Who cares in Europe?

A comparison of long-term care for the over-50s in sixteen European countries
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A comparison of long-term care for the over-50s in sixteen European countries

Debbie Verbeek-Oudijk
Isolde Woittiez
Evelien Eggink
Lisa Putman

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Foreword

Long-term care for people with chronic health problems is undergoing radical reform in the Netherlands. In a letter to the Lower House of the Dutch Parliament in April 2013, the State Secretary for Health, Welfare and Sport introduced plans for radical reform of the current Exceptional Medical Expenses Act (AWBZ), which has to date been the central funding vehicle for much of the long-term care provided in the Netherlands. The proposed new Long-term Care Act (Wet langdurige zorg, Wlz), which is expected to come into force on 1 January 2015, is likely to limit the availability of centrally funded care to people who require permanent supervision or who require residential care within an institution. Local authorities will be given responsibility for supporting other citizens with a long-term care need, through the Social Support Act (Wmo). Care insurers will be responsible for the delivery of personal and nursing care. The purpose of the reforms is to enable people to continue living at home for as long as possible, where necessary with support from the local authority and/or their care insurer.

It is well-known that people’s need for support is largely determined by their level of illness and disability. Physical and mental frailty mean that this need often increases with advancing age. People’s own financial resources and the presence or absence of a social network also play a role. In defining and developing an appropriate policy in relation to the provision of care for these people, and the way in which that care is organised, it is useful to look at experiences in other countries. What developments are taking place in long-term care in those countries? What disabilities and health impairments do people have in those countries? What help is available for them in principle and what help is actually offered? This report provides an answer to these questions. The study forms part of the multi-year Long-term Care project as described in the SCP research programme and which is co-funded by the Long-term Care Department at the Dutch Ministry of Health, Welfare and Sport.

This report draws on data from a major international survey, the Survey of Health, Ageing and Retirement in Europe (SHARE). This international survey of people aged over 50 living independently was set up in order to gather information about the health status, social networks and economic position of people as they grow older. Grateful use is made of the SHARE dataset in this report to obtain an insight into the extent to which the Netherlands differs from other countries as regards these factors and the degree to which formal or informal care is provided. As usual in SCP research, the starting point is the perspective of the citizen, in other words the need for and utilisation of long-term care. A word of thanks is of course due to the organisers of the SHARE project, who generously made the international dataset used in this study available at no cost (see www.share-project.org).

Prof. Kim Putters
Director, Netherlands Institute for Social Research
Summary and discussion

Long-term care undergoing change
Long-term care in the Netherlands has been changing for several years. Many people make use of this care, and the costs of the care sector amounted to 5% of Dutch Gross Domestic Product (GDP) in 2010 (OECD 2013a). In this report, long-term care means the help provided to people who, due to a chronic physical, cognitive or psychological impairment, need long-term support in their daily functioning (Colombo et al. 2011). Population ageing means the number of older persons needing care is rising, leading to concomitant rise in the costs of care. Through a series of economy measures and reforms, the Dutch government is seeking to create a stable and efficient care system. Comparison with other countries is a useful means of gaining an insight into how the Dutch care system could work better. In this report we compare the Netherlands with a group of countries which represent a wide array of care systems.¹ This report has been compiled partly at the request of the Dutch Ministry of Health, Welfare and Sport.

Specifically, this report describes the degree to which long-term care for people aged over 50 years living independently in the Netherlands differs from that in other European countries in the following five areas:

1. The long-term care system
2. The care need
3. The risk of a long-term care need and care utilisation
4. The family care network
5. Utilisation of paid and unpaid care

We describe both paid and unpaid care in this report. Although we would ideally like to map out long-term care utilisation for the entire population, data restrictions limit us to the population aged 50 years and older. Long-term care is received mainly, though not exclusively, by older persons (see e.g. OECD 2013b). Looking at the care situation of the population aged over 50 provides us with a broad picture of long-term care, in contrast to other studies which often focus on the care utilisation of people aged over 65 or the very oldest age groups in the population. As chapter 3 of this report shows, around half those aged 50-65 years have some form of health impairment. This approach also presents a picture of the care situation that we can expect to develop in the future. Hence our focus on the over-50s in this report.

¹ The choice of countries was also based on the availability of survey data.
Figure S.1
Topographical representation of the European countries with which the Netherlands is compared in this report.

2 AT = Austria; BE = Belgium; CH = Switzerland; CZ = Czech Republic; DE = Germany; DK = Denmark; EE = Estonia; ES = Spain; FR = France; HU = Hungary; IT = Italy; NL = The Netherlands; PL = Poland; PT = Portugal; SI = Slovenia; SW = Sweden.
To answer the research questions we draw on data from the Survey of Health, Ageing and Retirement in Europe (SHARE), a survey of persons aged 50 years and older living independently in a number of European countries. Since this report seeks to provide the most up-to-date overview possible, it mainly uses the most recently collected data on the care situation in 2011. Those living in residential care facilities are left out of consideration in this study. Unfortunately, we are also unable to present a complete picture of the utilisation of paid care due to gaps in the data: the most recent edition of SHARE contains information only on the extent to which paid care is provided from within the recipient’s social network. We do however use a number of assumptions to estimate the total amount of paid care received.

This study is an update of an earlier SCP publication (Pommer et al. 2007), but also incorporates the latest insights and additions, such as a description of the structure of the long-term care system in Europe and an inventory of the degree to which people aged over 50 are confronted with risk factors for care utilisation. This study differs from other international research which focuses mainly on macro-comparisons of systems (o.a. Colombo et al. 2011), specific countries (o.a. Courbage en Roudaut 2011) or in-depth analyses of particular aspects (o.a. Scheil-Adlung en Bonan 2012).

As a framework for tracking differences in care utilisation, we used the theoretical model developed by Andersen and Newman (1973) which describes the factors that influence use of care. Use of care is influenced by characteristics of the formal and informal long-term care system (described as the ‘health service system’ in the model), social norms concerning what are considered to be health impairments and how to deal with them (the ‘societal determinants’), and characteristics of individual users. These characteristics can be subdivided into care need (‘illness level’), predisposing factors and enabling factors.

This theoretical model forms the baseline on which this report is built.

Comparable problems, different approaches

With regard to the first two factors from Andersen and Newman’s model (the health service system and societal determinants), in this report we look first at the structure of the long-term care system by investigating what long-term care provisions are available, who is responsible for these provisions, how care is regulated and what the associated costs are.

As in the Scandinavian countries, the government in the Netherlands assumes a high degree of responsibility for providing long-term care. Additionally, at least in the Netherlands, providing help for people with relatively slight health impairments is also regarded as a task of the government. In the Southern European countries, by contrast, as well as in Switzerland and Eastern Europe, the family takes primary responsibility for caring for people with a health impairment. In Belgium, Germany, France and Austria, responsibility for providing long-term care is shared between family and government. Non-residential care in the Netherlands is regulated at central level, though implementation is increasingly being devolved to regional and local level. The organisation of care in a number of Southern and Eastern European countries is highly decentralised.

Broadly speaking, two policy trends can be observed in the countries covered in this study. The first trend is that countries with a large amount of publicly funded care are
increasingly shifting the focus towards family or social responsibility, and towards promoting informal care. At the same time, in countries where informal care already dominates, that care remains important, but efforts are also being made to improve the quality and accessibility of publicly funded care. The second trend is that the organisation and regulation of care is increasingly being devolved to local and regional authorities, based on the assumption that if the provision of care is organised close to the recipient, this will lead to more appropriate care solutions. These two trends can also be observed in the Netherlands. Those countries where care is seen as the responsibility of the government are characterised by relatively high public spending on long-term care. However, this is not a one-to-one relationship. Public spending on care is also high in some countries where care is seen as a responsibility of the recipient’s family. Public spending on long-term care does not appear to be related to whether the care is organised centrally or locally/regionally. Compared with the other countries in this study, the Netherlands spends an average percentage of GDP on non-residential long-term care. Based on the expenditure on non-residential long-term care and the entity that bears responsibility for providing care, the European countries in this study are clustered into groups when discussing the results. There is a Northern cluster (comprising the Netherlands, Sweden and Denmark), a Central European cluster (Austria, France, Belgium and Germany) and a Southern and Eastern European cluster (Italy, Spain, Portugal, Estonia, Hungary, Czech Republic, Poland, Slovenia and Switzerland). As a general rule, countries in the Northern cluster are characterised by high public spending and low family responsibility for care, the Central European cluster by average expenditure and average family responsibility and the Southern and Eastern European cluster by low public expenditure and high family responsibility.

**Diversity in health impairments of the over-50s in Europe**

The prevalence of health impairments in the population is very important for the volume of care utilisation. Following Andersen and Newman (1973), we describe this ‘illness level’ as the care need. Based on data from the SHARE dataset, we operationalise care need using three measures of health impairment: physical, psychological and cognitive, plus an overall measure summarising the care need. Roughly one in three over-50s living independently in Europe have no health impairment at all; just under one in three have a slight impairment, while the remainder (one in six) have moderate or severe impairment. Just under half the younger members of the over-50 age category have no health impairment, compared with only 6% of those aged over 85 years. A not inconsiderable proportion of the ‘younger’ over-50s thus have some form of impairment. The percentage of people with health impairments rises with age in an almost linear trend.

There are considerable differences between the countries in the study. The proportion of Dutch over-50s without health impairments is high (45%), as it is in the Scandinavian countries and Switzerland. This proportion is much lower in the Southern and Eastern European countries (around 30%). The same conclusions in terms of country differences apply for the age categories 50-64 years, 65-79 years and over-80 as for the entire
population aged over 50. Physical impairments occur commonly in all countries studied; psychological and cognitive disorders are less common. All forms of health impairment are more prevalent in the Southern countries.

Although a sizeable proportion of the population aged 50 years and older have some form of health impairment, not everyone experiences it as such. It may be that, with mobility aids, care and/or home adaptations, over-50s are perfectly capable of functioning well in their daily lives and therefore claim that they have no difficulties. Just under half those with a severe impairment report that their health is poor, while just over half say they experience limitations in their daily functioning. It is striking that there are relatively few over-50s in the Northern countries with health impairments but a relatively high number who experience limitations to their functioning, whereas in the Southern countries people often state that they experience no limitations in their daily functioning despite having health impairments.

**Wide differences in risk factors for care utilisation**

Based on the theoretical model developed by Andersen and Newman (1973), other characteristics in addition to health impairments, such as sex, age, marital status, education level and income, can play a role in explaining differences between countries in utilisation of long-term care. These are *predisposing* and *enabling* factors for care utilisation.

The proportion of single persons among the over-50s living independently is higher in almost all European countries studied than in the Netherlands. Additionally, the over-50 population in the Netherlands is relatively young. The Netherlands falls into the middle range in Europe in terms of the percentage of over-50s with a low education level; Spain, Italy and Portugal, in particular, have a high proportion of low-educated over-50s. The Netherlands has more highly educated over-50s than most other countries in Europe. Total annual household income in the Netherlands also differs markedly from the other countries studied. The share of higher incomes\(^3\) is greater in the Netherlands than in most of the other countries.

In addition to demographic and socioeconomic factors, life events can also create a care need (predisposition). We therefore investigate the degree to which the following life events occur in the various countries: serious illness as a child; going through one or more separations/divorces; death of a partner or child; and change of lifestyle.

We find a number of differences between countries in the degree to which people aged over 50 have experienced such events. Over-50s in the Netherlands have experienced a serious childhood illness considerably more often than their peers in the Northern and Southern countries. There is also a striking difference between the European regions as regards behavioural adjustments that can promote health. A higher proportion of over-50s in the Netherlands and Scandinavia have for example given up smoking,

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\(^3\) A standardised annual household income of €30,000 or more, corrected for differences between the countries using purchasing power parities.
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reduced their alcohol intake and began taking more exercise than in the other European countries. People in Southern Europe have least often changed their life habits.

Many people have a family network

Andersen and Newman argue that the social network of people aged over 50 is an important enabling factor for care utilisation on which those in need can draw. People who do not have access to a social network but who need help are more likely to have to seek recourse to publicly funded care. This report looks only at the presence of a family care network from which the person needing help might be able to receive unpaid care. That network consists mainly of partners and children. The SHARE dataset contains insufficient information on the availability of others, such as neighbours, friends and acquaintances. The family care network covers much of the entire network that is able to provide unpaid care. In practice, however, parents and children will not always be able to actually provide care if needed. They may face impediments that prevent them from providing care, because they are themselves sick or unfit for work, or in the case of children because they work full-time, have young children of their own or live a long way from their parents. In the light of this, the proportion of the potential family care network that experiences such impediments is considered in more detail.

Three-quarters of Dutch over-50s have a partner, a higher proportion than in most other countries. This percentage declines with advancing age. One in ten Dutch over-50s have one or more children living at home and two out of three (also) have children living away from home. In total, 90% of Dutch over-50s have access to a network that could potentially offer unpaid help. This is in line with the average in the countries studied. In the Netherlands and most Southern European countries, the network consists mainly of people within the recipient’s own household; elsewhere in Europe, it often comprises children living outside the home. Around 10% of all Dutch over-50s do not have access to a family network, and the same percentage applies in almost all other countries studied. This is potentially a very vulnerable group.

Just under 70% of over-50s living independently in the Netherlands have someone in their family care network who could provide care without encountering impediments. The average across the countries studied is 66%. Portugal is the only country where this figure is higher than in the Netherlands. It should be noted that in most countries those aged over 80 less often have a family care network that could provide care without impediments than those aged 65-79 years and those aged under 65.

Greater government responsibility for long-term care equates to more paid care

Finally, we describe the use of paid and unpaid care. We only have information about paid network care, i.e. paid private or public care that is provided by people in the social networks of people aged over 50. These may be people from home care organisations, but may also be private individuals or family members who are paid for the services they provide, for example from a personal budget held by the care recipient. This approach ignores care that is provided in other ways, for example by regularly changing caregivers who do not form part of the recipient’s network. As regards unpaid care, we include all care provided by family members, neighbours, friends and acquaintances, but also care
provided by voluntary organisations. Unpaid care is also referred to as informal care. In order to be able to construct a picture of total care utilisation, we use SHARE data from 2007 to estimate the total utilisation of paid care.

A small proportion (2%) of Europeans aged 50 years and older receive paid care provided by caregivers from within their networks. This percentage is slightly higher in the Netherlands (3%). The differences in utilisation of paid network care across countries reflect differences between the long-term care systems. Responsibility for long-term care in the Southern and Eastern European countries lies mainly with citizens themselves, and the use of paid network care is accordingly low in these countries. In the Northern and Central European countries, as well as in the Netherlands, the government has much more responsibility and the use of paid network care is accordingly higher.

Roughly six out of ten Dutch over-50s receive unpaid care, often from members of their own household (around a third), but also regularly from children living outside the home (about a fifth). Southern and Eastern European countries, in particular, score highly on receipt of unpaid help (approximately 70%). Given the earlier descriptions, there are broadly two explanations for this. It is often the norm for different generations to live together in these countries, so that the availability of unpaid care is relatively high. Moreover, there are few opportunities to use publicly funded care because of its limited availability. In countries where the availability of publicly funded care is much greater, such as the Netherlands and Scandinavia, the use and intensity of unpaid care is much lower.

On average, just under 70% of over-50s in Europe receive unpaid care or paid network care. The Netherlands scores below average, at 61%. Care utilisation in Southern and Eastern Europe is substantially higher than in most other countries, principally because people receive more unpaid care in those countries.

Paid network care accounts for only part of the paid care utilisation. According to the SHARE dataset, 7% of the European population received paid care in 2007. Although the level of paid network care use is considerably lower in the 2011 dataset, the country differences remain comparable. The use of paid care is higher in the Netherlands and the other Northern and Central European countries than in the other European countries. If we assume that the ratio of paid to unpaid care remained unchanged between 2007 and 2011, it can be deduced that 64% of over-50s living independently in the Netherlands receive paid or unpaid care. That is lower than in the countries of Southern and Eastern Europe, but higher than in countries such as Sweden and Austria. The percentage of people utilising care rises with age; people aged over 80, in particular, often receive care, but more than half of those aged between 65 and 79 and those aged under 65 also receive paid or unpaid care.

Conclusion

Briefly summarised, the Netherlands spends an average proportion of GDP on non-residential long-term care compared with other countries, whilst population ageing in the Netherlands is among the lowest in Europe. As in Denmark and Sweden, responsibility for long-term care in the Netherlands lies mainly with the government and much less with the family. Compared with their peers in other countries, relatively
few independent-living Dutch over-50s have physical, psychological or cognitive impairments. However, a relatively high proportion of this age group report that they experience their health problems as limiting. Most of the risk factors for care utilisation occur to roughly the same degree in the Netherlands as elsewhere. The Netherlands has few independent over-50s living alone and a lot of highly educated and affluent over-50s compared with the other countries studied. This age group do however report more often than the average in other countries that they had poor health as a child, but are more often inclined to modify their unhealthy lifestyle. Dutch over-50s have access to a family care network that could potentially offer unpaid help just as often as their peers in other countries. In contrast to elsewhere in Europe, the network mainly comprises partners rather than children. Family care networks in the Netherlands experience impediments in providing care slightly less than average. The percentage of over-50s living independently in the Netherlands who were receiving care in 2011 is estimated to be slightly lower than in most other countries. According to our estimates, only Sweden, Austria and Switzerland have fewer over-50s living independently who are in receipt of care; the use of unpaid care in those countries is the same as in the Netherlands, but the use of paid care is lower. The percentage of over-50s living independently in Southern and Eastern Europe who are in receipt of care is much higher than in the Netherlands, mainly because of the much greater use of unpaid care.

Discussion
The ability to sustain the long-term care systems lies at the heart of the policy debate in all the countries discussed in this report. The growing number of older people in the population and the ongoing recession reinforce the need to devise a resilient care system. In the Netherlands, the government has for decades been responsible for long-term care provision, and providing help for people with health impairments to enable them to continue participating in society is high on the political agenda. This is accompanied by an extensive range – compared with many other European countries – of publicly funded care provisions. This in turn gives rise to relatively high costs, particularly for residential long-term care. The Netherlands occupies a middling position in Europe for expenditure on non-residential long-term care. A certain rapprochement is taking place between the countries in the balance between publicly funded care and informal care: countries with a high proportion of publicly funded care are steering more towards informal care, while countries with a heavy emphasis on informal care are aiming for more publicly funded care. The Netherlands is following the same course as the other countries in this regard. However, despite the care home closures that hit the Dutch newspaper headlines, the Netherlands still has a relatively high volume of residential care, with around 150,000 people in residential care and nursing homes.

How is it that Dutch expenditure on non-residential long-term care is lower than in countries such as Denmark and neighbouring countries such as Belgium and Germany, which resemble the Netherlands in many other respects? A first reason could be the extensive availability of residential care in the Netherlands, which may have reduced demand for non-residential care. The extent of population ageing is also lower among over-50s living independently in the Netherlands compared with the other three
countries, resulting in relatively fewer people with a heightened risk of long-term care use. In addition, Dutch over-50s in each age category less often have health impairments than their German and Belgian peers. Denmark has a smaller proportion of over-50s living independently with health impairments, but those who do fall into this category more often report that their impairments limit their daily functioning. The lower prevalence of the risk factors for care utilisation in the Netherlands probably also plays a role: compared with their Danish and German peers, Dutch over-50s are affluent. Moreover, they often have a partner on whom they can call if they need help. Despite this, fewer over-50s living independently in the Netherlands receive unpaid care from other household members then in Belgium, Germany and Denmark, but make more use of paid network care (this also applies for the total volume of paid care – actual for 2007 and estimated for 2011). One explanation for this is that the less intensive forms of care are publicly funded in the Netherlands, which is not the case in Germany, for example: in 2007, 7% of Dutch over-50s with slight health impairments received paid care, compared with 1% in Germany. There is thus a relatively high number of paid care users in the Netherlands, but the intensity of that care, and therefore the cost per user, will be lower than elsewhere. Consequently, the costs of non-residential care as a whole are no higher than in the neighbouring countries. As more and more care has to be provided in the home setting, however, home care services will deliver increasingly intensive forms of care, which could potentially lead to an increase in non-residential care costs in the Netherlands.

Proposed spending cuts in Dutch long-term care are based in part on the assumption that a reduction in paid care will mean that more support is provided from the recipient’s network. It is however unclear from the literature to what extent paid and unpaid care substitute or in fact complement each other. While that also does not emerge clearly from this report, we can explore a number of considerations based on the somewhat old SHARE data from 2007. Compared with other countries, over-50s living at home in the Netherlands received more paid and less unpaid care in that year. Additionally, people often received both types of care. Although no more people received care in the Netherlands, this overlap makes it plausible that those who needed help received adequate care. The broad overlap between paid and unpaid care suggests that the two types of care are complementary in the Netherlands.

That picture is different in Germany, for example: the combination of less paid care with the same amount of unpaid care as in the Netherlands, with virtually no overlap between the two, illustrates that the two care types can be used as substitutes for each other. What consequences this has for quality of care is impossible to say because there are no internationally comparable data available. However, Comas-Herrera in (Mot et al. 2012) shows that the Dutch system scores higher than the German system on quality of life and quality of care, and much higher on adequacy of the care received. This suggests that a shift in the Dutch care system to one in which there is virtually no overlap between paid and unpaid care, as is currently the case in Germany, is very likely to impact negatively on the adequacy of care.
How much scope is there in the Netherlands to increase the use of unpaid care? What will placing greater demands on informal carers imply for their health, for example? Already, 17% of informal carers in the Netherlands are heavily burdened. And can expecting more of informal carers be combined with a higher labour participation rate, as in Denmark, for example, or will they choose to work less? In 2008, two-thirds of applicants for domestic help funded under the Dutch Social Support Act (Wmo) reported that family and friends were not able to provide any more help (De Klerk et al. 2009). Since then, the use of informal care has increased further, and this will have reduced the scope for family and friends to provide extra help even further.

And what does expecting more of informal carers imply for care quality? Is the quality of care delivered by a professional different from the care given by an informal carer, and how can the quality of informal care be monitored? Research by Vilans (Scholten en Van Dijk 2012) suggests that both care organisations and informal carers and volunteers foresee problems here. According to their report, the solution lies in a good interplay between formal and informal carers which goes beyond a clear division of tasks and explores the extent to which care organisations are willing to share delivery of care with informal carers.

Finally, we can ask whether care recipients would themselves rather receive paid care or informal care from a friend or relative. (De Boer en De Klerk 2013) show that many Dutch people expect their own network to step in if they have an occasional need for support, such as doing the shopping when everyone in the household is ill, but that only 11% think it can be taken for granted that family members should provide personal care for them. All in all, a shift from publicly funded to unpaid care will bring great changes for both informal and formal caregivers. Given the question marks that still exist regarding the degree to which unpaid care can meet the care need, the remaining capacity of informal carers and the consequences for quality of care and quality of life, it is arguable whether such a shift is an improvement or a deterioration.
1 Research questions and data

1.1 The changing face of long-term care

The provision of long-term care for people with chronic physical or cognitive problems who need support in their daily functioning (Colombo et al. 2011) has been changing in the Netherlands for several years, with an increasing emphasis on ‘own control’ and ‘own responsibility’ (TK 2012b/2013b). The aim is that older people should continue living independently for as long as possible, even if they need support to do so. In addition, those wishing to receive support or care will be expected to seek help in the first instance from their social network. Although the social network will not be strictly obliged to play a bigger role in providing care and support, that will be expected of them. This will often mean help from partners and children, but may also include other relatives, friends and neighbours.

In placing increasing emphasis on citizens’ own responsibility, the Dutch government is hoping to establish an efficient and stable system of long-term care. This policy was initiated in response to population ageing, which will lead to an increase in the number of older persons in society in the coming years, which in turn means that caring for those people will swallow up an ever greater portion of the government budget. In a letter on reforms to long-term care, the State Secretary for Health, Welfare and Sport, Martin van Rijn, argues that Dutch expenditure on long-term care is 2.5 times higher than the OECD average, and is therefore getting out of hand in an international context (TK 2012b/2013b). He also stresses the usefulness of a comparison with other countries: “Like the Netherlands, many countries are confronted with population ageing and an increase in chronic diseases. We can learn from each other in a dialogue about the sustainability and affordability of care” (Rijksoverheid 2013).

To provide information about the situation in the Netherlands and elsewhere in Europe, in this report we compare the situation of almost 57,000 over-50s in 16 European countries on different aspects relating to long-term care. The study was carried out partly at the request of the Long-term Care Department at the Dutch Ministry of Health, Welfare and Sport. This report is the first in an envisaged new series of studies in which trends in long-term care in the Netherlands are compared with those in other European countries. This first study is descriptive in nature and presents an overview of the current status of aspects including the variations in the structure of the care system, availability of long-term care, care need and long-term care utilisation. In a bid to present the most recent information possible, we draw on the latest data from the Survey of Health, Ageing and Retirement in Europe (SHARE). The data relate to the year 2011 and describe the care situation of people aged over 50 living independently in several European countries. This means that residents of care institutions are necessarily left out of consideration here, and that a proportion of long-term care use is therefore not represented. In the Netherlands, that proportion is substantial, owing to the considerable amount of residential care provision (Eggink et al. 2012). That does not apply for the other European countries, however
Moreover, comparing residential care between countries is not straightforward, due to widely differing definitions of residential care.

A cross-country comparison of home care is also a logical choice for this report given the emphasis placed in Dutch policy on providing care in the home setting. Long-term care is provided mainly, though not exclusively, to the older population. By investigating the care situation of the population aged over 50, we obtain a broad picture of long-term care, in contrast to other studies which often focus on the care utilisation of people aged over 65 or of the very oldest members of the population. This approach also presents a picture of the care situation that we can expect to develop in the future.

This study is in part an update of an earlier SCP publication (Pommer et al. 2007), but also incorporates the latest insights and additions, such as a description of the structure of long-term care in Europe and information on the degree to which people aged over 50 are confronted with risk factors for care utilisation. This study differs from other international research which focuses mainly on macro-comparisons of systems (o.a. Colombo et al. 2011), specific countries (o.a. Courbage en Roudaut 2011) or in-depth analyses of particular aspects (o.a. Scheil-Adlung en Bonan 2012). The use of paid care is not mapped out completely, partly because of the question formulations in the data we use. We have information on only a part of total paid care utilisation, namely paid network care, i.e. paid care received from people who belong to the recipient’s network. Despite this limited information, an attempt will nonetheless be made to present an impression of the total utilisation of paid care.

1.2 The research questions

The purpose of this report is to describe the extent to which long-term care for over-50s living independently in the Netherlands differs from that in other European countries. Our comparison takes as a basis the theoretical framework developed by Andersen and Newman (1973), because this model is very widely used in studies that analyse the use of various care provisions (zie ook bijv. Babitsch et al. 2012). The framework is not only flexible in terms of the characteristics that can be fed in to explain the use of care, but also as regards the type of care that is explained. Andersen and Newman’s model has been extended over the years to add different outcome measures, including for medical and other care (Wolinsky en Johnson 1991), social care provisions (Bass en Noelker 1987), informal care (Gaugler en Kane 2001) and care transitions (Geerlings et al. 2005). These extensions also answer the criticism that familial care aspects were missing from the original model. This report simply describes the differences between countries on aspects that according to Andersen and Newman’s model are related to care utilisation (‘health services utilisation’). Developing a model of care use will be a matter for a subsequent study. Andersen and Newman’s theoretical framework analyses care utilisation in which an individual’s behaviour depends not only on the characteristics of the individual themselves, but also on the characteristics of the setting in which they live. They argue that use of care is influenced by the following factors (see Figure 1.1):
– Environmental factors, such as medical technology and social norms regarding what are classed as health impairments and how they should be dealt with (‘societal determinants’);
– Characteristics of the long-term care system (‘health service system’);
– Characteristics of the users (‘individual determinants’).

Environmental factors here include technological developments that can lead to better care, and collective and organisational norms and values – for example, the importance that the community attaches to a particular service and the confidence in its proper functioning. Environmental factors also include the demographic and socioeconomic profile of a community.

Characteristics of the long-term care system include the resources within a care system and the organisation of care. Resources include things such as the labour capacity and number of beds that can be used to provide care. The organisation relates to access to care (how much is the patient’s co-payment?) and the way in which the care system is structured, for example how the assessment and referral system is organised.

The characteristics of individual users can be subdivided into three categories. One of the main determinants of care use is the individual’s care need (‘illness level’). This has a direct influence on an individual’s use of care. In addition, Andersen and Newman (1973) suggest that before the care need arises, people may have a predisposition or there may be predisposing factors to care utilisation. Some groups will be more likely to make use of care than others. For example, Andersen and Newman (1973) argue that demographic characteristics such as a person’s age, gender, family composition and medical history influence the take-up of care. The focus here is on the relationship between age and care utilisation at individual level, not the demographic profile of the population as a whole – that falls under environmental factors. Characteristics such as a person’s education level and occupation also contribute to their predisposition to utilise care. Those factors, to use the terms of Andersen and Newman (1973), represent a person’s social structure, and thus offer an indication of the individual’s lifestyle (and also the willingness and ability to change it). Finally, people’s personal ideas and thoughts about illness and care have a bearing on whether they will use care provisions. People with characteristics that suggest a predisposition to care utilisation will probably not do so if they do not have the opportunity to do so – what Andersen and Newman (1973) call the ‘enabling factors’. Included here are aspects such as the availability of financial resources.

The above factors all interact to determine a person’s use of care (‘health services utilisation’). That use can extend to all kinds of care, each with a different purpose, from primary care to highly specialised care, or from cure to care. In this report we describe
long-term care (resources and organisation), broken down into paid and unpaid care for people aged over 50, and the determinants of the use of that care.

Figure 1.1
Determinants of care use ('health services utilisation')

Source: Andersen and Newman (1973, p. 98); SCP treatment

In this publication we use this model as a basis for a description of the determinants of and actual care utilisation in the different European countries. The results can be used to put the Dutch situation in perspective. For example, it will enable us to see whether the Dutch policy focus on ‘own control’ and ‘own responsibility’ is also found in other countries. To facilitate comparison, we formulated five questions. The reasons for selecting these questions are briefly discussed below, as well as the way in which we intend to answer them.

In order to create a framework against which the differences in care use can be plotted, we first investigated what long-term care provisions are available; this provides information on the ‘societal determinants’ and ‘health service system’ in Andersen and Newman’s (1973) model. Long-term care funded by national governments depends

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5 The ‘individual determinants’ are described in a slightly different sequence in this report from that used by Andersen and Newman in their theoretical framework. As the illness level’ bears the most obvious relationship to care use, we decided to discuss this topic first.
on a number of factors, such as who is responsible for care, how care is regulated, and what costs are involved. In chapter 2 we use a literature review and a set of indicators to explain how the system of long-term care is organised in the 16 European countries in this study; we also summarise the formal care provision that results from this.6 We describe the age profile of the population and also look at spending on non-residential care. The countries in the study are then grouped into clusters based on the amount spent on long-term non-residential care and where responsibility for long-term care lies. This results in the first question addressed in this section:

– What differences are there between the way in which the long-term care system is structured in the Netherlands and in other European countries?

In designing their long-term care systems, national governments will take account of the ‘illness level’ (care need) in their populations. According to Andersen and Newman (1973), illness level is one of the primary determinants of care use. In this publication, it is measured on the basis of health impairments in three different domains of daily functioning: physical, psychological or cognitive. In chapter 3 we describe the health impairments confronting the over-50s in the European countries in this study, how they perceive their own health and to what extent their impairments impede them in activities of daily living. We then answer the following question:

– To what extent does the illness level (care need) of over-50s living independently in the Netherlands differ from that of their counterparts in other European countries?

In Andersen and Newman’s (1973) model, predisposition and opportunity to utilise care, as well as illness level, also influence the extent to which people use care provisions. This means that differences in illness level are not the only factors that play a role in differences in long-term care utilisation between countries: differences in predisposition and opportunity may also shed light on these differences. In chapter 4 we therefore summarise the differences between countries on a range of indicators that reflect the individual predisposition and opportunity for care utilisation – the risk factors. We describe the differences in the following risk factors: (1) predisposition to utilise care: (a) gender; (b) age; (c) household situation and past changes in that situation (e.g. a divorce or death of a partner or children); (d) childhood illness; (e) education level; and (f) changes in lifestyle; and (2) opportunity for care utilisation: (a) income level. The question answered through this analysis is as follows:

– To what extent does the Dutch population of over-50s living independently differ from that in other countries in the prevalence of risk factors for long-term care need and care utilisation?

People who need help because of their health impairments can call on professionals. Their social network, for example a partner and children, might also be able to provide

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6 This chapter relates mainly to formal care and only indirectly to informal care, about which very little information (recorded) is available.
care. The social network of people over 50 can therefore be interpreted as an opportunity for care utilisation on which recipients can draw. Bass and Noelker (1989) describe the presence of a network as an indicator of the opportunity for care utilisation. They translate the opportunity for care utilisation primarily into the individual availability of financial resources. We interpret the opportunity for care utilisation more broadly, and include the presence of non-material resources such as a social network. People who need help but do not have a social network will then be more likely to make use of paid care than others. Any differences we observe in long-term care utilisation across countries could then stem from the presence or absence of a social network. In chapter 5, we accordingly describe the differences between countries in the presence of a social network.

Data constraints mean it is not possible to map out the availability of the entire social network; we can only identify whether there are partners and/or children (living within or outside the home) present, who could potentially provide care if necessary. We refer to this specific group of potential providers as the family care network. The question we address in chapter 5 is therefore as follows:

– To what extent are over-50s living independently in the Netherlands able to fall back on a family care network, and to what extent does the Netherlands differ in this regard from other European countries?

After mapping out the differences in the structure of the long-term care system, documenting the need for care and the predisposition and opportunity for care utilisation, in the final chapter we report on the differences between countries in the utilisation of unpaid care and paid network care. By unpaid care we mean care provided by family, neighbours, friends or acquaintances. Paid network care includes care provided by people who belong to the recipient’s network and who are paid by the recipient. Unfortunately, the data we use provide no information on the total amount of paid care received, because they provide no information on care provided by professionals who do not form part of the recipient’s network. As this is an important component of the total care received, we estimate of total care received on the basis of comparable data from an earlier year for which information is available. The question addressed in the final chapter is therefore:

– To what extent do Dutch over-50s living independently who need support make use of paid and unpaid care, and to what extent do they differ in this regard from their counterparts in other European countries?

Our central aim has already been the subject of an earlier SCP publication (Pommer et al. 2007). This report is partly an update of that study, but also contains the newest insights. In view of its descriptive nature, this study can be seen as an overview study. Although trends are not described systematically, where relevant comparison will be made with findings from earlier years and the differences will be statistically tested. The emphasis in this report is also different from in the 2007 study. The first addition is the description of the structure of the long-term care system in European countries. The inventory of the extent to which the over-50s are confronted with risk factors also enriches the insights presented in the previous study. This study sets itself apart from other international
research which focuses mainly on macro-comparisons of systems (o.a.Colombo et al. 2011), specific countries (o.a.Courbage en Roudaut 2011) or in-depth analyses of particular aspects (o.a.Scheil-Adlung en Bonan 2012).

1.3 Data

Survey of Health, Ageing and Retirement in Europe (SHARE)
in order to be able to compare long-term care between different countries, the information on that care must naturally be comparable. The Survey of Health, Ageing and Retirement in Europe (SHARE) is specifically designed for this purpose. SHARE is a scientific data project focusing on ageing in Europe which is subsidised by the European Union (Börsch-Supan et al. 2003). Aspects such as employment, retirement, income and health are central issues. Identical questionnaires have been developed in the languages of the various countries, aimed at persons aged 50 and older. Research has already been carried out using the SHARE data, but as stated, that research either homes in on a specific aspect or focuses on a country other than the Netherlands. Much of the research is moreover based on older data (from 2004 and 2006). In this publication we mainly use the latest data, from 2010/2011, which became available at the start of 2013. Where necessary, however, we use older data to supplement the latest data and to pinpoint changes.

The first survey was conducted in 2004 among around 30,000 persons aged 50 and over in 12 countries, viz: Denmark, Sweden, Austria, Germany, France, Switzerland, Belgium, the Netherlands, Spain, Italy, Greece and Israel. The 2007 SCP publication ‘Comparing care’ was based on the first data collection. In 2006 and 2007, a high proportion of those who had participated in the first survey were re-approached. To compensate for dropout and keep the sample representative, new respondents were also surveyed. Three new countries were also included in the dataset, namely the Czech Republic, Poland and Ireland. This resulted in a sample of approximately 34,000 persons aged 50 years or older.

A third survey was conducted in 2008 and 2009, using a different type of questions from the previous versions, namely SHARELIFE, a survey that focuses on the life history of respondents. We use this information in chapter 4 of this report. Just under 30,000 respondents, who had also participated in one of the earlier surveys (2004 and/or 2006/2007) completed the questionnaires. This dataset provides detailed information on a number of important areas of the respondents’ lives, ranging from information about partners and children, home and work history and health and utilisation of health care services in the past.

A fourth wave of the SHARE survey began in 2010 and 2011. This was a repeat and enlargement of the first two surveys. Respondents who had taken part in earlier waves were re-approached, new respondents were recruited, and Portugal, Estonia, Hungary and Slovenia were added to the dataset. As stated, our study is based principally on the information from this most recent wave. Greece did not take part in the survey in 2011, and sadly our study also lacks data on Israel and Ireland because the information for these countries was either not known or not complete at the time of this study.
Approximately 1,400 households containing at least one person aged over 50 were approached in each country. Information was collected from these households not just about the person aged over 50 themselves, but about other household members as well. The detailed questions about aspects such as physical, psychological and cognitive health status, health impairments that impede daily functioning and utilisation of long-term care were submitted to all people aged over 50 in the household. More general data were obtained from members of the younger generations in the household and children living outside the home. That information included whether and how much they work, for example, whether they have children and how old those children are. We used these data to map out aspects such as the availability of a family care network (see chapter 5).

The data obtained in 2010/2011 provide us with a total of more than 66,000 observations of European over-50s. The number of observations in each individual country varies from 1,900 to 7,400. In processing the data, we took account of the size of each country, because in order to obtain an accurate picture for all the different European countries, small countries such as the Netherlands must be assigned less weight in the findings than large countries such as Germany.

In this report, the Netherlands is compared with the following countries:

<table>
<thead>
<tr>
<th>Countries with which the Netherlands is compared in this report:</th>
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<tbody>
<tr>
<td>Austria</td>
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<td>Belgium</td>
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<td>Czech Republic</td>
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<td>Denmark</td>
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<td>Estonia</td>
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<td>France</td>
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<td>Germany</td>
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<td>Hungary</td>
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<td>Italy</td>
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<td>Poland</td>
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<td>Portugal</td>
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<td>Slovenia</td>
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<td>Spain</td>
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<tr>
<td>Sweden</td>
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<tr>
<td>Switzerland</td>
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</tbody>
</table>

7 In Appendix A, the number of observations is broken down by country and their share in the total number of observations in the SHARE survey for the years 2004, 2006/2007, 2010/2011 and the SHARELIFE survey from 2008 is stated.
2 Long-term care systems

In this chapter we look at the differences between the structure of the long-term care system in the Netherlands and in other European countries. According to Andersen and Newman’s (1973) theoretical model, the characteristics of the long-term care system and the social norms in relation to health impairments are determinants of the care utilisation that forms the subject of this report (also see e.g. Babitsch et al. 2012). We look first at the rate of population ageing in the different European countries, and the concomitant increase in demand for care. We also explore long-term care policy and care provision in the Netherlands and the other European countries. This chapter thus relates to paid care as shown in the upper half of Figure 1.1. Based on the characteristics of the care systems, this leads to a clustering of countries which share many common features in their long-term care systems. In describing the care policy, the Dutch situation is discussed in detail, because it is the central focus of this report. The systems in the other countries are described in more general terms. We do not limit ourselves to home care in this chapter, but also discuss residential care. This is logical, because if residential care is not available, care automatically has to be provided in the recipient’s home setting. Unlike the rest of the report, this chapter is primarily concerned with publicly funded care. Virtually no information with national coverage is available on unpaid (informal) care, which is therefore by necessity left out of consideration.

2.1 Growing older population

A country’s demographic situation, and in particular the percentage of older people, provides an indication of the need for long-term care. The risk of health problems increases as people age, and with it the care need. The importance that is attached to long-term care, the amount of care that is available and the associated expenditure will all be related to the percentage of older people in the population and the increase in that percentage (population ageing). We start this section with a demographic description of the population in one specific year, namely 2010.8 We look more closely at the demographic characteristics of people over 50 living independently in chapter 4. In 2010, an average of 37% of people in the countries in this study were aged 50 or older; just under 18% were over 65 and nearly 5% were aged 80 or older (Table 2.1).

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8 This is the most recent year for which complete data are available from the databank of the Organisation for Economic Co-operation and Development (OECD).
Table 2.1
Total number of inhabitants and share in the population of people aged 50 years or older, 65 years or older and 80 years or older in different European countries, 2010 (number of inhabitants x 1,000, percentages).

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Inhabitants</th>
<th>Share 50+</th>
<th>Share 65+</th>
<th>Share 80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands (NL)</td>
<td>16,615</td>
<td>35.7</td>
<td>15.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Austria (AT)</td>
<td>8,390</td>
<td>36.3</td>
<td>17.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Belgium (BE)</td>
<td>10,896</td>
<td>36.5</td>
<td>17.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Switzerland (CH)</td>
<td>7,822</td>
<td>37.0</td>
<td>17.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Czech Republic (CZ)</td>
<td>10,520</td>
<td>36.1</td>
<td>15.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Germany (DE)</td>
<td>81,777</td>
<td>40.3</td>
<td>20.6</td>
<td>5.2</td>
</tr>
<tr>
<td>Denmark (DK)</td>
<td>5,548</td>
<td>36.1</td>
<td>16.6</td>
<td>4.1</td>
</tr>
<tr>
<td>Estonia (EE)</td>
<td>1,340</td>
<td>36.1</td>
<td>17.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Spain (ES)</td>
<td>46,071</td>
<td>34.5</td>
<td>17.0</td>
<td>4.9</td>
</tr>
<tr>
<td>France (FR)</td>
<td>62,959</td>
<td>36.2</td>
<td>16.9</td>
<td>5.4</td>
</tr>
<tr>
<td>Hungary (HU)</td>
<td>10,000</td>
<td>37.1</td>
<td>16.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Italy (IT)</td>
<td>60,483</td>
<td>39.4</td>
<td>20.3</td>
<td>5.9</td>
</tr>
<tr>
<td>Poland (PL)</td>
<td>38,184</td>
<td>34.5</td>
<td>13.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Portugal (PT)</td>
<td>10,637</td>
<td>36.8</td>
<td>18.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Slovenia (SI)</td>
<td>2,049</td>
<td>37.1</td>
<td>16.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Sweden (SW)</td>
<td>9,378</td>
<td>37.2</td>
<td>18.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Totala</td>
<td>382,669</td>
<td>37.3 (34.5 – 40.3)</td>
<td>17.9 (13.5 – 20.6)</td>
<td>4.9 (3.4 – 5.9)</td>
</tr>
</tbody>
</table>

a Minimum and maximum values between brackets.

Source: OECD Statistics (Population; Demographic references); stats.oecd.org (SCP treatment)

In the Netherlands, 36% of the population are aged 50 or older and more than 15% are aged 65 or older. This means that the Netherlands has a relatively young population. Germany and Italy had the highest percentage of over-50s in their populations in 2010, at around 40%, but well over a third of the population in the other countries were also aged over 50. Population ageing is also most advanced in Germany and Italy, with a fifth of the population being aged over 65 and almost 6% over the age of 80 in 2010. Italy and Germany are closely followed by Sweden. Poland is a ‘young’ country, with less than 14% of the population aged over 65 and under 4% over 80. The Czech population is also relatively young.

To obtain a picture of the future trend in care utilisation, it is important to be able to estimate the rate of population ageing within a given country. The share of people aged over 65 in the Netherlands is projected to grow from 15% in 2010 to 27% in 2040 (when population ageing will peak in the Netherlands) (Figure 2.1). This means that more than a quarter of the Dutch population will have reached an age in 2040 that could mean they face increased health impairments. A substantial number of them will also no longer be
participating in the labour market. The labour force will shrink, which not only means there will be fewer staff available to provide care, but also that public expenditure on care will have to be financed by a smaller number of people. The share of people aged over 65 will also be around 25% in most other European countries in 2040. Upside outliers are Germany, Italy and Spain (32%). These countries will also have the highest proportion of people aged over 80 in 2040 (11%; not shown in figure), closely followed by Switzerland (10%). These countries will thus face pronounced ‘double population ageing’. The anticipated share of people aged over 80 in the Netherlands in 2040 is 9%, comparable with the other European countries but more than double the figure in 2010.

Figure 2.1
Share of over-65s in the population in 2010 and 2040 (in percentages)

Source: OECD Statistics (Employment and Labour Market Statistics: population projections); stats.oecd.org (SCP treatment)

2.2 Different routes to achieving the same objectives

Although the population in all countries is growing older, the way countries view and structure their long-term care system is less comparable. The different countries are all aiming for common goals, but each has its own unique approach to achieving them.

Common goals

In 2000, the World Health Organization (WHO) formulated a number of goals for health care in general. Health care must respond to and meet the expectations of the public; the financial costs must be shared equitably; and the system must ultimately lead to improved health status (WHO 2000). However, this last objective has more to do with medical care than long-term care, which is aimed at providing care rather than cure.
Three years later, supplementary goals were formulated which are more specifically related to long-term care. The care system must be accessible for everyone, be of high quality and be financially sustainable (Council of the EU 2003). More emphasis has recently been placed on quality of care, which has been defined in more detail by the European Commission (European Commission 2011). Among other things, the Commission stipulates that the care recipient must be the central focus, that treatments and equipment must be used effectively and safely and that there must be proper coordination between the various organisations in the provision of care. For long-term care, the Commission also emphasises the importance of ‘tailored’ home and community care. The purpose of this care is to enable people to continue living at home for as long as possible despite having health impairments. High priority is also given to adequate training of professional caregivers and supporting informal carers.

Each country has its own approach
The goals formulated by the WHO and the European Commission provide a guideline within which each country can define its own policy. The policy on long-term care for people with long-term health impairments therefore differs from country to country and is subject to continual change. Publicly funded care provisions stem from the relationship between the complex systems of the welfare state, including social security and health care. Consequently, care in some countries is organised centrally, while in others the organisation is decentralised. Similarly, there are differences in the distribution of responsibilities for care, in the amount of care available and in the way in which care is funded (WHO 2008). This latter aspect, in particular, is under heavy pressure in the light of the recent economic recession and the increasing ageing of the population. With growing demand for long-term care and a shrinking budget, governments face the challenge of keeping the long-term care system affordable without losing sight of the quality of that care.

2.3 Long-term care in the Netherlands

Development of publicly funded care at a glance
In principle, it can be said that the Dutch long-term care system was established in 1968 with the creation of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AwBz), though it has undergone considerable change since then. The basic premise of this Act was (and is) that people with a long-term care need have a right to receive care. This includes people who have difficulty carrying out daily living activities because of an illness, disability or impairment. Initially this meant care in a nursing home; later, care in a residential home was also brought under the Act, having previously already existed outside the AwBz. The use of publicly funded care provisions increased so sharply in the beginning that the first cuts were made as early as the late 1970s and early 1980s, and this checked the growth slightly. The concept of home care was introduced at the same time, enabling people to receive care in their own homes. Around the turn of the century, the right to care was enforced in legal proceedings by clients who had received an indication for AwBz-funded care but had been placed on
a waiting list and therefore did not receive any help. Following this, a trend of policy adaptations was set in train which increased the availability and use of care provisions. This brought an end to the stringent budgeting in the AWBZ and to additional funding being made available to reduce waiting lists. The AWBZ was radically reformed in 2003. Instead of sector-specific assessments (e.g. for disability care), a functional approach was now followed and an indication had to be given of whether the client needed help with household work, for example, or required nursing or personal care. The ‘usual care’ protocol was also introduced to restrict access to care, whereby healthy members of the recipient’s household were expected to provide some of the care (CIZ 2005). A few years later, a system of care intensity packages (ZZP) was introduced for clients assessed as requiring residential care; these packages describe the care need in terms of both care functions and hours of care provided.

Move towards non-residential care and decentralisation

Many older people wish to defer admission to a residential institution for as long as possible (Verhoeven et al. 2011). They would rather live independently, and doing so improves their well-being (Verzijden en Fransen 2004). In order to meet this demand, and also because home care is generally cheaper than residential care, this trend towards non-residential care is also increasingly encouraged in policy (VWS/VROM 2007). Providing care in the home setting gives clients more control over the care they receive. One means of fostering that control is the personal budget: a sum of money given to the client to enable them to purchase the care they require themselves. The number of people opting for a personal budget grew very strongly, especially when compared with the number of users of care in kind (Sadiraj et al. 2011; Van der Torre et al. 2013). In order to halt this rapid growth, this popular instrument was converted into a reimbursement scheme with more stringent access criteria, and it is now no longer available for some groups (VWS 2011). These measures are however still very much subject to debate and change (TK 2011/2012). The government took a major step towards non-residential care when it replaced residential care provisions for less serious care needs with non-residential provisions (TK 2012a/2013a).

Funding for domestic help was transferred in 2007 from the Exceptional Medical Expenses Act (AWBZ) to the Social Support Act (Wet maatschappelijke ondersteuning, Wmo). Under the Wmo, local authorities are given responsibility for providing certain types of care, help and support, and must ensure that everyone in the municipality is able to participate as fully as possible in society and to continue living independently for as long as possible. From the perspective of long-term care, this means that vulnerable people should become less dependent on professional support. This decentralisation also means that, while people still receive payment, this is no longer an entitlement. This shift was accompanied by a cut in local authority budgets. The Wmo arrangements are still developing. Since 2009, individual support has also been placed within the Wmo, partly in order to keep the rapid growth of this form of care within bounds. The latest government plans also continue the trend towards decentralisation. There is for example a plan to place personal care under the responsibility of local authorities or to fund it through the Care Insurance Act (Zorgverzekeringswet, zw) (TK 2012a/2013a).
though this is still the subject of debate. According to the Coalition Agreement, non-residential nursing care will ultimately be placed under the Care Insurance Act (curative care). Domestic help, which already comes under the Wmo, will become less generous and its availability will be restricted. The result is that local authorities have a growing responsibility for providing care in the home setting and that the centrally funded ‘AWBZ-care’ will increasingly be reserved for people whose impairment makes long-term admission to a residential facility the most appropriate option.

Use of publicly funded care
The trends in long-term care policy are also broadly reflected in the figures on care utilisation. For example, the spending cuts introduced from 1985 onwards, when budgets were introduced for residential facilities, were accompanied by a slight fall in the number of users of home care and other forms of care, after which utilisation rates grew strongly from 1995 onwards (‘right to care’ initiative and reform of the AWBZ) (Pommer 2012; Eggink et al. 2010). The strong growth in home care in this period was partially offset by a declining number of care home residents, reflecting the trend towards non-residential care. The number of nursing home residents grew very slightly in the period 1985-2003. Figures for more recent years – the period 2004-2010 – suggest that this figure has also increased slightly in the last few years, whereas the number of older people in the population has grown much more strongly (Statistics Netherlands-Statline).

Roughly 10% of the Dutch population aged 30 years and older were using long-term care in 2009 (Eggink et al. 2012). That translates into a total of approximately 1.2 million users. In around 20% of cases, the care was of short duration, while a fifth used only (unpaid) informal care or private care. Just over 10% received care in a residential facility. The vast majority, however, made use of long-term publicly funded home care (49%), often in combination with unpaid or private care. Informal care plays a major role in total care utilisation (zie ook De Boer en De Klerk 2013). Some 30% of all care hours were provided at home by family, friends or acquaintances. Unpaid care was not only provided in the home setting, but also in residential nursing and care homes (Den Draak 2010; De Klerk 2011). It is striking that informal caregivers in residential facilities spend twice as much time providing that care as carers of people living independently. Residents of care and nursing homes often have more complex care needs and more often receive palliative care (Broese van Groenou 2010).

Shift towards informal caregiving
The trend towards non-residential care and the introduction of the Social Support Act (Wmo) reflect the increasing emphasis on people taking their own responsibility (zie ook De Boer en Kooiker 2012). The most recent government policy also sets a target of developing better basic care close to the recipient’s home, thus building on the continuing trend towards non-residential care and decentralisation (TK 2012a/2013a). On the other hand, the scrapping of some personal budgets and making others less generous, combined with the curtailing of the right to individual support and domestic help, imply that access to publicly funded care provisions is being reduced. More demands are therefore being placed on the person requiring care, as well as on their social network, which
Long-term care systems

is expected to meet part of the care need if necessary. There were roughly 3.5 million informal carers in the Netherlands in 2008, three-quarters of whom spent more than eight hours per week and/or more than three months per year providing care (Oudijk et al. 2010). Informal care often supplements publicly funded care provisions; often this is because of the classification ‘usual care’, whereby healthy members of the recipient’s household are expected to provide care before an application can be made for publicly funded care. Alternatively, informal care may replace private care.

The mismatch between demand and supply in respect of publicly funded care may lead to increasing demands on informal care. However, it is uncertain whether the amount of informal care available can meet this growing demand. The supply of and demand for informal care in the Netherlands is expected to reach a balanced position at macro-level in the near future (Sadiraj et al. 2009), but this is based on the assumption that the availability of publicly funded care will keep pace with the demand for it, whereas in reality the amount of publicly funded care is being cut. There are also other factors and trends which can influence supply and demand for informal care. Developments in medical technology and domestic aids (domotics) could reduce demand for (informal) care, while restricting access to publicly funded care could increase that demand. The availability of informal care could be jeopardised by the rising labour participation rate, shrinking family sizes, the growing geographical distance between family members and weakening social cohesion (De Boer en Timmermans 2007). Providing care can also be a heavy burden, especially if it has to be combined with a paid job and raising a family. In 2008, for example, 450,000 informal carers in the Netherlands (17%) experienced providing care as a severe burden (Oudijk et al. 2010). They felt that too much responsibility for providing care was being placed on their shoulders, that their independence was being squeezed and that providing care was affecting their health and creating conflicts at work or at home.

In response to this, Dutch government policy is increasingly focusing on providing support for informal carers and on the interaction between informal carers and publicly funded care provisions (vws 2012). The government argues that support and care, and therefore people’s daily lives are often unnecessarily – though with all good intentions – taken over by professionals (medicalisation), thus making people too dependent on health care. Those tasks are being returned to the care recipient’s family. The government is devoting specific attention here to the regulatory obstacles that informal carers encounter, but also to factors not related to the actual care, such as the combination of care, work and income. Here again, the aim is decentralisation, with an ever bigger role being assigned to local authorities via the Wmo in improving the position of informal carers.

2.4 Characteristics of long-term care systems in Europe

Responsibility for care

The European countries discussed here share the common principle that people who need support from others in their daily functioning but who do not receive it are entitled to publicly funded help. The way in which that entitlement is put into practice varies
widely, however. The availability of publicly funded care provisions is for example highly diverse between and sometimes even within countries. The presence of publicly funded care provisions depends very much on who is regarded by the state as responsible for providing long-term care. In the Netherlands, much of that responsibility lies with the government (Table 2.2). The same applies for the Scandinavian countries.

Table 2.2
Formal responsibility for long-term care

<table>
<thead>
<tr>
<th>country</th>
<th>mainly government</th>
<th>both government and family</th>
<th>mainly family</th>
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<tbody>
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<td>Netherlands</td>
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Source: Assessing Needs of Care in European Nations – country reports

In the Southern European countries, in particular, the family is held primarily responsible for providing care to people who need support in their daily functioning, and the same applies in Switzerland and Eastern Europe (zie ook bijv. Calzada en Brooks 2013). Portugal and Slovenia have clearly began steering a course towards more publicly funded care, but the long-term care systems in these countries are still in their infancy. In Central European countries such as Belgium, Germany, France and Austria, responsibility for long-term care is shared between the family and the government.

Organisation of care: centralised or decentralised?
The organisation of long-term care and the responsibility for it can be placed in different layers of government (Riedel en Kraus 2011). In the Netherlands, Germany and Austria, explicit criteria have been formulated at national level which describe the right to long-term care. However, there is wide diversity between these three countries. In Germany and Austria, the right to publicly funded care does not extend to short-term and less intensive forms of long-term care, and not all provisions are self-financing (Pommer et al. 2007); (Sadiraj et al. 2011). This latter aspect, in particular, means that care services are
organised at local level in these two countries, with central government merely formu-

Although frequent mention was made in the last section of the steps taken by the Dutch
government to decentralise the organisation of care, compared with other countries in
Europe long-term care in the Netherlands, both residential and in the home setting, is
still largely centrally organised (Table 2.3). Countries with a comparable organisation are
Sweden, the Czech Republic, Italy, Portugal, Hungary and Poland. France and Switzer-
land are the only countries in which care is organised chiefly at local level. The French
central government, for example, merely lays down a framework within which the gen-
eral advisory councils (counsels généraux) have to operate (Joël et al. 2010). Residential and
home care in Switzerland is also organised in part by the local authorities and cantons
(oecd 2011b). Slovenia falls between the two groups, organising residential care mainly
at central level but home care primarily at local level.

Table 2.3
Decision-making on publicly funded long-term care in different European countries

<table>
<thead>
<tr>
<th>Country</th>
<th>mainly centralised</th>
<th>both centralised and decentralised</th>
<th>mainly decentralised</th>
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a In Slovenia, decisions on residential care are taken mainly at central level and decisions on home
care at local level.

Source: (Riedel en Kraus 2011) Table 1, (oecd 2011b); scp treatment

The other European countries have a mix of organisations with central and local respon-
sibility. In Belgium, for example, central government is responsible for the care budget,
capacity and fees. The regional authorities are responsible for formally accrediting care
organisations and for monitoring and ensuring the quality of residential care. The re-
gional authorities also regulate home care provisions, which are in turn organised at
local level by the local authorities (Willemé 2010).
Quality assurance of long-term care
It is not only important that long-term care is available, but also that it is of good quality. Quality is to some extent a subjective aspect, which will be defined by each country in its own way; what one country regards as high quality of care may be regarded as no more than a basic condition in another country. We therefore look here not at the quality of long-term care, but at how that quality is assured by government agencies. In most countries both residential and home care must meet quality standards that are laid down by the authorities (Table 2.4). In the Netherlands, for example, there is a special law to guarantee the quality of care institutions (Care Institutions (Quality) Act, kwz). This Act sets four quality standards that care institutions must meet, namely responsible care; policy focused on quality; the setting up of a quality system; and the production of an annual report. The Dutch Health Care Inspectorate receives these reports and takes action if necessary.

Table 2.4
Quality assurance of long-term care in different European countries.

<table>
<thead>
<tr>
<th>country</th>
<th>residential care voluntary, but usual</th>
<th>mandatory</th>
<th>home care voluntary, but usual</th>
<th>mandatory</th>
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<td>Switzerland</td>
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\a In Hungary, quality assurance is mandatory for non-residential nursing care, but not for other forms of home care.
\b No information is available on quality assurance for Portugal.

Source: (Riedel en Kraus 2011) table 3; (OECD 2011b; OECD 2011a)

Although adherence to quality standards is not mandatory for institutions providing both forms of long-term care in Austria and Poland, it is usual for them to do so. In Slovenia and the Czech Republic, this applies only for care provided in residential facilities. There is no official quality assurance for home care in Slovenia, whereas in the Czech Republic it is mandatory. Adherence to the quality standards in Hungary is voluntary for both forms of
long-term care, probably due to the low availability of long-term care provisions (Riedel en Kraus 2011). Virtually no information is available on quality assurance in Portugal (Santana 2010).

**Waiting lists**

Virtually all countries face capacity problems (Riedel en Kraus 2011) and therefore have difficulty in offering adequate care to the older population. However, specific information on waiting lists is rarely available. In the Netherlands, agreements have been made on maximum waiting times, in the 'Treek standards'. In Denmark, long waiting lists resulted in the introduction of a 'maximum waiting time guarantee' of two months in 2009 (Schulz 2010). In Spain, the waiting lists for residential care are particularly long for families with an average or higher household income, because access for this group has been heavily curtailed (Riedel en Kraus 2011).

**Expenditure on long-term care**

There are wide differences in the expenditure on long-term care in the different countries, including as a share of the national economy.

shows the expenditure on long-term care as a percentage of gross domestic product (GDP) in 2010. Dutch expenditure on non-residential care in that year was slightly below the average for all countries studied, but the Netherlands spent significantly more on total long-term care. The reason for this is the high expenditure on residential care, an area where the Netherlands stood head and shoulders above the other countries. In terms of care users, two-thirds of the care was delivered in the home setting, but accounted for only one third of total long-term care costs (Eggink et al. 2012). The care need of residents of residential care and nursing homes is generally greater than that of recipients of home care, and the care costs per person are therefore also substantially higher. In addition, both the accommodation costs and sustenance costs (meals, etc.) in residential care facilities are publicly funded in the Netherlands, whereas elsewhere (e.g. in France) the latter costs are paid by residents themselves (Tk 2012a/2013a; Tk 2012b/2013b). Although the Netherlands is a relatively young country compared with the other European countries in this study (Table 2.1), the country had the second-highest expenditure on long-term care in 2010. Switzerland has far and away the highest total expenditure on long-term care, despite the fact that Switzerland also assigns a high degree of responsibility for care to the recipient’s family. However, a large slice of the total expenditure is funded by co-payments from users, which account for an average of 36% of Swiss long-term care expenditure (OECD 2011b). Compared with the other countries in this study, Switzerland is a wealthy country, and its residents are relatively better able to bear these costs (Oudijk et al. 2012). Estonia, Hungary, Czech Republic, Poland and Italy easily spend the least on long-term care, and the expenditure in these countries consists primarily of ambulant care provisions provided in the home setting (Table 2.5).9

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9 Ambulant care is outpatient care that is not provided in an institutional setting. It includes long-term home care provisions, but also provisions such as rehabilitation and transport. Unfortunately, we do not have complete information about the specific expenditure on home care.
Although primary responsibility for providing care lies with the family in Spain, too, this country spends only slightly below the average on long-term care, both residential and ambulant. And in Portugal, where responsibility is divided in the same way, spending is actually in line with the European average.

Table 2.5
Spending on long-term care as a percentage of GDP in 2010, subdivided into residential and non-residential care (% GDP)

<table>
<thead>
<tr>
<th>country</th>
<th>Residential care provisions</th>
<th>Ambulant (home) care provisions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>2.6</td>
<td>2.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Austria</td>
<td>0.9</td>
<td>2.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Belgium</td>
<td>1.3</td>
<td>3.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0.1</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Denmark</td>
<td>1.4</td>
<td>3.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Estonia</td>
<td>0.2</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>France</td>
<td>0.7</td>
<td>3.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Germany</td>
<td>0.9</td>
<td>3.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.3</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Italy</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Poland</td>
<td>0.1</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.1</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Slovenia</td>
<td>0.5</td>
<td>2.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Spain</td>
<td>0.7</td>
<td>2.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>-</td>
<td>2.0</td>
<td>-</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2.0</td>
<td>3.6</td>
<td>5.6</td>
</tr>
<tr>
<td>average</td>
<td>0.8</td>
<td>2.5</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Source: (OECD 2013a); stats.oecd.org; (Huber et al. (2009) Sweden, Italy 2007)

No clear pattern can be distinguished between the level of expenditure and the way in which care is organised. In countries where care is organised centrally, expenditure is sometimes high (the Netherlands) and sometimes low (Czech Republic). We find the same difference in countries where the organisation of care is decentralised. A much clearer trend emerges when we look at the degree of family responsibility; in countries where a high degree of responsibility is assigned to the individual or their family, government expenditure on long-term care is relatively low.

Expenditure in all countries rose between 2007 and 2010. However, the picture becomes more diverse if we include an earlier year (2004) in the trend (Figure 2.2). In a few countries, we find that the rise in spending on long-term care began as early as 2004. In Belgium and Germany, and to a lesser extent France, Spain and Estonia, expenditure in 2007 was comparable with that in 2004, but in the most recent period expenditure rose sharply. Spending in Austria and the Czech Republic initially dipped before rising again and reaching a level in 2010 that was higher than in 2004.
Spending on long-term care in the Netherlands rose very sharply, and was the second highest of all countries studied in 2010. This was very different in 2004, when expenditure on care was higher in all Northern European and continental countries than in the Netherlands. This also means that total spending rose fastest on average in the Netherlands between 2004 and 2010, whereas population ageing in the Netherlands has only just begun.

Care provision
There is thus wide variation in spending on long-term care. Are there also substantial differences in the availability of long-term care? The OECD gives information for individual countries on the number of beds available for long-term care. The Netherlands, together with Sweden, Switzerland, Austria and to a lesser extent Denmark, has a high number of long-term care beds. Sweden has by far the most long-term care beds available, at more than 81 per 1,000 inhabitants aged 65 years or over in 2009. That number is still lower than in earlier years, however, reflecting the shift from residential towards non-residential care. A similar trend can be observed in other countries with a large number of long-term care beds.

The Southern European countries and Poland expend few public resources on long-term care and accordingly have relatively few long-term care beds available per head of the older population compared with the other European countries (Figure 2.3). Although the number of long-term care beds in Spain has increased since the introduction of legislation on long-term care in 2006, the coverage is still low (PriceWaterhouseCoopers 2010).
The economic crisis is putting pressure on the availability of social provisions, including long-term care, in Spain and other Southern European countries (Cais en Folguere 2013; Moreno en Marí-Klose 2013).

**Figure 2.3**
Number of beds set aside for long-term care per 1,000 persons aged 65 years or over

In all countries studied, long-term care beds are distributed between institutions set up specifically to provide long-term care and hospitals which have allocated a few beds for long-term care provision. The distribution varies widely from one country to another, however. In the Netherlands and the Scandinavian countries, long-term care beds are located almost exclusively in residential care and nursing homes. In Italy, not only is the availability of care relatively low, but the regional distribution is also skewed. Publicly funded care is available mainly in the north of the country (Tediosi en Gabriele 2010); the southern regions depend mainly on family care. These differences are becoming ever wider as a result of the economic crisis (Andreotti et al. 2013). In Poland, 14% of long-term care beds are in hospitals and, like the other long-term care beds, are only available if the person concerned requires care for longer than six months (Golinowska 2010).

For a limited number of countries, we also have information about the availability of long-term care staff in the year 2010 (OEC D Statistics). This includes the share of nurses as well as carers working for home care organisations and within institutions. The figure
is relatively high in the Netherlands (8%), Estonia, Denmark and Sweden. The latter country has the highest proportion of nurses and carers involved in long-term care (13%). The percentage of long-term nurses/carers is substantially lower in Spain, Germany (4%), the Czech Republic and Hungary.

Formal versus informal care
The debate about the sustainability of long-term care systems is closely related to the discussion of whether care should be delivered formally or informally. There are various hypotheses about the relationship between formal, or publicly funded, care and informal care. The first posits that formal and informal care are substitutes for each other; this idea is particularly prevalent in the economic literature (Greene 1983). The second hypothesis is that formal care is brought in when informal care falls short (formal and informal care are thus complementary) (Chappell en Blandford 1991). The third hypothesis concerns the task-specific model, in which informal care relates to everyday care tasks with formal care being reserved for more specialist care (Litwak 1985). There is an extensive literature on this topic, but it does not provide a basis for a clear conclusion on the extent to which formal and informal care are each other’s substitutes or complements, and the relationship is therefore not investigated (further) in this report.

2.5 Grouping of countries
Based on the level of expenditure on non-residential care and on who carries responsibility for providing care, we have grouped the countries into clusters which resemble each other in terms of their long-term care systems (Figure 2.4). We concentrate on spending on non-residential care because residential (institutional) care is covered only in passing in this report. This clustering of countries will serve as a guideline when discussing the results in the remainder of the report. Based on where responsibility for care lies, a broad division can be made in the countries studied here between Northern Europe (the Netherlands, Sweden and Denmark), Central Europe (Austria, France, Belgium and Germany) and the remaining countries, which we will call here the Southern and Eastern European countries (Italy, Spain, Portugal, Estonia, Hungary, Czech Republic, Poland, Slovenia and Switzerland10). There is a marked difference in expenditure within these groupings. The first cluster consists of the Netherlands and Sweden, which are characterised by average expenditure on long-term non-residential care and high government responsibility for long-term care provision. Government also has a high responsibility for care provision in Denmark, but this is accompanied by high expenditure. In Austria, long-term care is felt to be a shared responsibility between family and government, and expenditure on non-residential care is average. Responsibility is also shared in Germany, Belgium and France, but is accompanied by high expenditure. The fifth group consists of countries where responsibility for long-term care lies with the

10 Geographically, Switzerland does not fall within Southern and Eastern Europe, but because of the division of responsibility for care, and for ease of reading, we place Switzerland within this group in this report.
family and which are characterised by low spending on non-residential care. This group comprises the Eastern European countries plus Spain and Italy. The last group (Switzerland and Portugal) is characterised by high expenditure plus family responsibility. The figure makes clear that there is no uniform relationship between who is responsible for providing long-term care and expenditure on home care services. As the division into clusters is not based on strict distinguishing factors, we use it merely as a guide for our discussion of the results of this study.

**Figure 2.4**
Relationship between formal responsibility for long-term care and expenditure on ambulant (home) care provision, as a percentage of GDP

Source: scp
2.6 Comparable challenges, different solutions

All European countries are witnessing an increase in the number and share of older persons in the population, rising expenditure on care, a shrinking labour force and diminishing public funds. However, the degree to which these changes are taking place varies. Population ageing is more advanced in some countries than others, and those countries are therefore facing a growing care demand from the older generation earlier than other countries. Broadly speaking, two trends can be observed in all countries. Those countries with a large amount of publicly funded care are placing more and more emphasis on family responsibility and increasingly focusing on informal or unpaid care. Conversely, countries where informal care already dominates are moving to improve publicly funded care provisions and access to them, though the informal care sector continues to play a crucial role. The organisation and regulation of care is increasingly been devolved to local and regional government in all countries, based on the idea that more appropriate solutions can be found if care is organised close to those who need it.

Dutch expenditure on non-residential care is just below the average for the countries studied. Yet the picture that the Netherlands spends a relatively large amount on long-term care holds good. This is primarily because of the high expenditure on residential care, which means that total spending on care in the Netherlands is among the highest of all the countries studied. There is no direct relationship between the level of expenditure on long-term care and the way in which it is organised or delivered. There is a much clearer relationship between the degree of family responsibility and total care expenditure. In countries where the individual or their family is assigned a high level of responsibility, government spending on long-term care is relatively low. The presence of publicly funded care provisions is also closely related to where the state places responsibility for long-term care delivery. The Netherlands is characterised by high degree of government responsibility, with a wide range of publicly funded care provisions and concomitant high expenditure.
3 Health impairments of the over-50s

The rate of population ageing varies from country to country, as we saw in the previous chapter. However, this is not the only factor that can explain differences in demand for care across countries. In the theoretical framework used by Andersen and Newman (1973) to shed light on utilisation of care provisions, care need (represented by ‘illness level’) occupies a prominent place (Babitsch et al. 2012). “Illness level represents the most immediate cause of health service use” (Andersen and Newman 1973: 110). This chapter therefore focuses on the question of whether the illness level of Dutch over-50s differs from that of their European peers (the second research question). We investigate which health impairments affect over-50s in 16 European countries studied and the number of people involved. The potential risk factors for poor health are discussed in chapter 4.

Several articles show that the health status of the older population cannot be described using a single health measure, but requires a measure with several dimensions (Lafor - tine 2007); (Fuscaldo 2012). In this report we therefore describe the different types of health impairments that people may experience: physical, psychological and cognitive. Fuscaldo finds several health aspects in his study, but is unable to rule out the possibility of one common health indicator because of the strong correlation between the individual aspects. For the sake of clarity, in this report we therefore also construct one general, overarching measure that indicates whether a person has a health impairment. We regard this as an objective measure because it is based on an observation of whether someone is able to perform certain tasks. In addition to this objective measure, the report also looks at the subjective health of people aged over 50, i.e. how healthy people feel. This is also an indicator of the need for care. Comparing this information provides a better insight into differences between over-50s in Europe as regards the health impairments they have and those that they experience as such. That in turn provides an insight into the differences in care utilisation between countries. Some distortion is possible in determining health impairments, because we are dealing with the health of over-50s living independently and because in Northern Europe the most impaired over-50s are often in residential care. However, these represent a very small proportion of the total population aged over 50; in the Netherlands, for example, where residential care is widespread, less than 2% of the over-50s are in a residential facility (source: AVO/011).12

Approach

The SHARE dataset contains a variety of questions indicating the health impairments affecting people aged over 50. Using Mokken analyses,13 the large amount of information

11 In their article, Andersen and Newman refer to ‘illness level’. We interpret that as the care need.
12 Based on figures from Statistics Netherlands, we know that this percentage rises with age; for example, 4% of people aged over 65 are in residential care homes (CBS 2013b; CBS 2013a), and the figure for the over-80s is 14%.
13 An explanation of the method can be found in Appendix B (available at www.scp.nl under the relevant report).
in the SHARE dataset was reduced to three measures. The analyses were carried out for all countries together and for the years 2004, 2006 and 2011 together\(^4\) and, following (Pommer et al. 2007), physical, psychological and cognitive impairment measures were validated (see Appendix B for further details). We divided the health impairments into the categories ‘none’, ‘slight’, ‘moderate’ and ‘severe’. By using the same classification for all countries, we were able to compare the number of people aged over 50 with health impairments across countries.\(^5\)

### 3.1 Physical impairments

The scale for physical impairments tells us something about the severity of impairment experienced by people in performing everyday household activities and ‘activities of daily living’ (ADL), such as preparing a meal, doing shopping, washing oneself and going to the toilet. We look at 22 activities (see Table B.1 for a list of the items). When assigning people to our four categories, we regard people who report that they have no problems with any of the 22 items as having no physical impairments (category: ‘none’). People who have difficulty with climbing several stairs or with kneeling or bending, for example, are regarded as having slight physical impairments; people with ‘moderate’ impairments experience these problems as well as frequent difficulty getting up out of a chair and carrying heavy items. They also report problems in climbing a single step. Those included in the ‘severe’ category report that they have difficulties with at least one or more of the remaining items, such as walking a distance of 100 metres, performing activities around the home, dressing themselves, washing and showering, preparing a meal or eating.

Some 59% of over-50s in the Netherlands have no impairments. Only Denmark and Switzerland have a higher share of over-50s without impairments. On average, just under half the over-50s in the 16 countries in our study have no physical impairments (Figure 3.1). The share of over-50s without impairments is much lower than average in the Central European and the other countries. Hungary heads this group, with 34% over-50s having no impairments.

There are relatively few over-50s with severe impairments in the Netherlands (6%). Only Switzerland has a significantly smaller proportion of over-50s with severe impairments. The percentages in Denmark and Sweden are comparable to those in the Netherlands. On average, just under 12% of over-50s in the countries studied experience severe difficulties in performing household tasks and/or ADL. The percentage in the Southern and

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\(^4\) Mokken analyses were also carried out separately for the years 2004, 2006 and 2011; the differences were slight. We use the combined analyses here because we can then base our analyses on a larger number of observations. This also allows the different years to be compared with each other.

\(^5\) The comparison may be distorted by the fact that some countries have no residential care provisions while others do, so that a proportion of the over-50s in some countries are included in the comparison while in other countries they are not. However, we do not have enough information available to resolve this.
Eastern European countries (with the exception of Switzerland) is well above the average, while it is lower in the Northern and Central European countries. Evidently, a high share of non-impaired people is associated with a low percentage of people with severe impairments, and vice versa. Mackenbach et al. (2005) also find a North/South divide for physical health (measured as walking speed and grip strength): physical health is better in the North. Differences in education level could offer an explanation for the differences between countries. Avendano et al. (2005) show that people with a low education level have poorer physical health in all countries studied than people with a high education level. This is because low-educated people often smoke more, are less physically active and eat less healthily, but also because they live in worse conditions. Michaud et al. (2007) also observe that the differences still exist.

**Figure 3.1**
Percentage of over-50s with physical impairments in different countries in Europe (2011)

The percentage of over-50s with physical impairments has not changed significantly in the Netherlands since 2006. Averaging across all countries together, there has been a slight (but significant) increase in the percentage of over-50s with physical impairments since 2006. This is primarily because of a sharp increase in the percentages in Belgium, Spain and especially Germany.
3.2 Psychological impairments

In this report, psychological impairments refer to forms of depression. According to the International classification (DSM-IV), core symptoms of depression include feeling sad and empty, and loss of interest in all or almost all activities (Trimbos-Instituut 2013). This is measured in the SHARE survey by items such as feeling sad, tired or weepy, sleeping badly, loss of appetite and reduced interest in one’s environment, or wishing one were dead (table B.2). These items were summarised in a psychological impairment scale based on our analyses. The scale is divided into four categories: few or no disorders; slight, moderate or severe depressive disorders. Compared with people without severe depressive disorders, people with severe disorders have generally more often lost interest in their environment, lost their appetite or would rather be dead.

Figure 3.2
Percentage of over-50s with psychological impairments in different European countries (2011)

Source: SHARE (2011) release 4.1.1 (SCP treatment)

There are relatively few over-50s with psychological impairments in the Netherlands; the numbers in the Southern and Eastern European countries are relatively high. Based on our chosen classification, 71% of over-50s in the European countries studied had no psychological impairments in 2011, while 8% had severe impairments (Figure 3.2). This is to some extent an age effect, because those countries also have a high proportion of people aged over 80 (Table 2.1). Hungary stands out with the lowest percentage of over-50s with no psychological impairments and the highest percentage with severe impairments.
This latter finding may be one of the reasons that Hungary has such a high suicide rate – twice as high as the average for the EU member states (Eurostat 2013). A comparison with 2006 shows no significant change in the percentage of people with psychological impairments across all countries together. This also applies for the Netherlands. As with physical impairments, however, the proportion of over-50s with psychological impairments has increased significantly in Spain and Germany.

3.3 Cognitive impairments

The third type of impairment distinguished in this report is cognitive impairment. By this we mean things such as memory disorders, limited verbal or written expressive ability, no longer being able to recognise objects, and no longer being able to organise one’s day-to-day life. Cognitive impairments are identified among other things using the Mini-Mental State Examination scale (MMSE, RIVM 2013). The scale we constructed for cognitive impairments takes the MMSE as a starting point. This scale is also used in practical situations to establish the existence of dementia. The scale contains questions focusing on memory, such as the ability to state the day of the week, the month and the year correctly, the ability to read and write accurately and to perform a number of arithmetical sums (table B.3).

This scale was also divided into the categories none/slight/moderate/severe. People were scaled in the ‘none’ category if they were able to answer all questions correctly. They were also regarded as not having an impairment if they were only unable to answer the sums involving fractions and interest rates correctly. This is because we see these sums more as an indicator of how well someone is able to solve arithmetical problems than as an indicator for dementia. People have slight cognitive impairment if they are no longer able to remember words properly, and moderate impairment if they themselves report that they can no longer write properly. People with severe cognitive impairment can no longer remember the days of the week or feel themselves that their reading ability is no longer adequate.

The Netherlands has relatively few over-50s with cognitive impairment. On average, 74% of over-50s living independently in the European countries in this study do not have cognitive impairment, while just over 2% have severe cognitive impairment (Figure 3.3). The prevalence of cognitive impairment is highest in the Southern European countries. This may be largely due to the low education level in those countries (Jonker 2012). Spain and Portugal are outliers, with a substantially above-average proportion of over-50s with severe cognitive impairment and a significantly lower proportion of over-50s without cognitive impairments. An outlier in the other direction is Switzerland, with relatively few people with cognitive impairment (89% have no cognitive impairments). Cognitive abilities remain fairly stable over people’s life course, except for declining memory as people grow older. The prevalence of dementia in Europe rises from 2% among 65-70 year-olds to 25-30% among 85 year-olds (Lobo et al. 2000). It is all the more striking in this light that Switzerland, with its relatively high proportion of people aged over 80, has relatively few people living independently with cognitive impairment. This can be explained partly by the high education level in Switzerland and partly by the wide
health impairments of the over-50s

Guven and Wang-Sheng (2011) show that the average height of a country’s population (a measure of good nutrition) correlates positively with good average cognitive skills in older age. In line with this, it is logical that they find that in countries with generally tall inhabitants (the Netherlands and Denmark), the cognitive skills of the over-50s are better than in other countries, even after correcting for self-reported health, opportunities in youth, parental characteristics and education level. Dewey and Prince (2005) show that having a cognitive disorder, especially in Northern Europe, leads to difficulties with ADL and more physical health problems. They also show that the correlation between having cognitive disorders and receiving care is greater in Southern Europe than Northern Europe.

Figure 3.3
Percentage of over-50s with cognitive impairments in different European countries, 2011

On average, the percentage of people with cognitive impairments has declined in all countries studied in recent years; the biggest falls have taken place in France, Spain and Poland.
3.4 An overall measure for health impairments

As stated earlier, Fuscaldo (2012) shows in his study that the different health aspects are strongly correlated. We find a large overlap between the different impairment measures; the correlations between these measures can be found in Appendix B. More than 80% of over-50s without physical impairments also have no psychological or cognitive impairments. More than half (57%) of over-50s with severe cognitive and/or psychological impairments also have severe physical impairments. It is therefore possible that there is one common health indicator. Such a general indicator would provide a more concise and comprehensive picture of someone’s care need than the individual, specific indicators. For this reason, and for simplicity of presentation, we construct one general, overarching impairment measure that indicates whether or not someone has an impairment, whether physical, psychological or cognitive. All three individual indicators say something about the same concept that we refer to as ‘health impairments’. We refer to this overarching health measure as the health impairment measure.

The health impairment measure is constructed in such a way that the highest score on physical, psychological or cognitive impairments is taken as the reference. In this way, each type of impairment carries equal weight in the overarching measure. In other words, people are regarded as severely impaired if they have a severe physical impairment, a severe psychological impairment or a severe cognitive impairment. If someone does not have a severe impairment according to any of the three measures, but has a moderate impairment according to one of those measures, they are classed as having a moderate impairment in the overarching measure. The same procedure applies for slight impairments. If someone does not have an impairment according to any of the three measures, they do not have a health impairment. The underlying assumption is that the individual measures are not cumulative: someone with a severe impairment on all three individual impairment scales is regarded as having a severe impairment, as is someone who has a severe impairment according to only one of the scales. The physical component is the most decisive in determining the general health impairment measure.

Measured using this overall measure, an average of 33% of over-50s in the countries studied have no physical, psychological or cognitive impairments, while 17% have a severe impairment on at least one of the three measures (Figure 3.4, see also Table B.9).

16 It is not possible to construct a single, hierarchical scale of all items together because there is no hierarchy between the items from the different scales. The three individual scales are however correlated. There is also a strong association (Dewey en Prince 2005) between depression and (i) adl (instrumental) activities of daily living), physical health and chronic illness: people with depression are between two and six times as likely to have problems with (i)adl.

17 Based on a regression analysis, we find that over 58% of the overall measure is determined by physical impairments, approximately 28% by psychological impairments and approximately 14% by cognitive impairments.
In the Netherlands, Northern Europe and Switzerland there are relatively few over-50s with physical, psychological or cognitive impairments; by contrast, there are a lot of people in these categories in Poland, Spain, Portugal and Hungary. Those countries with a large number of over-50s with no health impairments also have few people with severe impairments. The converse is also true: countries with few over-50s with no health impairments have a large number of people with severe impairments. Both groups are interesting because over-50s with no health impairments presumably do not receive care while those with severe impairments do.

If we look at combinations of impairments, we find that countries with a high proportion of over-50s with health impairments stand out unfavourably, because people in these countries relatively often have multiple impairments simultaneously (table B.10). The correlation between the different types of impairment is accordingly high in the Southern and Eastern European countries (see Appendix B).

The percentage of over-50s with physical, psychological or cognitive impairments has remained unchanged on average since 2006 in all countries studied. The percentage has fallen in some countries (Denmark and Austria), but risen in others (Belgium and Germany).

In the foregoing sections we saw that there are considerable differences between countries in the objective health of the over-50s. A first question that arises here is whether...
those differences can be ascribed to differences in population ageing. Although in this report we merely describe differences between countries without establishing links between care need and its determinants, we devote brief attention here to the relationship between impairments and age. As expected, the number of people with health impairments rises sharply with age (Figure 3.5). Almost half the younger over-50s have no health impairments, compared with only 6% of those aged over 85. A not insubstantial proportion of the ‘younger’ over-50s therefore have health impairments. Within this group, just over half those aged 50–54 years have a health impairment; for those aged 60–64 the figure is 55% and for 60–64 year-olds 65%. It is clear that the percentage of people with an impairment rises almost linearly with age. We will therefore specify the presence of the family care network (chapter 5) and the utilisation of care (chapter 6) in terms of age. To make it easier to read the findings, we distinguish between three age groups: 50–64 years, 65–79 years and 80 years and older. The same patterns apply for these three age groups across the different countries as for the over-50 population as a whole.

Figure 3.5
Percentage of over-50s with health impairments (overall measure) by age group, 2011

Source: Share (2011) release 4.1.1 (SCP treatment)
3.5 Subjective health

When comparing differences in care utilisation between countries, it is not only the health impairments that people have that are important, but also the extent to which those impairments make it difficult for them to perform their daily activities or the extent to which they perceive their health as poor. In this section, we therefore look at perceived health and perceived difficulties in performing daily activities. 13% of all over-50s in the EU countries studied perceive their own health as poor and 16% experience difficulties in their daily functioning due to health problems (Table 3.1). Slightly more than a fifth of European over-50s experience one or the other. This provides an indication of someone’s subjective health. A person’s objective health as measured in terms of impairment need not be the same as their subjective health: someone with a heart condition may for example regard their own health as poor but not experience any difficulties in their daily functioning. Conversely, people with age-related problems may experience difficulties in their daily functioning and yet not perceive their health to be poor.

Table 3.1
Share of over-50s with and without health impairments, by perceived health and difficulties in daily functioning in the EU countries studied, 2011 (column percentages)

<table>
<thead>
<tr>
<th>degree of health impairment</th>
<th>none</th>
<th>slight</th>
<th>moderate</th>
<th>severe</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>perceives own health as poor (%)</td>
<td>1</td>
<td>4</td>
<td>16</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>has difficulties in daily functioning due to health problems (%)</td>
<td>3</td>
<td>8</td>
<td>21</td>
<td>51</td>
<td>16</td>
</tr>
<tr>
<td>perceives own health as poor or difficulty in daily functioning (%)</td>
<td>4</td>
<td>10</td>
<td>30</td>
<td>63</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: SHARE (2011) release 4.1.1 (SCP treatment)

Yet there is a clear relationship between objective health impairments (from section 3.4) and the subjective impairments perceived by the individual. Almost none of the over-50s living at home with no objective impairments report that they have problems with their health or their daily functioning (4%). When we refer to the group of over-50s with no objective impairments in the rest of this report, therefore, we know that they generally perceive their own health as good and experience no difficulties in performing activities of daily living. 46% of people classed as having a severe impairment report that they perceive their health as poor, while 51% say they have difficulty in their daily functioning due to their health problems (Table 3.2). This group will probably have a high care need. Yet 37% of over-50s with severe impairments do not regard their health as poor or else report that their health problems do not cause difficulties in their daily functioning. This may explain why not all over-50s with severe impairments receive care. It may also be that it is the care they receive that causes their positive view of their own health. The difference between having a health impairment and poor subjective health may also be due to attitude to life. Someone may for example try to ‘rise above’ their problems, or be guided more by what they can do than what they cannot do (any longer).
The differences between the countries are striking (Figure 3.6). The percentage with severe impairments who perceive their own health as poor varies between 26% and 64%. Hungary and Estonia are the upside outliers (approximately 60%); Switzerland, the Netherlands and Belgium are the downside outliers (less than 30%). There are also wide country differences in the extent to which people experience difficulties in daily functioning. Here, Spain is a striking downside outlier (20%), while Germany (70%) and to a lesser extent the Netherlands (65%) are upside outliers. Spain is the country with the highest share of over-50s with severe impairments, but they do not perceive their health as being any poorer than over-50s in other countries, and report that they experience difficulties due to their health impairments to a lesser extent than average. The Netherlands and Belgium have a low percentage of over-50s with severe impairments who perceive their own health as poor, but they do often feel that their health impairments create difficulties in their daily functioning. Compared with the Germans, Dutch over-50s with a severe impairment much less often feel that their health is poor. This result is in line with the findings of (Mackenbach et al. 2005), who show that Germans assess their health more negatively than their Dutch and Danish counterparts. These authors attribute this among other things to cultural differences. According to (Jusot et al. 2010), the difference in health perception can also be explained by differences in the social background (measured by occupation) and health of the parents.
A caveat applies to the comparison of subjective health, in that everyone uses a different frame of reference for assessing their own health. In country comparisons, there is the additional problem that people from different countries attach a different meaning to the same word (Jürges et al. 2007; Pfarr et al. 2011 and Florence et al. 2010). The SHARE survey tries to counter this by devoting a great deal of attention to the linguistic aspects (Börsch-Supan and Jürges 2005).

### 3.6 Differences in health impairments

According to Andersen and Newman’s theory, the prevalence of health problems in the population is an important indicator of the demand for care in that population. To indicate the extent to which Dutch over-50s differ from their European peers in terms of demand for care, this chapter describes the physical, psychological and cognitive impairments of people aged over 50. These three measures are summarised in a common health impairment measure. Perceived health and difficulties experienced by over-50s are also discussed.

A third of over-50s in the countries studied have no health impairments; just under a third have a slight impairment; a fifth have a moderate impairment; and just under a fifth have a severe impairment. There are marked differences between the countries: the percentage of people aged over 50 with no health impairments is high (around 50%) in Switzerland and Denmark, and to a lesser extent the Netherlands; in Spain, Hungary and Poland it is low (just over 25%). Physical impairments are the most common, affecting more than half the over-50s. Psychological and cognitive impairments are the least common, affecting fewer than one in three people. All types of impairment occur more commonly in the Southern than the Northern countries.

There is a difference between having a health impairment and experiencing difficulties or poor health as a result. Just under half of European over-50s with a severe impairment report that their health is poor, and just over half report that they experience problems with their daily functioning. The fact that someone has a health impairment objectively therefore does not mean that it also causes them difficulty. It is for example possible that someone aged over 50 is perfectly able to function on a day-to-day basis with appropriate aids and home adaptations. The difference between having a health impairment and experiencing difficulty because of it varies widely across the countries. Put in somewhat non-neutral terms, relatively few Northern over-50s, including the Dutch, have health impairments but they most often feel those impairments cause difficulties, while in the Southern countries the situation is the reverse. Not everyone with health impairments will therefore need care.

Relatively few Dutch over-50s living independently have physical, psychological or cognitive impairments. This could explain why the Netherlands spends relatively little on non-residential long-term care. Later in this report we will examine care utilisation by the over-50s, but first the next chapter looks at the risk factors for care need.
4 Supplementary risk factors for care utilisation

In addition to the care need (or ‘illness level’) as discussed in the previous chapter, according to Andersen and Newman (1973) the risk characteristics of care utilisation can be broadly divided into one of the two other categories (see also chapter 1): predisposing factors or enabling factors for care utilisation. Characteristics that fall into one of these two categories have both a direct and an indirect influence on care utilisation, via the care need (‘illness level’ in Andersen and Newman’s terminology). Our exploratory study of differences in long-term care for over-50s living independently in Europe will consequently not be complete without an inventory of the degree to which risk factors for care need and therefore care utilisation occur in the different countries. Together with the characteristics discussed in chapters 3 and 5 (care need and presence of a family network, respectively) this chapter presents the most complete possible overview of the risk factors at country level. The central question addressed in this chapter is: To what extent does the Dutch population of over-50s living independently differ from that in other countries in the prevalence of risk factors for long-term care need and care utilisation?

In the theoretical model devised by Andersen and Newman (1973), age, sex and household composition are characteristics that can constitute predisposing factors for care utilisation. People who need care are often advanced in age, often live alone and are often female (zie o.a. Tas 2011; Strobl et al. 2013). A person’s medical history can also be a predisposing factor for care utilisation because people who have been ill in the past and consulted a doctor for this will also be inclined to do so in the future. The studies by Tas (2011) and Strobl et al. (2013) also show that a person’s socioeconomic position influences their health. People with a low education level are less inclined to make use of care. Finally, a person’s income level provides opportunities for care utilisation. It is therefore not a predisposing factor but an enabling factor for care utilisation.

It was recently demonstrated that life events also carry a risk of creating a care need (Renzaho et al. 2013). Getting married, having a child, separation/divorce, death of a partner, son, daughter or other loved one, buying a house, moving house, losing one’s job, retiring and giving up a bad life habit are all examples of events that change people’s lives and can influence their health. That influence operates mainly via the stress caused by such events (zie onder andere Cohen et al. 1995; Holmes en Rahe 1967). Positive life events reduce potential stress, while negative events increase it. Stress can make people ill and can even lead to physical and psychological complaints and/or impairments. As a result, help and support may be needed in order to continue functioning in daily life. In this chapter we study events that lead to a change in household situation: separation/divorce from a life partner, death of a life partner or death of a child. Another life event that belongs in this category is child illness. Finally, we study changes in lifestyle. In terms of Andersen and Newman’s theoretical model (1973), life events and changes in lifestyle can best be categorised as predisposing factors for health services utilisation.
Unfortunately, the risk factors cannot be identified for all the countries studied in this report. This applies especially for life events, for which we use data from SHARELIFE, a constituent study in the SHARE project. The information in this constituent study was gathered in 2008. Respondents who had completed earlier surveys (in 2004 and/or 2006/2007) answered questions about their life history in 2008. For those countries which took part in the SHARE project for the first time in 2011 – Estonia, Hungary, Portugal and Slovenia – we are therefore unable to present any information on life events.\(^{18}\) We are aware that retrospective questionnaires are problematic because respondents are no longer able to remember everything that happened in the past – and even if they do, they may no longer know precisely how and when events took place (zie bijvoorbeeld Mathiowetz en Duncan 1988; Jürges 2007). Although the events discussed here can have such an impact on someone’s life that it is plausible that they will be remembered, we will still interpret our findings on life events with some caution.

4.1 Predisposition to care utilisation

4.1.1 Sex, age and household composition

People aged over 50 who are at risk of developing health impairments are mostly female, of advanced age and often living alone. Comparison with the proportions of men and women in the population aged 50 years and older in the SHARE database shows that the number of women aged over 50 is higher in all countries than the number of men aged over 50; see Table 4.1. That is not surprising: women have a higher life expectancy than men in all countries studied. The Netherlands has proportionately fewer women aged 50 years and older (52%) than the average in the European countries studied (55%). The number of women aged over 50 is particularly high in Estonia, Hungary and Poland, at 62%, 58% and 57%, respectively. The share of women in the over-50 population in these countries therefore differs significantly from the situation in the Netherlands. The age profile of the Dutch population aged over 50 living at home more or less corresponds to that in the rest of Europe. Sweden and Spain are among the countries with a relatively high proportion of very elderly persons, aged 85 years and older. These two countries, as well as Belgium, Germany, France, Estonia, Italy and Switzerland, have a significantly older over-50 population than the Netherlands. More than 70% of people aged over 50 in the Netherlands have a partner, above the European average. The Dutch situation thus differs significantly from most other countries. Only Germany, Spain, Italy and Poland have a share of over-50s with a partner that is comparable with that in the Netherlands. The share of over-50s with a partner in Portugal is significantly higher than in the Netherlands.

\(^{18}\) For the sake of completeness, the ‘new’ respondents, i.e. those who took part in the SHARE survey for the first time in 2011 in countries that had already participated in the earlier SHARE surveys, are also left out of this chapter; they did not complete the SHARELIFE questionnaire.
Table 4.1
Composition of the population aged over 50 by sex, age and household situation in different European countries (in percentages), 2011

<table>
<thead>
<tr>
<th>sex</th>
<th>female</th>
<th>age (years)</th>
<th>sex</th>
<th>household</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50-64</td>
<td>65-74</td>
<td>75-84</td>
<td>≥85</td>
</tr>
<tr>
<td>Netherlands</td>
<td>52</td>
<td>55</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>Sweden</td>
<td>52</td>
<td><strong>48</strong></td>
<td><strong>31</strong></td>
<td>15</td>
</tr>
<tr>
<td>Denmark</td>
<td>52</td>
<td>52</td>
<td>29</td>
<td>15</td>
</tr>
<tr>
<td>Austria</td>
<td>54</td>
<td>52</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td>Belgium</td>
<td>53</td>
<td><strong>52</strong></td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Germany</td>
<td>53</td>
<td><strong>49</strong></td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td>France</td>
<td>55</td>
<td><strong>51</strong></td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>55</td>
<td>54</td>
<td>27</td>
<td>15</td>
</tr>
<tr>
<td>Estonia</td>
<td><strong>62</strong></td>
<td>51</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Spain</td>
<td>54</td>
<td><strong>48</strong></td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Hungary</td>
<td><strong>58</strong></td>
<td>54</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Italy</td>
<td>55</td>
<td><strong>47</strong></td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Poland</td>
<td><strong>57</strong></td>
<td>55</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Slovenia</td>
<td>54</td>
<td>54</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Switzerland</td>
<td>53</td>
<td><strong>50</strong></td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>Portugal</td>
<td>55</td>
<td>53</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>total</td>
<td>55</td>
<td>50</td>
<td>27</td>
<td>17</td>
</tr>
</tbody>
</table>

Bold: significant (5%).
‘Netherlands’ is the reference category.
‘Male’ is the reference category.
‘Single’ is the reference category.

Source: SHARE (2011) (SCP treatment)

4.1.2 Changes in household composition

Changes can occur in the composition of a person’s household over the course of their life. Those changes may be perceived as predominantly positive – for example marrying and having children – but may also be the result of negative situations, such as a divorce or death of a life partner or child. Following Cohen (1995) and Holmes and Rahe (1967), we expect these changes in household composition to have an influence on health and therefore also on utilisation of care. This section focuses on life events that can have a negative influence on health and could therefore lead to care utilisation.

Separation/divorce from a life partner
Separation/divorce, even where both partners want it, causes stress. It may be accompanied by a reduction in income and possibly by social stigma. People with children
who decide to end their relationship face the added stress of having to bring up their children alone or negotiating with their former partner about this. Separation/divorce may therefore be linked to a potential negative impact on health in both the shorter and longer term. This is confirmed by a number of studies (Marks en Lambert 1998; Simon 2002; Williams 2003; Wade en Pevalin 2004; Williams en Umberson 2004; Hughes en Waite 2009). The Dutch are in a large ‘middling’ group in Europe as regards the ending of relationships (marriage or cohabitation). Around a fifth of respondents have at some time split up with a cohabiting or married partner (Table 4.2). The share of over-50s who have broken off a relationship is highest in the Scandinavian countries: more than a third of Swedes and Danes have at some time gone through a serious relationship break-up. A high proportion of over-50s in Switzerland have also experienced a break-up, and around a quarter of Austrian over-50s have gone through the same experience. By contrast, in most Southern European countries, respondents aged over 50 have less often ended their marriage or partnership; around 5% of Spaniards and Italians have at some point broken up with their life partner. The differences between countries thus appear to signify a clear pattern. In the countries of Southern Europe, relationships with life partners are broken off much less frequently than in the Scandinavian countries.

Death of a life partner

The death of a partner can also lead to health problems for the widow or widower (Williams 2004). The partner who remains behind is exposed to all kinds of stress stemming from the mourning process, loss of support and companionship as well as difficulties (including financial) in keeping the household going alone. The partner who has died will in many cases have been ill prior to their deaths. During that period of illness, the deceased partner will therefore not have been able to offer help and support. Moreover, the widow or widower will often have provided intensive care in the final stages of their partner’s life. As a result, they may have become isolated, with all kinds of potential health complaints as a consequence. Research on the impact of the death of a loved one on the health of the remaining partner shows that widows and widowers have poorer mental health than married men and women (Wilcox et al. 2003; Schaan 2013). However, the impact on daily functioning does not appear to be permanent as the long-term health effects suggest (Stone et al. 2013; Wilcox et al. 2003; Williams 2004). The health complaints should therefore not be linked to the fact of ‘being’ a widow or widower, but rather to the ‘phase through which a widow or widower has to go’ (Stone

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19 Research also shows there are clear health differences between married and unmarried people. (Gordon en Rosenthal 1995; Cohen et al. 1997; Goodwin et al. 1987; Marks en Lambert 1998; Mirowsky en Ross 2003; Umberson et al. 1996; Waite en Hughes 1999; Williams 2003). Our study, however, did not include the differences between countries as regards whether their older populations had at some point been married or had never married. This is because there were virtually no respondents who reported that they had never been married.

20 We did not investigate the cause of these differences. It is however quite possible that they mask family values linked to religion.
et al. 2013). As with the number of relationship break-ups, the Netherlands is in the large group around the European average when it comes to death of a partner. In the majority of European countries, roughly a fifth of people aged over 50 have at some time been confronted with the death of a partner (Table 4.2). Austria, Italy and Poland are the only countries where this percentage is higher than in the Netherlands, at around 25%. In Switzerland, by contrast, the percentage is significantly lower than in the Netherlands (at 15%). We are not aware of the reason for this.

Death of a son or daughter
Although research on the impact of the death of a child on the parent(s) is still fairly unexplored territory (Hendrickson 2009; Humbeeck et al. 2013; Rostila et al. 2012), the studies that do exist show that the consequences for the health and well-being of the parents is considerable. Song et al. (2010) summarise findings of earlier studies showing among other things that mourning parents experience more emotional stress, are more often admitted to psychiatric institutions and have a higher risk of death than parents who have not faced the loss of a child. An average of 8% of over-50s in Europe have gone through the death of a son or daughter. This may be a stillborn child, the death of a child before adulthood or the death of an adult son or daughter (Table 4.2). The Netherlands has one of the lowest figures for over-50s who have had to deal with the death of a child (5%). The figures in Poland and Spain, by contrast, are more than double those for the Netherlands. The Netherlands therefore differs significantly from those countries, but also from Austria, Belgium, France, Italy and Switzerland, all of which have a higher percentage of over-50s who have gone through the death of a child than in the Netherlands.

21 In the SHARELIFE dataset, respondents were asked to give the reason for the ending of each relationship in which they had conducted a joint household. Given the age of a number of respondents, it is quite possible that they have gone through the death of a partner more than once. We do not make a distinction based on the number of times that respondents have faced the death of a partner.

22 It is possible that the death of a child before adulthood has a greater impact on the (health of) parents than the death of a son or daughter who is themselves already aged over 50. The limited research that has been done on the impact of the death of a child on parental health does not support this, however. For want of information on the child's age at death, we have to assume that the age of the deceased child does not affect the impact on the health of the parents. This lack of information also means that we do not know how long ago parents lost their child.
Table 4.2
Share of over-50s in different European countries who have at some time gone through a change in household composition, 2008 (in percentages)

<table>
<thead>
<tr>
<th></th>
<th>NL</th>
<th>SW</th>
<th>DK</th>
<th>AT</th>
<th>BE</th>
<th>DE</th>
<th>FR</th>
<th>CZ</th>
<th>ES</th>
<th>IT</th>
<th>PL</th>
<th>CH</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>separated/divorced from partner at some time, yes (%)</td>
<td>21</td>
<td>37</td>
<td>36</td>
<td>17</td>
<td>20</td>
<td>23</td>
<td>23</td>
<td>22</td>
<td>5</td>
<td>6</td>
<td>10</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>lost partner at some time, yes (%)</td>
<td>19</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>20</td>
<td>16</td>
<td>19</td>
<td>19</td>
<td>25</td>
<td>24</td>
<td>15</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>lost a child at some time, yes (%)</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>10</td>
<td>6</td>
<td>10</td>
<td>7</td>
<td>11</td>
<td>7</td>
<td>14</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Bold: significant (5%).
‘Netherlands’ is the reference category.

Source: SHARELIFE (2008) release 4.1.1 (SCP treatment)

4.1.3 Childhood illness

As we saw in the introduction to this chapter, a person’s medical history can play a role in the (future) use of care provisions. People who have been ill in the past and used the services of a doctor are more likely to utilise care in the event of future illness. This applies not only for their recent medical history, but also for illnesses they had in childhood.

Several studies make reference to the influence of the circumstances in which children grow up in their later lives (zie o.a. Currie 2009). If someone suffered poor health as a child, this could be an indication of a weak constitution. Respondents in the SHARELIFE survey were asked whether they had had an illness as a child that lasted for a month or longer and that was severe enough to confine them to bed, and whether they had spent long or frequent periods in hospital. Combining these questions produces an indicator for someone’s health as a child. This shows that 17% of Dutch over-50s had poor health as children (Table 4.3). That is the highest figure of all European countries in this study. It may be connected to the Dutch famine (hongerwinter) in the winter of 1944/45. On average, 13% of all over-50s in the countries included in this study suffered poor health as a child. Just over 5% of those in the Southern European countries were affected, which means that the over-50s in this region enjoyed significantly better health as children than their peers in all other European countries in this study. Dutch over-50s reported significantly poorer health as children to a much greater extent than their peers in Sweden, Denmark, France, Spain, Italy, Poland and Switzerland.
Table 4.3
Share of over-50s in different European countries who had poor health as children, 2008
(in percentages)

<table>
<thead>
<tr>
<th>poor health as a child</th>
<th>NL</th>
<th>SW</th>
<th>DK</th>
<th>AT</th>
<th>BE</th>
<th>DE</th>
<th>FR</th>
<th>CZ</th>
<th>ES</th>
<th>IT</th>
<th>PL</th>
<th>CH</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes (%)</td>
<td>17</td>
<td>11</td>
<td>12</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td>12</td>
<td>14</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Bold: significant (5%).
‘Netherlands’ is the reference category.
Having enjoyed good health as a child is the reference category.

Source: SHARELIFE (2008) release 4.1.1 (SCP treatment)

4.1.4 Education level

People with a high education level are generally better able than people with a lower education level to understand and familiarise themselves with medical knowledge and advances. They are also often better able to find their way through the care system than those with a lower education level. In the dataset, the education levels of over-50s were classified using the International Standard Classification of Education (ISCED). This makes it possible to compare education levels across countries because educational programmes are classified on the basis of uniform and internationally agreed definitions. The shares of the population aged over 50 broken down by education level are shown in Table 4.4. A substantial proportion of Dutch over-50s have a low education level: 43%. Spain, Italy and Portugal have a substantially higher proportion of low-educated over-50s than the Netherlands. In these countries 67% or more of the over-50s have a low education level. In Portugal the figure is even higher at 84%. It is striking that Austria and Switzerland also have a high proportion of low-educated over-50s, at around 55%. Countries where over-50s have a significantly higher education level than their Dutch peers include Denmark and Germany, and to a lesser extent the Czech Republic, Estonia and Belgium.

23 Research has shown that this classification adequately represents education levels in the different countries (Schneider 2008).
Table 4.4
Composition of the population aged over 50 by education level in different European countries (in percentages), 2011

<table>
<thead>
<tr>
<th>Country</th>
<th>Low</th>
<th>Intermediate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>43</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>Sweden</td>
<td>41</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>Denmark</td>
<td>18</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>Austria</td>
<td>55</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Belgium</td>
<td>30</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>Germany</td>
<td>14</td>
<td>57</td>
<td>29</td>
</tr>
<tr>
<td>France</td>
<td>39</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>26</td>
<td>56</td>
<td>17</td>
</tr>
<tr>
<td>Estonia</td>
<td>27</td>
<td>45</td>
<td>28</td>
</tr>
<tr>
<td>Spain</td>
<td>67</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Hungary</td>
<td>39</td>
<td>49</td>
<td>12</td>
</tr>
<tr>
<td>Italy</td>
<td>68</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Poland</td>
<td>40</td>
<td>52</td>
<td>8</td>
</tr>
<tr>
<td>Slovenia</td>
<td>38</td>
<td>45</td>
<td>17</td>
</tr>
<tr>
<td>Switzerland</td>
<td>56</td>
<td>32</td>
<td>12</td>
</tr>
<tr>
<td>Portugal</td>
<td>84</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td>42</td>
<td>38</td>
<td>20</td>
</tr>
</tbody>
</table>

Bold: significant (5%).
‘Netherlands’ is the reference category.

Source: SHARE (2011) (SCP treatment)

4.1.5 Changes in lifestyle

None of us can escape the decline in physical and mental strength that comes with growing older, referred to as ‘primary ageing’ (zie onder andere Holloszy 2000; Oliveira 2007). However, primary ageing is not the only cause of functional impairment in daily activities; disease can also have this effect. This process of ‘secondary ageing’, unlike primary ageing, can be influenced (Holloszy 2000) by avoiding disease or adopting a healthier lifestyle. This is supported by research (Balzi et al. 2010; Omodei en Fontana 2011; Smith et al. 2010; Spindler 2010; Willcox et al. 2007; Witte et al. 2009).

The degree to which people aged over 50 change their lifestyle depends on their present lifestyle. People who drink little alcohol, do not smoke, are not overweight and already take a lot of exercise need not change their lifestyle. Identifying the number of over-50s who have made changes to their lifestyle will not provide an insight into the potential effect that lifestyle change has on the health of over-50s, and thus on their utilisation of care. We therefore place changes in lifestyle in perspective. Unfortunately, neither the
SHARE nor the SHARELIFE datasets provide information that can be used to identify the drinking, smoking, dietary and exercise habits of all over-50s. To indicate the lifestyles in a given country we are forced to rely on data from the OECD. These data do not relate only to the population aged over 50, but to the entire population aged 15 years and older. Moreover, the information relates to the recent past, and it is not impossible that the changes in lifestyle that we observe in the SHARELIFE dataset are already incorporated in the OECD data on lifestyles. It should also be noted that the effects of a change in lifestyle on health and potential care utilisation could be linked to the duration of that change. Several studies (see e.g. Witte et al. 2009; Spindler 2010) appear to suggest that a change in lifestyle itself has a positive influence on health.

The OECD data on lifestyles show that the Dutch population aged 15 years and older drink an average of just under ten litres of alcohol per person per year (see also Table 4.5). Only the Swedes and Italians drink less. The lower alcohol consumption in Sweden is likely to be due to the very high price of alcoholic drinks in this country. The lower alcohol consumption in Italy is striking, because the image of Southern European countries is that people there more often enjoy life ‘glass in hand’. Roughly one in five Dutch people smoke daily, and the figure is comparable in virtually all other European countries in this study. Sweden is the only country where habitual smoking is less common than in the other European countries, with only 14% smoking on a daily basis. Just under half the Dutch population consider themselves overweight, putting the Netherlands in the middle group of the countries studied. People in the Czech Republic, Spain and Poland consider themselves overweight more often than other Europeans, while the Swiss and French do so less often – though 40% of the population in these countries still feel they are overweight.

Table 4.5
Non-medical determinants of health: number of litres of alcohol per person per year, share of population who smoke on a daily basis and percentage of the population who are overweight

<table>
<thead>
<tr>
<th></th>
<th>NL</th>
<th>DK</th>
<th>SW</th>
<th>BE</th>
<th>AT</th>
<th>DE</th>
<th>FR</th>
<th>CH</th>
<th>CZ</th>
<th>ES</th>
<th>IT</th>
<th>PL</th>
</tr>
</thead>
<tbody>
<tr>
<td>litres of alcohol per person per year</td>
<td>9.4</td>
<td>10.3</td>
<td>7.3</td>
<td>10.8</td>
<td>12.2</td>
<td>11.7</td>
<td>12</td>
<td>10</td>
<td>11.4</td>
<td>11.4</td>
<td>6.9</td>
<td>11.4</td>
</tr>
<tr>
<td>% daily smokers</td>
<td>20.9</td>
<td>20</td>
<td>14</td>
<td>20.5</td>
<td>23.2</td>
<td>21.9</td>
<td>23.3</td>
<td>20.4</td>
<td>24.6</td>
<td>26.2</td>
<td>22.1</td>
<td>23.8</td>
</tr>
<tr>
<td>% overweight</td>
<td>48.2</td>
<td>46.7</td>
<td>46.9</td>
<td>46.9</td>
<td>47.7</td>
<td>51.4</td>
<td>42.9</td>
<td>37.3</td>
<td>54.3</td>
<td>53.6</td>
<td>46</td>
<td>52.2</td>
</tr>
</tbody>
</table>

a This is the number of litres of pure alcohol. To arrive at this figure, alcoholic drinks such as beer, wine and spirits are weighted according to their average percentage alcohol content in order to estimate the total number of litres of pure alcohol. This makes it possible to compare alcohol consumption between the different countries because it takes into account the type of drink consumed.

b This is self-reported overweight.

Source: OECD Statistics (Health: non-medical determinants of health); stats.oecd.org (SCP treatment)

24 Alcoholic drinks such as beer, wine and spirits are weighted according to their average percentage alcohol content in order to estimate the total number of litres of pure alcohol. This makes it possible to compare alcohol consumption between the different countries because it takes into account the type of drink consumed.

25 Unfortunately, this information is not available specifically for the over-50 populations.
More than 60% of Dutch people aged 50 years or older have changed their behaviour at some point in their lives to improve their health (Figure 4.1). They may have started taking more exercise, eating more healthily, consuming less alcohol or have given up smoking. Some have changed only one aspect, while others have made changes on all fronts. The motivations for these changes in lifestyle are not known. In some cases it could be a preventive action with a view to enjoying a healthy older age; in other cases it may be a reaction due to disease.

Figure 4.1
Share of over-50s in different European countries in 2011 who have at some point in the past changed their behaviour* to improve their health, 2008 (in percentages)

Together with Sweden and Denmark, the Netherlands has the highest share of over-50s who have made a change in their lifestyle. Poles are considerably less inclined to do this, as are Austrians, French, Italians, Spaniards, Czechs and Swiss. The over-50s in these countries thus differ significantly from their Dutch counterparts in their willingness to change their lifestyle. The main changes made by Scandinavian and Dutch over-50s are taking more exercise and stopping smoking. The high percentage of over-50s who have given up smoking cannot be explained by a higher share of the population who are smokers, as we saw earlier in Table 4.5 (although the percentage of women who smoke in these countries is above the average Oudijk et al. (2012)). It is unclear whether over-50s who give up smoking do so permanently or take up the habit again at a later time. That would of course have a different impact on later health. The most common lifestyle changes made by over-50s are adjusting their diet and giving up smoking. Reducing alcohol consumption appears to be very low on the list of priorities in all countries, especially among over-50s in the Southern European countries and

* More exercise, going on a diet, giving up smoking, reducing alcohol consumption.

Source: SHARELIFE (2008) release 4.1.1 (SCP treatment)
Poland. Those over-50s who change their lifestyle do so between the ages of 40 and 65. There are only two exceptions: Dutch and Swedish over-50s more often gave up smoking at an earlier age (below the age of 40) than their European peers. Swedish over-50s also more often began taking exercise at a younger age on average; that does not apply for their Dutch peers.

4.2 Enabling factors for care utilisation: income level

The more affluent someone is, the more opportunities they have to purchase long-term care themselves. Table 4.6 shows the annual standardised net household income expressed in euros and in ‘purchasing power parity’ (PPP). This means that allowance is made in computing household incomes for price levels in the different countries. Incomes in the Central and Eastern European countries are generally lower than in the other parts of Europe covered in this study. Often, however, the products that can be purchased with those incomes are also cheaper. Taking these price differentials across countries into account by using purchasing power parity as a measure means that income levels in the different countries can be compared more accurately. Household incomes are divided into four categories. Households are placed in the low-income category if their disposable income amounts to less than €15,000 per year. Households with a lower middle income have annual disposable income of between €15,000 and €30,000. Households with an annual disposable income of between €30,000 and €45,000 are placed in the upper middle income bracket. Finally, there are the high-income households, with disposable incomes of more than €45,000 per year.

Just under 40% of the Dutch population aged 50 and older have an annual household income in the higher income categories, in other words an income of €30,000 or more. Even after correcting for price levels, the most low-income households are found in the Central and Eastern European countries; between 81% and 86% of the over-50 population in Poland, Estonia and Hungary have a low annual household income. The majority of the over-50 population in Portugal (74%), Spain (58%) and Italy (53%) also have a low annual household income, i.e. less than €15,000.

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26 The comparison is based on price levels in the Netherlands in 2011.
Table 4.6
Composition of the over-50 population by income level in different European countries (in percentages), 2011

<table>
<thead>
<tr>
<th>Income</th>
<th>Netherlands</th>
<th>Sweden</th>
<th>Denmark</th>
<th>Austria</th>
<th>Belgium</th>
<th>Germany</th>
<th>France</th>
<th>Czech Republic</th>
<th>Estonia</th>
<th>Spain</th>
<th>Hungary</th>
<th>Italy</th>
<th>Poland</th>
<th>Slovenia</th>
<th>Switzerland</th>
<th>Portugal</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>24</td>
<td>29</td>
<td>30</td>
<td>36</td>
<td>27</td>
<td>38</td>
<td>31</td>
<td>62</td>
<td>84</td>
<td>58</td>
<td>86</td>
<td>53</td>
<td>81</td>
<td>51</td>
<td>12</td>
<td>74</td>
<td>47</td>
</tr>
<tr>
<td>Lower middle</td>
<td>37</td>
<td>37</td>
<td>39</td>
<td>36</td>
<td>31</td>
<td>35</td>
<td>35</td>
<td>29</td>
<td>13</td>
<td>27</td>
<td>11</td>
<td>28</td>
<td>18</td>
<td>24</td>
<td>23</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Higher middle</td>
<td>18</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>14</td>
<td>16</td>
<td>17</td>
<td>6</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>11</td>
<td>1</td>
<td>9</td>
<td>20</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>High</td>
<td>21</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>28</td>
<td>12</td>
<td>17</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>17</td>
<td>45</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>

Bold: significant (5%).
‘Netherlands’ is the reference category.

Source: SHARE (2011) (SCP treatment)

4.3 Summary

The list of risk factors for care need and care utilisation reveals striking differences between countries in the degree to which those risk factors occur. For example, there is particularly marked variation between the European countries studied in affluence: the risk factor which in the theory propounded by Andersen and Newman (1973) represents the opportunity for use of health services. Almost 40% of Dutch over-50s living independently have an annual income of more than € 30,000, putting them among the wealthiest in Europe along with Switzerland, Sweden and Belgium. Switzerland is the most affluent, with more than 65% of the population aged over 50 and living independently having an annual per capita household income of more than € 30,000. Most of those who are affluent are aged under 80; the percentage of people aged over 80 in the highest income categories varies across the countries between 0 and 8%. There are also differences between the countries for the risk factors that influence the predisposition for care utilisation. One such factor is the social structure. Together with
their Danish, Belgian, German and Swedish counterparts, Dutch over-50s living independently are among the best educated in Europe. People with a higher education level are more likely to change their lifestyle than those with a lower education level. It is therefore not surprising that over-50s in the Netherlands and Sweden, in particular, have more often made a change in lifestyle than their peers elsewhere in Europe. Southern and Eastern Europeans are much less willing to do this. Younger over-50s with a high education level are the most likely to make lifestyle changes: between 50% and 70% of those with a higher education level are aged between 50 and 65 years. Most demographic risk factors, which also represent the predisposition for care utilisation, differ little across the European countries. The gender distribution of the over-50 population is virtually identical in all countries. Population ageing is in an early phase in the Netherlands, which has a relatively young over-50 population. As in Germany, Spain, Italy and Poland, many over-50s in the Netherlands have a partner. With the exception of Portugal, where more over-50s have a partner than in the Netherlands, a substantially lower share of the over-50s in the other European countries have a partner. Those with a partner are mostly aged under 80: between 5% and 10% of those aged over 80 have a partner. There is almost no variation as regards changes in household competition, the extent to which over-50s separate/divorce or face the death of their life partner or child. There is more variation between countries when it comes to childhood illness. A relatively high though comparable share of over-50s in the Netherlands, Austria, Germany, Belgium and the Czech Republic had a serious illness as a child. This is much less common in Spain and Italy.
5 Presence of a family care network

People who need help can use the services of professionals, but they could also call on those close to them. The differences in long-term care utilisation between the European countries in this study could thus be due not only to the risk factors that we considered in the previous chapter, but also to the presence or absence of a social network, or ‘care potential’ (zij bijv. De Boer 2013; De Boer en Timmermans 2007). People who do not have access to a social network but who need help will be more quickly forced to use paid care than people who do have a social network at their disposal. In the context of Andersen and Newman (1973), the social network of the over-50s can thus be interpreted as an extra opportunity (‘enabling factor’) for care utilisation on which those who need help can draw.

In this chapter we look only at the presence of a family network. By that we mean the presence of a partner and/or children (living at home or outside the home) from whom those needing help could potentially receive (unpaid) informal care. To what extent they could rely on other members of their social network besides these family members is unfortunately impossible to determine using the SHARE dataset. This is because it is unknown to what extent members of the social network face impediments to providing care. A partner may for example have health problems themselves, or a child may work full-time and therefore find it less easy to make themselves available. Such information is not available for other members in the social network. The question we address in this chapter is therefore To what extent are over-50s living independently in the Netherlands able to fall back on a family care network, and to what extent does the Netherlands differ in this regard from other European countries?

5.1 Measure for the presence of a family network

Family care
The presence of family members is regarded as an important resource in many countries (zie bijv. Daatland en Herlofson 2003; Chiatti et al. 2013). It is known that, where a partner is present, they often take on a large share of responsibility for providing ‘family care’. After the partner, children are the most important source of family care for parents (Oudijk et al. 2010; Tarricone en Tsouros 2008; Triantafillou et al. 2010). This is also driven in part by policy. In Germany, for example, there is a moral obligation (and until recently a legal obligation) to provide help, or at least to pay for it (Boom 2008). Only where this family care is inadequate can people in Germany access publicly funded services.

In this study we draw a distinction between the presence of family members within and outside the care recipient’s own household. This reflects the fact that these are two different situations. Those sharing the care recipient’s household usually consider it natural to provide help when needed; they are present in the household every day, something that frequently does not apply for people living outside the household. Moreover, those
who share the care recipient’s household often have a closer bond with the recipient than people living outside the household. Governments also often expect household members to provide family care, and therefore offer less or no publicly funded services. This can vary from only being expected to provide the lighter forms of care all the way up to intensive care. The Netherlands applies the principle of ‘usual care’, which refers to normal domestic and short-term caring activities by adults sharing a household. Partners and children living at home are expected to do what they can to carry out both household tasks and provide personal care. Similar expectations apply in other countries, including in Southern Europe as well as Germany and Switzerland.

Our analyses look first at family care within the household, reflecting the logical expectation that those in need of help will initially appeal to those who share their household. Here we look only at the presence of children and a partner of people aged over 50: we have sufficient information for these to determine their availability for providing family care.27 Sufficient information on the family care network outside the household is only available for partners and/or children living outside the home. The remaining social network – other family members, neighbours, friends, acquaintances and possibly other volunteers – are left out of consideration, as the information on these categories in the SHARE dataset is too limited for us to present here.

Impediments to providing family care
The presence of a partner and/or children merely gives an indication of the potential family care network. Not all fellow household members or children living outside the home are actually able in practice to provide family care. There may be all kinds of impediments. Partners with a moderate or severe health impairment will find it difficult to provide help and will often need help themselves. If the children of people aged over 50 are themselves ill or unfit for work, or have young children (below the age of 12), they will also often find it difficult to provide family care. Participation in the labour market can also pose an obstacle in some countries. The labour participation rate and pay of informal carers varies (zie bijv. Bolin et al. 2008b; Triantafillou et al. 2010). Having a full-time job, in particular, can make it difficult to provide family care. However, De Boer and De Klerk (2013) show that the association between working and providing informal care should not be overstated. We therefore do not automatically assume in this study the people with a full-time or part-time job will deliver less informal care. The labour participation rate of older Dutch people (over-55s) (58.7%) is around the OECD average (OECD 2013c). A high proportion of women in the Netherlands, and more latterly men as well, work part time; on average, over 37% of all people in work are in part-time jobs.

27 Insufficient information is available about the parents of people aged over 50. There is for example a lack of information about the health impairments and employment situation of the other household members. However, we make the assumption that they are no longer able to provide care, because as the parents of people aged over 50 they are themselves likely to be aged over 70 and may be receiving help themselves rather than providing it. The same assumption is made where parents live elsewhere and for other household members.
The average for the OECD countries is just over 16%, putting the Netherlands well ahead in terms of part-time working (OECD 2013c). Part-time employment is less common in Southern and Eastern Europe, in particular, and children living outside the home in these countries therefore often find it difficult to provide family care. Travel times can be an impediment for children who no longer live in the parental home; research has shown that a shorter travel distance is often associated with offering more help to loved ones (Yoo et al. 2004; Hogerbrugge en Komter 2012; Rainer en Siedler 2012). We apply a radius of 25 kilometres as a criterion in this regard. This is based on the Dutch situation, where 25 kilometres is a manageable distance. Dutch research has shown that greater distances do not have a major impact on receipt of care (De Boer 2005). Other studies based on the SHARE data also apply this distance (zie bijv. Kohli et al. 2005).

Overestimate or underestimate of actual availability?

It is not clear in advance how closely the criterion used here to measure the presence of a family care network corresponds with the actual availability of unpaid care by family members, or whether the reality is higher or lower. For example, a partner or child will not always be able or willing to provide help. This applies even when allowance is made for any health impairments or illnesses of the partner or impediments for children due to their employment, having young children or the travel distances involved. As a result, the family care network may be an overestimate of the actual availability of family care. In practice, however, the lack of information about the availability of family care from other family members is likely to point to an underestimate. There may also be parents living outside the home who are able to offer (some) help despite their own advanced age. The family network also underestimates the availability of neighbours or acquaintances are to offer help. As stated, insufficient information is available about that informal network. On the other hand, at least in the Netherlands, the potentially available help (informal care potential) from non-family members in the networks of older persons does not often lead to actual, structured informal care (Broese van Groenou en Van Tilburg 2007). Not including this potential source of help will therefore not greatly distort the picture of the informal or unpaid care potential.

5.2 Family ties

The presence of children or other family members within and outside the household is an important factor determining the availability of family care. It is therefore important to obtain an impression of family ties in the different countries in Europe. In the 16 countries studied here, a high proportion of over-50s have a partner (68%, Figure 5.1). The share of over-50s in the Netherlands with a partner is fairly high (71%). This reflects the fact that the life expectancy of men and women in the Netherlands is similar, so that couples grow older together (Oudijk et al. 2012). Portugal is the only country where the

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28 Other geographical limits lead to a greater or lower availability of family care. Broadly speaking, however, the availability remains unchanged.
Figure 5.1
Share of over-50s with a partner, 2011 (in percentages)\textsuperscript{a}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure51.png}
\caption{Figure 5.1 Share of over-50s with a partner, 2011 (in percentages)\textsuperscript{a}}
\end{figure}

\textsuperscript{a} This includes partners living inside and outside the home together. The share of over-50s with partners living outside the home is too small (1\%) to report on it separately.

Source: SHARE (2011); SCP treatment

A high proportion of over-50s have children aged 12 years or older. In the Netherlands, 9\% of over-50s have a child aged 12 or older living in the home. Denmark and Germany are the only countries with a comparable percentage, and Sweden is the only country where the percentage is lower (5\%). On average, roughly a fifth of over-50s in the countries studied have one or more children living at home (Figure 5.2). The figure in the Southern and Eastern European countries is often above this average (zie ook bijv. Therborn 2013). The Czech Republic is an exception to this, but the share of over-50s with a child living at home is still on the high side, at 15\%.

More than six out of ten over-50s in the countries studied have one or more children living outside the home. The Netherlands scores somewhat above the average, at 65\%; children in the Netherlands have more often moved out of the parental home than in many other countries.

The differences between the countries are considerable. This is due partly to cultural differences, but also to different opportunities on the labour market and the housing market (Kohli et al. 2005). The latter aspect will have a particular influence on the age at which children leave the parental home, and therefore on the number of children both living at home and outside the home.
The number of over-50s in the Netherlands with a partner changed little between 2007 and 2011, while the number of over-50s with children living outside the home fell over the same period (not shown in figure). Of the other European countries studied here, Belgium is the only country where the percentage of over-50s with a partner has fallen, while in Germany and the Czech Republic the figure has increased slightly. In addition, as in most other countries, the number of over-50s in the Netherlands with children living at home is declining. The percentage of over-50s with children living outside the home is also falling in the Netherlands and most of the other countries. This is due in part to the declining birth rate, though having fewer children need not always mean that less unpaid help is available (Herlofson en Hagestad 2011). Trends such as the falling marriage rate and rising divorce rate, the growing number of people living alone and a downward trend in different generations living together all play a role here (Kohli et al. 2005; Oudijk et al. 2012). Although fewer and fewer children live with their parent(s), there is still lots of contact and consequently opportunity for daily support (Kohli et al. 2005). It is possible that the economic crisis will mean that children remain living with their parents for longer in the future for financial reasons (Isengard en Szydlik 1012). As a result, the economic crisis and, certainly in the Netherlands, the tight housing market may mean that the age at which adult children leave the parental home increases. All in all, family structures in the Mediterranean countries are still stronger than in the Northern countries, even after correcting for personal characteristics such as age and education level (Hank 2013).
5.3 Presence of a family care network within the household

Inhibiting factors such as a partner with health impairments, children living at home with a busy life (working full-time and raising a family) mean that the family of over-50s with a care need is not always in a position to provide family care in practice.

Table 5.1
Share of over-50s with a family care network within the household, 2011 (in percentages)

<table>
<thead>
<tr>
<th></th>
<th>partner living in the home</th>
<th>children living at home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>potential no impediments</td>
<td>potential no impediments</td>
</tr>
<tr>
<td>NL</td>
<td>71</td>
<td>64</td>
</tr>
<tr>
<td>SW</td>
<td>66</td>
<td>61</td>
</tr>
<tr>
<td>DK</td>
<td>67</td>
<td>59</td>
</tr>
<tr>
<td>AT</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>BE</td>
<td>67</td>
<td>53</td>
</tr>
<tr>
<td>DE</td>
<td>69</td>
<td>60</td>
</tr>
<tr>
<td>FR</td>
<td>66</td>
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</tr>
<tr>
<td>CZ</td>
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<td>EE</td>
<td>52</td>
<td>36</td>
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<tr>
<td>ES</td>
<td>69</td>
<td>50</td>
</tr>
<tr>
<td>HU</td>
<td>59</td>
<td>38</td>
</tr>
<tr>
<td>IT</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>PL</td>
<td>68</td>
<td>53</td>
</tr>
<tr>
<td>SI</td>
<td>64</td>
<td>52</td>
</tr>
<tr>
<td>CH</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td>PT</td>
<td>77</td>
<td>68</td>
</tr>
<tr>
<td>total</td>
<td>68</td>
<td>57</td>
</tr>
</tbody>
</table>

Bold: differs significantly from the Netherlands

Source: SHARE (2011); SCP treatment

We saw in Figure 5.1 that around seven out of ten over-50s in the countries studied have a partner. This figure also holds for the Netherlands (71%). However, some of these partners have health issues themselves, and this can prevent them providing help. In the Netherlands, this applies for 7% of over-50s. This means that 64% of over-50s have a partner who (based on our assumptions) have no impediments to providing family care (see Table 5.1). This share is higher than in almost all other countries; only Portugal has a higher percentage. Averaged out across all countries studied, more than half the over-50s have a partner without impediments (57%, Table 5.1). The Southern and Eastern European countries mostly score low, especially Estonia and Hungary (below 40%). This is because the share of over-50s with a partner is relatively low in these countries and a relatively high proportion of those partners face impediments to providing care.
Although almost one in ten Dutch over-50s have a child living at home (aged over 12 years) who is potentially available to provide family care, virtually all these children face impediments in actually providing care (Table 5.1). Most of these children have a young child themselves (under 12 years), and some of them also work (see Table C.2). The Netherlands accordingly scores very low on the presence of children living at home who could provide care without impediments. Averaged out over all countries in the study, 20% of over-50s have one or more children living at home, but the majority of them face impediments in providing family care. As in the Netherlands, the presence of young children at home in particular plays a key role here (Table C.2). The differences between the countries in the availability of children to provide care are considerable, ranging from around 17% in Spain and Italy to less than 10% in the Netherlands and Scandinavia. This illustrates the fact that parents much more often live with their adult children in the Southern European countries.

Overall, over six out of ten over-50s in the countries studied have potential access to family care within the household, provided by their partner and/or children living at home (Figure 5.3). As Table 5.1 showed, this will usually be the partner. However, a proportion of partners and children will have difficulties in providing help. More than 10% of over-50s have a partner and/or children who encounter these difficulties because of their own health problems, because they have a full-time job or because they have young children. The percentage of over-50s in the Netherlands with a partner (without impediments to providing care) is high, but the percentage with children living at home is relatively small. The Netherlands occupies a middling position as regards the availability of family care within the household. That availability is more limited in the Eastern European countries, especially Estonia, while in most Mediterranean countries the presence of a family network within the household is much more common.

In most countries, the presence of a partner or children living at home does not change over time. However, in most countries, including the Netherlands, they do experience fewer impediments to providing care as time goes by. Belgium and Spain are an exception to this: here, the percentage of partners and children living at home with impediments to providing care rises significantly over time.
WHO CARES IN EUROPE?

Figure 5.3
Share of over-50s with a family network within the household, 2011 (in percentages)

Source: SHARE (2011); SCP treatment

5.4 Presence of a family care network outside the household

Roughly two-thirds of Dutch over-50s have one or more children living away from home. But only 6% of over-50s have children living outside the home who do not face impediments to providing help (Figure 5.4). More than half these children have young children of their own; a quarter work full-time or have a long-term illness; and around a sixth live more than 25 kilometres from their parent(s) (see Table C.3).

Around 1.5% of over-50s have a partner who lives at a different address. There is little variation on this point between the different countries (see Table C.1). These partners are therefore not discussed separately here.

The picture in the other European countries studied is the same as that for the Netherlands on average: between 3% and 8% of over-50s have one or more children who are able to provide family care without impediments (Figure 5.4). Sweden is the exception here: the low percentage of children living outside the home means there are fewer such children without impediments than in the Netherlands. In most other countries, there are more children living outside the home with no impediments than in the Netherlands. On the other hand, working full-time much less often forms an impediment in the Netherlands than elsewhere, because of the high proportion of part-time workers (see section 5.1). Broadly speaking, over-50s in the Eastern European countries most often have children living outside the home, and the Southern European countries...
least often. If we look at children living outside the home without impediments, the picture changes. Relatively few children in the Southern European countries have young children of their own, and travel distance plays virtually no role (Table C3). Most children living outside the home in the Eastern European countries work full-time. The presence of a family care network outside the home, both with and without impediments, has fallen in all countries studied since 2007; the reason is the declining share of over-50s with children living outside the home.

Figure 5.4
Share of over-50s with a family care network outside the household, 2011 (in percentages)

Source: SHARE (2011); SCP treatment

5.5 Presence of a family care network within or outside the household

In the foregoing sections we looked separately at the presence of a family care network within and outside the home. In this section, we consider the two components of the family network together. The reason for doing so is that the lack of a network within the household can be compensated by a network outside the household. In the Netherlands, more than nine out of ten over-50s potentially have access to some form of family care (Figure 5.5). The majority of these people potentially have access to family care both within and outside their own household (46% of the Dutch respondents). A quarter of the over-50s only have a family care network within the household, and one in five only have a family care network outside the household. These figures are around the average for the European countries studied: across Europe, the presence of a family care network ranges from 87% (Switzerland) to 95% (Portugal). These high percentages mask differences between help within and outside the household. For example, few over-50s in the
Southern European countries have a family network outside the household, but this is compensated for by a high presence of family care networks within the household.

Figure 5.5
Share of over-50s by presence of a family care network within or outside the household, 2011 (in percentages)

If we look at the presence of a family care network which could provide care without impediments, we find that a large proportion of the potential family caregivers outside the household work full-time. Just under two-thirds of respondents have access to family members who have no impediments to providing unpaid care (Figure 5.6). In the Eastern European countries, the presence of a family care network that could provide care without impediments is generally lower than in the Netherlands. No substantial changes took place in most countries between 2007 and 2011 in the presence of a family care network without impediments. The only exception is Spain, where this figure increased.
Presence of a family care network for people with severe health impairments

The presence of a family care network is especially important for people with health impairments, and particularly those with severe impairments. Research has shown that people with (severe) health impairments have a smaller network than people with no health impairments (zie bv.Broese van Groenou en Van Tilburg 2007). We therefore examine the extent to which people with severe impairments could potentially fall back on family care (Figure 5.7). See Section 3.4 for information on the prevalence of health impairments in the population aged over 50 in the various countries. More than half the people with severe impairments have one or more family members who could provide care and who are not impeded by illness, work or looking after young children. In addition, 40% of over-50s have family members who do face impediments in providing care. The proportion of people with severe impairments with a family network without impediments is therefore lower (52%) than for all over-50s together, regardless of their degree of health impairment (63%).

The Netherlands scores fairly high on the presence of a family network with no impediments to providing care for over-50s with severe impairments (55%), but scores lowest on the presence of a potential family care network. This means that the overall score for the Netherlands is lower (80%) than average. There are relatively few family members in the Southern European countries who are available to provide care without impediments, but the presence of a family care network (regardless of perceived impediments) is high.
The presence of a family care network for over-50s with severe impairments changed little in most of the European countries studied between 2007 and 2011. Spain is the only country to show a significant increase in the presence of a family care network for those with severe impairments.

Figure 5.7
Share of over-50s with severe health impairments with a family care network (2011)

Presence of a family care network varies with age
The presence of a family care network varies with the age of the person over 50. This applies in particular for the family care network that could provide informal care without any impediments. The age differences for the potential presence of a family care network are small. As people grow older, the presence of one or more family members who could provide informal care without impediments shrinks (Figure 5.8). This holds for most countries, except that in Hungary, Poland and Portugal the network is smallest for those aged between 65 and 80 years.29 To some extent, of course, the shrinking presence of a family care network with advancing age is explained by the declining number of older persons with a partner (without health impairments).

29 The reason for this difference is not clear. It could be related to the relatively small number of people aged over 80 present in the sample for these countries.
Figure 5.8
Presence of a family care network without impediments, by age (2011)

Source: SHARE (2011); SCP treatment

5.6 Conclusion

In order to be able to interpret the differences in long-term care utilisation, it is necessary to know to what extent over-50s have access to a family care network on which they may be able to call if they are in need of care. People who need care but do not have access to a family care network will be forced to make use of publicly funded care or buy in the services they need.

In this chapter, the presence of a family care network was determined on the basis of the presence of a partner and children living at home or elsewhere. The fact that a partner and/or children are present does not mean that they will actually be able to provide family care. There may be several impediments to this: the partner may themselves have health issues; the children may be ill or unfit for work, may work full-time, have young children to look after or live a long way from their parents.

Almost three-quarters of Dutch over-50s have a partner. One in ten have one or more children living at home, while 65% have children living away from home. Together, 90% of Dutch over-50s thus have a potential family care network. This is in line with the average for the European countries studied. On average, two-thirds of over-50s have a family network that could actually provide care because they are not impeded by health issues, working full-time, looking after small children or excessive travel distances. Where children living away from home are not able to provide care, that is often because they work full-time. This is true particularly in the Eastern European countries.
In the Netherlands and most Southern European countries, the presence of a family care network within the household is relatively common. In the Netherlands that is because there is relatively often a partner the present (without health impairments); in the Southern European countries it is because adult children often live with their parents.

Over-50s with no family network at all are the most vulnerable group (10%). In the Netherlands and Scandinavia, people with severe impairments less often have a family network that could potentially provide care than their peers with less severe or no impairments. By contrast, relatively few Southern European over-50s with health impairments appear to lack a family care network on which they could call if they need help.

The presence of a potential family care network varies little between age groups, though the percentage of people with a family care network without impediments to providing care does decline as people grow older. This pattern is the same in most of the countries studied.

The presence of a family care network within the household has remained virtually unchanged since 2007. Furthermore, the impediments to providing care within the family care network have declined in most countries over time. On the other hand, fewer over-50s have a family care network outside the household compared with 2007, with or without impediments to providing care. The presence of a family care network for over-50s with severe impairments changed little in most cases between 2007 and 2011.

Due to data restrictions, the potential care from neighbours, acquaintances and other relatives was not included in this study. This may have led to an underestimation of the total availability of unpaid care. On the other hand, our measure for the presence of a family care network may be an overestimate, because not everyone will actually be willing or able to provide help (possibly because of impediments not reported by us), or at least not the kind of help that is needed.
6 Care utilisation by over-50s in Europe

In the foregoing chapters we described the extent to which countries differ on a number of factors that according to Andersen and Newman (1973) could be determinants for the use of care (what they call ‘health services utilisation’): the structure of the long-term care system, the demand for care and the predisposition and enabling factors for care utilisation. In this final chapter, we describe the differences between countries in the utilisation of care services, i.e. the care actually received by people aged over 50 living independently in the various countries. We investigate both paid and unpaid (informal) care. In chapter 5 we were forced to limit ourselves to the availability of care provided by family members. In this chapter, by contrast, we describe not only (unpaid) family care, but also unpaid care provided by people other than the recipient’s immediate family.

It is not possible to present a complete picture of paid care in this study, because our information covers only part of paid care, namely paid network care. By paid network care we mean private or public care that is given to over-50s in return for payment by people who belong to the recipient’s network. Paid network care may be delivered by private individuals/organisations or by acquaintances or family members. It can include care given to holders of a personal budget who use that budget to pay an informal or formal carer. This corresponds with a portion of the public care described in chapter 2 concerning home care staff. We are therefore not measuring the paid care that is given by constantly changing caregivers, for example, with whom the care recipient feels no bond. This limitation is unfortunately inevitable due to the lack of sufficient information in the SHARE dataset for 2011.

As in the previous study (Pommer et al 2007), unpaid care is interpreted broadly in this study. It includes all unpaid care provided by family, neighbours, friends and acquaintances, but also organised voluntary work.

Where possible, a distinction is made by the type of care that people receive. Help with personal administration or household tasks is for example of an entirely different order from help with personal care and nursing. There can be wide differences between countries in these areas due to the entirely different way in which responsibilities are interpreted. This kind of information is available for family care from within the household for 2011, while for paid care it is only available for earlier years. Appendix D contains a summary of this information for 2007. The frequency and/or intensity of the care delivered is also examined in this study. Here again, countries can differ from each other. In Germany, for example, only long-term and intensive care need is eligible for paid network care. As a result, it is likely that more intensive forms of family care are more common in Germany than in the Netherlands.

As stated in chapter 5, the availability of care as we have been able to measure it here ignores any help provided by neighbours or acquaintances. It is possible that people are
not able to receive help from their family because they live too far away, for example, but that neighbours or acquaintances can step in. In that case, the help actually delivered will exceed the available help as measured in this study. Unfortunately, this inconsistency cannot be avoided because of the available data. On the other hand, although this can occur for some individual over-50s, it is found not to occur at national level.

6.1 Utilisation of paid network care

In this section we explore the use of paid network care. The SHARE survey in 2011 did not explicitly ask about formal paid care received, but only about paid care received from members of the social networks of over-50s. In the SHARE survey, the social network comprises persons who are sufficiently important for the person over 50 that they share their good and bad experiences, problems and concerns. If care is provided by the home care services or a regular private carer, it is possible that the recipient will build a personal relationship with the caregiver. We describe this as paid network care. This by no means maps out the complete utilisation of paid care. The likelihood that someone will class a caregiver as part of their network is influenced by the size of the nuclear and extended family and the number of social contacts. Therefore, we cannot make any statements about the utilisation of publicly funded care in a given country.

This limited picture of paid care means that the percentage of paid network care users turns out much lower than in earlier years, in which respondents were asked about all forms of paid care (see Appendix D). A comparison of the percentages of users of paid network and other care as measured in 2011 with SHARE data for earlier years shows that the level of utilisation was much lower in 2011 than in 2007, in which the questionnaire was more extensive. The patterns in the different countries are not substantially different, however. We therefore mainly discuss the differences between the countries, rather than the absolute percentage of users of paid network care. Section 6.4 contains an estimate of the total amount of paid care in 2011 at the level of the individual countries.

In 2011, 2% of respondents reported that they were receiving paid network care from their social network (see figure 6.1). The percentage is slightly higher in the Netherlands, at 3%. This is because the Netherlands has an extensive system of publicly funded care (as we saw in chapter 2). The share of over-50s receiving paid network care in Belgium is not significantly different from that in the Netherlands. The figure in France is higher, mainly because many people in France receive publicly funded nursing and care services in the form of a personal budget (Joël et al. 2010; Willemé 2010). In addition, Figure 6.1 shows the differences between the long-term care systems in the various countries:

30 The question was: “Most people discuss with others the good or bad things that happen to them, problems they are having, or important concerns they may have. Looking back over the last 12 months, who are the people with whom you most often discussed important things? These people may include your family members, friends, neighbours, or other acquaintances” The people reported by respondents constitute the social network in the remainder of the questionnaire.
responsibility for providing long-term care largely lies with citizens themselves in the Southern and Eastern European countries, and the use of paid network care is accordingly low in these countries. In the Northern and Central European countries, including the Netherlands, responsibility lies much more with government and the use of paid network care is correspondingly higher. As respondents were asked only about care received from their network, the percentage of users in Denmark, for example, turns out low. Publicly funded care is frequently used in Denmark, but people may not regard formal caregivers as being members of their social network. This contrasts with France and Switzerland, where many people hold personal budgets. Evidently, the care recipient and the caregiver have a more personal bond when a personal budget is used, so that this care is recorded as paid network care by the respondents. We shall return to this in section 6.4.

Figure 6.1
Share of over-50s receiving paid network care, 2011 (in percentages)

![Graph showing share of over-50s receiving paid network care in 2011](image)

Source: SHARE (2011); SCP treatment

No information is available on the type of paid network care people received in 2011. If we assume that the distribution does not change much over time, we can conclude that just under half received only domestic help, while over half received personal care, possibly in combination with domestic help (see Appendix D). In some countries, domestic help is regarded as a lighter form of care and is therefore not publicly funded. As a consequence, there are wide differences between the countries.

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31 This is a plausible assumption. The differences between 2004 and 2007 were small, and only significant in Belgium.
32 The Netherlands is one of the few countries where domestic help is publicly funded.
Simply stating the number of people receiving paid network care does not give an accurate picture of the actual care utilisation. Some people will receive care for only a short time, or for only a few hours per week. Others receive care throughout the year, and sometimes that care will be intensive (many hours per week). Here again, based on the generally non-significant changes between 2004 and 2007, we assume that this situation remains stable over time in each country. We can then deduce from the information from earlier waves of the SHARE survey that domestic help in particular is provided for a long period, and nursing and care services much less so.

### 6.2 Utilisation of unpaid care

Not all over-50s who have access to family care will actually receive it. Some do not need help; others will receive paid care; and yet others will make only partial use of the available family care. As in chapter 5, a distinction can be made here between care provided by people within the household and by people outside the household. The SHARE survey asked respondents whether they had received unpaid personal care from a member of their household. The SHARE dataset contains no information on help provided by members of the recipient’s household with things such as domestic or administrative tasks. Household members will generally help unquestioningly with these kinds of tasks. We therefore make the assumption that over-50s with physical, cognitive or psychological impairments receive domestic and/or administrative help from members of their household where these are present. Put differently, we assume that over-50s with a health impairment for which family care is available within the household, will actually receive help with the household (or administration). It is known from the literature that recipients of unpaid care often underestimate the amount of help they receive. In particular, help provided by members of the household in running the home is often not seen as unpaid care, but as something they take for granted.

More information is available on unpaid care provided by non-household members. We know the type of help provided: personal care and/or nursing services, or domestic and administrative help. We also know who provides this unpaid care: relatives, friends and acquaintances or volunteers.

**Unpaid care received from within the household**

More than a third of over-50s in the Netherlands receive domestic or administrative help and/or personal care from someone within the household (Figure 6.2). Roughly 3% receive personal care from someone within the household, possibly in combination with domestic help. Based on our assumptions, the remaining 30% receive only domes-

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33 There may be differences between male and female household members, but the extent of these differences is not known and they are therefore left out of consideration here.

34 The percentage of recipients of domestic help is rather lower than in (Pommer et al. 2007) because we assume here that people with no health impairments do not receive informal domestic help.
tic help. On average over the countries studied here, just under 40% of over-50s receive domestic help and/or personal care from someone within the household. The majority (35% of the over-50s) receive only domestic help; the remainder receive personal care, possibly in combination with domestic help. The high percentage of recipients of domestic help is caused by our assumption that people with health impairments actually receive domestic help if they have someone available in the household who can provide it. Other Dutch research also shows that much more unpaid domestic help is received than unpaid personal care (Sadiraj et al. 2009). There are wide differences between the countries. The Netherlands scores fairly low on receipt of family care from within the household: only the Northern European countries score lower. In the Southern European countries, by contrast, family care is received more often, both domestic and administrative help and personal care. Household composition plays a role here: many over-50s in the Southern European countries have children living at home (see Figure 5.2). The percentage of recipients of personal care is especially high in the Southern and Eastern European countries. The low percentage of recipients in the Netherlands is mainly due to the fact that relatively little personal care is provided by family members, but is more generally provided by publicly funded care professionals. It is also possible that this help is taken for granted and is therefore not considered to be help received. Personal and nursing care are largely provided by professionals in other countries, too. Brandt et al. (2009) show for example that three times as many children help their parents with household tasks than with personal care.

Figure 6.2
Share of over-50s receiving unpaid help from within the household, by type of help, 2011 (in percentages)

Source: SHARE (2011); SCP treatment
Unpaid care received from outside the household

People may can receive unpaid help not just from members of their own household, but also from other members of the social network such as children living away from home, brothers or sisters or acquaintances. A fifth of over-50s in the Netherlands receive unpaid help from someone who does not live in the household (Figure 6.3). This is in line with the average across the countries studied. However, there are wide differences between individual countries. Portugal and Slovenia, for example, score very low (approximately 10% of over-50s receive this help), while the Czech Republic and Denmark score high (over 30% receive unpaid help from outside the household). The percentages are also fairly high in Germany and France, though this is hardly surprising: family members outside the household have a duty of care in these countries (see chapter 2, Joël et al. (2010)).

Figure 6.3
Share of over-50s receiving unpaid care from outside the household, 2011 (in percentages)

There are not only differences between countries in the percentage of people receiving care, but also in the frequency with which they receive that care. Recipients of unpaid care from people outside the household were asked how often they receive that care. The country clusters are again clearly identifiable here (Figure 6.4). The frequency with which unpaid care is received is low in the Netherlands and the Northern European countries and high in the Southern and Eastern European countries. In Denmark, for example, only 12% of recipients receive care on a daily basis from someone who does not live in their own household, whereas in Spain the figure is 57%. The picture is similar for weekly care provision. The frequency and intensity of the care appear to balance each other out. For example, in Northern Europe, the frequency of care received is often high but it is not time-intensive, whereas in Southern Europe it is often precisely the other way round. This is also connected to the care system: family care in Northern Europe is often
voluntary, because publicly funded care is also available. In Southern Europe, by con-
trast, family care is necessary because publicly funded care is unavailable or inadequate
(Brandt 2013).

Figure 6.4
Frequency of unpaid care received from outside the household, 2011 (in percentages)

Source: SHARE (2011); SCP treatment

Finally, it is interesting to look at who provides care from outside the household. We saw
in Figure 6.3 that around 20% of over-50s receive help from outside the household. In
many cases, these are children living outside the home: over 7% of over-50s received help
from such a child in 2011 (Table 6.1, top row). Those children are therefore often the only
people outside the household who provide help: over 5% of over-50s only receive help
from the children (Table 6.1, second row). Financial help often flows from parents to
children, whereas ‘social’ help often flows in the other direction (zie bijv. Attias-Donfut
et al. 2005). A relatively high proportion of over-50s also receive family care from non-
family members such as neighbours and acquaintances. In more than half of cases,
that non-family care is the only form of help that these over-50s receive (2.7 percentage
points of the 4.7 percentage points).
### Table 6.1
Share of European over-55s receiving unpaid care from outside the household, by caregiver*, 2011
(in percentages)

<table>
<thead>
<tr>
<th></th>
<th>Partner parents</th>
<th>brother/sister</th>
<th>child</th>
<th>other relative</th>
<th>others</th>
<th>unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>0.7</td>
<td>0.6</td>
<td>1.1</td>
<td>7.3</td>
<td>1.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Percentage sole caregiver</td>
<td>0.4</td>
<td>0.3</td>
<td>0.4</td>
<td>5.1</td>
<td>0.7</td>
<td>2.7</td>
</tr>
</tbody>
</table>

*a The row 'percentage' shows the share of over-50s receive unpaid care from this kind of caregiver from outside the household. The column 'unknown' indicates the percentage of recipients of care from outside the household where the caregiver is unknown. The second row, ‘percentage sole caregiver’, concerns the number of over-50s who receive unpaid care only from this type of caregiver.

Source: SHARE (2011); SCP treatment

There are wide differences between the countries (not shown in table), but everywhere, the help provided by someone outside the household is mainly provided by children and non-family members. In most countries, children outside the household provide help more often than in the Netherlands. The percentage ranges from 3% in Portugal, where children often live in the same household, to 16% in the Czech Republic. The Northern European countries score higher than the Netherlands on care provided by others (not family members), while the other countries score lower.

### Total unpaid care received
The total picture of unpaid care received (from within and outside the household) reveals that roughly 60% of over-50s in the Netherlands receive unpaid care (Figure 6.5). That is slightly below the average of 65%. Portuguese over-50s receive unpaid care most often (70%). The Southern and Eastern European countries, in particular, score highly. The Dutch and Northern Europeans receive less unpaid help, but the differences are not great. These countries accordingly have extensive systems of publicly funded care. It is less automatic in the Northern countries than in the South to provide care to parents, for example (Daatland en Herlofson 2003). The biggest differences, however, emerge in unpaid care received exclusively from someone within the household. Here, the Southern and Eastern European countries score high, with the exception of Estonia, while the Northern and Central European countries (including the Netherlands) record low scores. This is because of the differences in the extent to which different generations live in the same home, and the opportunities to utilise publicly funded care. Other studies also conclude that the variation between countries in the use of unpaid care reflects differences in the availability of publicly funded care (zie bijv. Bolin et al. 2008a; Pickard 2011). This information indicates that unpaid care is configured differently in the Netherlands than in the Southern European countries, for example. Where children living outside the home play an important role in the Netherlands, that role in the Southern European countries is played by children living at home. This means that greater distances have
to be travelled in order to provide care in the Netherlands. That increases the likelihood that informal carers will find providing care to be a burden.

**Figure 6.5**
Share of over-50s receiving unpaid care from within or outside the household, 2011 (in percentages)

As expected, people with severe impairments receive unpaid care more often than people with no health impairments (Figure 6.6). In the Netherlands, almost 80% of over-50s with a severe impairment receive unpaid care, whereas for all Dutch over-50s together the figure is just over 60%. The Netherlands scores just below the average in the countries studied. The patterns we find for the countries as a whole (over-50s with and without health impairments, see Figure 6.5) are repeated among people with severe impairments, but the figures are higher. In the Southern European countries, for example, 80-90% of people with severe impairments receive unpaid care. This is connected to the reach and importance of family ties in those countries.\(^{35}\) It is worth noting here that the family structures in the Southern countries, too, are changing, and social ties are becoming looser.

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\(^{35}\) It should be noted here that we are assuming that people for whom informal care is available within the household actually receive domestic help if they have health impairments. This reinforces the relationship between health impairments and receiving informal care as measured here.
6.3 Utilisation of unpaid care and paid network care

Now that we have some insight into the differences in paid and unpaid care utilisation across countries, we will look at the two forms of care use together (Figure 6.7). Around 70% of all over-50s make use of paid network care or unpaid care. The figure for the Netherlands is below the average, at 61%. Here again, the differences in care systems are clearly reflected: utilisation of unpaid care is high in the Southern and Eastern European countries and use of paid care low. The picture in the other countries is the reverse of this. Taken together, care utilisation in the Southern and Eastern European countries is substantially higher than in most other countries. We saw in chapter 3 that people in those countries also more often have health impairments. As stated, respondents in earlier editions of the SHARE survey were asked about a much wider range of paid care. The responses showed that three-quarters of those receiving paid care were also receiving unpaid care. This means that, despite the fact that information on some users of paid care are absent from the data for 2011, those people do mostly use unpaid care. This means that the percentage of care users (paid and unpaid together) is a less severe underestimate than it appears at first sight.

As expected, the percentage of care recipients with severe impairments is higher than when we look at all over-50s together. In 2011, 78% of Dutch over-50s with severe impairments received unpaid care or paid network care. That is below the European average of 84%. This means that two out of ten people with severe impairments in the Netherlands do not receive unpaid care or paid network care. That is comparable with the situation in other countries.
Figure 6.7
Share of over-50s and over-50s with severe health impairments receiving unpaid care or paid network care, 2011 (in percentages)

Source: SHARE (2011); SCP treatment

6.4 Utilisation of paid network care and publicly funded care

This chapter describes how much paid network care European over-50s utilise. As stated, that represents only part of the total utilisation of publicly funded care. The SHARE survey from 2007 in which respondents were asked about paid care shows that the amount of paid care received is much higher in practice than the paid network care discussed here (see Figure 6.8). Here we look at the extent to which we can make statements about the use of paid care as a whole in 2011 (when the SHARE survey contained fewer questions about paid care). We looked in various ways at whether we could estimate the amount of paid care utilised in 2011 in a comparable way to the measurement used in the SHARE survey in 2007. A few other methods are described in Appendix E, which produced less good results than the approach presented here.

The estimate of the amount of paid care in 2011 is based on the relationship between the number of users of paid care and users of unpaid care in 2007 and the number of users of unpaid care in 2011. By applying the same ratio from 2007 to the figures for 2011, we can derive an estimate of the number of recipients of paid care in 2011 from the number of recipients of unpaid care in 2007. We assume that this ratio did not change in the various countries between 2007 and 2011. That assumption may not hold in practice, but there are no sources which provide information on this. This calculation cannot be carried out for the countries that did not take part in the 2007 SHARE survey (Estonia, Hungary, Slovenia and Portugal).
Averaged out across the countries, ten times more unpaid than paid care was received in 2007 (not shown in figure). There are wide variations between individual countries, from three times as much in France to more than 100 times as much in the Czech Republic. In most countries, including the Netherlands, the percentage of users of unpaid care in the population aged over 50 has not changed much. Austria is the only exception, with a significant reduction. Applying the 2007 ratio between paid and unpaid care to the unpaid care figures in 2011 suggests that on average the number of recipients of paid care in 2011 was 3.4 times as high as the number of recipients of paid network care measured in this study. Once again, there are wide differences between countries. In the Netherlands, the difference between paid network care and paid care as a whole is just above average. In the Czech Republic, users of paid care outnumber recipients of paid network care by 10%. In Denmark, the figure is more than nine times as high see (figure 6.8). This means that people in the Czech Republic do not receive much paid care from outside their network: the difference between the percentage of paid network care and the calculated percentage of paid care as a whole is small. That is not surprising given the small amount of publicly funded care in the Czech Republic. In Denmark, with its extensive system of publicly funded care, the difference between paid network care and unpaid care as a whole is accordingly much greater.

**Figure 6.8**
Approximation of paid care received by over-50s in 2011 for the countries that were also studied in 2007 (in percentages)

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*No information is available for 2007 for Estonia, Hungary, Slovenia or Portugal. It is therefore not possible to estimate the amount of paid care for these countries. These countries also play no role in the ‘total’ column.

*The percentage of recipients of paid care in 2011 was derived from the percentage of recipients of unpaid care in 2011 and the ratio (per country) between the percentages of paid and unpaid care in 2007.*

*Source: SHARE (2007, 2011); SCP treatment*
As the amount of paid network care heavily underestimates the total amount of paid care in virtually all countries, it is plausible that the percentage of over-50s (with or without health impairments) who do not receive care is still underestimated in the figures presented here. There is a large overlap between unpaid care use and utilisation of paid care. If we further extend the assumption about an unchanging ratio between the number of users of paid and unpaid care to include an unchanged overlap between paid and unpaid care, we can estimate the total utilisation of care in 2011 and therefore the percentage of people who do not receive care.

**Figure 6.9**

Estimate of care utilisation by over-50s in 2011^ab^ (in percentages)

![Chart showing care utilisation by over-50s in 2011](chart.png)

a No information is available for 2007 for Estonia, Hungary, Slovenia or Portugal. It is therefore not possible to estimate the amount of paid care for these countries. These countries also play no role in the ‘total’ column.

b The percentage of recipients of paid care in 2011 was derived from the percentage of recipients of unpaid care in 2011 and the ratio (per country) between the percentages of paid and unpaid care in 2007. The overlap between paid and unpaid care utilisation in 2011 is derived from the percentage of users of paid care in 2007 who also received unpaid care (per country).

Source: SHARE (2007, 2011); SCP treatment

The majority of the total care received in the Netherlands is unpaid care and the amount of that care is estimated to be slightly lower in 2011 than in most other countries (Figure 6.9). This is because in the other countries where the utilisation of unpaid care is also relatively low (France and Belgium), the utilisation of paid care is still higher than in the Netherlands. Only Sweden, Austria and Switzerland have fewer over-50s living independently who receive no care according to our estimates: the utilisation of unpaid
care is at the same level as in the Netherlands, but there is less utilisation of paid care. The percentage of over-50s living independently in Southern and Eastern Europe who receive care is much higher than in the Netherlands, mainly because the utilisation of unpaid care in these countries is much higher.

We also find that the ratio between the percentage of users of paid and unpaid care in 2007 was greater in the Netherlands than in the other countries, which means that more paid care was received on average in the Netherlands than elsewhere (Figure D5). In addition, a relatively high proportion of over-50s with slight health impairments received paid care in the Netherlands (Figure D6). In 2007, for example, 7% of Dutch over-50s with slight impairments received paid care, compared with just 1% in Germany. This means that people were more likely to receive paid care in the Netherlands. In Germany, the percentage of over-50s living independently with severe impairments who received paid care in 2007 was one third lower than in the Netherlands. The percentage of Dutch over-50s with severe impairments receiving unpaid care was not very different from the figure for Germany in 2007: 72% versus 78%. This does not however mean that fewer people with severe impairments receive care in Germany: there is much less of an overlap in Germany between paid and unpaid care. It is therefore not the case that more or fewer people receive some form of care in the Netherlands, but that they much more often receive a combination of paid and unpaid care. The situation in Belgium was different again; here, more paid and more unpaid care was received than in the Netherlands, both by people with severe and slight impairments.

The question now arises of whether people use more care as they grow older. Figure 6.10 provides information on this. People aged over 80 are estimated to utilise care more often than those aged under 80, and this applies for both paid and unpaid care. That said, those under 80 also make frequent use of care services: over 60% of people aged under 80 in the countries studied here receive unpaid care. There is very little difference between those aged under 65 and those aged 65-79 years. The differences are greater for paid care; we estimate that around 3% of those aged under 65 received paid care in 2011, compared with 7% of 65-79 year-olds and 27% of the over-80s. Despite the smaller share of people aged under 65 using paid care, they form a not inconsiderable group. The share of people aged under 65 in the population is larger than that of the older age groups, so that the share in total care use is substantial.

It is striking that the Netherlands is the only country where the percentage of people aged over 80 receiving unpaid care is lower than the percentage of 65-79 year-olds and those aged under 65 (not shown in figure). This may be linked to the wide availability of residential care in the Netherlands, which is not considered in this study. The wide availability of residential care will also mean that those people living at home are less impaired and require less care.
Figure 6.10
Estimate of care utilisation by over-50s in 2011, by age\textsuperscript{a,b} (in percentages)

<table>
<thead>
<tr>
<th></th>
<th>&lt; 65</th>
<th>65−79</th>
<th>≥ 80</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>unpaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{a} No information is available for 2007 for Estonia, Hungary, Slovenia or Portugal. It is therefore not possible to estimate the amount of paid care for these countries. These countries also play no role in this figure.

\textsuperscript{b} The percentage of recipients of paid care and total care in 2011 by age was derived in the same way as in Figure 6.8 and Figure 6.9, but this time by age group. Given the relatively small numbers of users in each country, we only show the aggregate distribution by age for the countries together.

Source: SHARE (2011); SCP treatment

6.5 Conclusion

In this chapter we investigated how many over-50s in the various countries actually receive care. This may be unpaid care provided by family, neighbours or friends (informal care) or paid network care, either private or publicly funded. We made a number of assumptions in seeking to determine who receives care from people within the household. For example, we assumed that available members of the household provide domestic and/or administrative help to over-50s with physical, cognitive or psychological impairments.

A third of over-50s in the Netherlands receive unpaid care from fellow household members, mainly in the form of domestic or administrative help.\textsuperscript{36} Over-50s in the Netherlands receive care from their partners more often than their counterparts.

\textsuperscript{36} Given the assumption that available domestic help is actually converted into practical help.
elsewhere. More than a fifth also receive unpaid care from children living away from home. In total, six out of ten Dutch over-50s receive unpaid care. That is just below the average for the countries studied, mainly due to the relatively low share of care provided by someone within the household. Not only do relatively few Northern European and Dutch over-50s receive unpaid care, but those who do receive it relatively infrequently. In Denmark, for example, only 12% receive care on a daily basis from someone who does not form part of their own household; in Spain, the figure is 57%. The Northern European countries and the Netherlands have an extensive system of publicly funded care.

The Southern European countries, in particular, score highly on receiving unpaid care, both domestic and administrative support and personal care. This is because different generations often share the same home in these countries, and the opportunities to use publicly funded care are small. The same applies for the Eastern European countries, with the exception of Estonia.

Roughly 2% of over-50s receive paid care from someone in their network. Over-50s in France receive substantially more paid care than average, mainly because publicly funded nursing and care is often provided in the form of a personal budget. Responsibility for long-term care lies mainly with citizens themselves in the Southern European countries. Utilisation of paid care is therefore low in these countries. In the Northern and Central European countries, and also in the Netherlands, responsibility lies much more with the government and utilisation of paid care is correspondingly higher. In the earlier years of the SHARE survey, respondents were asked about a wide range of paid care. Although the level of paid care utilisation is substantially lower in the data for 2011 (paid network care), the differences between countries remain comparable.

The percentage of care users rises with age. People aged over 80, in particular, often receive care, though more than half of those aged under 65 and 65-80 year-olds also receive paid or unpaid care.

Some 20% of all over-50s with severe impairments do not receive any informal care or paid network care. There are wide differences between countries on this point. The percentage of over-50s with health impairments who do not receive care is high in many countries, including the Netherlands (over 20%). For some countries, this will be in part because paid care is not fully reflected in our data. In the Southern European countries, the percentage is relatively low (below 20%) because people in these countries mainly receive unpaid care.
References


Chiatti, Carlos, Maria Gabriella Melchiorre, Mirko Di Rosa, Andrea Principi, Sara Santini, Hanneli Döhner en Giovanni Lamura (2013). Family Networks and Supports in Older Age. In: C. Phellas (red.), Aging in European Societies (6, p. 133-150). Springer US.


Golinowska, S. (2010). The long-term care system for the elderly in Poland (ENEPR1 research report No. 83). Brussels: CEPS.


Greene, V. (1983). Substitution between formally and informally provided care for the impaired elderly in the community. In: Medical Care, jg. 21, nr. 6, p. 609-619.


Nationaal Kompas: Diagnostiek van Dementie. rivm. vergaderjaar 2013.


Triantafillou, Judy, Michel Naiditch, Kvetoslava Repkova, Karin Stiehr, Stephanie Carretero, Thomas Emilsson, Patrizia Di Santo, Rastislav Bednarik, Lydia Brichtigova, Francesca Ceruzzi, Laura Cordero,
REFERENCES


Symbolen Depressie. Trimbos-Instituut. vergaderjaar 2013,


Willemé, P. (2010). The Long-Term Care System for the Elderly in Belgium (ENEPRI Research report No. 70). Brussels: CEPS.


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