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Invited Article II

Financial Support for Informal Care Provision in European Countries: A Short Overview

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Background and introduction

Long-term care (LTC) systems all over the world rely heavily on provision of care by unpaid carers, mostly family members without specific training in this field. In several developed countries, the share of informal care provided to the elderly is estimated to amount to about three quarters of all long-term care provided, thus forming one of the most important building blocks of national care systems. Several international developments, however, raise concerns if and how this most important type of care provision will be able to retain its role.

OECD (2011, p. 61ff) summarises the main reasons why future LTC systems will come under pressure, some of them underlining the importance of analysing conditions for provision of informal care. First, demographic shifts are expected to increase demand for LTC services in all societies, which raises concerns that a by then diminished proportion of the younger generation will have to struggle in order to provide similar levels of informal care as current and previous generations have done. Second, societal changes are expected to result in lower availability of family and other informal carers, leading to increasing demand for paid (formal) care. Changing residential patterns, household composition and size, and rising female participation in the formal labour market are expected to accelerate this process.

Receipt of formal LTC services, however, is often subject to cost sharing (see e.g. OECD 2011, chapter 7). This is even more often the case if it concerns supervision and domestic care rather than medical care, the latter in many countries being provided through health systems with no or only low cost-sharing requirements. Financial necessities might therefore further increase the considerable care demand which will rest on the shoulders of informal carers.

Pickard (2011) perceives that provision of informal care varies within and between countries: rising age, lower education levels, and being a woman all are connected to higher likelihood of providing informal care. With regard to international differences, she shows that provision of informal care is also connected to differences between LTC systems. Using a recently developed typology of European LTC systems (Kraus *et al.,* 2010), she shows that in one cluster of countries, consisting of Denmark, the Netherlands and Sweden, the likelihood of providing personal care is significantly lower than in the remaining three clusters. Differences between this and the other clusters are perceived to be particularly marked where provision of the most demanding type of informal care is concerned, that is help with two or more personal care tasks.

This background asks for the most efficient and effective measures to support provision of informal care in order to achieve sustainable LTC systems. To identify these, more information on national LTC

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systems is needed. The report underlying this summary tries to narrow this gap by providing an overview of the availability of cash benefits that can be used to finance informal care in 21 Member States of the European Union and was written in during the ANCIEN project.

The project ANCIEN—Assessing Needs of Care in European Nations[1]—was funded by the Austrian Ministry of Science and the European Commission (FP7 Health-2007-3.2.2, Grant Nr 223483). ANCIEN asks the following questions: *1) How will need, demand, supply and use of LTC develop?; 2) How do different systems of LTC perform?* ANCIEN started by collecting and analysing information from 21 EU member countries and projecting future scenarios on LTC needs, use, quality assurance and system performance for four representative countries. State-of-the-art demographic, epidemiologic and econometric modelling was used to interpret and project needs, supply and use of LTC over future time periods for different LTC systems. The Institute for Advanced Studies, Vienna participated as Austrian partner, coordinated the data collection on national LTC systems and, together with the Central Planning Bureau (Netherlands) and the Federal Planning Bureau (Belgium), derived a typology of European LTC systems. The research started in 2009 and is being concluded in 2012. A multitude of research reports resulting from this project are available for download at *www.ancien-longtermcare.eu/node/27*. The present article summarises some findings relating to support for informal care.

Under the 7th EU Research Framework Programme, the European Commission financed two more major studies on LTC. Each of them covers different aspects of LTC, thus complementing each other: *Interlinks* concentrates on the link between health and care systems, and *Shelter* validated a comprehensive assessment tool, the Minimum Data Set for LTC residents as a methodology to assess the provision of care in nursing homes in Europe.[2]

Monetary benefits apt for informal care

Monetary support for informal care can either be directed at the person in need of care, or at the person providing care. With regard to support directed at the person in need of care, quite often there is no special support scheme labelled as support for informal care, even though often there are programmes which are usable by recipients of informal care. Such programmes typically relate to some medical or social definition of need of care, or to some degree of recognised disability, as in England or Romania. Fourteen of the 21 European countries in the ANCIEN sample do offer some kind of cash benefit to persons in need of care (see figure 1). Across these countries, there are large variations in how much money is granted to cover the financial needs for care. Information on the amounts granted is unfortunately not available in a systematic way. It can be as low as about €100 per month in Finland, or as high as about €1,660 per month in Austria. These examples show that a comparison of average levels granted offers only limited information on the generosity of systems: typically, some kind of assessment process is necessary in order to become eligible for the allowance, and high monetary benefits are usually only granted if assessments have certified a high level of need. Only Poland grants the main allowance without any kind of assessment: reaching the age of 75 is seen as sufficient to become eligible[3] for a flat payment, which was designed in order to help cover the need for care. Polish authorities seem to assume that in this age most people do have already some kind of care needs. Furthermore, in about half of all ANCIEN countries with allowances, eligibility is subject to means-testing.

1 For further information see *www.ancien-longtermcare.eu*.
2 For further information see *interlinks.euro.centre.org* and *www.shelter-elderly.eu*.
3 Technically, this is true only for persons with insurance coverage. The Polish minority without such coverage, however, is eligible for a similar benefit via the welfare system.

Figure 1: Availability of cash benefits usable for informal care by primary type of beneficiary

		Care recipient		
		No cash benefit	**Means-tested benefit**	**Benefit, not means-tested**
Carer	**No income supplement or substitute**	Lithuania	France	Austria Germany Netherlands
	Income supplement	Czech Republic[1] (Hungary) Slovakia	England[2] Finland Italy	England[2] Latvia[4] (Poland)
	Income substitute	Bulgaria Denmark Estonia Sweden	Belgium[5] Romania Spain	Slovenia

Notes: [1] Allowance was transferred from carer to recipient in 2007. [2] Individual budget is means-tested, attendance allowance not. [3] Carer benefit intended more for other groups like disabled children, not so much for the old. [4] Allowance can be given to carer instead of care recipient. [5] There is an additional non-means tested benefit for carers in Flanders.
Source: ANCIEN data collection and other national reports.

In about three quarters of all ANCIEN countries, public authorities provide some kind of monetary benefit to informal carers. In three more countries, there are no monetary allowances which are granted to providers of informal care, but authorities support them financially in other ways: in Austria, Germany and Slovenia, for instance, the public covers contributions to retirement schemes, and many countries run schemes for respite care. Such benefits typically require some certified minimum level of care needs. Also with benefits for persons in need of care, there are large variations in the generosity of support. About half of the ANCIEN countries with carer support schemes offer allowances which qualify as mere support for carers, while the other half of the countries could be described as substituting a (typically modest) income a carer could have achieved otherwise on the labour market. For the sake of financial sustainability, especially the more generous carer, support schemes are designed in a way that keeps numbers of beneficiaries rather low. For instance, eligibility rules require very demanding levels of care (e.g. England), or apply a maximum duration of care (e.g. Denmark).

Also forms of providing the cash benefit vary, from simply providing cash to formal employment through the person in need of care or through public authorities, usually municipalities.

Conclusion

This summary provides a short overview of the availability of cash benefits that can be used to support informal care for the elderly in 21 Member States of the European Union. We classify benefits by two types of primary beneficiary, recipient of care versus carer. This classification, however, serves more to systematise information than to interpret which group receives more or better benefits. It is well understood that in this context, benefits can often provide direct or indirect support for each of both groups of primary beneficiaries.

It is mostly, but not exclusively, "richer" countries that provide separate monetary benefits directed primarily at each of both recipient and provider of informal care. But the mere existence of benefits schemes does not necessarily tell much about the generosity of the LTC system, as cash benefits are only one, albeit important, building block of LTC systems. Especially where care needs are high, benefits in kind may be the more important services for care recipients (Triantafillou *et al.,* 2012). Also in Scandinavian countries, care systems traditionally relied by far more than in most other European countries on formal care being provided in kind. Low levels or absence of cash benefits have to be seen in the context of a country's overall LTC system. In recent past, however, with more emphasis being laid on informal care provision also, e.g. in Sweden, cash benefits gained importance.

Only in few countries direct financial support for informal carers can be regarded as a substitute for a (typically modest) income gained on the labour market, with Denmark being the probably most generous example in our sample—but this opportunity is offered for limited time only (six months). More often, benefits can be seen as income support or as recognition of the efforts in care-giving, but would not suffice as remuneration. For a discussion of incentives attached to both types of financial support versus benefits in kind see OECD (2011, chapter 7).

Where financial support for informal care is high, it is usually used by a low number of carers, either because regulations limit benefits to very high levels of care needed, or because of a traditional smaller role of informal care, as is the case in Nordic countries. Most high-use countries could not afford this level of support today, and probably even less in the years to come with shifted demographic proportions.

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