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20 The economic crisis, fiscal austerity and long-term care: Responses of the care mix in three adjustment countries

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- ▶ Did austerity in the three southern countries reduce access to long-term care?
 - ▶ The proportion of needy individuals without any care ('the care gap') *shrank* between 2007 and 2016. Despite austerity, *professional* care and not family based solidarity expanded
 - ▶ This paradox can be partly explained by the maturation of formal systems and partly by beneficiaries' incomes falling less than the wages of carers in the open market
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20.1 Introduction

SHARE Wave 2 was collected in the year immediately preceding the financial crisis; SHARE Wave 6 was collected in the year during which most countries considered the financial crisis to be over. Three southern European countries that participated in both waves (Greece, Spain and Italy) were affected by the financial crisis and implemented deep austerity programmes aimed to, *inter alia*, control public expenditures (Tinios, 2017). Long-term care (LTC) is an example of a family need that is met by a mix of public, private professional and family care. Given that most formal care is provided by public entities, LTC is likely to be on the receiving end of austerity policies (GBD, 2018). If access to public LTC is affected, the family will be called on to make up any deficit using its own resources. These resources could entail access to bought-in professional services from the private market and could also mean relying on informal solidarity provided by the family or other social networks.

Thus, LTC is an interesting case that lies on the cusp between public and private, formal and informal markets and family. The timing of economic developments is also important because they have occurred when at least two other secular changes were underway: the rapid ageing as the (slightly delayed in southern Europe) baby boom generation advanced in age and the transformation of gender roles as cohorts of women with very different career profiles (better educated, more exposed to paid work) entered retirement.

Studying the effects of the crisis during an 8-year period in countries anyway undergoing social change could give us a glimpse into how families marshal their resources – both social and economic – to meet challenges (Lyberaki and Tinios, 2014). Final outcomes on access to care, as well as on the LTC care mix, will be affected by supply (austerity) and demand factors (income falls) and price factors such as co-payments, and the relative price of care may also play a role.

The aim of this chapter is to identify how and whether LTC needs were met. We do so by focusing on three southern European countries that participated in both Wave 2 and Wave 6 (Greece, Italy and Spain) and that share a familial LTC model (Bettio and Plantenga, 2004; Lyberaki, 2011). The focus will be on the care gap (as a measure of unmet need) and the care mix (as a measure of household response). Greece, the country facing the deepest crisis, participated in the first three waves of SHARE, dropped out of Wave 4 and Wave 5 and only re-joined with an enlarged sample in Wave 6. Thus, SHARE affords a unique opportunity to track how a deep and protracted crisis affects the decisions made by older individuals.

20.2 Have needs for care changed?

If ageing is proceeding rapidly, we would expect that the *needs* for LTC are growing if they are largely physiologically determined. We can measure needs conventionally using the reported limitations in Activities of Daily Living (ADL) (e.g., Clark, 2004). If we focus on the group chiefly affected by longevity – those aged over 80 years – we *should* see an increase in care needs as reflected in the demand for care.

Figure 20.1 confounds easy expectations. The care needs of those over 80 between 2007 and 2015 were certainly *not* increasing and, at least for some women, may have *declined* considerably. This decline was particularly marked for Greece, where the needs of women clearly diverge from those of men.

20.3 Did the crisis leave more needs unmet?

The indicator we examine next could be called the ‘care gap’ – the people who, having declared that they cannot fulfil more than two ADLs, appear not to receive *any* care, whether formal or informal. Given the austerity narrative, our central expectation is that care gaps would *increase*. Again, we see that these

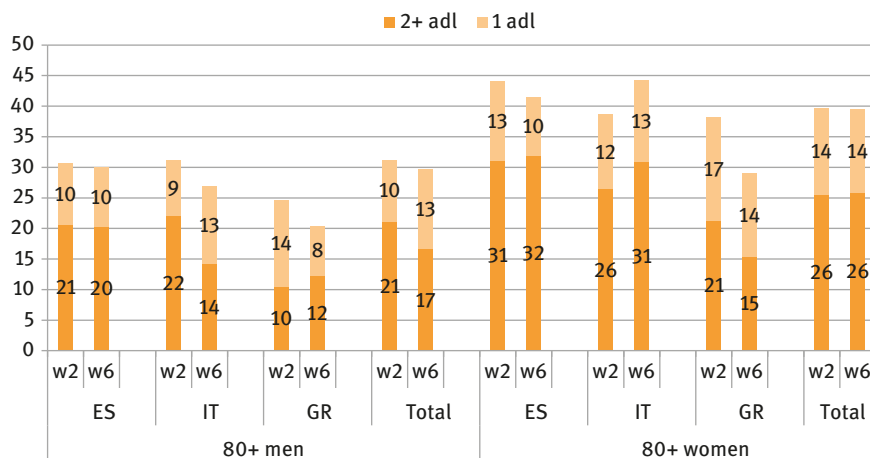


Figure 20.1: Persons with ADL limitations, by gender, persons 80+, Wave 2 and Wave 6.

Note: 'Total' refers to the 12 countries that participated in both Wave 2 and Wave 6.

Source: SHARE Wave 2 and 6 release 6.1.0.

expectations are not confirmed (Figure 20.2). Care gaps do not increase but, in contrast, appear to *decrease* – substantially for those older than 80 years of age. The decline is largest in Greece, the country hardest hit by austerity – in direct opposition to expectations. Comparing our southern European picture with other countries in the SHARE sample, we see that the decline in gaps (especially for the older group) is a European phenomenon that most likely results from the maturation of LTC as a social policy sector (the most dramatic declines occur in Scandinavia and eastern Europe).

20.4 Type of care received

SHARE distinguishes care as professional (*both* public and bought-in, but supplied by professionals) and informal, which is typically supplied free by members of social networks (mainly within the family).

The austerity narrative predisposes declines in *formal* care; state provisions were continuously under threat, whereas family incomes were severely squeezed. Again, the opposite holds. Figure 20.3, which shows changes in the care mix between 2007 and 2015, indicates that *formal* care and *not* informal care is increasing. This situation is particularly noticeable for those 80+ years

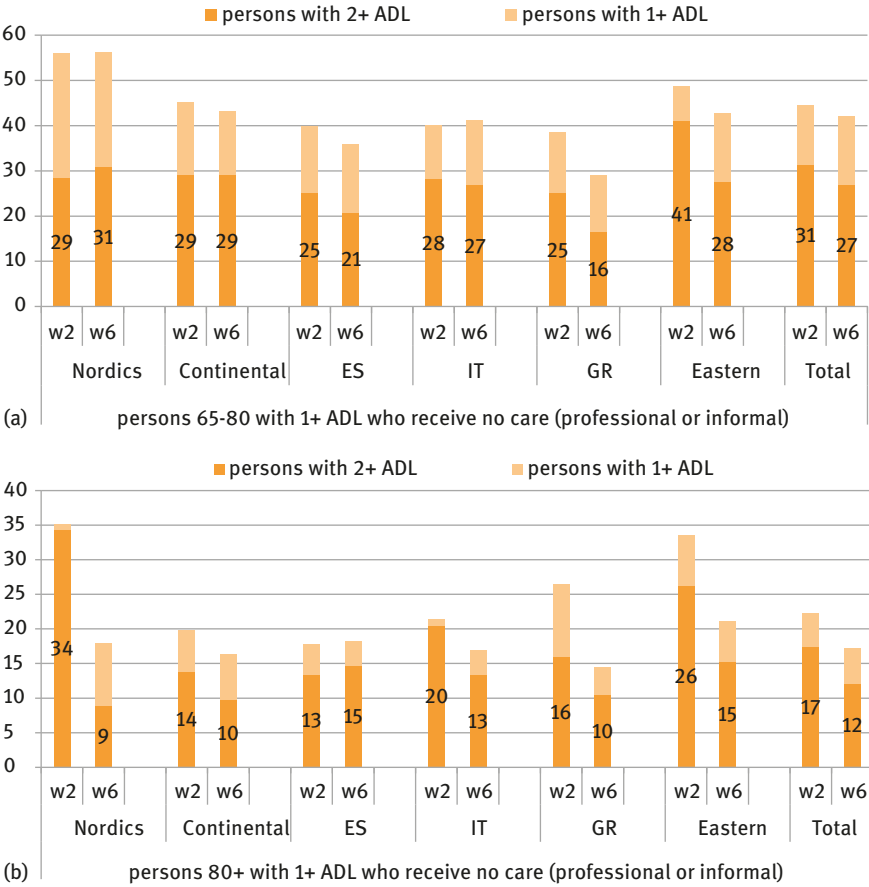


Figure 20.2: Care gaps, by number of ADL and age group, cross section, Wave 2 and Wave 6.
Source: SHARE Wave 2 and 6 release 6.1.0.

of age. Although informal care in the southern countries remains the dominant channel to meet needs, the care mix shifted in favour of exclusively formal care in Italy and an increase in the combination of formal and informal care in Greece and Spain. *Total* formal care increased everywhere.

A further point to note is the coincidence of formal and informal. Informal care is important even in systems that heavily rely on formal care, which signals complementarities between the two types: when both types are available, many people would probably choose both. However, this is not to say that the austerity narrative, in which formal care is *either* withdrawn *or* no longer affordable, is not applicable.

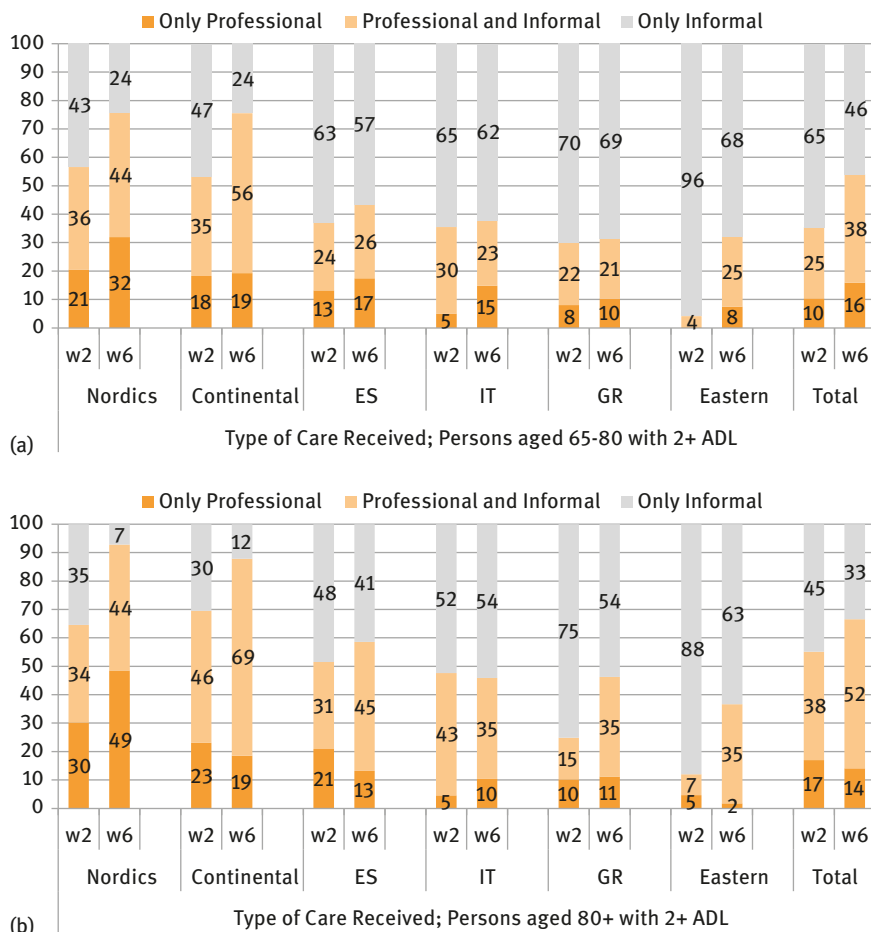


Figure 20.3: Type of care received, persons with 2+ ADL by age group, cross section, Wave 2 and Wave 6.

Note: 'Total' refers to the 12 countries that participated in both Wave 2 and Wave 6.

Source: SHARE Wave 2 and 6 release 6.1.0.

20.5 Seeking explanations: Individuals and LTC in Wave 2 and Wave 6

The aggregate picture does not conform to the austerity narrative. Easy expectations were disproved, leaving many issues unanswered. We deal with these by exploiting the 'added value' of SHARE – the possibility of directly approaching the individual experience.

For the three southern European countries, we set up two statistical models to explain whether a person in need (2+ ADL): (a) receives *some* care (i.e., the reverse of the care gap); and (b) receives *professional care* – whether on its own or in combination with informal care.¹ Each of two probit equations relating probabilities to underlying factors was run separately, once on 2007 data and again on 2015 data. This approach can show us whether there was meaningful change during the crisis in how the determinants of need and ability are related to care gaps and care mix. The key question to be asked is, *Did the crisis increase the needs of care?* Given that our main interest is on austerity, income is our central focus.

Both equations (for receiving some care and for professional care) use a common set of variables. Some capture need (demand): three bands for age (50–65, 65–80, 80+); ADL>3; possibility of depression (EURO-D); dementia and poor health (SPH bad). Others capture access (supply): rural living; gender; lives alone; childless and pensioner. The probability of receiving professional care is also affected by the presence of informal support. Country dummies capture country-specific effects, such as differences in systems but also differences in average income. The logarithm of *equivalent* income is included in both equations, as is a dummy for very low income (< 10% of country's mean); people near the poverty line may be eligible for means-tested benefits.

We estimated two sets of equations, for 2007 and 2015, for people with more than two ADLs in the three southern countries. From the four equations:

- Explanations *after* the crisis are far sharper (the statistical fit is much better), especially for receiving *some* care. Care gaps but also receipt of professional care, are more closely linked to the explanatory variables – individual needs and potential.
- The fact that outcomes are better aligned with *needs* could mean that the mechanisms in place are more discerning. This could be the result of either *formal* LTC systems (which were being reformed) coming into maturity or that austerity could be forcing prioritisation.
- The institutional maturation hypothesis – that formal systems are better at discerning need – receives support from three indirect observations: living in a rural area is not linked to less professional care, dementia begins to be important only in 2015 and the presence of informal care reduces the probability of professional care in only 2007 and not 2015. Professional and informal care may now operate less as substitutes and more as complements.

¹ We use the entire sample from age 50, as long as ADL limitations are >2.

- Certain influences with roles of equal significance confirm the continuing familial character of the systems: age, health, being childless, being a woman.
- Country effects show that most of the transformation is taking place in Greece. In terms of the care gap, Greece is significantly *more* likely to face one (after allowing for other effects). In terms of *professional* care, Greek exceptionalism is reversed: whereas a needy Greek person was *less* likely to access that type of care in 2007 (by approximately 20%), country differences disappear in 2015.

Therefore, it is clear that income plays a key role. Although it played *no* part in 2007 in predicting receiving care, it becomes important and positive in 2015. The growth in influence is more notable in the explanation of professional care, where it exercises three times the effect than before. Being poor *becomes* important in explaining access but adds *less* to simply having low income in predicting professional care.

Figures 20.4 and 5 convey the complex influence of income by looking at how it affects predicted probabilities in the two years. We calculate the probabilities for a reference individual (Greek, 65, alone; in poor health, income

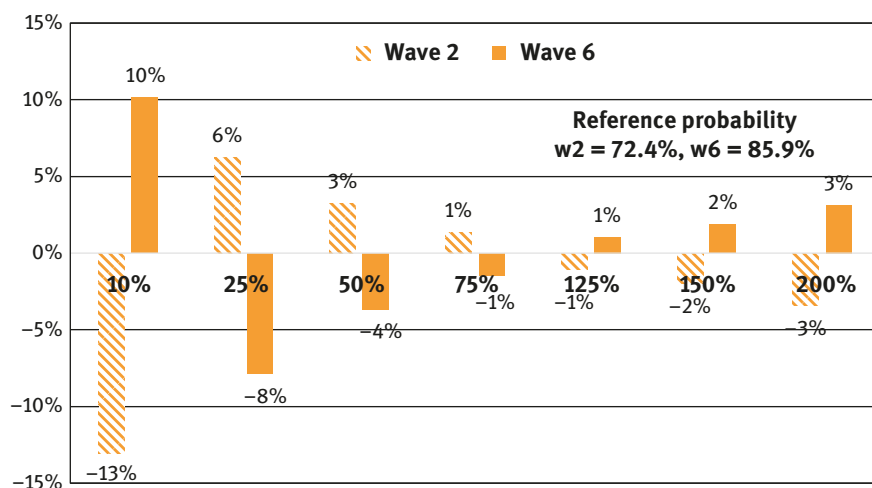


Figure 20.4: Difference in the predicted probability of receiving *some* care by persons with 2+ ADL; by income (% of mean income).

Note: Reference: 65–80, poor health, alone, rural; income at GR W2 mean (€10k) W2 coefficients not statistically significant.

Source: SHARE Wave 2 and 6 release 6.1.0.

equal to the 2007 Greek average). The income of that individual is then varied, which alters predicted probabilities. At 10% of the average income, the separate effect of poverty kicks in. The two figures report *differences* in probabilities relative to the reference individual as income is varied in the seven steps of the Wave 2 average, from 10% to 200%).

Figure 20.4 shows the predicted probability of *not* suffering a care gap given a need for care. In 2015, a well-defined relationship existed: at very low incomes, people suffer *less* from care gaps that then decline as income rises. The 2007 relationship is shaded because it is not significant. We should note that the reference point involves a significant general *decline* in care gaps.

Figure 20.5 equivalently charts the influence of income on *professional* care, which in Greece means mostly out-of-pocket care from unregulated markets. We see a strong link with income, which operates on top of a *doubling* of the overall levels of professional care for the reference individual (from 19% to 43%). Professional care rises across the board but more decisively for the better off.

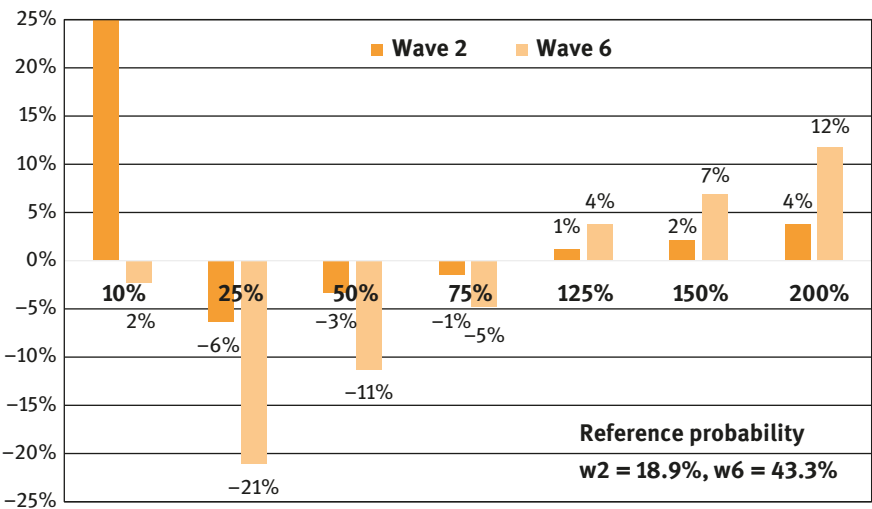


Figure 20.5: Difference in the predicted probability of receiving *professional* care by persons with 2+ ADL; by income (% of mean income).

Note: Reference: 65–80, poor health, alone, rural; income at GR W2 mean (€10k), has access to informal care.

Source: SHARE Wave 2 and 6 release 6.1.0.

20.5 Conclusions

Easy expectations can be deceptive. Far from austerity affecting LTC, southern Europe seems to suggest the opposite, despite the deepest recession since the Second World War. It was *not* the family that adapted but the provision of professional services. This phenomenon could be the result of formal systems becoming better at discerning need; however, the influence of income – in enabling access to bought-in services from the open, unregulated market – plays a key role.

Why should households whose average income declined by a quarter decide to spend *more* to buy LTC services? Such behaviour is understandable if the *prices* of care services declined. Such a decline could be a byproduct of the ‘internal devaluation’ that was implemented in Greece but also – to a smaller extent – elsewhere. For instance, minimum wages in Greece declined by far more than pensions, which pensioners perceived as a decrease in relative prices and the possibility of buying more LTC despite their falling incomes.

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