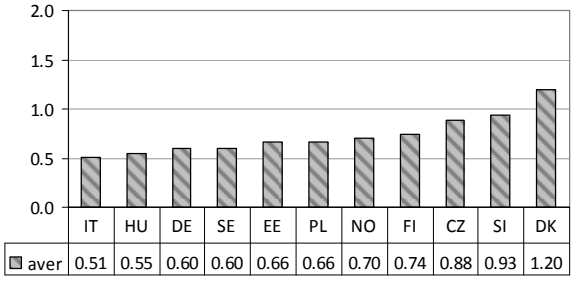
Figure 14 collates the most comparable evidence reviewed by the national experts. The first two panels (a and b) show gross monthly wages for care workers in residential and home care, while wages for professionals (nurses or equivalently skilled occupations) are shown in panels c and d. The left section of each panel reports maximum and minimum values, the right hand section average values. Data in the graphs refer to either the public sector, or to the public and private sectors combined. Reference years are the latest available, generally 2008 or 2009, and

Figure 14. Standardized monthly gross wages for care workers and professionals (wages in relation to the OECD average , latest year available)

a) Residential care: basic qualifications

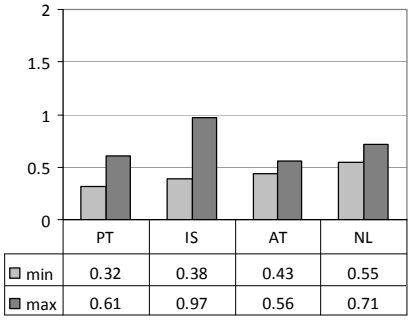


	PT	EL	CY	AT	NL	IS
min	0.32	0.38	0.40	0.43	0.55	1.00
max	0.61	0.41		0.56	0.71	1.30

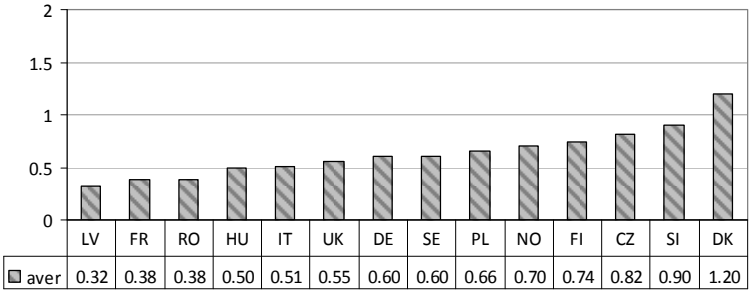


	IT	HU	DE	SE	EE	PL	NO	FI	CZ	SI	DK
aver	0.51	0.55	0.60	0.60	0.66	0.66	0.70	0.74	0.88	0.93	1.20

b) Home care: basic qualifications

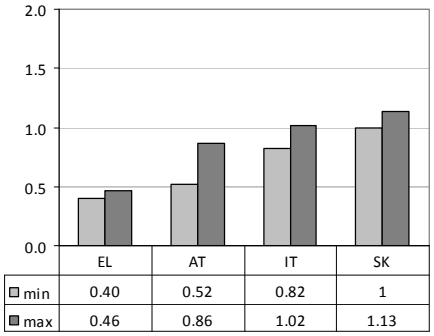


	PT	IS	AT	NL
min	0.32	0.38	0.43	0.55
max	0.61	0.97	0.56	0.71

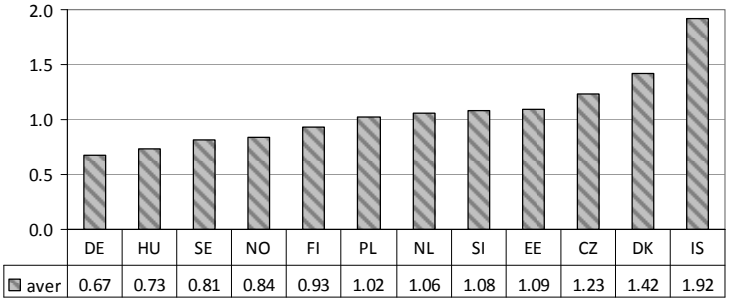


	LV	FR	RO	HU	IT	UK	DE	SE	PL	NO	FI	CZ	SI	DK
aver	0.32	0.38	0.38	0.50	0.51	0.55	0.60	0.60	0.66	0.70	0.74	0.82	0.90	1.20

c) Residential care: skilled care workers

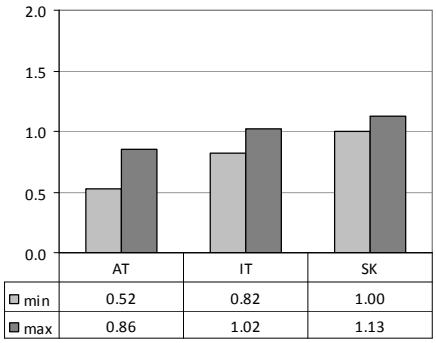


	EL	AT	IT	SK
min	0.40	0.52	0.82	1
max	0.46	0.86	1.02	1.13

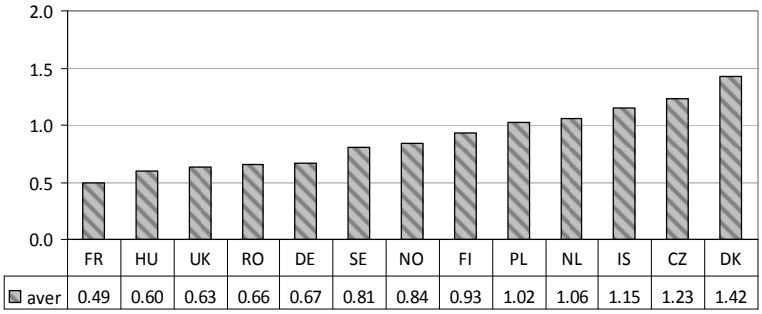


	DE	HU	SE	NO	FI	PL	NL	SI	EE	CZ	DK	IS
aver	0.67	0.73	0.81	0.84	0.93	1.02	1.06	1.08	1.09	1.23	1.42	1.92

d) Home care: skilled care workers



	AT	IT	SK
min	0.52	0.82	1.00
max	0.86	1.02	1.13



	FR	HU	UK	RO	DE	SE	NO	FI	PL	NL	IS	CZ	DK
aver	0.49	0.60	0.63	0.66	0.67	0.81	0.84	0.93	1.02	1.06	1.15	1.23	1.42

Note: for the Czech Republic, Finland, and Germany average values refer to female pay only; for other countries they refer to the overall male and female average.
Source: own calculations using national reports of the EGGE network.

wages are measured in ratio to the OECD average figure for the same country. This yields both a measure of relative wage within the country and a comparable indicator across countries.[52]

Despite reference to the common OECD standard, cross-country comparability is less than full. Figures for wages are derived from different sources (some refer to contractual and others to actual wages), they may not exactly reflect equivalent skill levels or they may hide differences in (full-time) hours. Where average values for men and women are not available, moreover, we report the female average, but this is much less consequential than might appear at first sight. Given the predominance of female employees, the difference between overall and female-only average wage levels tends, in fact, to be rather small.

Bearing this heterogeneity in mind, the evidence presented is informative about the overall pay positions of formal LTC care givers in Europe, while specific inter-country comparisons warrant more caution. The overall indication from Figure 14 is that wages in the long-term care sector are low.

Workers with basic qualifications in residential care earn as much as the average worker in the economy only in 2 out of the 17 cases for which monthly figures are available: Denmark[53] and Iceland. In two further countries – the Czech Republic and Slovenia – low-qualified care workers earn between three-fourths and nine-tenths of what the average worker in the economy makes, while in the majority of the reporting countries wages are lower. For low-qualified home care workers, the comparison with the average employee in the economy is even less favourable. The overwhelming majority of the countries included in panels a and b (Austria, Finland, Germany, Hungary, Italy, the Netherlands, Norway, Poland, Portugal and Sweden) report the same figure for workers in residential and home care since the employer is often the same – the state – and/or statistics are not separately available. However, in the three countries that report separate figures – Iceland, Slovenia and the Czech Republic – wages in home care are comparatively lower. Moreover, the values for home care workers in Romania,

[52] Table A5 in the Appendix reports absolute values for wages buttressed by full specifications. The OECD average wage refers to an 'average' worker on a 40 hours schedule p.w. [http://www.oecd.org/document/3/0,3343,en_2649_34637_39617987_1_1_1_1,00.html].

[53] As from Table A5, the monthly figures for Denmark and the UK are derived from hourly earnings on the assumption of a 40-hour weekly schedule and may therefore overestimate actual wages if actual hours are lower.

Latvia and France are less than 50% of the OECD average, as well as being below the lowest values reported for residential care. This is consistent with the indications from the national reports that wages tend to be lower in home care.

Skilled care workers are comparatively better paid, as to be expected. Half of the 16 countries featured in Panel c (residential care) report average or minimum values higher than or equivalent to the country's average OECD monthly figure (Iceland, Denmark, the Czech Republic, Estonia, Slovenia, the Netherlands, Poland and Slovakia); however, when values are higher the difference is often below 10%. In two further countries, relative wages for skilled carers are comprised between 90% and 100% of the national OECD figure (Finland and Italy), whereas the remaining countries (Austria, Greece, Germany, Hungary, Norway and Sweden) record values below the 90% mark. Given that in many European countries nurses are currently required to attain a college degree, it is tempting to conclude that they are better paid than their less skilled LTC colleagues, but perhaps not as much as their level of schooling and skill would warrant. Where separate figures are given for wages accruing to (skilled) nurses in home care, they are generally lower than in residential care (Figure 14 c-d).

The collection of data included in Figure 14 may understate the wage disadvantage of workers in long-term care because it only considers full-timers in regular employment and primarily in the public sector (see Table A5). Depending on the country, part-time employment is a frequent finding in the home care segment: in France, for example, where the *chèque service* scheme has been able to 'regularize' part of this employment, but jobs are often part-time or marginal (section 4.2). Moreover, instances of low earnings are more easily found in the private home care segment of labour markets featuring widespread irregular employment. Italy is an example of the wage implications of irregular employment for the weakest segments in the market: the (gross) contractual wage for an 'inexperienced' live-in carer corresponds to about 42% of the OECD wage figure according to specifications of the wage agreement in force since 2007, while that of an unskilled worker hired on a health-care sector contract (the equivalent of a home helper) is 51% (Table A5). Yet the *de facto* skill and responsibility expected from a live-in carer are comparatively higher, whilst his/her actual hours of work are generally much longer (for the

same wage). As repeatedly noted, moreover, irregular employment of live-in care workers is a frequent occurrence and often implies a 'discount' on contractual wages (section 4.2).

For women, the gender pay gap adds to the problem of low pay, but evidence on this point is available for very few countries (Table A5). A large gap is found in Germany, where female care workers earn about 20% less than male ones on a monthly basis, while in Finland values range between 12% among low-skilled and 9% among skilled care workers. Data for Poland and Latvia enable a comparison between the gender pay gap in the public and the private sectors. In the public sector, the gender gap is 10% at most in both countries, while in the private sector values are more dispersed, with a peak of 32% among professional nurses in Latvia (Table A5).

The importance of pay can hardly be overstated; but for formal workers in long-term care wages are only part of the concern. On reviewing working conditions, numerous experts cite the findings of qualitative or medical studies on the mental and/or physical side-effects of being a long-term care worker or professional – all of which (and more) are illustrated in the recent OSHA/EU inventory of occupational hazards for care workers (OSHA/EU 2008). Hard physical work, stress and depression are the side-effects most frequently mentioned by the national experts, especially in residential care. The following excerpt from an interview administered to a female, semi-skilled care worker in the Italian cooperative firm 'Gulliver', gives a vivid summary of what it means to work with patient suffering from dementia, one of the most common syndromes affecting older people in residential care:

> *"It is something beyond imagination. An Operatore Socio Sanitario [*job title*] like myself usually works for a unit hosting between 20 and 30 elderly patients, half of whom suffer from senile dementia: some yell incessantly, others call you, and call you, and call you again. I mean they call you by the most disparate names, your own name when you are lucky, other names when you are not. They obsessively repeat some gestures. Since they are able to move, it is not so strenuous to look after them, but they are forever moving, doing the most disparate things and at the wrong time: you are feeding them and one of them pees in a corner and you must reconcile this with the needs of the rest; you can hardly scold them, poor things … and the action goes on. Then comes that stage of the disease when they tend to run away. They do not know where, but they run away. They get to the door but then they do not know where to go. You must always be on the alert. [….] So you may understand that 6 hours in this setting put you to a hard test…" (Solinas et al. 2006: 21-22)*

As the Portuguese expert points out in her review of qualitative studies on the issue, caring for older people can be rewarding as well as stress-causing, but the negative aspects have been investigated more frequently (Ferreira 2010). However, when unpalatable working conditions are not sufficiently compensated for by adequate earnings, turnover rates are high, supply is short, or both.

High turnover in the care sector is a frequent finding in national research. It is associated with low levels of pay and harshness of working conditions, and it is reported to significantly impair the quality of care. In the assessment of experts, this is consistently the case in countries as different as Austria, Belgium, Bulgaria, Iceland, Italy, the Netherlands, Poland and the UK. To give just two examples, in the Netherlands turnover rates in nursing and caring homes, as well as in home care, are among the highest in the health care sector. In 2008 gross turnover, which is defined as leaving the organisation, was 13% in nursing and caring homes and 17% in home care (Plantenga and Remery 2010). In the UK, total average staff turnover in the paid social care workforce was 17.9% according to the 2005 National Employers Skills survey. Turnover was higher in the private sector than the voluntary sector (19.9% compared to 13.3%) and in domiciliary care (22.1%), and lower for more senior positions (Skills for Care 2008, quoted by Fagan 2010).

The combination of low pay and poor conditions has encouraged emigration in a number of East European countries. An example is Latvia, where pay and working conditions are reportedly poor for all medical and social workers. Allegedly, occupational diseases are frequent even among relatively young employees (Rastrigina 2010). Medical and social workers are not informed about the risk factors associated with the working environment, their potential adverse effects on health, and the necessary preventive measures. Low pay and poor working conditions encourage the emigration of medical and care workers, either abroad or to other sectors. As a result, a shortage of social workers has been reported in the municipalities of Latvia in 2007 (Ministry of Welfare 2008).

Personnel shortages in LTC – especially of semi-skilled care workers and professionals – are reported or forecasted in a large number of countries, both in Western and Southern Europe (Austria, Belgium, Cyprus, Germany, Finland, Italy, the Netherlands, Malta, and the UK) and in

several Central and Eastern European countries (Bulgaria, Latvia, Poland, Hungary). A shortage of nurses is most frequently reported, but intermediate-skill care workers are also affected. To give a concrete example, a recent Delphi group consultation among experts and practitioners in Italy found that, while shortages of nurses are already apparent, many believe that in the medium and long run shortages will also arise for intermediate-skill positions such as that of 'operatore socio sanitario' or 'operatore socio-assistenziale', both of which are personal care workers with some nursing competence (Piperno 2009).

By contrast, Nordic countries no longer complain of shortages, because the crisis has brought temporary respite, although in different ways in different countries. Owing to high unemployment, in Iceland people who had abandoned the public sector for higher paid employment opportunities are coming back to it. In Denmark, local authorities reacted to cuts in local budgets by curtailing care services, and the resulting unemployment has curbed not only shortages but also the inflow of migrants into the care sector. Norway had taken measures against shortages in the years preceding the crisis, and recent studies show that the current supply of care workers and professionals should suffice in the near future as long as care standards do not rise. However, shortages may reappear once the economy picks up again.

The various ways in which the crisis is 'solving' shortages in Nordic countries raises the question of whether persisting apprehensions about shortages outside the Nordic bloc simply linger on from pre-crisis times or reflect the resilience of the phenomenon. This is not a question that can be satisfactorily answered within the scope of this report. However, the evidence just reviewed on low wages and high physical and mental demands on care workers suggests that fears are well-founded, since pay and working conditions have long been known to strongly influence inflows into a sector as well as outflows. The current crisis is more likely to defer the problem than to eradicate it.

Wages may be low and working conditions may be poor for the majority of national (female) care workers as well as for LTC professionals, but they continue to attract (female) migrants, as documented in the previous section. However, protracted reliance on intra-European mobility or immigration from outside Europe in order to address shortages may be short-sighted. The recent experiences of Estonia, Hungary, Latvia, Lithuania, Slovakia and Romania indicate that, in

the long run, intra-European mobility of skilled care workers may amount to a zero-sum game where some countries 'gain' at the expense of others, but Europe as a whole does not gain. Since the 1990s, all these countries have exported skilled care workers – nurses, but also paramedics and care workers – to richer Member Countries, Austria, Ireland, Italy, Norway, the UK and Spain in particular.[54] However, this has already created shortages in some of the sending countries without radically solving the problem in destination countries. Examples are recent shortages of carers in Latvia, Estonia, as well as in Slovakia's regions bordering on Austria. Romania has 'lost' some hundreds of thousands of female family carers to Mediterranean countries. Experts believe this loss may soon be felt in the country, although there is not yet much public awareness of the issue (Albu 2010). To the extent that ageing is a common problem across Europe, intra-European migration in the LTC sector helps in rebalancing supplies among countries on a short- to medium-term basis, but not in addressing shortages on a permanent basis.

4.3. Summary view: outstanding issues for informal and formal providers

Overall, the evidence reviewed in this chapter indicates that, from the perspective of care givers, pay and working conditions, on the one hand, and participation of men on the other are still outstanding issues. Similarly to childcare, long-term care comprises heavily feminized occupations across the skill spectrum. Unlike in childcare, however, skills in long-term care are both social and medical, and occupations are physically and mentally highly demanding. Reversing a historical trend, occupational hazards in both childcare and long-term care are being increasingly acknowledged, for example back injuries or voice disorders among pre-school teachers (Bright and Calabro 1999; Da Costa et al. 2010), and exposure to infectious diseases, mental stress, or road traffic accidents when driving to the client's residence among home-based LTC workers and professionals (Osha/EU 2008). Very high turnover rates in long-term care may indicate that the problem is particularly severe in this branch.

[54] For sending countries: Karu 2010, Frey 2010, Rastrigina 2010, Braziene 2010, Piscová and Bahna 2010, Albu 2010. For receiving countries: Mairhuber 2010, Barry 2010, Bettio and Verashchagina 2010, Ellingsæter 2010,

Neither long years of education and training to master medical knowledge nor hard working conditions have apparently sufficed to sustain the pay level in LTC occupations adequately. Despite the caution necessary in the presence of non-negligible problems of comparability, the evidence reviewed shows that, in the majority of cases, even top-paid workers in LTC, i.e. nurses in residential care, do not do better than the average employee in the country.

This issues a warning about the possible limitations of any attempt to tackle poor pay and career prospects in this sector by concentrating resources and action exclusively or even primarily on training. As discussed in the next chapter, well-targeted training, re-design of the skill ladder by creating semi-skilled occupational categories, formal recognition of skills, or campaigns to improve the public image of long-term caregivers may contribute to improving wages and career prospects at low and middle ranks of the occupational scale. In so doing, they may also contribute to easing shortages at low and middle ranks of the skill scale. At the very top, however, the paradox is that (skilled) nurses may be 'overtrained' or 'overeducated' for the pay that they receive. This has contributed to care shortages in many of the richest European countries, where it is easier to find better-paid jobs in occupations other than nursing.

Informal care givers in LTC are less feminized than in childcare. Men participate more in unpaid long-term care partly for employment reasons – most male carers are retired – partly for perceived biological reasons – there is less perception of the 'natural' advantage of female carers compared with childcare. However, the reasons are also cultural: in many cultures, including familistic ones, husbands are expected to take care of their spouses, and brothers of their sisters, albeit in a second instance, i.e. if no other woman in the family is available.

Long-term care may therefore represent a natural 'port of entry' for men into care work (paid or unpaid). This can be exploited in order to consolidate a more gender-balanced public image of the typical carer. Moreover, working time provisions can be designed so as to encourage employed men to share unpaid caregiving on a more equal basis. Assessment in this chapter of existing time-off work schemes to take care of the elderly has indicated that:

Fagan 2010, González Gago 2010.

(i) long-term care leaves should not 'imitate' parental leave, because care needs are more unpredictable and variable over time, and because informal long-term care tends to be more readily substituted with formal services than parental care;

(ii) several of the current leave schemes suffer from poor design and a lack of coordination with the other provisions in place: for instance, they may be *de facto* targeted on full-time workers only (the two-year care leave schemes proposed in Germany); they may be too long, or, conversely, inaccessible to employees in certain sectors and firms (leave for medical assistance in Belgium); or they may not ensure sufficient protection against dismissal after completion (the family hospice leave in Austria);

(iii) a right to flexible working time can be a socially cheaper and an individually more effective response to the needs of carers at initial stages of disability, or at the last stages, when formal, professional assistance typically assumes a greater role;

(iv) last but not least, leave design should be such to encourage participation by men. In this regard, however, not much can be gained from the experience of member countries because there is practically no information on take-up rates for men and women. This knowledge gap could be addressed at European level.

5. LONG-TERM CARE POLICY

5.1. Long-term care, gender equality and the policy agenda of Member States

Reportedly, long-term care is not as high on the political agenda of Member States as childcare was until response to the financial crisis came to predominate. Experts from different countries convey this message in different words:

- 'In contrast to child care, in Austria care for dependent elderly and gender equality has hardly been a subject of discussion' (Mairhuber 2010);
- 'In France the issue of reconciling life time and working time is posed above all for parents, not in relation to dependent elderly' (Silvera 2010);

- 'Elderly care has never risen as high as childcare on the Greek public policy agenda' (Karamessini 2010);
- 'Services for the elderly have not been as much debated in the public arena as are day care services for children in Iceland' (Johannesson 2010);
- 'In Latvia child care has always been discussed more actively than elderly care' (Rastrigina 2010).

However, the Norwegian and the UK experts suggest that the theme is gaining prominence in the public arena. In the wake of the debate on childcare, issues about reconciliation and long-term care are receiving increasing attention in the UK (Fagan 2010). Similarly, Huseby & Paulsen (2009) conclude for Norway that, with five green papers focusing specifically on care services and thirteen white papers investigating municipal long-term care services, LTC did receive considerable political attention between 1997 and 2007. The Norwegian press allegedly helped. Persons in need of care who do not receive the services they need quickly attract the attention of newspapers (Ellingsæter 2010). Moreover, most national experts agree that, in discussions about long-term care policy, the gender dimension is underplayed or absent, although there is widespread knowledge that women form the majority of care receivers and care givers.

All this notwithstanding, important policy choices about long-term care have been and are being made, sometimes behind the scenes but with considerable implications for gender equality and labour-market outcomes. In this chapter, we review the most significant policy developments in the past fifteen to twenty years, giving priority to the latest measures and proposals. The review is structured under three main headings: overarching reforms, shifts in the mix of provisions (e.g. from institutional to home care, from in-kind to in-cash, from public to private and so forth), and labour-market policies.

5.2. Overarching reforms

Despite major setbacks, on which more will be said below, Nordic countries have retained a universalistic approach. At the same time, a Mediterranean and 'familistic' country like Spain has witnessed a policy breakthrough when the 'Ley de Dependencia' was enacted in 2006 and

gave a universal right for care to all people with disability and holding the state responsible for meeting their needs. Actual implementation may fall short of expectations, as seen in section 3.3, and the financial crisis is a serious hindrance to ongoing progress, but this does not diminish the significance of the policy choice. Furthermore, there are now four Member Countries that furnish universal financial coverage under long-term care insurance schemes – Austria, Germany, Luxembourg, and the Netherlands – and more countries are considering such schemes.

Countries seriously contemplating this idea include France – reportedly 'ready to join an insurance-based programme' (Silvera 2010) – but also Hungary, Poland, Romania and Slovenia (Frey 2010, Plomien 2010, Albu 2010, Kanjuo-Mrcela 2010). In the summer of 2003, the Hungarian government began serious consultations on launching a long-term care insurance scheme for the elderly population starting from January 2004. The idea was to introduce nursing-care insurance based on the German long-term care insurance system, but all the plans were postponed after they had been publicly debated (Frey, 2010). In Poland, members of parliament, government officials, and experts in the field consider implementation of an insurance-based scheme in order to remedy the current shortage of both staff and services in long-term care. According to Senator Mieczyslaw Augustyn, the chair of the Parliamentary Family and Social Policy Committee, long-term care insurance would facilitate the creation of formal employment (Plomien 2010). In Slovenia, as recently as February 2010, the Ministry of Labour, Family and Social Affairs proposed draft legislation to introduce the Long-Term Care Insurance Act (Kanjuo-Mrcela 2010).

It should not be surprising that the list of candidates for future enactment of long-term care insurance is dominated by Central and East European countries. In the attempt to introduce welfare provisions for long-term care – a sector largely neglected during the socialist years – they enjoy the typical advantages of late-comers: few entrenched interests to counter when introducing radical reforms, and the opportunity to 'copy' the latest innovations. Moreover, long-term insurance has not always proved to be the most 'expensive' solution for public budgets. As Rothgang (2010) maintains, for example, LTC in Germany was introduced also in the hope of curbing the rise in public expenditure on assistance following reunification with

East Germany and, thanks to benefits capping, the rates of growth in public expenditure have been moderate until recently.[55]

5.3. Service mix, cash transfers and privatization of services

5.3.1 Shifts in the service mix

Against this background of positive developments and prospects, policy choices about the actual mix of provisions raise important concerns, especially from a gender perspective. Developments over the past two decades have followed trends that set in earlier and that can be summarized as a progressive shift

- away from institutionalized care and towards home care;
- away from public provisions and towards private or mixed services backed up by cash transfers (in lieu of publicly-provided services);
- in favour of services that complement rather than replace informal care.

These trends are common to all countries, but to different degrees and with different implications[56]. For countries offering poor provisions, the challenge so far has been to maximize coverage under often tight financial constraints rather than get the balance among residential, semi-residential and home care right. A large number of East European countries had practically no long-term care infrastructure until the mid-1990s and even later: In Estonia, day care centres and home care services were introduced in 1996 (Karu 2010); in Poland, as in other socialist economies, social care was a component of health care until 1990, health concerns dominated over care provisions, and assistance was underfinanced (Tarkowski 2000 quoted in Plomien 2010); in Slovakia, elderly people and long-term care entered the policy agenda in their own right only in 1999 (Piscová and Bahna 2010); in Lithuania, institutional care services are quite new achievements, and there still is a general lack of information about the care provided for the dependent elderly and the disabled (Braziene 2010). Since several of these countries are trying to create infrastructure almost from scratch, some have set themselves ambitious goals, as just noted with regard to long-term care insurance.

[55] From 1994 to 2008 Long Term Care Insurance benefits in Germany were kept constant in nominal terms. The first adjustment for inflation was introduced in 2008 (Rothgang, 2010:440).

[56] For a collection of essays with detailed analysis of very recent reforms in LTC in Europe see Costa-Font (2011).

Some fifteen to twenty years ago, Portugal and Greece were as poor in infrastructure as some of the New Member States are now. In an effort to build up supplies of home and residential services, these countries have pursued their own preferred mix. Greece has used structural funds to develop community care services, namely home help programmes and day care centres (KIFI: Karamessini 2010, see also Box 12). In Portugal, many experts share the view that the right model is the mixed LTC, with flexible residential care flanking home care services (Ferreira 2010). Thanks to parallel programmes set up to develop an integrated network of services – PARES, the Programme for the Widening of the Social Facilities Network, and RNCCI,

Box 12. Trends in provisions – highlights from the national reports of the EGGE network

A. Services

Belgium. The range of provisions has become more differentiated. There are initiatives to separate the housing and service functions of nursing homes in order to meet the individual needs of residents. In general, the importance of day care is increasing. There are also special short-duration nursing homes (Meulders 2010).

Finland. The share of over-75s receiving regular home care services decreased during 1995-2008 from 13.8% to 11.2 %, although the number of clients increased due to demographic change. A specific change has taken place regarding the coverage and quality of home care services: whilst at the beginning of the 1990s home help services were provided to a larger clientele but in smaller quantities to each recipient, today they have become less available and more targeted on the most needy. At the same time, they have also intensified, e.g. the share of clients receiving more than 40 visits per month has increased (Voutilainen et al 2007b, Kröger 2009). All this shows up in the share of the over-60s experiencing a lack of services, which tripled in 1998–2004 from 7% to 22 %. Even among those receiving public home care services, about 20% currently experience insufficient assistance (Laine et al. 2009). At the same time, informal care has been deliberately promoted, and the number of recipients of support for informal care has increased: in 2008, some 4% of over-75s were covered by support for informal care, as against 2.7% in 1995. (Sutela 2010)

Greece. Since the mid-1990s, the availability of EU resources has funded the development of new community care services provided by the local authorities, such as the "Home Help" programmes and the Day Care Centres (KIFI). To provide free residential care to elderly persons lacking sufficient financial means, in 2003 and 2004 the Ministry of Health and Social Solidarity signed subcontracts for 166 beds with 13 not-for-profit residential homes.

Latvia. Personalized and integrated service delivery is planned for 2013. Personal care will combine multiple services (generally provided by different service providers) in a package offered by a single institution. The package of services will be specifically designed for the person in order to optimally meet his or her needs. (Rastrigina 2010)

Luxembourg. The system of long-term care was marked during the 1990s by three major initiatives: hospital restructuring (beginning of the 1990s), introduction of LTC insurance (voted in June 1998 and in force since January 1999), and a change in the management of long-term care institutions (voted in December 1999). The distinction between acute and long-term care became one of the key principles in the restructuring of hospitals. Some local hospitals (small units) were converted into nursing homes (MS) or Integrated Centres for the Elderly (CIPA). Many new facilities for the elderly have been built and several projects are now underway. (Plasman 2010)

Norway. Fewer elderly persons receive home help services, but those who receive services get more help (Huseby and Paulsen 2009). Family care does not hold a strong position in Norway. Elderly people prefer help from the public services, if possible in their own home or in community care housing. (Ellingsæter 2010)

B. Service vouchers and increasing service privatization

Finland. The Service Voucher is a relatively recent measure in social care. The Act on the Service Voucher was passed in 2004, and two years later it was in use in 123 municipalities by some 4000 clients. The service voucher

brings benefits for the municipalities since the users of service vouchers invest a larger amount in their care than others. Furthermore, it is a way to shorten the queues for public services as long as better-off clients purchase their services by themselves from the private sector (Mikkola 2009). The introduction and increased use of service vouchers is an indicator of the ongoing privatization of social services. (Sutela 2010)

France. The 2006 plan introduced the *Cheque Emploi Service Universel* aimed at promoting personal services, which represent a "source of jobs" (estimated at 500,000). The government considers the result of this initial stage to be positive: 100,000 jobs were created each year between 2006 and 2008. In 2008, 2 million people worked in the sector. Moreover, 16,000 service providers have been registered. The CESU are the result of a long process of refinement of the service vouchers first introduced in 1994 to combat unemployment.
Nevertheless, the needs of dependent elderly are far from being met, even if the APA constitutes progress. Services on offer are insufficient (2 to 4 hours per day) and only those with financial means or considerable family help can manage. For others, retirement homes are the only solution, but the conditions of these homes are sometimes very poor (promiscuity, abuse, dilapidated accommodation etc.). To top it all, the principle of *tax reductions* in addition to the APA means that paying for personal services (especially for many hours, sometimes at night) is significantly cheaper for the rich! (Silvera 2010)

Greece. To make the private hiring of *home care workers* more affordable, *employer social security contributions* were reduced in 1998. Since 1994, the elderly themselves, if financially independent, or the persons taking charge of them, have also been entitled to *tax deductions* for residential care expenses conditional on financial dependency. (Karamessini 2010)

Italy. The country features two allowances. The traditional statutory cash transfer called 'attendance allowance' (*Indennità di Accompagnamento*) has recently been flanked by the 'care allowance' (*Assegno di Cura*), which regional authorities fund and deliver discretionally. The latter is paid either in cash or as a tax credit, and it is tested for means and psycho-physical competence. Under this scheme the recipient can spend the money freely; in exchange for the allowance s/he is supposed to assume responsibility for delivering care in person but, as Ranci (2001) notes, there is no effective monitoring. One of the intentions of the legislator was to have the care allowance flanked by services for a comprehensive 'prise en charge' of the older persons in need, but this has rarely materialized. Both allowances are frequently used to pay for family assistants. According to the GALCA survey (Bettio et al. 2004), 56% of the families employing paid carers received one or more allowances. (Bettio and Verashchagina 2010)

Spain. The Law on Dependency explicitly gives preference to vouchers over cash transfers in order to promote formal, skilled, care over family care. Cash transfers, in fact, are considered the last resort when there are no services available for the dependent elder. Despite this specific regulation, the reality is that most of the new help is given through cash transfers to family carers. Since cash transfers are cheaper than creating the infrastructure needed to provide care services, most administrations are using them widely, instead of vouchers or providing the services themselves. (González Gago 2010)

Sweden. The LOV (*Lag om valfrihet* or Legislation on Choice) act aims at making it easier for the municipalities to introduce a 'customer choice' (voucher) system for publicly financed care services (Meager and Szebehely 2010). At the same time, state incentives to municipalities were introduced to promote the development of voucher systems. These incentives have been taken up by 60 percent of the Swedish municipalities (*ibid.*). Despite these changes, around 85 percent of tax-financed services continue to be publicly provided in Sweden as a whole.
It is often found that the largest income differences in the country are between singles and couples. A national survey, called Senior 2005, showed that among single people aged 65-69, about 20% will have an income under what is considered a reasonable standard of living (according to the national standards for granting financial aid) for a long time into the future (SOU 2003, p. 91). The purpose of the new system was to protect the individual against excessively high costs of municipal care (maximum rate or high cost insurance), and to ensure that all individuals have a minimum sum for living expenses once all fees have been paid known as a reservation sum (Socialstyrelsen 2002). (Nyberg 2010)

the Portuguese National Network for Integrated Care – the government has invested heavily in care services for the elderly, refusing to postpone the scheduled investment until well into the financial crisis (Ferreira 2010).

While relatively poor providers were searching for their preferred mix, the financial crisis of the 1990s forced some change in the existing mix on some of the best providers: the Nordic countries. The change is more noticeable for Sweden and Finland. While residential care has been rescaled downwards as part of the move towards home care, the latter too has been rationalized and partly handed back to family and friends. In Finland, home care is now more narrowly targeted on clients with higher disability, who receive more hours, while some of the clients with milder disabilities have been handed back to family care. The drawbacks are lower coverage rates, a tripling of cases of lack of services among 60+ year-olds, as well as an increase in the number of recipients of informal care (Box 12). The story is similar for Sweden, where more resources have been devoted to supporting family care givers since 1999. Norway has been less affected by the downsizing of services, although the country shares with Finland the rationalization of hours of care in favour of more dependent clients (Box 12). Iceland may be especially affected by the current crisis, but so are many other European countries, and it is too early for stocktaking on the impact of the present budget cuts.

5.3.2 Increased cash transfers

Over the past two decades an especially important development has been the practically universal shift in favour of financial transfers, in parallel with the privatization of services.[57]

Cash transfers have been distributed primarily via two types of allowances. The first is paid to the older person in need for him/her to purchase care services, and it is often – although not consistently – called 'attendance allowance'. The second allowance is paid to the family carer, or the older person as compensation for the (family) carer's services, and it is often called 'care allowance. The discussion that follows adopts this distinction in the interest of clarity and brevity.

While care and attendance allowances are the main cash transfer schemes, they are by no means the only ones. Examples of additional schemes include tax refunds and tax credits, disability pensions, subsidies to buy assistive devices or to carry out house adaptations, waiving

[57] Portugal is an exception worth noting. Here the priority of the government has been to invest in the expansion of the network of services, a political option that is relevant from the point of view of gender equality. Cash transfers have not been object of consideration. (Ferreira 2010)

of social security contributions for care workers (especially if hired by the family), and others besides.

Table A6 in the Appendix reports the amounts of, and the main eligibility criteria (or restrictions) for, the principal 'care' and/or 'attendance' allowances in each country. In the case of multiple care or attendance schemes, and if no clear indication was made available about the relative order of importance (e.g. with regard to take-up rates), the scheme included in the table is the most generous in amount. Table 3 below reports the amount of cash transfers in ratio to the reference income for the same country and year (i.e. median net income for a person older than 65 living on his/her own, as defined in chapter 3). Additional information shown in the table concerns means testing, duration, and relation with the degree of disability of the person cared for.

Attendance allowances are more widespread than care allowances (25 countries against 20), and they tend to be greater in amounts. In seven countries (Austria, the Czech Republic, France, Germany, the Netherlands, Portugal and Slovakia), the maximum amounts for the attendance allowance are at least 90% of the reference income, while in the case of the care allowance this holds true only for Hungary.[58] In about half of the countries reported to operate a care allowance scheme, moreover, the fixed or maximum amount is below 50% of the reference income (Bulgaria, Iceland, Italy, the Netherlands, Poland, and the UK).

Nordic countries tend to offer care rather than attendance allowances because they still prioritize services in kind despite a greater reliance on informal carers and the recent introduction of the service voucher option (see Box 12 above). The care allowance can thus be seen as an additional option that increases families' choices. Turkey and two East European countries, Hungary and Lithuania, also offer care, not an attendance allowance.

When the amount of the attendance allowance is fixed, eligibility is made conditional on severe disability, while variable amounts are generally paid according to a disability scale, and sometimes tested against personal or total household income. The amount is fixed at below

[58] Cyprus and Denmark cannot be compared because the allowance is exclusively devoted to house adaptation in the former country and it is limited in time in the latter.

50% of the reference income in Italy and Greece, while it rises to 88% in Latvia[59] and to 64% in Cyprus. In none of these cases is the allowance means tested, i.e. public support is *de facto* rationed for mildly dependent elderly, well-off or poor, in favour of all the severely dependent, well-off or poor.

Table 3. Main cash transfers in ratio to reference income, 2008-2010

Country	Transfers to care recipients ('Attendance allowance')			Transfers to compensate family carers ('Care allowance')		
	Fixed amount (in ratio to reference income)	Range (in ratio to reference income)	Eligibility criteria/ Restriction	Fixed amount (in ratio to reference income)	Range (in ratio to reference income)	Eligibility criteria/ Restrictions
AT	-	0.12-1.3	Means tested	-	na	Means tested. Temporary
BE	-	0.07-0.48	Means tested	-	-	-
BG	-	0.13-0.37	Severe disability	0.37	-	Severe disability
CY	0.64	-	Severe disability, not means tested	-	Up to 1.50	Only for house adaptations
CZ	-	0.22-1.23	Depends on level of disability, not means tested	-	-	-
DE	-	Home: 0.17-0.54 Residential: 0.82-1.18	Place of care	-	-	-
DK	-	-	-	1.79	-	Severe disability, max. 9 months
EE	-	0.05-0.17	Depends on level of disability, not means tested	-	-	-
EL	0.50 of basic pension	-	Severe disability*, not means tested	-	-	-
ES	-	na	Severe disability only*	-	-	-
FI	-	0.06-0.29	For pensioners only, affected b Illness or moderate to severe disability	-	Min 0.33 (2010) 0.31-0.63 (2006)	For 'suitable' care-giving family member or kin
FR	-	0.41-0.95	Depends on the level of disability, not means tested	-	0.77	Paid at the terminal stage of life, for a maximum of 3 weeks
FYROM	-	0.23-0.26 of the average salary	Depends on the level of disability, number of the family members and total family income.	-	-	-
HR	-	Up to 0.50 of household income per person	Means tested	-	-	-
HU	-	-	-	-	1-1.3 of old age pension	Depends on stage of disability *
IE	-	-	-	-	Up to 0.88	Full-time care, means tested
	-	-	-	-	Up to 0.78	Full-time care, max 2 years
IS	-	-	-	0.32	-	For partner who quits job/cuts hours if not pension recipient
IT	0.47	-	Severe disability, not means tested		≈Up to 0.25	Moderate to severe disability, varies by region
LI	-	-	-	-	-	-

[59] Provided to a small number of people with severe disability.

LT	-	-	-	Basic pension	-	Severe disability, not for recipients of social/state pensio
LU	na	na	Depends on the level of disability, not means tested *	-	-	-
LV	0.88*	-	Severe disability, not means tested	-	-	-
MT	-	Up to 0.64	Depends on the level of disability, not means tested	-	Up to 0.67	Full-time care
NL	-	0.18-0.92	Only for specific care services	-	Up to 0.18	Severe disability, for non-residential care only, not means tested
NO	-	-	-	na	-	Severe disability, not means tested¸ 3-10 hours of care p. w.
PL	-	0.13-0.16	Permanent or severe dis.	0.45	-	Pension recipients are not eligibl
PT	-	0.45-0.90 of soc. pension	Severe disability, not means tested	-	-	-
RO	-	na	Severely disabled	-	-	-
SE	-	-	-	Wage of assistant nurse	-	-
SI	-	0.25-0.72	Depends on the level of disability	-	Min 0.34	-
SK	-	0.22-1.61	Moderate to severe disability, means tested	-	-	-
TK	-	na	Means tested		Up to twice min wage	Full-time care, means tested
UK	-	0.20-0.29	Moderate to severe disability	0.22	-	Moderate to severe disability, at least 35 hours of care p.w. *

Note: † The information on cash transfers refers to the latest year available for the country, as in Table A6. The ratio was taken with respect to the reference income in 2008.

Note: * **EL** - people who became unfit after their retirement are not entitled to this allowance. **ES** - limited to family carer (up to third degree) or friends residing in the same municipality for at least one year. **HU** - if the carer is entitled to nursing allowance, the period of time spent on caring is taken into account when calculating the service period to old age pension. **LU** - beneficiary cannot be older than 65. **LV** - this benefit is provided to a restricted number of people with severe disabilities. **UK** - The carer must be aged over 16, not attending school or college for more than 21 hours/week, not earning more than £95/week.

na - information is not available.

Source: national reports of the EGGE network (for more details see Table A6 in the Appendix).

All the countries implementing long-term care insurance or a fairly universal cash scheme (France and Belgium) feature attendance-type allowances of variable amounts. But so do also the majority of the former socialist economies – Bulgaria, the Czech Republic, Estonia, FYROM, Croatia, Poland, Romania, Slovenia and Slovakia – together with Finland, Spain, Portugal, Malta, Turkey and the UK. In LTC insurance countries, however, top amounts tend to be significantly higher than elsewhere (in ratio to the reference income), although there are exceptions either way. This suggests that LTC insurance actually leads to higher income protection in the event of severe disability.

To summarize on cash transfers, allowances of the care type tend to yield lower amounts than attendance-type allowances. In countries with low levels of formal provisions, offering care allowances only may not be unambiguously positive from a gender perspective. On the one hand, care givers are compensated for work that would otherwise go unpaid; also the dependent elderly may prefer to receive care from the family than from care workers, as reported for Hungary.[60] On the other hand, such compensation hinders the outsourcing of care and the development of formal, including skilled, employment.

Countries operating LTC insurance schemes tend to associate with financial options that are more favourable to the elderly at greater risk of disability compared with piecemeal financial provisions. All other things being equal, moreover, allowances that modulate the amount depending on disability tend to be more equitable than fixed-amount allowances, since the latter may end up by rationing out mildly disabled, but needy, older people.

5.3.3 Growing privatization of services

A further characteristic of financial transfers that matters to families is whether or not they are untied. Attendance-type allowances that can be spent freely (or whose destination is not effectively monitored) are a prime example of (*de facto*) untied schemes. Service vouchers exemplify tied cash transfers. Both are conducive to the greater privatization of services but the respective implications differ with regard to hours and quality of care, actual access to services, as well as the labour-market conditions of the carers.

As repeatedly noted, two different patterns have recently emerged: the use of cash transfers to hire (migrant) care workers and professionals, and the development of service vouchers as an alternative to pure cash transfers (see section 3.2.3). The service voucher scheme pivots on allowances that beneficiaries can use to pay for services that they buy from public authorities, from private firms, or from individual care providers. Public authorities set the rules and the fees for services, identify, assess and monitor the providers to choose from, organize the training for the care workers that will eventually be engaged, define and monitor the quality standards. The family serves as both care manager and informal care provider.

[60] Author's e-mail correspondence with Maria Frey (4th of October 2010)

Service vouchers are meant to encourage the emergence of irregular labour, ensure at least some skilling for the workers involved, and some uniformity of care quality, all at affordable costs for public budgets. The French and the Belgian experts, however, give a sober assessment. In their assessment, service vouchers did create employment (or made it surface from the irregular, black or 'grey' markets), and they are gradually improving the learning and recognition of skills, but they have not ensured as many hours of care as needed. Also large segments of the employment that has been created do not offer 'decent' pay and working conditions (Silvera 2010, Meulders 2010; see also Box 12 and section 3.2.3). In spite of these reservations, the French and the Belgian systems are the current trend-setters in long-term care. One main attraction of service vouchers is that not only do they save on costs with respect to publicly delivered services (private providers are often cheaper), but they also offer more customized solutions. This is enough to account for the fact that they have inspired the recent reform in Spain and have been recently introduced in Finland and Sweden as an alternative to traditional public supplies.

In Italy, Greece, Cyprus and (to date) Spain, cash allowances, as well as rebates on social contributions, have been put to a different use (see Box 12). As noted in the previous chapter, families use cash transfers to directly hire and pay care workers and professionals. Irregular and cheap migrant labour offers families the advantage of relatively long hours of care – longer than a service voucher option might allow. Evidence from the literature and from the EGGE national reports suggests, however, that quality standards of care are not enforced, and pay and working conditions are very poor for at least some of the migrant workers. Above all, the direct hiring of care workers and professionals is not affordable for all families – especially so the 24-hour live-in carer solution (Bettio and Verashchagina 2010, Karamessini 2010, Lyberaki 2009).

Spain still resembles Italy or Greece in many respects, despite the reform enacted in 2006. While borrowing from the Nordic model the universalistic principle of a right to care in case of disability, the Spanish reform modelled the practical implementation of this principle on the voucher system. In practice, however, families have been given the choice between cash and vouchers. To date, the preference has mainly been for cash, which is used to compensate family members for informal care or to hire migrants, thus slowing down actual change (Gozalez Gago 2010, Leon 2010; see also Box 12).

A not too dissimilar behaviour on the part of families explains why, in Austria and Germany, full implementation of long-term care insurance has not prevented the growth of large pockets of irregular, migrant labour (Mairhuber 2010, Maier 2010) and may even have created the conditions for it. These examples highlight a theme that runs through this report as well as the recent literature on social care (Ungherson and Yeandle 2007, Simonazzi 2009, Leon 2010), namely that policy choices inspired or dictated by financial considerations have had large and partly unintended effects on the labour market for care.

5.4. Training and wage policies

Labour-market policies have been primarily focused on training as a means to address labour shortages, whilst segregation, wages and other working conditions have received less attention.

Actual or expected shortages of care workers and professionals are an important concern for governments. The most articulated policy responses have attempted to provide fresh training while also redefining educational or vocational requirements or redesigning career paths – all with a view to improving the recruitment and retention of personnel in the sector. The majority of countries, however, simply put in place new training initiatives. Very few countries have addressed low wages in order to incentivise workers to enter the long-term care sector and remain therein, and in practically no country have efforts or even attempts to encourage more men to enter this sector made it on to the policy agenda (Boxes 9 and 10).

As documented in earlier reports (Bettio and Verashchagina, 2009: Part II, Home helpers in long-term care) career paths in long-term care, especially home care, tend to be short, with few, if any, skill positions between generic 'care workers' at the bottom and highly qualified nurses at the top. Introducing new steps into the skills ladder is a way to improve the career prospects of workers at the bottom, who may, therefore, be encouraged to enter and discouraged from exiting. In Austria, this has led to the establishment of a new occupation – assistance nurse – positioned between qualified nurses and home helpers. Similarly, in Belgium the occupation of 'nursing carer' has been created in order to assist nurses in the care and education of patients: they are usually in charge of all hygienic care tasks, such as weighing patients or taking their temperature. In Romania, home caregiving has earned a separate job title and has been included in the official occupational code (Box 13).

Other initiatives are more traditional, and are intended to increase participation in training courses or the number of training positions within firms (Estonia, Germany, Norway, Portugal and Spain: Box 13), to raise the level of vocational training or formal education required for carers at each skill level (Germany, Latvia, Norway, the UK), to raising minimum skill standards, or to certify training for low-skilled workers (Romania). Efforts to enhance opportunities for further training have been extended to family carers: as part of the 2006 reform Spanish family members or friends who receive the care allowance in order to assist dependent elderly are also entitled (and encouraged) to receiving formal training, and they are guaranteed recognition of the skill acquired through experience. In France, higher qualifications for long-term care workers are being pursued via service vouchers: care workers participating in the system are now covered by a 'quality agreement' whose aim is to turn 'personal assistant' into a skilled occupation.

Box 13. Training and re-designing career paths

Austria. To enhance skill and career prospects at the bottom of the pyramid of care workers, in recent years efforts have been made to increase professionalism within the care sector. In Austria, this has led to the establishment of a new occupation, which, in terms of qualification level, lies between qualified nurse and home helper: i.e. the job of 'assistant nurse'. The impact of this new development – especially on gender relations – is still unclear, as studies and evaluation have not yet been carried out (Krenn et al. 2010, p. 138). (Mairhuber 2010)

Belgium. Two ministerial decrees concerning the occupational category of "nursing carer" were published in the *Moniteur belge* on January 12, 2006. The first decree determines which nursing tasks may be performed by nursing carers, as well as in which circumstances they may do so. The second decree describes the procedure for registration as a nursing carer. Nursing carers are health professionals specifically trained to assist nurses in the care and education of patients. They are usually in charge of all hygienic care tasks, such as weighing patients or taking their temperature. (Meulders 2010)

Estonia. Lack of personnel has recently become an issue in Estonia. Qualifications of the care and nursing workers have been improved by introducing nursing as a field of study in higher education in the 1990s. According to statistics by the Ministry of Education and Research, the number of nurses being trained has recently increased. In 1999 only 21 nurses graduated in higher education, but by 2004-2005 the figure had risen to almost 500 students per year. (Karu 2010)

France. In France, long-term care policy is based on the *Allocation Personnalisée à l'Autonomie*, APA (see preceding Box and text). The latter is now covered by a 'quality agreement' and the professionalisation of personal assistants has been organised. With the Introduction of DEAVS (Diplôme d'Etat d'auxiliaire de vie) training has improved. Although working conditions are still precarious because carers are paid according to the numbers of hours that they have worked, with no systematically stable monthly wage yet introduced, the APA has significantly increased the numbers of qualified workers. (Silvera 2010)

Germany. More firms are introducing quality management tools in their operations because of widespread opinions that the quality of nursing homes is low. As an occupational category, long-term elderly care was never at the centre of interest for the state, the trade unions, or employers, and only in 2000 was vocational training reorganized so as to raise the standards of training (Altenpflegegesetz 2000). A three-year vocational training course is now necessary to become a skilled geriatric nurse: the training is delivered in schools and within the firms providing ambulant and residential care. People below this skill level may receive one year of training as a semi-skilled geriatric nurse assistant. During the past ten years, both the number of vocationally trained geriatric nurses

and the number of semi-skilled nurse assistants has increased. The Federal Agency of Labour has been prominent in offering unemployed women and women wanting to re-enter the labour market courses in long-term care at various skill levels. Reports show an overall scarcity in terms of both the supply of trainees and training places within firms, which are expected to grow in the years to come. (Maier and Carl 2010)

Latvia. The law on social services and social assistance (adopted on November 19, 2002) specifies the education level that allows a person to perform social work. The programme for the development of professional social work (Ministry of Welfare, 2005) is aimed at enhancing the skills of social workers. The programme contains the following measures: state-financed and ESF-financed training of social workers (including social carers); ESF-financed further education for social care professionals; state co-financing of wages for certain groups of care workers. (Rastrigina 2010)

Norway. One of the most important challenges in the future will be to ensure access to sufficient health and social services personnel, primarily through educational and recruitment initiatives. Recruiting students to many years of education is a long-term initiative that is best resolved by gradual development. The Competence Lift 2015 is an important part of the care plan, consisting of several policy elements. For example, the Skilled Health Care Worker Action is a collaborative project aimed at ensuring sufficient training places in municipalities and health enterprises, contributing to the effective recruitment of a new group of 'health care workers' (two years of practical training, two years of theoretical education), and increasing the share of personnel with university college education, and vocational education for personnel with upper-secondary schooling. (Ellingsæter 2010)

Portugal. While there is no public concern about shortages of carers, worries are expressed about the difficulties faced by family carers and about the low qualifications of the workforce. The policy response has been to increase the number of trainees on specialized courses. The creation of university courses in Geriatrics and Gerontology originates from the same concern. (Ferreira 2010)

Romania. Home caregiving has earned a separate job title in Romania and has been included in the official occupational code. One of the main regulations of the New Legal Framework for long-term care under discussion is intended to ease the certification of home caregivers with a view to reducing waiting times for home services. The care givers are being trained in new techniques for rehabilitation and specialized assistance. The government's strategy in this area focuses on complying with occupational standards by organizing programmes for initial and continuous vocational training, depending on the professional development skills required in LTC. Following the Action Plan for implementing the National Strategy for Development of the Elderly People Social Assistance System in the Period 2005-2008 (Romanian Government 2005) regulations have been enacted to certify caregivers on the basis of the training received. (Albu 2010)

Spain. Efforts have been made to set up continuous professional training programmes which adapt workers´ skills to the tasks needed in the long-term care sector and to put in place occupational training programmes furnishing unemployed people with the knowledge and skills needed to enter the labour market in the sector. The Law on Dependency provides an example of the attempts made to enhance the qualifications of informal carers: family members or friends receiving the care allowance in order to assist dependent elderly persons are also entitled (and encouraged) to receive formal training, and they are guaranteed recognition of the skill acquired through experience. (González Gago 2010)

United Kingdom. Formal long-term care is characterized by high turnover and vacancy rates. This reduces the quality of care provided and also indicates the limited attraction of social care jobs for those seeking to develop their skills and careers. The government estimates that two million additional workers in social care will be required within twenty-five years' time (Department for Work and Pensions 2008). It has introduced a programme of reforms to improve the recruitment and retention of the social care workforce, and the quality of care provided, which focuses upon improving their training and skills. Historically, no formal qualifications were required for home care workers for older people in the UK until the Care Standards Act (2000) introduced various national minimum standards and specified qualification levels for intermediate and lower-level social care positions. This set standards that had to be achieved in the social care workforce by specific dates, mostly in terms of vocational qualifications (NVQs). (Fagan 2010)

The Ministry of Health, Welfare and Sport in the Netherlands believes that a more comprehensive approach is needed to dealing with shortages in the health and social care sector. Not only should more investment be made in lifelong learning, for example, in favour of internships or the more intensive use of accreditation, but more room should be created for wage differentiation, with a view to anticipating diversity in the industry. Change in work organization geared to creating more autonomy for care workers is also recommended, e.g. via self-rostering, together with a renewed and improved public image and reputation of employees in the health and care sector (Box 14).

In contrast to training, very few countries have directly addressed low wages. That the latter may be responsible for high turnover, shortages, or the emigration of skilled personnel to richer neighbouring countries has been publicly debated in at least two of the countries involuntarily exporting qualified personnel – Estonia and Hungary (Box 14) – but no measure has been taken. The issue of low pay in care jobs has also been officially addressed by the Women and Work Commission in the UK but, again, no concrete action has followed.

Box 14. Wage policies

Instances where low pay is not being addressed

Estonia. One of the problems with the formal long-term care sector is a lack of nurses and caregivers. Despite the shortage, the salaries of Estonian medical workers were retrenched at the end of 2009. The low income of care workers and professionals has caused a situation where more than half of medical students enter their first jobs outside the Estonian health system (Andres Kork, Estonian Medical Association 2006). (Karu 2010)

Hungary. There has been some public discussion of low wages in long-term care. Low wages and hard work are the main explanations of the high turnover rates in long-term care. Turnover of workers would probably be reduced with increased wages in this sector. (Frey 2010)

Latvia. The shortage of care workers and professionals is widely acknowledged, and it was especially acute in the boom years. In order to reduce this shortage, the wages in the LTC sector should be increased so as to channel more labour into care occupations, which currently command low prestige. At the same time, municipalities should receive more money from the central government in order to boost their hiring capacity. Unfortunately, the financial crisis stands in the way. (Rastrigina 2010)

Portugal. Largely as a consequence of the decision to privatize public services, the state is relinquishing its traditional role as social regulator. In particular, it is encouraging the expansion of the powerful *'third sector', currently the main contractor in public tenders.* Given the weight that the third sector is gaining in the market for personal care services, it is important to ask what kind of working conditions and labour relations will predominate therein. Current conditions give little reason for optimism. (Ferreira 2010)

United Kingdom. The problem of low pay is not being addressed as part of the social care policy agenda, even though the connection with care work and low pay was identified in the government's 'Women and Work Commission' which was set up to tackle the problem of the large gender pay gap in the UK. Improvements in pay and career structures are necessary to retain women in the sector, to encourage men to enter and thus alleviate

labour shortages through desegregation, and to contribute to reducing gender inequality in the economy overall. Efforts to date in the social care sector have been insufficient. Labour shortages are unlikely to be resolved unless wages rise, yet low pay is reinforced by the budget constraints which local authorities' social services departments operate when subcontracting services. (Fagan 2010)

…and some attempts to address the problem

Austria. In order to facilitate regularization and the emergence of the 'grey' market of carers, with foreign workers often commuting between Austria and neighbouring countries, regulations were amended by the federal state in 2007 and 2008 ("Act on Home Care", HBeG 2007). Since 2008 foreign care workers, too, have been authorized to help clients with personal hygiene and ingestion. "Even a few medical treatments – like administering medication according to physicians' instructions – have recently been added to the list of legally recognized tasks for this group of personal care workers." (Schneider and Trukeschitz 2008, p. 22) (Mairhuber 2010)

Germany. The care sector is associated with difficult working conditions, and there is significant illegal employment because the care insurance does not cover all the expenses of home-based care. The introduction of a minimum wage in the care sector is a signal that wages are declining and are seen as a market failure problem by the majority of the actors. The first question that this raises, however, is whether the care insurance will increase the allowances for services and residential care so as to cover higher wage costs. Or will the people in need of care have to pay more? (Maier and Carl 2010)

The Netherlands. Expected labour shortages (for care workers and nurses, in particular) are an important policy issue. Each year the Ministry of Health, Welfare and Sport publishes a policy letter on the labour market for health. In order to deal with shortages in the long-term, the Care Innovation Platform has been asked for advice (ZIPb 2009). This advice addresses all relevant actors in the field – such as government, care providers, social partners, regional networks and branch organizations – and puts forward four recommendations under four main headings. The first heading is 'investment in lifelong learning': examples of recommendations are increasing the success rates of studies, investing more in internships, and making more use of the accreditation of prior learning. The second heading is 'anticipating diversity by means of terms of employment': examples of recommendations are to increase the room for wage differentiation, to improve the fit between school hours and working hours, to increase employability for all age groups. The third heading is 'organization and employability'; examples of recommendations here are the introduction of self-rostering, more autonomy of employees, and higher job differentiation and job reshuffling. The final heading is 'recruiting with focus', the main goal in this respect being improvement in and renewal of the image and reputation of health care as an occupation. (Plantenga and Remery 2010)

Only two countries, Germany and Austria, have taken concrete steps to regularize a large segment of irregular migrant workers. In Germany the minimum wage has recently been introduced in the care sector partly in response to the growing number of irregular migrants. However, it is not clear who will foot the bill, i.e. whether older people will have to meet the increase in fees or whether the long-term care insurance scheme will correspondingly raise the allowance in order to compensate for higher fees. In Austria, a range of measures have been taken since 2007 to regularize foreign care workers and professionals. In this case it is primarily the government that foots the bill because the measures include the waiving of social security contributions (which in Austria are high for workers employed by the family).

5.5. Summary remarks

Although in several Member States long-term care has received less public attention than childcare during the last fifteen to twenty years, public policy in this sector has made a difference. Progress is undeniable with respect to the financial infrastructure or the range and the scope of provisions. However, demand for long-term care has grown very rapidly at a time when public budgets were already under pressure, which was bound to require choices on which provisions to prioritize. Although allowing the expansion of services and of employment, such policy choices have not successfully addressed certain endemic weaknesses of the labour market in this sector: segregation, poor pay, and harsh working conditions in the formal segment; risk of exploitation and lack of basic standards of work in the irregular segment.

It is somewhat paradoxical that narrowly-defined labour-market policies may have been less consequential for labour-market outcomes (and gender equity within it) than choices about the mix of provisions. Across Member States, labour-market policies appear to have addressed the symptoms of labour-market malaise in the long-term care sector – i.e. shortages and turnover – rather than the root causes, i.e. wage and working conditions or segregation. Whilst the importance of further education or training for meeting shortages is not under discussion, disproportionate reliance on these measures may lack effectiveness.

Concluding notes

Long-term care in Europe is a large, rapidly-growing and evolving field of activity that brings promises and risks to gender equality within the family, in the labour market, and in society at large. These concluding notes will wrap up the present report by first summarizing the findings from the analysis of national data and of the specialized literature in Chapters 1-4. Selective policy stocktaking will follow, with special attention paid to the options still open and their likely impact on equality between men and women.

Women are the main stakeholders in the provision of long-term care. On the demand side, they account for the majority of beneficiaries. On the supply side, they are still largely

overrepresented among caregivers, paid or unpaid. Ageing is at the same time a risk and an opportunity for equality.

As documented in Chapter 1, there is little doubt that demand for care services will continue to grow rapidly, despite some unresolved uncertainties about future disability trends. In line with the 'constant disability' scenario, and allowing for the fact that life expectancy is still rising, we may anticipate that in the next fifty years the actual numbers of elderly people with at least one ADL disability will more than double in the EU27: from 20.7 million to almost 44.5 million. Such a large rise in the number of women and men in need of assistance may be seen either as a bleak prospect or as a price worth paying for living longer, depending on one's perspective. From an economic point of view it is a major employment opportunity. From the point of view of gender equality it is also an opportunity to redress the imbalance in caregiving.

However, the actual significance of this opportunity for women and its equality-enhancing potential hinges on future developments in three areas (i) the growth of formal as opposed to informal or irregular care services, (ii) pay and employment conditions for care workers and professionals, and (iii) gender balance among formal and informal care providers. The primary contribution that this report has offered is comparative assessment of how European countries are faring in all these three areas. The findings also allow for selective stocktaking with regard to past and current long-term care policies.

Formal and informal caregiving

The availability, prevailing mix and affordability of formal provisions all impinge on the balance between formal and informal caregiving. The overall level of formal provisions is still very diversified across European countries, but there are signs of selective improvement with respect to fifteen to twenty years ago, although most of the improvement concerns West and South European countries (Chapter 2).

First, coverage rates for residential care have converged towards relatively modest values among West, Nordic and South European countries, consistently with the objective of shifting services away from institutional care and towards home and semi-residential care. With the exception of Iceland at the top of the ranking and FYROM at the bottom, all these countries display values comprised between 0.5 for Turkey and Romania and 6.7 for France. Second,

Southern countries have caught up with Western (continental) countries with respect to home and semi-residential care: Greece, Italy and Spain are now around the 5% mark for home care coverage, while Portugal and Malta are only 1 percentage point away. Semi-residential services have grown apace in Greece reaching a 9% coverage rate, but they are also important in Estonia, Finland, Portugal, and Denmark.

The dominant feature of home and semi-residential care coverage remains high dispersion across countries, for two reasons. There still is a large distance between a small group of top providers that can boast rates of around 20 percent (Iceland, the Netherlands and Denmark) and a large group of middle providers recording values between 5% and 7% (rounding up decimals: Belgium, the Czech republic, Luxembourg, the UK, Germany, France, Ireland, Hungary, Finland, Greece Italy and Spain). Part of this distance may be accounted for by limited comparability of the available data, but some of it is bound to be real. More importantly, enlargement to the East has brought into the Union a large number of countries with poorly and sometimes very poorly developed home care infrastructures (Romania, Lithuania, Latvia, Poland, Slovenia, Slovakia, Estonia). However, the persisting dispersion of coverage-rate values in a larger Europe cannot reduce the significance of catching up on the part of at least some countries.

High coverage rates for formal provisions do not necessarily correspond to greater care outsourcing on the part of families, i.e. to a better balance between formal and informal caregiving. For example, coverage rates may include cash benefits that are not spent to purchase care services. In reality, the balance between formal and informal caregiving continues to show marked disparities among countries that do not entirely correspond to differences in coverage rates. Even if we confine the analysis to the subgroup of countries included in the SHARE survey and to the beneficiaries of home care most likely to resort to care workers – those who receive care on a daily or almost daily basis – exclusive reliance on informal caregivers ranges from between 70% and 80% in countries as different as Germany, Italy and Spain, down to less than 30% in Denmark, the Netherlands, France and Belgium.

Families take decisions about outsourcing on the basis of the availability of services but also of fees and prices. One of the drivers of the ongoing change in care systems is the search for solutions to the problem of making costly services available to families at affordable fees.

Within countries, residential care tends to be less affordable than care at home for all those families that are not poor enough to be entitled to free services or that are rationed out of free services by some other criterion. If, however, an absolute criterion for affordability is used, the surprising finding from the evidence collected in this report is that countries furnishing publicly subsidized and affordable residential services may not be the minority. The criterion adopted is that fees absorbing at most 85% of the reference income may be considered 'affordable', (given that care in an institution covers all basic needs). Under this assumption, out of the 21 countries for which fees for publicly subsidized services can be meaningfully compared, 12 satisfy this affordability criterion, 6 fail to meet it, while insufficient information is available for the remaining 4 countries. For the Nordic group of countries, affordability is simply a facet of those countries' universalistic care aspirations. In countries with poor provisions, affordability is often the other side of rationing. Limited provisions are put in place as 'last resort' solutions targeted on the elderly who cannot count on, or pay for, any other alternative, including family care.

Comparisons of home care costs across countries are more problematic although they are important for understanding differences in the balance between informal and formal care or in the take-up rate of provisions. In order to overcome complex issues of comparability we have chosen to identify the typical costs for a selection of four distinctive organizational profiles of home care provisions. The selection encompasses the 'comprehensive care but rationalized face time' pattern typified by Sweden, the 'migrant-in-the-family' arrangement typified by Italy, 'service voucher' programmes exemplified by France, and 'minimal reliance on care outsourcing' epitomized by Poland. To our knowledge this is the first attempt in the literature to compare costing and distributional strategies in LTC for the elderly.

Comparison of these four organizational and pricing profiles highlights two intertwined trade-offs. The first is between hours of care, on the one hand, and distributional equity on the other: the most universally affordable solutions existing in Nordic countries must rationalize hours of care in order to ensure the widest coverage at affordable prices to clients. In Iceland and Sweden, average hours of care are, in fact, less than 3 per week, while in Denmark they range between 4 and 6 hours per week. Extended hours of care tend to be expensive across countries and therefore affordable for a minority of families. Only where poorly trained care givers are employed, and where wages are kept low by immigration and large irregular markets does this

minority become sizeable, as the 'migrant-in-the-family' arrangement illustrates for Italy or Greece. French-style service vouchers seem to provide a compromise solution for this trade-off because the scheme does not compel the extreme rationalization of hours, although it does not make extensive hours of care equally affordable for all.

The second trade-off is between job-creation potential and quality of employment. When extensive hours of care are provided, a large portion of the care time involves social and emotional rather than professional skills (i.e. for minding or providing companionship to the older person). Rationalized hours of care require a comparatively smaller but more skilled workforce, because medical and nursing tasks are less easily compressed or neglected than social skills. Hence extensive hours of care may promote more employment than rationalized hours, but a comparatively less skilled workforce. And where large irregular markets operate, low-skilled employment is more exposed to risks of exploitation.

These trade-offs clearly matter from a gender perspective. Extended hours of care may appeal to everybody, men and women, if only because they allow for richer social and emotional interaction with the care giver(s). However, longer hours may imply the rationing out of the most severely dependent and poor elderly – women being especially at risk. As to the trade-off between employment creation and quality of employment, women stand to benefit disproportionately from employment expansion in the care sector, but also to suffer disproportionately from low pay or irregular employment, given current conditions in the sector.

Gender equity: pay and working conditions in the long-term care sector

From the standpoint of gender equity, pay and employment conditions in the long-term care sector are perhaps the foremost issues. Employed care workers and professionals are an extremely feminized employment segment. In 2007 women accounted for about 90% of all care workers and nurses (plus midwives), and there is no reason to believe that the proportion is much lower in the long-term care segment (for which no specific data are available).

Pay conditions in long-term care are well illustrated with reference to the best-paid segment, that of nurses or equivalently skilled professionals working full time in residential facilities. Of the 16 countries reporting sufficiently comparable data, half record average or minimum values

higher than or equivalent to the country's average OECD monthly figure (Iceland, Denmark, the Czech Republic, Estonia, Slovenia, the Netherlands, Poland and Slovakia). In two further countries, relative wages for nurses are comprised between 90% and 100% of the national OECD figure (Finland and Italy), whereas the remaining countries record values below the 90% mark (Austria, Greece, Germany, Hungary, Norway and Sweden). Yet in many of these countries nurses are required to attain college degrees or to acquire vocational training over a long period (three years in Germany, for example). In the least 'favourable' case, that of basic-skill workers in home care, pay conditions are considerably worse, as to be expected: in 11 out of 18 countries examined, wages are below two-thirds of the OECD average wage. However sombre these figures may appear, they actually overestimate actual wages in long-term care, because they refer to full-timers and, in at least half of cases, to public-sector employees only.

Occupational hazards often compound the problem of low pay for people employed in the LTC. Hard physical work, stress and depression are the side-effects most frequently mentioned in the national reports, but acknowledged hazards also include substantive risks of exposure to infection diseases due to close physical contact and of road accidents due to frequent travelling to the client's home.

In response to poor pay and working conditions, turnover is reported to be very high in countries as different as Austria, Belgium, Bulgaria, Iceland, Italy, the Netherlands, Poland and the UK. Moreover, shortages of semi-skilled care workers or nurses are being experienced or are anticipated in the long-term care sector of a large number of countries, both in Western and Southern Europe (Austria, Belgium, Cyprus, Germany, Finland, Italy, the Netherlands, Malta and the UK) and in several Central and East European countries (Bulgaria, Latvia, Poland and Hungary).

Gender equity: the conflict between caring and working

Informal care givers face different problems if they are in employment, and primarily a potential conflict between working and caring for older people. However, the available evidence in this respect offers more reasons for qualified optimism.

The first reason for optimism is evidence that the trade-off between caring and working may be less substantial than has been found by previous comparative surveys of family care givers (Eurofamcare). National level research indicates that female informal carers who have jobs tend to quit employment more often than men, but the incidence of quits is often below 10%, or just above this figure even in countries relying heavily on the family, such as Poland, Italy or Spain. This is broadly in line with the findings of comparative econometric research confirming that the impact of informal care on the probability of exiting employment or of reducing hours of work is positive and statistically significant, but the order of magnitude is limited (Box 14). A notable qualification in this case is that the conflict between working and caring for older people may at present be modest, but it may intensify with postponement of the age of retirement.

The second reason for optimism is that men already take a substantial part in informal caregiving and may increase their participation in the future. With 61% of the total, women are the majority of informal care givers, but not the vast majority, according to SHARE data. As a general rule, men still represent 'second instance' informal care providers, and their caregiving is much more conditional on employment status than it is among women. Within elderly couples, however, 44% of the caring spouses are men, with 6 out of 13 countries showing near gender parity among spouses (Austria, Belgium, Italy, the Netherlands, Spain and Poland). Given that life expectancy is estimated to increase faster among men, the number of countries boasting near parity among spouses may well rise.

Policy options and designs

In principle, working time policies such as leave provisions, options to reduce working time or to work flexible hours can be used to mitigate this conflict. The detailed review of leave and other time-related provisions carried out for this report (chapter 4) shows that in some countries provisions are simply underdeveloped. In many other countries, however, the problem is not so much a lack of provisions as poor design and poor coordination with the long-term care services in place. It also shows that leave off-work should not necessarily be prioritized over other working time policies, especially the right to flexible hours.

While working time has attracted some attention from policy-makers over the past two decades, training and cash transfers have been prioritized. The focus on training is justified by concerns about shortages of care personnel, the underlying assumption being that more and better training can effectively address excessive turnover and low pay, thus retaining more workers and attracting others. With a few exceptions, the training initiatives put in place are fairly conventional: more training positions within firms, more training courses, higher educational/training requirements for care jobs. A few innovative examples include attempts to re-design career paths in order to make them more attractive (e.g. in Austria and the UK, where intermediate-skilled occupations have been created) or to improve recognition of the specific skills involved in caring for the elderly (e.g. In Romania, where caregiving in LTC has been recently added to the occupational code).

While the importance of further education or training in meeting shortages is not in question, almost exclusive reliance on these measures may prejudice effectiveness. Yet very few countries have directly addressed the problem of low pay in long-term care. Exceptions are Austria, where social security contributions have been abated in order to encourage the emergence of irregular migrant care workers, and Germany, where the minimum wage has been introduced in the care sector. Furthermore, practically no expert mentions occupational de-segregation among the options that have been considered to cope with shortages, i.e. attempts to get men to take up employment in the care sector.

It is somewhat paradoxical that policies not aimed at labour or gender issues have influenced both, albeit unintentionally. Cash transfers are a case in point. The past two decades have witnessed a practically universal shift in favour of financial transfers, in parallel with the privatization of services. Cash transfers have been distributed primarily via two types of allowances: that paid to the older person in need, generally on grounds of disability, to finance purchase of care services; and the allowance paid to the family carer as compensation for the carer's services. The former is often – although not consistently – called 'attendance allowance', the latter 'care allowance'. Attendance allowances are more widespread than care allowances (25 countries against 20) and tend to be higher in amount. In Nordic countries, care allowances are more frequent than attendance allowances because services in kind remain the policy priority.

The comparison between Germany and France illustrates some possible repercussions of cash transfer design, where 'design' refers not only to the amount or coverage but also to the option between 'free to spend' and 'tied' allowance. In Germany the LTC allowance is *de facto* an attendance allowance and is universal in coverage. In France the APA (*Allocation Personnalisée à l'Autonomie*) is not universal, although coverage is high; spending is tied not only because personalized care budgets are agreed with the health authorities, but also because personal care and home help are purchased using service vouchers. Care workers paid via service vouchers are regularly hired and can be supervised and trained. These differences in the design of cash allowances between the two countries may contribute to explaining why French families rely on care workers more than German families do (Figure 9). The choice in favour of 'tied' allowances also sheds light on the quality of employment in the care sector. In the assessment of the national experts, employment created/organized via the service voucher scheme does not consistently ensure 'decent' pay and working conditions; nevertheless, it has favoured the emergence of care workers and professionals from the grey market, and it allows for some training, as well as for the monitoring of quality.

Prospects

A vital policy issue has not and could not be included in this report: the impact of the crisis on LTC policies. Publicly subsidized provisions, in particular, are unlikely to merge unscathed from the ongoing process of fiscal consolidation in European Member States. It would, however, be a great loss of opportunity for the economy, and not only for gender equality, if the prevalent response to the financial crisis were confined to rationalizing provisions and putting pressure on the family to insource rather than outsource care. Rather, the challenge lies in reversing this perspective and turning a rapidly-expanding sector like long-term care into an employment growth engine. At the same time, employment expansion could also be used to turn this employment segment into a port of entry for men into the larger care sector.

Appendix of Tables

Table A1. Coverage rates, 65+ (default)

Country	Year	Source	Residential care	Semi-residential care	Home care
AT	2006	Huber et al.	3.3	na	14.4
BE *	2007, 2004 ǂ	OECD	6.6	na	7.4
BG *	na	na	Na	na	na
CY *	2008	National	3.0	na	na
CZ	2006	Huber et al.	3.5	na	7.2
DE	2008	National	3.5 † (M: 1.7; F: 4.8)	-	6.6 (M: 5.2; F:7.7)
DK	2008	National	2.5	2.4†	20
EE	2008	National	1.8 (M: 1.7; F: 1.9)	7.5	2.3¥ (M: 1.3; F: 2.8)
EL	2001, 2007 ǂ	National	0.6	9.0	5.6 ¥
ES	2008	National	4.4	0.8	4.7
FI *	2008	National	3.1 (M: 2.1; F: 3.9)	3.4 (M: 2.2; W: 4.2)	6.3 ¥ (M: 4.5; W: 7.5)
FR	2007	OECD	6.7	na	6.5
FYROM	2009	National	0.2ǂ	1ǂ	na
HR	2008	National	1.6	na	na
HU	2008	National	2.8 † (M:2.1; F: 3.2)	1.6 (M: 1.2; F: 1.9)	6.4 (M: 4.1; F: 7.8)
IE	2006, 2004 ǂ	OECD/Huber et al.	3.9	na	6.5
IS	2005/03/08 ǂ	National	8.3 (M: 6.4; F: 9.8)	3	20.5
IT	2005	National	3	na	4.9 ¥
LI	na	na	Na	na	na
LT	2007	Huber et al.	0.8	na	0.6
LU	2007	OECD	4.8	na	7
LV *	2008	National	1.4 (M: 1.45; F: 1.34)	na	1.6 ¥ (M:0.8; F:2.1)
MT	2008	National	≈4.3	na	≈4 ¥
NL	2009	National	6.3	na	21
NO *	2007	Huber et al.	5.3	na	19.3
PL	2009	National	≈1	≈0.3	≈1.7 ¥
PT	2006	National	3.4	3.3	4.3
RO	2009	National	0.5	1	0.3 ¥
SE	2008	National	5.8 (M: 3.9; F: 7.2)	0.7 (M: 0.8; F: 0.7)	9.4 (M: 6.8; F: 11.5)
SI	2009	National	4.8 †	0.2	1.8 ¥
SK *	2007, 2005 ǂ	OECD/Huber et al.	3.3	na	2.3
TK	2009	National	0.48	0, 02	na
UK	2004	OECD	4.2	na	6.9

Notes:

* National estimates also exist for **BE** - around 5% coverage rate for both residential and home care, **NO** - 7% for residential care, and **SK** - 2.08% for residential care. They have not been reported in the table because the corresponding age group is different, respectively 60+ for BE, 67+ for Norway and 62+ for Slovakia. The figures would not be comparable: wider/narrower age group in this case leads to lower/higher coverage rates. **BG –** some information is available at the local level, see p.6 of the national report. **LV** - The reference age group is 62+. **FI** - the figures are quite different from those reported in Huber et al. (2009). According to the national expert, the latter source may have used the information for the 75+ group. **CY** - national experts' estimates are very similar to those obtained from the 2001 Population Census (≈3% coverage rate for residential care).

‡ **BE** - 2007 for residential, 2004 for home care; **EL** - 2001 for residential, 2007 for semi-residential and home care; **IE** - 2006 for residential (from OECD), 2004 for home care (from Huber et al.); **IS** - 2005 for residential, 2003 for semi-residential, 2008 for home care; **SK** - 2007 for residential (OECD), 2005 for home care (Huber et al.).

† **HU, SI, DK -** assisted living is included;

† **DE** - Semi-residential and home care were treated as one category.

‡ **FYROM** - coverage rates are estimated based on institutions capacity.

¥ Only in-kind services were considered in calculations of the coverage rate for home care in the following countries: **EE, EL, FI, IT, LV, MT, PL, RO, SI**.

For data drawn from **Huber et al. (2009):** whenever cash benefits and in-kind benefits overlap for home care, the broader (more beneficiaries) benefit was used. That is why, e.g. for the Netherlands, the coverage rates for home care are higher than those from OECD Health Data. We have reported the national estimates, which are similar to Huber et al., but more recent.

Sources: The three sources used to compile this table were national estimates recommended by the national experts; the data collected by Huber et al. (2009); and OECD Health Data 2009. No single source was used as a default option. When a choice had to be made, the broad rules were as follows: national sources were selected if (i) other sources available were in broad agreement but less updated, detailed or complete or (ii) national experts gave well-grounded reasons for not endorsing alternative sources. When reliable national figures were not available, a choice was made between Huber et al. and OECD Health Data based on a number of criteria that included year (the most recent), and range of benefits/services covered: for example, OECD Health Data do not necessarily include home help if the latter is given separately from health or personal care. In general, OECD data have not been the default choice for this table.

Details of national sources:
CY - Ellina (2010), based on statistics from the Ministry of Labour and Social Insurance and personal interview with the President of the Association of private nursing homes. **DE** - Maier and Carl (2010), calculations based on BMG 2010 and Statistisches Bundesamt 2008; **DK** - Sjørup(2010), calculations based on official data from Statistics Denmark; **EE**- Karu (2010), calculations using data from Ministry of Social Affairs; **EL** - Karamessini (2010), calculations based on administrative sources for users and official population statistics; **ES** - IMSERSO (2009), quoted in González Gago (2010); **FI** - Sutela (2010), calculation based on data from SOTKAnet (2008). **FYROM** - Androsik (2010), based on data obtained via personal interview with the representative of NGO HUmanost, Ms. Donevska (June 2010); **HR** - Mrnjavac (2010), calculations using official statistics; **HU** - Frey (2010), calculations using official statistics; **IS** - Johannesson (2010), calculations using data from the state reviser (2005), Services to the elderly (Þjónusta við aldraða) and Iceland Bureau of Statistics; **IT** - NNA (2009), quoted in Bettio and Verashchagina (2010). **LV** - Rastrigina (2010), calculations based on data from Social Service Board and Central Statistical Bureau of Latvia; **MT**- Camilleri-Cassar (2010), calculations using official statistics; **NL** - CBS (national statistical institute, 2009), quoted in Plantenga and Remery (2010); **PL** - Plomien (2010), estimate based on data from GUS(2009) and MPiPS (2009); **PT** - ANCIEN project quoted in Ferreira (2010); **RO** - Albu (2010), calculations using official statistics; **SE** - Nyberg (2009), calculations using official statistics; **SI** - Kanjuo-Mrčela (2010), figures obtained via personal correspondence with the Secretary at the Ministry of Labour, Family and Social Affairs, Mr. Aleš Kenda (February and March 2010). **TK** - Ozar (2010), calculations based on data from SPO (2007);

Table A2. Source of regular care

Country	Home care provisions	Total		Disability scale					
				Not limited		*Mildly Limited*		*Severely limited*	
		number	%	number	%	number	%	number	%
AT	Family carers only	59	*55.1*	6	*46.2*	19	*54.3*	34	*57.6*
	Family and non family care providers	20	*18.7*	2	*15.4*	4	*11.4*	14	*23.7*
	Non family care providers only	28	*26.2*	5	*38.5*	12	*34.3*	11	*18.6*
	All home care providers:	107	*100.0*	13	*100.0*	35	*100.0*	59	*100.0*
BE	Family carers only	58	*27.8*	9	*19.1*	19	*35.8*	30	*27.5*
	Family and non family home care providers	62	*29.7*	8	*17.0*	5	*9.4*	49	*45.0*
	Non family home care providers only	89	*42.6*	30	*63.8*	29	*54.7*	30	*27.5*
	All home care providers:	209	*100.0*	47	*100.0*	53	*100.0*	109	*100.0*
CZ	Family carers only	139	*78.5*	7	*70.0*	43	*78.2*	89	*79.5*
	Family and non family home care providers	23	*13.0*	1	*10.0*	4	*7.3*	18	*16.1*
	Non family home care providers only	15	*8.5*	2	*20.0*	8	*14.5*	5	*4.5*
	All home care providers:	177	*100.0*	10	*100.0*	55	*100.0*	112	*100.0*
DE	Family carers only	102	*71.3*	13	*92.9*	27	*81.8*	62	*64.6*
	Family and non family home care providers	24	*16.8*	-	*0.0*	2	*6.1*	22	*22.9*
	Non family home care providers only	17	*11.9*	1	*7.1*	4	*12.1*	12	*12.5*
	All home care providers:	143	*100.0*	14	*100.0*	33	*100.0*	96	*100.0*
DK	Family carers only	35	*25.2*	4	*16.7*	12	*23.5*	19	*29.7*
	Family and non family home care providers	24	*17.3*	2	*8.3*	7	*13.7*	15	*23.4*
	Non family home care providers only	80	*57.6*	18	*75.0*	32	*62.7*	30	*46.9*
	All home care providers:	139	*100.0*	24	*100.0*	51	*100.0*	64	*100.0*
EL	Family carers only	195	*88.2*	36	*87.8*	87	*89.7*	72	*86.7*
	Family and non family home care providers	10	*4.5*	-	*0.0*	-	*0.0*	10	*12.0*
	Non family home care providers only	16	*7.2*	5	*12.2*	10	*10.3*	1	*1.2*
	All home care providers:	221	*100.0*	41	*100.0*	97	*100.0*	83	*100.0*
ES	Family carers only	168	*73.7*	28	*84.8*	88	*75.2*	52	*66.7*
	Family and non family home care providers	30	*13.2*	1	*3.0*	9	*7.7*	20	*25.6*
	Non family home care providers only	30	*13.2*	4	*12.1*	20	*17.1*	6	*7.7*
	All home care providers:	228	*100.0*	33	*100.0*	117	*100.0*	78	*100.0*
FR	Family carers only	44	*25.7*	14	*41.2*	11	*25.6*	19	*20.2*
	Family and non family home care providers	46	*26.9*	3	*8.8*	6	*14.0*	37	*39.4*
	Non family home care providers only	81	*47.4*	17	*50.0*	26	*60.5*	38	*40.4*
	All home care providers:	171	*100.0*	34	*100.0*	43	*100.0*	94	*100.0*
IE	Family carers only	37	*59.7*	10	*76.9*	15	*55.6*	12	*54.5*
	Family and non family home care providers	15	*24.2*	1	*7.7*	7	*25.9*	7	*31.8*
	Non family home care providers only	10	*16.1*	2	*15.4*	5	*18.5*	3	*13.6*
	All home care providers:	62	*100.0*	13	*100.0*	27	*100.0*	22	*100.0*
IT	Family carers only	164	*73.5*	16	*66.7*	55	*78.6*	93	*72.1*
	Family and non family home care providers	35	*15.7*	1	*4.2*	3	*4.3*	31	*24.0*
	Non family home care providers only	24	*10.8*	7	*29.2*	12	*17.1*	5	*3.9*
	All home care providers:	223	*100.0*	24	*100.0*	70	*100.0*	129	*100.0*
NL	Family carers only	28	*23.5*	4	*11.8*	10	*32.3*	14	*25.9*
	Family and non family home care providers	13	*10.9*	1	*2.9*	2	*6.5*	10	*18.5*
	Non family home care providers only	78	*65.5*	29	*85.3*	19	*61.3*	30	*55.6*
	All home care providers:	119	*100.0*	34	*100.0*	31	*100.0*	54	*100.0*
PL	Family carers only	209	*100.0*	8	*100.0*	48	*100.0*	153	*100.0*
	Family and non family home care providers	-	*0.0*	-	*0.0*	-	*0.0*	-	*0*
	Non family home care providers only	-	*0.0*	-	*0.0*	-	*0.0*	-	*0*
	All home care providers:	209	*100.0*	8	*100.0*	48	*100.0*	153	*100.0*
SE	Family carers only	45	*54.9*	9	*64.3*	11	*52.4*	25	*53.2*
	Family and non family home care providers	12	*14.6*	1	*7.1*	3	*14.3*	8	*17.0*
	Non family home care providers only	25	*30.5*	4	*28.6*	7	*33.3*	14	*29.8*
	All home care providers:	82	*100.0*	14	*100.0*	21	*100.0*	47	*100.0*

Source: own elaboration using SHARE 2006/2007 data

Table A3. Affordability of residential care, publicly subsidized (default) or private (indicated)

Country	Year	User fee, Euro	Median net income of 65+ person living alone, for the same reference year as in (1), €/month	Ratio aver	Ratio min	Ratio max
(1)	(2)	(3)	(4)	(3)/(4)	min fee/ (4)	max fee/ (4)
AT	2006	* €500 -€1200/month	1208.67	-	0.41	0.99
BE	Na	na	na	na	na	na
BG	2008	*€73-€83/month *€350-€400 /month (private)	94.42 94,42	- -	0.77 3.71	0.88 4.24
CY	2008	744 (min for private)	663.50	-	1.1	
CZ	2005	6000 CZK (≈€240) / month	251.17	0.96	-	-
DE	2009	Level I: €1577-€1977/month (plus €1023 covered by insurance) Level II: €1721-€2721 /month (plus €1279 covered by insurance)	1244.17	- -	1.27 -	- 2.19
DK	2009	10-20% of income for housing. Meals and laundry are paid extra, on average ≈€ 700-1000/month	1436.08	-	0.59	0.88
EE	2009	Nursing hospitals: €182/month since 1 Jan. 2009 (free before). Care homes: €320-770 (up to €1086)/month (private)	241.83	0.76 -	- 1.32	- 4.49
EL	2009 2005	Free **€470-€1500 /month (private)	589.17	-	0.80	2.55
ES	2008	Maximum €1145/month. Can be free. ***	700	-	-	-
FI	2010	(***) At most 85 % of net income with at least €97 left for own consumption. Estimated average: ≈€887/month	1043.75	-	- -	- 0.85
FR	2003	**€1050-1400/month	1095.58	-	0.96	1.28
FYROM	2009	€200/month €350-400/month (private)	na	-	-	-
HR	2009	€350/month €700/month (private)	na	-	-	-
HU	2006	***€100-230 (average ≈€150) /month	268.42	0.56	-	-
IE	2009	Fee is fixed at 80% of income	1176.92	0.80	-	-
IS	2009	Max €1590 (280,000 ISK)/month. Can be also free of charge	1732.58	-	-	0.92
IT	2005	€1065/month	998.92	1.07	-	-
LI	Na	na	na	-	-	-
LT	2009	*€430-740/month. There are also big regional differentials.	194.08	-	2.2	3.8
LU	2009	Min €1437/month	2484.75	-	0.60	-
LV	2009	Max 90% of pension [€233/month], thus equal ≈€210/month, the rest is paid by family or municipality.	162.5	-	-	1.3
MT	2004	Max €31.45/day	584	-	-	1.62

NL	2003	** €42/week for care home and €48/week for nursing home care. (***)	1251.75	-	-	-
NO	2009	Max 85% of income	1827.75	-	-	0.85
PL	2007	Estimated average: €214(840 PLN)/month based on average retirement income in 2007. Maximum: €450 (1765 PLN) /month based on 250% ceiling of lowest guaranteed pension.	296	0.72 -	- -	- 1.52
PT	2009	*,** Can be free. If paid, Minimum: €50-170/month Maximum: €360-712/month	454.5	-	-	-
RO	2009	**€45-70/month	113.67	-	0.40	0.62
SE	2009	*Maximum €417 /month = €170 (1696 SEK)/month base fee +€247 (2500 SEK)/month fee for food + rent [housing costs vary depending on size, but most residents receive a housing allowance for pensioners].	1119.42	-	-	0.37
SI	2009	*€570 /month for disability level I, €712/month for disability level II, €855 /month for disability level III and €978 /month for disability level IV.	568.42	-	1	1.72
SK	2009	**, ***€150-300 /month **, ***€350-400/month (private)	279.08	- -	- -	- -
TK	2009	€190-390 /month	na	-	-	-
UK	2005	€477/week or €2065 /month	1234.75	1.67	-	-

Notes: The range of fees may refer to
* different levels of disability,
** different type or quality of facilities/services;
*** different income levels (means-tested);
(***) household type and income.
na - information is not available.

Sources: Eurostat online database for the median net income of 65+ person living alone.
National reports of the EGGE network for fees: **AT** - Österle (2006), quoted in Mairhuber (2010); **BG** - Beleva (2010); **CY** - Ellina (2010); **CZ** - Křížková (2010); **DE** - Maier and Karl (2010); **DK** - Sjørup(2010); **EE** - Karu (2010); **EL** - Karamessini (2010); **ES** - The elders in Spain 2008 report, quoted in González Gago (2010); **FI** - Sutela (2010), figures obtained via personal consultation with special advisor Anne-Mari Raassina from the Ministry of Social Affairs and Health (March 2010); **FR** - Silvera (2010); **FYROM** - Androsik (2010), figures obtained via personal interview with the representative of NGO HUmanost, Ms. Donevska (June 2010); **HR** - Mrnjavac (2010); **HU** - Frey (2010); **IE** - Barry (2010); **IS** - Hrafnista, Reykjavík, Tryggingastofnun ríkisins, quoted in Johannesson (2010); **IT** - N.N.A. (2009), quoted in Bettio and Verashchagina (2010); **LT** - Ministry of Social Security and Labour quoted in Braziene (2010); **LU** - Rapport général du Ministère de la Sécurité Sociale 2008, quoted in Plasman (2010); **LV** - Rastrigina (2010); **MT** - Camilleri-Cassar (2010); **NL** - Eggink et al. (2009), quoted in Plantenga and Remery (2010); **NO** - Ellingsæter (2010); **PL** - Plomien (2010); **PT** - Ferreira (2010); **RO** - Albu (2010); **SE** - Nyberg (2010); **SI** - Ministry of Labour, Family and Social Affairs, quoted in Kanjuo-Mrčela (2010); **SK** - Piscová and Bahna (2010); **TK** - Ozar (2010); **UK** - Commission for Social Care Inspection (CSCI 2005), quoted in Fagan (2010).

Table A4. Leave and flexible time provisions to care for older persons

Country	Name of provision (in action)	Paid (replacement rate) / Unpaid	Full-time/ part-time	Min/Max duration	Motivation/eligibility
AT	Family hospice leave system (since 2002)	Unpaid	Full-time	Max 3 months, can be extended up to 6 months.	Right granted to care for a dying relative.
BE	Leave for medical assistance	Unpaid	Full- or Part-time	1-3 months Full time leave can be extended to 12 months, part-time to 24 months.	Right granted to care of a household or family member with a serious illness (medical certificate required). Normally not conditional on approval of employer, except for firms with less than 10 or 50 employees for which different restrictions apply.
	Leave for palliative care	Lump-sum. Amount varies with type of leave, sector, seniority and size of firm. In 2008 full-time leave up to €627.88 p.m. May be topped up by care credits.	Full-time, half-time or at a rate of 1/5	1 month, can be extended for another month.	Right granted to care of a person with an incurable disease who is approaching the end of his/her life (medical certificate required). There does not necessarily need to be a family tie with the person cared for.
	Leave for compelling reasons	Unpaid	Full-time	10 days (more in unionized sectors)	Right granted in the event of Hospitalisation, illness or an accident of someone who lives under the same roof as the employee (child, spouse, parent).
	Leave without pay	Unpaid	Full-time	On agreement	Employees can take a leave without pay for a certain period. Conditional on approval by employer
	Time credit in private sector / Career interruption in public sector (since 2002, extended in 2007)	The state offers compensations for loss of pay to beneficiaries of time credits. For f-t employee the amount is proportionally reduced according to working hours. 1/2 leave: below 50 y.o. - €371/month; 50+ y.o. - €629 /month. 1/5 leave: below 50 y.o. - 126 €/month, below 50 y.o. and single parent - 169 €/month, 50+ y.o. - 252 €/month.	Full- or part-time	3 months to 1 year for full-time or part time options. For 1/5^{h} part-time or employment suspension 6 months to 5 years (until retirement in large firms).	In the private sector no more than 5 % of the employees in a firm can use it at the same time. Other eligibility restrictions are based on seniority. Conditional on approval by employer.
BG	Care leave	Paid	Full- or part-time	Up to 40 working days	Right granted in the event of illness of family member, including old person.
CY	Leave on grounds of *force majeur*	Unpaid	Full-time	Max 7 days per year	Right granted in the event of Illness or accident that involves dependent person.
CZ	Leave for care of family	≈ 60 % of daily wage paid for six	Full-time	Max 9 days, renewable	Right granted in the event of Illness of family member.

	member	calendar days		(there is no yearly Max).	
DE	Short care leave	Often unpaid ()paid only if it is included in the contract or makes part of a collective agreement.	Full-time	Max 10 days	Right granted in the event of unexpected care need. Applies to all employees regardless of firm size.
	Long care leave	Unpaid, but deemed contributions are paid	Full- or Part-time	Max 6 months	Right granted to care for more than 14 hours a week and when part-time work is less than 30 hours a week. Ensures the right to return to work under the same terms. Only for firms with mote than 15 employees.
DK	Care leave	€ 2566 per month (paid by municipality)	Full-time	Max 6 month	Right granted to care for a close relative, primarily a spouse, child or parent. Taken up more often for care of children.
EE	Care leave	Benefit is 80% of the wage	Full-time	Max 7 days	Right granted to care for an ill adult family member.
EL	Leave for sickness of elderly dependents	Unpaid	Full-time	Max 6 days per year	Right granted to full-time workers in the public or private sector or working married couples. If users are spouses, they may take the leave one at a time.
ES	Care leave	Unpaid, but deemed contributions are paid for the first year	Full-time	Max 2 years	Option granted to take care of dependent relatives. The care leave is conditional on approval by employer for workers of the private sector in the case that two or more workers of the same company demand it at the same time and if there are productive reasons that can be argued. In the case of public servants there is not such a condition.
	Work hours reduction	Proportional reduction in pay	Part-time	No limit	Right granted to family carers to reduce their working hours to take care of dependent relative. The reduction is limited to a min of 1/8 and a max of 1/2 in the private sector. In the case of public servants, the limit is established depending on administration.
FI	Job alternation leave	70-80% of the unemployment benefit or earnings-related unempl. benefit	Full-time	Max 12 months	Right granted to full-time working wage and salary earners in employment for at least 10 years (the last 13 months with the same employer).
	Part-time for health or social reasons	Part-time supplementary benefit	Part-time	Benefit paid for up to 12 months	Option to reduce working hours for social or health reasons. Conditional on approval by employer.
	Leave for urgent family reasons	Mostly unpaid	Full-time	Temporary, upon agreement	Right granted in the event of Illness, accident or other unforeseeable incidence requiring the presence of the person in question.
	Flexible working time	Pay in proportion to work-hours	Full-time and part-time	No limit after entry into the scheme	Right granted and widely in use in Finnish workplaces and can be motivated by care of an elderly.
FR	Family Solidarity Leave	There is an allowance that can be used for 3 weeks - €47/day.	Full-time	3 months (renewable once)	Right granted to look after people who are at the end of their lives.
FYROM	na	na	Na	na	na
HR	Short-term leave	Unpaid	Full-time	Up to 7 days	Right for important reasons, such as own marriage, serious illness or death of a

					family member.
HU	Care leave	Nursing allowance (100-130% of the old age pension plus deemed contributions.	Full-time	No limit in practice. The duration is decided by the body of representatives of the local government and that of the Institute of Rehabilitation and Social Expert Services.	Right granted to employees providing full-time care to family members who are disabled or under 18 years of age and permanently ill.
IE	Care leave	Unpaid, but there is a possibility to ask for carers benefit until 65 weeks and carers allowance after that.	Full- or part-time	13 to 65 weeks	Right granted to the person who takes care of a dependant.
	Homemakers Scheme, (since 1994)	Pays deemed contributions			Periods spent providing full-time care to children up to 12 years of age or an incapacitated person; gives entitlement to deemed contributions
	Career Breaks	Unpaid	Full-time	Max 5 years	Option available to public sector workers for educational, care responsibilities or other reasons. Flexi-time working is also available to public -sector workers. May be conditional on employer's approval
IS	Care leave	Mostly unpaid. Sometimes funds run by unions are open for applications for cash transfers.	Full-time	Max 3 months	Severe illness of husband/wife.
IT	Short duration leave	Paid	Full- or part-time	Up to 3 days per year	Right granted upon medical certification of disability of family member.
	Leave for family reasons	Paid or Unpaid	Full-time or part-time	2 years all together during the working life of a person	The right to the leave to care of disabled children was recently extended to parents of live-in children. There must be no 'suitable' alternative carer and disability must be certified
LI	na	na	Na	na	na
LT	na	na	Na	na	na
LU	na	na	Na	na	na
LV	Short care leave	Paid	Full-time	Upon agreement	The right is given to somebody providing care to the sick family member.
	Flexible working time	-	-	-	Flexible working time schemes can be negotiated directly between employees and employers.
MT	Responsibility leave	Unpaid	Full-time	Not less and not more than 1 year at a time. Max 8 years during the whole working life.	Right granted to public employees to take care of dependent elderly parents, sons and daughters, or spouses if no other live-in carer is available. Certification of care need is required and minimum seniority restrictions apply.
NL	Short duration leave	Paid	Full-time	Max 10 days/year	Right granted to care for a sick parent, partner or child

	Long-term leave	Unpaid	Part-time	Six time working hours per week.	For employees whose child, parent or partner got life-threatening illness.
	Reduced work hours	Pay in proportion to hours worked	Part-time	No limit	Right of every employee to request a reduction of working time within the context of the Working Hours Adjustment Act . S/he must have worked for the firm for at least 1 year.
NO	Care leave	Unpaid	Full-time	Max 10 days	Unconditional right granted to care for a close relative (parent, spouse/partner).
	Reduced Hours/ Flexitime	-	-	-	Right to reduce working hours in relation to care. Flexible working hours are used in mild/moderate stages of disability.
PL	Care leave	Care allowance is paid for a max of 2 weeks; replacement rate is 80%.	Full-time	Max 2 weeks	Right granted in order to care for a sick / elderly family member if no other family member can provide such care. Not intended for LTC provision.
PT	Leave to assist spouse	Paid: 100% replacement rate in public sector. In private sector varies.	Full-time	Max 30 days per year	Right granted to public sector employees to care for a spouse/partner with chronic illness or incapacitated (for both formally married or de facto unions). In the private sectors eligibility conditions and the amount of the allowance vary depending on collective agreements.
	Leave to assist family members	Paid: 100% replacement rate in public sector. In private sector varies.		Max 15 days per year	Right granted to all wage workers in order to take care of sick spouses or other close relatives (father, mother, sisters, brothers, sisters and brothers-in-law).
RO	Leave to care for an elder	Paid. The amount corresponds to the initial gross wage of a social worker. Funded by local government.	Part-time [half working time]	No limit, depends mainly on the availability of the local budget funds.	Right granted to care for husband/wife or an older dependent relative.
	Flexible hours	-	-	-	Flexitime has been introduced by the collective 2007-10 agreement.
SE	Care leave	Benefit from a Social Security Agency.	Full-time	Max 100 days	Right granted to care for closely related and seriously ill person.
SI	Care leave	Paid: 100% replacement rate	Full-time	Max 7 days/year	Leave to care for a family member is defined as worker's right.
	Flexitime	-	-	-	Flexitime arrangements are possible.
SK	Care scheme	Unpaid, but a subsidy is provided in the amount of max €198 /month.	Full-time		The right for somebody taking care of other family member with disability.
TK	na	na	Na	na	na
UK	Flexible working hours, since 2007	-	-	-	The Right to request flexible working was extended to include employees with elder care responsibilities; previously it was only available to parents of dependent children. Employees are required to consider such requests seriously, although they can be refused. Only one application can be made per year and any alteration constitutes a permanent change of contract.

Sources: national reports of the EGGE network.

Table A5. Pay for care workers and professionals by types of services and level of qualification

Country (1)	Year (2)	Type of services (3)	Qualification (4)	Wage data Type (5)	Gross pay, average or range of min-max based on skill/experience (6)	OECD AW¤, €/month (7)	Ratio aver (6)/ (7)	Ratio min min pay/(7)	Ratio max max pay/(7)
AT	2009	Residential	Basic	Pb, C, NE	€1366 – 1770 /month [ft]	3149	-	0.43	0.56
			Nurse	Pb, C, NE	€1650 – 2700 /month [ft]		-	0.52	0.86
	2009	Home	Basic	Pb, C, NE	€1366 – 1770 /month [ft]	3149	-	0.43	0.56
			Nurse	Pb, C, NE	€1650 – 2700 /month [ft]		-	0.52	0.86
BE	na	na	na		na	na	na	na	na
BG	na	na	na		na	na	na	na	na
CY ¥	2008	Residential	Basic	Pb, C	min €743 /month	1861	-	0.40	-
		Home	Basic	Pr, A	€300-350 /month+food and accommodation	1861	-	-	-
CZ	2008	Residential	Basic	Pb&Pr, A	M: €695 /month F: €610 /month	758	0.92 0.80	-	-
			Nurse	Pb&Pr, A	M: € 966 /month F:€ 930 /month	758	1.27 1.23	-	-
	2008	Home	Basic	Pb&Pr, A	M: € 625 /month F: € 620/month	758	0.82 0.82	-	-
			Nurse	Pb&Pr, A	M: € 966 /month F:€ 930/month	758	1.27 1.23	-	-
DE	2006	All care services/ institutions	Basic	Pb&Pr, A	M: € 2656/month F:€ 2130/month	3578	0.74 0.60	-	-
	2006	All care services/ institutions	Nurse	Pb&Pr, A	M:€ 2947/month F:€ 2.410/month	3578	0.82 0.67	-	-
DK	2007	Residential	Basic	Pb, A	€ 27 /hour	3874	1.20 [fte]	-	-
			Nurse	Pb, A	€ 32 /hour	3874	1.42 [fte]	-	-
	2007	Home	Basic	Pb, A	€ 27 /hour	3874	1.20 [fte]	-	-
			Nurse	Pb, A	€ 32 /hour	3874	1.42 [fte]	-	-
EE	2008	Residential	Basic	Pb&Pr, A	€ 478/month	725	0.66		
			Nurse	Pb&Pr, A	€ 793/month	725	1.09		
EL *	2010	Residential	Basic	Pb, C	€ 769-839/month	2036	-	0.38	0.41
			Nurse	Pb, C	€ 813-946 /month	2036	-	0.40	0.46
	2010	Home	Basic	Pr, A	€ 750-850 /month	2036	-	0.37	0.42
			Nurse	Pr, A	€ 800-100 /month	2036	-	0.39	0.49
ES ¥	2008	Home	Not specified	Pb, C, NE	Min € 849.37 /month, extra hours are paid at € 11.72 /hour.	1935	-	0.44	na
FI	2009	Not specified	Basic ISCO 513	Pb&Pr, A Pb, A Pr, A	M: € 2396 /month F: € 2110 /month T: € 2135 /month T: € 2094 /month	2888	0.83 0.73 0.74 0.73	-	-
	2009	Not specified	Nurse ISCO 523	Pb&Pr, A Pb, A Pr, A	M: € 2911/month F: € 2644 /month T: € 2678 /month T: € 2539 /month	2888	1.01 0.92 0.93 0.88	-	-
FR	2005	Home	Basic	Pb&Pr, A	≈€ 1014/month	2659	≈0.38	-	-
	2008	Home	Nurse	Pb&Pr, A	€ 1300 /month [ft]	2659	0.49	-	-
FYROM	2009	Residential	Nurse	Pb, A Pr, A	€ 300-400 /month ≈€ 400 /month	na	-	-	-
		Home	Not specified	Pr, A	€ 100-250 /month	na	-	-	-
HR	2009	Residential	Basic	Pr, A	€ 480 /month (*net*)	na	-	-	-
			Nurse	Pr, A	€ 550 /month (*net*)	na	-	-	-
HU	2008	Residential	Basic	Pb, A	€ 390 /month	715	0.55	-	-
			Nurse	Pb, A	€ 520 /month	715	0.73	-	-
	2008	Home	Basic	Pb, A	€ 350 /month	715	0.50	-	-

			Nurse	Pb, A	€ 430 /month	715	0.60	-	-
IS	2007	Residential	Basic	Pb, A	€ 3600-4680 /month§	3606	-	1	1.30
			Nurse	Pb, A	€ 6925 /month	3606	1.92	-	-
	2009/ 2010	Home (the capital)	Basic	Pb, A	€ 1380-3500 /month§	3606	-	0.38	0.97
			Nurse	Pb, A	€ 4200 /month	3606	1.16	-	-
IE	2009	Residential	Basic	Pb&Pr, A	€ 14 /hour	2729	0.88 fte	-	-
			Nurse	Pb&Pr, A	€ 15 /hour	2729	0.95 fte	-	-
	2009	Home	Basic	Pb&Pr, A	€ 12 /hour	2729	0.76 fte	-	-
			Nurse	Pb&Pr, A	€ 25 /hour	2729	1.58 fte	-	-
IT	2009/ 2007	Residential	Basic	Pb, C, NE	€ 1128/month	2192	0.51	-	-
			Nurse	Pb, C, NE	€ 1722-2149 /month	2101	-	0.82	1.02
	2009/ 2007	Home	Basic	Pb, C, NE Pr, C	€ 1228 /month € 882 /month †	2192 2101	0.51 0.42	- -	- -
			Nurse	Pb, C, NE	€ 1722-2149 /month	2101	-	0.82	1.02
LI	na	na	na	Na	na	na	na	na	na
LT	2009	Residential	Not specified	Pb&Pr, C	€ 507-637 /month	527	-	-	-
LU	na	na	na	Na	na	na	na	na	na
LV	2009	Residential	Not specified	Pb, A Pr, A	M: € 437 /month F: € 440 /month M: € 592 /month F: € 400 /month	558	0.78 0.79 1.06 0.72	-	-
	2005	Home	Basic (personal care worker)	Pb&Pr, A	T: € 177/month; M: € 156/month F: € 179/month	558	0.32 0.28 0.32	-	-
MT	2009	Residential	Social assitant (semi-skilled)	Pb, C	€ 696-796 /month [€ 8356-9546 /year]	1398	-	0.50	0.57
	2009	Home	Social assitant (semi-skilled)	Pr, A	€ 297 /month [€ 68.66 /week]	1398	0.27	-	-
NL *	2005	Residential or Home	Basic	Pb, A	€ 11-14 /hour	3414	-	0.55 fte	0.71 fte
			Nurse	Pb, A	€ 21 /hour	3414	1.06 fte	-	-
NO *	2009	Municipal care worker	Basic: home help	Pb, A	€ 3075/month	4376	0.70	-	-
			Nurse	Pb, A	M: € 3694 /month F: € 3686 /month	4376	0.84	-	-
PL	2008	Residential or Home	Basic	Pb, A Pr, A	M: € 518 /month F: € 468 /month Priv. :M: € 441 €/month F: € 436 €/month	711	0.73 0.66 0.62 0.61	-	-
	2008		Nurse	Pb, A Pr, A	M: € 753 /month F: € 728 /month M: € 723 /month F: € 622 /month	711	1.06 1.02 1.02 0.87	-	-
PT	2008	Residential or home	Basic (Operational assistant)	Pb, A	€ 426-814/month	1341	-	0.32	0.61
			Social workers (semi-skilled)	Pr, A	M: € 758-988 /month F: € 630-821 /month	1341	-	0.56 0.47	0.74 0.61
RO	2009	Home	Basic	Pb, A	€ 175 /month	455	0.38	-	-
			Nurse	Pb, A	€ 300 /month	455	0.66	-	-
SE	2009	Municipal care employee	Basic	Pb, A	M: € 1 814 /month F: € 1 825 /month	3034	0.6 0.6	-	-
			Nurse	Pb, A	M: € 2 495 /month F: € 2 455 /month	3034	0.82 0.81	-	-
SI	2010	Residential	Basic	Pb&Pr, A	€ 1130 /month	1219	0.93	-	-
	2006		Nurse	Pb&Pr, A	€ 1313 /month ft	1219	1.08	-	-
	2010	Home	Basic (soc. careworker)	Pb&Pr, A	€ 1100 /month	1219	0.90	-	-
SK	2008 2010	Residential	Not specified	Pb, A Pb, A	€ 459 /month € 531/month	607	0.76	-	-

	2010	Not specified	Nurse	Pb, A	€ 600 -685 €/month depending on type of facility (social or health service)	607	-	1	1.13
TK	2010	Residential	Basic	Pb&Pr, A	€ 300-500 /month (*net*)	1569	-	-	-
			Nurse	Pb&Pr, A	€ 400-800 /month (*net*)	1569	-	-	-
	2010	Home	Basic	Pb&Pr, A	€ 100-450 /month (*net*)	1569	-	-	-
			Nurse	Pb&Pr, A	€ 600-1500 /month (*net*)	1569	-	-	-
UK	2009	Residential	Not specified	Pb&Pr, A	€ 15.6 /hour [£9.74/hour] (houseparents & residential wardens)	3977	0.67 [fte]	-	-
	2009	Home	Basic (home carers & assistants	Pb&Pr, A	€ 12.7 /hour [£7.93 /hour]	3977	0.55 [fte]	-	-
			Nursing auxiliaries & assistants	Pb&Pr, A	€ 14.5 /hour [£9.07 /hour]	3977	0.63 [fte]	-	-

Notes: M – men, F – women., T- total. [ft]= full-time. [fte]= full-time equivalent estimate assuming 40 hours per week.
Wage data type: Pr - private sector, Pb - public sector, A - actual, C - contractual, NE- no extras, i.e. basic pay.
Pb&Pr means that the average for the two sectors is reported.
*** EL:** 'Care worker' is not a recognized occupation in residential homes. The first figure refers to chambermaids and the second to cleaners, food servers and linen washers. **NL:** Differences between home care and nursing home care are presumably small.
NO: Care workers in the municipal sector; not possible to differentiate between home care and nursing home care as many municipalities have integrated services/employment. Owing to compensation for shift work, nurses earn more.
§ IS: the lower figure is for basic-skill workers, the higher for semi-skilled workers.
† IT: Contractual monthly wages inclusive of board and lodging allowance for privately employed care workers called 'family assistants'.
¥ CY: For residential care € 743 /month is the minimum wage when first hired, which is increased to 789 after six months with the same employer. This minimum wage covers the category of 'nursing aid'. For home care, € 300-350/month+ food/accommodation is a standard contract (prepared by the Immigrations dept) only for third-country migrants on temporary 4-year contracts. **ES:** the level of pay may vary by region and is much lower for irregular workers (even below the minimum wage).
The 2008 OECD data on average wages was also used for later years.

Sources: OECD data on average wages, national reports by the EGGE network for the data on pay.

Table A6. Cash transfers aimed to increase the affordability of care

Country (1)	Provision (2)	Year (3)	Description and amount (4)	Median net income of 65+ person living alone, for the reference year as in (3), €/month (5)	Ratio aver (4)/(5)	Ratio min min/(5)	Ratio max max/(5)
AT	Care allowance *Bundes-pflegegeld*	2009	Tax funded cash benefit scheme covering all groups of people with disabilities and in need of care, irrespective of the reason and the age of the person requiring long-term care. The cash transfer is untied, is paid to the person in need of long-term care but can be passed on to other persons (e.g. family caregivers). For older people in residential care the allowance is paid to the care home, except for pocket money. € 154-1655 /month depending on the intensity of (assessed) care needs. The minimum is for at least 50 hours of care per month, the maximum for 180 hours.	1290.67	-	0.12	1.28
	Respite care allowance	2009	For family members who provide informal care to a partner or close relative but cannot do so temporarily. Means-tested.	1290.67	-	-	-
BE	Aid allowance for the elderly *Allocation pour l'aide aux personnes âgées*	2009	Elderly people (65+) with limited autonomy are entitled to this allowance, if a medical certificate proves the lack of or reduction in the degree of autonomy, and if a number of income criteria are met. The amount depends on the person's degree of autonomy: € 76-507 /month [906.91 - 6087.86 €/year]	1060.92	na	0.07	0.48
BG	Allowance for elderly people	2009	Up to € 12.5 /month	94.42	-	-	0.13
	Disability and personal care allowance	2009	€ 35 /month, for people with 100% disability and personal care.	94.42	0.37	-	-
CY	Care allowance	2008	The amount of allowance depends on the beneficiary's needs for house repairs, extensions and/or house equipment. The maximum grant is €997 /month [€11.960 /year]	663.50	-	-	1.50
CZ	Care allowance	2009	Allowance to buy social services or publicly provided care is given to the person in need of care. The care allowance has four categories of "dependency" or levels of needs of care based on four payment levels. The person in need of care can use the allowance to buy care from the public providers of care and social services or to give it to a caring family member. The care allowance is currently the most direct cash transfer to pay for care services. Amount: 2000-11000 CZK (€ 78-433)/month depending on the level of disability.	352.75	-	0.22	1.23
DE	Care allowance	2009	Care Allowances are regulated under the Long Term Care Insurance. The cash benefits are paid to the person in need, who may reward a family member or others for caring. Care allowance includes several other cash-benefits which may be called vouchers as the person is free to choose the provider. Amount varies by stage of disability and place of care. Home: € 215-675/month. Institution: € 1023-1750 /month.	1244.17	-	0.17	1.41

DK	Care allowance	2009	Allowance to compensate for the family carer. Can be paid for up to 9 months. Amount: € 2566 /month	1436	1.79	-	-
EE	Disability allowance	2008	Paid monthly to a person of retirement age with a disability to compensate for additional expenses caused by the disability and, upon existence of a rehabilitation plan, for the activities prescribed therein. Amount: € 13-41 /month	241.83	-	0.05	0.17
EL	Total unfitness allowance or allowance for care by a third person	2010	Total unfitness allowance or allowance for care by a third person is granted to all non self-sufficient persons receiving disability or survivor pensions who are in need of permanent care from another person. Old-age pensioners who become unfit after their retirement are not entitled to this allowance, except for the blind. Amount: 50% of basic pension.	721	-	-	-
ES	Attendance allowance *Prestacion economica para cuidos en el entorno familia*	2009	Since 2006 the dependent person is entitled to a benefit to pay expenses related to his/her care if there are no public alternatives for the care needed. This benefit is limited to family carers (up to 3rd grade) or friends residing in the same municipality for at least a year and implies the inclusion of the carer in the social security system.	700	-	-	-
FI	Care allowance	2010	Tax free allowance targeted on pension recipients with an illness or disability living at home. Amount depends on the need of assistance and costs: € 57-302/month.	1043.75		0.06	0.29
	Support for informal work	2006 2010	There is a mixed provision of cash benefits and services to a family member or other close person taking care of a person in need of assistance: € 300-600/month, on average 416 €/month (2006). Min € 347/month in 2010	959.92 1043.75	0.43 -	0.31 0.33	0.63 -
FR	Personalised Autonomy Allowance *Allocation personnaliséeà l'autonomie, APA*	2009	The APA is an allowance awarded to the dependent person, who uses it as they desire (paying for help; for a family carer other than their partner; or for an institution). Amount depends on the level of disability: €524.8-1224.6 /month	1290	-	0.41	0.95
	End of life allowance *Allocation fin de vie*	2009	Payable for up to three weeks to people who stop working in order to accompany a close relative near the end of life and living at home. Amount: € 47/day for max 3 weeks.	1290	-	-	0.77
FYROM	Allowance for assistance and care	2009	The allowance for assistance and care by another person is a financial right granted to adults who need assistance and care from another person because they cannot satisfy basic life necessities. The basis for calculation is the average monthly net salary of employees for the previous year. The allowance paid depends on the severity of the disability, the number of family members and the incomes of the family in relation to the average salary as basis. Amount: 23-26% of the basis - average monthly net salary of employees for the previous year.	na	-	-	-

HR	Support for care of disabled persons	2009	Up to € 60/month if HH income per person is not over € 120/month.	na	-	-	0.50*
HU	Nursing allowance	2009	Nursing allowance is paid to persons who provide full-time care to family members who are disabled or under 18 years of age and permanently ill. If carers are entitled to nursing allowance, the period of time spent on caring is taken into account when calculating the service period to old age pension. Amount depends on stage of disability: 100-130% of old-age pension[€ 105/month] or € 105-137/month.	320.92	-	0.33	0.43
IE	Carer's allowance	2010	Paid to carers who meet the requirements of a strict household-based means test. The latter condition and the requirement that an applicant is providing full-time care limits the percentage of carers (27%) who are deemed eligible. Carers who are providing care to more than one person may also be entitled to an additional 50% of the maximum rate of Carer's Allowance. The means test for the Carer's Allowance operates on a sliding scale. Amount: max € 239 /week.	1176.92	-	-	0.88
	Carer's benefit	2010	Paid to people who have been in paid employment, have the required level of social insurance contributions , have recently left the workforce and are providing full-time care. Carer's benefit is paid for a max of 2 years for each person being cared for (continuous period or in any number of separate periods). If one is caring for more than one person, s/he may receive payment for each care recipient for 104 weeks. Amount: max € 213/week	1176.92	-	-	0.78
IS	Pensions for taking care of elderly	2010	Pensions for taking care of the elderly is paid if the husband/wife of an elderly person needs to reduce or quit work to help the elderly. Only paid if the receiver does not receive a pension him/herself. ≈ € 560/month.	1732.58	0.32	-	-
IT	Attendance allowance. *L'indennita di Accompagna-mento*	2008	Provided to all disabled persons, not only elderly, it is a national cash benefit scheme paid for by the National Social Security Institute (INPS) to people assessed to suffer from disabilities that prevent them from performing ADL. This benefit is not means tested but is conditional on certification of (severe) disability by the Health authorities. Amount: € 465/month	998.92	0.47	-	-
	Care allowance *Assegno di cura*	2008	Financed by municipalities or National Health Service Units (Aziende Sanitarie Locali, ASL). It is paid either in cash or tax credit form, means tested and tested for psycho-physical needs. The amounts vary considerably among granting institutions.	998.92	-	-	0.25
LI	Helplessness allowance *(Hilflosenent-schädigung)*	2009	Helplessness allowance is a cash benefit provided in case of sickness and granted according to three categories of disability. Amount: 456CHF(€ 299)-912CHF(€ 598)/month.	na	-	-	-

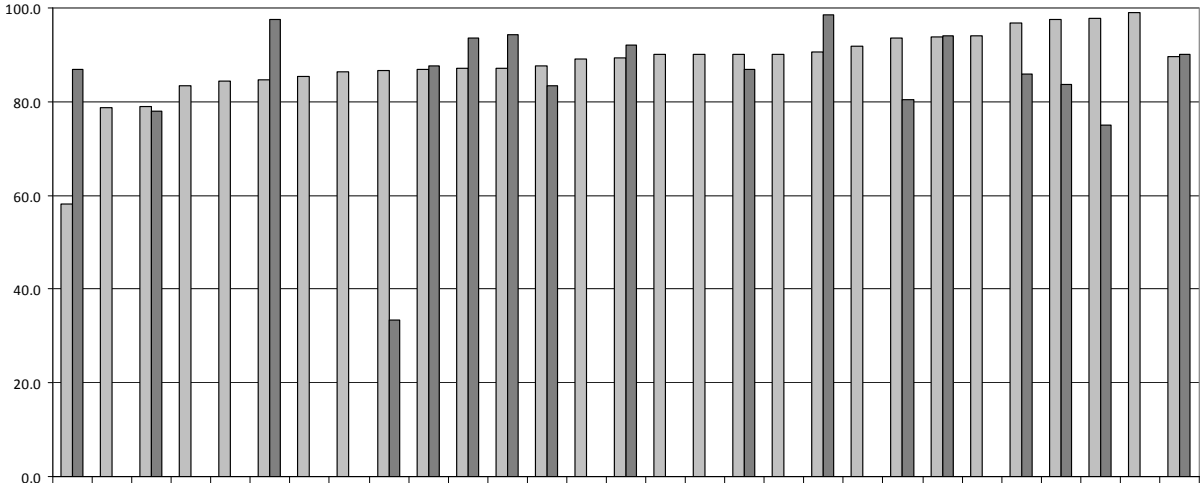
LT	Care allowance	2009	A caregiver to a fully disabled person, or a trustee of a person, determined by the State to be fully disabled, is socially insured at the expense of the state and thus entitled to a basic pension (except for cases where such an individual is already a recipient of social or state pension). € 250/month is an average pension.	194.08	-	-	-
LU	LTC Insurance Attendance allowance or nursing allowance (Huber)	2009	The LTC Insurance foresees a cash benefit to fund the informal carer. The applicant must have a strong need for regular assistance by another person for ADL. This assistance must reach at least 3.5 hours per week and the dependence should last six months (at least) or be irreversible. One of the main advantages of the LTC Insurance is the possibility for the elderly person to benefit from financial help and/or aid in kind to the amount of the guaranteed minimum income: € 1198.67 /month.	2484.75	0.48	-	-
	Attendance allowance	2009	Elderly persons can benefit from an allowance if they are dependent, which needs to be evaluated by doctor. As the dependency is declared, the amount is a function of the needs. Recipients cannot be older than 65.	2484.75	-	-	-
LV	Benefit for a Disabled Person In Need Of Care	2009	The benefit is granted if a person has a status of disabled and has been acknowledged to need special care. Amount: 100 LVL (€ 143)/month. It is provided to a restricted number of people with severe disabilities.	162.50	0.88	-	-
MT	Care allowance	2009	Social assistance is provided for somebody taking care of a relative on a full-time basis if the household does not include another person who is not in employment. Amount: max € 90.93 /week=€ 391/month	584	-	-	0.67 -
	Disability pension	2009	Amount: the highest rate is € 86.58/week=372€ /month	584	-	-	0.64
NL	Personal Budget *Persons-gebonden budget, PGB*	2009	A person who is entitled to (formal) care has the option to receive it in the form of a personal budget (*PGB, persoonsgebonden budget*). This budget is, however, only available for certain types of care (nursing, general care and guidance). Treatment or institutional accommodation is excluded. Average amount: 65-74 y.o.- € 1279/month, 75-84 y.o.- € 1345/month, 85+ y.o.- € 1707/month.	1357.08	- 0.94 0.99 1.26	- - - -	- - - -
	Informal care complement	2009	Max € 250 /year, for non-residential care only.	1357.08	-	-	0.18
NO	Care allowances *Omsorgslønn*	2009	Persons carrying out particularly burdensome care work for elderly, sick and disabled people in their home may apply for care allowances from the municipality. Usually limited to 3-10 hours weekly.	1827.75	-	-	-
PL	Nursing benefit	2010	Paid to a person who has resigned from paid employment to care for a disabled. Carers entitled to pension / social assistance benefits are not eligible or if the cared-for person is married or resident in a care facility. Amount: 520 PLN (€ 133)/month.	296	0.45	-	-
	Nursing allowance	2010	Granted to a dependent person with severe disability	296	-	0.13	0.16

PT	Long Term Care Supplement	2009	Benefit granted by the Social Security Department to pensioners in need of care which can be used to pay for services or to receive services in-kind. The amount is determined according to the degree of disability and corresponds to an established percentage of the social pension: 45-90%.	454.5	-	-	--
RO	Allowance for personal assistance	2010	Severely disabled people, including elders, have the right to an allowance for personal assistance. Amounts to at least the minimum wage at country level, € 125/month in 2010.	na	-	-	-
SE	Employment to care for fam. member *Anhöriganställning*	2009	A person taking care of a relative is employed by the local authority with a salary comparable to a nurse's aide.	1119.42	-	-	-
SI	Care allowance	2007	Municipalities subsidize at least 50% of costs of home care. Average subsidized price for home care (paid by user) was in 2007, € 4.3/hour, while the full cost of the service was on average €13,9 /hour. Amount: (13.9-4.3)*20 [for average hours of home care].	568.42	-	0.34	-
	Disability allowance	2009	Varies by degree of disability: from € 142,6 to € 407,6 /month.	568.42	-	0.25	0.72
SK	Financial contribution for disabled	2008	Granted only to severely disabled persons and is divided in 2 categories: 1) personal assistance, indispensable requisites for transport, buying a car, adjustment of the apartment or house; 2) dietary feeding, motor vehicle operation, providing care. Amount: 1) varies according to the level of disability and income/pension of recipient; (Range: € 62-449 /month Table.3 in the report) 2) normatively defined according to the law.	279.08	-	0.22	1.61
TK	Old age allowance	2008	Provided to those aged 65+ without any liable caregiver, not entitled to pension benefit, in poverty and deprivation (as of 01/07/2008 receiving monthly income below 83,08 TL).	na	-	-	-
	Social Solidarity Fund	2010	Cash transfers are allocated to families from the Social Solidarity Fund to care for the elderly and disabled, subject to the condition that the carer does not work outside the home and his/her per capita income is less than two-thirds of the minimum wage. Amount: up to 2 times the minimum wage.	na	-	-	-
UK	Attendance allowance	2010	Is a tax free payment for people aged 65 or over who have personal care needs due to physical or mental disability for at least six months. Amount: £47.1 -70.4 (€ 56.3 -84.2) /week depending on the level of disability.	1234.75	-	0.20	0.29
	Carers allowance	2010	Paid to someone who looks after a friend, relative or neighbour for at least 35 hours/week. The carer must be over 16 y.o., not studying for more than 21 hours /week, not earning more than £95/week. Basic rate is £53.10 (€ 63.6)/week.	1234.75	0.22	-	-

Sources: National reports of the EGGE network.

Appendix of Figures

Figure A1. Female share among care workers and nurses



	MT	SI	EL	CZ	IT	HU	RO	AT	LU	SE	DK	NO	SK	DE	IE	FR	BG	ES	UK	PL	LV	PT	FI	HR	BE	NL	CY	EE	EU27
isco_513	58.1	78.6	78.9	83.5	84.5	84.7	85.5	86.3	86.7	87.0	87.1	87.1	87.7	89.2	89.4	90.0	90.1	90.1	90.1	90.7	91.8	93.5	93.7	94.1	96.7	97.5	97.9	99.0	89.6
isco_223	86.9		78.1			97.5			33.5	87.6	93.5	94.4	83.3		92.1			86.8		98.4		80.3	94.0		85.9	83.6	75.0		90.0

Note: isco_513 stands for Personal care and related workers; isco_223 stands for Nursing and midwifery professionals.
Source: own calculation using LFS 2007 data.

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