Policies for Later-Life Families in a Comparative European Perspective

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Discussions of "family friendly" policies tend to focus on young children and their parents, disregarding the fact that those parents are also children, even grandchildren, in a multigenerational family structure. Writing on public support to the oldest members of society comes under headings such as "pension policy", "health policy", or "long-term care policy"—as if people in later life phases have no families. The lack of policy attention for family members who are helping older relatives is all the more remarkable given that growing numbers of frail older adults rather than growing numbers of children are putting pressure on families' ability to provide care (Kröger & Yeandle, 2013).

In this paper, we consider cross-national differences in policies for later-life families, focusing on state support enabling family members to carry out their caring responsibilities towards older generations. We address questions such as: to what extent do public arrangements lighten the task of providing care to frail relatives? To what extent are family members financially compensated for carrying out caregiving tasks? To what extent do public provisions help to redress gender inequalities in caregiving roles? We start with a discussion of how countries in Europe support and/or complement care given by families to their older relatives. Next we consider ways in which the policy context shapes caregiving in families, with a specific focus on inequality with respect to both class and gender, not only for frail older adults but also for those who care for them.

Models of long-term care

Long-term care (LTC) includes "in-kind" services, where care is provided by professionals at home or in an institution, and "cash benefits" which can be used to purchase professional care or which can be paid to informal caregivers as income support. In Europe, LTC provision is characterised by significant cross-national differences regarding the division of responsibilities between families, the state, for-profit organisations and the volunteer sector. Several LTC models have been identified, ranging from a *residual* model, also termed informal care-led model (Pavolini & Ranci, 2008) or family care model (Anttonen & Sipilä, 1996; Bettio & Plantenga, 2004), to a *universalistic* model (Ranci & Pavolini, 2015), also termed services-led model (Pavolini & Ranci, 2008) or Scandinavian model (Anttonen & Sipila, 1996), with various intermediate models in between.

In countries with a residual LTC model (most of the Mediterranean and central-eastern European countries), care for the frail is mainly provided by families, volunteer organizations, and religious associations. In countries with a universalist LTC model (the Nordic countries and the Netherlands), there is generous state funding for nursing care, personal care and medical help via recognised institutions. Countries with an intermediate LTC model (Austria, France, Germany

and the United Kingdom) have made significant financial investments into LTC in the past 25 years, at different times and following diverse institutional and organizational models (Carrera, Pavolini, Ranci, & Sabbatini, 2013). The differences in LTC models stem largely from cultural and political traditions regarding the role of families in society (Pavolini & Ranci, 2013). Is care primarily a private obligation with the state stepping in only when absolutely necessary? Or, is care a social right, a basic need of citizens? Models of LTC define relations of *generational interdependence* (Dykstra & Hagestad 2016; Hagestad & Dykstra 2016): the extent to which public policy arrangements impose reliance on older and younger family members or enable individual autonomy between family generations (Frericks, Jensen, & Pfau-Effinger 2014; Leitner, 2003; Lohmann & Zagel 2016; Saraceno & Keck, 2010).

Recent decades have shown a blurring of differences in LTC models as countries have reacted to what scholars identified as "problem pressures" (Ferrera, 2005) and "new social risks" (Taylor-Gooby, 2004). One of the identified *pressures* concerns the supply of family care. International organizations like the OECD repeatedly report possible shortages of available kin to support older adults in the future (e.g. Haberkern, Schmid, Neuberger, & Grignon, 2012). Due to reduced fertility rates and increased divorce rates there may be fewer adult children and spouses to take care of older adults in need. Note however, that having multiple children does not mean that all of them are providing care (Fontaine, Gramain, & Wittwer, 2009). Moreover, increases in longevity imply that higher proportions of future older adults are likely to have a surviving child than any generation ever born (Murphy, Martikainen & Pennec, 2006). If the family's capacity to provide support diminishes in the future, it is less likely the result of changes in fertility and mortality patterns, and more likely connected to changes in family structure (e.g. the increase of single-parent families), the unequal but steady rise in the labor force participation of women, and the changing nature of work which results in less free time, longer commuting and greater residential distances between family members (Limmer & Schneider, 2008). Later in this chapter we describe policy measures that aim to support family members in their caregiving tasks: cash for care, care leaves, and care credits.

Numerous reports have pointed to financial pressures linked with the expansion of an older population in need of care. Notwithstanding a potential compression of morbidity, the numbers of older people with cancer, hip fractures, strokes, and dementia will grow, and many older people will have multi-morbidities (Rechel et al., 2013). Public spending on LTC is projected to increase from 1.6% to 2.9% of GDP in the EU between 2016 and 2070 (European Commission, 2018a). Although older people account for a substantial proportion of long-term care, other factors, especially progress in health sciences and the development and use of new technologies have a much larger effect on aggregate costs (De la Maisonneuve & Martins, 2013). It has also been suggested that new generations of older people, who might be wealthier or more educated than were previous generations, will have greater demands for care services (Rechel et al., 2013). Cost containment measures that have been adopted in recent decades in countries with more generous care provisions include the freezing of service levels, shifts from institutional to home-based care, targeting care services to those with the most severe needs, and increased co-payments (Van den Broek, Dykstra, & Van der Veen, 2019).

Changes in the organization of LTC provision can also be traced to cultural shifts emphasizing self-determination and autonomy with regards to care (Genet et al., 2011; Ranci & Pavolini,

2013). The expansion of cash for care measures is at least partially a response to demands by disability groups for freedom of choice in care receipt (Da Roit & Le Bihan, 2010, 2019; Le Bihan, Roit, & Sopadzhiyan, 2019). Moreover, the growth of home-based care and the contraction of residential care in countries with universalistic LTC models fits older European's preferences to live in a familiar environment, traditionally the family home, as long as possible and to avoid moving to a form of institutional care (European Commission, 2007).

Cross-national comparisons of long-term care provisions

Cross-national comparisons of systems of LTC in Europe are rather challenging, given differences in definitions of disability and dependency, divisions between government departments and state agencies in the delivery of care, and different methods of financing LTC (European Commission, 2018b). Differences in definitions provide additional complexity. Sometimes publicly funded LTC is used synonymously with "formal care", a broader category that also includes privately paid professional care. Sometimes "informal care" also includes care provided by family members that is partially paid by public funds in the form of cash for care benefits. Thus, merely distinguishing between formal and informal care does not capture the complex policy arrangements that vary greatly across European countries. Additional challenges in the comparative investigation of LTC arise from country-specific definitions of residential long-term care facilities. Most countries provide information about beds in residential long-term facilities as a ratio between recipients and the older adult population (recipients per 1000 adults aged 65 and over). Unfortunately, definitions of what constitutes a "residential bed" have been subject to change. For example, in 2017, Austria reclassified large parts of alternative living facilities in residential long-term care facilities as inpatient services (OECD, 2019a). In 2012, the Netherlands expanded the definition of beds in residential long-term care facilities to also include places in care residences for disabled persons and not only nursing and residential care homes for older adults (OECD, 2019b).

Figure 1, based on harmonised data compiled by the OECD, reveals changes between 2005 and 2017 for 25 European countries in the *availability of beds* in residential long-term care facilities per 1000 persons of the population aged 65 and over. In virtually all countries (Czech Republic, Finland, France, Iceland, the Netherlands, Norway, Poland, Sweden, Switzerland, United Kingdom), the number of beds decreased over time. Some of these reductions have occurred due to countries implementing policies to move LTC out of residential facilities and into the community (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). As noted by Spasova and colleagues (2018), deinstitutionalisation is not a problem per se but becomes one when it is not matched with a sufficient and affordable increase in home care and community-care provision. Germany, Italy, Lithuania, and Slovakia, and more so Estonia and Spain show modest increases in the availability of residential long-term care.

The OECD also has harmonised data on developments between 2005 and 2017 in the receipt of *long-term care at home* (see Figure 2). Data for some countries refer only to people receiving publicly funded care, while other countries include people who are paying for their own care (OECD, 2017). In 2017, the proportion of over-65s receiving long-term care at home varied from 1% in Portugal to 16% in Switzerland. The proportion of LTC recipients living at home declined over the past decade in Denmark, Finland, the Netherlands, and Norway—countries with a

universalistic LTC model. The decrease of home-based care in these countries is linked to fiscal measures aimed at cost-containment and greater means-testing of services (Spasova et al., 2018). The decrease in Estonia is attributable to a reduction of the number of "curators" appointed by local government to care for people at home (OECD, 2017). An expansion of home-based care is evident in Italy, Portugal and Spain—countries where home care services were relatively underdeveloped. In Germany, Hungary and Sweden, the expansion resulted from a deliberate policy to strengthen community care (Spasova et al., 2018). The proportion of older adults receiving long-term care at home also increased in Switzerland, a country where LTC costs are predominantly funded from private sources (Colombo et al., 2011). The proportion of LTC recipients living at home showed no change in France, Luxembourg, and Slovenia, which belong to the group of countries where home care has priority over residential care (Spasova et al., 2018).

A novelty since the 1990s in long-term care schemes in Europe has been the introduction of *cash for care* policies (see the left-hand column of Table 1 for an overview), but it served different purposes and was elaborated in different ways (Da Roit & Le Bihan, 2019). In some countries (e.g. the United Kingdom), cash benefits were primarily framed as compensation for the costs of disability. In other countries (e.g. the Netherlands), the rationale for introducing cash benefits was to increase users' choice and control, in addition to cost containment. In yet other countries (e.g. Germany), the cash benefit was designed as support for family caregivers. Finally, there is the model (e.g. Spain) of fee for professional service along with creating and regularizing care employment. Not surprisingly, given the different rationales underlying their introduction, cash for care schemes differ widely across Europe (Spasova et al., 2018). One difference pertains to eligibility: it can depend on the degree of care dependency, income and assets, and the age of the dependent person. Countries also differ widely regarding the requirements on the use of and accountability for the cash benefit. At one end of the spectrum, the benefit serves as an income supplement for the household without any requirements on how it is spent. At the other end, the benefit is to be used only to pay professional services and home assistants. Some countries require proof of a formal employment contract. There is also considerable variation in payment levels, which is a function of the roles cash benefits play in each country's LTC program (Nadash, Doty, Mahoney, & Von Schwanenflugel, 2010). A limited number of countries grant cash benefits directly to the carer (Spasova et al., 2018). Such a program can act to replace lost income, linked to social protection coverage, but can also serve as recognition (albeit often symbolic) of the labour of caring.

Leave policies focus on the well-being, labour force attachment and work-life balance of the carer rather than the person being cared for. All European Union countries, with the exception of Cyprus and Latvia have introduced leave schemes in recent decades (see the middle column of Table 1 for details). The leaves are not necessarily only for workers caring for frail older adults but also for workers caring for ill and handicapped adults more broadly. Most countries have both short- and long-term leaves, and they generally allow the carer to continue building up social security rights (Bouget, Spasova, & Vanhercke, 2016). Moreover, job protection is guaranteed during the carer's leave. Remuneration also varies: some countries apply a flat rate (e.g. Belgium, Denmark and Hungary), others pay a proportion of previous earnings subject to various ceiling conditions. In Denmark, Ireland, the Netherlands, Norway, Sweden and the United Kingdom, workers are entitled to leave to look after dependents outside the family circle

(Bouget et al., 2016). Unfortunately, information on the take-up or non-take-up of care leaves is often unavailable (Heymann, McNeill, & Earle, 2013). Hence, it is unclear to what extent factors such as non-payment, lack of flexibility or perceived barriers restrain workers from using the leaves to which they are legally entitled.

In late life, the risk of poverty is generally higher for women than for men (European Commission, 2018). Reasons are women's over-representation in less paid occupations, a lower statutory pension age for women in a number of countries, and women's greater likelihood to engage in part-time work or to have career breaks due to caring activities (D'Addio, 2013). To mitigate pension inequalities, a number of countries provide *care credits* that count towards a basic state pension, but such credits are more often given as compensation for childcare rather than family care or eldercare (Vlachtoni, 2011). Care credits reflect an amount of time in months/years that is "credited" to the carer's working record as if the carer were employed in the labour market. They do not, however, compensate for wage penalties associated with being outside the labour market (D'Addio, 2013). The right-hand column of Table 1 shows that fewer than half of EU-28 countries offer pension credits for periods providing unpaid care to adult dependents. It is important to note that that countries like Denmark, Finland, the Netherlands and Sweden do not offer credits for family or eldercare because their basic old-age pension is based on years of residence, and hence automatically covers periods spent outside the labour force providing unpaid care (D'Addio, 2013). Care credits are a topic of debate in the policy literature (Foster, Chau, & Yu, 2017). The issue concerns the extent to which they promote women's emancipation or perpetuate existing structures of gender inequality (Ray, Gornick & Schmitt, 2010). One view (espoused by "care feminists") is that care credits are a justified reward for invaluable unpaid activities that generally fall on women. An opposing view (espoused by "employment feminists") is that care credits create disincentives to engage in gainful employment and reinforce traditional assumptions about gender roles.

LTC policies and caregiving in families

Early research on the intersection of families and the welfare state was guided by policy concerns that public provisions would weaken family members' propensity to care for their dependents. By now, cross-sectional findings have repeatedly shown that generous long-term care services complement rather than "crowd out" family care (Motel-Klingebiel, Tesch-Römer, & Von Kondratowitz 2005). The availability of social service professionals in a given country shapes the types of supportive tasks that adult children perform for their aging parents. It is crucial to distinguish practical help (e.g., assistance with household tasks, paperwork) and physical care (e.g., assistance with bathing, dressing, eating) given to parents. The proportion of adult children providing practical help to parents is higher, but the proportion providing physical care is lower in countries with a larger social service sector (e.g. Attias-Donfut, Ogg, & Wolff, 2005; Bonsang, 2007; Brandt, Haberkern & Szydlik, 2009). There is a "crowding in" of practical help, but a "crowding out" of physical care. When professionals take on the complex, demanding and routinisable physical care tasks, family members have greater opportunities to provide spontaneous and non-technical forms of help. Hence, professionals and family members *specialise* in performing caregiving tasks for which they are best equipped (Balia & Brau, 2014; Brandt, 2013; Igel, Brandt, Haberkern, & Szydlik, 2009).

The expansion of repeated cross-sectional data sets has enabled research into the impact of *changes* in LTC provision on exchanges in families. Pickard's (2012) study is rather unique because it considers both the expansion and subsequent retrenchment of institutional care in the United Kingdom. She shows that the increase in residential long-term stay for older people during the late 1980s and early 1990s led to a decline in the most intense types of intergenerational care, but when numbers in nursing homes/hospitals began to fall in the late 1990s, very intense co-resident care by adult children began to rise. The majority of studies have solely focused on the effects of decreases in access to publicly funded long-term care services. In the United Kingdom (Patsios, 2008) and Sweden (Johansson, Sundström, & Hassing, 2003) cutbacks in the 1980s and 1990s in care provided to older adults in the community were accompanied by increases in the provision of care by relatives and in the purchase of private help. Apparently, when the coverage of public services declined, older people turned to their families and to the market. A similar pattern has been observed in Finland, where declining eldercare services since the 1990s have been followed by an increase in family care (Kröger & Leinonen, 2012) and a marketisation of social care (Anttonen & Häikiö, 2011). In the Netherlands, stricter eligibility criteria for LTC services introduced in the 2000s have also been accompanied by a rise in care provided by adult children (Van den Broek et al., 2019). We have not found any studies from Southern, Central and Eastern Europe on family care over time.

A number of investigations have revealed that the decrease in public provisions in Sweden affected older people in *different social groups* in different ways: those with more economic resources increasingly bought services on the market, whereas older people with fewer economic resources increasingly received help from family members (Jegermalm & Grassman, 2012; Szebehely & Trydegård, 2012). Another issue has been whether cutbacks in public provisions have differentially affected the help-giving roles of adult sons and daughters (Van den Broek, 2013). Findings are mixed. Focusing on the period 1994-2000 in Sweden, Johansson et al. (2003) found an increase in help by adult daughters but not by adult sons. Ulmanen and Szebehely (2015), whose study covers the period 2002-2010 in Sweden, found an increase in help by adult daughters mainly among older adults with lower education and an increase in help by adult sons mainly among older adults with higher education. Thus, the assistance given by children became more gender equal among older people fewer resources, and less gender equal among those with more resources. In the Netherlands, daughters more often provided household support to parents than did sons between 2002 and 2014, but there was no increase in the gender gap over time (Van den Broek et al., 2019).

The act of giving is rewarding in the sense of being valued by and being important to others (Batson, 1998). Nevertheless, the provision of unpaid care to dependent family members or friends can be *costly*—to one's health and to one's financial status. A wide body of research has demonstrated a negative relationship between informal caregiving and well-being outcomes, such as depression, stress, self-efficacy, general subjective well-being, and physical health (Pinquart & Sørensen, 2003). Assessing the causal impact of caregiving on mental and physical *health* in a recent review of studies, Bom and colleagues (2019) reported that especially female and married caregivers and those providing intensive care experience negative health effects (Bom, Bakx, Schut, & Van Doorslaer, 2019). Studies investigating whether the magnitude of costs to well-being depends on the policy context are starting to emerge. Verbakel (2014) shows that the negative relationship between caregiving and happiness was smaller in European

countries that provide more generous public LTC resources, and greater in those with few LTC provisions. Interestingly, the gap in happiness between caregivers and non-caregivers did not vary by level of services offered to informal caregivers, such as leaves, cash benefits, flexible work hours, counselling, and respite care. Rather crude measures of support services might be the reason why no effect was found. Verbakel suggests that future work should more precisely measure services, and determine which types help, under which conditions, for which groups of caregivers. Using data collected between 2004 and 2015, Van den Broek and Grundy (2018) examined the influence of declines in LTC coverage on caregiver quality of life in Denmark and Sweden. Both countries traditionally had generous LTC coverage, but cutbacks were implemented in the 1990s in Sweden and after 2005 in Denmark. Over time, the difference between Denmark and Sweden in the magnitude of the negative impact of caregiving on quality of life lessened. Presumably, caregiving was more strongly perceived as a matter of choice in Denmark at the start of the period under examination, and less strongly so at the end.

A large part of the *financial* costs of caring for frail family members, a role that is more often adopted by women than men (Eurofound, 2016), derive from temporary or permanent detachment from the labour force. Women's greater responsibilities for caregiving influence their labor supply decisions in ways that reduce earnings and make them less attractive to employers (Folbre, 2018). To date, little research has been carried out on how policy arrangements might mitigate the financial risks of caregiving. Consistent with the hypothesis that women are more likely to give up work if there is no viable alternative to family care, Kotsadam (2011) found that the negative effects of caregiving on women's labour force participation were more negative in Southern Europe (Portugal, Spain, Greece, Italy), less negative in Nordic countries (Denmark, Finland), and in between these extremes in Continental Europe (Netherlands, Germany, Belgium, France). Contrary to Kotsadam, who did not include actual measures of policies in his analysis, Naldini, Pavolini and Solera (2016) incorporated indicators of home care and residential facilities in addition to total public spending on LTC in their comparison of women's labour force participation in 21 European countries. Their findings show that women's attachment to the labour force was stronger in countries with generous state support in the form of home care or residential homes. Total expenditure on LTC did not make a difference, suggesting according to the authors, that the *type of policy* rather than the total effort is a crucial determinant of carers' employment career. Services such as home help and institutional facilities enable carers to be gainfully employed, whereas cash for care schemes encourage carers, particularly those with those with lower levels of education, to give up work by providing an alternative source of income (Frericks, Jensen, & Pfau-Effinger, 2014; Leitner, 2003; Saraceno, 2010).

Studies on the impact of the type of LTC policy on caregiving in families are starting to emerge, with a specific focus on *unfavourable consequences* of cash for care schemes. One of them is increased gender inequality in intergenerational care (Da Roit, Hoogenboom & Weicht, 2015; Pavolini & Ranci, 2008). Intended to enable choice in care receipt and to support the activities of informal carers, evidence suggests that cash for care benefits subtly incentivise women to fall back on traditional divisions of roles. Using data from 14 European countries, and confirming earlier findings, Haberkern, Schmid, and Szydlik (2015) show that women were more likely to provide intensive care to aging parents than men are. However, the gender gap in the provision of such care was highest in countries with low provision of professional home-care services and

high public spending on cash benefits. Additional analyses revealed that professional home-care services substituted only for care by daughters, not for care by sons, who showed lower levels of engagement generally. Moreover, cash payments encouraged intergenerational care, but motivated only daughters not sons. Apparently, public services (home help and home nursing) reduced inequality in intergenerational care by reducing the engagement of daughters, whereas cash for care payments increased inequality in intergenerational care by increasing the engagement of daughters. In general, caregiving by sons was hardly influenced by social care policies. Another unfavourable consequence of cash for care schemes, particularly when users can freely spend their benefits, is unregulated marketisation of care (Lutz & Palenga-Möllenbeck, 2010; Saraceno & Keck, 2010). In Italy, for example, families have increasingly resorted to often undocumented low-paid migrant workers providing around the clock care (Da Roit & Weicht, 2013), a development that is facilitated by a considerable level of undocumented migration and a large underground economy.

Conclusion

The 2017 European Pillar of Social Rights[1] lists access to "affordable long-term care services of good quality, in particular home-care and community-based services" as one of its twenty core principles. To what extent do European countries guarantee their ageing citizens this right to long-term care? Our overview of developments since the 1990s in LTC systems across Europe revealed "*limited convergence*" (Ranci & Pavolini, 2013, p. 312): while universalistic systems retrenched their provisions, most of the residual care regimes expanded theirs. The exception is Italy, which undertook no major reform in its LTC policies and by default uses cash-for-care schemes (Costa, 2013; Da Roit & Le Bihan, 2019). Our review has also revealed that, notwithstanding the "limited convergence", several countries in Europe, particularly in Southern and Eastern regions, do not ensure that their ageing citizens have access to timely and affordable long-term care of appropriate quality. In these countries, the more affluent can purchase care services at market price, whereas poorer people have few other options than to turn to their families.

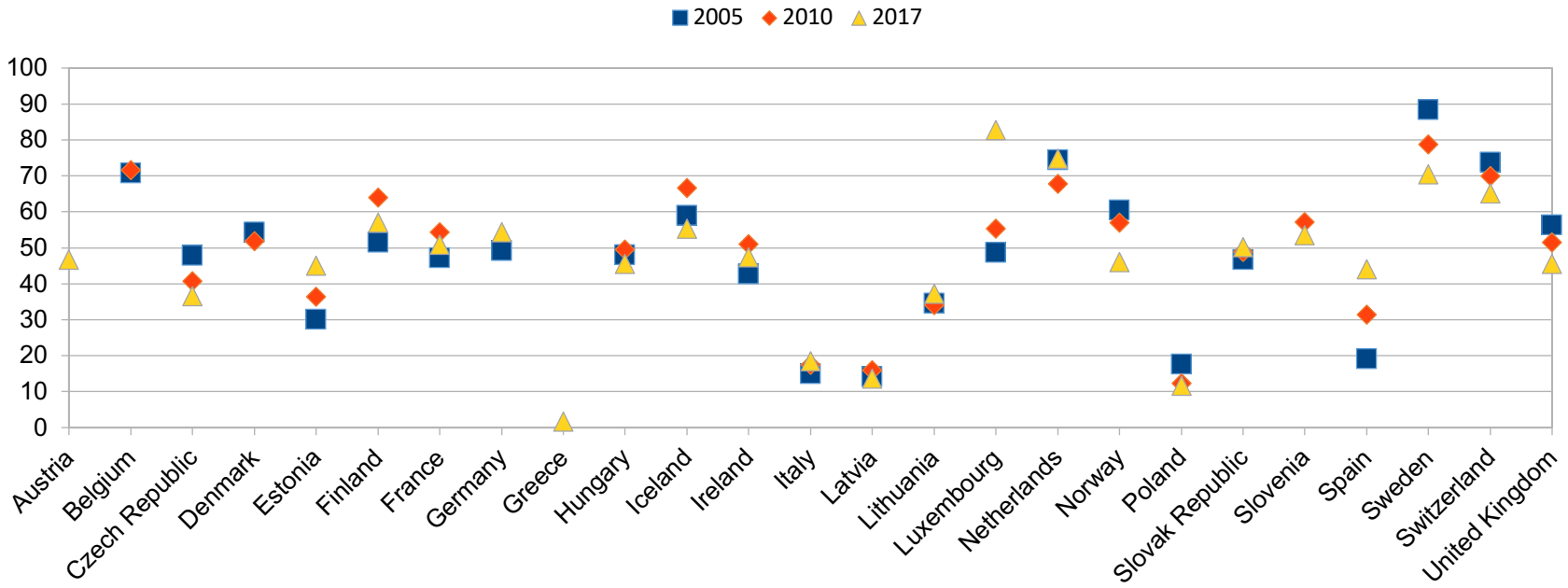
Across Europe, the broad changes in long-term care provision have involved shifts towards more home care, more cash for care, less residential care, and greater targeting to those with the most severe needs (Ranci & Pavolini, 2015). In countries with universalistic systems, the driving forces were not only cost containment but also served the purpose of meeting demands for free choice and consumer direction. In countries with residual care regimes, the reforms offered new entitlements but were also aimed at supporting the caring role of families. Throughout Europe, there has been a trend towards *re-familialisation* of care, that is, shifting responsibility for long-term care from the state to individuals and their families (Ranci & Pavolini, 2013). Both "passive" (i.e. withdrawal by the state) and "active" (i.e. introduction of cash for care benefits) re-familialisation have occurred (Leibetseder, Anttonen, Øverbye, Pace, & Vabo, 2017). In addition, there has been a trend towards *marketisation* of care, where those in need of long-term care receive publicly funded services from private providers or pay for services out-of-pocket, with some financial compensation through tax rebates (Ranci & Pavolini, 2013). Our review has revealed that re-familialisation and marketisation bring the risk of a *dualisation* of care

[1] https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights_en

(Szebehely & Meagher, 2018), where high-resource older adults find the best providers and low-resource older adults are faced with declining public service coverage.

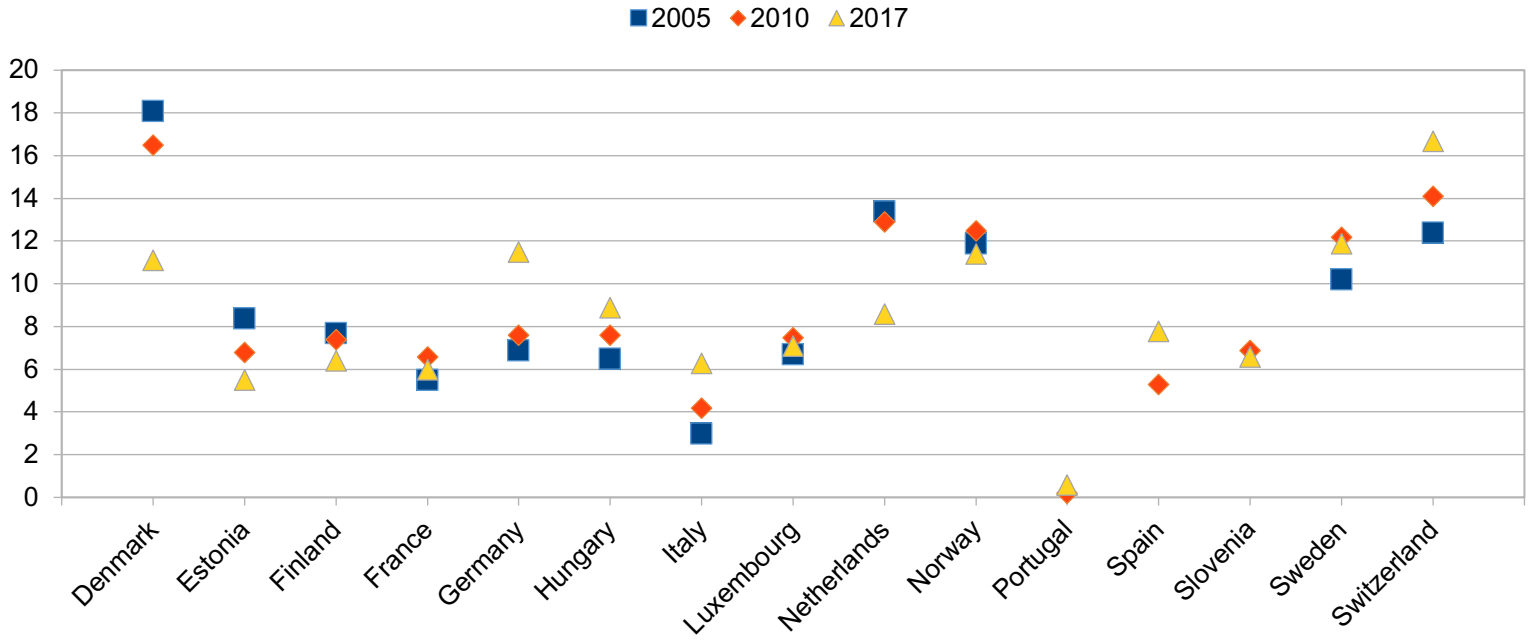
The shift towards more home care and less residential care fits efforts to enable older people to "age in place" (Lawton, 1982): to live independently in their own homes for as long as possible. There is a crucial distinction, however, between "ageing in place" and simply "*staying put*" (Boldy, Grenade, Lewin, Karol, & Burton, 2011). Services must be available to enable older people to live in their own "place". Moreover, for those facing poor housing conditions, the home is not an appropriate environment to "age in place". Coping at home for too long can result in great harm, leading to physical and mental exhaustion for both the older people and their carers (Horner & Boldy, 2008). Coordination between multiple care providers is necessary to avoid that older adults living in the community fail to be noticed or assisted.

Figure 1: Beds in residential long-term care per thousand of the total population aged 65 and over, selected European countries, 2005-2107



Data from:
OECD. (2019). *Long-term care resources and utilization, OECD Health Statistics* [Database]. doi:10.1787/data-00543-en

Figure 2: Recipients of long-term care at home as percentage of the total population aged 65 and over, selected European countries, 2005-2107



Data from:
OECD. (2019). *Long-term care resources and utilization, OECD Health Statistics* [Database]. doi:10.1787/data-00543-en
Note. Data for Slovenia from 2011 and 2016; data for Denmark and Estonia from 2008

Table 1: Cash benefits, leave policies, and care credits towards statutory pension entitlement for family/eldercare in European countries

	Cash benefits for eldercare (ESPN 2018)	**Leave policies for eldercare (ESPN 2018)**	**Credits for family/eldercare (MISSOC Tables 2019)**
Austria	Long-term care benefit (*Pflegegeld*); EUR 157.30 per month at level 1 (the lowest level of benefits), but may be as high as EUR 1,688.90 at level 7. Additional care-leave benefit (*Pflegekarenzgeld*)	Care leave (*Pflegekarenz*) and Family hospice leave (*Familienhospizkarenz*); up to six months to care for terminally ill relative)[a]	None
Belgium	Cash benefit (*Tegemoetkoming voor hulp aan bejaarden/ Allocation pour l'aide aux personnes âgées*) is granted to persons aged 65 and older for whom a severe need for care is ascertained Service Voucher Scheme: persons living in the same household) can buy a maximum of EUR 1,000 (or 2,000 for some categories) service vouchers per year for cleaning, ironing, preparing food and doing occasional sewing work; also for ironing, shopping, supervised transport of persons with reduced mobility	Time credit leave (*Tijdskrediet/ Crédits temps*): full-time or part-time career break or a one-fifth working time reduction to provide palliative care (for a maximum of 36 months), to support seriously ill relatives (for a maximum of 36 months) Leave for palliative care (*Uitkering mantelzorg/ Allocation d'aidant proche*) for up to 3 months	Periods caring for a family member
Bulgaria	No cash for care benefit	Short-term leave to care for an ill person whatever the illness-related reason	None
Croatia	No cash for care benefit, but flat rate amount of EUR 276 monthly (approximately 40% of the net average earnings of a single person) is paid to carers during leave	20 leave days for illness of the spouse; 7 leave days if an immediate family member is seriously ill[a]	None
Cyprus	In some cases, the state pays for home care provided by a domestic helper (EUR 397.78 allowance per month)	No care-specific leave schemes and flexible time arrangements for carers	None
Czech Republic	Monthly cash for care benefit ranging from EUR 33 for level 1 (slight dependence) to EUR 488 for level 4 (full dependence)	9 leave days for illness of a relative at home[a]	Periods caring for a severely disabled close relative
Denmark	No cash for care benefit, but monthly flat rate of at least EUR 2,000 (approximately 70% of the net average earnings of a single person) is paid to carers during during leave	Respite and flexible care leave of up to six months for persons attached to the labour market, e.g. wage earners, self-employed, and unemployed people, but not for persons above pensionable age	None

Estonia	Average monthly allowance for caregivers of working-age adults and elderly people with official severe disability status is about EUR 21	7 leave calendar days for those caring for a dependent adult	None
Finland	No cash for care benefit, but there is a tax deduction (*Kotitalousvähennys*) for the expenses of caring for parents or grandparents; for up to EUR 2,400 per person per year	Different types or different spells of care leave according to age groups Leave to provide end-of-life care	None
France	Monthly cash for care benefit (*Allocation personnalisée d'autonomie* (APA)) ranges from maximum EUR 1713 for level 1 (high dependency) to max EUR 662 for level 4 Financial support of up to EUR 500 per year for respite care	Unpaid leave (3 months, renewable up to 1 year) to care for relatives with significant loss of autonomy Unpaid family solidarity leave (with daily allowance EUR 55/day for maximum 21 days; 3 months, renewable once) to assist a dying relative	Credit of max. 2 years insurance to take care of a severely disabled child, or to permanently take care of a disabled adult (disability of at least 80%, conditional)[b]
Germany	Care allowance amount varies from EUR 125 per month for care-grade 1 to EUR 901 for care-grade 5 Substitute care up to 6 weeks a year provided by close relatives varies from EUR 474 per month for care-grade 2 to EUR 1,351 for care-grade 5 Substitute care up to 6 weeks a year provided by other persons is fixed at EUR 1,612 per month Short-term care up to 8 weeks a year varies from EUR 125 per month for care-grade 1 and EUR 1,612 for all other care-grades	Reduction of working hours (by at least 15 hours per week) for up to 24 months, including a maximum of 6 months off work Short-term care leave of up to 10 working days a year without prior notice[c]	Periods of informal care
Greece	No cash benefits to compensate informal family carers for services they provide	22 days leave entitlement to care for spouse with certain medical conditions[a]	None
Hungary	Relatives who care for a disabled or permanently ill family member can apply for a not means tested, unindexed nursing allowance (EUR 105). Depending on the health status of the care recipient, an increased nursing allowance (*Emelt összegű ápolási díj*) may be paid or an extra nursing allowance (*Kiemelt ápolási díj*) of HUF 58,680/ EUR 190 a month.	Labour Act allows relatives to go on unpaid leave for a maximum of 2 years to provide personal care to a permanently ill relative	None

Ireland	Carer's allowance (means-tested social assistance, EUR 201 per week), Carer's benefit (insurance-based, EUR 209 per week) and Carer's support grant (annual payment of EUR 1,700 made to recipients of either Carer's allowance or Carer's benefit)	2001 Carer's Leave Act provides a minimum of 13 weeks up to a maximum of 104 weeks to care for relative, friend or colleague	Periods of up to 20 years spent by an insured person providing care to incapacitated persons of any age to incapacitated persons of any age
Italy	Flat-rate cash 'companion allowance' for individuals with severe disability at around EUR 515 per month	Short-term leave for urgent cases and longer leave provisions (Laws No 104/1992, 388/2000 and 183/2010; and all the legislative changes later made to these three laws) No more than one worker in a household has the right to care leave as a carer for a severely disabled person: 3 working days of paid leave (at 100% of the last salary) per month; and up to 2 years of paid leave (at 100% of the last salary, but within an annual ceiling – EUR 47,446 in 2016)	Periods of absence from work for looking after an adult in need of care
Latvia	No specific cash benefit for eldercare, but there is a personal care benefit for disabled people (EUR 213.43 monthly)	No care-specific leave schemes and flexible time arrangements for carers	None
Lithuania	Cash benefits for dependent persons (disabled and persons of retirement age) at not less than EUR 112 per month. The amount is determined according to the target compensation base, from 2.5 times the base for Compensation for Nursing, and 0.5 times the base (EUR 56) for Attendance Assistance for the elderly.	Short-term leave to care of a sick person whatever the sickness-related reason	None
Luxembourg	Older persons can opt for cash benefits instead of in-kind benefits (paid minutes per week in residential or home care), varying from EUR 12.50 per week for level 1 (low dependency) to EUR 262.50 for level 9 or higher levels of dependency	Fully paid carer's leave	Periods caring for a dependent person
Malta	'Carer at home' scheme grants older persons a maximum of EUR 5,200 per year to employ a carer of their choice to assist them in their daily needs	Only public sector employees are entitled to reduced working hours, and short-term and extended leave	None
Netherlands	Older persons living at home who want to organise their own care can choose to apply for a personal budget (*Persoonsgebonden budget*) to hire and pay their own caregivers who may be relatives or other persons. Municipalities and care offices decide	Employment and Care Act (*Wet arbeid en zorg*) gives carers the right to take leave to care for a sick partner, child or parent, siblings, grandparents, grandchildren, housemates or acquaintances. Short-term care leave (partially-	None

	whether older persons are eligible for the personal budget that is overseen and managed by an independent Social Insurance Bank (SVB)	paid 10 days per year), emergency leave and long-term care leave (unpaid 30 days per year); leave duration is shorter for part-time workers	
Poland	Cash benefits cannot be combined with employment, benefits for carers of older people are granted only in the case of disability. Special means-tested care allowance (*Specjalny zasiłek opiekuńczy*) can be granted when family income per capita is below EUR 182, to the amount of EUR 124 monthly Another allowance for carers (*Zasiłek dla opiekunów*) is paid at the rate of EUR 118 monthly Both types of allowance are not universal	14 days per year leave entitlement to care for sick family member[a]	None
Portugal	Cash benefit (*Complemento por dependência*) granted to a person requiring the permanent assistance of a third person to perform the essential activities of daily living The monthly amount varies between EUR 103.51 and EUR 186.31. Benefits granted under the general social security scheme	15 days per year to care for close relative (+15 days leave entitlement to care for severely disabled/chronically ill spouse)[a]	None
Romania	Family members of severely disabled people can be hired as a personal assistant of the disabled person, but the disabled person can opt for a monthly indemnity (equivalent to the net minimum salary payable to the personal assistant) instead The amount of indemnity is between EUR 245.73 and EUR 287.17	20-21 days rest leave (+ up to 5 days paid free days for personal issues)[a]	None
Slovakia	Means-tested nursing allowance ('attendance service benefit') is paid directly to caregivers in the form of a social transfer only for severely disabled persons, ranging from EUR 249.35 to EUR 315.96 per month if the caregiver does not receive any statutory pension benefit	Leave for informal carers under a 'respite care' service, for a maximum period of 30 days per year, organised by municipalities	Periods of caring for an adult person or periods of providing personal assistance (*Osobná asistencia*) for at least 140 hours monthly
Slovenia	Cash benefit granted to retired residents of Slovenia who need assistance in meeting their basic needs	7-15 days leave entitlement to care for an ill spouse[a]	None

	The allowance is not means tested; there are three different rates of assistance and attendance allowance, ranging from EUR 292.11 to EUR 418.88 per month		
Spain	Cash benefits for informal care at home (care must be provided by family members) and for personal assistance and purchasing of services that must be provided by an accredited company or a worker registered with social security as self-employed The cash benefits range from EUR 153 (Degree I dependents) to EUR 387.64 (Degree III dependents) per month for informal care at home; and from EUR 300 to EUR 715 per month for personal assistance or for the purchase of services	2-4 day leave entitlements (*Permiso por enfermedad grave de un familiar*) per event (serious illness, hospitalization, death) to care for a relative to a second degree of consanguinity or affinity[a]	The first year of leave to care for relatives (*Excedencia para el cuidado de familiares*) who, on account of age, illness or incapacity, require constant assistance to carry out the most essential daily activities
Sweden	Two types of municipal cash benefits available for family carers, but they are decided upon locally and are not provided everywhere One allowance is attendance allowance (*Hemvårdsbidrag*), a net cash payment given to the care recipient to be used to pay for help from a family member (about 4,000 SEK/ EUR 450 per month) The other benefit is a carers allowance (*Anhöriganställning*), a payment by the municipality when a family member is employed to do the care work	Short-term and long-term leaves to care for frail elderly dependents, including persons outside the family circle Period of leave can depend on collective agreements	None
UK	Cash for care benefit provided through the Care and Support Act 2014 in cases of caring for 35 hours a week or more for a person who receives a qualifying disability benefit Carers might also be eligible for means-tested benefits (Carer premium, Carer addition and Carer element)	Working age carers have rights to request flexible working arrangements and to 'reasonable' time off work to deal with crises involving a dependent	Periods looking after adults who receive a disability benefit for at least 20 hours a week

Sources: European Social Policy Network (ESPN) 2018 Thematic Report on Challenges in long-term care (for each country); MISSOC Tables 2019; Retrieved from: https://www.missoc.org/missoc-database/comparative-tables/results/ (Accessed on 4 September 2019), updated from Vlachantoni, 2011; Blum, S., Koslowski, A., Macht, A., & Moss, P. (Eds.). (2018). International review of leave policies and related research 2018. Retrieved from: https://www.leavenetwork.org/leave-policies-research/archive-reviews/ (Accessed on 4 September 2019);

[a] from Blum et al. (2018) International review of leave policies and related research 2018;
[b] under special circumstances care credit may be granted;
[c] the statutory right to the 6 months' care leave applies only to employees in companies with more than 15 workers, and the statutory right to work part time for up to 24 months applies only to employees in companies with more than 25 workers.

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