Home care and cash transfers.
Effects on the elderly care-female employment trade-off

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Abstract

Two common trends uniting otherwise still very different elderly care systems have been observed in Europe: a shift to home care away from institutional care, and a shift from in-kind to cash transfers. The paper presents an analysis of the impact of these policy changes on the division between formal and informal care and on the trade-off between care-giving and female labour supply. The main objective is to assess the effects of various models of cash-for-care schemes on women's incentive to care and on care workers in the labour market.

Key words: care regimes, cash for care, female labour supply

JEL:I38; J22; J16; O15

1. Convergence of long-term care regimes?

Projections of sharp increases in the demand for long-term care (LTC) have prompted the search for new organisational solutions aimed at cost efficiency to ensure both availability of resources and long term financial sustainability. Two common trends, uniting otherwise still very different care systems, have been observed in Europe: a shift to home care away from institutional care, and a shift from in-kind to cash transfers. The ultimate aim of this policy shift is to strengthen families' caring capacities and transfer more weight onto informal care. In fact, home or community care (whether formal or informal) is considered to be far cheaper than institutional care, while responding better to the preferences of the elderly. With families at the limit of their care-giving capacity, monetary benefits and other non monetary support schemes are increasingly provided to care users and their families as support for their caring activities. When combined with monetary transfers, this policy shift seems to meet both cost-efficiency and customer–satisfaction requirements?.

Cost considerations pushing in the direction of encouraging and supporting a greater role of family care may run counter to other economic and social trends/goals pushing in the opposite direction. Demographic developments, changing family structures, and women's drive for emancipation and higher participation in the labour market will give rise to an increase in the demand for formal long-term care services. Governments may be caught between two apparently conflicting goals: a higher female activity rate and a greater reliance on home care. The impact of these policy changes on the division between formal and informal care, on the one hand, and care-giving and female employment on the other, may vary widely across countries with care regimes and labour market models.

The various systems differ in substance also in the conditions regulating monetary benefits, such as those who are entitled to the transfer and how it must be spent. The range varies from freely disposable monetary transfers that can be treated by families as income support (as is the case of the dependence allowance in Italy and Austria) to tightly controlled benefits conditional upon the employment of regular paid carers (as in the case of France, Belgium, or the Netherlands) (Ungerson 1997; Yeandle and Urgenson 2007). The differences in their effects can be equally large (Simonazzi 2009). By reducing the cost of market care, tied monetary transfers encourage the creation of a formal market (which, in turn, may or may not entail good working conditions). Conversely, untied cash payments provide a support for family income that may or may not be used to hire formal or informal carers. The effect can be either an increase in the "informal", but subsidised, family care, with possible negative effects on female labour market participation; or an increase in the demand for paid care (subsidised market demand). When the latter is the case**,** unconditional monetary transfers may encourage the development of a particular form of home-based, often irregular, low-paid care generally accessed privately through the market (as is the case of the female immigrant carers in the Mediterranean countries, in Austria, and increasingly in Germany).

The aim of the paper is to analyse the implications of different models of subsidised home care and cash-for-care schemes on women's incentive to care and on the features of the care labour market. In particular, it will analyse how cash payments in different employment and care models affect the trade-off between care-giving and female employment and on working conditions in the care labour market. Section 2 examines the factors regulating the choice between formal and informal care; sections 3 and 4 analyse how labour market institutions and the features of care regimes affect the opportunity cost of caring and the cost of paid care. Section 5 focuses on how monetary transfers affect the division between formal and informal care, and its effects on the quality of care jobs. Section 6 concludes.

2. The cost of care

The decision to provide care is influenced by several motivational factors, such as love, duty, guilt. Regardless of the motivation, provision of care clearly conflicts with alternative allocations of the carer's time, namely leisure and paid work. While all care systems rely heavily on informal carers (mostly female family members) for the provision of home care, on the assumption that it is the cheapest solution, carers' time is often not even included in cost calculations.

If we leave 'non-economic' motivations aside, the choice between providing care directly or buying care in the market is regulated by the carer's opportunity cost relative to the price of care. The trade-off between care-giving and paid work can be illustrated by a simple budget constraint.

$$P_c L_c + X = w(T - L_l - L_f)$$

with

$$T = L_l + L_f + L_w$$

$$wL_w = P_c L_c + X$$

$$C = Lc + L_f$$

where P_c = the price of formal/market care; w = the wage rate that the carer can command in the labour market, that is, the opportunity cost of care; Lc and L_f = the amount of paid care and of family/informal care respectively (hours of care); T = the total time available; L_l = leisure; L_w = time spent on paid work; X = the value of the main carer's contribution to the family income[1]; C = total time of care.

Generally speaking, if the family carer's opportunity cost is greater than the price of formal care, he/she will buy formal care; otherwise she will provide care herself (Ettner 1995). Any factor that reduces the cost of care, relative to the carer's opportunity cost, will favour the demand for market care (regular or irregular).

In practice, the carer may face income constraints, which increase with the intensity of care. If the needed amount of care (in value) exceeds the income that can be normally earned in the labour market, the carer must either reduce consumption (X), shifting a part of the resources to buy care, or reduce leisure to increase the total time of work (L_w) (assuming that she is not rationed on the labour market) or to provide care herself. An alternative arrangement is offered by solutions that can reduce the price per hour of care, such as those adopted by the Mediterranean countries with the "migrant in the family" or live-in migrant carer.[2] Technology can provide yet another alternative for cost reduction by drastically reducing the labour content of care, as is the case in high labour cost countries.[3] Monetary subsidies can relax the budget constraint, making it possible to consume a greater amount of paid care or to supplement the family income.

Formal and informal care are usually complementary activities. In no care regime does formal care, whether public or private, completely crowd out family care (Bonsang 2008): while in the Scandinavian countries informal, family care complements public care, in other care regimes the family must search for ways to combine public and private sources to complement its own caring. Fixed and inflexible working schedules may restrict carers' choices in their allocation of time, preventing them from deciding how much work to offer. If reduction in working hours is

[1] We are assuming that there are no other sources of income, e.g., elderly persons' pensions or other family members' income, or savings to draw upon. Alternatively, we may re-define X as the difference between the family's normal consumption – X* – and the family's sources of income other than the main carer's, that is, her contribution to the family's necessary consumption.

[2] When, as in Italy, home paid care is organised on a live-in, round the clock basis, the pay is often set on a monthly basis; when account is taken of all the hours during which the minder is on call, this amounts to an extremely low per hour wage. Bettio and Solinas (2009) have found that the cost effectiveness of home care in Italy, relative to Ireland and Denmark, is based on low wages/and or long hours for the paid carers and low opportunity costs of family care.

[3] Bettio and Solinas (2009) have found that Italy and Denmark have approximately the same percentages of total cost for home paid care, but Italy provides 43.6 hours of care versus 12.3 for Denmark.

unavailable, outright exit may be the only option. Similarly, carers may also be rationed by the availability of formal care services (Spiess and Schneider 2003).

We conclude that the opportunity cost of family carers and the cost of paid care will vary with the conditions governing the labour market - such as employment opportunities, the market wage, flexible working time arrangements and other measures aimed at reconciling care giving and wage earning - on the one hand, and the features of the care regimes - such as the different weight of formal and informal carers and of public care provision, flexible and affordable market care, the availability of cheap migrant labour, and monetary and non-monetary schemes aimed at supporting informal care-giving - on the other. Highly diverse conditions in labour markets and care regimes will result in large cross-country differences in the division between family and market care as well as in the quality and conditions of care jobs.

3. The opportunity cost of caring and the labour market

Although the negative correlation between care-giving and employment is fairly well documented, the causality running from care-giving to employment is more problematic (Fevang et al. 2008). In the Eurobarometer Survey on Health and long term care (EC 2007), only a small proportion of respondents declare that they have given up paid work in order to take care of an elderly parent: 2% have quit their jobs completely and 3% have switched from full-time to part-time work. This proportion is low in all surveyed countries, including those care regimes where care is still mostly a "family business". These results may be a consequence of the combined effect of low activity rate and carers' old age, but they may also reflect the increasing private marketisation of care due to reconciliation problems (see Bettio et al. 2006). In fact, although the traditional male breadwinner model has been substantially eroded throughout Europe, making room for various earner models, cross-country differences in female participation rates are still relevant. Employment models and welfare and care regimes still affect the female activity rate (table 1), the division between formal and informal care, and the urgency of the reconciliation issue. This is all the more true because the commitment to care comes at a fairly advanced stage in the carer's life cycle, reaching its apex when women are well into their fifties. However, demographic change, smaller families, and increased female participation have strained the capacities of the family to provide care. Women's increasing participation in the formal labour market poses a serious challenge of reconciliation between caring and paid work. How serious the challenge is depends largely on the features of the national employment and care models.

The first empirical research on the impact of care-giving on labour market participation decisions, based on US data[4], provided mixed evidence. The trade-off between labour supply and care-giving decisions was often small, or not statistically significant. Evidence from EU countries is equally mixed. Differences in the unit of analysis - the trade-off is measured either in terms of reduction in hours spent on paid work (Carmichael and Charles 1998), or as a shift from employment to non participation or from full time to part time work – make meaningful comparisons difficult. In fact, differences in the functioning of labour markets and in working times arrangements may restrict the range of choice in the allocation of time, and account for the differences in results. However, a general finding is that the intensity and duration of care are key factors affecting the trade-off. No significant differences are found across Nordic and Southern EU countries in the trade-off between intensive care giving and labour market participation of adult working women (Crespo 2008; Spiess and Schneider 2003): intensive care-giving affects labour-market participation negatively in both groups of countries, though possibly with a different timing (see also Fevang et al, 2008 for Norway).[5] Low income or education and availability of social services are other important factors.

[4] See Jacobzone and Jenson (2000) and Crespo (2008) for overviews.

[5] Spiess and Schneider (2003) find that starting care-giving significantly reduces work hours for women in Northern European countries (except Ireland), but have no effect in Southern European countries. By contrast, the increase in the

Re-entering employment after the caring episode may prove almost impossible, owing to the erosion of skills and human capital. This explains both informal carers' preference for reducing the number of hours worked rather than leaving the labour market altogether (after adjusting for carer's age and intensity of care) and the key role played by institutional factors, such as availability of flexible working arrangements, job protection, training, part time, and support structures in reconciling care and paid work (Jenson and Jacobzone 2000; Carmichael et al. 2008).

We can conclude that intensive care-giving negatively affects women's employment in all employment and care regimes, although the opportunity cost of care-giving varies across countries with female activity rates and working arrangements. In the Southern European familistic countries, given the low activity rate of women in the older age bracket (54-65), the trade-off between care and work does not yet appear quantitatively conspicuous (fig.1). Reconciling work and care may become more difficult in the future, when the increase in the female activity rate, by now very strong in the younger cohorts, will display its effects along the life-cycle. Various estimates suggest that these cohort effects are substantial (Pissarides et al. 2003: 60; Simonazzi et al. 2009)[6], and may combine with those produced by pensions reforms aimed at postponing the retirement age in substantially increasing the number of working carers. This implies that the opportunity cost of care will increase substantially for those countries (like the Mediterranean and the "Bismarckian" regimes) which still rely most heavily on the family to provide care, all the more so if the increase in the level of education of younger cohorts of women raises the level of their potential wages.

4. Wage gaps, sticky floors, and the cost of care

It is widely documented that men earn higher wages than women even after controlling for measurable characteristics related to their productivity (Dolton et al. 2008). Comparative studies show that there are significant differences across EU countries in the extent and the structure of the gender pay gap. Recent research has investigated how the gender pay gap evolves through the income distribution. Using harmonised data from the European Community Household Panel (ECHP) across ten European countries, Arulampalam et al. (2005) find that gender pay gaps are typically bigger at the top of the wage distribution, and that for some countries they are also bigger at the bottom of the wage distribution. However, the authors could not find a clear pattern in the existence of glass ceilings and sticky floors across different countries. Conversely, comparing the distribution of the gender wage gap in Spain and Sweden, De la Rica et al. (2005) find a U-shaped pattern for Spain which stands in sharp contrast to the pattern found for Sweden.[7] In Sweden the gap is at its minimum at the bottom of the wage distribution, increasing continuously by 35 percentage points from the bottom to the top. Conversely, in Spain the gender gap is much higher at the bottom of the wage distribution, falls below average after the 25th percentile, and starts increasing sharply at the top quintiles. A similar U-shaped pattern is documented by Addis (2008) for Italy (fig. 3). One plausible explanation for the divergent pattern of the gender wage gap at

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intensity of care reduces women's labour supply in Southern Europe and Ireland but has no such effect in Nordic countries. The authors suggest that this result can be explained by the different role played by the extended family and by public care services in the two groups of countries: the family can better tackle the emergency when the care need abruptly arises, but cannot cope with its increasing intensity, where the more comprehensive Nordic care regime performs better. It should be noted that the results derive from the ECHP surveys of 1994 and 1996: since then, huge recourse to the immigrant care market in the Mediterranean countries may have somewhat reduced the trade-off in the intensive stage of care (Bettio et al 2006).

[6]According to Pissarides et al. (2003:60), for the Mediterranean countries as a whole, the cohort effects can result in an increase in the female employment rate of some 6-7 percentage points. In the case of Italy, by 2010 the employment rate is estimated to be 49 per cent, up from a level of 41.3 per cent in 2001 and 46.4 per cent in 2007.

[7] De La Rica et al (2005) use the 1999 European Community Household Panel (ECHP) for full-time workers to derive quantile measures of the (unexplained) gender gap in Spain and Sweden at the end of the 1990s. They then compare the gender gap (in terms of the differences of logged gross hourly wages of male and female workers) at different points of the income distribution with the mean gap for the two countries (fig. 3).

different points of the income distribution – and one that is supported by the analysis of the care labour markets across different regimes that is presented in the following section - is that the high level of female employment created in services by the welfare state in the Nordic countries, together with a generally more egalitarian wage policy, have contributed to shoring up the floor. The same mechanism does not seem to have been at work in the two Mediterranean countries.

While low levels of education are more of a penalty for women than for men in terms of hourly wage, the return to education is much higher for women than for men. These two facts account for the much sharper increase in the ratio between the wages at the top and those at the bottom of the income distribution in the case of women rather than men. This pattern is especially marked in the US, as documented by Gordon and Dew-Becker (2008), but it is also evident in Europe. Once again, institutional factors are of relevance in explanation of the widening gap. In the US, the greater increase in the 50-10 ratio for women is consistent with a decrease in the real minimum wage, particularly in 1980-86, since women are roughly twice as likely as men to be paid the minimum wage , while decreased union density was identified as the main factor for men (ibid.: 6-7). This may also be true in Europe, where the widening of the within-gender pay differential may be explained more by the sluggishness of wage increases at the bottom of the distribution than by high increases at the top.

The pattern of the wage gap at the bottom of the distribution can be related to that of the female participation rate. If low-skilled women's wages fall through the floor at levels well below men's wages at the bottom of the wage distribution, and well below the average wage, it is plausible that they will have less of an incentive to participate in the labour market, since their wage will not cover the cost of domestic, unpaid work. Female labour supply will consequently be discouraged.

The elderly care sector is a labour intensive, highly gender-segregated, low-pay sector. It is also highly segmented: qualified professional workers co-exist with less qualified, often irregular workers; wide disparities in working conditions divide staff employed by private contractors (or not for profit organisations) and staff employed by public institutions, and workers in home care from those in residential care, regular and irregular workers. We observe huge cross country differences in care job quality and the degree of wage compression. In the Netherlands, for instance, care work is paid better than other low paid sectors, while the opposite is true for the UK, where the minimum wage sets the level for care work pay. In Sweden the cross-sector wage differential is much narrower than in the Mediterranean countries.[8]

Institutional and cultural factors and policy choices can explain these differences. Those countries aiming at a narrower wage dispersion have resorted to two main policies: technology and training, and public provision. Generally speaking, education and skill levels are mostly low for care workers in the Mediterranean countries, France and the UK, while they are reasonably high for skilled and semi-skilled workers in the vocational systems of Austria and Germany, and they are highest in Scandinavian countries (Simonazzi 2009). Public employment (the solution typically pursued by the Nordic countries) has been an important factor in determining job quality and setting a floor for lower wages. Conversely, a shift towards the contracting out of previously publicly provided services for the sake of cost reduction is an important factor in job quality deterioration (as in the UK).

As argued above, working conditions in the care sector may discourage the domestic supply of care labour, but the high cost of market care can discourage demand. Faced with a sharp increase in the demand for care labour, all countries are experiencing problems in recruiting enough workers to meet demand. In some countries the shortage of care workers has been met by a large inflow of immigrant, mostly female, workers (Bettio et al. 2006). The magnitude of the labour shortage in the

[8] In Italy, for instance, using data from the 2002 Survey on Household Income and Wealth (SHIW), Addis (2008) estimates a 17% wage penalty of the domestic sector relative to industry.

LTC sector, in total and across the skill spectrum, the extent of recourse to migration to fill the gap, and the modalities of migrant involvement in the labour market differ widely across countries and across the various segments of the care labour market. Sweden and France seem to rely least on immigrant carers. In Sweden, substantial public spending has resulted in a largely native workforce, which is well paid and highly trained. There is a small but growing number of foreign-born workers mostly employed by public agencies. In spite of a very different care system, native care workers are still predominant in France: care reforms and (tied) cash subsidies have been directed at supporting the female participation and employment rate. Conversely, the UK is one of the largest importers of professional health care workers, a large percentage of whom work in the long-term care system; since the beginning of the decade, immigrants from Eastern European countries employed in unskilled, personal care have been on the rise, especially in the larger cities. Substantial cash benefits, little regulatory oversight, and a tradition of home care have encouraged extensive use of foreign care workers in Austria and Germany, and especially in Southern European countries. Unlike in the UK, many of these workers are undocumented immigrants, hired informally by families through informal networks.[9] These workers often co-reside with the elderly person round-the-clock, and stay for a three-month period on a rotating basis. Foreign long-term care workers fill the gaps in the care chain; they are more likely to take jobs in the less desirable tasks or segments of the market; and they do not compete with professional care workers. However, since illegal carers are incomparably cheap, they may raise serious competition against home service providers and prevent the formation of a more equitable and sustainable care system.

We can now try to pull the various arguments together. Given the features of the care sector, we may expect female care workers to be heavily represented in the low quintiles of the income distribution. It could be argued that in many countries relatively low wages at the bottom of the distribution may be a necessary substitution for the lack of publicly provided services, making it easier for working women to hire household help and elderly carers. However, at the bottom of the income distribution, there seems to be a thin line separating the opportunity cost of the female carer and the cost of a paid carer. If care labour wages are too low to stimulate a sufficient supply of care labour, the increase in its price may be thwarted by the fall in demand brought about by the increase in the budget constraint, which pushes the carer back towards informal care provision. Immigration can provide yet another way out of the financial constraint of care, while introducing a third inequality gap besides income and gender: ethnicity.

5. Cash for care (and other support schemes)

Monetary transfers affect the care-employment trade-off through income and substitution effects. Untied cash benefits soften the budget constraint leaving the relative cost of formal to informal care (P_c/w) unaffected. Conversely, tied monetary transfers (e.g., vouchers) reduce the market price of care, making paid care more affordable. We may thus have different effects on the formal/informal division of care according to the conditions regulating the disbursement and utilisation of cash transfers.

The amount of the subsidy is clearly a crucial factor. Given their generally low levels, cash allowances are unlikely to be the decisive factor in freeing up unpaid carers to participate in the labour market. They are more likely to be considered as an income subsidy which rewards previously unpaid carers or subsidizes the cost of formal carers. However, when combined with other sources of income, such as the dependent elderly's pension, unconditional cash allowances can help in meeting the cost of paid care.

[9] In the three Mediterranean countries, foreign (mostly female) workers provide an increasing share of home care: the underground economy covers one-third of the market in Spain, where language is less of a problem, since workers migrate from Latin American countries. More or less legal flows from bordering Eastern countries are supplying the market for informal carers in Greece and Italy.

In the case of untied monetary transfers, a flat rate subsidy will be most effective in discouraging the market participation of women on low incomes, since even a low subsidy may compare not too unfavourably with the wage that they could earn on the market. The flexibility of working times, the possible wage penalty related to caring obligations, the need to resort to some form of paid care, combined with the likely old age of the carer, are likely to tilt the choice in favour of care-giving. Re-entering the labour market after the care-giving has concluded obviously becomes very difficult. For lower-middle income families, conversely, the subsidy may be decisive in turning the choice in favour of buying the services in the market. A large availability of cheap care labour, combined with unconditional cash allowances, can open the market opportunity also to a large share of lower-middle income families even at relatively low levels of subsidies.

All things considered, cash transfers are unlikely to be the key factor capable of changing the trade-off between care and paid work, but they may affect the care labour market by favouring the emergence of a low-pay, largely irregular supply of paid carers. The various European countries differ widely in their conditions regulating cash transfers for care. Leaving out the Scandinavian countries, where cash benefits are still very limited, we can distinguish different country patterns (table 2).[10] On the one hand we have countries (such as France and the UK) that are more restrictive in the use of monetary transfers to pay the family carer. In France vouchers are provided to families for the direct recruitment of paid care workers. In the UK direct payments are a relatively recent experience; it is a highly regulated scheme aimed at enhancing the elderly person's freedom and independence (Yeandle and Stiell 2007: 128). At the other extreme lie the Mediterranean and the Bismarckian countries. In Italy both the state and families perceive the various allowances as forms of income subsidy that can be freely used to complement the family budget. In spite of the institution of a long-term care insurance, Germany and Austria more closely resemble the Mediterranean countries with regard to its use. In both cases, the LTC insurance started from the premise that home care should take precedence over care in nursing homes. Hence the allowance was by no means intended to reduce the quantity of care provided informally. The idea was instead to make caring more attractive, so that caregivers, especially women of working age, would continue to care rather than enter the labour market (Morel 2007:15-16).[11] By contrast, other countries (such as France and Belgium) resorted to tied cash benefits with the primary aim of integrating low skilled women into the regular labour market, while responding to the increasing need for care.[12]

Systems relying on in-kind provision (Sweden), contracting-out (the UK), and 'tied' cash allowances to be used to hire private carers (France) favour the formation of a formal and regular care labour market. Systems relying mostly on unconditional cash allowances (the Mediterranean countries, Austria and Germany) favour the informal market. In Austria, cash benefits, coupled with little regulatory oversight, a tradition of home care, the permeability of the country's Eastern borders (due also to historical ties) have encouraged a large inflow of migrant carers, many of whom are illegal but are openly recruited by agencies for short-term, rotating care duties (Hermann 2006). In Germany, in spite of the prevalence of unconditional cash benefits, reliance on illegal foreign workers does not yet seem to have reached similar proportions (Kummerling 2006). In regard to the Mediterranean countries, the limited amount of public involvement in care financing explains their failure to develop a formal private market of paid care for older people and the dominance of individual suppliers. The unconditional character of monetary transfers, in an

[10] See Simonazzi (2009) for a more detailed description of the various systems. See also Ungerson and Yeandle (2007) for an overview of the various cash-for-care schemes.

[11] In the Netherlands, where elderly-care was mainly institutionalised, a new policy taking the form of a 'Personal Budget', entitles dependent people to a care allowance to be used for the purchase of care services, whether informal (from relatives) or professional. The introduction of this benefit is part of a move towards providing care recipients with greater freedom in deciding how best to service their needs. It is also, as in other countries, a way to offer some form of remuneration to informal carers (Morel 2007:19).

[12] I wish to thank an anonymous referee for providing information on the Belgian case.

unregulated labour market with a large grey economy, has led to the development of a large supply of irregular, often undocumented, immigrant carers to fill the gap in the supply of affordable care workers. We may conclude that cash for care schemes largely reflect the characteristics of care regimes, ending up by reinforcing their effects in terms of the division of care labour between formal and informal care and of the quantity and quality of care work. Thus, the conditions regulating the trend towards subsidised home care may have important consequences for the future sustainability of the various care regimes.

The flow of cheap, legal carers since EU enlargement is changing the features of care regimes and care labour markets across Europe. We may envisage two possible outcomes. The first is an increase in the supply of cheap, regular labour, possibly on a temporary basis, in those countries where the formal care market predominates, as in the UK, France, possibly Sweden. The second outcome concerns those countries which rely on untied monetary transfers or which have large informal markets. Here, greater freedom of movement within the enlarged Europe may have the effect of fuelling the informal/irregular market for care. In Germany and Austria, reforms aimed at dealing with the financial difficulties of their insurance schemes will be decisive in determining in which direction the care regimes of these two countries will move: whether towards greater recourse to immigrant carers but on a formal basis, or towards the Mediterranean model with its reliance on irregular migrant carers. The latter's capacity to move towards a more regulated care market will depend very much on how the cash benefits are disbursed and on the conditions regulating the formal and informal care markets. The case of Italy provides a good example. The irregular carers' pay is often extremely low compared with that earned by a regular worker, though much higher than what they could earn in their home countries. A new national contract for domestic workers (in March 2007) raised the cost to a family of a live-in elderly minder on a regular contract to a level roughly comparable to the average female net earnings in industry and services (1000 - 1300 euros per month for the live-in carer, in addition to board and lodging costs, versus 950 – 1250 euros for the industry wage). With these new wages, even if social contributions can be deducted from tax, the regular minder solution is no longer sustainable for lower-middle income families, which used to rely on the extremely cheap supply of informal carers, and it is no longer competitive with residential care, especially if the latter receives a state subsidy. The risk is therefore that this form of work will be pushed back into the black market. If this is to be prevented, both the level and the conditions regulating the provision of monetary transfers need to be monitored: the level should be in line with what is considered a fair wage in the care market, and the transfer should be earmarked in order to guarantee that conditions are met.

However, our analysis has highlighted that, in order to ease the trade-off between care-giving and labour market participation, measures in support of family carers on top of and beyond cash benefits are likely to be much more effective. European countries are introducing different schemes in support of the family carer: from support services such as respite care, counselling and a larger supply of home-care providers in the community, through quasi monetary provisions such as pension rights, social and accident insurance, tax exemption, to measures easing the reconciliation of care-giving with flexible participation in paid labour such as training courses, rights to employment leave, reduction of working time. While some of these measures, such as entitlement to pension contributions, reduce the opportunity cost of forgoing a paid job, and others, such as rights to work leave and respite care, can be equated to an increase in the opportunity cost, they all basically work through the easing of care-work reconciliation.

6. Conclusions

The shift to home care will undoubtedly increase the burden on the family carer. While the large cohorts moving into old age in the coming decades will challenge the fiscal sustainability of current health and long-term care systems, the simultaneous increase in female participation will increase the opportunity cost of the family carer and make reconciliation more difficult. Part of the increased

female employment will end up in the care sector if public care policy tackles the issue of the trade-off between affordable market care and fair care pay and working conditions. This calls for a carefully targeted policy on publicly funded formal home care and on the conditions regulating cash-for-care schemes in support of informal care.

Unconditional cash benefits may either create "incentive traps" attracting informal care givers away from the normal labour market, or, conversely, reliance on a low-quality, low pay, irregular care market, if the relation between the opportunity cost of the family carer, the subsidy and the functioning of the care market are not controlled (Lundsgaard 2005). In fact, where labour markets are deregulated, or where service buyers are free to spend their benefits with no restrictions, the market has not been able to produce a sustainable solution in terms of the quantity and quality of care labour. Conversely, tied cash benefits may ensure, through substitution and income effects, a greater reliance on paid/regular care. Countries with more regulated labour markets have been more successful in securing an adequate supply of native workers to meet demand. However, cash for care is not the definitive solution to the trade-off between care-giving and employment. For this purpose, the provision of services in support of families may prove more effective.

References

Addis E. (2008), "Il differenziale salariale tra i sessi in Italia e il patto di genere", mimeo.

Arulampalam, W., Booth, A.L., and Bryan, M.L. (2004), 'Is There a Glass Ceiling over Europe? Exploring the Gender Pay Gap across the Wages Distribution', *IZA DP*. 1373, October

Dolton, P., Marcenaro-Gutierrez, O., and Skalli, A. (2008), 'Gender Differences across Europe', in F. Bettio and A. Verashchagina (eds.) *Frontiers in the Economics of Gender*, Routledge, London.

Bettio, F., A. Simonazzi, and P. Villa (2006) 'Change in care regimes and female migration: the care drain in the Mediterranean', *Journal of European Social Policy*, Vol 16(3): 271-285.

Bettio, F. and Solinas, G. (2009), 'Which European Model for Elderly Care? Equity and Cost-Effectiveness in Home Based Care in Three European Countries", *Economia & Lavoro*, 43, no. 1, pp. 53-71.

Bonsang, E. (2008), 'Does informal care from children to their elderly parents substitute for formal care in Europe?', *CREPP WP* 2008/01, CREPP, University of Liège

Carmichael, F., and Charles, S. (1998), 'The labour market costs of community care', *Journal of Health Economics*, 17, pp. 747-65.

Carmichael, F., Hulme, C., Sheppard, S., and Connel, G. (2008), 'Work-life imbalance: Informal Care and Paid Employment in the UK', Feminist Economics, 14 (2), pp. 3-35.

Crespo, L. (2008), Parental Caregiving and Employment Status of European Mid-Life Women, *mimeo*.

De La Rica, S., Dolado, J.J., and Llorens, V. (2005), "Ceiling and Floors: Gender Wage Gaps by Education in Spain", *IZA Discussion Paper* no. 1483.

EC (2008), *Employment in Europe*, European Communities, Luxembourg.

EC (2007), *Health and long-term care in the European Union*, Special Eurobarometer, December, http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

EC, Long-term care in the European Union, Employment, Social Affairs and Equal Opportunities DG, 2008 http://ec.europa.eu/employment_social/news/2008/apr/long_term_care_en.pdf

Fevang, E, Kverndokk, S. and Røed, K. (2008), Informal Care and Labor Supply, *IZA Discussion Paper* No. 3717, September

Glover, Stephen, Ceri Gott, Anais Loizillon, Jonathan Porter, Richard Price, Sarah Spencer, Vasanthi Srinivasan and Carole Willis (2001), *Migration: an Economic and Social Analysis*, RDS Occasional Paper 67, London: Home Office.

Gordon, R.J., and Dew-Becker, I. (2008), "Controversies about the rise of American inequality: A Survey", *NBER*, WP no. 13982 (April).

Hermann, C. 2006. Elderly care Austria, EU Project 'Dynamo' (Dynamics of National Employment Models), 6th Framework Programme

Himmelweit, S. (2007), "Policy on care: a help or a hindrance to gender equality?", in J. Scott S. Dex and H. Joshi (eds) *Women and Employment*, 25 years of change. Edward Elgar

Jenson, J. and Jacobzone, S. (2000), 'Care Allowances for Frail Elderly and their Impact on Women Care-givers', OCED, *Labour Market and Social Policy -Occasional Papers* no. 41, OECD Publishing.

Ku¨mmerling, A. 2006. The elderly care sector in Germany, EU Project 'Dynamo' (Dynamics of National Employment Models), 6th Framework Programme

Lewis, J. Campbell, M., Huerta, C. (2008), "Patterns of paid and unpaid work in Western Europe: gender, commodification, preferences and the implications for policy", Journal of European Social Policy, vol. 18 (1): 21-37.

Lundsgaard, Jens (2005), "Consumer direction and choice in long-term care for older persons, including payments for informal care: how can it help improve care outcomes, employment and fiscal sustainability?", OECD Health Working Papers, 20.

Morel, N. (2007), "Care policies as employment strategy. The impact of Bismarckian welfare state institutions on child- and elderly-care policy reforms in France, Belgium, Germany and the Netherlands., Florence

OECD (2002), "Women at Work: Who Are They and How Are They Faring?" in *Employment Outlook*, Paris.

OECD (2005) *Trends in International Migration*, SOPEMI Report, Paris: OECD

Pissarides, C., Garibaldi, P., Olivetti, C., Petrongolo, B., and Wasmer, E., (2003), "Women in the Labour Force: How Well is Europe Doing?" Fondazione Rodolfo de Benedetti, Milano, now in Boeri, T., Del Boca, D. and Pissarides C. (eds.), *Women at work. An economic perspective*, Oxford University Press, Oxford, 2005.

Simonazzi, A. (2006), "Disparità, opposizioni, complementarietà", in A. Simonazzi (ed.), *Questioni di genere, questioni di politica*, Carocci, Roma.

Simonazzi, A. (2006b), *The elderly care sector in Italy*", http://www.dynamoproject.it

Simonazzi, A. (2009), "Care Regimes and national employment models", *Cambridge Journal of Economics*, 33, pp. 211-32.

Simonazzi, A., Villa, P., Lucidi, F., Naticchioni, P. (2009), 'Continuity and change in the Italian model', in Gerhard Bosch, S. Lehndorff and J. Rubery (eds), *European employment models in flux. A comparison of institutional change in nine European countries*, London, Palgrave, Macmillan, pp. 201-222.

Ungerson, C. and Yeandle, S. eds (2007*) Cash for Care In Developed Welfare States* Basingstoke: Palgrave

Wolf, D.A., and Soldo, B.J. (1994), 'Married Women's Allocation of Time to Employment and Care pf Elderly Parents', *Journal of Human Resources*, XXIX, 4, 1259-1276

Tables and figures

Table 1. Female employment rates. 1960-2007. Persons aged 15-64 years.

		1960	1980	2000	2007	Men 2007	Lisbon Distance*
Nordic		**40.5**	**64.3**	**70.3**	**71.9**	**77.3**	**11.9**
	Denmark	**42.7**	**66.2**	**71.6**	**73.2**	**81.0**	**13.2**
	Finland	**54.9**	**65.0**	**64.2**	**68.5**	**72.1**	**8.5**
	Norway	**26.1**	**58.4**	**74.0**	**74.0**	**79.7**	**14.0**
	Sweden	**38.1**	**67.6**	**70.9**	**71.8**	**76.5**	**11.8**
Anglo-Saxon		**43.1**	**54.5**	**64.7**	**65.5**	**77.3**	**5.5**
	UK	**43.1**	**54.5**	**64.7**	**65.5**	**77.3**	**5.5**
Mediterranean		**30.8**	**40.1**	**40.9**	**49.7**	**73.9**	**-10.3**
	Greece		**30.7**	**41.7**	**47.9**	**74.9**	**-12.1**
	Italy	**28.1**	**28.4**	**39.6**	**46.6**	**70.7**	**-13.4**
	Spain	**21.0**	**28.4**	**41.3**	**54.7**	**76.2**	**-5.3**
Rest of Europe			**41.0**	**57.0**	**62.3**	**74.9**	**2.3**
	Austria		**52.4**	**59.6**	**64.4**	**78.4**	**4.4**
	Belgium	**29.6**	**35.0**	**51.5**	**55.3**	**68.7**	**-4.7**
	France	**42.9**	**50.0**	**55.2**	**60.0**	**69.3**	**0**
	Germany	**35.0**	**34.8**	**58.1**	**64.0**	**74.7**	**4.0**
	Ireland		**32.3**	**53.9**	**60.6**	**77.4**	**0.6**
	Netherlands		**35.7**	**63.5**	**69.6**	**82.2**	**9.6**
	Portugal		**47.1**	**60.5**	**61.9**	**73.8**	**1.9**
EU average 15				**54.1**	**59.7**	**74.2**	**-0.3**

Notes: * Lisbon distance is the difference between the female employment rate in 2007 and the Lisbon target of 60%.

Source. 1960 and 1980: Pissarides et al. (2003) on OECD data; 2000 and 2007: EU (2008); Norway: OECD.StatExtracts.

Figure 1

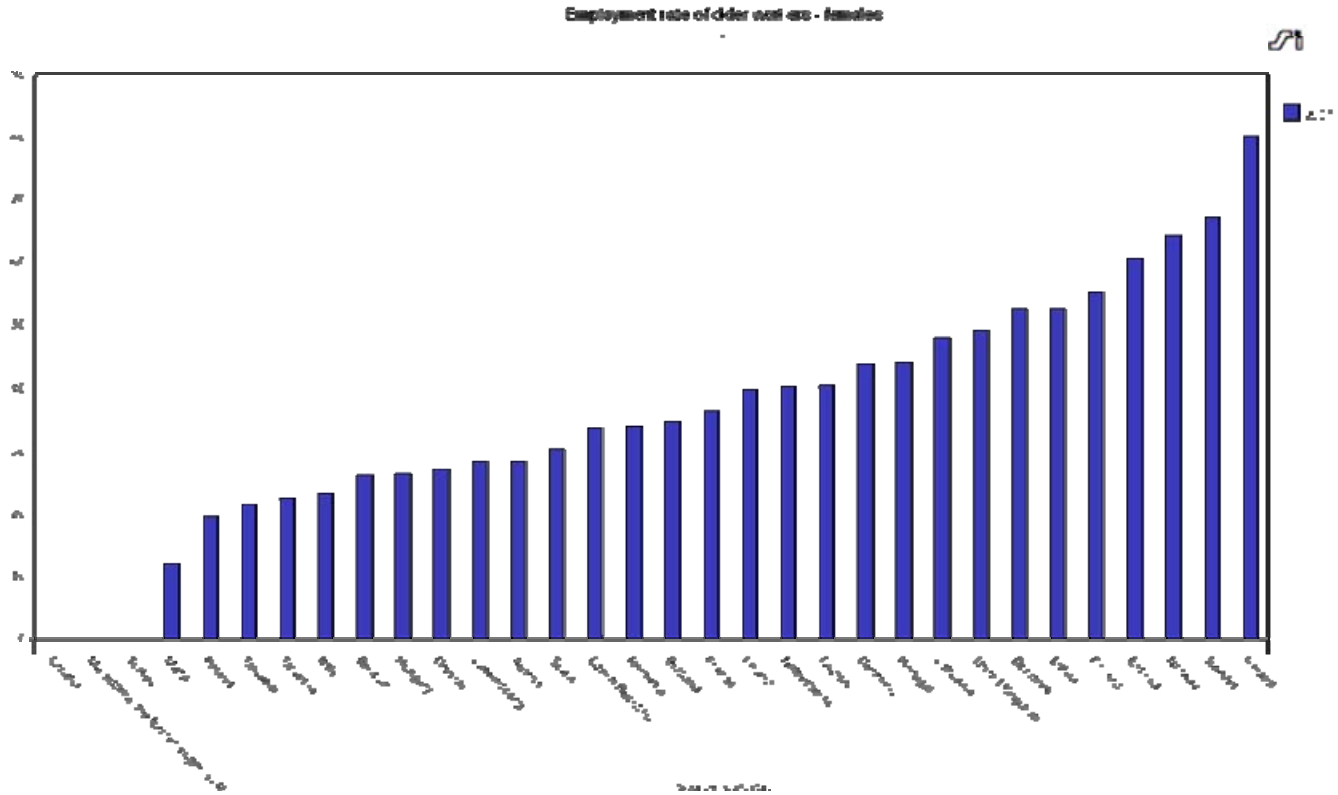


Table 2 Family eligibility and conditionality of monetary transfers

	Mediterranean/ Familialistic	**Continental/ Bismarckian**			**Anglo-Saxon**	**Nordic**
	Italy	**Austria**	**Germany**	**France**	**UK**	**Sweden**
Spouse	**yes**	**yes**	**yes**	**no***	**no**	**nr**
Other kin	**yes**	**yes**	**yes**	**no**	**no**	
Use of transfers yearmarked?	**no**	**no**	****	**yes**	**yes**	**nr**

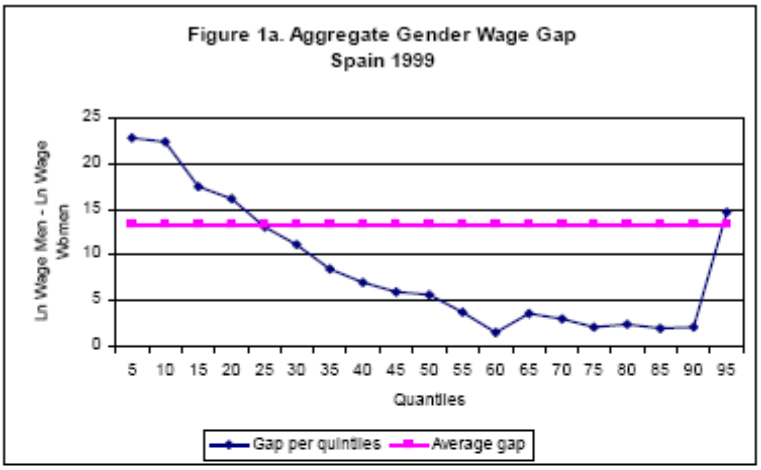
* Family members can be paid if officially unemployed.

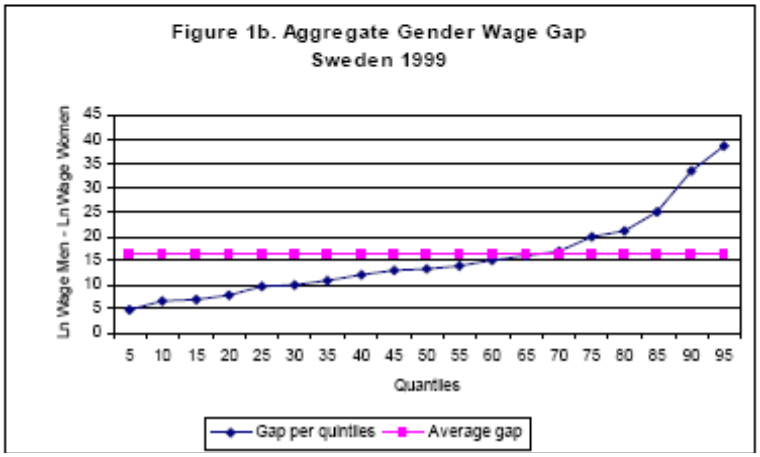
** The cash payment is subject to the definition of a care plan.

Nr = not very relevant

Source: Simonazzi (2009)

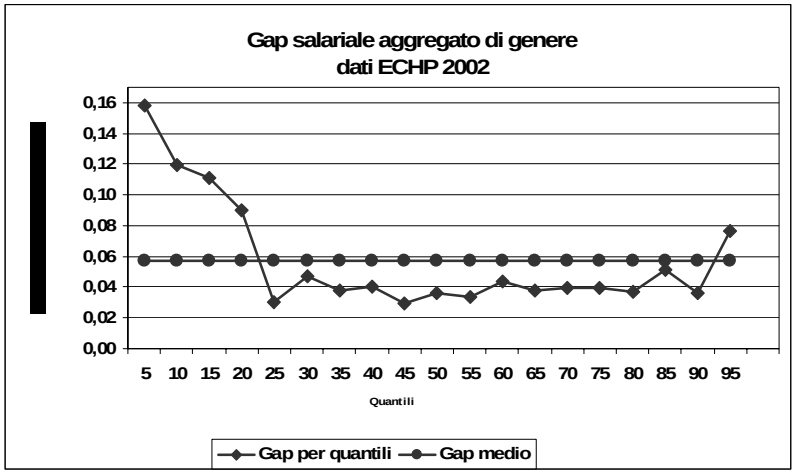
Figure 2a and b





Source: De La Rica et al. 2008. ECHP, 1999.

Fig. 2c Aggregate gender wage gap Italy 2002.



Source: Addis (2008). Computed on ECHP 2002 database.