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Protecting an Endangered Resource?

Lessons from a European Cross-Country Comparison of Support Policies for Informal Carers of Elderly Dependent Persons

Michel Naiditch (Irdes)

Although important inter-country differences exist in organisations for the delivery of care and support to dependent elderly people, the contribution of informal carers (family or friends) predominates everywhere. LTC policies focusing on the disabled older population are thus facing a major challenge in how to ensure their continued contribution over the long term. This is particularly crucial because of the role informal carers play in reducing the costs of LTC. The implementation of policy measures addressing the needs of informal carers in Europe is therefore considered a major component of policies focused on meeting the needs of dependent older persons.

Within the framework of the European research programme INTERLINKS, a working group examined the possibility of identifying and describing a series of measures that would constitute the backbone of a specific policy for supporting informal carers. How does one evaluate the impact of such a policy on its beneficiaries? How does one judge its capacity to act synergistically with policies addressing the needs of elderly people in need of care? To answer these questions, a conceptual framework was created for the classification of measures intended at supporting informal carers. It was based on several criteria – the primary distinguishing criterion being defined as measures targeting only informal carers (specific measures) on the one hand, and measures targeting both carers and care recipients (non-specific measures) on the other.

The first results show that in Europe, with the exception of the Scandinavian countries and the Netherlands, no policies addressing the specific needs and expectations of informal carers were found that could be described as working in true synergy with overall policies focused on addressing the needs of dependent elderly people.

What is the nature of problems confronting informal carers of the dependent elderly, whether they work outside the home or not? Why has the elaboration of specific policy measures to support informal carers been neglected for so long? What recent changes have led government decision-makers to include this issue in the political agenda? Answers to these questions are important to understand the rationale underpinning the implementation of a range of measures meant to meet the challenges facing informal carers. In order to better understand their expected and observed impact on informal carers' well being as well as study the way in which they are positioned within overall policies for the dependent elderly, we shall first describe the most significant developments in those global policies since the 1990s in Europe. We then present the conceptual framework developed within the INTERLINKS research project (insert 1). This framework proposes a classification of all measures addressing the needs of informal carers of dependent elderly persons; it thus permits a comparison of informal care policies implemented in six European countries: Germany, England, France, Italy, Sweden and

the Netherlands. This cross-country comparative study should help in designing the contours of a French active policy that would address the needs of informal carers in France whilst being firmly embedded in the realm of LTC policy reforms expected in the coming years.

How and why have policies to support informal caregivers emerged?

The role of caregivers and the place of informal care have long been neglected in the public debate. Until the beginning of the 1990s the situation was extremely contrasted between two groups of countries.

In the first group comprised of Scandinavian countries and the Netherlands, informal care was taken into consideration from the end of the 1960s; it was explicitly defined as supplementary to formal care, as social protection programmes guaranteed that all elderly in need of care could have access to formal care services.

In the second group, comprised of Southern European countries as well as France, England and Germany, informal care was considered more as a feature of the private sphere. It was viewed as stemming from a form of intergenerational solidarity resulting from a 'natural give and take' mechanism or even altruism. Furthermore, in these countries, a negative view of ageing coupled with an absence of political lobbying and a lack of influence on the part of informal carers contributed to the social invisibility of informal carers as a group.

Awareness of the need to 'care for the carers' emerged only in Europe in the middle of the 2000-2010 decade when the financial and economic crises undermined the Welfare States' capacities to finance their social policies and in particular professional care services. Regarding the second group of countries, an awareness of this situation occurred about ten years after the beginning of the expansion of publicly funded care services addressing the specific needs of the dependent elderly population. A second determinant of this new policy was an increased commitment to policies enabling elderly people to stay in their homes rather than having to enter institutions because of elderly persons' and their families' preferences as well as eonomic expected gain (Eurobarometer, 2007). These changes, implying a greater reliance on informal carers, occurred at a time when their availability was being challenged by various changes taking place both in society as a whole and within the traditional family structure: decrease in the number of children per household, changing intergenerational relations with de-cohabitation and an increase in the number of composite and stepfamilies, increased promotion of female participation in the labour market

E1

The different phases of the INTERLINKS project

The main aim of the INTERLINKS project was to construct and validate a model to describe, analyse and compare long-term care systems in Europe targeting elderly people aged 60 and over. The project also aimed to provide new avenues for reflection and reform.

The first phase of the project (eighteen months) consisted in describing long-term care for elderly people in the fourteen participating countries by focusing the analysis on four domains: prevention/rehabilitation, regulating the quality of services, carer support policies, modes of governance and financing of measures for frail elderly people. These reports formed the basis of four European summary reports.

In the second phase (twenty months) a multidimensional descriptive model of long-term care was developed to permit identifying the main shortcomings in terms of medical and social sector governance and financing, in the coordination/integration between the different types of service provider and professionals and between formal and informal care. The researchers also constructed a descriptive framework permitting the critical analysis of experimental or routine practices, covering the 6 main dimensions of the model addressing the revealed shortcomings. Research was validated as it progressed by a panel of experts at national and European level.

The main elements of this research are available on the project's interactive web site:
http://interlinks.euro.centre.org/

CONTEXT

This article falls within the framework of IRDES research on dependency prevention. It is issued from the European INTERLINKS project: Modelling the Interfaces and Links between prevention, quality of services and informal care developed in response to the VIIth PCRD call for projects. This three-year project (2008-2011) was coordinated by the European Centre for Social Welfare Policy and Research (ECWPR) based in Vienna. It involved multidisciplinary research centres (11 public universities and 3 private institutes, including IRDES), in fourteen countries. The author gratefully acknowlegdes the contribution of the INTERLINKS team, particularly Judy Triantafillou and Elisabeth Hirsch Durrett.

all contributed to a reduced availability of informal caregivers. According to forecasts, these factors would outweigh those leading in the opposite direction such as the reduction in the difference in life expectancy between men and women resulting in fewer elderly people living alone, and the increase in healthy life expectancy (even though data leading to this forecast has recently been challenged [Sieurain et al., 2011]).

As more and more consistent data revealed the negative effects of intense care giving on informal carers themselves (insert 2), policy makers began set a high priority in their political agenda on measures meant to ensure the continued long-term contribution of informal carers; such measures were even deemed of utmost necessity given plans for raising retirement age and in view of continued increases in life expectancy.

Even where good access to professional care exists, informal care quantitatively surpasses formal care provision

Informal care provided by family members of elderly dependent persons is extremely diverse. It not only involves help with activities of daily living (ADL) including personal hygiene and grooming, and instrumental activities of daily living (IADL), but also moral and psychological support and all forms of support aimed at ensuring continued participation in social life for dependent elderly people.

E2

Beyond a certain level of intensity, the provision of care produces deleterious effects on the well-being of carers…

Based on family and intergenerational solidarity that persists to this day, the greatest proportion of informal care is provided by women (from 50 to 90%). The type of care delivered is also gendered: men concentrate on administrative and logistical tasks, less physically and psychologically constraining, whereas women provide personal care and grooming as well as domestic chores that are more demanding mentally, emotionally and physically (Colombo et al., 2011).

A body of works using SHARE and ELSA survey data shows that a limited amount of care results in an improvement in the health status of care providers (Fontaine, 2009). Beyond a threshold that differs between countries) but is determined by common factors such as volume, duration and intensity of the care provided, the well-being of carers suffers due to physical, mental and psychological health problems (Eurocarers, 2009). These problems are caused by a decrease in the time devoted to family, work and social life that can lead to social isolation or even poverty, burnout and/or mental distress (Eurofamcare, 2006). These negative effects are more marked in older carers, spouses or daughters, who live with the care recipient and are solely responsible for providing the care required. The effects are more limited when the provision of care is shared between family members or relatives depending on the degree of dependency and type of care needed (Fontaine et al., 2007).

… and can lead to reducing carers' labour market participation

Providing care makes it more difficult to access the labour market; data shows that a greater number of working age carers than non-carers are unemployed. Data provided by different European surveys referenced in the present article show that working carers would like to keep their jobs without having to reduce their working hours. They explain that work helps them to avoid being totally absorbed by their care responsibilities and emphasize that they are prepared to accept adjustments to their working hours and conditions, even to the detriment of their careers. This partially explains their partial rather than total withdrawal from the labour market; working carers tend to work two hours less per week than non-carers. The progressive increase in the time devoted to care, however, makes it more difficult to reconcile work and care responsibilities and eventually leads to withdrawal from the labour market, especially among women. The threshold at which this occurs, and its elasticity, varies from one country to another, withdrawal being more frequent in Southern and Eastern European countries than in Northern countries and the Netherlands; France, Germany and England occupy a middle position between these two poles. (Colombo, 2011).

Carer support policy therefore concerns not only the long-term care sector but also the work and employment sectors.

The proportion of informal care (as defined above) provided to elderly dependent people reached an average 85% in 2008, with a fairly low dispersion across countries (SHARE survey). The contribution of informal carers thus proves to be considerably higher than that of formal carers, even in Scandinavian countries or the Netherlands where professional care is easily accessible.

The paradoxical existence of high levels of informal care even in countries with highly developed professional services can be explained by the large inter-country variations in the structure of the help and care provided in terms of regularity, intensity, duration and tasks performed. In Mediterranean or Eastern European countries, where formal care provision is very limited, informal carers perform the majority of ADL and all the IADL tasks. In the Scandinavian countries and the Netherlands, however, informal carers are able to leave the more demanding tasks to professionals and they can then concentrate on more simple domestic tasks (home help) and support aimed at bolstering the elderly person's social life. In these countries, easy access to formal care has not reduced families' involvement but has transformed the nature of the help provided, suggesting that public solidarity does not replace family solidarity (Bonsang, 2009). Formal care responding to the needs of frail elderly people is thus to be considered as an essential, though indirect, component of any policy addressing the needs of informal carers.

The turning point in the mid 1990s: informal care is rendered visible by the introduction of cash benefits schemes and the promotion of competition between care providers

The underlying goals of policies implemented to support informal carers can be better understood by examining the changes in overall long-term care policy orientations for the dependent elderly. These changes have mostly been implemented since 1995 within the context of a liberal market economy. They corresponded to the introduction in the care sector of new private for profit care organisations meant to compete with the long standing public or quasi-public providers, whose service provision was considered inefficient and insufficiently flexible to meet older people's expectations and needs (Rostgaard, 2011). Simultaneously and according to each care regime in addition to in-kind services, various types of 'cash benefits' were introduced (Ungerson and Yeandle, 2007): The most common scheme targeted the older person in the form of a specific care attendance allowance such as the Personal Autonomy Allowance (APA) in France. Others, called 'personal budgets' in England and the Netherlands bundled together different types of cash or related benefits (vouchers) provided to the older person but also to their family. In the Southern European countries, Germany, England and France, these cash benefits served as the financial backbone of policies targeting the dependent elderly by providing them with the means to pay for professional services; They did, but only indirectly, target family carers, as they could be used as a financial compensation for their caring tasks. In the more 'advanced' countries such as Sweden and the Netherlands, where a high level of formal services exists, these cash benefits were mainly promoted as an instrument giving elderly dependent people more freedom to choose the type of services or the provider they wanted, thus giving them more ability to challenge the decision-making power of professionals (Da Roit and LeBihan, 2010).

A second type of cash benefit introduced in England and to some extent in Sweden, though not in France, the Netherland or Germany directly targeted informal carers: and called 'care allowance'. Beside acting as a token of social recognition towards non-working informal carers, the goal of this benefits was to foster older carers' continued and long-term contribution to the care of elderly dependent persons by fighting against their poverty effect and the adverse health outcomes of intensive informal care provision. This was meant to be achieved, in particular, by facilitating access to specific services, particularly respite care, Regarding working carers or persons willing to enter the labour market, this type of cash benefit was intended to facilitate a more manageable balance between work and care responsibilities by enabling carers to pay for some amount of substitutive formal care. The impact of cash benefits

should be assessed through an examination of their contribution to all these objectives. (Glendinning et al., 2009).

What logic should be utilized when describing measures addressing the needs of informal carers?

Over and above the aforementioned factors, the difficulty in isolating a policy addressing the specific needs of informal carers also comes from the overriding idea that the needs and expectations of the latter are 'naturally' aligned with those of the dependent older person. In turn, this supposed 'positive dynamic' between the carer and the care recipient suggests that any measure in favour of one party will automatically contribute to answering the needs of the other. This belief fails to take into account the existence of conflicting dynamics in the heart of the informal care-giving relationship in terms of choice of services, of distribution of tasks between formal and informal carers, or of type of providers (professional/caregiver) (Glendinning, 2006). Whilst access to professional services often benefits both the elderly person and the family carer, conflicts can nevertheless arise when the elderly person is opposed to the substitution of the family carer by a professional when the carer is exhausted or wishes to take up paid work; conflicts can also come to the surface when carers refuse respite care because professional services are viewed as inadequate by either the carer or the elderly person. In all cases with no agreement is found, none of the expected advantages will materialise. Cash benefits targeting the elderly can also give rise to relationships characterized by dominance, as they may either place the carer in a subordinate position, or inversely lead the carer to taking control of the allowance and determining its use without heeding the needs or wishes of the elderly person. The existence and level of stringency of regulation and control mechanisms for monitoring the use and quality of cash benefits are thus a major determinant of their impact (Da Roit and LeBihan, 2010) both on carers and on dependent elderly persons.

The Interlinks framework: its approach of measures implemented to support carers, and its use in describing policies addressing their needs

The central challenge to informal carer policy lies in its capacity to evenly distribute its various components in order to respond to the diverse but not always congruent needs and interests of both types of actors involved. Introducing a distinction between measures specifically targeting informal carers (specific measures) and those targeting both formal and informal carers (non-specific measures) is thus essential if one wishes to evaluate their combined impact. The descriptive framework for measures supporting caregivers based on this distinction was specifically elaborated to facilitate the description and comparative analysis of these policies. Expanding on the work of Glendinning, the various measures identified have been divided into four categories based on two criteria (Triantafillou et al., 2011).

The first criterion determines whether the measure is specific (targeting only informal carers) or non-specific (simultaneously targeting informal carers and care recipients). The second criterion refines this first subdivision. A specific measure will be referred to as 'direct' if it aims to improve the effective delivery of support services in the field: for example carer training programmes. It will be referred to as 'indirect' if its goal is creating a favourable institutional or organisational context for the provision or maintenance of home care (flexible working hours for working carers or cash benefits targeting carers). A non-specific measure will be referred to as direct if it primarily targets carers (such as respite care), and indirect if it primarily targets care recipients, (as in the case of home adaptations). In this perspective, all in-kind services delivered to frail elderly people by professionals are defined as indirect non-specific measures (see table).

A first level analysis allows each measure to be examined according to its eligibility criteria (universal or resource-related conditions), financial accessibility (level of out-of-pocket payments), geographical accessibility and rate of use (uptake).

A second level analysis evaluates the effectiveness and efficiency of policies addressing the needs of informal carers. In order to achieve this goal, the analysis of measures is supplemented by the study of the legislative or regulatory elements framing the governance mechanisms of the overall LTC policy. The goal is to measure the degree of recognition towards informal carers in terms of their collective place and role, for example as a group with specific interests called upon to participate in the construction of the policy. The various measures are then examined in relation to other policy sectors in order to evaluate the respective weight of each measure and their degree of complexity/comprehensiveness, with special attention paid to measures affecting work, employment, the environment, transport and housing.

These carer support policies can then be assessed in terms of their internal consistency with their explicit objectives, when stated, as well as in terms of their impact on the overall well-being of informal carers. They should also be evaluated in terms of their 'external consistency' as measured by their compatibility and synergy with overall policies targeting the dependent elderly.

Using the framework to analyze policies: Sweden, the Netherlands, England, Germany, Italy and France

As an example of the way the proposed classification framework is used, we present a short analysis of six countries with different social protection models. These results are based on data taken from the literature and enriched by additional analyses provided by Interlinks experts for each member country.

In Sweden, carer support policy is characterised by easy to obtain professional services, a regulated market and a cross-sector approach aimed at helping carers balance the competing demands of work and care.

Like other Scandinavian countries, Sweden invested early (1960s/1970s) and durably in policies for the elderly with reduced autonomy (first country in Europe in terms of percentage of GDP, 3.5% in 2010), finan-

cing care services by income tax. Easy access to professional agencies is coupled with moderate competition through strict regulation leading to a relatively constrained choice of private service providers; the latter thus exert a limited influence on care delivery This LTC policy allows for the nature of support to be adapted to the needs and expectations of carers and dependent elderly without diminishing either the regularity or volume of the care provided. In addition, active labour market policies and a focus on gender equality facilitated the introduction of more flexible working hours and conditions. Women from the 'sandwich generation' (women who care for their ageing parents while supporting their own children) are thus able to continue working; members of the older generations also boast the highest employment rate in Europe thanks to the adaptation of their work tasks.

T1

Classification of carer support measures according to INTERLINKS

Specific direct measures Direct specific measures	
In kind	
Cognitive approach	
• Information, advice, counselling	
• Training by...	Informal carers / Formal carers
Emotional, psychological approach	
• Support provided by...	Professionals / Peer groups
Social approach	
• Recreation, happy hours, Alzheimer cafés...	
'Health' approach	
• Check ups, medical visits	
• Healthy ageing program	
In cash	
Types of use	
• Maintenance	
• Formal recognition	
• Substitutive for formal care	
Indirect specific measures	
Political recognition	
• Advocacy groups	
Encouraging and supporting carers' working activity	
• Retirement rights	
• Social protection rights	
• Existence of work leaves with salary continuance	Yes / No
• Organisation of working time	Legal / Informal
Recognition of carers' needs	
• Assessment of specific needs	
Direct unspecific measures	
Respite modalities	
• Short stays (nursing homes)	
• Day care	
• Home custody (day, night, weekends, 24/7)	
Indirect unspecific measures	
In cash	
• Care attendance allowance	
• Personal budget	
• Tax exemption	
• Vouchers	
In kind	
• Access to publicly funded long-term care services	
• Housing adaptation	
• Information technology	Simple telemonitoring / Complex telemonitoring

This context favoured the development of solutions adapted to the specific needs of working carers: the right to paid leave at a rate of 80% of earnings in the case of end-of-life care, coupled with maintenance of all social security rights and a return-to-work guarantee. From the 1990s, marked by a more restricted access to professional services, it became necessary to increasingly rely on the use of informal carers, but support was provided yet again; legislation passed in July 2009 obliged municipalities to implement individualised support measures for informal carers. Non-specific direct support measures were implemented such as easy access to respite care.

New cash benefits aimed at informal carers were created but on a small scale as the only apply to 4% of the dependent elderly. These benefits are highly regulated, taking the form of contracts with the municipality involving training, working conditions, pay and social protection as well as an evaluation of neede care tasks, bringing carer status closer to that of a professional. The one drawback may be that decentralised policy implementation tends to lead to disparities between municipalities.

In the Netherlands, carer support policy, founded on the same basic principles as in Sweden, differs in that it is open to competitive tendering: elderly persons, receiving cash benefits, are free to choose their service providers.

In the Netherlands, the financing of long-term care (representing 2.8% of GDP – the second highest proportion in Europe) renders access to professional services almost as easy as in Sweden. Dutch legislators, however, opted for a programme of cash benefits that would enable dependent elderly to pay the carer of their choice, notably a family carer. This choice is partially controlled by a management organisation: a case manager will verify the suitability of the carer to the recipients' needs and evaluate the quality of the services purchased. However, the choice of cash benefits rather than opting for services from an accredited agency implies a 25% drop in allocated service levels. Nevertheless, in 2008, 107,000 dependent elderly (17% of this population) used the Personal Budget scheme; 20% of them combined cash options with in-kind services. Drawbacks in the control of the use of Personal Budgets by externally mandated agencies led to stricter regulation meant to insure real freedom of choice.

Reconciling work and care responsibilities, facilitated by a high level of part-time work among women, is also made easier by incentives to keep carers employed. Legislation pertaining to the organisation of work time allows carers to adapt their working hours during periods of intense care by carrying over hours accrued in less demanding periods. Moreover, all main informal carers who also hold a job have a right to ten days paid leave per year at 70% of earnings to look after a dependent relative. Carers are also entitled to twelve weeks of unpaid leave to care for a terminally ill relative, coupled with a return-to-work guarantee. Non-specific direct (easy access to respite) and indirect (home adaptation)

support measures complete the support programme. Concerning specific direct support measures, carers of patients with Alzheimer have easy access to training and support groups (40%), and relatively easy access to case managers in severe cases. The significant role played by carer associations in the policy elaboration process should be emphasised, notably in the way professional and informal carers are trained.

In England, carer support policy, strongly influenced by carers' associations, was developed to offset the serious shorfall in professional services.

In England, national policy for the elderly is based on a safety net system for the most deprived, leading to a very limited access to professional services, notably public services managed by city and town councils (only about 10% of dependent elderly people are eligible). Municipalities tend to rely more and more on private service providers that are costly and poorly regulated.

Cash benefits, introduced in 1972 and targeting the dependent elderly aged 65 and over, are a non means-tested cash allowance financed by central government. The programme's contribution is insufficient to cover an appropriate amount of required professional care not only because of its modest level (300 euros on average) but also because of limited uptake due to administrative difficulties. Altogether this makes the intervention of informal carers vital: 88% of the dependent elderly benefit from care provided by four million carers of whom 30% provide over 20 hours of care per week (CAS, 2011).

The role played by carers' associations in carer support policy has been and remains significant: UK Carers federates all types of carers' associations (for the disabled as well as for the elderly) and benefits from the powerful lobbying power of Alzheimer associations. It contributed to the implementation of the 'National strategy for carers' document that has constituted the backbone of measures in support of carers over the past fifteen years. The considerable influence of UK Carers in the legislative field notably contributed to the creation of legislation favouring the reconciliation of work and care responsibilities. Carers are entitled to an evaluation of their specific needs. Working carers are protected by a 'anti-discrimination' law that grants them the right to several weeks' leave to look after an elderly parent. The specific components of this leave programme (duration, remuneration, and benefits) depend on employers. This leads to significant disparities between companies according to company size and business sector. Whilst the service sector (insurance, banks) has developed interesting work-care balance initiatives, these measures remain limited despite evaluations carried out on the initiative of UK Carers which demonstrated the benefits a company could derive from carer- friendly policies (Employers for Carers 2010).

Among the various types of cash benefits deployed since the beginning of the decade, some targeted specific categories: job seekers, dependent elderly persons or persons with income levels lower than the minimum retirement rate. The three main types of cash benefits implemented contained very restrictive eligibility criteria (resources), and amounts granted remained relatively low. This explains why evaluations show a relatively modest impact both in terms of combating poverty and in reducing the negative effects of care on the well-being and employment level of informal carers; however the programmes were shown to increase the feeling of control over their choices as reported by carers. (Wilberforce et al., 2011).

Numerous experiments with computerised monitoring systems have been implemented; they are viewed as carrying a strong potential to enhance the well-being of both informal carers and care recipients, even though currently available data is insufficient to provide validation of this hypothesis (Carict 2012). They are also perceived as a means of reducing costs by means of a complementary/substitution effect for professional services. One question must however still be addressed: will these different support measures for carers be able to fully compensate for the persistent shortage of professional services? Growing calls for increasing the share of unpaid voluntary care represent an additional attempt to find a solution to this problem.

In Italy, political decision-makers have implemented carer support policies focusing on the employment of female immigrant workers as a substitute for insufficient professional service provision as well as for traditional informal care.

In Italy, the responsibility for policies in the field of care for dependent elderly people is divided between different levels of political authority (State, regions, municipalities…) and poorly integrated. Until the beginning of the decade, informal care was dominant (90%) and relied on families and more specifically on women. Rates of intergenerational cohabitation were high, female employment rates low, and professional public care services all but absent. However since 1980, all disabled persons aged over 65 have had the right to a cash allowance (480 euros in 2008) to help cover the cost of their care; the actual use of this allowance was (and still is) poorly controlled. Working carers could also benefit from three days paid leave per month to look after highly dependent persons.

This situation has radically changed over the past fifteen years (Di Santo, 2005). Immigrants from Eastern Europe or Africa, often working illegally, have become the main providers of home help. These mostly female (90%), 'live-in' carers ensure care delivery five or six days per week and/or 'in-home' weekend care. This enables adult daughters of care –dependent elderly who wish to work to have an easier access to the labour market.

These 'live-in carers' are financed by various cash benefits targeting families and provided by the region or municipality. During the past five years, in order to better control the employment of in-home personnel and ensure a minimum level of service quality, the State has instituted legislation aimed at legalizing their status (issuing work permits) on the condition that they follow language and vocational training courses. This type of policy is also being developed in Austria, but less systematically.

In Germany, carer support policies have evolved since 2008 due to the higher employment rate of women, previously very involved in supplying care.

In Germany, a dependency insurance scheme was created in 1995 based on the assumption that access to professional help was under-financed. It was explicitly intended that the gap would be filled by women, according to the traditional model in which men are the sole income providers, and female employment rates are low, women who do work mostly holding part-time jobs.

The elderly dependent insurance beneficiary is able to choose between cash or in-kind benefits, or a combination of the two. Cash benefits permit the payment of a family or outside carer. Cash benefits are more frequently chosen by low-income families as they provide additional income without controls over its use. However, this choice can lead to potential problems in the quality of the services delivered. Compared to in-kind benefits for the same level of needs, the cah option only finances 60% of the service level required. The scheme thus has contributed to increasing social inequalities in terms of dependency, as in-kind benefits were (and still are) more frequently chosen by wealthier families, with the advantage of a better control of the quality of services delivered.

To offset these shortcomings the reform of 2008 increased the level of financing of dependency insurance, making it easier to gain access to respite care. The Länder were provided with new means for controlling quality of care, now provided mainly by the private sector, and informal carers choosing cash benefits were offered more information and support.

In addition, new incentives for employers to facilitate reconciling work and care responsibilities were written into the legislation. Working carers thus benefit from a week of paid leave per year for which the employer is reimbursed by the dependency insurance scheme (Stier, 2005).

In France, a carer support policy has yet to see the light of day (Joël, 2011); existing measures remain limited to the long-term care sector without any real consideration being gives to the problem of reconciling work and care responsibilities.

In France, carer support policy has not been a major component of the debate on reforming dependency policy even though the involvement of carers is high (Drees, 2011). The promotion of home-care versus institutional care, implying, a higher contribution by families has not led to a corresponding redirection of financial resources. One of the reasons is to be found in the importance of the nursing home sector for dependent elderly persons (EHPAD) in terms of its lobbying power. Another reason, related to the former, stems from the lack of available transitional solutions to bridge the gap between institutionalisation and maintaining elderly people at home. The remuneration of carers - notably family carers that the APA scheme allows to finance - has a poor rate of uptake (9% of carers in 2009). It is thus unlikely to contribute to solving the economic or health problems a large proportion of informal carers providing high levels of care as well as working carers encounter.

Other than the 'family solidarity leave' allowing a carer to accompany a parent suffering from a terminal illness - unpaid leave for a three months renewable duration - few measures exist favouring the reconciliation between work and care responsibilities. Reasons for the absence of such measures are numerous: The view that equates ageing with physical and cognitive decline, synonymous with loss of productivity, is deep-seated and employers are reluctant to keep older workers on the job. Poor access to professional training for older people is an indication of the lack of faith in their ability to adapt, notably to technological changes and innovation For women, the lack of flexibility in working conditions creates an unfavourable context that fails to answer their specific needs as carers, made worse by the fact that fewer women work part time than in Sweden, Germany and the Netherlands.

It is thus up to the health and social care sector to provide 'humanitarian relief' through different forms of carer support mechanisms such as the provision of information, training and discussion groups, or access to respite care. These activities are still largely focused on carers of dementia patients.

In conclusion, what lessons might France learn from these European examples ?

Foreign examples clearly show a general trend towards developing carer support to supplement professional support while helping carers to achieve a better reconciliation between care duties and employment. A policy perspective of this type can only be envisaged if elderly dependent persons have adequate access to professional services (unspecific indirect measures) within a policy frame that also includes measures (specific direct, indirect and unspecific direct) that respond to the needs of older carers as well as working or working-age carers.

Only the Scandinavian countries and the Netherlands have implemented this type of policy. Family policies addressing employment, housing and transport, whether at legislative level or within companies, provide a favourable context for the implementation of additional specific support measures for working informal carers. This broader view of carer support policy, breaching the limits of the health and social care sector, facilitates the social participation of all types of carers. It contributes to making informal care both an individual tool promoting the well-being of the care recipient and a collective tool contributing to the strengthening of social bonds and a stronger economy.

In other countries where access to professional services is more restricted and carers intervene more intensively, the implementation of specific support carer policies reconciling recipients' needs and expectations with those of informal carers is more difficult. These policies are sometimes viewed more as substitutes rather than as complements of support policies for the dependent elderly themselves (England, Italy). Overall they are less likely to respond in a balanced manner to the respective needs and expectations of both actors concerned, as well as to those of professional care staff. Moreover, measures aimed at

reconciling work and care responsibilities are not sufficiently developed. It should be noted that their effectiveness depends on the nature of overall work and employment policies as well as on the quality of the social climate within companies.

The German example speaks for itself: whereas the female employment rate was low at the time of the introduction of the dependency insurance scheme (1995), the reconciliation between work and care became a major challenge in the years 2000 following new employment policy incentives brought in to improve women's access to the labour market (Eurostat, 2010). The reform of 2008 specifically responded to these changes by introducing innovative measures for working carers. Regarding this latter point, France appears in a difficult position due to a tight job market and a poor social climate within companies (Philippon 2007). The lack of flexibility in work organisation, especially regarding older workers have played the part of an 'adjustment variable' of the unemployment rate over the past 30 years, as well as gender equality policy that are still lagging behind those in place in Northern Europe, add to the difficulties outlined above.

Carer support policies in France continue to be underpinned by compassion rhetoric; they focus primarily on carers of patients with Alzheimer disease, this illness having been promoted as a major national issue for the past ten years. Yet this orientation tends to divert authorities from taking actions on other dimensions of support (housing) and in addressing the needs of other categories of carers (working carers) that should also be the targets of an overall carer support policy. Strengthening older carers support measures while making the care/work reconciliation a priority action area of a new carer support policy implies a radical reform of the overall policy to support elderly dependent people (Henrard, 2012). The policy briefs devoted to carer support policy issued by the National Solidarity Fund for Autonomy (CNSA, 2012), following up on CAS recommendations (CAS, 2010), are proof of a growing awareness in France of the crucial need to set up an efficient support policy for informal carers within the framework of overall policies targeting dependent elderly persons. ♦

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