Dependency as a factor of vulnerability in Europe

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Giuliana Costa and Costanzo Ranci

Abstract

The paper describes the living conditions of the European population in conditions of severe dependency (among them elderly people) and the informal caregivers who care for them using data from ECHP and EU-SILC surveys, including all the European western countries. The basic hypothesis is that dependency constitutes a significant risk factor which considerably increases the probability to fall into situations of social vulnerability. Firstly social, economic and demographic characteristics of the dependent population (characterised by a high proportions of females and ageing) are analysed. What emerges generally is that dependency causes a strong concentration in the use of economic resources rather than any substantial risk of poverty. The picture, however, varies appreciably from one European country to another according to the generosity of the welfare programmes and the availability of family resources. Implications for long-term policies and further empirical analysis are presented in the last part.

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1. Introduction

At the beginning of the new Millennium there were, in the EU 15, around 25 million people needing assistance to perform the basic activities of daily living: 40 per cent of them are aged between 20 and 60 years, and 60 per cent are aged over 60 years (Grammenos, 2003). These figures include persons with various levels of functional difficulties due to mental or physical disability. According to estimates by Eurostat (2003), one-third of such persons were in need of substantial help. Dependency is thus a widespread condition in our societies. The loss of capacity to take care of oneself, and the need to rely on the constant help of another person to perform the most basic of everyday activities, compel profound redefinitions of material, organizational and symbolic aspects of life because it attacks many areas of a person's functioning, and not only his/her body (Anderson and Bury, 1988). Using Amartya Sen's terminology, dependency (meaning one person's reliance for constant help on another in order to lead a dignified life) diminishes both the functionings and the capabilities of individuals and families. Severe chronic diseases, disabilities, and the forms of dependency which derive from them, restrict opportunities for everyday living, and they reduce people's capacities in numerous spheres of their lives (Lyons,Sullivan and Ritvo, 1995). Although they do not necessarily give rise to individual and social breakdown, they nevertheless entail a reorganization of material and symbolic resources which requires support from public policies.

The thesis of this article is that physical and/or mental dependency is a social risk likely to disrupt the organizational routine of households and to decrease the life chances of people. However, dependency is only one among several risk factors: for dependency may have very different impacts according to the type of household, the economic and social resources on which people draw, and the generosity of welfare programmes designed to protect dependent persons. The right to be cared has been called an 'incomplete social right'

(Leira, 1999) because it is rarely granted as an enforceable right. In countries where care provision is a right, it takes mainly the form of an entitlement to economic benefits paid to the caregiver or the care recipient. The impact of welfare policies on the vulnerability of the dependent person must therefore be carefully evaluated, taking both the quantity and types of benefits in consideration.

It's important to remember that when dependency is severe and of long duration, it involves not only the dependent person, but also those persons who care for him or her, and primarily family members (both cohabitants and otherwise). As a large body of research has shown (Oesterle, 2001; Eurofamcare Consortium, 2006), albeit with significant differences among countries, care is still – at least in Europe – a 'family matter' which requires a reorganization that sometimes involves several households. Care was for long time confined to the sphere of intimacy and of private solidarity. Only in the last two decades, with the explosive growth of the elderly population, has it moved into the public domain. '*Who will care?*' was the title of a research report published fifteen years ago. It was accompanied by a subtitle significant in how it positioned the entire issue: 'Future Prospects for Family Care of Older People in the European Union' (European Foundation for the Improvement of Living and Working Conditions, 1995). The problem of how, and with what resources, communities can deal with the increase in the dependent population has arisen as a consequence of two processes: the extraordinary increase in life expectancy, and the progressive demise of the family as the crucial caring institution for the most fragile. In regard to the former phenomenon, it should be remembered that – because the increased life expectancy in the EU countries has been accompanied by a greater disability-free life expectancy– different scenarios have been put forward on the link between ageing and increased dependency. The majority of researchers agree that if there are 'more sick but less disabled' (Freedman and Martin, 2000), then also the care needs of over 85-year-olds will increase (in absolute value and as a percentage of the total population), this being the age-group with the highest disability rate and long-term needs (Jacobzone, Cambois, Robie, 1998).

In this article we analyse in which sense and to what extent dependency compromises the 'normal' functionings whereby people self-determine their lives, whether dependency can be considered a specific vulnerability factor (Ranci 2010). The vulnerability due to dependency will be identified in the fact that many families with dependents, because of their care responsibilities and their relative costs, experience a marked decline in their living standards. The comparative analysis will be done using the last available EU-SILC survey data (they refer to 2006) and it will rely largely on the distinction drawn by Anttonen and

Sipilä (1996) among different care regimes in Western Europe (the Scandinavian model, two Continental models - Francophone and German-speaking one-, the Anglo-Saxon model and the Mediterranean) with the addition of a supranational aggregate for the EU Eastern Countries[1].

2. Dependency and its working definition in the EU-SILC Survey

Disability and care needs are not adequately represented in national statistical systems. Information on these aspects is collected on the basis of logical schemes, sampling techniques, and variables selected in accordance with rather diversified objectives (Fujiura, Rutkowski-Kmitta, 2001). Defining what is meant by 'dependent person' is anything but straightforward and free of ambiguity. The operational definition of 'dependency' used in this article, on the basis of EU-SILC data, entails choices which should be explained in detail.

Before providing a working definition of dependency – inevitably conditioned by the limited data available – we shall discuss the concepts correlated with it. The concept of disability has been subject to constant discussion on its definition with many controversies (Barnes, Mercer and Shakespeare, 1999). Disability has been defined by the WHO International Classification of Impairments, Disabilities and Handicaps (ICIDH) – which was used until 2001 – as 'any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being' (1980). Whilst impairment is the physical damage incurred by a person due to an illness or an accident, disability is the incapacity to perform the normal activities of daily life consequent on impairment. Handicap is instead defined as the social disadvantage due to having a disability. Although this classification has been superseded, it still informs the majority of the

[1] In this first attempt to include Central and Eastern European (CEE) countries in the analysis of vulnerability issues related to dependency (see Costa and Ranci 2010 for and analysis of Western European countries using ECHP 2001 data), we use a residual Welfare Regime category including all of them, aware that there is an ongoing debate about how distinguish them internally and that this kind of classification is in any case "transitional". Some scholars (i.e. Rys 2001) argue that it's not possible to distinguish a post-communist welfare pointing out the high order variety across these countries. Others, as Fenger (2007), propose to position the countries comprised in EUSILC 2006 in two different Regimes: Former USSR Type (including Estonia, Latvia and Lithuania) and Post-Communist European Type (including Czech Republic, Hungary, Poland and Slovakia). These countries shared in the early years of transformation high levels of inflation, unemployment and poverty that created an urgent need for forms of social protection (Fultz 2002) what explains the introduction of relatively elaborate unemployment, disability, sickness and early retirement schemes.

instruments used by national statistics offices[2]. Yet it still leaves the concept itself of disability undefined.

Three main new interpretative frames have been recently introduced in this discussion. The first, based on a medical perspective, connects disability with the presence of an illness or an impairment. The second one ties disability to functional limitations in performing everyday activities. The third one takes an ecological perspective and regards disability as the result of interaction between the individual (with his/her specific characteristics) and the social and physical context (Fujiura, Rutkowski-Kmitta, 2001). The second frame most frequently informs European statistical surveys. According to it, limitations in the performance of everyday activities (walking, seeing, listening and speaking) determine a more or less pronounced level of disability. The majority of studies use batteries of questions relating to two indexes: one developed by Katz, the other by Lawton and Brody[3]. These indexes are respectively based on two typologies of activity: ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living). ADL and IADL are often combined, but they yield definitions of disability which vary considerably according to the criteria used to establish cut-off thresholds in the levels of impairment that is considered disabling.

The international literature shows a clear connection between the presence of substantial health problems and problems of severe disability[4]. Data on disability are generally constructed by verifying the presence of physical or mental anomalies, chronic illnesses or disorders and, consequently, the presence or absence of limitations on the ability to perform everyday activities, or a loss of functions. This is also the approach taken by the EU-SILC, which first asks 'do you suffer from any chronic (long-standing) illness or condition?'. It then asks whether, because of health problems, the respondent is 'limited or

[2] The WHO has recently adopted a new instrument and a new conceptual scheme to describe and measure the population's health and disability: the International Classification of Functioning, Disability and Health (ICF). It has thus superseded a conception of disability centred on the individual which neglected environmental and social factors. Although the concept of disability is extended in this new conceptual scheme, it is often used as 'an umbrella term covering any or all of the following components: impairment, activity limitation and participation restriction, as influenced by environmental factors' (Lafortune, Balestat et al., 2007).

[3] This applies mainly to elderly people. Eurostat, for instance, when collecting data for its Health Status Statistics, uses a disability indicator for adults of working age constructed by combining three variables relating to restrictions on the type of work performed, the amount of work that can be done, and mobility to and from the workplace.

[4] There is substantial agreement on their underlying causes: mainly muscular-skeletal problems, arthritis, cardiovascular problems, and respiratory disorders (Freedman and Martin, 2000).

strongly limited in activities'. The purpose is to distinguish long-term problems from acute ones, which may be severe and limiting but are contingent and with rapid remission. Moreover, the reference to the severity of impediments to daily life (the possible answers to the specific question in the EUSILC survey are 'no, no limited', 'yes, limited' and 'yes, strongly limited') comes very close to the phenomenon of serious disability. In 2006, 16,5% of respondents defined themselves as limited in the performance of daily activities, while only 7,9% regarded themselves as severely limited. These values are much more congruent with national data collected by surveys conducted specifically to measure states of health and disability (Eurostat 2003, Lafortune, Balestat et al., 2007). However, also this definition of dependency requires caution because not all severe limitations in daily life necessarily give rise to a need for constant help and care. The notion of dependency in this context comprises some specific types of limitation: long term dependency and with a substantial need for help in terms of intensity and/or frequency.

In the absence of specific information on the need for help, in what follows dependency is defined on the basis of a threefold criterion: defined as dependent are persons who, besides suffering from a chronic condition and besides being 'strongly limited', also declare that they suffer from bad or rather bad health (replying to the question 'how is your health in general?'). For these persons, perception of the severity of their activity limitation is heightened by the fact that they declare to not enjoy good health. Here, therefore, dependency is construed as a long-term condition connected to problems of illness and chronic disability, which restricts the performance of daily activities and has a negative impact on the person's perception of his/her state of health.

3. The dependent population, it's general characteristics

According to EU-SILC data for 2006, on the basis of the working definition given above, 6.8% of the population of the EU countries was dependent with the following differences per age: 23,4% of those aged 75 or more, 12,8% of aged 66-75 and 4,1% for adults, those are 16-65 years old. Excluded from this estimate are persons in residential facilities – an important component of the population definable as 'dependent'. Overall, the sample of the dependent population (20.672, 6.477 over 75 years old, 4.995 from 66 to 75, 9200 aged 65 or less) refers to individuals of 25 countries (there are no available data for Bulgaria and Denmark in EU-SILC 2006). Dependency rate varies from 13,3% of Hungary and 11,2% of Finland to 4,5% of Luxembourg or 4,7% of Ireland. It is due to various factors,

such as different linguistic and cultural interpretations of the terms used in the survey, the different demographic compositions of populations, as well as differing perceptions of dependency as a public issue and therefore declarable matter. The volume in supply of residential institutions can change also the amount of dependent people in a country. Dependency rate increases with age, and there are more women dependent than men (Table 1). The joint effect of these two features is the presence of a large component consisting of elderly women. Overall, therefore, the dependent population is characterized by a high degree of old age and feminization.

Table 1. Dependency rates in EU 25 per sex and age (2006)

	Men	Women
Over 75 years old	20,4%	25,5%
66-75 years old	12,2%	13,4%
Up to 65 years old	3,9%	4,3%

Table 2. Dependency rates in EU per Welfare Regime (2006)

Welfare regime	Dependency rate
Scandinavian area	8,6%
German speaking area	7,1%
Francophone area	5,6%
Anglo-Saxon area	7,4%
Mediterranean area	6,4%
Eastern area	7,5%
Total EU 25	6,8%

4. Dependency and profiles of vulnerability connected to it

Dependency is a factor which indubitably places those who experience it in a situation of vulnerability. However, adequate assessment of this effect requires to consider the situation of the whole household in which the dependent person lives. In Europe, more than one household in every ten (11,8%) has a dependent member; 7,5% of households has an adult

dependent, 20,9% in case of households has a dependent elderly person (table 3). These are extremely high proportions, which reflect the effects of the general ageing of the population. The share of households with at least one dependent person is higher in the Eastern area (14,6%) and it is substantially lower in the Scandinavian area (8.6 %), with intermediate levels in Continental countries (11.3% in the German-speaking area, 9,6% in the Francophone area), in the Anglo-Saxon area (12.1%) and in the Mediterranean one (12,5%). These differences among the Scandinavian area and the rest of Europe are mainly due to the more frequent institutionalization in residential facilities of dependent persons in the countries of North Europe.

Table 3. European households with a dependent member (2006)

Welfare regime	Families with 1+ dependent adult	Families with 1+ elderly dependent	Families with 1+ dependent
Scandinavian area	6.4	16.0	8.6
German speaking area	8.2	18.3	11.3
Francophone area	5.7	19.0	9.6
Anglo-Saxon area	8.8	20.4	12.1
Mediterranean area	6.7	22.1	12.5
Eastern area	8.9	26.4	14.6
Total EU 25	7.5	20.9	11.8

4.1. The compression of living standards

Families with dependent members often experience a 'compression' of their living standards due to two main factors: the lesser capacity to work of dependent people and the fact that dependency entails increased expenditures for routine activities. Let's see them separately.

The lesser capacity to work of dependent people is evident through the data analysis and is reflected by their different educational attainments too. Dependent adults with low educational levels attained (only pre-primary or primary education) are 18,9% while this percentage is almost half (9,5%) among non dependent adults in Europe. The activity rate among dependent adults is 40,1% for men and 27,3% for women, while in the rest of the adult population is respectively 85,6% and 66,2% (table 4). German-speaking countries offer

greater employment opportunities to adult dependent persons than do the other regimes, both for men and for women. In the countries belonging to this regime, in fact, the activity rate rises to almost 60% for dependent men and 40,1% for women. Scandinavian, Francophone and Mediterranean countries are positioned under the European mean. The countries with the major gaps in the activity rate for dependent and non dependent individuals belong to the Anglo-Saxon and the Eastern areas. These last are also the countries which offer fewer work opportunities for adult dependents.

Table 4. Activity rates among dependent and non dependent individuals per sex and per welfare regime (2006)

	Men			Women		
Welfare regime	dependent	Non dependent	% variation	dependent	Non dependent	% variation
Scandinavian area	46,6	85,6	- 46%	40,8	79,6	- 49%
German speaking area	59,6	87,1	- 32%	40,1	72,6	- 45%
Francophone area	45,6	85,8	- 47%	34,5	70,9	- 51%
Anglo-Saxon area	23,4	87,3	- 73%	22,8	72,2	- 68%
Mediterranean area	40,2	86,6	- 54%	19,8	53,9	- 63%
Eastern area	26,8	80,1	- 67%	21,9	70,0	- 69%
Total EU 25	40,1	85,6	- 53%	27,3	66,2	- 59%

The lesser capacity to work of dependent adults emerges also from the data about part-time work and unemployment rates . Their share of part-time work (32% vs. 18,7%) and their unemployment rate (29,9% vs. 8,6%) are much higher than in the rest of the population (table 5). Greater variations in terms of part-time work are found in Eastern countries (which have in general quite low level of part-time work) and in Scandinavian ones. Unemployment differentials are quite high everywhere.

Table 5. Part-time work rate and unemployment rate among dependent and non dependent adults (2006)

Welfare regime	Part-time depen-dents	Part-time non depen-dents	Dependents/ non dependents	Unempl. dependents	Unempl. non dependents	% variation
Scandinavian area	36,0	16,8	214%	18,0	5,8	310%

German speaking area	47,9	33,8	142%	27,9	8,5	328%
Francophone area	24,2	17,6	138%	29,1	10,1	288%
Anglo-Saxon area	28,6	23,4	122%	13,3	4,1	324%
Mediterranean area	19,9	10,6	188%	28,7	10,7	268%
Eastern area	20,0	6,7	299%	31,2	14,5	215%
Total EU 25	32,0	18,7	171%	29,9	8,6	348%

The work difficulties of dependent persons significantly affect both the organization of their families (the household members who assume caregiving responsibilities must reconcile paid work with care by accepting jobs with reduced hours or low wages), and the household's overall income. Moreover, in countries where welfare benefits are linked to the contributive capacity of citizens, the low activity rate of dependents and their family members, or the presence of family members with low wages, also reduces welfare transfers. Therefore, the lost earnings due to dependence are hardly compensated by welfare measures targeted on persons with diminished work capacity or on caregivers.

The second compression factor is related to the fact that dependency entails increased expenditures for routine activities (using public transport, shopping, home cleaning, preparing food, and so on), which are more costly for a disabled person, and for the care activities made necessary by the state of dependency (help with physical mobility and care of the person, rehabilitation, and so on).

The first step in our analysis concerns the income differentials between the dependent and non-dependent populations. The average per capita eq uivalent income of households with at least one dependent member is almost 30% less than the income of households without dependents. The gap largely diminishes when the dependent is aged over 65 (15%). In Anglo-Saxon countries the differential increases substantially in households with adult dependents (reaching 44,6%), while Scandinavian countries show the lowest differentials. Income differentials in families with adult dependents increase sizeably in the regimes where the activity rate of dependent people is lower. The possibility of finding and keeping a job therefore is an important factor in the defence against the economic vulnerability due to dependency. The elderly population exhibits smaller income differentials, owing to the presence of generous income pensions support programmes.

Table 6. Income differentials among households with and without dependent adults and dependent elderly (2006)

Welfare regime	Households with no dependent adults	Households with dependent adults	% variation	Households with no dependent elderly	Households with dependent elderly	% variation
Scandinavian area	22.835	20.625	-10.7%	17.531	15.743	-11.4%
German speaking area	18.418	15.201	-21.2%	16.402	15.114	-8.5%
Francophone area	19.292	15.969	-20.8%	16.772	15.239	-10.1%
Anglo-Saxon area	24.535	16.965	-44.6%	17.242	16.208	-6.4%
Mediterranean area	15.384	11.851	-29.8%	12.886	11.654	-10.6%
Eastern area	4.500	3.504	-28.4%	3.796	3.506	-8.3%
Total EU 25	16.868	13.045	-29.3%	13.915	12.105	-15.0%

Note: The income considered is the equivalent household income (modified-OECD scale)

These wide income differentials to the detriment of the dependent population have several consequences. The first is the greater exposure of these households to the risk of poverty (Table 7). In general, dependency determines a 40% increase in a household's poverty risk. The probability of being poor because of dependency substantially increases everywhere, with the exception of the Eastern area (only plus 7%): it is more than the European mean in the Francophone area (61%), in the Anglo-Saxon area (48%) and in the German-speaking area (43%) while it is under the average level in the Mediterranean countries (38%) and in Scandinavia (39%). As we shall see, this variation depends closely on the extent and generosity of public welfare programmes. In any case, the incidence of poverty among households with dependents is quite significant, given that it affects more than two European households in every ten.

Table 7. Poverty rates among households with and without dependent members

Welfare regime	Poor households without dependent members	Poor households with dependent members	Variation %
Scandinavian area	14,8%	20,5%	+39%
German speaking area	13,7%	19,6%	+43%
Francophone area	13,6%	21,9%	+61%
Anglo-Saxon area	19,5%	28,9%	+48%

Mediterranean area	19,8%	27,4%	+38%
Eastern area	15,8%	16,9%	+7%
Total EU 25	16,3%	22,9%	+40%

Much more frequent, instead, are situations of weak material compression, such as impossibility to have money savings or cutbacks in consumptions. Rather than a factor of impoverishment, therefore, dependency is a vulnerability factor which decreases economic resources, restricts possible options, reduces protection against other negative events, and compresses the overall standard of living. The EU-SILC data show that households with a dependent member are notably financially compressed (see Table 8). Almost 30% of them report problems of affordability regarding two or more of the following goods and services: a week of holiday away from home, eating meat, chicken and fish (or vegetarian equivalent) every second day, facing unexpected financial expenses and to make ends meet. The proportion is more than twice as high in households with dependents as in households without dependents. Taken as a whole, these data suggest that dependency, in mature welfare systems, strongly reduce the use of economic resources, whilst the poverty risk affects a smaller proportion of the dependent population. In the Eastern area the proportion of compressed households with dependent members in very high, more than 50%, followed by Mediterranean countries.

Table 8. Levels of economic compression (incapacity to enjoy two or more of having holidays, eating meet, meet unexpected expenditures, make ends meet) (2006)

Welfare regime	Households without dependent members	Households with dependent members	Variation	Variation %
Scandinavian area	4,6	18,0	+ 13,4	+ 390%
German- speaking area	7,1	17,0	+9,9	+ 240%
Francophone area	11,9	21,8	+9,9	+ 180%
Anglo-Saxon area	8,9	19,9	+11,0	+ 120%
Mediterranean area	16,4	33,3	+16,9	+ 200%
Eastern area	35,3	52,6	+17,3	+ 150%
Total EU-25	14,2	28,6	14,4	+ 200%

One of the factors responsible for the economic compression of households with dependent members is that they incur additional costs in their everyday activities. An indirect

way to assess their need for additional income is to consider income differentials solely for households which declare that they can *easily* 'make ends meet'. These represent only 10,1% of all European households with at least one dependent member, while they represent 15,4% of households without dependents (table 9). The territorial distribution is markedly uneven: such households exceed 21% % in the Scandinavian and German-speaking area, but they amount to only 2% in Eastern countries and 4% in the Mediterranean ones. It can be presumed that the average income of these 'satisfied' households indicates the average economic threshold above which households with dependents are able to meet all their expenses, including those relative to care needs and the transport of dependents. The percentage increase in income with respect the average income of all households with dependents is 38%. It increases enormously in Mediterranean countries (where income must almost double for all material needs to be easily satisfied, plus 81%) and greatly in the Eastern area (65%) , while it is quite low in Scandinavian and German speaking countries (only plus 16%). In the latter countries the abundant availability of services and forms of public support therefore brings a net improvement to the life-quality of low-income dependent persons. In absolute terms, a household with a dependent member in the Mediterranean area needs an additional income which is relatively four times higher than that required by a Scandinavian or German household.

Table 9. share of families with dependent members that EASILY satisfy their material needs and Percentage increase in income with respect to the average income of all households with dependents

Welfare regime	% share of families with dependent members that EASILY satisfy their material needs	Percentage increase in income with respect to the average income of all households with dependents
Scandinavian area	21,1	+ 16%
German- speaking area	17,9	+ 16%
Francophone area	9,6	+ 44%
Anglo-Saxon area	14,5	+ 33%
Mediterranean area	4,2	+ 81%
Eastern area	2,4	+ 65%
Total EU-25	10,1	+ 38%

To sum up, dependency strongly compresses the material life of households, and this compression in its turn drastically reduces their living standards. Rather than increasing the poverty risk, dependency produces a general situation of economic vulnerability generated by the decrease in income that is consequent of the reduced activity rate of dependent persons and of the higher expenses incurred by their families. Only a minority of households have high incomes to afford specific care services and maintain a satisfactory standard of living. However, marked differences are apparent in the economic conditions of households with dependents in different care regimes. The next section therefore examines the specific role performed by policies to reduce the economic vulnerability of dependent people.

4.2 The role of policies in reducing the economic compression

The income level of the dependent population is strongly related, in all the EU countries, to public monetary transfers. It is important therefore to analyse the role of welfare benefits in reducing the risk of economic deprivation for households with dependents. We will thus concentrate on two issues: the coverage of support programmes and their ability to reduce poverty risks and attenuate economic compression. We will analyse which kind of impact **disability benefits** (henceforth DSB) have in this sense. As stated in EU-SILC guidelines "disability benefits refer to benefits that provide an income to persons below standard retirement age whose ability to work and earn is impaired beyond a minimum level laid down by legislation by a physical or mental disability". In this context, "disability is the full or partial inability to engage in economic activity or to lead a normal life due to a physical or mental impairment that is likely to be either permanent or to persist beyond a minimum prescribed period" (ibidem). It's important to point out that these DSBs are allowances implemented and accessed on the base of different eligibility criteria across the European countries. Two types of benefits can be distinguished: benefits intended to substitute the lack of income due to dependency, and benefits provided to pay for care services. The former are disability pensions, highly standardized in European countries and compensating for a continuous inability to work. The latter are care allowances paid in order to support the direct provision or the purchase of daily home assistance[5]. Unfortunately, the information available

[5] As information on expenditure by the families of dependent persons is not available in EUSILC, this aspect can only be investigated indirectly.

from the EU-SILC survey cannot be used to distinguish between the two types of benefits, which will therefore be considered jointly[6].

Table 10 shows that more than 40% of households with a dependent adult receive some benefits[7]. The coverage is broad, more than 50%, in the Scandinavian and Eastern area and narrower in Southern Europe and in the Continental area. While Germany has a model of economic support based on generous but strongly selective programmes, the Anglo-Saxon and the Eastern areas exhibit the reverse model based on the broad coverage of less generous measures. In Scandinavian countries the ample coverage of measures combines with relatively high amounts, while the Francophone and the Mediterranean areas have relatively lower amounts and a limited coverage of programmes.

Table 10. Percentage of families with dependent adults receiving DSB, percentage of DSB on total income of households with working and not working dependent members (2006)

Welfare regime	Coverage rate of DSB among adults	% of DSB on total personal income among those who work	% of DSB on total personal income among those who do not work	% of DSB on total household income
Scandinavian area	55,9%	33,9%	82,5%	38,7%
German- speaking area	35,0%	40,6%	91,5%	24,1%
Francophone area	32,0%	35,7%	95,1%	22,9%
Anglo-Saxon area	41,5%	24,1%	76,1%	25,6%
Mediterranean area	29,5%	46,1%	93,3%	16,2%
Eastern area	54,9%	49,9%	95,2%	33,8%
Total	38,8%	41,4%	83,2%	24,2%

Note: the average amount of DSB per regime is not weighted by the purchase power parity so it's not possible to make comparisons inter regime on these specific issue.

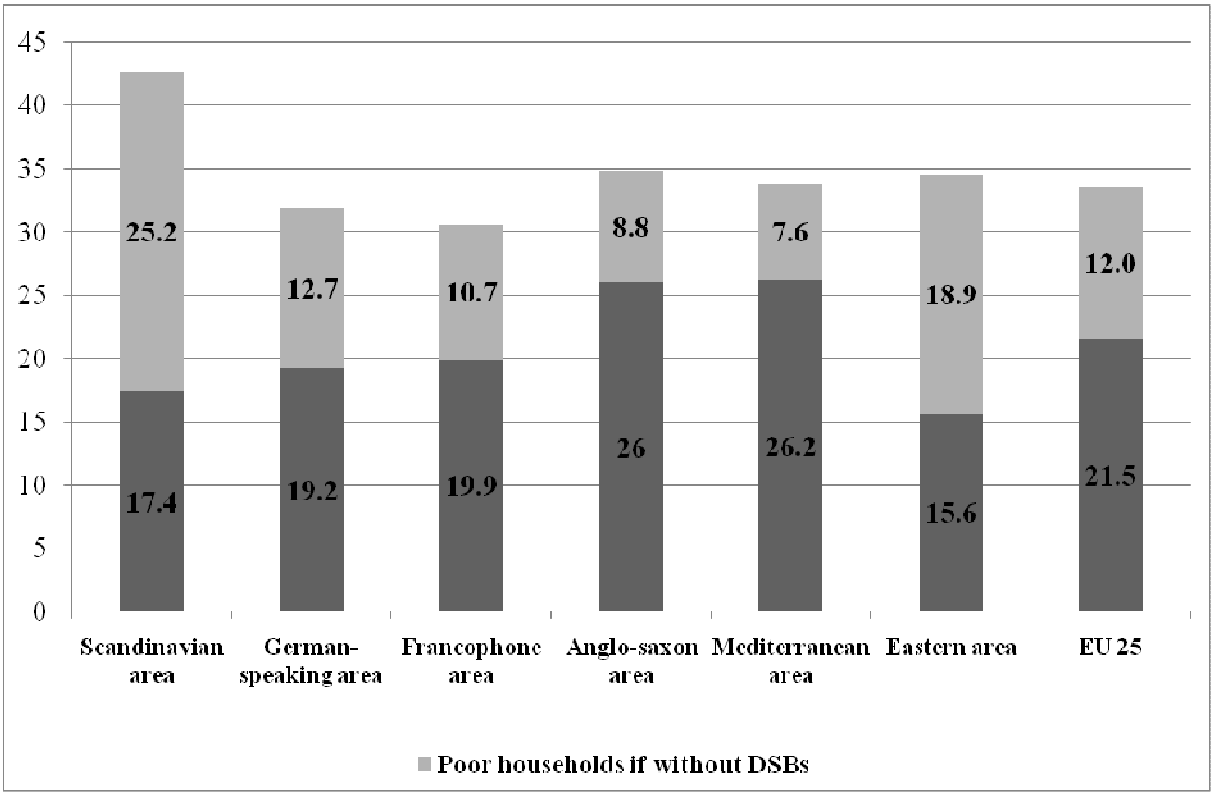
Let's now examine the effect of DSBs on the poverty risk and on the compression on the living standards of households with dependent members. DSBs altogether represent 83,2% of the total income of households with dependents in the EU-25 countries. The percentage

[6] Unfortunately, the EUSILC survey (and the same the former ECHP survey) does not furnish information on the receipt of services in kind as alternatives to monetary transfers. For this reason, given the variety of mixes between cash and care in the European countries, not considered here are the economic benefits deriving from social assistance measures, it not being possible to estimate the benefits delivered through services in kind.

[7] Considered here are only benefits paid to dependent people of working age, given that above this age in many European countries disabilities benefits are converted in seniority pensions.

does not substantially change across the areas considered, excluding the Anglo-Saxon one. Benefits therefore make a substantial contribution to the incomes of these families. The role of these measures in countering poverty is also significant, as shown in Figure 1. Around 55% of households with dependents whose incomes would fall below the national poverty thresholds are able to rise above them because they receive a DSB. The share is particularly high in Scandinavian and Eastern countries, where the relative amount of DSBs is larger if compared to household and personal incomes. In Southern Europe and in the Anglo-Saxon areas the capacity of DSBs to combat poverty is weakened by their lower amounts: in these areas the households which avert poverty thanks to DSBs are respectively 29 % and 34 %. The effect of DSBs on the degree of household economic compression is less clear. In general, the distribution of DSB is unable to reduce significantly the share of households finding it difficult to satisfy their material needs.

Figure 1. Effect of DSBs on the poverty risk of families with dependent people (2006)



Households with dependent members are therefore strongly exposed to economic vulnerability. Only a very small proportion of these households have a standard of living enabling them to easily satisfy their material needs. For the majority of households, instead, the presence of a dependent member significantly reduces their living standards. Even if welfare benefits decrease significantly the poverty risk for these families, they seem

insufficient to prevent dependency from being frequently associated with some degree of material deprivation.

Within this general picture, marked differences emerge among care regimes. In the Scandinavian and Continental (both Francophone and German speaking) areas, the activity rate of adult dependent people is higher. This gives rise to better income levels and living standards compared with the rest of Europe; also DSBs act as significant shock-absorbers by protecting a large proportion of households against the risk of poverty (but without significantly attenuating the economic compression) and they perform a significant redistributive function. In the Anglo-Saxon, Mediterranean and Eastern areas the situation is more difficult: here households with dependents suffer from a higher income differential and from a tighter economic compression, which is only slightly attenuated by lower and less widely available state income support.

5. Families and dependency

We have already said that the loss of self-sufficiency is a 'family matter' which involves not only dependent persons but also their family networks. Throughout Europe caring for dependents is entrusted primarily to family solidarity (Österle 2001, Alber and Köhler 2004, Eurobarometer 2007, Thévenon 2008). The persistence of the central role played by family in care delivery has been explained in two different ways. In a first interpretation care is founded on norms regulating the relationships between individuals and their families (Finch, 1989). In a second interpretation the persistence of family care responsibility depends mostly on the architecture of social protection systems (Leira, 1999; Leira and Saraceno, 2002), on disparities in the levels of residential facilities provision, level and extension of disability pensions and delivery of home care services. The impact of dependency therefore varies substantially according to the type of family and to the quantity and type of support that the family is able to provide. State support remaining equal, whether or not dependent persons have families able to look after them largely determines the quality of their life.

Unfortunately, in the EU-SILC survey no data are available to reconstruct relations between care recipients and family caregivers. The analysis must therefore be restricted to the kind of family where dependent people can live, without considering the helping relations among non-cohabiting family members (Cioni 1999; Attias-Donfut, 1995). Dependent people more frequently live with other relatives that do non-dependent people of the same age. The

percentage of dependent persons living alone are quite high in Northern Europe and it decreases going South as marked differences emerge according to the Welfare regime considered (see Table 11). In all of them the proportion of elderly dependents compared to adults ones living alone is much higher (the same arrangements are found among non dependent). In Scandinavian countries single dependent people form the overwhelming majority among elderly ones – almost 70%–. In Mediterranean countries and in the Eastern and in some way Francophone area, by contrast, the proportion of single dependents is small, while cohabitation presumably accounts for the majority of household forms: which is indicative of the resilience of family solidarity in those countries. In the Germanic and Anglo-Saxon areas the model is more individualized and resembles the Scandinavian pattern.

Table 11. Share of families with dependents consisting of single individuals by Welfare regime (2006) (row percentages)

Welfare regime	Families with adult dependents single	Families with elderly dependents single
Scandinavian area	43,3%	69,8%
German- speaking area	31,0%	38,9%
Francophone area	20,5%	43,1%
Anglo-Saxon area	25,3%	47,3%
Mediterranean area	8,8%	29,2%
Eastern area	13,6%	40,0%
Total EU-25	21,3%	38,5%

Data evidences that loneliness is very widespread among the dependent elderly. Almost fourth each ten elderly dependent people, in fact, live alone. Loneliness increases up among individuals aged over 75 years. The absence of co-resident family members compels care arrangements to be made by resorting to external resources, both informal and formal, an aspect that unfortunately can't be explored trough EU-SILC data base.

The family arrangements issue is very important to understand to what extent dependency arises levels of vulnerability because we know that most of the care problems of dependent persons arise at the point of intersection between forms of family cohabitation and state support (Costa and Ranci 2010). When the family is lacking in an institutional context with abundant services, the quality of life may continue to be relatively high. Where the endowment of public care services is lower, the living arrangements of dependent persons are based on cohabitation among different generations of adults can be a crucial solution.

8. Conclusions

In this paper we have argued that dependency (as a specific combination of severe difficulties in performing everyday activities and poor health) is a cause of vulnerability which compromises the 'normal' functionings whereby people self-determine their lives. We mainly investigated how dependency diminishes families life-chances, at least from the economic point of view. In Western Europe, 7,5% of families have an adult dependent member, 20,9% a dependent elderly person. Dependency is therefore rather widespread in Europe. The two features shared by all countries is that the dependency rate increases with age, and it is more frequent among women than men. In all the European countries dependency is associated with a decline in the living standards of dependents and their families. It increases the risk of poverty but above all dependency generates a general situation of material compression due to increased spending on care and to lower activity rate of dependent people. These factors depress household consumption and the capacity to make ends meet.

However, the economic impact of dependency displays marked geographical differences. Countries able to create greater work opportunities for dependent persons exhibit smaller differentials in average income between families with and without dependents, compared with countries unable to create such opportunities. Public monetary transfers for care (DSBs) have a significant capacity to reduce the poverty risk: indeed, more than half of families with dependents receiving such benefits in the enlarged Europe rise above the poverty threshold. The effect of DSBs on the degree of economic compression of families is instead less evident. This result shows that income support to dependent people plays a major role in avoiding poverty and economic compression in a relevant part of the elderly population over Europe: a fact that should be accounted by policy makers and should be better considered by social policy scholars.

A second aspect considered has been the protection furnished by families. Throughout Europe care is still a 'family matter': families deliver the bulk of care to dependent people. The impact of dependency therefore varies substantially according to the type of household in which the dependent person lives and the support that the family is able to furnish. However, there are significant differences among care regimes. Scandinavian, German-speaking and Anglo-Saxon countries exhibit a more individualized model, with a large proportion of elderly dependent people living alone. Instead, in Mediterranean countries, and to some extent in the

Francophone area, the proportion of dependent persons living alone is low, to confirm that cohabitation of the dependent with other family members is widespread. Policies have an important role in his sense: the absence of accessible personal supports (mainly home care and assistance as well as incentives for independent living) makes family arrangements more probable. In these countries, the frequency of cohabitations reduces the poverty risk connected with dependency. The analysis of this dimension confirms the Welfare regimes typology used.

Summarizing we can argue that two specific vectors of social vulnerability emerge. The first concerns the material circumstances of life; the second has to do with family organization. Dependency creates economic vulnerability with pronounced effects on the living standards of families notwithstanding generous public benefits which often prevent the onset of poverty, but not severe material compression. Since this vulnerability is closely correlated with the worklessness of dependent people, it has been attenuated in those countries (particularly Scandinavian and Germanic countries) with greater labour-market participation by dependent adults. In any case, throughout Europe dependency brings about economic risks insufficiently recognized and protected and it still has a weak citizenship in the public discourse and in public policies.

But dependency, as we try to figure out, has a major impact on people's lives. The analysis proposed here highlights some challenges for research and for social policy-making, it calls for a new approach by policy-makers and a radical change in welfare systems. Of course, there are structural dynamics that claim for such change and which increasingly manifest the gap between the growing care needs of the population and the weakening care capacity of contemporary society: becoming a dependent person is increasingly a widespread experience.

References

Alber, J.- Köhler, U.

2004 *Health and Care in the Enlarged Europe,* European Foundation for the Improvement of Living and Working Conditions, Office for Official Publications of the European Communities, Luxembourg.

Anderson, R. e Bury, M.

1988 *Living with Chronic Illness. The Experience of Patients and their Families*, London, Unwin Hyman.

Anttonen, A.- Sipilä, J.

1996 *European social care services: Is it possible to identify models?,* in "Journal of European Social Policy" 6: 2, pp. 87- 100.

Attias-Donfut, C. (a cura di)

1995 *Les solidarietés entre générations. Vieillesse, Famille, Etat*, Paris, Nathan.

Bury, M.

1991 *The Sociology of Chronic Illness: A Review of Research and Prospects*, in "Sociology of Health and Illness", 13, pag. 451-468.

Costa, G.- Ranci, C.

2010 *Disability and Caregiving: A Step Toward Social Vulnerability?*, in in Ranci C. (ed.) *Social Vulnerability in Europe. The New Configuration of Social Risks*, Palgrave MacMillan, New York.

Eurobarometer,

2007 *Health and Long-Term Care in the European Union*, European Commision, reperibile a http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

EUROFAMCARE Consortium (Eds.),

2006 *Carers of Older Dependent People in Europe: Characteristics, Coverage and Usage*, reperibile sul sito del programma EUROFAMCARE, http://www.uke.uni-hamburg.de/extern/eurofamcare.

Eurostat

2007 *Living Conditions in Europe*, 2007 edition

2003 *Feasibility Study- Comparable Statistics in the Area of Care of Dependent Adults in the European Union-*

Fenger, H.J.M.

2007 "Welfare Regimes in central and Eastern Europe: Incorporating Post-Communist Countries in a Welfare Regime Typology", in Contemporary Issues and Ideas in Social Sciences, August 2007.

Finch, J.

1989 *Family Obligations and Social Change*, Cambridge, Polity Press.

Fultz, E.

2002 "Social Security Reforms in Central and Eastern Europe: How Effective, Equitable and Secure?" In ISSA European Regional Meeting, Budapest.

Freedman, V.- Martin, L.

2000 "Contribution of chronic conditions to aggregate changes in old-age functioning", American Journal of Public Health, 90 (11), pp.1755-1760.

Fujiura G.T.- Rutkowski-Kmitta,

2001 *Counting Disability*, in (eds.) Albrecht G.L., Seelman K.D., Bury M. *Handbook of Disability Studies*, Sage, Thousand, pp. 69-96.

Grammenos, S.

2003 *Illness, Disability and Social Inclusion*, European Foundation for the Improvement of Living and Working Conditions, Office for Official Publications of the European Communities, Luxembourg.

Jacobzone, S.- Cambois, E.- Robie, JM.

1999 *The health of older persons in OECD countries: Is it improving fast enough to compensate for population ageing?*, OECD Labour Market and Social Policy Occasional Papers, n° 37, OECD.

Lafortune, G.- Balestat,G. and the Disability Study Expert Group Members

2007 *Trends in Severe Disability Among Elderly People: Assessing the Evidence in 12 OECD Countries and the Future Implications*, OECD Health Working Papers, n° 26..

Leira, A.

1999 *Reflections on caring, gender and social rights*, paper presentato alla conferenza ESA Will Europe Work?, Amsterdam 1999.

Leira, A. - Saraceno, C.

2002 *Care: Actors, relationships, contexts*, in B. Hobson, J. Lewis, B. Siim (Eds.), *Contested concepts in gender and social politics*, Edward Elgar, Cheltenham, 2002.

Lyons, R. F.- Sullivan, M. J.-Ritvo, P.

1995 *Relationships in Chronic Illness and Disability*, London, Sage.

Österle, A.

2001 *Equity Choices and Long-Term Policies in Europe*, Aldershot, Ashgate.

Ranci, C.

2010 *Social Vulnerability in Europe*, in Ranci C. (ed.) *Social Vulnerability in Europe. The New Configuration of Social Risks*, Palgrave MacMillan, New York.

Rys, V.

2001 "Transition Countries of Central Europe entering the European Union: some Social Protection Issues", International Social Security Review 54(2-3), pp. 177-189.

Thévenon, O.

2008 *Family policies in Europe: available databases and initial comparisons.* Vienna Yearbook of Population Research, 165-177.

WHO,

1980 *International Classification of Impairments, Disabilities and Handicaps,* www.who.org.