The future of care in Europe

Exploring the trade-offs that are driving change

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Introduction

In this paper we update the mapping of care provisions in Europe and examine change therein. Our main line of argument is that change under way in the organization of personal care stems from the often conflicting goals of ensuring sustainability of public finances and affordability of services for the family. We also argue that the process of change impinges on the issue of who the employer is. To this purpose we introduce a distinction between »formal« care services and »family-managed« care, i.e. when the family hires and manages care workers directly.

First we bring up to date statistics about care provisions in European countries focusing primarily on eldercare and separately accounting for formal and family-managed care provisions. We then show by means of standard clustering techniques how European countries are re-grouping with respect to the level and type of eldercare care provisions in ways that only partly conform to familiar typologies of care regimes. Finally, we examine how issues of affordability and financial sustainability are driving change in care regimes and how this impinges on the question of who the employer is. The concluding section rounds up the discussion.

The growth of paid care

The growing importance of families that hire and manage care workers directly warrants some change in the semantics of care provisions. It is fairly common in the literature to oppose formal and informal care, where informal is identified with unpaid care by families and friends while formal is understood residually and often made to coincide with paid care. Eurostat has recently introduced a different concept of formal care. With specific reference to childcare Eurostat clarifies that »*Formal arrangements include all kind of care organised/controlled by a structure (public, private). Care provided by childminders without any structure between the carer and the parents (direct arrangements) have been excluded from the definition of ›formal care‹ in order to take into account only childcare recognised as fulfilling certain quality patterns.*«[1] Formal childcare provisions thus defined include: (i) pre-school education or equivalent; (ii) compulsory education; (iii) childcare at centre-based services outside school hours; (iv) childcare at day-care centre organised/controlled by a public or private structure.

Eurostat does not provide an equivalent list of formal elderly care provisions, since there is no systematic data collection on this issue. Broadly speaking, however, all institutional care can be viewed as conforming to the aforesaid definition of formal care, together with home care services bought by families from market agencies and firms or furnished by public concerns.

While in this paper we conform to the Eurostat definition of formal care, we deem unsatisfactory to lump together under the heading of »informal care« unpaid care from families and friends and services furnished by care workers hired, paid and managed directly by the family such as childminders. We propose instead to separate out these two components and let the term »family managed care« denote services from workers directly hired by families. Household helpers, personal care workers and paramedics giving assistance to the elderly at home thus come under the heading of family managed care, alongside childminders. Throughout this paper, therefore, paid care refers to both formal and family-managed care, while unpaid and informal care are used interchangeably.

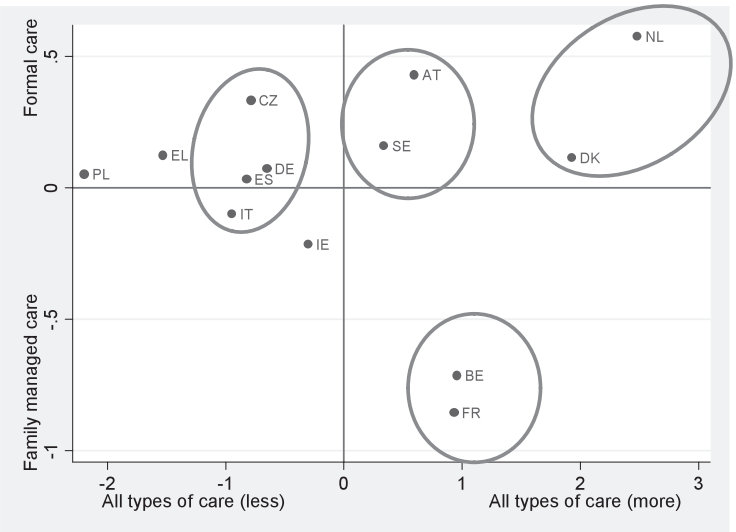
Unpaid care by family and friends, still largely outweighs paid, commoditized care. However, the balance is changing in favour of the latter across European countries. For pre-enlargement Europe there is clear evidence of the growing incidence of commoditized care services over the recent decades (Table A1). The paucity of comparable statistics and the partial demise of formal care infrastructures during the transition – childcare facilities in particular – complicate identification of trends regarding the former socialist countries. Even for these countries, however, there is some evidence that the trend in commoditization may have been upwards in most recent years.[2]

With specific reference to elderly care, residential services declined over the past decades in all the countries except Italy, but the decline was more than off-set by the fast expansion of home care (Table A2). This expansion was not confined to home help and personal care services furnished by organizations (formal care). Family-managed care services have grown considerably in the wake of the so-called »cash-for-care« policy shift, a move evident throughout Europe away from the direct provision of subsidized services towards the granting to households of allowances to be spent on services (Ungerson and Yeandle 2007). The process has been especially marked in elderly care in concomitance with the progressive transition from institutional to home care. Despite a common name, cash-for care schemes may actually be very different and carry different implications for patterns of use, quality of care and of employment that they foster (Le Bihan and Da Roit 2010, Simonazzi 2009, Simonazzi and Picchi 2011), but the claim that they now represent important income supplements for older citizens in a large number of European countries is soundly based[3]. By all evidence, therefore, the cash-for-care policy shift adds to the reasons why family-managed services can no longer be ignored.

The re-grouping of countries by level and mix of care services

In Chart 1 countries are clustered according to the level of and mix between formal and family-managed provisions for the elderly. The indicator used for formal care is the combined coverage rate for home and institutional care, while that used for family managed care is the share of home care recipients resorting to (paid) care workers and professionals when care is needed daily or almost daily (Table A2). Component one (X axis) captures comparative recourse to all types of elderly care provisioning (higher from left to right). Thus countries included in the left panels have less of both formal services and family managed care, those on the right panels more of both. The Y axis opposes formal care to recourse to paid care workers and professionals on

Chart 1: Clustering European countries: elderly care[4]



Source: own calculation; Table A2 for the data.

the part of families: the higher up a country is the stronger its comparative reliance on formal care, the lower down it is the higher its recourse to paid and professional workers. Four clusters are identified that comprise, respectively, the Netherlands and Denmark, France and Belgium, Austria and Sweden, and a larger group formed by Italy, the Czech Republic, Germany and Spain. Ireland, Greece and Poland stand alone.

There is some continuity between this clustering and the earlier typologies of long-term-care regimes. For example, France and Belgium formed a stand-alone group in the typology of Bettio and Plantenga (2004) as they do here. However, discontinuity prevails, as illustrated by the cluster comprising Austria and Sweden, two countries traditionally allocated to different regimes.

There is more than one way to make sense of this discontinuity. Differences in the number and composition of the countries considered, and the limited focus on formal versus family-managed services in the present analysis may be rightfully invoked. However, the evidence in Chart 1 is also consistent with the hypothesis that care regimes are changing. And change has been more pronounced where care services have grown faster, namely home care for the elderly. The specific line of reasoning that we develop in the sections to follow is that change ensues from the need to accommodate the potentially conflicting goals of ensuring sustainability of public finances and affordability of services.

Drivers of change in care regimes

In order to develop our argument, we briefly review evidence on the financing and the affordability of home care services in two home care arrangements, ones that we denote as the »migrants-in-the-family arrangement« and the »voucher-based

system«. As the term of comparison we take the architecture of home care in Nordic countries, which has undergone less dramatic change in recent years.

Nordic countries. The hallmark of Nordic countries' response to the search for affordability and financial sustainability in (home-based) elderly care is universal access to subsidized care, with affordability for users and financial sustainability made (more) compatible by the pronounced rationalization of care hours. Rationalization typically hinges on a comparatively skilled workforce, as well as on assistive technology. In order to look into this response in some detail we need, however, to examine specific countries. We take Sweden as a representative case while referring very briefly to other countries.

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

In July 2002, a new system of fees was introduced for the long-term care of the elderly and the disabled. The purpose of the system was to protect individuals against excessively high costs for municipal care, and to ensure that all citizens retain a minimum sum for living expenses after all fees have been paid. This minimum is known as »reserve sum« (förbehållsbelopp) amounting to between € 475 and € 400 in 2010 depending on household composition (Socialstyrelsen 2002). The reserve sum should cover all household expenses except care facilities. At any rate, the maximum fee that the municipal authorities may charge for home care services corresponded in 2010 to 15% of the »reference income«. The latter is defined as the actual, average income in the country for a person aged 65 years or more and living on her/his own.

Other countries traditionally assigned to the Nordic care or welfare model report rather affordable home care services for the user. In Denmark, an elderly person receiving care plus meals on wheels pays, on average, 14% of the reference income as just defined (Sjørup 2010: Grid 4). In Finland, home care can be free. Paying users are charged about € 170 per month, i. e. about 16% of the reference income (Sutela 2010[5]: Grid 4). In Iceland, the per hour fee for home care was approximately € 3 in 2009 (Hrafnista, in Johannesson 2010: Grid 4).

In all these countries, home care is made affordable not only because it is highly subsidized by general taxation but also because face time is extremely rationalized. In the late 00s the average number of weekly hours in home care was 2.9 per week in Sweden and 2.5 in Iceland (Nyberg, 2010 p. 16; Hrafnista, in Johannesson 2010: Grid 4). In Denmark, average referral hours per week ranged between 4 to 6 per week (Sjørup 2010: p.5). Of course, these figures are averages across levels of disability, and may therefore distort rigorous inter-country comparisons. Nevertheless, they are indicative of the strong rationalization of hours.

The »migrant-in-the-family« innovation in elderly care. At the opposite extreme of publicly organized and highly rationalized home care services lies the 24-hour

live-in care workers arrangement to be found in countries as different as Austria, Cyprus, Turkey and Portugal, but very widespread in Greece, Spain and Italy. In these countries, the home care segment has grown in parallel with the supply of migrant workers hired by the family: primarily female migrants from Central and Eastern Europe to Italy, Greece, Austria and Turkey, from the Philippines and Sri Lanka, to Cyprus and from Eastern Europe or Latin America to Spain. Key features of this arrangement are extended hours of care and selective affordability based on an abundant supply of foreign workers from within or outside the EU. The vast majority of such workers are poorly trained, and a sizeable number of them do not have regular employment contracts.

The phenomenon has been studied in some detail in Italy, where it has assumed large proportions. It is estimated that about 700-800 thousand foreign carers worked in childcare or long-term care around 2008, primarily the latter (Censis 2008: p.16). Different sources of evidence concur that these workers supply the bulk of all commoditized home-based long-term care in the country.[6]

By law and tradition, long-term care in Italy is the responsibility of the family. The modest expansion of public services over the past decade has been intended to complement rather than substitute for services provided or bought by families. Caught between the strong rise in demand and sluggish public provisions, Italian families have taken advantage of cash transfers to hire cheap (female) immigrants from Eastern Europe soon after the fall of the Berlin Wall. Live-in, all-purpose long-term care workers known as »minders« (*badante*) have become popular, and the market has extended to per-hour or per-day minders, who now represent the growing segment. Migrant care workers often also perform paramedic tasks, relieving families from the need to hire skilled carers, at least to some extent.

The minimum cost to the family of a regularly employed live-in care worker can be estimated at around € 1100 a month for 2007, including social security contributions. The figure exceeds by 10% the reference income (for older people) in the same year. Only if the older person receives the most widespread cash-for care scheme – *indennità di accompagnamento* – does the ratio between the cost of a regular live-in carer and total income (i. e. reference income plus the allowance) diminish to 74%. Alternatives are to hire care workers on an hourly basis when disability is not severe, or to hire in-living workers in the black market, or both. The black market may yield a discount up to 40%-50% in the poorer regions of the country (the South). The combination of the black market and a sufficiently wide coverage of the attendance allowance makes the live-in care worker option affordable for a sizeable minority of families. The latest estimate of elderly-care workers irregularly hired by families is around 50% (Pasquinelli and Rusmini 2008: Table 3).

The live-in carer option is popular in other countries that are destination venues for migrant workers: Mediterranean countries such as Spain and Greece, but also Turkey and Cyprus, and non-Mediterranean countries such as Austria. In Cyprus, home care is largely provided either by informal, unpaid carers within the family or paid, live-in female migrant workers mostly from Asian countries. Standard contracts set by the government contribute to keeping the wages of these workers very low (Ellina 2010). The case of Greece is similar to that of Italy in important respects. Public home care services cover a modest share of the older population in the country, while a not negligible proportion of the existing demand is met by hiring

migrant care workers, mostly from the Balkans and Eastern Europe (Lyberaki 2008, Karamessini 2010). In Spain, the text of the Ley de Dependencia enforced in 2006 prioritizes services in kind over cash transfers. But the current rationing of these services as well as the level of fees are inducing families to opt in favour of cash transfers and hire live-in migrant, all-purpose, care workers for between € 700 and € 800 per month (León 2010: p.15). Even in Turkey, Turkish-speaking female workers migrating from countries such as Bulgaria, Moldova, Romania and Ukraine are hired by families who can afford to pay a monthly wage of 500-1500 euros (depending on the severity of the client's disability, Ozar 2010).

The case of Austria deserves attention because it illustrates how the live-in care option can be attractive also in countries other than South European ones. Home care services in Austria have grown considerably since implementation of the long-term care insurance scheme in 1993, but geographical proximity to East European countries has boosted immigration in the LTC sector, especially from Slovakia. Experts estimate that approximately 40.000 illegal care workers supported people in need of long-term care and their families in the mid-2000s (see Rudda and Marschitz 2006, and Schneider and Trukeschitz 2010). Foreign care workers are often qualified nurses who commonly choose to commute between their home country and Austria every other week or every two weeks, staying with a care client for a full week or fortnight. Since the estimated cost to the user of regular nursing home care on a full 24-hour basis was between € 3.000 and € 4.000/month in the mid-2000s (Schneider/Trukeschitz 2008, quoted in Mairhuber 2010), most foreign workers were hired illegally. In response to these developments, a new scheme offering financial support of between € 500 and € 1.000 per month was enacted in 2007. It was intended to offset the considerable burden of social security contributions for families hiring carers and thus favour the emergence of irregular employment in this sector. Furthermore, legislation was passed one year later to »ease« contractual duties on families (Mairhuber 2010: p.22).

Service vouchers in France. The organization of home care for the elderly in France can be viewed as offering a response to the twin goals of affordability and sustainability intermediate between that of Nordic countries and that of Mediterranean countries. Belgium operates a system partly inspired by France. Specific features of the French system are strong reliance on private as well as public providers, less rationalized hours of care compared to Nordic countries or the Netherlands, but hours much shorter than those that a migrant-in-the-family arrangement may offer. In principle, the system encourages the emergence and regularization of foreign labour, and has the potential of ensuring a fairly well-trained workforce.

The French National Health Service offers medical and nursing services to the elderly at home, mostly for free, whilst home help and personal care (including some nursing and paramedic services) are increasingly provided through a user-friendly, universal service voucher scheme (*Chèque Emploi-Service Universel – CESU)*. Vouchers can be used to buy home help and personal care from accredited care providers, the cost to the families being subsidized by a combination of tax allowances, rebates on social security contributions, and the Allocation Personnalisée à l'Autonomie or APA, a (near) universal allowance enacted in 2002. Affordability can be viewed as intermediate between the Nordic and the Mediterranean solutions. With reference to 2003, and for the bracket comprising the reference income, it was estimated that,

users' co-payment ranged from 25% of income for people with mild disability to 55% for those with severe disability. The corresponding number of hours of care was 44 and 105 per month, i.e. between 10 and 30 hours per week, respectively (Cour des Comptes 2005, quoted in Silvera 2010).

The future of care in Europe: balancing difficult trade-offs

If a hypothetical policy-maker had to choose among the different solutions to the affordability and sustainability problem adopted by European countries, s/he would be confronted with two intertwined trade-offs. The first is between hours of care, on the one hand, and universal affordability on the other; the second is between job-creation potential and quality of employment. As noted, moreover, the quality of employment strongly impinges on the quality of the services being provided.

Nordic countries have long been aware of the tension between generosity with care time and affordability. The most affordable solution for home care typified by these countries must rationalize hours of care in order to ensure the widest coverage. At the other extreme lies the round-the-clock, live-in care worker arrangement of Mediterranean countries, which is made affordable for a significant minority of families by public subsidies and large supplies of migrants working in the irregular segment of the market. Such extended hours of care, however, become expensive as soon as migrant labour is regularly employed, and more so when skilled, nursing care is given. The clearest example in this regard is Austria.

When extended hours of personal care are provided, a non negligible portion of the care time involves social and emotional rather than professional skills (i.e. for minding or providing companionship to the older person). Rationalized hours of care require a comparatively smaller but more skilled workforce, because paramedic tasks or assistance with personal hygiene are less easily compressed or neglected than social skills. Hence extended hours may promote more employment than rationalized hours, but a comparatively less skilled workforce. When the hiring and managing of care workers is done by organizations, public or private, there are both the incentive for the employer and the organizational capacity to rationalize hours, while the pressure from workers may facilitate investment in skill and structure career paths. When the hiring and managing of care workers is entrusted to the family, the latter is typically interested in maximizing the hours of work if the hiring and the salary are per period, or minimizing hourly costs if the hiring is on a per hour basis.

Families also tend to be less concerned about workers' skilling or career, and to hire on the irregular market if the option is easily available and helps keep hours long and/or salaries low. This in no way implies that low wage, low skill care firms or agencies do not exist or that families cannot be encouraged by public policies and incentives to regularize workers, facilitate training and make sure that the desired standard of care is delivered. Families cannot, however, be assumed to systematically do all this on their own. Evidence of large pockets of irregular employment not only in Mediterranean countries but also in Austria (at least before the 2007 reforms) and in Germany where families can use the Long Term Insurance to finance their purchase of care services bears out this point (Simonazzi 2009; Le Bihan and Da Roit 2010).

The relative pay and the working hours of care workers in Italy concretely illustrate how the nature of the employer may matter for the quality of employment. In

around 2007 the gross, average, monthly contractual earnings of a full-time blue collar in industry amounted to € 1647; the base contractual earnings of a full-time, semi-skilled care worker employed in the public sector ranged between € 1475 and 1706 depending on seniority; and the contractual earnings of an in-living »family assistant« – the official job title for in-living care workers hired by families – were set at between € 882-1032 depending on seniority in family employment (Bettio and Verashchagina, 2010: Table 12).[7] Thus semi-skilled care workers in formal employment tend to be paid less than the average blue-collar worker even when they are hired by the public sector, and top-experience »family assistants« earn even less. But the most controversial issues are hours of work and regular hiring. The contract for in-living workers specifies a maximum of ten hours per working day. To date, however, the *de facto* tacit understanding between (foreign) workers and families has been that the former are »available« round the clock, including those hired on a regular contract. The option of going irregular facilitates tacit infringement of contracts. Moreover, it tempts families with a salary »discount«.

With the *chèque services* system that abates the cost to the families (and to the state) of supplying sufficiently long hours of care, France – and to a lesser extent Belgium – may have found a more balanced response to the trade-off between hours of service and affordability. The system has also revealed good job-creating potential. According to the French government, 100 thousand jobs were created each year between 2006 and 2008, and this positive trend is expected to continue[8].

It is still unclear, however, to what extent a French-type system can ensure good quality employment in the personal care sector. On summarizing evidence and research on working conditions for employment created via *chèque services*, Silvera (2010) states that the sector is still marked by poor employment, training and working conditions – atypical hours, fixed-term contracts, low levels of education and of vocational training« (Ibidem: p.11). However, *chèque services* are used to buy gardening or home help and not only care services. In the specific case of home care for the elderly, other French scholars maintain that the introduction of the APA allowance and the universalization and rationalization of service vouchers (CESU) are making a real difference to care workers. Allegedly, the majority of care hours subsidized by the APA are being paid through a service provider and not directly by the care beneficiary or his/her family, thus moving part of employment to the formal segment and away from family management. The training received by care workers has recently been reorganized, resulting in a significant increase in the number of trained personnel, and the services provided are now subject to quality regulations (Campéon et al. 2008, quoted in Silvera 2010).

Conclusion

Growing commoditization of personal care is pushing for change in care regimes as new national responses are being found to the often conflicting goals of ensuring financial sustainability of publicly subsidized provisions on the one hand and affordability of services on the other. The conflict has become more apparent in the fastest expanding segments of the (personal) care market, namely home based care of the elderly. Here two intertwined trade-offs typically arise from the way different countries balance financial sustainability and affordability. The first trade-off is between

care service time and universal versus selective affordability of services while the second opposes job-creation potential and quality of employment in the care sector, including regularity of contract, training and career prospects.

Given forecasts of fast increasing demand for personal care over the next decades it is the second trade off that is likely to dominate debates and policy choices about care in the future. It has been estimated that, under the assumption that elderly care policy will not change (i.e provisions will be increased in proportion to the rise in disability) those receiving care in institutions will almost triple in the European Union between 2008 and 2060, reaching 8.3 million, and those receiving informal or no care will increase from 12.2 to 22.3 million (European Commission 2009: Table 34). The demand for (paid) childcare is also likely to grow as the bringing forward of the pensionable age will reduce care by grandparents and female employment will presumably resume its growth when a sustained recovery from the ongoing crisis will finally sets in.

Countries have balanced these trade-offs differently. At one pole stands the Nordic response where strongly rationalized care time supported by assistive technology and comparatively regular and skilled employment has been put into operation in exchange for universal or near universal affordability. At the opposite pole, is the »migrant-in-the family« arrangement which dominates home care for the elderly in Mediterranean Europe. Here long hours of (paid) care are made affordable for a large minority of the population by cost-effective hiring and management of migrant labour on the part of families. Such cost-effectiveness, however, rests on the availability of large supplies of poorly trained care personnel not infrequently hired on the irregular market.

Other countries have given responses that are intermediate between these two poles, or are groping towards them. Arguably, the French combination of a tied cash allowance, the APA, and a universal voucher system, the CESU, is the farthest reaching attempt to combine the flexibility and employment creation potential of family-managed employment with the need to regularize and train personal care workers. Austria, a non Mediterranean country where the migrant-in-the family arrangement has spread, has improved the quality of employment by granting families social security rebates for them to regularize care workers, and by upgrading skills; for example, the position of »assistant nurse« was recently created in order to enhance career prospects and training among care workers (Mairhuber 2008). Germany has recently reformed the so called »mini jobs« in order to favor the emergence of irregular care work within families (Erler 2011).

While it is still early for conclusive assessment, all these attempts indicate that the future of care in Europe will hinge on European countries' ability to ease the trade-offs that we have been exploring in this paper.

References to the National Reports on Long-Term Care, network EGGE (Employment and Gender Equality Issues):

Bettio, F. and Verashchagina, A. (2010); Ellina, C. (2010); Karamessini M. (2010) Johannesson, S. (2010); Mairhuber, I. (2010); Meulders, D. (2010); Nyberg, A. (2010); Ozar, S. (2010); Silvera, R. (2010); Sjørup, K. (2010); Sutela (2010), all refer to the following country report:
Long-Term Care for the Elderly in (country). Provisions and providers. External report commissioned by and presented to the European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, Unit G1 »Equality between women and men«.
The countries are, in order, Italy, Cyprus, Greece, Iceland, Austria, Belgium; Sweden, Turkey, France, Denmark and Finland.

Other references

Bettio, F. and Veraschagina, A. (2012) Long-Term Care for the Elderly. Provisions and providers in 33 European countries, European Commission's Expert Group on Gender and Employment (EGGE): Luxembourg: Publications Office of the European Union (forthcoming).
Bettio, F. and Plantenga, J. (2004) Comparing Care Regimes in Europe, *Feminist Economics*, 10 (1): 85-113.
Bettio, F., Simonazzi, A. and Villa, P. (2006) Change in Care Regimes and Female Migration: the »Care Drain« in the Mediterranean, *Journal of European Social Policy*, 16 (3): 271-285.
Calinski, T. and Harabasz J. (1974) A Dendrite Method for Cluster Analysis, Communications in Statistics, 3: 1-27.
Campéon, B., Le Bihan, B. and Martin, C. (2008) Balancing Care of the Ederly and Employment in France, French National Report, Programme WOUPS (Workers under pressure and social care).
CENSIS (2008) Un mese di sociale: gli snodi di un anno speciale, Centro Studi Investimenti Sociali, Roma.
Available at: www.anolf.it/archivio/download/rapporto_CENSIS_10_06_08.pdf.
Cour des Comptes (2005) Les personnes âgées dépendantes, November, Paris, La documentation française.
Da Roit, B. and Le Bihan, B. (2010) Similar and Yet So Different: Cash-for-Care in Six European Countries Long-Term Care Policies, *Millbank Quartely*, (88) 3: 286-309
Erler, D.(2011) Household Services. Il quadro tedesco, Presentation at the Conference »Bisogni delle famiglie, caregiver e servizi alla persona:una sfida sociale ed imprenditoriale«, Bologna, October 2011. Available at http://www.cnaemiliaromagna.it/NewsVedi.php?id=7108.
European Communities (2009) 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008 – 2060), *European Economy* no.2. Available at: http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf.
Gauthier, A.H. (2000) Public Policies Affecting Fertility and Families in Europe: A Survey of the 15 Members States, European Observatory on Family Matters. Accessed March 2002 and downloaded from:
http://europa.eu.int/comm/employment_social/eoss/downloads/sevilla_gauthier_en.pdf.
León, M. (2010) Care: Provision, Quality and Inequalities in Late Life, 21-23 June 2010, Eigtveds pakhus, Copenhagen.
Lyberaki, A. (2011) Migrant Women, Care Work and Women's Employment in Greece, *Feminist Economics*, (17) 3: 103-131.
Mairhuber, I. (2008) Gender Segregation in the Labour Market: Root Causes, Implications and Policy Responses in Austria. External report commissioned by and presented to the European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, Unit G1 »Equality between women and men«.
OECD (2001) Balancing Work and Family Life: Helping Parents into Paid Employment, *Employment Outlook*: 129-66. Paris: OECD.

Pacolet, J., Bouten, R., Lanoye, H. and Versieck, K. (1999) Social Protection for Dependency in Old Age in the 15 EU Member States and Norway. Synthesis report commissioned by European Commission and the Belgian Minister of Social Affairs. Luxembourg: Office for Official Publications of European Communities.

Plantenga, J. and Remery, C. (2009) The Provision of Childcare Services. A Comparative Review of Thirty European Countries, European Commission's Expert Group on Gender and Employment Issues (EGGE). Luxembourg: Publications Office of the European Union.

Pasquinelli, S. and Rusmini, G. (2008) Badanti: la nuova generazione, Istituto per la Ricerca Sociale (IRS), Milano.
Available at: http://www.qualificare.info/upload/DOSSIER_Badanti_la_nuova_generazione.pdf.

Rudda, J. and Marschitz, W. (2006) Reform der Pflegevorsorge in Österreich, Soziale Sicherheit, November: 445-453.

Schneider, U. and Trukeschitz, B. (2008) Changing Long-Term Care Needs in Ageing Societies: Austria's Policy Responses, Working Paper, Vienna.

Schneider, U. and Trukeschitz, B. (2010) Changing Long-Term Care Needs in Ageing Societies: Austria's Policy Responses, Presented at the Conference »Transforming Care: Provisions, Quality and Inequalities in Late Life«, 21-23 June 2010, Eigtveds pakhus, Copenhagen.

Simonazzi, A. (2009) Care Regimes and National Employment Models, *Cambridge Journal of Economics*, 33 (2): 211-232.

Simonazzi, A. and Picchi, S. (2011) Affordability of Care and Quality of Work. New Trends in Elderly Care, Presented at the Conference »Making Connections: Migration, Gender and Care Labour in Transnational Context«, April 2011, Oxford.

Socialstyrelsen (2002) The Social Services Act (Socialtjänstlagen). What are your rights after 1 January 2002? Stockholm. Available at: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/11039/2002-114-9_20021149_rev.pdf.

Ungerson, C. and Yeandle, S. (eds) (2007) Cash for Care Systems in Developed Welfare States, London: Palgrave.

Endnotes

1 Eurostat, Childcare Arrangements , Reference Metadata in Euro SDMX Metadata Structure (ESMS) *(epp.eurostat.ec.europa.eu/cache/ITY_SDDS/en/ilc_ca_esms.htm).*

2 The comparison of the coverage rates in the mid and late 90s and the late 00s set out in Table A1 clearly indicates the shifting balance in favour of formal care provision, although caution is needed due to issues of comparability. Additional evidence is offered by Eurostat data series on childcare starting from 2005.

3 See, among others, the recent compilation of facts and figures on the two main cash schemes for the elderly – care and attendance allowances – in Bettio and Verashchagina (2012: section 5.3.2)

4 For this clustering exercise we adopt a two-step procedure running Principal Component Analysis in the first step and using the results to identify clusters in the second step as proposed by Calinski and Harabasz (1974).

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

6 See, in particular, Bettio and Verashchagina, 2012: footnote 38.

7 Note that these figures include a board and lodging allowance, not social security contributions.

8 In Belgium too the volume of employment revolving around service vouchers is considerable. The number of workers was estimated at between 90000 and 120000 for a total of 62 million vouchers bought (Meulders, 2010: Grid 1).

Appendix 1

Table A1: Coverage rates of formal care: late 1990s and most recent figures

	CHILDREN				ELDERLY (65 and over)			
	0-2 years, 1998-2000	0-2 years, 2009	3-school year age, 1998-2000	3-school year age, 2009	Institut. care, mid to late 1990s	Institut. care, 2008-2010	Home care, mid to late 1990s	Home care, 2008-2010
Denmark	64	73	91	84	13.1	2.5	10.8	20.0
Sweden	48	63	80	94	8.7	5.8	7.2	9.4
Ireland	38 (<5 yrs.)	20	56	87	7.4	3.9	3.0	6.5
Belgium	30	33	97	99	8.6	6.6	2.5	7.4
Luxembourg		34		72	8.2	4.8		7.0
France	29	41	99	95	7.9	6.7	0.8	6.5
Finland	22	27	66	77	7.3	3.1	4.1	6.3
UK	20	35	60	91	11.4	4.2		6.9
Nl	20	49	98	87	11.3	6.3	2.7	21.0
Portugal	12	36	75	81	1.6	3.4		4.3
Germany	10	19	78	88	5.5	3.5	0.7	6.6
Italy	6	25	95	93	2.0	3.0		4.9
Spain	5	36	84	94	2.9	4.4	1.4	4.7
Austria	4	9	68	79	5.0	3.3	1.9	14.4
Greece	3	11	46	58	0.5	0.6		5.6

Source: Bettio and Plantenga (2004: Tables 2 and Figure 6) based on OECD (2001), Gauthier (2000) and Pacolet (1999); Bettio and Verashchagina (2012: Table A. 1-A.2 in particular)

Note: The coverage rate is the share of actual beneficiaries in all potential beneficiaries, e.g. the coverage rate of institutional care is the ratio between elderly people cared for in institutions such as care homes and the elderly population (65 years and over).

Table A2: Indicators for elderly care

	ELDERLY CARE		
	Coverage rate of residential care, around 2008/10	**Coverage rate of home care, around 2008/10**	**Share of care recipients relying on (paid) care workers/ professionals when care is given daily or almost daily, 2006/7**
Austria	3.3	14.4	44.9
Belgium	6.6	7.4	72.2
Bulgaria			
Cyprus	3.0		
Czech Republic	3.5	7.2	21.5
Germany	3.5	6.6	28.7
Denmark	2.5	20.0	74.8
Estonia	1.8	2.3	
Greece	0.6	5.6	11.8
Spain	4.4	4.7	26.3
Finland	3.1	6.3	
France	6.7	6.5	74.3
Hungary	2.8	6.4	
Ireland	3.9	6.5	40.3
Island	8.3	20.5	
Italy	3.0	4.9	26.5
Lithuania	0.8	0.6	
Luxemburg	4.8	7.0	
Latvia	1.4	1.6	
Netherlands	6.3	21.0	76.5
Norway	5.3	19.3	
Poland	1.0	1.7	100.0
Portugal	3.4	4.3	
Romania	0.5	0.3	
Sweden	5.8	9.4	45.1
Slovenia	4.8	1.8	
Slovakia	3.3	2.3	
United Kingdom	4.2	6.9	
EU27			

Sources: Bettio and Verashchagina (2012: Tables A1 and A2); own calculation