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Assessing Needs of Care in European Nations

INFORMAL CARE PROVISION IN EUROPE: REGULATION AND PROFILE OF PROVIDERS

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Abstract

This report investigates regulations for the provision of informal care in 21 member states of the European Union. We focus on the comparison of public support for informal care, and compare in detail the monetary benefits that can be used to finance informal care. Additionally, we use SHARE data to compare characteristics of informal carers in a subset of countries, looking at how much care and what kind of care is being provided, and the relationship between the carer and the care recipient. Finally, we contrast characteristics of informal care provision with existing typologies of long-term care systems.

Our review shows that almost all the countries studied offer some kind of cash benefit that can be regarded as a support to finance long-term care provided by informal carers. More than half of all countries studied provide a payment directed to the recipient of care, and slightly more countries offer payments directed to informal carers. We find an overlap of ten countries where both informal carers and recipients of care can be eligible for some kind of payment. There is, however, broad variation regarding the amount of support provided: very few countries provide benefits that can be seen as a substitute for other paid employment, and some countries provide rather low payments that are more symbolic in value.

Keywords: informal care, long-term care, benefits, European overview.

SEVENTH FRAMEWORK PROGRAMME

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Contents

List of Figures

List of Tables

Informal Care Provision in Europe: Regulation and Profile of Providers

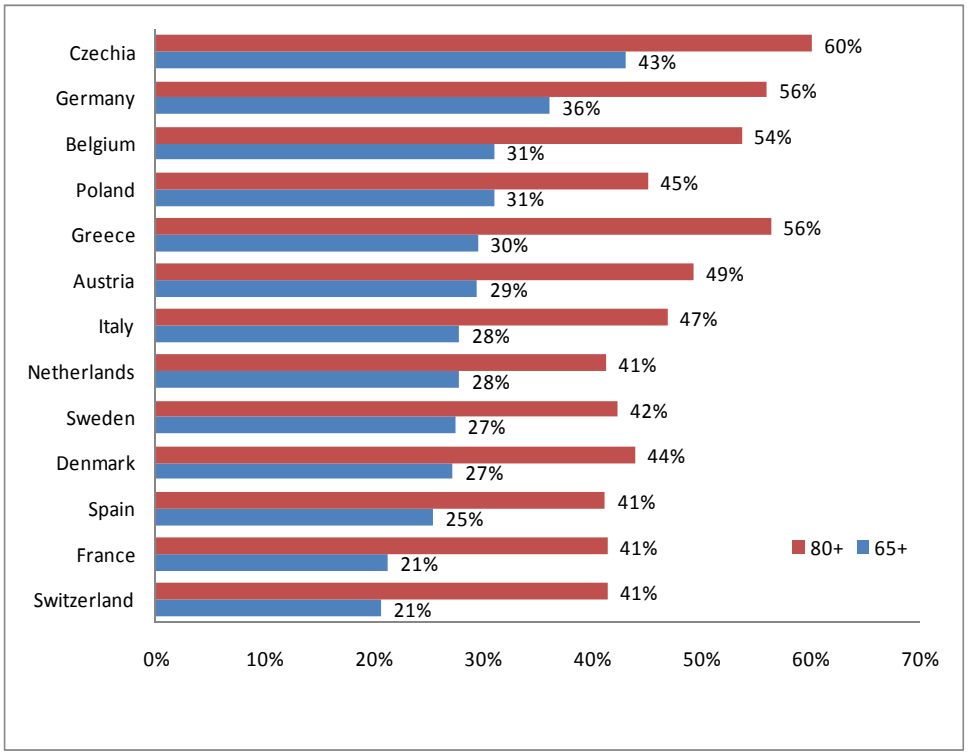
ENEPRI Research Report No. 96/November 2011

Monika Riedel and Markus Kraus*

1. Introduction

All over Europe a major share of the older population in need of care is receiving care from informal carers like spouses, children or other family members, and presumably even more so in many non-European countries. Naturally, this proportion is higher in older age groups: according to data from the SHARE project, 21% (in France and Switzerland) to 43% (Czech Republic) of the non-institutionalised population of 65 years of age or over receive help or support at least sometimes on an informal basis. Of the population group aged 80 years and over, 41% receive informal support (in France, the Netherlands, Spain and Switzerland) rising to 60% (Czech Republic), see Figure 1. [1]

Figure 1. Receivers of informal help or support, in % of population group, 2006



Source: IHS HealtEcon calculation 2010 using SHARE 2.3.1.

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[1] For more information on the SHARE (Survey of Health, Ageing and Retirement in Europe) database, see section 2.1 or http://www.share-project.org/, April 4th 2011.

Considering the likely future demographic development and the fiscal strains on public budgets in most if not all countries, it is to be expected that the major part of care for the older population will be delivered by informal carers. As informal care often is very time-consuming, many carers are no longer active on the labour market. In Germany, for example, about one in three informal carers is of retirement age, and one in four is aged between 55 and 65 years. Of all informal carers aged between 15-64 in Germany, 60% of those caring for people with a recognised dependency level from I to III are not employed (Schulz, 2010b). One can assume that the situation will change and more future informal carers will have to balance informal care and paid employment on the labour market. The average age of parents has been increasing: this leaves fewer children as prospective informal carers above retirement age. At the same time reforms of retirement schemes in several countries aim at increasing the average age of retirement in order to ease the fiscal strain on retirement plans, as occurred recently in Germany, Ireland and Italy. Furthermore, the bulk of informal care work is provided by spouses, especially when we focus on the support needed on a daily basis. Rising shares of single-person households will therefore require more support for carers if current levels of informal care provision are to be maintained or even increased.

In order to design future support for informal carers in a sustainable but efficient way it is important to know more about the carers' situation, and what kind of support they receive currently. Support services for such carers, however, vary considerably throughout Europe, being virtually non-existent in several countries and piecemeal, fragmented and ad hoc in a number of others. In many European countries such services did not receive much attention until recently, albeit for different reasons: in Nordic countries the neglect was usually based on the assumption that sufficient formal care was being provided for the elderly and that there was simply no need for additional support for their families or other informal carers. Conversely, in several Southern European countries, the role of the family as the 'natural provider' of care for the older population was being taken for granted, with the state playing no role other than in cases of extreme economic hardship (EUROFAMCARE 2006, p. 17). Similarly, several Eastern European societies also saw provision of care for the older population as the traditional task of other, mostly female, family members.

In recent years, however, this notion has changed and the need for public support of informal carers has moved on to the agenda of social policy in several countries. Faced with the burden of extensive formal care capacities, informal care is being increasingly taken into consideration in countries like Sweden, and explicit means of support for informal carers are gradually being discussed and sometimes also implemented in countries like France, which have been relying on, but perhaps not yet sufficiently supporting, informal care.

This report seeks to shed some light on the current situation of informal care in 21 European countries. After providing statistical information on some characteristics of informal carers derived from the SHARE database, we focus on the support they can expect to receive, be it indirect (via support for the care recipients) or direct. National data on such benefits were collected using a standard questionnaire. For details on the data selection process and data providing institutions, see Kraus et al. (2010). The report is organised as follows: section 2 provides information on data and methods. Section 3 focuses on providers of informal care, using public databases like SHARE or EUROSTAT. Section 4 provides an overview of support services for informal care in 21 member countries of the European Union (Austria, Belgium, Bulgaria, the Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, the Netherlands, Poland, Romania, Slovakia, Slovenia, Spain, Sweden),

using data collected and provided by participants of the ANCIEN[2] project. The report was written as deliverable no. 3.1 of Work Package 3 of the ANCIEN project.

2. Data and methods

Both sections 3 and 4 present descriptive analyses but rely on different data sources. Unless otherwise stated, information refers to the year 2006.

2.1 Providers of informal care

The focus of this study is on informal care for the population aged 65 years and over, and aims to exclude care for small children or disabled persons younger than 65 years of age. Availability of quantitative data concerning informal care is limited, and even more so if information should be comparable across countries. Basic information like 'number of persons providing care' is often available only following national definitions, if at all. We therefore choose to use demographic data, which provide more reliable information for cross-section analyses than collections of national data based upon different and presumably often contradictory definitions (compare ANCIEN country reports for national definitions for the need for care, http://www.ceps.eu/catalog/101, February 10th 2011). Instead we use demographic information from EUROSTAT to calculate proxy variables that are available and comparable for all 21 countries under study.

Additionally, for characteristics of providers of informal care we use data from the SHARE database, which is 'a multidisciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks of more than 45,000 individuals aged 50 or over (http://www.share-project.org/, March 8th 2011). We use release 2.3.1 of wave 2 (the newest release available at the time of preparing this report in October 2010). Those data were collected in 2006; they are, however, only available for 11 of the 21 countries covered by the data collection used for section 4, namely Austria, Belgium, the Czech Republic, Denmark, France, Germany, Italy, the Netherlands, Poland, Spain, and Sweden. Greece and Switzerland are covered by SHARE but not in section 4.

By using SHARE data, information regarding informal care can be derived from two starting points, either from respondents who are carers, or from respondents who receive care. As all respondents are 50 years of age or over, information on carers younger than 50 years is only available indirectly, from responses of the person receiving care. Those responses, however, do not contain much information on the person providing care, e.g. age and sex of the carer are missing. We therefore concentrate on information provided from the viewpoint of the provider, thus excluding care providers younger than 50 years of age.

SHARE distinguishes care recipients from inside and outside of the care provider's household, and asks whether different kinds of care are provided. SHARE does, however, not use the expression 'informal care'. Instead, respondents are being asked:

(sp009) "Which family member from outside the household, friend or neighbour have you helped (most often) in the last twelve months?" and (sp010) "Which types of help have you given to this person in the last twelve months? i) Personal care, e.g. dressing, bathing or showering, eating, getting in or out of bed, using the toilet, ii) Practical household help, e.g. with home repairs, gardening, transportation, shopping, household chores, iii) Help with paperwork, such as filling out forms, settling financial or legal matters?"

[2] Assessing Need of Care in European Nations, for more information on the project see www.ancien-longtermcare.eu, March 8th 2011.

Additionally, people helping others outside of their own household were asked about the frequency of such help (sp011):

"In the last twelve months, how often altogether have you given such help to this person? Was it...1) almost daily 2) almost every week 3) almost every month 4) less often?"

In order to get closer to a definition of informal care in contrast to occasional help, we selected personal help being provided on an almost daily basis. For members of the same household, on the other hand, the corresponding question (sp018) asks for personal care only being provided on a regular, i.e. almost daily basis. Tables in section 3 therefore refer to personal care provided on an almost daily basis only, rather than all kinds of informal care (personal, paperwork, housekeeping), unless stated otherwise.

Using responses by persons providing care, the SHARE database does not give information about the care recipient's age, but provides information about the relationship between the carer and care recipient. Starting from the carer's viewpoint, we included care recipients defined as spouse, mother, father, mother-in-law, father-in-law, stepfather, stepmother, brother, sister, grandparent, aunt, uncle but not child, son/daughter in law, grandchild, niece, nephew, other relative, friend, colleague, neighbour, or other acquaintance.

The SHARE questionnaire allows every respondent to report help being provided to up to three persons outside of the household. The respondent is asked to rank his/her answer by the amount of help or support being provided. If the first care recipient did not qualify for our definition of care (because of other than personal care, or being non-elderly) we also consider the next care recipient(s).

We assume that the proportion of informal personal care might be underestimated for two reasons: first, we excluded cared-for friends who might be in retirement age, for example. Second and probably more importantly, it may be the case that because the social distance between children and parents is very close, 'true' rates of support given to parents are underestimated in the SHARE survey (Attian-Donfut, Ogg, Wolff, 2005, p. 175). Furthermore, this in conjunction with the construction of the SHARE database might help to explain why the proportion of informal care in Mediterranean countries is perhaps lower than expected: in those countries, extended families frequently still live within one household, but SHARE does not ask for help with housekeeping or paperwork between members of the same household, only for personal help.

Finally, it should be noted that SHARE is a survey using everyday language, but does not apply any specific definition of informal care. Thus, it is likely that sometimes support mentioned by respondents would not be seen as care and levels of received support would therefore be higher in SHARE than the need for care according to national definitions. In the analyses of section 3, we do not apply a minimum requirement of need in order to consider levels of care as 'informal care', but restrict our focus to frequent and personal support. This focus should help to decrease the deviation from other definitions of informal care.

2.2 Regulation of informal care

For the description of regulations concerning informal care we use information gathered in work package 1 of the ANCIEN project. The objective of work package 1 was to portray the long-term care (LTC) systems in EU member states in light of the provision and financing of care and derive a typology of LTC systems. For this purpose a questionnaire was developed and distributed to project partners in order to collect a comparable set of comprehensive information on national LTC systems. The questionnaire was organised in several blocks of questions focusing on macrostructure, funding and financing, informal care, formal institutional care, formal home-based care and policy issues. Special emphasis was put on the comparability of

data. Therefore, a set of relevant definitions was discussed and agreed upon between project partners. Contributed data were checked with regard to comparability and plausibility; in several cases data provided could not be included in further analyses due to severe deviations from definitions. For further information on the ANCIEN project and cooperating partner institutions see: www.ancien-longtermcare.eu, March 11th 2011, and for further details on the data collection process see Kraus et al. (2010).

In collecting country specific data, we aimed at applying common definitions to all countries. Following OECD (2005, p.17), we defined informal care as care provided by informal caregivers (= informal carers) such as spouses/partners, other members of the household and other relatives, friends, neighbours and others, usually but not necessarily with an already existing social relationship with the care recipient; informal care is usually provided in the home and is unpaid. National regulations, however, usually apply country-specific definitions which may deviate to a larger or smaller degree from the definition above.

3. Providers of informal care

3.1 Demographic background

The availability of as well as the need for informal care in a country are closely related to the demographic situation. If no relative exists or lives nearby, the chances of receiving informal care are low. An analysis of the SHARE database shows that in the countries covered, less than 10% of all persons providing personal care on a regular basis are not family or relatives, with partners/spouses making up over 50% and children over 30% (Table 4) of all carers. These numbers highlight the relevance of the demographic status quo when talking about the current and likely future provision of informal care. Table 1 provides some key figures on the current demographic situation in several European countries.

Although the countries seem to be similar at first glance, there are nevertheless some striking differences. Generally speaking, we find that the ageing of the population is less pronounced in the new member states, and the share of persons 80+ differs significantly. A high share of old and very old people correlates with smaller shares of people of working age, and both can be linked statistically by means of a dependency ratio (see Table 1). Again, we can observe differences between the old and new EU member states, especially regarding the dependency ratio of the very old (mean ratio of old member states: 6.9%, new member states: 4.6%). Almost all European countries have experienced an increase in the dependency ratio during the last five decades (EUROSTAT, 2009, p. 142), although a low ratio would be desirable in terms of the availability of informal caregivers, as well as in terms of funding for formal care. This increase has been substantial; in most countries the increase amounted to at least half of its 1960 value, in some countries, e.g. Bulgaria, Italy and Poland, the ratio doubled. EUROSTAT (2009, p. 139) projects further demographic movements in this direction.

The parent-support ratio links the number of older persons to the number of persons in their children's generation as the most likely informal carers apart from partners. Reflecting lower life expectancy, the average parent support ratio for the new member states is considerably lower than that of the old member states (16.9 and 24.5, respectively). The lowest parent support ratio is found in Slovakia (13.6), the highest in Italy (28.8).

Considering that the provision of informal care often is a very time-consuming task, the potential carer ratio counts only non-employed members of the respective age-group as potential carers.

Table 1. Key demographic figures on the share of older persons in European countries, 2007

Country	Share of persons 65+	Share of persons 80+	Dependency ratio 65+	Dependency ratio 80+	Parent Support Ratio 80+
Austria	16.9	4.5	25.0	6.7	25.6
Belgium	17.1	4.6	25.9	7.0	24.9
Bulgaria	17.3	3.5	25.0	5.1	17.2
Czech Republic	14.4	3.3	20.2	4.6	15.6
Denmark	15.3	4.1	23.1	6.2	20.5
Estonia	17.1	3.5	25.1	5.1	19.6
Finland	16.5	4.2	24.8	6.3	19.9
France	16.2	4.8	24.8	7.4	26.4
Germany	19.8	4.6	29.8	6.9	25.0
Hungary	15.9	3.6	23.1	5.2	17.6
Italy	19.9	5.3	30.2	8.0	28.8
Latvia	17.1	3.4	24.8	4.9	19.3
Lithuania	15.6	3.1	22.8	4.5	18.7
Netherlands	14.5	3.7	21.5	5.5	19.1
Poland	13.5	2.9	19.1	4.1	15.3
Romania	14.9	2.7	21.4	3.9	15.2
Slovakia	11.8	2.5	16.4	3.5	13.6
Slovenia	15.9	3.4	22.7	4.9	17.3
Spain	16.6	4.5	24.1	6.5	26.8
Sweden	17.4	5.4	26.5	8.2	27.4
United Kingdom	16.0	4.5	24.1	6.8	25.1

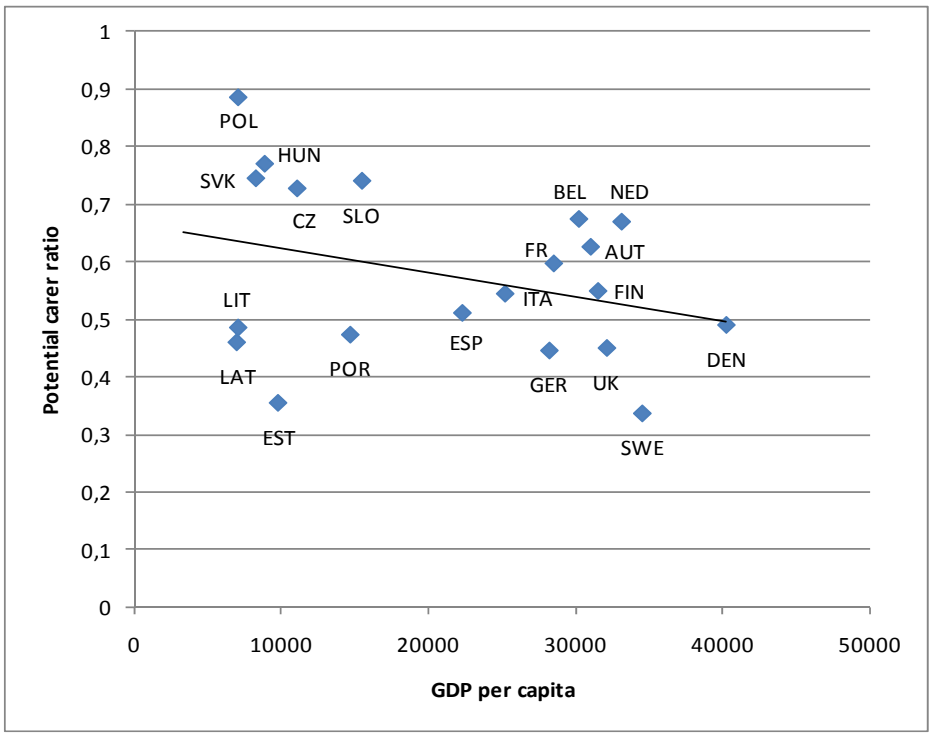
Notes: Dependency ratio yy+ = share population yy years of age or older / share population (15-64 years), Parent support ratio 80+ = share population 80 years of age or older / share population (50-64 years).

Source: Eurostat yearbook 2009, IHS HealthEcon calculations 2010.

Figure 2 shows that there is a wide variation between the (theoretical) availability of informal care between countries. In old member states, Sweden ranks on the low side with 34 potential carers per 100 persons aged 65 or older, while the theoretical availability of informal care is twice as high in Belgium and the Netherlands. Differences between new member states are even greater: in the Baltic States, possibilities for informal care are as low as in old member states with low availability, but potential carer ratios in the remaining new member states are higher than in any one of the old member states.

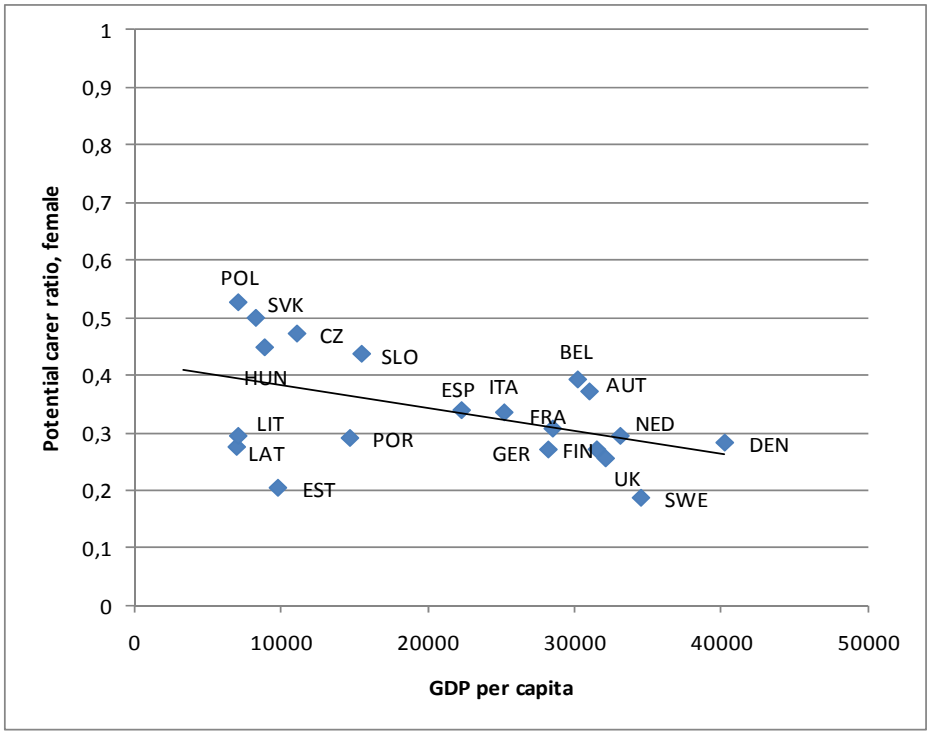
Figure 2 and Figure 3 link (female) potential carer ratios with GDP per capita, and demonstrate the obvious relation: potential carer ratios, and even more so when calculated for female carers, display a weak tendency to be lower in richer countries, and to be higher in less wealthy states (correlation coefficients -0.47 and -0.32, respectively). Higher (female) employment contributes to GDP, but lowers potential carer ratios.

Figure 2. Potential carer ratio by GDP per capita, 2006



Note: Potential carer rate = (persons 50-64, not employed) / (population 65+).
Source: IHS HealthEcon calculation 2010, using EUROSTAT and Silc Database.

Figure 3. Potential female carer ratio by GDP per capita, 2006



Note: Potential female carer rate = (female persons 50-64, not employed) / (population 65+).
Source: IHS HealthEcon calculation 2010 using EUROSTAT and Silc Database.

3.2 How many persons provide informal care?

About 6% of the population aged 50 or over provide personal care for an older relative or family member, see Table 2. More than half of them (54%) are in the 50-64 age group. Corresponding to expectations, we find the highest share of carers in Spain and Italy, and the lowest in Sweden and the Netherlands, and also in Switzerland. More women than men are providing personal care: averaging over all countries included here, 59% of all persons providing personal help on an almost daily basis are women. A similar picture holds if regular help with paperwork or housekeeping is also included; see columns marked 'informal care' in Table 2. Percentages for providers of informal care are about one percentage point higher than those for personal care alone. Again, provision of informal care for the older population is least frequent in Sweden and most frequent in Spain and Italy, where the respective shares are more than twice the level observed in Sweden. At the same time, countries as close as Belgium and the Netherlands differ by the factor 2.

The share of women providing personal care in their respective population group is somewhat higher than or equal to (Germany, the Netherlands) the respective share of the male population; this holds for all SHARE-countries but Poland and Switzerland. We find the largest sex-specific differences in Sweden, Greece and Spain, no matter whether we look at personal care only or include also other kinds of care.

Table 2. Providers of care by sex and kind of care, in % of population group

Country	Personal care			Informal care		
	Total	Male	Female	Total	Male	Female
Austria	6.0%	5.9%	6.2%	7.3%	7.0%	7.5%
Belgium	6.8%	6.3%	7.2%	8.8%	8.0%	9.5%
Czech Republic	6.4%	6.0%	6.7%	7.3%	7.2%	7.5%
Denmark	4.4%	4.0%	4.8%	5.3%	5.5%	5.2%
France	6.0%	5.1%	6.7%	7.2%	6.5%	7.7%
Germany	5.8%	5.8%	5.8%	7.4%	7.9%	6.9%
Greece	6.9%	4.7%	8.8%	7.8%	5.4%	9.9%
Italy	8.1%	7.4%	8.6%	9.5%	8.7%	10.0%
Netherlands	3.7%	3.8%	3.7%	4.4%	4.7%	4.1%
Poland	5.8%	6.1%	5.5%	6.5%	7.0%	6.2%
Spain	9.0%	6.8%	10.9%	9.8%	7.8%	11.6%
Sweden	2.7%	1.5%	3.8%	3.4%	2.3%	4.4%
Switzerland	4.3%	4.5%	4.2%	5.0%	5.2%	4.9%
MEAN	**5.8%**	**5.2%**	**6.4%**	**6.9%**	**6.4%**	**7.3%**
Weighted Average	**6.5%**	**5.8%**	**7.0%**	**7.7%**	**7.2%**	**8.0%**
% of all carers	**100%**	**41%**	**59%**	**100%**	**43%**	**57%**

Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1.

In addition to a relatively large share of care providers in the population, each average informal carer in Italy and Spain provides large quantities of care: using the first wave of the SHARE survey, Bolin et al. (2007, Table III) show that Italian and Spanish adult children provide on average more than 1,000 hours of care per year for their parents, Greek more than 600 and French more than 400 hours, where adult children provide care for their parents. Nordic countries rank among the countries with the lowest provision of care (Sweden: 119, Denmark:

132, Netherlands: 132). Bolin et al. (2007) study all kinds of informal care or support (personal care, help with household tasks and paperwork) provided by children for parents living in a single household (never married, divorced, separated, widowed).

3.3 Relationship between carer and recipient

On average two out of three persons who provide personal care to an older relative or friend do this within the same household, and consequently about one in three personal carers does this for relatives or friends living separately, (see Table 3, the highest shares of care within the same household can be observed in such diverse countries as Poland and Denmark, and the lowest in France. It should be kept in mind, however, that the overall level of provision of personal care differs considerably between those countries. We find, however, only a very weak correlation between the overall provision of personal care and the provision of care within (22.4) or outside of (-16.3) the household, see Figure 4. Note, however, that in all countries both numbers, care provision inside and outside of the household, add up to percentages higher than 100%: this reflects the fact that frequently one person provides care for more than one person; some inside and some outside of the carer's household.

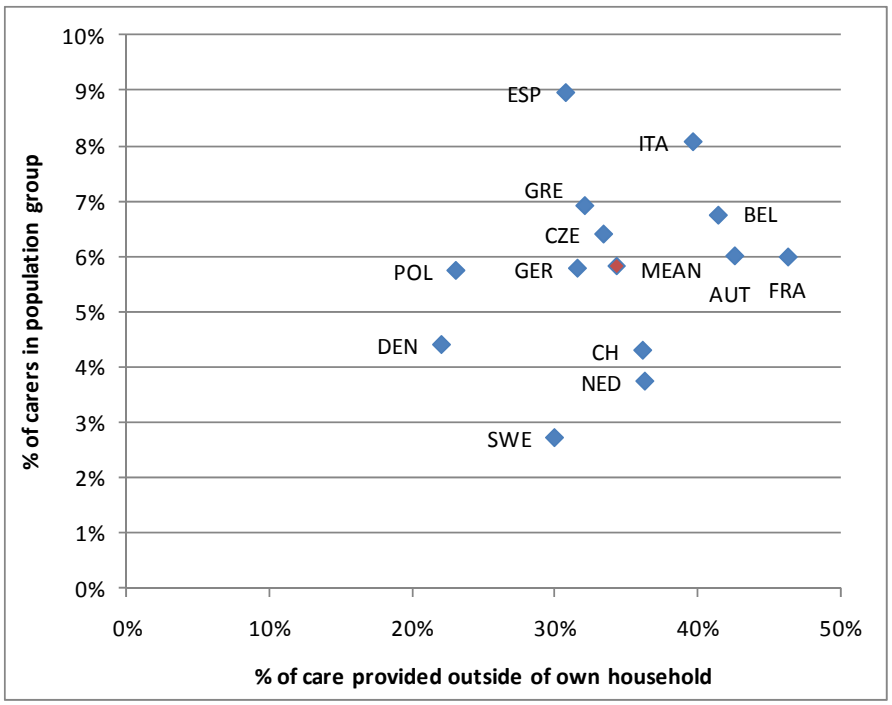
Table 3. Provision of personal care inside/outside of the household in % of all caregivers

Country	% of personal caregivers who provide care outside of the household	% of personal caregivers who provide care inside of the household
Austria	42.6%	61.9%
Belgium	41.5%	65.1%
Czech Republic	33.4%	73.8%
Denmark	22.0%	82.9%
France	46.4%	56.5%
Germany	31.6%	70.6%
Greece	32.1%	75.9%
Italy	39.7%	63.9%
Netherlands	36.3%	65.7%
Poland	23.0%	82.2%
Spain	30.8%	73.6%
Sweden	30.0%	73.8%
Switzerland	36.2%	70.6%
MEAN	34.3%	70.5%
Weighted average	**36.2%**	**68.9%**

Note: Percentages add up to more than 100% when carers provide both kinds of care.

Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1.

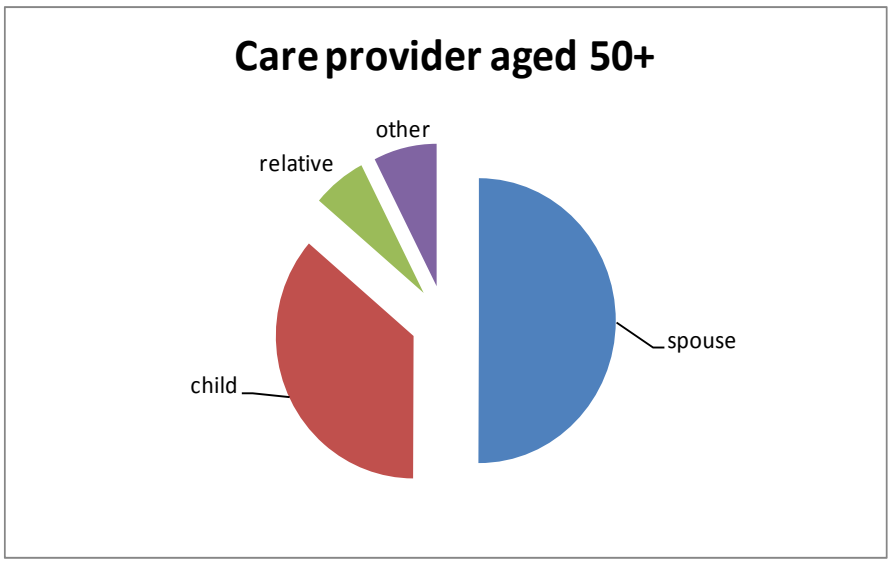
Figure 4. Personal care provision and location of care recipient



Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1.

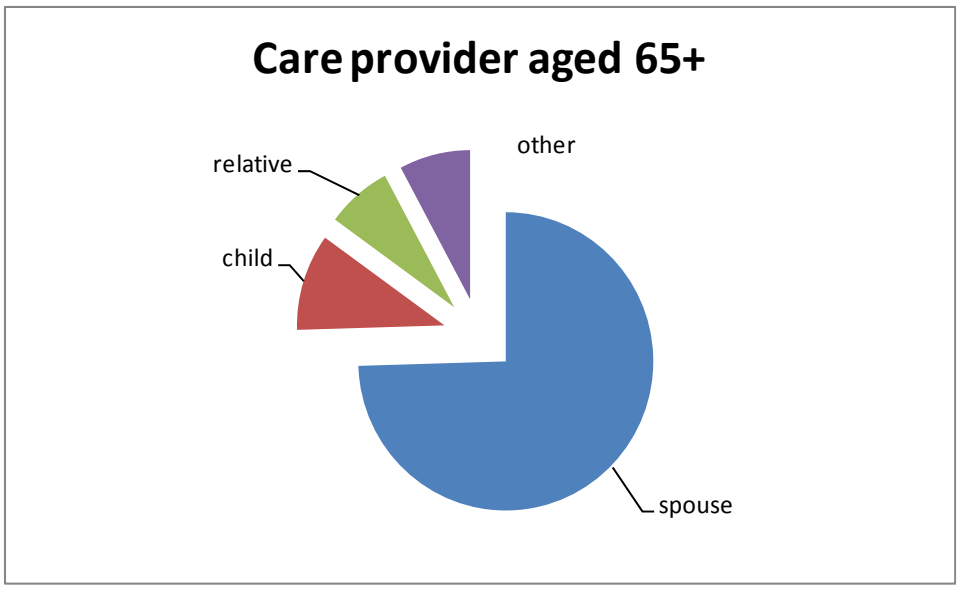
SHARE provides information on the relationship between the informal carer and care recipient. With regard to personal care, we see that in more than half of all cases, care is provided by the partner, and in one in three cases by the child. With the increasing age of the care provider, informal regular personal care is provided increasingly by partners, see Figure 5. In Spain, Italy, France and the Czech Republic, we find the lowest proportion of care provided by partners, and in Scandinavian countries the highest, especially for older care providers. In Belgium and the Netherlands we find the highest shares of informal care providers from outside of the family, but across Europe non-family carers provide less than 10% of all informal carers, see Table 4.

Figure 5a. Relationship between care provider and recipient, 13 SHARE countries



Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1.

Figure 5b. Relationship between care provider and recipient, 13 SHARE countries



Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1.

Table 4. Relationship between carer and care receiver

Country	Providers aged 50+				Providers aged 65+			
	Partner	Child	Other relative	Other	Partner	Child	Other relative	Other
Austria	63%	33%	9%	4%	86%	2%	12%	5%
Belgium	59%	38%	11%	16%	82%	11%	12%	20%
Czech Rep.	53%	42%	8%	4%	83%	6%	16%	4%
Denmark	86%	12%	4%	10%	100%	0%	3%	7%
France	53%	47%	3%	7%	83%	16%	1%	6%
Germany	58%	43%	3%	10%	85%	14%	3%	9%
Greece	69%	26%	7%	4%	85%	4%	11%	1%
Italy	53%	39%	12%	7%	81%	11%	13%	7%
Netherlands	70%	28%	7%	16%	94%	4%	2%	12%
Poland	63%	32%	9%	5%	89%	4%	10%	8%
Spain	45%	49%	12%	9%	72%	19%	17%	12%
Sweden	68%	25%	13%	11%	90%	8%	12%	16%
Switzerland	66%	30%	5%	14%	87%	8%	5%	15%
MEAN	**62%**	**34%**	**8%**	**9%**	**86%**	**8%**	**9%**	**9%**
Weighted Average	**57%**	**41%**	**7%**	**8%**	**83%**	**12%**	**8%**	**9%**

Source: IHS HealthEcon compilation 2010 using SHARE 2.3.1. Note that sums can exceed 100% as carers can report support to more than one person.

4. Regulation of informal care

Informal care by definition is provided in a rather private surrounding, which at first glance severely limits the sphere of regulation concerning those services. Once the need for care is recognised and the decision for informal rather than formal care is made, there are, however, at least three topics where regulations can severely affect the situation of recipients and providers of informal care: i) what, if any, benefits or public support do **providers** of informal care receive and under what conditions, ii) what, if any, public benefits do **recipients** of informal care receive and under what conditions, and iii) is there some kind of public **quality** control or assurance mechanism of informal care? The present report concentrates on the first two questions, for regulations regarding quality of (informal) care, see ANCIEN work package 5.

Lundsgaard (2005) notes that support for informal care is important in its own right as it improves flexibility and the possibilities for choice of persons in need of care. The question of what is meant by *carer* support is not straightforward. Twigg & Atkin (1994, cited in EUROFAMCARE 2006) note that such support can either be direct (targeted at the carers themselves) or indirect (targeted at the person receiving care with potential benefits for the carer). Due to its indirect nature, we categorise indirect support as a benefit for care recipients rather than providers of informal care, as the effect on informal care is varying and uncertain. In the case of cash benefits for care recipients, for instance, the cash may be (e.g. Austria) / does not need to be (e.g. Germany) / needs to be (e.g. France) used to buy formal care, depending on national regulations.

There are, however, many possibilities other than cash benefits to support informal care.[3] Other support may well be more important than direct financial support especially when cash benefits are low. Many countries report that at least some benefits in kind are available. Such benefits are typically technical aids to make life at home easier for persons with restricted mobility, or to make care at home easier, or simply cheaper, e.g. by providing or supporting the purchase of special beds for example. It is increasingly recognised that not only the health of care recipients, but also the health of carers needs support. A second group of support services for informal carers therefore seeks to provide possibilities for the short-term relief of carers and comes under headings such as respite care. A third important group of support services comprises counselling and information services, which may relate to a variety of topics from efficient home nursing over access to other benefits and self-support groups for informal carers. Detailed international information on the provision of such goods and services is not easy to obtain, and available information is usually not systematic. We mention such support in each country section as far as we could obtain such information and restrict our focus to the provision of monetary benefits.

4.1 Benefits for care recipients

With regard to benefits for care recipients, several questions arise:

- How much money is awarded for what definition of need?
- In what form is the cash benefit organised? Are recipients free to spend the money as they see fit, or is it necessary to prove that the money is indeed spent for care, for example? Are they free to employ carers with this money?
- How is the access to benefits organised? Is there an assessment process? Are the benefits means-tested?

Table 5 provides an overview of the availability of and the access to cash benefits that can be used to support informal care.

[3] For suggestions for a comprehensive carer support programme see EUROFAMCARE (2006, p. 22).

Table 5. European overview of monetary benefits for older recipients of informal care

Country	Care recipient		
	Benefit	**Assess-ment**	**Means tested /Income related**
Austria	Pflegegeld: €154-1,656/month (2009)	yes	no
Belgium	Federal allowance of Ø €274/month (2008)	yes	yes
	Flanders: flat-rate benefit of €130/month (2010)	yes	no
Bulgaria	No	-	-
Czech Republic	Care allowance €127/month (2005) switched in 2007 from carer to recipient	yes	no
Denmark	No	-	-
England	Attendance Allowance: £47.80 (day)/£71.40 (night or day+night) per week (2010/11), based on disability not receipt of care	yes	no
	Individual budget	yes	yes
Estonia	No	-	-
Finland	Ca. €100/month	yes	yes
France	APA: Ø €490/month	yes	yes
Germany	Pflegegeld: €225-685/month (2010)	yes	no
Hungary	No	-	-
Italy	Ø €472/month (2009), some regions: additional smaller benefits	yes	yes
Latvia	Yes: 75LVT (ca. €105), fixed amount but based on disability not receipt of care	yes	no
Lithuania	No	-	-
Netherlands	Personal budget	yes	no
Poland	Special allowance for persons 70+ of age, ca. 10% of Ø old age pension	no	no
	Marginal payment (social assistance)	no	yes
Romania	Only for recognised disabilities, but many elderly chronically or terminally ill are granted disability status	yes	yes
Slovakia	No	-	-
Slovenia	Assistance and Attendance Supplement	yes	no
Spain	Payment is intended to hire personal assistants rather than for 'purely' informal care	yes	yes
Sweden	No	-	-

Note: Includes benefits that are not specially designed for informal care, but are (often) used for this purpose. '-' = not applicable; Ø = on average.

Source: IHS HealthEcon compilation based mostly on ANCIEN partners' contributions.

Of the 21 countries studied, 14 provide some kind of monetary benefit for recipients of informal care, including Poland, where the more substantial payments are provided for everyone aged 70 or over, irrespective of care needs. In some countries, the main financial benefit that can be used to finance informal care is linked to some degree of recognised disability, e.g. in England and Romania. In all countries (except Poland) an assessment of medical or nursing need is required. In half of all countries with cash benefits for recipients of informal LTC, payments are granted

irrespective of the recipient's income. Usually, the recipients of monetary support are free to decide whether the money should be used to buy formal or informal care. There are, however, exceptions like in Germany where either cash benefits are used to remunerate informal care or formal care is provided in kind. We can observe that countries with a stronger insurance tradition tend to provide cash benefits without means testing (Austria, Germany, the Netherlands, also the Czech Republic and Slovenia)[4] while countries without this tradition more often implement means-testing (England only with individual budgets, Finland, Italy, Spain, also Romania), given that their systems do provide cash benefits. Table 5 provides a summary of cash benefits; details for each country follow, below.

Austria

In general, the Austrian long-term care system is a combination of benefits in cash and in kind. The core part of it is a long-term care allowance programme at federal and provincial level. Thus, unlike in other European countries, the cash benefits are higher than the in-kind benefits. All persons in need of care can receive benefits in cash according to the *Federal Long-Term Care Allowance Act* (*Bundespflegegeld*). Persons in need of assistance not covered by this law (disabled people or recipients of social assistance) can apply for benefits in cash provided by the provinces (*Landespflegegeld*). Federal and provincial allowances are designed in exactly the same way; their only differences are the population covered and the responsible budgets for funding, i.e. general federal budget (Bundespflegegeld) and the nine provincial budgets (Landespflegegeld). Both cash benefits can be used to buy formal care services from public or private providers or to reimburse informal care giving. In contrast to the German or Dutch systems, this choice does not affect the amount of the benefit. Both cash benefits are granted irrespective of income and assets and are based upon a legal entitlement (Riedel & Kraus, 2010). At the time of writing (spring 2011), the ministry of social affairs is preparing to unify both kinds of cash allowance (*Bundespflegegeld, Landespflegegeld*). The goal is to bring legislative and administrative responsibilities to the central level by 1 January 2012. Funding for these allowances is expected to remain unchanged in the short term, but will be part of a planned overall re-allocation of funding responsibilities among different levels of government.

The assessment of need for long-term care is based on individual requirements of personal services and assistance, with need for both personal services and assistance subject to qualification for federal or provincial care allowance. Needs assessment is based on a doctor's expert opinion; representatives from other fields (e.g. nursing) are also brought in for an extensive assessment of the situation. The expert opinion is usually drawn up after an examination in the home. A third party can be present during the medical examination if the prospective receiver of the allowance so desires. The eligibility decision is made by means of an official notification, with the possibility to appeal against this decision at the appropriate Labour and Social Court. The medical examination, the classification as well as the payment of the long-term care allowance are carried out by social insurance institutions, specifically pension insurance and accident insurance (Riedel & Kraus, 2010).

The law defines seven levels of care need, resulting in a care allowance of between €154.20 for need between 60 and 85 hours of care per month (level 1) and a maximum of €1,655.80 (level 7) for more than 180 hours of care per month in cases of complete immobility. The amount of time spent on care services is the relevant criterion to qualify for levels 1-4. An additional

[4] Note, though, that the definition of the French APA (allocation personnalisée d'autonomie) as a benefit in cash or kind is not unambiguous: While Joël et al. (2010) classify it as a benefit in kind, other analysts consider it to be a cash benefit (Da Roit et al., 2007). The amount of APA varies with income levels.

criterion has to be met to qualify for levels 5-7 (see Table 6). There is no mechanism of regular increases of the care allowance, which has resulted in the heavy loss of its purchasing power since its introduction in 1993.

Table 6. Eligibility criteria for care allowance levels and allowance per month in Austria, 2011

Level	Need of care per month	Care allowance in € per month
I	More than 60 hours*	154.20
II	More than 85 hours*	284.30
III	More than 120 hours	442.90
V	More than 160 hours	664.30
V	More than 180 hours of care needed per month, if an unusual need for long-term care is required	902.30
VI	More than 180 hours of care needed per month, if 1) care measures are required, which cannot be coordinated in terms of time and these are provided on a regular basis during day and night or 2) the continuous presence of a caregiver is required during day and night, because it is probable that there is a danger for the care recipient or for other persons	1,260.00
VII	More than 180 hours of care needed per month, if 1) it is not possible for the four extremities to move intentionally or 2) a similar situation occurs	1,655.80

* The number of care hours necessary for level I was raised from 50 to 60 and for level II from 75 to 85 with effect from 1 January 2011.

Source: Translated from Bundespflegegeldgesetz.

Bulgaria

Some technical means and devices needed by disabled people are provided in the context of social care at home, provided by respective municipal departments (Mincheva & Kanazireva, 2010).

Belgium

Long-term care in Belgium is predominantly provided as a service in kind, with little or no co-payment for nursing care at home or in a residential setting. Two exemptions are the federal Allowance for Assistance to Elderly Persons' and the Flemish Care Insurance, which are cash benefits aimed mainly at alleviating the burden of non-medical costs related to long-term dependency. These cash benefits may be used to compensate informal caregivers, but the recipient is in fact free to spend the allowance as he or she sees fit. As a rule, there is no choice between in-kind services and cash benefits (Willemé, 2010). The federal cash benefit for care receivers is on average €274 per month (2008), while beneficiaries of the Flemish Care Insurance currently receive a flat-rate benefit of €130 per month. There are clearly defined rules for the access to benefits.

Czech Republic

Since the social services reform of 2006, benefits in cash are granted to individuals in need of care, whereas before the reform it was the informal carer who received the allowance. Now the allowance is aimed at dependent persons who are provided with personal, full-time care by a

person close to them, typically a family member. Despite the fact that the benefit is not targeted towards the older population, 67% of recipients of benefits in cash are aged 65+, and 57% are aged 75+. The allowance takes the form of a personal budget benefit and can be used to cover the costs of arranging assistance for the dependant, to pay for care provided within social services, or to pay costs incurred by the carer. Thus, the allowance is not solely used to finance informal care, but concentrates on home care rather than home nursing care. To be granted a care allowance, an assessment by a doctor is needed. The care receiver needs to be mostly or full incapacitated, or older than 80 and partially incapacitated. Care allowances are not means-tested and are not treated as income for tax purposes or other social benefit system purposes. The average benefit per month amounted to about €127 in 2005.[5] Overall, it is estimated that the total cost of care allowances is approximately €650 million per year (i.e. 0.5% of the GDP) (Sowa, 2010; CASE, 2009).

England

The English long-term care system relies heavily on informal or unpaid care provided by family, friends or neighbours. Approximately 85% of all older people with a functional disability living in private households in England receive some informal care. Community care services are primarily directed at disabled older people who do not receive informal care. The availability of informal care is taken into account in determining eligibility for service allocations, so that older people with similar levels of disability do not receive the same amounts of formal service support. Therefore, unlike a number of other long-term care systems in Western Europe, the long-term care system in England is not 'carer-blind' (Pickard, 2001 and Fernandez et al., 2009, cited in Comas-Herrera et al., 2010).

There are several types of cash-benefits available in England, but not all allow recipients to pay for informal care. The so-called Direct Payments (in lieu of formal publicly-funded services in kind, available for the older population since 2000, with the amount depending on a means-tested assessment of need for support and calculated according to costs of equivalent services in kind) cannot be used to buy services from the local authority or be used to remunerate informal carers. Individual budgets were introduced in 2005 and pool resources from various sources for any one person. The total amount is made transparent to the individual. The individual budget can be used to secure a flexible range of goods and services, from a wider variety of providers than is possible with direct payments, including informal care and services from local authorities (Comas-Herrera et al., 2010).

The main source of non-means-tested funding for older people with disabilities, however, is the Attendance Allowance. To be eligible the claimant must normally have needed help for six months before the allowance is paid, and the allowance is not paid if only housekeeping help is needed. Attendance allowance is paid at two rates, depending on whether the older person needs assistance during the day (2010/11 £47.80 (ca. €56) a week) or during the night (£71.40 (ca. €84) a week, including during the day and night). There are two ways of qualifying for Attendance Allowance during the day, based on the need for frequent attention during the day in connection with physical care, or supervision during the day to avoid danger to the individual or others. It is important to note that the claimant does not have to actually receive such support and may qualify even if they do not receive formal or informal care. The benefit is a compensation for the disability rather than a payment to cover the costs of services. There are two ways of qualifying for Attendance Allowance during the night, based on the need for repeated attention in connection with physical care or another person to be awake for the

[5] Note, however, that the benefit receiver was switched in 2007 from care provider to care recipient.

purpose of supervision to avoid danger to the individual or others (http://www.disabilityalliance.org, 17th March 2011). In 2006, 1.2 million people received Attendance Allowance in England. There is concern that substantial numbers of disabled people are not claiming the benefits they are due, but any estimation of the take-up rate is hampered by the lack of information available on the size of the eligible population (Kasparova et al., 2007, cited in Comas-Herrera et al., 2010).

Recent analysis suggests that receipt of the Attendance Allowance is strongly related to the severity of disability and that there is no evidence of significant numbers of older people receiving the benefit without any accompanying health problems (University of Essex and East Anglia, 2010). Analysis of data from the English Longitudinal Study of Ageing (ELSA) showed that only a minority (27%) of Attendance Allowance claimants used either state funded or privately funded social care. Some 29% were receiving neither formal nor informal care (Wanless, 2006, p. 94). Given the severity of disability of those receiving Attendance Allowance, this suggests the presence of unmet needs for care in this disabled population in England.

Finland

Although the Finnish LTC system is mostly a system based on benefits in kind, there are also some benefits in cash. These benefits are paid out by the Social Security Institution (KELA). The Care Allowance for Pensioners is intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The mean monthly allowance is around €100. There is also a special housing allowance for pensioners. However, it is not entirely clear if this benefit should be seen as part of the LTC system (Johannson, 2010).

France

The French long-term care policy is based on a specific scheme, the 'allocation personnalisée d'autonomie' (APA), which has three main features (Da Roit et al., 2007, p. 660). First, it is a benefit delivered to old people at home and in institutions according to their level of dependency. The French care system is based on a single assessment grid, the AGGIR (Autonomie Gérontologique – Groupe Iso Ressources), which distinguishes between six levels of dependency, the APA being allocated to the four more severe levels. Because the French scheme is a national one implemented at local level, and in order to guarantee access to the same services right across the country, care packages are defined according to the level of dependency (i.e. the level of GIR) and give entitlement to a certain maximum amount of money per GIR. Second, the benefit is paid to finance a specific care package, determined by a team of professionals, according to their diagnosis of the needs of the recipient. The use of the benefit is therefore controlled and it can only be used to finance services identified as necessary by the professionals. It is, however, possible to employ someone to deliver the necessary services, including the possibility to employ family members (except spouses). Finally, France has adopted a twofold system to finance care packages. On the one hand, an 'assistance principle' is applied: below a fixed income threshold recipients do not contribute at all to the funding of their care packages. Above this threshold, on the other hand, a 'user fee' or co-payment system has been introduced, whereby the recipient contributes to the care package according to his or her level of income. Put differently, the benefit is not exactly means-tested but the amount is reduced progressively (from 0% to 80%) for beneficiaries, in line with their income.

Thus, unlike cash benefits e.g. in Austria or Italy, the APA could be seen as a benefit in kind because its receipt is linked to specific services (Joël et al., 2010), but can still be used as a

means to encourage informal care in that sense as also family members (except spouses) can be employed to provide care.

The average APA benefit is about €490 for a person at home and thus higher than the average APA benefit for persons living in an institution (Joël et al., 2010).

Germany

Persons in need of care have been entitled to receive benefits from LTC insurance since 1995 for care giving at home, among other benefits not discussed here. Persons in home care can choose between community services in-kind and cash benefits or can receive a combination of both. Cash benefits are given directly to the dependent person, and the use is at the beneficiary's discretion, given that care is actually provided. Thus, the beneficiary is free to pass on cash to informal care providers. For considerations of quality of care, recipients of cash benefits have to call for review by a professional care worker at least twice a year, who then reports to LTC insurance funds (Schulz, 2010b).

All benefits are capped and seen as just a contribution towards the costs. There usually remains a considerable portion to be covered by private means. As the nominal benefits were constant between 1995 and 2008, their purchasing power diminished remarkably. LTC-insurance distinguishes three levels of dependency, depending on how often assistance is needed and how long it takes a non-professional caregiver to help the dependent person. The value of the benefits depends on the chosen setting of care, even though the same levels of dependency are defined for all settings, see Table 7.

Table 7. German LTC insurance benefits by dependency level and setting of care, 2010, maximum benefits per month

Setting of care	Level I (€)	Level II (€)	Level III (most severe need) (€)
Home care – benefit in cash	225	430	685
Home care – benefit in kind	440	1,040	1,510
Semi-institutional care	440	1,040	1,510
Full-time institutional care	1,023	1,279	1,510

Source: Schulz (2010b).

Fifteen medical boards nationwide conduct in-home assessments for the statutory LTCI funds (at home or in nursing homes). For private LTCI, Mediproof, a private company, carries out this task. Nurses and physicians with geriatric training assess the prospective beneficiary's health and functional status on the basis of national standards, but also the home and the social environment. Thus, also the situation for informal carers is assessed and if possible, help is offered to them as well, e.g. by measures to improve the home environment. The assessment does not focus on income or assets. Individuals are assessed for limitations in activities of daily living (ADL), instrumental activities of daily living (IADL), as well as hours of care needed per day. After criticism that the assessment did not sufficiently respect the needs of some patient groups, first of all dementia patients, the assessment criteria were updated during a major LTC reform in 2008.

The result of the assessment will be reported to the LTCI fund and the applicants receive a written report from their insurance fund. In the report, the care services and the intensity of care needed (classification of care level) will be stated as well as the option of care giving at home or

the requirement of care giving in an institution. The applicant can reapply to the medical unit for reassessment of the reported disability level. This is also the case if their functional status changes. In general, the assessment will be repeated in a required time interval appointed in the assessment notification. Detailed guidelines for assessment procedures and standards are specified and drawn up by the medical board. These rules are agreed by all involved parties, are the same and binding nationwide (Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V. (MDS), 2006, cited in Schulz, 2010b).

Italy

Cash benefits (indennità di accompagnamento) are provided and funded directly to all disabled persons by the National Institute of Social Security INPS (Istituto Nazionale Previdenza Sociale). They are granted independently of the care recipient's age and economic conditions. This monetary aid is not directly linked to purchasing LTC services, but is generally considered part of the LTC system. It is, for instance, also included in public expenditure for LTC as used for the long-term forecasts by the Economic Policy Committee – Working Group on Ageing. The national cash benefit scheme, funded by the central government from general taxation, is a universalistic intervention, neither linked to the payment of social security contributions nor means-tested. Persons eligible for this cash benefit must be assessed as being 100% disabled and non self-sufficient but not in residential institutions with costs charged to the public administration. Beneficiaries are free to use this monthly benefit to purchase LTC services or not, and in 2009 it amounted to €472.04 per month (Tediosi & Gabriele, 2010).

Regions, provinces and, most frequently, municipalities also fund other types of cash benefits to households of non-self-sufficient persons. There is high variation in both level and nature of this cash benefit across Italian geographical areas. Nevertheless, they are only of minor importance to the target population. The most prominent of these regional schemes (in Emilia Romagna, Veneto) reach barely 1-1.5% of the population aged 65 or over and provide monetary support averaging between €1,200 and €2,200 per year (Da Roit et al., 2007, p. 661).

Furthermore, invalidity pensions provided by INPS could be seen as LTC cash benefits as they are de facto a long-term income support tool for non-self-sufficient persons. They are, however, usually not counted as LTC benefits (Tediosi & Gabriele, 2010).

Access criteria for cash benefits are in some cases set at the local level, in others by the regions, and sometimes they are mixed (regions set an ISEE[6] threshold and some broad evaluation criteria) (Tediosi & Gabriele, 2010).

Latvia

Regulations are usually designed for persons with disabilities and do not relate to the receipt of informal care, but both will often occur simultaneously. According to the Law on Social Services and Social Assistance, persons needing assistance can receive diverse services, including home care. Care at home can be received by persons who cannot take care of themselves without assistance due to their state of health, functional impairments or old age. The services of social care are available for those individuals who have difficulties in caring for themselves because of their age or functional disabilities. They are provided either by state, by the local municipality or by non-governmental organisations depending on the service. The state is concerned that citizens have alternatives to LTC at home or in close proximity that would be

[6] ISEE denotes Equivalent Economic Situation Indicator, a tool to assess the economic household condition which combines income and assets.

more similar to a family environment. There are benefits in cash and kind available and the applicant can choose between both (Gulbe, 2010). There is a special payment of 45 LVL (ca. €65) for persons 5 years above retirement age, but this is for persons not receiving a state pension and is not linked to the receipt of informal care.

Netherlands

Dutch people in need of care can choose between care in kind and cash benefits in the form of personal budgets for most types of long-term care. Patients who choose cash receive a personal budget which is 25% lower than the costs of care in kind because one assumes that they can buy their care more efficiently. They are free to choose who should deliver their care: an institution, a care worker, or an informal carer like family members, friends, or neighbours. For most of their budgets, patients need to be able to show that they spent the benefit on care; for budgets below a certain margin this is not necessary. Personal budgets are not limited to a special age group and can be granted for several kinds of impairment (somatic, psycho-geriatric, physical, sensory or intellectual handicap. Psycho-social problems used to be included but were recently excluded). The laws regulating these cash benefits were modernised in 2003 with the result that total expenditures for personal budgets tripled from 2002 to 2007 and are expected to keep growing. In 2007, total expenditure for personal budgets amounted to €1.3 billion and to roughly €17,000 per personal budget holder. The budget for cash benefits for 2011 is €2.7 billion. Analyses of one big insurer (VGZ) showed that persons over 70 years of age on average hold lower budgets (2007: average €12,681) than younger budget holders. Long-term care for the elderly plays a relatively small role in the use of personal budgets (Mot, 2010).

But the growth of total expenditures on personal budgets is a threat to the financial sustainability of the long-term care system. In fact, expenditure on cash benefits were increasing so fast that a stop on personal budgets for the second half of 2010 was introduced. People who wanted to make a new request for a personal budget could choose between going on the personal budget waiting list or applying for in-kind care. In the first four months of the stop, about 80% chose the waiting list, with almost every second person on the waiting list younger than 18, many with psychiatric problems. From January 2011 on, the stop will end and new cash benefits can be requested. However, some people will no longer be eligible for cash benefits (e.g. people without a permanent place of residence) and fraud will be opposed more actively.

Poland

Persons over 75 years of age receive a permanent allowance additional to the old-age pension and disability pension; a so-called care allowance. It is the same amount each month and forms the main benefit supposed to cover informal care costs. This is a universal allowance, regardless of the degree of dependency – fit and independent persons receive the same amount as severely dependent persons. The value of this allowance (173.1 PLN/ca. €44) is symbolic in comparison to the actual costs of care (which may be up to 10-20 times higher at market prices of LTC institutions). The care allowance is granted to almost 2 million persons. Older persons who do not earn old-age or disability pensions do not receive the extra payment either. They can, however, obtain a slightly lower nursing allowance (153 PLN/ca. €39 per month) in the frame of family benefits. Persons needing care staying in any public place or nursing home financed from public sources are entitled to neither the extra payment, nor the allowance (Golinowska, 2010).

Romania

There are no cash benefits legalised in Romania for the care of elderly people at this time. Like benefits in kind, cash benefits are available to people who are officially recognised as having a

disability. Many older persons who are chronically or terminally ill or have multiple co-morbidities are assessed and granted a degree of disability and the number of these cases has risen consistently in recent years. There is therefore a legal delimitation between care for elderly people (Law 17/2000) and care for the disabled (Law 448/2006), but in reality many services and classifications overlap and the beneficiary could combine other benefits (old age, invalidity or survivor) with disability benefits (Popa, 2010).

Slovenia

Under certain conditions, users of care services can receive the Assistance and Attendance Supplement; a major benefit in cash. It can be used for any type of care and is intended to cover part of the costs incurred by permanent changes in the recipient's health status. This applies if poor health makes the recipient unable to satisfy most or all of his/her basic life needs and permanently dependent on care and help from others. In February 2009, there were 29,800 recipients of the supplement in Slovenia. The total amount intended for benefit in 2006 was around €70 million (Prevolnik Rupel & Ogorevc, 2010).

Spain

In the Spanish system, there is a strict priority of benefits in kind over benefits in cash. Apart from a financial benefit that is linked to the provision of formal care services, there are two more cash benefits: one is linked to informal care provided by the family (see section on benefits for carers) and the other aims at promoting the autonomy of severely dependent people. Its objective is to contribute to the hiring of a personal assistant, for a number of hours, in order to provide the beneficiary with access to education and employment, as well as a more autonomous life in the exercise of the basic activities of daily living (Gutiérrez et al., 2010). Thus, also the latter cash benefit does not entirely fit here as it targets younger dependent persons and formal care.

4.2 Benefits for care providers

As with benefits for care recipients, we focus on two questions:

- What benefits or support are available?
- How is access to benefits organised?

More than half of all countries studied have some kind of cash benefit to support informal carers. Financial support for informal carers, however, can come in several forms: cash benefits might be sufficiently generous to be considered as replacing the income a carer might otherwise have achieved on the traditional labour market. This option, obviously, comes at considerable cost to the funder (usually local or national government) and is therefore an option found not too often, and only then available to a limited number of informal carers (e.g. the Danish benefit is restricted to 6 months, the Spanish cash benefit of €727 is granted only on an exceptional basis, and it is estimated that only one in ten 'heavy duty' providers of informal care in England receives a carer's allowance). Even where cash benefits are available, they are often limited to situations with a considerably severe need for care, as in the English situation where 35 hours of care per week are necessary to become eligible for the carer's allowance, or that the carer had to reduce working hours or give up paid employment altogether (Poland, Czech Republic before the 2006/2007 reform).

The public attitude towards financial support for informal carers differs considerably between countries: Sweden's attendance allowance is considered a 'symbolic payment' to support family caregivers but in fact is as large as the respective Italian benefit (around €487 according to Da Roit & Le Bihan, 2010). In most countries where a cash benefit for informal carers is present at

all, the amounts granted show that this is to be understood as support for carers or recognition of their efforts rather than as remuneration. Last but not least, there are countries where direct financial support for carers does not even result in an immediate payment to the carer's purse: in Austria and Germany, public authorities take over the payment of contributions to public retirement schemes for informal carers who do not participate in the labour market. Table 8 provides a European overview of cash benefits for informal carers; for national details please see below.

Table 8. Overview of monetary benefits for informal carers in Europe

Country	**Benefit**	**Benefit can be characterised as:**		
		Income supplement	**Income substitute**	**Other benefit**
Austria	Payments to cover respite care and contribution to public retirement scheme			yes
Belgium	Paid care leave schemes	-	yes	yes
Bulgaria	Sometimes, depending on individual situation		Minimum pay after training	
Czech Republic	Only until 2006, and then for full-time care	yes		
Denmark	Employment at municipality, special regulation for terminally ill, respite care		Monthly salary of 16,556 DKK (ca. €2,220) for up to 6 months	
England	Carer's Allowance: £53.90 (ca. €80)/week if min. 35h care/week	yes		
Estonia	yes, depending on local government		yes	
Finland	Usually €336/month, but max. €637/month	yes		
France	No	-	-	-
Germany	Payments to cover respite care, contribution to public retirement scheme			yes
Hungary	Social allowance is applicable but no specific LTC benefit, Ø €87/month	yes		
Italy	yes, regional differences	yes		
Latvia	Cash benefits of 100 LVL (ca. €140) can be given to representatives / carers instead of the disabled person	yes		
Lithuania	No	-	-	-
Netherlands	No	-	-	-
Poland	Nursing benefit: 529 PLN (ca. €135), more for disabled children than elders	-	-	-
Romania	Yes		yes	
Slovakia	Since 2009, 1.39 % of subsistence level (€2.58)/h of care for max. 4h/day	yes		
Slovenia	Yes			yes
Spain	Under special circumstances, Ø €727/month		yes	
Sweden	Many different benefits including the possibility of employment		yes	yes

Note: Ø = on average.
Source: IHS compilation based upon ANCIEN partners' contributions.

Austria

In Austria there is no benefit that could be seen as a direct payment for informal carers. As in France or the Netherlands, however, the cash benefit paid to the person in need of care is often used to pay informal carers, mostly without any formal agreement. In a survey, 58% of responding carers stated that only the existence of the care allowance makes care at home possible. At the same time it was stated that the care allowance cannot be seen as sufficiently high to enable carers to refrain from seeking employment (Pochobradsky et al., 2005).

There are, however, some kinds of direct support for providers of informal care, with financial support to cover social insurance contributions probably being the one affecting the largest number of carers: since 2006, informal carers for dependants of at least level III can receive financial support for contributions to the public retirement plan; since a recent reform the public covers all mandatory contributions for those entitled. In 2002, a family hospice leave system was introduced (*Familienhospizkarenz*): informal carers can take work leave, change jobs or change working hours in order to care for terminally ill close relatives or severely ill children. The time of leave is restricted to six months. In 2004, temporary limited financial support for informal carers was introduced, which is earmarked to finance respite care. In addition to this financial support, several services were introduced to facilitate information gathering for carers, like a '*Pflegetelefon*', a telephone hotline offering counselling for informal carers, an internet-based information pool on technical aids, and a platform for informal carers to facilitate the exchange of information and experience.

Belgium

In Belgium an extended system of paid leave schemes is in place, some of which are applicable to the provision of informal care. In order to be entitled to the usually flat-rate benefit, workers in general have to fulfil certain requirements, such as a minimal period with the employer. The level of the benefit is dependent on the age of the employee, the formula chosen (like amount of working time reduction chosen), the number of working years and the family situation. Those taking a career break keep all their social security rights and are protected from dismissal. In general, conditions regarding leave for specific circumstances (like the provision of care) are more favourable than those for less specific career breaks (De Lathouwer et al., 2005).

Bulgaria

Informal care is not regulated by legislation and it is not legally recognised or financially encouraged within the system of LTC services. No cash benefits are envisaged for informal care. The cultural traditions in Bulgaria encourage care for older people to be provided by family members, who accept this responsibility out of a sense of family duty. The legal situation reflects this tradition, as, for example, one of the placement requirements of LTC institutions for elderly people is that the clients should not have any family members capable of providing care for them (Mincheva et al., 2010; Dimova & Dimov, 2004, p. 7).

One recent development has been the possibility for unemployed family members to apply for and, following training, start work for minimum pay as personal or social assistants to a disabled family member, including older members (Mincheva et al., 2010).

Czech Republic

Only prior to 2007 were benefits provided to persons giving care. The benefit was given to a full time personal carer of a person who is mostly or fully incapacitated, or older than 80 and partially incapacitated. After the social services reform of 2006, the individual in need became the one to receive the allowance (Sowa, 2010; CASE, 2009).

Denmark

Danish social policy prefers formal care to informal care. Public authorities play a significant role in the provision of all kinds of long-term care and consequently a family's contribution to the personal care for older people, for example, is seen as being insignificant (Leeson, 2004, cited in Schulz, 2010a). In general, family members do not regard themselves as caregivers; they see themselves more as having a socially supportive role in relation to their older family members. Consequently, they understand their help in practical tasks as a natural part of this supportive rather than caring role (Schulz, 2010a). Lewinter (2003, cited in Schulz, 2010a) analysed the division of labour between informal carers and formal home helpers. She finds that basic cleaning and personal care is mostly the responsibility of the home help while other tasks are shared with the family members according to the individual situation.

Whereas informal personal care giving is not common in Denmark, the government supports family caregivers with specific measures that are fixed by law. The municipal council offers substitute or respite services to a spouse, parents or other close relatives caring for a person with impaired physical or mental function (Consolidation Act on Social Services, Chapter 16, Section 84(1), cited in Schulz, 2010a). Municipalities have to employ closely connected persons who are already employed or are seeking employment, and who wish to care for a relative with substantial and permanent impairments to physical or mental function in the person's home, if specific conditions are fulfilled. The carer may be employed for up to a continuous period of six months and receive a monthly salary of 16,556 DKK (ca. €2,220). Furthermore, a carer of a person who wishes to die in his/her own home is entitled to a constant care allowance, which amounts to 1.5 times the sickness benefit to which the recipient is entitled (Schulz, 2010a).

England

There has been an increasing emphasis on support for informal carers in government policy in England over the last two decades (Pickard, 2001 and Beesley, 2006, cited in Comas-Herrera et al., 2010) The national strategy for carers puts emphasis on providing support for carers to enable them to continue providing care (Her Majesty's Government, 2008). Since the mid-1990s, providers of substantial and regular care have had the right to a local authority assessment of their needs for services and, since 2001, they have been entitled to receive services in their own right. However, only a minority of 'heavy duty' carers receives assessments and only around one in ten receives carer-support services (Beesley, 2006, cited in Comas-Herrera et al., 2010). However, perhaps the most important type of support offered to informal carers in England is not the carer-specific services, on which policy has focused over the past 20 years, but a longer-established cash benefit for carers.

The long-term care system in the UK has been characterised as one in which there is "limited or average provision of formal home care but extensive financial support for informal care" (Lundsgaard, 2005). Informal carers providing at least 35 hours of care per week can apply for a cash benefit called the Carers' Allowance. It amounts to £53.90 (ca. €63) a week, is paid to informal carers who earn less than £100 (ca. €118) per week, are not in full-time education and look after someone who receives any of the qualifying disability benefits, like Attendance Allowance. Carer's Allowance is based on a social security model of payments for care and is regarded by the Department for Work and Pensions as a compensation for loss of earnings, not as a wage for caring. There were approximately 510,000 recipients of Carers' Allowance in England in 2008, and UK expenditure on the allowance was approximately £1.3 billion (€1.5 billion) according to the National Audit Office (NAO) 2009, cited in Comas-Herrera et al. 2010). Carer's Allowance (and its predecessor, the Invalid Care Allowance) is often criticised, primarily because of its low level, its poor coverage of heavily committed carers, its complexity and its failure to facilitate employment and caring (Pickard, 1999, National Audit Office

(NAO), 2009, cited in Comas-Herrera et al., 2010). The present (2010) Coalition Government has recently published a White Paper proposing the introduction of a Universal Credit, which may involve changes to Carer's Allowance (Department for Work and Pensions, 2010, p. 19).

Estonia

Informal care is mainly funded by local governments and is closely related to the economic possibilities of the local governments; they also decide whether to pay benefits to caregivers or not (Paat & Merilain, 2010). Local governments offer supporting services to assist persons taking care of their relatives, e.g. domestic help, and assistance for the establishment and activities of various support groups. Local governments pay compensation to carers to cover the costs related to caring, which is not considered a remuneration/salary. These cash benefits amount to €13-81 per month. In addition, there is a special kind of family care: care of a person in a suitable family where he/she is not a member of the family (Paat & Merilain, 2010).

Finland

As in the other Nordic countries, the Finnish LTC system tends to favour formal care but does offer support for informal care and informal carers. Carers who stay at home to take care of a relative can be eligible for a special home care allowance. This allowance is given to the carer by the municipality and constitutes a taxable income. The amount of support is usually €336 per month, but can be up to €637 per month if the work to be done is particularly demanding. The home care allowance can also be combined with various types of home care (Johansson, 2010). In Finland there is no national definition of 'need for care' or a common national procedure of needs assessments. Municipalities can to a large extent decide on how needs are to be assessed. However, the Ministry for Social Affairs and Health has issued guidelines for what is to be considered good practice in needs assessment (Johansson, 2010).

France

As the care allowance 'APA' can be used either to purchase formal care or to employ other persons (including unqualified carers and family members) to provide the special care, it can be seen as an indirect form of support for informal carers, even though APA is paid to the person in need of care. There is, however, no direct financial and not much other support for informal carers in France. Several smaller measures have been recently discussed, however, like better combination of working and caring, better recognition of informal care and the development of respite services. Since 2007 working carers have the right to leave their job for three months without losing retirement rights (Joël et al., 2010).

Germany

LTC insurance pays contributions to the retirement plans of informal carers whose employment does not exceed 30h/week and who provide care for at least 14h/week. The amount paid depends upon the level of dependency and the amount of care provided. LTC insurance covers the expenses of a professional carer or another informal carer up to four weeks a year and up to €1,470 when the main carer is ill or on vacation. During the provision of informal care or travel connected to this care, informal carers are protected by social accident insurance. Informal carers can apply to be covered by unemployment insurance, contributions for which, however, have to be borne by the carer alone (Schulz, 2010b).

Informal carers can attend courses that are organised by or in cooperation with LTC insurers. Courses cover nursing care but offer also other relevant topics, information, counselling and an opportunity to exchange experience. LTC insurers pay some contribution to measures that adapt

the domestic situation to caring needs, like wider doors, ramps or special bathroom appliances. The contributed amount depends on the income situation of the care recipient, but is intended to facilitate the informal carer's work (see www.bmg.bund.de, April 4th 2011).

The 2008 reform introduced, among others, nursing care time (*Pflegezeit*): employees may take leave from work for up to ten days in order to organise LTC for a close family member in cases of sudden need. Furthermore, employees may stay absent from work for up to six months in order to provide informal care to a close relative. This entitlement is valid only for employers with at least 15 employees, and there is neither a provision for the continuation of payments, nor a respective insurance benefit. Nevertheless, LTC insurance pays contributions to unemployment insurance, health insurance and LTC insurance for respective caregivers.

Hungary

Relatives caring for a severely disabled or a permanently ill young (<18yrs) family member can submit an application for a social care allowance called a 'nursing fee' to the local authorities. Applications need to be based on the expert opinion of the GP. This allowance, however, is not targeted to the long-term care of elderly people. Additionally, social legislation provides an opportunity for local governments to give financial help to relatives caring for a family member aged over 18. In 2007, only 19,000 family carers received such support (including younger care receivers) while the number of 60+ was 2.2 million persons. On average, the support amounted to €87 per month (Czibere & Gal, 2010).

Italy

Traditionally, in Italy specific policies for family carers have never existed, since family care by other family members has always been taken for granted, as a sort of compulsory duty. During the last few years politicians seem to have become more aware of the issue of caring for dependent older people, but this has not yet resulted in specific norms. Meanwhile, among carers and organisations for older people, debate about the rights of carers is growing, with a view to questioning this 'traditional' mentality and to take steps to promote assistance and support for family caregivers through social-institutional services. The health plans for 1998-2000 and 2003-05 include the objective to support families in their role as carers for elderly people in need at home. But very rarely have these general guidelines been followed closely, and if they have, through services not integrated with one another. Furthermore, some regulations run the risk of remaining only on paper and regions are assimilating them in different ways (Polverini et al., 2004, p. 32).

Thus, Italy does not have any national legislation concerning cash benefits to households in order to support the care of relatives. Existing cash benefits from regional or municipality level were originally conceived as a measure to support relatives – typically spouses or daughters/sons of the older person – but are now mainly targeted to co-fund private home helpers and carers. These cash benefits are provided both as mere monetary support or integrated with the other personal and social services provided by the local authorities (Tediosi & Gabriele, 2010).

Latvia

There are no statistics available about the demand and supply of informal care in Latvia. However, in 2005, 1,073 informal care providers received some benefit in cash (Gulbe, 2010). Disabled persons older than 18 years who need special care can receive 100 LVL (about €140) per month. This benefit can be paid to the disabled person or his/her representative, who might be an informal carer; it is, however, not a special benefit designed for informal care but is rather linked to disability.

As in most European countries, the ageing population in Latvia is adding to the urgency of developing alternative care services – including informal care – to provide care to all persons who need it; this is also what social policy claims to set as its goal. The main reason why informal care is not developed in Latvia is the assumption that family members cannot provide sufficient care to older family members due to their engagement on the labour market and the generally small size of living space. Most families do not have sufficient financial means to leave a job and take care of their relatives (Gulbe, 2010).

Netherlands

There are no special benefits for providers of informal care. This may be seen in the context of analysts like Pommer et al. (2007) or Kraus et al. (2010) placing the Netherlands among Scandinavian countries, where formal care is rather more widespread than informal care. About 250,000 persons in the Netherlands receive informal care, more than 600,000 persons receive formal home-based care and about 253,000 institutional care, among which 164,000 persons are elderly (Mot, 2010). People in need of care who are granted a personal budget, however, can and often do use this money to pay for informal care. Appropriate payment for informal care was one of the reasons for the implementation of these budgets (Mot, 2010).

Poland

Nursing benefits for the family caregiver of disabled or older (i.e. 75 or more years of age) dependent persons were introduced in 2003, if the caregiver had resigned from professional work in order to provide informal care. Access to this benefit is limited by the income criterion that is obligatory in the family benefit system (part of the social assistance). It is used mainly by parents of disabled children, and to a lesser extent by informal carers of the elders. The nursing allowance for caregivers amounts to 520 PLN (ca. €117) per month (2009). The total expenditure for this benefit decreased from 357.4 million PLN (ca. €91.7 million) (2006) to 336.5 million PLN (ca. €95.8 million) (2008); this figure comprises expenditure for care recipients of all ages (Golinowska, 2010).

Romania

Most dependent elderly people are cared for by family members. However, family care is ensured mainly in rural areas, where the traditions and moral values are maintained to a greater extent. There is very little statistical data available on the extent of informal care among the population. The importance of informal care is widely recognised throughout the country but no official estimates have been made so far (Popa, 2010).

The spouse or relative who takes care of a dependent older person can benefit from compensation from the local budget. If the individual is salaried and working part-time, they can claim support for the remainder of their salary. Alternatively, they may receive the equivalent of a gross monthly salary of a newly qualified social assistant with an intermediate level of training (Vladescu et al., 2008, p. 127).

Slovakia

Since January 2009, family members or close contacts can receive some payment for the provision of personal assistance; before this date only professionals could receive remuneration for this service. The payment is set at 1.39% of the subsistence level per hour of care (in 2009, this amounts to €2.58), but is limited to four hours of care. Alternatively, a provider of informal care can receive a care allowance of €206.16 per month, provided that informal care is delivered for at least eight hours per day (level 5 on the scale of disability – ADL). On average, carers

receive about €150 per month (Radvanský & Páleník, 2010). Furthermore, there are some supportive benefits like coverage of social insurance contributions, leave entitlements from the regular job, or temporary care assistance (SAS-BIER, 2009).

Spain

In the Spanish system, there is a strict priority of benefits in kind over benefits in cash. There is a financial benefit for family care, but it should be used on an exceptional basis only, when the beneficiary is being cared for in the family setting and as long as the home meets adequate requirements regarding co-habitation and habitability. The carer must comply with the rules on affiliation, registration and contribution to social security that are laid down in the regulations (Gutiérrez et al., 2010). The average monthly cash benefit amounts to €727, which is an indicator that the benefit can be regarded as an income substitute (FEDEA, 2009).

Sweden

For the greater part of the 20th century, there was a tradition of elderly people's care predominantly being a concern of the state rather than of individuals or their families. Informal care has therefore been of minor importance; formal care was and still is the backbone of LTC for the older population. Only recently, facing the current and likely future demographic situation, as well as likely budgetary impact, formal home care has gained in importance, attributing a more pronounced role also to informal care (Fukushima et al., 2010).

Since the first initiative to support informal care providers in 1997, an increasingly long list of services has been created with this aim. A research institute with the aim of coordinating research and development in the field of informal care and supplying information and documentation to caregivers was founded in 2008 (Nationellt Kompetenscentrum Anhöriga – NKA). Furthermore, the law has required municipalities to support informal caregivers since 1 July 2009. The Social Services Act states that municipalities are obliged to respect and cooperate with informal caregivers and offer individually tailored support when needed. The objectives of the act are to help reduce the workload, prevent illness, and provide informal caregivers with the knowledge and the information they need in order to continue the support. An additional purpose of the introduction of the act is to officially recognise informal care providers and to acknowledge the importance of their work.

The support provided to informal caregivers is not clearly defined in Sweden today, and different municipalities offer different types of support to relatives, due to the lack of clear definition. For instance, only 38% of the municipalities offered education for informal care providers in 2008 (Länsstyrelsen i Västra Götaland, 2009, cited in Fukushima et al., 2010).

Fukushima et al. (2010) provide a list of public services available to support informal carers in Sweden. For instance, there is the possibility to employ the carer and thus fully compensate for the work of caring for an older person when the care provided by formal home care is insufficient; assessment is required. There is also a cash benefit to compensate informal carers for their efforts since these may reduce the care provider's ability to work. This benefit amounts to 1,000-3,000 SEK (ca. €108-324) per month but is not available in all parts of Sweden. The number of recipients of such support was 5,200 in year 2006, which is an increase from 4,600 in year 2000. National social insurance offers a temporary cash benefit to carers for up to 60 days to compensate for lost income when caring for a close relative who is terminally ill. Other benefits include respite care, short-time care in nursing homes, and several counselling and educational services.

5. Discussion

Our review of European countries shows that almost all the countries studied offer some kind of monetary benefit that can be used as support to finance long-term care provided through informal carers. The only exception is Lithuania, see Table 9. Roughly two thirds of all countries studied provide a payment directed to the recipient of care, and slightly more countries offer payments directed to informal carers. In eleven countries both informal carers and recipients of care can be eligible for some kind of payment. The mere existence of payments, however, should not mislead: not only do the levels of these benefits vary considerably between countries, but also the rules governing access are extremely heterogeneous. In many countries, including several new members of the EU, even though there are no special (cash) benefits designed to support informal care for all or older age groups there are other kinds of benefits that can be used for this purpose. For example, in several countries regulations require some recognised level of disability, and in some other cases (Poland) there are more or less substantial universal benefits for an age group like 70+ (Latvia, but restricted to persons without state pension), which are intended to cover costs arising from special needs. Consequently, we have to assume that coverage through cash benefits varies accordingly across Europe.

The literature emphasises that benefits in cash broaden the care recipient's choices (Lundsgaard, 2005; OECD, 2005). Cash benefits designated for LTC may or may not be earmarked to be used for formal LTC services only; but in our context those benefits that at least *could* be used to remunerate informal care providers are mainly of interest. In many cases, however, the recipient of the benefit is free to decide whether the payment should be used to buy formal or informal care, e.g. the Austrian Pflegegeld, Dutch personal budgets or the French APA can be used for either purpose. A significant difference remains, however, because the use of APA for care purposes is strictly controlled, which is not the case with the Austrian cash benefit.

Another difference between benefit regimes relates to the level of benefit: German and Dutch LTC systems provide cash benefits and allow for a choice between both formal home care services (which in the German case would be provided as service in kind, and in the Dutch example would be financed at least partly by means of the cash benefit) and informal care. But German and Dutch insurers pay considerably lower benefits for given severity of need if informal care is chosen: the assumption is that informal care can be purchased more efficiently than formal care, and consequently authorities offer lower benefits for informal than for formal home care (for Germany, see Table 7). Other cash benefit systems like the Austrian or the Italian one, however, do not make such a distinction.

In Work Package 1 of the ANCIEN project two approaches for a typology for European systems of long-term care were developed (see Kraus et al., 2010). Table 9 compares the availability of cash benefits for informal care with those typologies. One typology relies more intensively on organisational matters and a classification of the respective LTC system is available for all 21 countries studied, while the second typology also takes the use of different kinds of LTC services into account, but can provide a classification only for a subset of countries. For two reasons a comparison with the organisational clustering is more straightforward than a comparison with the typology of take-up of care: first, the present paper focuses more on the regulatory characteristics than on empirical measures of informal care, and second, the sample of countries analysed in this paper coincides with the organisational clustering.

We find that seven out of the ten countries with some kind of cash benefits usable by both care recipients and informal carers can be found in the same group of the organisational typology. Put differently, all members of group two of the organisational clustering provide cash benefits for care recipients as well as informal care providers. In group 4 of the organisational clustering all varieties can be found, monetary benefits for both (Poland, Romania), neither (Lithuania), and only one (Hungary) possible recipient of a payment, while group 3 perhaps tilts towards a

lower availability of cash benefits. All members in group 1 provide cash benefits usable by at least one party, either carers or care receivers, and two members (Germany, Belgium) for both.

Table 9. Availability of cash benefits by type of LTC system

Country	Monetary benefit for:		Organisational typology	Use of care typology
	Care recipient	Informal carer		
Belgium	yes	yes	1	1
Denmark	no	yes	1	2
France	yes/no	no	1	3
Germany	yes	yes	1	1
Netherlands	yes	no	1	2
Sweden	no	yes	1	2
Austria	yes	yes	2	3
England	yes	yes	2	3
Finland	yes	yes	2	3
Italy	yes	yes	2	4
Latvia	yes	yes	2	n.a.
Slovenia	yes	yes	2	n.a.
Spain	yes/no	yes	2	3
Bulgaria	no	sometimes	3	n.a.
Czech Republic	yes	no	3	1
Estonia	no	some regions	3	n.a.
Slovakia	no	yes	3	1
Hungary	no	yes	4	4
Lithuania	no	no	4	n.a.
Poland	yes	yes	4	n.a.
Romania	yes	yes	4	n.a

Source: IHS HealthEcon compilation 2010, Typologies: Kraus et al., 2010.

As was already noted in the organisational typology, Eastern European countries vary considerably with respect to the design of their LTC systems. This is very much also the case for cluster 4 of the typology and benefits usable for informal care: while Romania and Poland provide some kind of monetary benefit for both care recipients and providers, we find the reverse situation in Lithuania, which belongs to the same cluster: Lithuania provides monetary benefits for neither informal care receivers nor informal care providers. The general attitude towards the provision of informal care also varies considerably: in countries like Poland and Bulgaria the traditional role of the family as the most important provider of care still seems very intact. In Bulgaria this results in persons being placed in institutions only if there is no family member who can take on informal care. In some Baltic countries, on the other hand, it is assumed that families are too dependent on the salaries of all adult family members to be able to spare the time for informal care, so informal care is therefore perceived as being a rather rare option. This difference in perceived roles seems very plausible when labour market statistics are considered: in the Baltic States: a far lower number of persons is at least theoretically available for care provision than in other new EU member states, as e.g. Figure 2 and Figure 3 show.

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ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).