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Chiara Saraceno
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Social inequalities in facing old-age dependency: a bi-generational perspective

Chiara Saraceno,*

WZB Social Science Research Center, Berlin, Germany

Summary  Population ageing implies the ageing of family and kinship networks. Because the absolute number of the frail elderly is set to increase, notwithstanding the increase in life expectancy in good health, a top-heavy intergenerational chain is likely both to put stress on the middle generation, and result in the older and younger generations competing for their support. Thus, issues of the redistribution of financial and time resources become relevant in the middle and younger generations when frailty emerges in the older generation. This article adopts a bi-generational perspective in order to examine not only whether social inequality affects resources available to the dependent elderly, but also whether and how a frail elderly person’s demands impact differently on children’s resources and life chances across gender and social classes, as well as what the impact of specific patterns of public care provision (other than healthcare) is on these inequalities.

Key words  de-familialization, dependency, familialization, intergenerational relationships, social care, social inequality

Introduction

Social inequalities in old-age dependency may be examined from at least three perspectives. The first considers whether social inequality affects the risk of becoming dependent in old age (Dannefer, 2003; Grundy and Sloggett, 2003; Huisman et al., 2004; Grundy, 2006); the second looks at social inequalities in the resources available to deal with (one's own) dependency (Groenou et al., 2006; Sarasa, 2007; Albertini, 2009); and the third examines the impact of old-age dependency in the structuring of inequality not only on the dependent persons, but also on those who provide care for them. Whereas the first two perspectives are well established in epidemiological and social inequality research, the third has been pursued to a lesser extent, and mainly with regard only to gender differences and inequalities in the allocation of caregiving responsibilities within families. Yet this perspective may be expanded to analyse how a frail elderly person’s demands impact differently on children’s resources and life chances not only across gender, but also across social classes, strengthening pre-existing inequalities and/or creating new ones. Welfare state arrangements are a crucial dimension in these processes.

In this article, I focus on the third perspective, drawing on literature from different research fields, work done on intergenerational relationships within a Network of Excellence, and original research on social policies in the field. In particular, I address the issue of whether and how having a frail elderly parent interacts with gender and social class inequalities and the role played by welfare state arrangements.

The relevance of assuming a bi-generational perspective is threefold. First, population ageing implies ageing of family and kinship networks. This phenomenon has been aptly defined in terms of the
development of the ‘beanpole’ family, in which more generations cohabit the same temporal space, but there are few (or fewer) members in each generation, therefore changing the demographic framework of intergenerational exchanges. In particular, because the absolute number of the frail elderly is set to increase, notwithstanding the increase in life expectancy in good health, a top-heavy intergenerational chain is likely both to put stress on the middle generation and to have the older and younger generations competing for the middle generation’s support. Thus, issues of the redistribution of financial and time resources within families become relevant in the middle and younger generations when frailty emerges in the older generation.

Dependency not only involves dealing with the health system, its organization and its costs. It also involves dealing with needs linked either to the inability to perform basic everyday activities or to the loss of cognitive and intellectual abilities, such as in the case of Alzheimer’s disease. The dependent person may need more or less constant, and often physically strenuous, physical care and/or supervision in order to prevent accidents or injury. These activities tend to be left, totally or in part, to the family (or to the market). Second, the demands of old-age dependency are as time-intensive as those of young children’s dependency, if not more so. Old-age dependency is also less predictable with regard to duration. It poses, therefore, as crucial a work–life–care conciliation problem as the presence of a young child, though without always being as gratifying. Furthermore, it may coincide both with other family obligations and interests of the potential carers and with the carers’ experience of their own ageing. Conciliation discourses and policies, however, tend to focus on the early stage of family formation, when there are small children, largely ignoring the demands and issues emerging in this later phase. Very little research either on conciliating issues and strategies or on conciliating policies addresses the issue of responsibility with respect to old-age dependency, which is the most widespread form of dependency outside that of very young children. This circumstance is partly due to the fact that most family carers are spouses – that is, individuals who for the most part are no longer of working age. Adult children (mainly daughters) become primary carers when a parent, usually the mother, becomes a widow.

Increased women’s labour market participation, however, together with the reduced fertility of the cohorts that are progressively entering the age of highest vulnerability to dependency, is likely to increase the number of adult children who will be faced with the responsibility of caring for a frail parent while being in the labour force and having their own family to care for.

In the first section of this article, I present a conceptual framework for the development of a bi-generational analysis of the social care package for the dependent elderly and of its impact on social inequalities. I then present an updated overview of elderly care policies in all EU countries on the basis of that framework, and discuss the existing knowledge on social class and cross-country differences in patterns of intergenerational support. In the conclusion, I discuss the gender- and class-specific tensions that arise in the caregiving generation as a consequence of the differing availability of private and public resources to cope with the dependency needs of the older generation. On this basis, I argue in favour of research that specifically addresses the bi-generational dimension of policies for care of the elderly.

A conceptual framework

The concept of the welfare mix is particularly fitting when considering care other than healthcare. As pointed out in the social care concept (Daly and Lewis, 1998; see also Anttonen et al., 2003), care – whether it concerns children or other dependent persons – always involves a combination of different providers, among whom the family plays an important role. Furthermore, as both Leitner (2003) and Jensen (2008) indicate, when policies involving (child and elderly) care are at issue, conceptions concerning family obligations emerge much more clearly than in any other area of welfare policy. According to Jensen, these differences in expectations explain why cross-country differences are greater in the area of social care than in that of health, which is apparently so similar.

Elaborating on Korpi’s (2000), Leitner’s (2003) and Leitner and Lessenich’s (2007) conceptual frameworks, I propose to distinguish three different patterns along the familialization/de-familialization continuum. First, familialism by default, or unsupported familialism, is when there are no publicly
provided alternatives to family care and financial support. It can be implicit, but also explicit, as in the case of financial obligations within the generational chain and kinship networks as prescribed by law. Second, supported familialism is when policies, usually through financial transfers, support families in keeping up their financial and caring responsibilities. The third pattern is de-familialization, which is when the individualization of social rights (e.g. with regard to minimum income provision, or unemployment benefits for the young, or entitlement to higher education or to receiving care) reduces family responsibilities and dependencies. In principle, de-familialization of caregiving may occur through both state (publicly financed services) and market provisions (market-provided services or private insurance against social risks). Yet these two paths to de-familialization do not have the same conceptual footing, not only from the point of view of social justice, but also from that of the role assigned to the family. Particularly in the field of care, recourse to market services is inevitably mediated by family resources, and thus is one possible outcome of familialism by default. Families remain a relevant, and highly socially differentiated, actor at least as employers or buyers of paid care. Social and economic inequalities are therefore relevant when de-familialization occurs through the market rather than the state. There may also be a fourth pattern, optional familialism, when, particularly in the area of care, some kind of option is given between being paid to provide care to a family member and using publicly supported care. However this pattern is very residual.

The higher the familialism by default, the higher the possibility that social inequalities have a negative impact on the quality and the quantity of care received (other than healthcare) and even more so on the resources and options of the family caregivers. Inequalities in access to public and market services, in fact, might be compensated with an increased recourse to family support (Rostgaard, 2002; Albertini, 2009), reducing inequalities among old people needing care, but increasing inequalities between potential family carers. This development in turn affects both gender inequality and inequalities among women. To a lesser degree, this situation may also develop with supported familialism (see also Korpi, 2000).

Unfortunately, the available data on non-healthcare-related policies for the frail elderly are far less systematic, complete and updated than data on childcare policies. This circumstance is partly due to the often scattered and locally based nature of social care policies, as well as to their great diversity across countries. Compared with data collection for the childcare sector, there is still little systematic effort at data collection for the various kinds of provision and their actual coverage. Data on institutional care are more readily available than data on home care, which represent two quite different modes of de-familialization. Furthermore, notwithstanding a growing body of research on intergenerational exchanges between the frail elderly and their adult children, the insights gained from these studies remain fairly marginal in policy research.

Patterns of care policies for the frail elderly in Europe: how much is left to families?

Access to social care resources and forms of familialism and de-familialization

Three important dimensions of welfare state arrangements are relevant for comparative purposes and also for the issue of the – social class mediated – intergenerational impact of old-age dependency. The first is whether support (not related to healthcare) is income-tested or universal. The second is the threshold of dependency above which one is entitled to receive support. The third is how much of the individual need is covered (see also Rauch, 2007).

The first two dimensions of programme design impact on individual and family resources in two ways: they define who is entitled and when, and thus who is left, and for how long, to his or her own and family resources. The third dimension defines how much individual need is left to be provided for by private means after public intervention. They can therefore be used as a first indicator of the degree of de-familialization of needs in the various countries versus familialism by default. To these, two other important dimensions of programme design must be added: whether support is offered in kind or in money or a combination of the two (see also Jensen, 2008); and, if it is offered in money, whether there are specific rules on how it should be spent. These two further dimensions allow a
distinction between de-familialization through publicly provided services, de-familialization through market services supported by public money and supported familialism. The higher the amount of care left to families due to the interplay between threshold levels and intensity of the care provided, the greater the role that socio-economic and gender differences play in the ability to substitute one’s own care. Furthermore, when support is offered in money rather than in kind, trade-offs between using it to buy services and keeping it for the family budget while providing care directly, even at the cost of reducing labour market participation, are different for women in different socio-economic circumstances.

Unfortunately, no sound comparative data exist on all these dimensions. Figure 1, which is based on both available comparative sources and national sources (often gathered through the help of informants), gives only a very general idea of the diversity in the coverage and the composition of public effort in care provision. Missing from these data are payments for care. Such payments may represent an alternative way of providing services, allowing beneficiaries to purchase services of their choice directly; thus, they may be conceptualized as a form of supported de-familialization through the market, as in the Dutch individual budget or in the care allowances in France, Portugal and, to an increasing degree, Spain. However, they may also be offered instead of providing services, as in Italy and some of the eastern European countries, thus encouraging a form of (implicit) supported familialism. Or, as in the case of Germany, they may be offered as an alternative to services, providing a choice between supported familialism and (partial) de-familialization.

In its extreme simplification, Figure 1 shows that availability and type of services vary widely across the EU and that no specific clustering of countries emerges. Denmark clearly stands out for its high level of coverage and, thus, de-familialization. However, as noted by Rauch (2007), there is no clear Scandinavian pattern, for the Netherlands and Austria offer higher coverage than Sweden and Finland. Also, the UK, France and Belgium are not very dissimilar from the two less de-familialized Scandinavian countries. The Mediterranean countries and the eastern European countries are generally the least de-familialized. However Portugal, the Czech Republic and Estonia distinguish themselves for their relatively high provision of home-care services.

Of course, these figures give just a very generic overview of the degree of coverage. Data are missing on intensity of coverage in terms of the number of hours of services, particularly in the case of home care. With the present state of available knowledge, it is in fact impossible to calculate full-time equivalents, as attempted by Rauch (2007) for a much smaller number of countries, as only a limited number of countries have the rules concerning time coverage clearly spelled out in official regulations at the national level. Furthermore, Rauch’s decision to lump together as ‘full time’ residential care and care for at least 10 hours per week is highly debatable.

Qualitative information drawn from the literature and from research conducted within the MULTILINKS project allows for a more integrated picture of the different policy approaches from the perspective of the degree and patterns of familialism or de-familialization, and therefore of their possible impact on social inequalities both among the frail elderly and on their children. In Denmark, municipalities have the legal responsibility to provide services free of charge to all who are above a given dependency threshold. Coverage is high and has increased in recent years (37% of those over 65 years old received some support in 2005), but domiciliary care intensity (i.e. care time) is relatively low. Thus, de-familialization is widespread in terms of people covered, but not in terms of overall individual need (Rauch, 2007; Doyle and Timonen, 2008). A similar situation, with lower levels of coverage, is found in Norway (Pacolet et al., 2000). Sweden in recent years has restricted coverage, introducing also some ‘family availability’ test (Rauch, 2007), while intensifying the care provided. Dependency thresholds that give access to public support have been raised, but the care provided for the most dependent is more intensive (Theobald, 2005; Larsson, 2006). As a consequence, de-familialization has increased for the latter, whereas familialism by default has increased for the less dependent. In addition, according to Rauch (2007), decentralization of decision-making has opened the way to a higher degree of discretion, weakening the universalistic approach. In the Netherlands, where there was a strong tradition of residential care, there has been a shift since the 1990s towards home care, which is less time-intensive. The introduction of personal budgets, which may be used to compensate both formal and informal care providers, has further facilitated the shift from formal
Figure 1  Institutional and at-home care for the elderly in the EU (percentage of the total population over 65 years old).

Note: The period for which information is available ranges between 1996 and 2006, but for most countries it is around 2003.

Source: Author’s calculations on the basis of various sources within the MULTILINKS project. See Saraceno and Keck (2008).
de-familialization to de-familialization through supported commodification. Coverage is fairly high (22% of those over 65). The relatively low time-intensity of home services, together with the fact that users must contribute to the cost of services and the possibility that the individual budget may be used to hire a family member, leaves room both for familialism by default and for supported familialism. France has a similar model, but with more rigidly defined and tighter thresholds. The share left to familialism by default is therefore greater. In Portugal since its 2006 National Action Plan and in Spain since the passing of its 2006 law on dependency, there has also been a shift from an allowance system (supported familialism) to a pattern of provision somewhat similar to the French and Dutch schemes, though overall coverage remains low and thus the space left to familialism by default is therefore greater. In Portugal since its 2006 National Action Plan and in Spain since the passing of its 2006 law on dependency, there has also been a shift from an allowance system (supported familialism) to a pattern of provision somewhat similar to the French and Dutch schemes, though overall coverage remains low and thus the space left to familialism by default is therefore greater. In Portugal since its 2006 National Action Plan and in Spain since the passing of its 2006 law on dependency, there has also been a shift from an allowance system (supported familialism) to a pattern of provision somewhat similar to the French and Dutch schemes, though overall coverage remains low and thus the space left to familialism by default is therefore greater.

Since the 1980s, the UK has moved away from residential care and towards home care, increasing its provision of domiciliary services and, like Denmark, developing systematic coordination between the healthcare, social-care, transportation and housing sectors. Some form of de-familialization through home-care services has thus been extended to a larger share of the population. This shift has, however, also implied a greater explicit reliance on informal, supported and unsupported family care (Twigg, 1998; Milne et al., 2001). Dependent persons who previously would have been in residential care are now cared for at home through a cooperative arrangement between formal and informal carers. This pattern is prevalent also in Finland (Rostgaard, 2002). Furthermore, while generally payments for care are directed to the person needing care, not to the family carer, in the UK and Finland payments for care may be received directly by the family carer. Thus in these two countries supported familialism is more clearly formalized than in others.

In recent years, in eastern European countries there has also been a growing tendency to move away from institutionalization as the main means of providing care and towards home care and day care (European Commission, 2008). However, coverage remains low, and families continue to be the main providers of care.

In Germany, access to support became universal in 1995 with the introduction of the insurance scheme for long-term care. However, the minimum dependency threshold is higher and more formally defined than in the Netherlands and Denmark, thus leaving a larger proportion of need unsupported (Rauch, 2007). Furthermore, in Germany support may be received in the form of residential care, domiciliary or day care, or money that can be spent without restriction. Given that the services provided cover only a fraction of needs (although they do increase with the level of dependency), the majority opt for the financial allowance, which can be used either to supplement the household budget or to pay for informal care. Only recently, probably due to the increase in women’s labour force participation, has the service option increased. Overall, Germany seems to represent a case in which a share of the care needs of older persons is met through an option between de-familialization and supported familialism, with another large share left to familialism by default. Social assistance helps to partially reduce the bridge between those who cannot pay for additional services and those who can.

In Italy and some of the eastern European countries, the main support policy for disabled adults and frail elderly persons is the dependency allowance. Residential care covers only a fraction of dependent persons, who must contribute on the basis of their income. Home-care services are scarce and often means-tested or paid on the basis of household income. The dependency allowance is intended to cover the additional expenses incurred through meeting (non-medical) care needs. It is universal, but the dependency threshold giving access to it is very high. Only completely disabled persons may receive it (Ranci, 2008). In these countries, therefore, the balance is tipped towards a combination of familialism by default and (implicit) supported familialism. In recent years in Italy, the latter is also partly evolving towards commodification, with recourse to the migrant labour market (Bettio et al., 2006; Naldini and Saraceno, 2008). However, the lower the income both of the frail elderly person and of his or her family carers, the more likely it is that the allowance will be used for needs other than care and that the care will be completely provided within the family.

Policies to support work–family conciliation for working carers

Since a larger or smaller proportion of care is undertaken by family members, the ability to remain in the labour market when a family member requires care may be affected not only by care policies aimed to the care dependent persons, but also to carers.
Once more, this impact differs across countries, depending on the amount of care left to families. It differs between men and women, given the prevalent division of labour and the different position of men and women in the labour market. It also differs across social classes depending both on the private resources available to buy care and on the position in the labour market.

According to the 2005 European labour force surveys, 6.2% of all people in employment – 7.8% of women and 4.9% of men – had some care-related responsibility for an adult relative. There are relevant cross-country variations, ranging from 14% of women and 9% of men in Cyprus to slightly over 1% of women and 0% of men in Luxembourg. The percentage increases with age and is highest in the 50–64 age bracket, where it involves 10.5% of all the employed (13% of women, less than 8% of men). There is no clear pattern overlapping with any welfare state typology. However there does seem to be an inverse relationship between the percentage of working women, particularly in the older age bracket, and the percentage of employed persons who have this kind of caring responsibility, suggesting some kind of trade-off between working and caring. Data on the number of hours and overall frequency are not available.

A survey of older workers in Europe (European Foundation, 2008) found a higher incidence of caring obligations. According to this study, 20.3% of all workers (25.6% in the 45–56-age group) provide care in some capacity for a disabled or elderly relative. In particular, slightly less than 10% of workers in the 45-and-over age group cares for a disabled relative or frail elderly person for at least one hour every second day. Women between 45- and 54-years-old often combine this care with care for children or grandchildren.

Whatever the difference in estimates, these data indicate that a small but not marginal share of older workers in Europe, particularly women, have some kind of work–family conciliation problems with regard to caring demands from a dependent person. Others may have had to drop out of the labour force because of these demands. The share of workers with care responsibilities for older persons will probably increase in the coming years due to changes in women’s labour force participation and changes in the retirement age. Although supported familialism, which encourages family care, may partly compensate the loss of income due to care responsibilities, it does not compensate for the risk of poverty in old age created by these ‘choices’, particularly among those more likely to make such choices if there are no other care provision alternatives: women with low wages.

The issue of work–care conciliation in later phases of working life has started to be addressed only very recently and only in very few European countries. Most countries are still far from developing an integrated approach like that found for childcare. In particular, the instrument of – for the most part unpaid – leave is very rare. Germany finally introduced a six-month unpaid leave in June 2008. Italy has offered such an option since 2000. In addition, employees who carry the main responsibility for a dependent relative are entitled to 25 days of paid leave per year to assist a disabled family member. In France, an unpaid leave of three months was introduced in 2006. Austria and Belgium have a similar provision. In the Netherlands, employees may take up to 10 days per year, with at least 70% pay, to care for a sick child, partner or parent living at home. They may also request a longer leave, reducing their working time, but there is no entitlement and access to leave is subject to negotiations with the employer. In Portugal, workers are entitled to a maximum of 15 unpaid days per year to care for an ill child, partner or close relative. In Sweden, entitlement to a paid short leave pertains only to situations in which there is impending death. In the UK, employers are required to allow employees to take time off in case of a family emergency under the family leave directive, but they are not required to pay the employee during that period (Montgomery and Feinberg, 2003). Specific agreements within labour contracts, such as working time accounts, which are particularly widespread in the Netherlands and Germany, may also be used to cope with dependency needs in a family, though their gender-typical use might be a further cause of gender inequality among workers.

From these examples, it seems that countries which have moved further towards de-familialization are less likely to acknowledge the needs and problems of working family carers and vice versa. Recently, in response to a consultation by the European Commission with regard to the conciliation of work and family life, an umbrella group of associations – AGE – advanced a proposal for an EU-wide introduction of a care provision leave for
workers carrying the responsibility for older depend-ent family members.

Cross-country and cross-class differences in patterns of intergenerational support

So far, I have argued that different policy approaches may have a weakening or on the contrary strengthening impact on social inequalities, particularly among carers. But is there any empirical evidence of social class differences in providing care to a frail parent? And, if there are, to what degree is there evidence that they depend also from policy settings?

Comparative data on younger generations providing care for older generations are scarce. Both the European Social Survey and the Labour Survey, while rich on data on childcare, offer very generic information on elderly care. Only data from the Survey of Health, Ageing and Retirement in Europe (SHARE) allow one to specifically focus on intergenerational support and on the characteristics of both parents and adult children, although the specific impact of caring is not thoroughly analysed. Available data, however, offer an important starting point in this direction. In particular, studies on intergenerational exchanges indicate that in the developed countries financial transfers flow downwards from the older to the younger generations through inheritance, gifts and *inter vivos* donations (Kohli, 2004; Attias-Donfut and Wolff, 2000a; 2000b; Albertini et al., 2007). A prevalence of financial transfers upward from the middle to the older generation is found only in countries or social groups with high levels of poverty and/or where the elderly have no access to an adequate pension, which is the case in particular for first-generation migrants from developing and/or poor countries (Attias-Donfut and Wolff, 2008; Baykara-Krumme, 2008; Björnberg and Ekbrand, 2008). Care/time transfers, by contrast, flow both downwards, from parents to children and grandchildren, and upwards, from adult children to frail elderly parents. For this reason, the middle generation, and particularly the women in this generation, is sometimes referred to as the ‘sandwich generation’: caught between the dual demands of support (primarily in the form of care provision) coming from both above and below (Grundy and Henretta, 2006).

At the comparative level, for both types of transfers, both European Community Household Panel (ECHP) data and SHARE data suggest that there is a north–south gradient, with more people providing some kind of support in the northern (more de-familialized) than in the southern (less de-familialized) countries. However, the gradient is reversed when intensity is considered, with many more people providing help regularly and frequently in the southern countries than in the northern ones (Ogg and Renaut, 2005). For instance, based on ECHP data, Sarasa and Mestres (2007) found that only 20% of Danish family carers spend at least 20 hours per week taking care of any adult, compared to 48% in the UK, 40% in Austria, 39% in Germany and over 70% in Spain. If we enlarge the range of countries, however, the picture is less clear and even suggests a poor countries–rich countries gradient, including for the frequency of giving support. For instance, the 2002 Eurobarometer survey found that 17% of all adults in the EU-15 provided care in some capacity for a ‘frail elderly or disabled person’ not living with them and that a similar percentage of adults provided care for a co-resident dependent person (Alber and Kohler, 2004). The figures were, respectively, 18% and 23% in the 10 new member states and the (at that time) three candidate states. The same picture emerged in the 2003 European Quality of Life Survey, although with lower percentages (Saraceno and Olagnero, 2004).

Generally, these findings contradict the thesis that generous, more de-familialized welfare states crowd out intergenerational solidarity, and that expectations of public responsibility weaken willingness to take up individual responsibilities (see also Künemund and Rein, 1999; Keck, 2008; Künemund, 2008). Rather, these findings suggest a division of labour between publicly provided or financed services and family care – a mixed economy of care, as Motel-Klingebiel et al. (2005) have put it. At the same time, these findings suggest that in less de-familialized caring regimes, intergenerational solidarity is a crucial resource that must be managed selectively and in the most efficient way possible. Kalmijn and Saraceno (2008) find, for instance, that need plays a stronger role in the southern than in the northern and continental countries in activating intergenerational support for the elderly. Thus, in the southern countries, the generation in a position ‘to give’ is under more pressure to do so when needs arise, for lack of alternatives. As a consequence, more than elsewhere, the trade-offs are likely to be
tighter, and resources of time and/or money may be overstretched (and somebody may have to go without, if the resources are insufficient).

Sarasa and Billingsley (2008), on the basis of SHARE data, offer important insights from this perspective. First, no matter the welfare regime, the parents’ economic status is a key factor in whether adult children provide help with personal care and household tasks: the lower the parents’ socio-economic status, the higher their (female) children’s involvement. This finding corresponds with that of Groenou et al. (2006), who found that, in general, individuals with a low socio-economic status receive substantially higher levels of informal care even after adjusting for other individual characteristics. Second, children’s economic status is also important. Children with a higher level of education, and whose parents are on average also better educated and wealthier, are less likely to help directly with personal care and household tasks than are children with lower educational levels; thus, their daily engagement is lower and less intensive. Only in Sweden and Denmark does children’s education not make a difference, probably because the intensity of such help is generally low. Third, in the southern countries, where almost all non-family care must be bought on the market, access to non-family care by the frail elderly is very unequal across social strata. In these countries, low-income children of low-income dependent parents, particularly daughters and daughters-in-law, are left with a larger share of care work than are middle- and upper-class children, further reducing their ability to remain in the labour market and hence creating the conditions of old-age poverty for themselves. Furthermore, some studies (Olagnero et al., 2005; Albertini, 2007, 2009; Kohli and Albertini, 2007) indicate that, although the family networks of the poor are able to mobilize as much support as those of the non-poor, on average these networks are more restricted and therefore also more vulnerable to burnout. The degree of de-familialization, more than of supported familialization, is therefore particularly crucial for them.

It is possible that social class differences in patterns of intergenerational solidarity depend also on differences in cultural norms, as suggested, for instance, by Johnson and Lo Sasso (2000) and Kalmijn (2006). The different opportunity structures within which working-class and middle-class adult children reach their decisions about providing care for a frail elderly parent should however not be overlooked. First, studies indicate that working class children are on average less geographically mobile than middle class ones. Therefore, they more often live near a parent when he or she becomes dependent (Kulis, 1987; Tester, 1996). Second, the middle-class has more resources to buy care than does the working-class. In this perspective, the degree of care coverage offered by public policies is crucial for the impact that these social class differences have on the options available to meet caring obligations. According to some studies (Carmichael and Charles, 1998; Sarasa, 2008), over 20 hours per week of caregiving significantly contributes to the likelihood that the caregiver will reduce or altogether abandon his or her paid work. Hence, not having the option either to use publicly provided care or to buy it on the market exposes a carer to economic losses with both short- and long-term consequences (e.g. with regard to pension wealth). Furthermore, the trade-off is tighter when current and prospective income from paid work is low (Henzi, 2006; Tjadens and Pijl, 2000). In countries where familialism by default is highest, therefore, social inequalities have a greater impact on what options are available than they do in the most de-familialized countries.

Both cultural expectations and opportunity structures are gender-specific. It is women, more than men, who are directly affected by cultural expectations about caregiving across the intergenerational chain. Moreover, the trade-off between work and caregiving, including care provision for one’s own family and for a frail elderly parent, is more constrained for women than it is for men. The impact of dependency demands, however, is not homogeneous across all women. On the one hand, moral careers (Finch and Mason, 1993) may be different within a particular family among daughters/sisters, as well as among sons/brothers. When there is more than one child of the same sex, the decisions about who will take on the main responsibility for caring for a frail elderly parent depend on a complex set of circumstances, where individual biographies (e.g. whether or not one has children, is married, lives near the parent, has paid employment) interact with moral careers as well as with power struggles (e.g. Keck and Saraceno, 2009). On the other hand, women with limited economic means have fewer resources than do women with better wages, who can purchase part of the caregiving work. In countries
where support takes the form of financial transfers, these women may face an even more difficult trade-off between staying in a poorly paid job and paying for some service, keeping the money for the family budget and caring full time, or keeping the money for the family budget while juggling work and caring obligations. A qualitative study on employed family carers in Germany (Keck and Saraceno, 2009) found that it is mainly the households and carers in difficult economic conditions that opt for the ‘allowance only’ take-up of the country’s long-term insurance, providing the care themselves, in addition to work and other family obligations. In Italy too, the lower the household income of both the recipient and his or her family carers, the higher the probability that the allowance will be used to cover household needs, not to purchase outside services (Da Roit, 2008).

Conclusion

Patterns of public support for care provision are neither gender-neutral nor neutral in terms of social class. Furthermore, the little empirical evidence that does exist suggests that the impact is greater on family caregivers than on care recipients, at least in terms of coverage. On the one hand, in fact, the less generous countries tend to target their support to the poorer, thus partly reducing the latter’s comparative disadvantage. On the other hand, data on patterns of intergenerational support indicate that there seems to be a substitution effect within the care package: the fewer public services provide, the more the recourse to family or market care. However precisely this mechanism places a heavier burden on family carers – the spouses and children, particularly those in low-income households who cannot take recourse to the market. Research data indicate, in fact, that not only the lower the parents’ socio-economic status, the higher their (female) children’s involvement, but also the lower the children’s economic status, the higher their (female) involvement in hands on care. What may be functionally equivalent from the perspective of the frail elderly person (Rostgaard, 2002), is not so from the perspective of caregivers. As suggested by Leitner and Lessenich (2007), de-familialization and the varieties of familialism must be looked at from the perspective of both the cared for and the carers.

In no EU country is care for the elderly (other than healthcare) fully de-familialized, although in all countries there is some universal entitlement to some form of support, through services or through money. Furthermore, means testing is more frequently implemented, if at all, in the case of service provision than in the case of financial benefits. Families, therefore, still play an important role in providing care. However, for the same level of need, the intensity and indispensability of this role vary depending on the institutional framework, which in turn brings into play the gender and socio-economic inequalities among family carers. The most significant cross-country differences concern the dependency thresholds giving access to support, of how much of the caregiving needs is assumed as a public responsibility, and whether the support is provided mainly in services or in money (i.e. by means of direct de-familialization or by means of either supported familialism or supported commodification). Although payment for care has become quite widespread in Europe (Ungerson, 2004; Pavolini and Ranci, 2008), its role and meaning vary significantly depending on the particular context. In the Netherlands, France, Spain and Portugal, payment for care represents a different way of paying for formal services. In Italy, Germany, Austria and some of the eastern European countries, where payments are made – instead of providing services – to the care dependent person who can use them as they see fit, including paying for informal care, it represents a form of acknowledgement of the additional costs supported by a disabled person. In the UK and Finland, where there are specific payments for informal, including family, carers, it is a way of acknowledging the costs incurred by the carers. These cross-country differences result also in different systems of incentives and constraints, which can have an impact on the social inequalities experienced by the care recipients and, even more so, their family carers.

National and comparative survey data, as well as qualitative studies on intergenerational support, show that the higher the space of familialism by default, and to some degree also of supported familialism, the higher the impact of gender and social class differences among the potential family carers. Gender and class interact. Women with a weaker position in the labour market – due to either a lack of skills or a history of caregiving – are more likely than both men and higher skilled women to be in the forefront of familialism by default or supported familialism. Households with tight budgets...
may have less recourse to services either because they cannot afford them or because they ‘prefer’ to use the care provision payment for everyday expenses. When low income characterizes both the dependent and the caregiving generations, the scarcity of resources and of options redoubles. These situations present high risks both of overburdening and of under-caring. Caregiving obligations with no (even partial) alternative and no conciliating instrument may also make it difficult to remain in the labour market, thus setting in motion processes of short- and/or long-term impoverishment.

Even in contexts with a relatively high level of service provision, forms of cost containment or rationalization are not always neutral with respect to social class and gender. Knijn (2001), for instance, argues that the introduction of co-payments for public services in the Netherlands has led to quite different behaviour among low- and high-income groups. The former has increased its family care provision. The latter has increasingly turned to the market. Targeting the most dependent elderly persons, as in Sweden, may relieve their family carers, but at the same time it reduces support for those with lower levels of dependency who are left to their own – unequal – means and those of their family members. This situation might in turn intensify social-class and gender inequalities.

All these consequences affect the well-being and the options both of dependent persons and of family carers. The two perspectives, however, are rarely considered together in research and even less so in policy-making. Not only in the countries where there is a greater likelihood for familialism by default, but increasingly also in the most de-familialized countries, under the pressure of budget constraints, policies seem to assume as given the presence of family carers, without really addressing their actual availability and the effect that caregiving obligations have on their life chances and well-being. Furthermore, whereas social inequalities among care-dependent persons are a more or less explicit focus of policies, social inequalities among family caregivers are not. As a consequence, the issue of how specific forms of provision impact on social inequalities among family carers remains largely ignored in policy design and policy debates. In addition, empirical research and available data are scarce, particularly with regard to children who have caregiving responsibilities for a parent. A bi-directional and bi-generational approach in research as well as in policy planning needs to be developed. Such an approach is necessary particularly because the caregiving obligations of the younger to the older generation may become a new form of gender and social inequality and of the inter-generational transmission of inequality.

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Notes

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2 Following Leitner, I disagree with Rauch’s (2007) assumption that leaves and payments for care are a form of de-familialization. On the contrary, they represent a form of supported familialism.


References

Social inequalities in facing old-age dependency


