DEPENDENCY AND POVERTY:

THE EFFECT OF LTC SPENDING ON DEPENDENT ELDERLY PEOPLE AND THEIR FAMILIES' INCOME

Thesis

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INTRODUCION

In 2060 the percentage of people aged 65 years and older will reach 30% in most European countries (Eurostat 2011), an increase of 13 percentage points over 2010 (see also Economic Policy Committee, 2001). This increase gives an idea of the needs connected with the LTC services in the near future. Lafortune et al. (2007) notes that, even if the disability rates are decreasing to a certain extent in some countries (Denmark, Finland, Italy, The Netherlands and USA) (Gruenberg, 1997, Fries, 1980, Manton, 1982) and the increase in the elderly population does not translate automatically into a corresponding increase in the number of individuals with more or less serious disability, it is necessary to pay attention to the increasing demand for long-term assistance. Such attention is, however, a recent phenomenon, in fact, as stated by Costa and Ranci (2010, 3) "*care was for long time confined to the sphere of intimacy and of private solidarity, and only in the last two decades, with the explosive growth of the elderly population, has it moved into the public domain*". Due to these demographic changes the Long Term Care (LTC) policies are one of the welfare state fields which have experienced throughout western Europe, in the last ten-fifteen years and in countertendency with respect to the main sectors of social policies, an overall growth of public financing, an increase in beneficiaries, and a broadening of public responsibilities. Nonetheless all European countries, to different degrees, are facing the problem of the sustainability of their LTC system, and consequently a reorganization and/or reduction of their costs. A central aspect of the reform processes that are affecting the LTC system concerns *"the capacity of public spending to meet rising long term care expenditure […] and the issue of sustainability arises in relation to private as well as public expenditures* (OECD, 2005; 82). As suggested by Pommer (*et al.,* 2007), a possible outcome of these reform processes concerns the reduction of the public role in favor of an increase in the private dimension, concerning both care provision and financing.

There is a relation linking the reforms of the LTC sector and the level of private resources that these systems demand from the beneficiaries of care and their families, which is governed by the characteristics of the system of care and assistance. The latter do not concern only the level of public services that a state ensures. We shall argue, in fact, that in answering the need of sustainability , the national LTC systems have pursued different reform trajectories encompassing: *i)* the structure and the role of the different actors of the market of care services; *ii)* the sharing of

resources among formal care services; *iii)* the financing modalities of the system; *iv)* the public responsibility of care in terms of services accessibility.

For each one of these features, it is possible to identify specific aspects affecting the degree of private involvement in the care of elderly people. Our aim is, firstly, to single out those factors directly affecting the degree of reliance on private resources, and to investigate how the European countries are distributed in relation to this aspect. This analysis will be instrumental to our main goal, which is to investigate whether a relation exists between the level of private care resources and the risk of poverty of dependent elderly people and their families.

More specifically, on the basis of selected indicators of LTC system characteristics, we present the results of a cluster analysis that considers the EU LTC systems from the standpoint of the resources - both financial and in time - which frail elderly people and their families allocate to care. The cluster analysis provides two outcomes: 1. a map of the clustering of European countries with respect to the characteristics that we have singled out as directly affecting private care resources; 2 the identification of six European countries, representative of the various clusters, that will make up the case studies of the second part of this work. In this second phase, using the data of the Survey of Health, Ageing and Retirement in Europe (SHARE), we investigate how the reforms which have been implemented by these countries have affected the dependent population (and their adult children), in terms of: 1. support received, both services in-kind and cash benefits; and 2. involvement in the care process, informal care received (and provided) and private care expenditure. The last part of this work is devoted to the presentation of the main results of our research. Through the use of binary logistic regression models, we test the hypothesis that the dependent condition and the extent of private resources devoted to care increase the probability to be at risk of poverty for the dependent elderly persons' and their adult children's families.

CHAPTER 1

THEORETICAL MODEL

This work starts from the premise that dependency represents a significant risk factor which considerably increases the probability to fall into the risk of poverty. Families with dependent members often experience a 'compression' of their living standards due to two main factors: the reduced capacity to work for both the dependent elderly and their family caregivers, and the fact that dependency entails increased expenditures for routine activities and especially for the health related costs. In this regard, research findings (OECD 2011) show that, in several countries, the cost associated to the care and assistance to the elderly with a high level of dependency exceeds the available income of (dependent) individuals including those comprised in the sixth income decile. As claimed by Costa and Ranci (2010), the presence of dependent persons significantly affects both the organization of their families (the household members who assume care-giving responsibilities must reconcile paid work with care by accepting jobs with reduced hours or low wages), and the household's overall income. While family caregivers often act as a social safety net for older care receivers (Lubben,1988), research findings consistently indicate the associated caregiving burden that family caregivers experience, and its financial cost (Lai, 2012). Based on these considerations, our intent is to understand how these dimension, care cost and informal care, are affected by the LTC characteristics and, in turn, how they affect the dependent elderly's family income and the risk of poverty.

1.1 Hypothesis and conceptual framework

Private care resources are the focus of our research: indeed, they represent the link between the LTC national systems characteristics and the probability to be at risk of poverty of the elderly people and their relatives. According to Fast et al.(1999), who propose a taxonomy of hidden costs

related to the elderly care[1], private resources devoted to care include both direct monetary expenses (out of pocket) and time, unpaid labour and employment related costs (informal care).

As diagram 1 shows, the level of private resources devoted to the care of the frail elderly is the result of the specific aspects of the LTC system, and, in turn, it plays a role as possible cause of the impoverishment of the elderly population and their relatives.

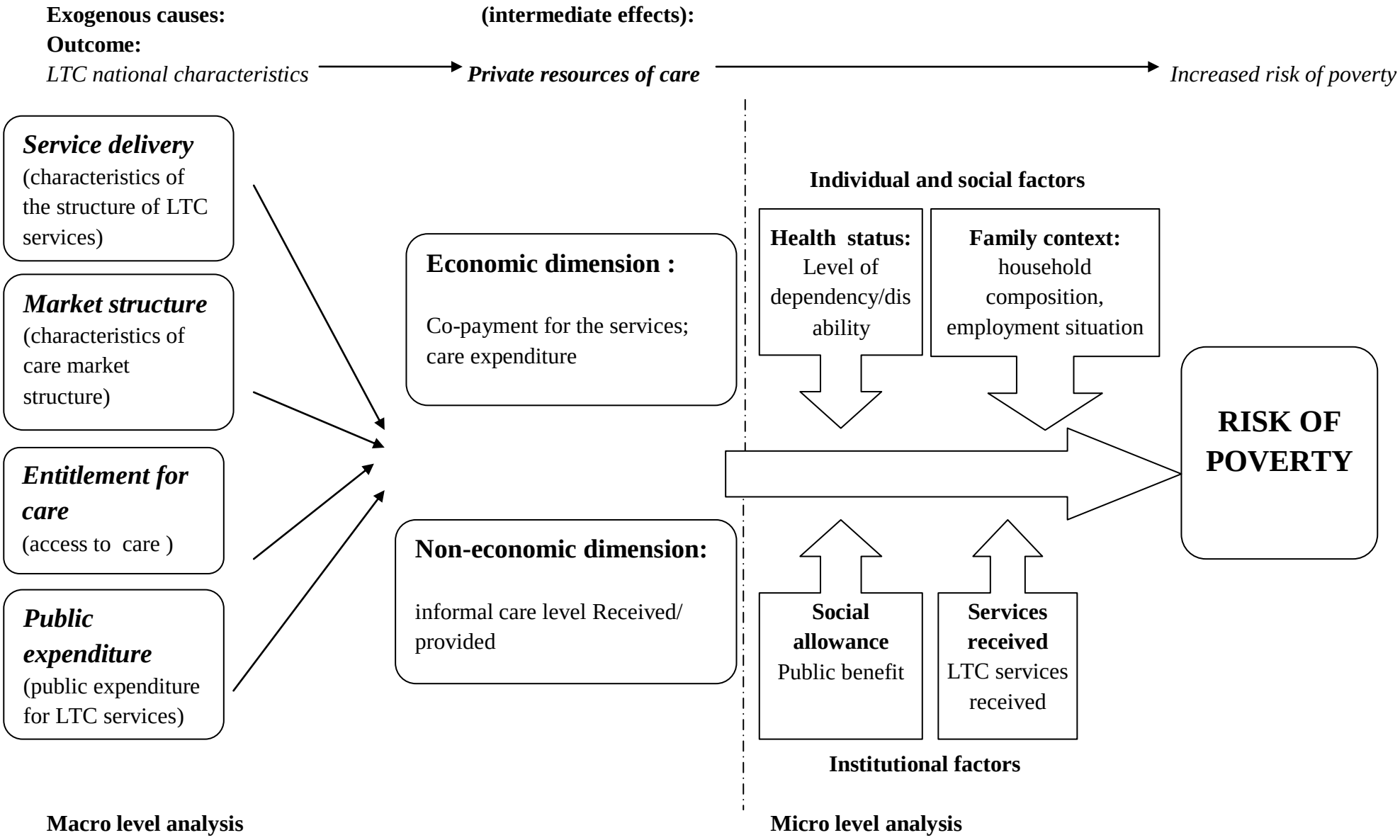
As for the relation between private care resources and LTC system characteristics, following the literature on care regimes (Albert, 1995; Anttonen and Sipilä 1996; Bettio and Plantenga 2004; Daly and Lewis 2000; Lewis 1992; Jensen, 2008; Orloff 1993, Ranci and Pavolini, 2008), it is possible to identify three factors that are crucial for understanding the effects of the reforms of the national LTC systems: the structure of the services and of care provision; the structure of the care market; and public responsibility for care (OECD 1996, 2005; Jacobzone 1999).

On the basis of these works, it is possible to identify specific aspects of the LTC national systems that may condition the private involvement in the care of elderly people. There are four aspects of LTC systems that are of interest for our research, and we briefly summarize their characteristics:

i) services provision **(characteristics of the structure of LTC services):** the level of private resources devoted to care is directly connected to the level of services provided in a given LTC system. The availability of formal services in kind (public and private) or in cash, providing support to the dependent elderly people, limits the burden of care falling upon the individual sphere. The care of dependent elderly people through the informal (and formal) sphere entails the need for private resources in terms of time and money;

[1] They identify two components of hidden costs in elderly care, economic costs and non economic costs. In turn the first aspect derives from three distinct factors: employment related costs; out- of-pocket expenses and unpaid labour; whilst the second aspect derives from: physical costs; social costs; and emotional costs.

Diagram 1 The risk of poverty for dependent elderly



ii) market structure **(characteristics of care market structure):** private resources for care depend on the care market structure. We do not deny that the presence of a plurality of providers entails, through competition mechanisms, a benefit for the dependent elderly people and their families, both in economic terms and in terms of time; but we maintain that the end result is influenced by the role played by the public actor in two ways: by ensuring a fair access to care of potential beneficiaries, with regard to their income and/or their level of disability; and by regulating and sustaining the development of private providers and private services, so that it does not entail a deterioration of the quality of the services provided and/or an increase of the economic burden required from the families.

iii) entitlement to care **(access to care);** the regulation of the access to care affects private care resources. The criteria regulating access to care that a public LTC system applies, both for services in kind and for cash benefits, define the extent and the characteristics of beneficiaries of the public services and ultimately affect the amount of private care resources falling upon the family;

iv) public expenditure **(public expenditure for LTC services)**: the public expenditure allocated to the LTC sector directly affects the private care resources. It is assumed that the generosity of a LTC system is directly proportional to the share of public expenditure that is allocated to it; thus, greater levels of coverage of the services - and smaller need for private resources - correspond to greater levels of expenditure. However, since public expenditure is financed through general fiscality, the issue of the re-distribution of private resources must be considered.

Regarding the aspect of services provision, at European level new trends are observable: a new "discovery" (and use) of informal care-giving (Kröger and Sipilä, 2005, Wiener 2003), an increasing use of home based solutions instead of *institutionalization* (Lundsgaard, 2005; OECD, 1996, 2005; Marin et al., 2009; Bettio and Verashchagina, 2010), and a growing importance of cash transfers in substitution or integration of services (Da Riot *et al.* 2007; Ungerson and Yeandle, 2007). Nevertheless, meaningful differences still exist across countries in the levels of the provision of services and in the degree of coverage of social needs. These differences affect the effort, both in terms of time and money, which the elderly and their families have to sustain for care: we can assume that countries with a higher degree of formal services in kind (public and private), or a more

developed system of cash benefits, the burden of care reserved to the individual sphere can be more limited.

In response to the issue of sustainability, and as a consequence of the reorganization of services provision, an increasing number of countries are shifting to market principles (Anxo and Fagan 2005; Pavolini and Ranci, 2008,). Although the entry of for-profit actors in the provision of welfare state services dates back to the last century - specifically in the last two decades (Everse and Laville, 2004) -, as claimed by Shutes *et al.* (2011) different market-oriented reforms have characterized the recent restructuring of welfare states. In relation to the LTC system, this change is detectable in: *i)* the increasing outsourcing (contracting-out) of home care services and the consequent shift in the balance of provision in favor of private or not-for-profit providers (Daly and Lewis, 2000); *ii)* a shift towards the direct purchasing of care by individuals and their families through the public transfer of cash payments (Ungerson, 2007, Simonazzi 2009) or vouchers (Bode and Chartrand, 2010; Beltrametti *et al.*, 2011); *iii)* and greater reliance on private funding of care by individuals and their families (Shutes and Chiatti, 2011). As the OECD (2011) claims, the presence of a plurality of providers may entail - through competition mechanisms - a benefit for the dependent elderly people and their families, though this benefit is bound to the presence of monetary subsidies and to the recipient's freedom of choice between different providers (ibidem). However, the relation between the process of marketization of the care sector and the private care resources is more complex, since it is affected by other aspects, such as –at the institutional level - the existence and the quality of instruments favouring the promotion and affordability of the private services, and – at the micro level – families' characteristics, such as the capacity to pay for the services. We assume that the process of marketization generates a negative impact on the private care resources in countries with a less developed system of support of access to services: as Szebehely and Trydega°rd (2011) have noted, this process can limit the availability of formal services for the low-income families.

Another aspect affected by the process of reform for the sustainability of the LTC system is the dimension of the *entitlement to care*[2]. The main form of *targeting of care* (*financial accessibility*, for Pommer *et al.*, 2007) regards the provision of benefits and it concerns, on one hand, targeting of a services package and, on the other, eligibility for the cash benefit schemes. In the EU countries the

[2] We consider this dimension as the possibility to take advantage of a service through public subsidies or facilities (total or partial). This definition differs from that used by WHO (2003), which concerns the possibility (entitlement programmes) or impossibility (Non entitlement programmes-Budget constraint) to receive a public service.

definition of a services package is individualized as much as possible. (MISSOC 2006): it is affected by the level of incapacity, the place of residence, the living conditions, the environment, the availability of informal care, and by the income of the recipients of care. Similarly, eligibility for cash benefit schemes can vary according to age, need and income, and it may relate only to the frail elderly person or also to his/her family (OECD 2011). Another aspect related to the regulation of access to care and to the sustainability of LTC systems is the mechanism for sharing the costs of care by the beneficiaries. All public LTC systems involve a degree of cost sharing, albeit at significantly different levels; and usually, the copayment is related to the income or assets of the beneficiary. The criteria for access to care that a public LTC system applies, define the extent and the characteristics of beneficiaries of the public services thus affecting the amount of private care resources falling on the subjects. Specifically, we assume that countries lacking an effective balance between the eligibility criterion based on the dependent elderly income (or, in some cases, household income) and those based on the level of disability and family characteristics, a higher level of private care resources is required. Another interesting aspect related to the targeting of care is the role played by the family legal tie: it is possible to assume that the degree or presence of this tie affects the allocation of the care cost between the dependent elderly, their relatives and the state.

A final aspect connected to the sustainability of the system and closely related to the amount of private resources involved in elderly care is the public expenditure devoted to the LTC sector. As Kraus (2010) notes, public expenditure is the most important source of financing for LTC services in almost all countries and it can be seen as a measure of the generosity of an LTC system. As remarked by the European Commission (2009), it might be thought obvious that differences in public expenditure allocated to the LTC sector are directly related to the level of development of the services in that sector, but this assumption it not always true since the relation between the public expenditure and the effective level of benefits received by the dependent elderly can vary because of different factors. Firstly, the definition of the amount of public expenditure is complex because, in almost all the EU countries, the functioning of the LTC system involves different levels of government, and the services are often provided and funded at the regional/local level, with differences both in terms of type/intensity of and access to the services. Moreover, although a high level of public expenditure can be associated to a developed LTC system, the relation between public financing and generosity of an LTC system is affected by the aspects presented above.

The interaction between the characteristics of the four aspects presented defines the capacity of the system to meet the demand of care of the dependent population, and indirectly, determines the amount of private care resources that the families have to integrate in order to compensate the unmet demand of care. To fill the gap between supply and demand, the families can be involved indirectly, by purchasing services and assistance through the market, or directly, by providing themselves care to their relatives. The former solution, presented in figure 1 as "the economic dimension of private care resources", generates a loss of family income proportional to the elder person's disability level, and inversely proportional to the public support received; the latter, defined as "the non-economic dimension of private care resources", reduces the work capacity of the members of the family that take care of the elderly, generally the partner or the adult children, and as the economic dimension, is affected both by the disability level and by the public support, but also by the family capacity and possibility to share the burden of care. Whereas these two dimensions are not mutually exclusive, but rather coexist, it is possible to maintain that the double reduction of income caused, on the one hand by the care expenditure, and on other hand by the drop of income from work, can lead the dependent person's family below the poverty threshold.

In order to understand if the need for private care resources can increase the risk of poverty, we must consider two dimensions: institutional factors and individual and social factors. The institutional factors represent the support that the elderly receives from the formal LTC system, and can be divided in two broad category: services in kind, such as home care and domestic help services, semi-residential and residential facilities; and cash benefits, such as disability allowances, tax credits and vouchers. Both types reduce the family economic burden, by taking care of the elderly or by subsidizing care. The second dimension considers the individual characteristics that can affect the family risk of poverty, such as age, gender, disability level or health status of the dependent person, and the social factors that, at the household level, act both on the care process and on the household's income, such as the family dimension, the number of siblings of the informal caregiver, the household' employment situation, the economic transfers between generations, and the presence of a legal tie that recognizes the duty of care within families, generally between parents and children.

On the basis of these considerations we have defined two consequential hypotheses, which are related to the macro (H1) and micro (H2) assumptions respectively. These hypotheses are:

H1= the LTC reform processes aimed at increasing sustainability through:

i) public spending reorganization/reduction;

ii) a growing individualization of care, through both the process of marketization of care, and greater reliance on the family ;

iii) the narrowing of the accessibility to services through the process of targetization of care;

determine a shift of the responsibility of care from the public to the private sphere, generating a growing involvement of the family in the care process;

H2= due to this shift of responsibility, the families became the main actor in the care of the elderly, both directly, providing care, and indirectly, financing services; this reduction of the public role can have an economic impact on the dependent elderly and their relatives, increasing their probability to be at risk of poverty.

1.2 Relevance

This research attempts to bring together two levels of analysis that have been usually considered separately in social policy studies. In diagram 1 we presents the relationships linking together the processes of reform that have interested the LTC systems at the macro level with the economic impact that they generate at the micro/individual level. Additionally, this analysis tries to consider simultaneously both the risk factors and the prevention factors related to the dependent condition, in order to assess the extent to which greater reliance on the private care resources can affect the household's risk of poverty. The macro analysis highlights the existence of a trade-off between the two dimensions of private care resources, showing that the LTC systems are distributed on a continuum, from countries in which the families are scarcely involved in the care process, to countries in which the elderly care is almost exclusively a private matter. On the basis of these results it is possible to identify four typologies of elderly care systems. The micro analysis has allowed to better understand the consequences of the reform processes on services perception in the Swedish case, highlighting, counter-trend with macro data, how the LTC system of this countries is moving away from the Scandinavian model. This research is the first study (to the author's knowledge) that tries to link together, in a causal relationship, two of the main social risk at EU level: the ageing population and the risk of poverty of dependent persons and their families.

CHAPTER 2

MACRO ANALYSIS

This chapter is dedicated to the macro analysis of the functioning of LTC systems. The aim of this phase is twofold: to identify typologies of national LTC systems based on the characteristics related to the four aspects defined in the theoretical model; and to understand if and how these typologies differ in relation to the dimensions of private care resources. The first paragraph provides a definition of the variables used, the second section, applies an univariate and bivariate analysis to the structure and the characteristics of LTC systems, and the third part presents the results of the cluster analysis. In the last paragraph we identify four typologies of LTC systems on the basis of the need for private care resources.

2.1 DATA, SAMPLE AND VARIABLES USED

The analysis covers 14 EU countries, and we collected 12 variables, 3 for each aspect of the LTC system being examined. In the following, we present a synthetic description of the variables and the source of data used.

Services delivery

Home Care recipients (label: Home_ rec)

This variable defines the share of dependent elderly persons receiving formal care at home in total population aged over 65.

Institutional Care recipients (label: Instut_ rec)

This variable measures the level of residential care available in a country, and is defined as the e ratio of dependent elderly people receiving institutional care services in total population over 65.

Cash Benefit recipients (label: Cash_rec)

This variable defines the share of elderly people receiving monetary transfers related to their condition of non-self-sufficiency. Like the other variables, it compares the population over 65 receiving cash benefits with the entire over-65 population.

Market structure[3]

Public providers (label: Public_prov)

In constructing this variable two aspects were taken into account: *i)* the different role of the public actor in providing home care services or institutional care services respectively; *ii*) and the level of coverage of these two services. In other words, this variable is constructed by means of a weighted average:

$$\frac{\left(\text{Market share of public providers for Home care} * \text{home care recipients}\right) + \left(\text{Market share of public providers for residential care} * \text{Institutional care recipients}\right)}{\left(\text{home care recipients} + \text{Institutional care recipients}\right)}$$

This variable tries to synthesize in a single value the role played by the public actor on the care market, taking into account the different role that it plays in the provision of the two different services and the level of coverage, and therefore the capacity, of those services.

Not-for-profit providers (label: Notprofit_prov)

This variable makes it possible to understand the role of the not-for-profit actor in the care market. The mechanism used for constructing the variable is the same as that used for the preceding one.

For-profit provider (label: Forprofit_prov)

This variable aims at estimating, on the basis of the mechanism used for the two preceding variables, the share of the care market held by private for-profit actors.

[3] The three variables used to define the market composition consider only the professional operators, omitting the role of private individual caregivers and informal care . According to the literature, especially in Southern European countries, but not only there, a good part of private provision of services comes from non-professional caregivers employed in the grey market, usually immigrant women directly hired by the families. We had to omit this aspect because- due to the non-professional nature of these workers, there are no reliable data that allow a comparison between countries in relation to this aspect. Nevertheless, in the micro level analysis, we take account of this aspect through the variable of family care expenditure. This variable represents all kind of expenditure that the families sustain for care, included the cost of individual caregiver. In relation to the informal care, these variables consider only the formal services and operators, while for detect the role played by this kind of care a specific variable is dedicated (infocare).

Entitlement for care

***Share of means-tested expenditure (label: MT_exp*)**

the share of means-tested evaluation procedures in the total public expenditure allocated to services in- kind.

Formal Care of Dependent population (label: Formal_dep)

The share of persons that receive formal care (Home and Institutional care) in the total number of elders with problems related to the condition of non-self-sufficiency. We use this variable as an indicator, at the aggregate level, of the possibility of accessing formal care.

Cash benefits on dependent population (label: Cash_dep)

The share of dependent persons that receive monetary transfers.

Public expenditure

Gross Domestic product for LTC (label: GDP_LTC)

The share of public expenditure for LTC in GDP, not corrected by the share of the older population.

Public expenditure on LTC per capita(label: Per_cap)

This variable measures the level of public expenditure used by a country for the care of dependent elderly people[4]. The variable is constructed as follows:

$$\left\{ \frac{\text{public expenditure on LTC/GDP}}{\text{share of persons aged 65 and older}} \right\}$$

In other words, this variable compares the LTC expenditure per inhabitant over 65 with the national per capita income. By standardizing the public expenditure on LTC per elderly person with the national per capita income we obtain a variable which is comparable across European countries with different levels of GDP).

This variable and the previous one provide a complete information of the public effort in financing the elderly care, per head and in the aggregate.

[4] This variable is a variation of the "Income and needs-corrected spending" indicator used by Kraus et al. (2010)

Cash and In-kind expenditure rate (label: cash_kind)

This variable gives the ratio of the expenditure allocated to cash benefits in relation to the amount of expenditure allocated to services in-kind. Values equal to 1 indicate an identical amount of expenditure for the two kind of service; values equal to 2 indicate that the expenditure for cash benefits is twice the expenditure for services in kind.

Private care resources

Out-of-pocket expenditure (label: priv_exp)

This variable measures the share of expenditure by private parties for the purpose of care, in the total expenditure of the LTC sector. In other words, the variable defines how much of the total cost of care falls upon dependent elderly people and their families.

Informal care (label: infocare)

This variable reports the share of population aged over 65 that receives care and assistance from relatives, friends or their partner on a voluntary basis.

Table 1 presents the main sources of the data for each variable and the reference years. The selected countries are: Spain, United Kingdom, Germany, France, Austria, Poland, Estonia, Belgium, Italy, Czech Republic, Slovenia, Finland, Sweden and Denmark. The selection criterion is the availability of comparable data for all the variables considered. In order to ensure comparability between countries we decided to rely on international databases, that guarantee a standardized procedure of data processing. So as to obtain the national public expenditure of LTC systems, we have used the same methodology applied by the European Commission for the Ageing Report (2012), based on two international data sources: System of Health account (SHA) and ESSPROS. The European System of Integrated Social Protection Statistics, abbreviated as ESSPROS, is a common framework developed in the late 1970's by Eurostat and the European Union Member States providing a coherent dataset of social benefits to households and their financing, thus making international comparison of the administrative national data on social protection possible. The System of Health Account, is the result of a collaboration between EUROSTAT, OECD and WHO, started in 2000, and provides a standard framework for producing a set of comprehensive, consistent and internationally comparable accounts to meet the needs of public and private-sector health analysts and policy-makers.

Table 1. Sources and reference years of the variables used in the cluster analysis

Variables	Sources	Reference years
Home_rec	OECD 2011, ESSPROSS and EUROSTAT	mid-2000s
Institut_rec	OECD 2011, ESSPROSS and EUROSTAT	mid-2000s
Cash_rec	ESSPROS, EUROSTAT	2010
Public_prov	Allen *et al.* (2011), Barnett *et al.* (2010) and Sowa (2010) [Rodrigues *et al.*, 2012]	mid-2000s
Notprofit_prov	Allen *et al.* (2011), Barnett *et al.* (2010) and Sowa (2010) [Rodrigues *et al.*, 2012]	mid-2000s
Forprofit_prov	Allen *et al.* (2011), Barnett *et al.* (2010) and Sowa (2010) [Rodrigues *et al.*, 2012]	mid-2000s
Formal_dep	ESSPROS, EUROSTAT	mid-2000s
Cash_dep	ESSPROS, EUROSTAT	2010
MT_exp	System of Health Account (SHA); ESSPROS	2010
Per_cap	System of Health Account (SHA); ESSPROS	2010
GDP_LTC	System of Health Account (SHA); ESSPROS	2010
Cash_Kind	System of Health Account (SHA); ESSPROS	2010
Infocare	OECD 2011	mid-2000s
Priv_exp	System of Health Account (SHA); ESSPROS	2010

As table 1 shows, these two database together with the EUROSTAT data, represent the main data sources for the definition of the LTC system characteristics, relating to provision, accessibility and financing of services. The market composition has been defined on the basis of information provided by Rodriguez et al. (2012), in "Fact and Figures on Healthy Ageing and Long-Term Care". In this work the authors dedicated a chapter on the care market composition under a double perspective: public or private nature of providers, and type of services (home care or residential care), putting together information provided by international researches.

The results of the operation of data collecting are reported in table 2. The comment of the figures reported in the table is provided in the next paragraph, which focuses on the analysis of the LTC systems characteristics based on the data provided in table 2.

Table 2 Countries values of the variables used in the macro analysis

Countries															
LTC aspects	**Variables**	*ES*	UK	DE	FR	AT	PL	EE	BL	IT	CZ	SI	FI	SE	DK	mean
Service delivery	*Home_rec*	4,2	12,6	6,7	4,9	14,8	1,2	1,6	8	2,8	7,3	2,2	9	9,7	14	**7,1**
	Institut_rec	4	3,8	4,1	3	3,5	0,5	1,8	4	2	3,8	4,1	5,5	6	4,8	**3,6**
	Cash_rec	3,9	15	4,6	10,6	18,2	10	5	0	12,5	16	9,2	13	1	18	**9,8**
Market structure	*Public_prov*	23	12,2	3,1	18,6	30,6	64,4	51,9	38	30	65	100	79	75	73,9	**47,1**
	Notprofit_prov	24	11,5	43,5	50,5	55,5	30	21,7	36	50	32	0	0	10	0	**26,1**
	Forprofit_prov	53	75,6	54	30,9	13,9	5,6	12,3	26	20	3	0	21	15	26	**25,45**
Entitlement for care	*Formal_dep*	20	43	49	66	69	6	8	54	18	48	56	48	62	79	**44,71**
	Cash_dep	12	11	23	48	70	65	15	1,5	58	62	55	44	5	57	**37,6**
	MT_exp	0,86	0,644	0,376	0,305	0,348	0,009	0,037	0,007	0,219	0,043	0,064	0	0,009	0	**0,209**
Public expenditure	*Per_cap*	0,086	0,087	0,089	0,133	0,134	0,056	0,037	0,127	0,054	0,054	0,111	0,124	0,046	0,211	**0,096**
	GDP_LTC	0,014	0,014	0,018	0,022	0,024	0,008	0,006	0,022	0,011	0,008	0,018	0,028	0,008	0,035	**0,017**
	Cash_Kind	0,296	0,154	0,333	0,315	0,553	0,879	1,24	0,017	2,861	1,976	0,703	0,205	0,197	0,323	**0,718**
Private care resources	*Infocare*	15,3	15,2	11,5	10,2	9,8	10,3	24	12,1	16,2	12	10,5	8	8	9,3	**12,31**
	Priv_exp	28	20	25	25	17	1	22	16	35	35	2	15	4	9	**18**

Source: Author's elaboration

As noted by various authors (Pavolini, Ranci *et al*, 2013), in spite of the great number of studies on elderly care and LTC system and the increasing attention on this topic, due to the recent definition of the LTC system as a distinct sector within the welfare system, the first step of an analysis must be the definition of a coherent set of data. That's why, in this paragraph, we have taken care to use, as far as possible, data that are comparable and provide a detailed description of the variables on which the macro analysis is based, specifying the information that each variable brings to the analysis.

2.2 CHARACTERISTICS OF LTC SYSTEMS

Over the past fifteen years the Long Term Care (LTC) sector has experienced an overall growth in public financing, an increase in beneficiaries, and a broadening of public responsibilities throughout Western Europe. This has taken place in counter-tendency with respect to the main sectors of social policies. However, all European countries, in different degrees, are facing the problem of LTC system sustainability and, consequently, a reorganization and/or reduction of their costs. A central element of the reform processes that are affecting the LTC system concerns *"the capacity of public spending to meet rising long term care expenditure […] and the issue of sustainability arises in relation to private as well as public expenditures* (OECD, 2005; 82). As suggested by Pommer (*et al.,* 2007), a possible outcome of these reform processes consists in the reduction of the public role in favour of an increase in the private dimension, care provision and financing.

Therefore, it is possible to assume the existence of a relation between the reforms in LTC sectors and the required level of family involvement in elderly care. This relation is governed by the characteristics of care and assistance systems. The latter are not limited to the level of public services ensured by the state. In fact, an answer to the need of LTC sustainability has been provided by the different reform trajectories that have concerned - and are concerning - the national LTC systems, whose main scopes are to re-define: *i)* the structure and role of the different actors of the care service market; *ii)* the sharing of resources among formal care services; *iii)* the types of financing; *iv)* and the public responsibility of care in terms of service accessibility.

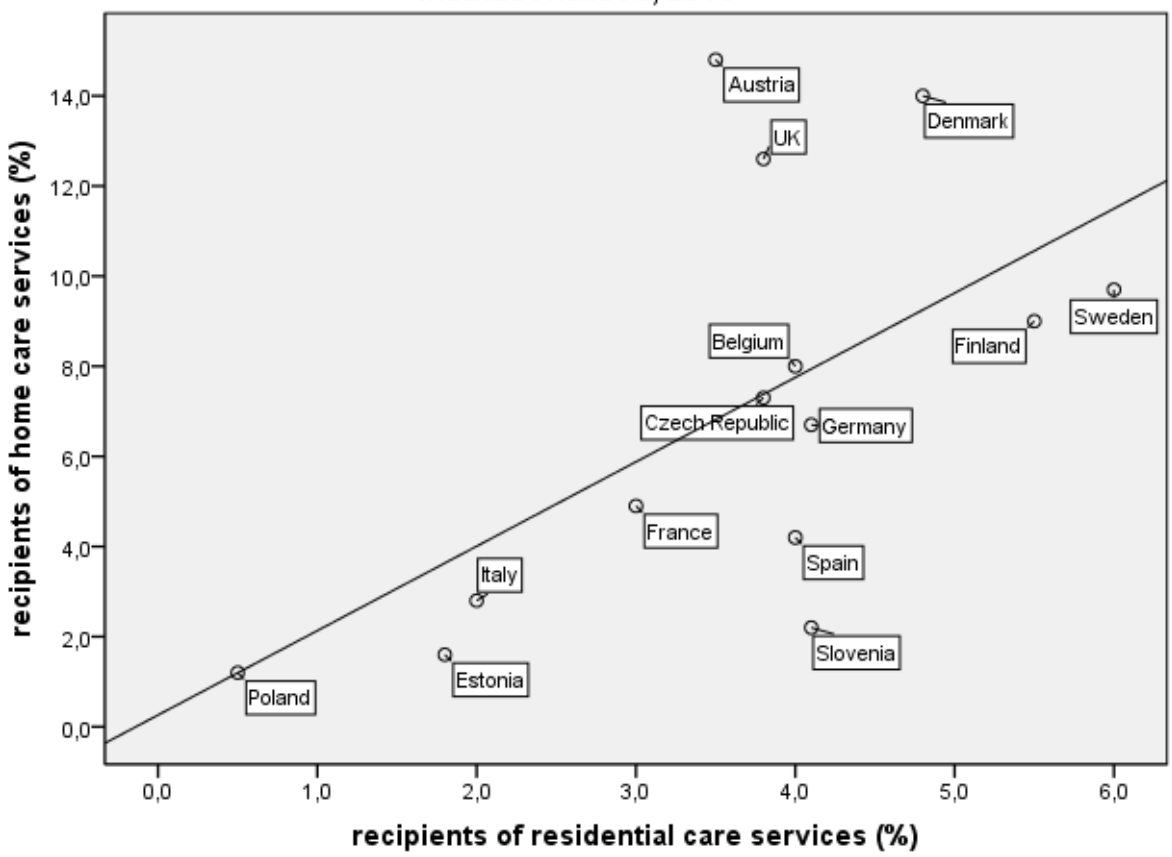
The care regime literature (Albert, 1995; Anttonen and Sipilä 1996; Bettio and Plantenga 2004; Daly and Lewis 2000; Lewis 1992; Jensen, 2008; Orloff 1993, Ranci and Pavolini, 2008) has identified three main lines of change of the national LTC systems: *i)* the structure of the services and the provision of care; *ii)* the structure of the care market; *iii)* public responsibility for care (OECD 1996, 2005; Jacobzone 1999). Our aim is to analyze the impact of these changes on the private involvement in the care of elderly people, by focusing on four aspects of LTC national systems: service delivery, market structure, entitlement for care and public expenditure. These aspects and their characteristics at the national level are analyzed in the following paragraph.

Services delivery (*characteristics of the structure of LTC services*)

The configuration of LTC systems varies considerably depending on whether in-kind services or cash benefits are provided. In-kind services are provided directly to recipients by way of residential

or home care, while cash benefits have the effect of passing the responsibility to individuals and families for the organization of their own care services. As far as in-kind services are concerned, we note an increasing use of home-based solutions compared to *institutionalization* (Lundsgaard, 2005; OECD, 1996, 2005; Marin et al., 2009; Bettio and Verashchagina, 2010). At the same time, there has been a growing importance of cash benefits in replacement or integration of services (Da Riot *et al.* 2007; Ungerson and Yeandle, 2007).

Figure 1: Share of population over 65: receiving home care services and institutionalised, 2010

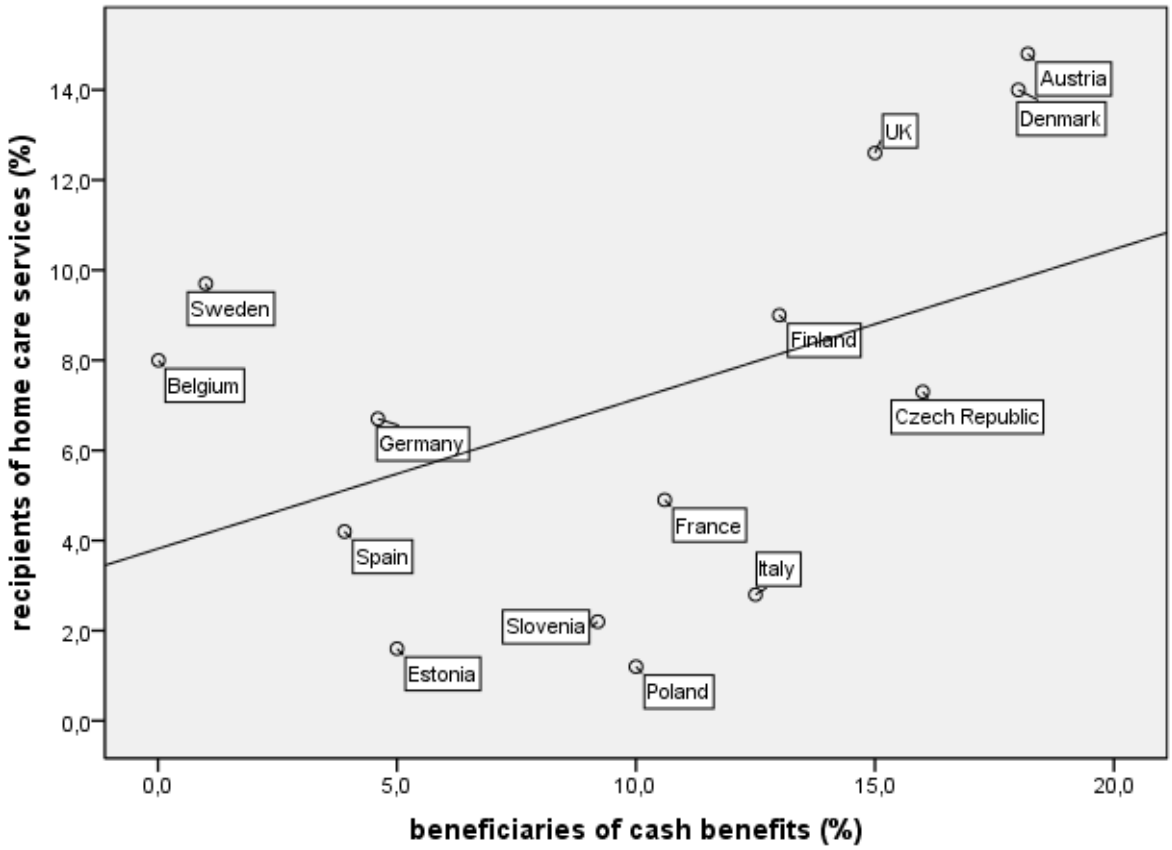


The macro data[5] partly confirm this reconfiguration between these different types of public involvement. In 2010, all European countries present a higher coverage of home care services compared with residential services. This means that the European Commission's target of "ageing in place" has been partly acknowledged by the EU countries. It is interesting to note, however, that there is a positive correlation (0.598) (figure 1) between the rate of coverage of residential services and the share of home care services, which indicates that, in each country, the extent of home care services is proportional to the degree of residential care. Assuming the coverage level as a proxy of

[5] For an overview of the data and variables used for the macro analysis refer to the Appendix (A1 and A2).

the level of development of in-kind services, the correlation between home and residential care indicates that European countries tend to range from countries with an undeveloped sector, to countries with a high rate of coverage for both home and residential care services.

Figure 2: Share of population over 65: receiving home care services and cash benefits, 2010



Data also suggest that cash benefits play a key role in the functioning of the LTC system, even in those countries with a strong tradition of in-kind services, like the Scandinavian countries. At the EU level, the share of cash benefit recipients in the total population over 65 is around 10%. This is a significant share, especially when compared with the average percentage of institutional users, that is only around 4%. However, European countries differ widely in their reliance on cash benefits. In countries where the services are provided by private operators, the cash-for-care is an instrument for subsidizing the provision of care, in line with the idea of free choice. This means that the (old) disabled people and/or their families may choose among different kinds of care and care providers (Da Roit, Le Bihan, 2010b). The European countries differ widely in terms of regulation of access and use of cash transfers. For example, in Italy the main cash benefit (Indennità di

Accompagnamento) is not means-tested, and its amount is not related to the level of disability, while in France the amount of the benefit is related to the disability level and it is paid to finance a specific care package established by a team of professionals. We can thus conclude that the mechanism of regulation of access to cash benefits generates two opposite effects. In countries where there is a limited supply of in-kind services and the cash benefits are not strictly regulated, they can be a form of family support, a payoff for the family caregiver. Viceversa, where the public transfers are designed for the support of the care process the cash benefit schemes work as a mechanism that favours the development of the system of in-kind services. It is therefore not surprising that there is a positive correlation (0.443) (figure 2) between the percentage of users of home care services and the share of beneficiaries of cash transfers.

It seems safe to assume that the differences in the mix of services and their degree of development affect the effort, in terms of time and money, that the elderly and their families have to make for care. However, in our analysis based on macro data, the only clear relationship between private care resources and services provision that we could find is a negative relation between the percentage of recipients of services in-kind and the level of coverage of informal care (home care -0.429; institutional care -0.516). No significant correlation could be found between the out-of-pocket care expenditure and the degree of development of cash transfers. Nor we could find a correlation between cash transfers and reliance on informal care, while there is weak evidence that in those countries with a high degree of formal (public and private) services the economic burden of the care reserved to the individuals can be limited (respectively home services; -0.084, and residential care, -0.152).

Market structure (*characteristics of care market structure*)

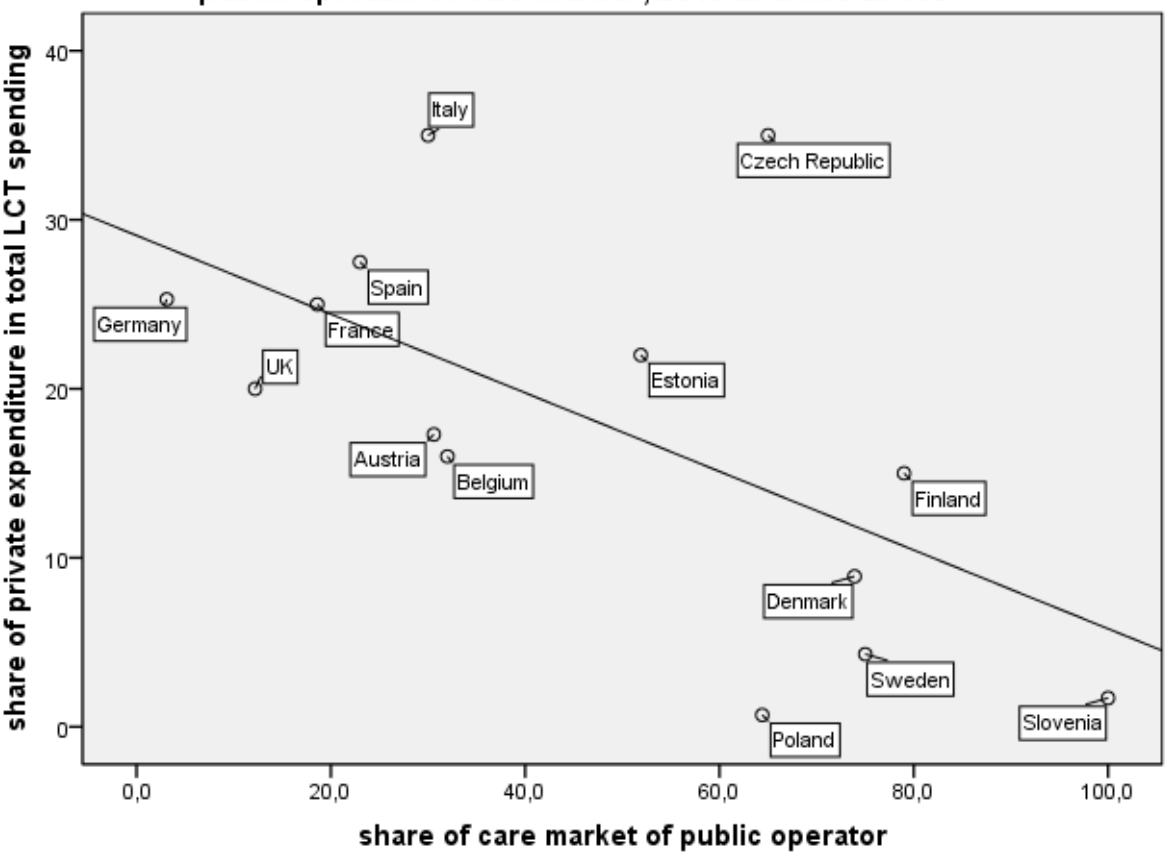
In response to the issue of sustainability, a second trajectory of reform that has involved a large number of European countries concerns the reconfiguration of the care market, and specifically, the shift to market principles (Anxo and Fagan 2005; Pavolini and Ranci, 2008). Although it is since the last century that for-profit actors were involved in the provision of welfare state services, in the last two decades (Everse and Laville, 2004) - as claimed by Shutes *et al.* (2011) - different market-oriented reforms characterized the recent restructuring of welfare states. In relation to the LTC system this change is detectable in: *i)* the increasing outsourcing of home care services and the consequent shift in the balance of provision in favour of private or not-for-profit providers (Daly and Lewis, 2000);

ii) a shift towards the direct purchasing of care by individuals and their families through the public transfer of cash payment (Ungerson, 2007, Simonazzi 2009) or vouchers (Bode and Chartrand, 2010; Beltrametti *et al.*, 2011); and *iii)* the greater reliance on private care funding by individuals and their families (Shutes and Chiatti, 2011). As noted by Riedel and Kraus (2010), EU countries have responded quite differently to an optimal (or at least feasible) public-private mix in the provision of long-term care services. Simonazzi *et al* (2012) highlighted that in those countries where services used to be provided by the state, contracting out has increased, and reforms might concern - or affect - the "terms of trade" between public authorities and providers, and between providers and final users. As a result, profit providers are allowed to enter the market. On the contrary, in countries where public involvement has been more limited and/or there is a substantial reliance on cash transfers, it is possible to observe a shift from family to market (Simonazzi, 2009) and/or the transition from supply-side subsidies to demand-side subsidies through cash for care or vouchers.

The result of the interaction between the marketization processes and the national LTC system characteristics is the creation of different care markets. The latest available data on market composition (Rodriguez *et al.*, 2012) show that, with the exception of the Eastern European countries, private operators hold a significant share of the care market in Europe (at least 10% of total operators). It is therefore possible to identify a common trend. The Scandinavian countries (FI, DK, SE) are characterized by a predominance of the public operator, supported by an increasing role of private providers (Sjørup, 2010; Sutela, 2010; Nyberg, 2010). Likewise, in the Eastern European countries, the public provider is still the main actor on the market, but private operators are replaced by not-for-profit providers (Karu, 2010; Plomien, 2010; Křížková, 2010). In those countries, characterized by a strong tradition of not-for-profit operators, combined (for Italy) with a weak presence of the public operator, the process of marketization has generated different outcomes. In Italy and Austria the not-for-profit operator has increased its importance, becoming a fundamental actor on the market (in combination with the role played by the public operator). The expansion of the private providers is limited to the provision of specific services: home care services in Italy (Fondazione Istud, 2010) and residential care in Austria (Rodriguez *et al.*, 2012). An important issue affecting both countries is the importance of immigrant workers employed in the grey care market and/or directly hired by the families. It is difficult to estimate the number of these workers, but they play a fundamental role for the functioning of the LTC system, filling the gap left by the formal sector (Mairhuber, 2010; Bettio and Verashchagina 2010). In France and Belgium the reform processes have generated a deeper reorganization of the care market, and the public and not-

for-profit operators remain the main actors in residential and institutional care. On the contrary, especially in France, in home care and domestic help the for-profit firms and the private carers have substantially increased their role (Silvera, 2010; Meulders 2010). In the United Kingdom, Spain and Germany more than half of the operators of LTC services belong to the private sector, and the not-for-profit providers hold an equal (Spain) or greater (UK and Germany) share of the market than the public provider (Gago, 2010; Maier 2010; Fagan 2010). In the UK the home care and institutional services are provided almost exclusively by private operators, while in Germany the not-for-profit sector is still the major operator for residential services (Rodriguez *et al.*, 2012). In Spain nursing homes and residential homes are mainly managed by private operators, and an important share of home care services and domestic services are also provided by immigrant (and irregular) workers (IMERSO, 2005, 2009).

Figure 3: Share of out-of-pocket expenditure for LTC services, and share of public operator in care market , 2010 and mid-2000s



The relationship between the marketization process of the care sector and private care resources is complex. In fact, it is affected by institutional factors, such as the presence and quality of

instruments that allow the promotion and affordability of private services, and by individual characteristics, e.g., the capacity to pay for the services. As highlighted by the OECD (2011), the presence of a plurality of providers may entail a benefit for dependent elderly people and their families through a competition mechanism. However, it is also true that this benefit depends on the monetary subsidies and the instruments that support the recipient's freedom of choice between the different providers (ibidem). The analysis of macro data does not provide a clear understanding of this relationship. The use of informal care is not related to the different mix of operators, even if it seems that in those countries where there is a prevalence of the public operator the recourse to this kind of care tends to be limited. While in some countries, like the Scandinavian ones, the public supply of services seems to keep the level of private expenditure low (-0.611) (Figure 3), when the not-for-profit operators hold a significant market share the family economic involvement tends to grow (0.555). It is interesting to note that, even if the market share held by private operators is slightly positively related to the increase in informal care (0.138) and to out-of-pocket expenditure (0.310), it does not seem to be a main factor for the increase of private care resources.

Finally, there is evidence that the process of marketization can generate a negative impact on private care resources in those countries with an inadequate support to access services, and, as Szebehely and Trydega°rd (2011) have noted, this process can limit the availability of formal services for the low-income families.

Entitlement to care (factors favouring *access to care*)

Another element that has been affected by the process of reform of LTC systems is the *entitlement to care*. The targeting of care can potentially help in reaching a reasonable balance between two competing priorities: "fair" protection and fiscal sustainability (OECD 2011, 266). Therefore, if on the one hand, the entitlement to care determines the amount of resources that each society is willing to bestow on the dependent elderly (Simonazzi, 2009), on the other hand there has been increased targeting of eligibility for public provision, with a shift in the direction of public funding to older people with higher needs (Shutes and Chiatti, 2011).

The main form of *targeting of care* (*financial accessibility* for Pommer *et al.*, 2007) regards the provision of benefits and it may concern either the targeting of a service package or the eligibility

for the cash benefit schemes. In the EU countries the definition of the service package is extremely individualized (MISSOC 2006): it is affected by the level of incapacity of the person concerned, but also by the place of residence, the living conditions, the environment, the availability of informal care, and the income of the care recipients. Similarly, eligibility for cash benefits can vary according to age, need and income; the latter may relate only to the frail elderly or also to their families (OECD 2011). Another element related to the regulation of access to care and to the sustainability of LTC systems is represented by the mechanism regulating the sharing of the costs of care with the beneficiaries. All public LTC coverage systems involve an element of private cost sharing, albeit at significantly different levels, with the co-payment usually related to the income or the assets of the beneficiary.

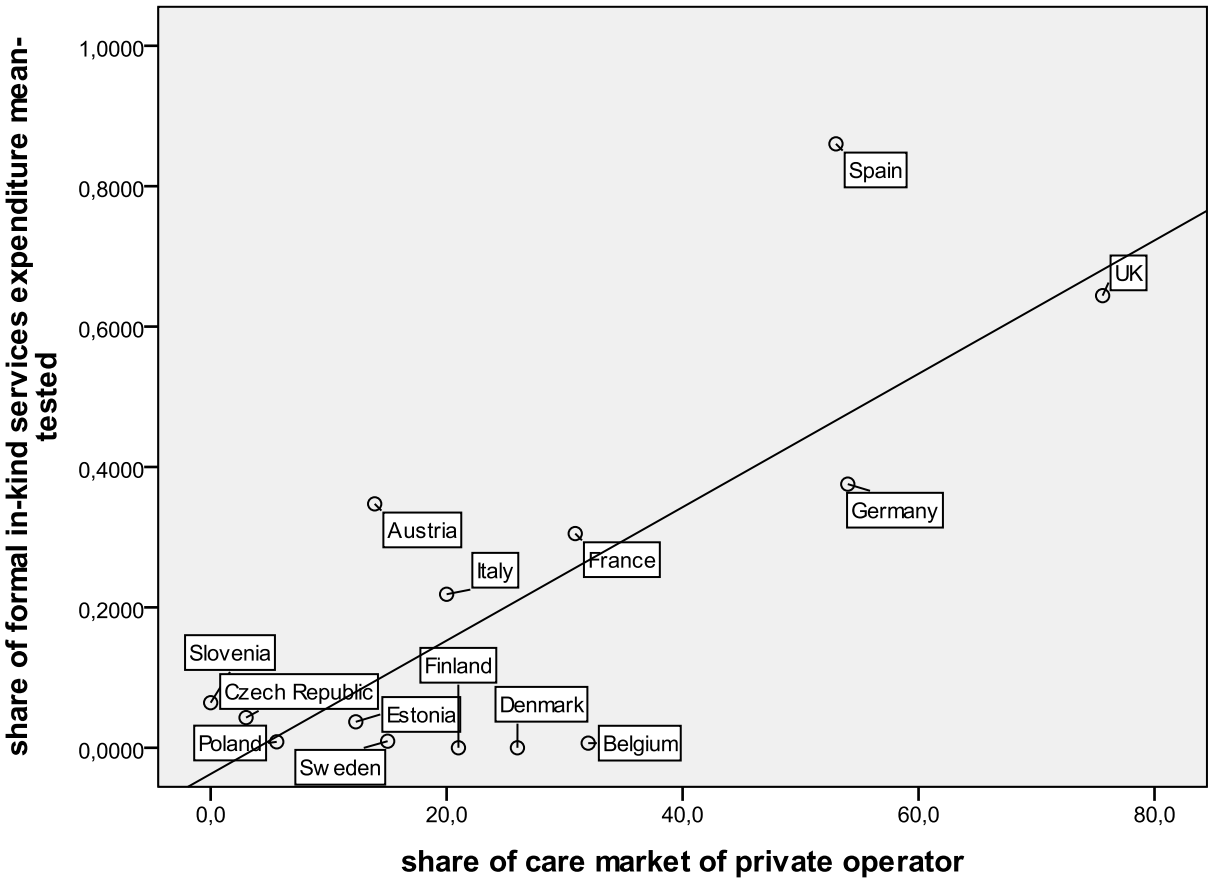
It is difficult to define the national level of accessibility of the LTC services in the European countries. Normally, the regulation of the access criteria is set at the regional or local level, and the accessibility level is directly related to the availability of public funding, that similarly, varies across regions (MISSOC, 2006). Moreover, the lack of comparable LTC data across countries affects the availability of information on this aspect. We use the share of dependent elderly that actually receive LTC services (in-kind and cash) as a proxy of the system capacity to respond to care needs[6]. It is not surprising that in the Nordic countries, where there is a very high coverage of in-kind services, the rate of accessibility to these services is high (around or more than 60% of the dependent population). The same level of access to home and residential services is present in some continental countries like France, Belgium, Austria and Slovenia. On the other hand, in those countries where the development of the services sector has been more limited - like in Italy, Spain, or in the Eastern countries - the share of people with access to care services is restricted: around or below 20% of the dependent population.

Another option to analyse how the various countries differ in terms of accessibility is to look at the share of public expenditure devoted to means-tested services in-kind in relation to the total public expenditure for in-kind services. There is a strong linear correlation between the share of means-tested expenditure and the market share held by private operators (0.763) (Figure 4), which suggests that if the government decides to prioritize the prevention of the social risk of poverty over the needs related to disability (means versus needs testing), the middle and upper income classes may

[6] These variables have to be considered as a rough indicator of the accessibility level of a LTC system, as they do not take into account the kind of services providers and completely or partly exclude the services purchased by the recipients.

have to decide how to finance and organize the care of their dependent elderly on the market. If the access criteria are too restrictive, however, the low-income families that do not fulfil these criteria, and do not have enough resources to face the care cost, must share the care burden among family members.

Figure 4: accessibility and marketization: share of mean-tested expenditure and importance of private operators in care market.



As highlighted before, UK, Germany and Spain are the most "privatized" countries, allocating a higher share of expenditure in services, subject to means testing. This rate is high also in countries with a different care market composition. In fact, in Italy, Austria and France between 20% and 35% of public expenditure is allocated to means-tested services. It should be noted that there is a negative correlation between the share of in-kind services that are means-tested and the dimension of the public operator: in the Nordic countries and in the group of Eastern countries only a small percentage (less than 6%) of in-kind services provision is allocated through the mechanism of income assessment.

It is obvious that the access criteria , by defining the extent and the characteristics of public services beneficiaries, affect the amount of private care resources demanded from families. The data suggest that in those countries where there is a high rate of accessibility to the services, especially services in-kind, the recourse to the use of informal care is more limited. Conversely, a high share of expenditure devoted to means-tested services is related to a greater amount of private expenditure. It can be assumed that in those countries where there is a lack of balance between the eligibility criteria based on means-testing (of the elderly person or of the household) and those based on the level of disability and family characteristics, a higher level of private care resources is required

Public expenditure (*public expenditure in LTC services*)

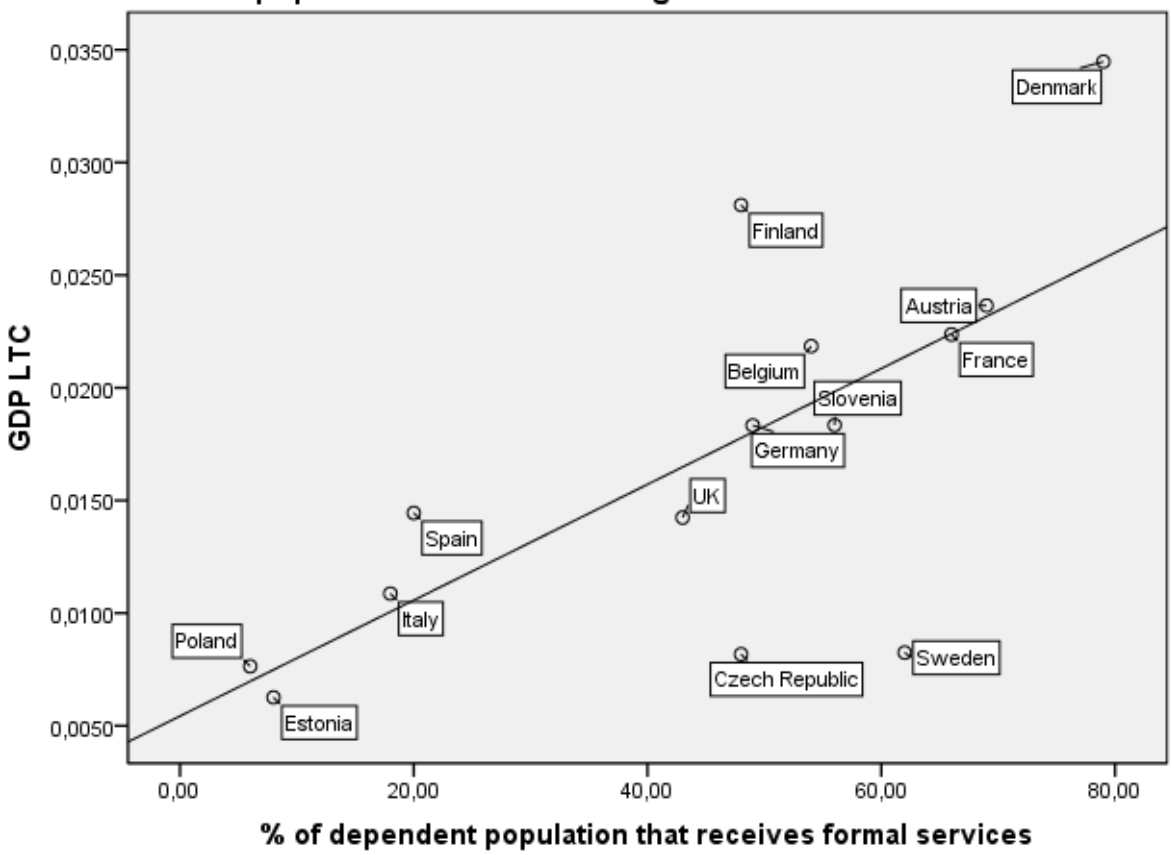
LTC is defined differently in the various EU countries, the delivery of care is often shared between various government departments and state agencies, and countries use different methods for the financing of LTC (OECD 2005, 2011). This helps explain why current available statistics on public LTC programmes are somewhat patchy (Oliveira Martins 2006; Fernandez 2009). For this reason our analysis is limited to the data provided by international sources (ESPROSS and SHA) that ensure a reasonable comparability, since the same methodology has been used to identify the various items of expenditure. This is the methodology adopted by the European Commission for the Ageing Report (2009, 2012). As we have observed earlier, the main goal of the reform processes that have interested the LTC sector is the sustainability of the system, that is, a reduction of the public financial burden. As a consequence, the level of spending that a government allocated to the LTC system directly influences the characteristics of the variables described above, and determines the level of private care resources required from the families. Based on the information provided by the System of Health Account (SHA) (OECD, 2011), it emerges that in all European countries the public share represents the most important source of financing for LTC services (covering at least three-quarters of the total expenditure)[7]. This, in spite of the fact that, compared with other sectors of the welfare state (e.g. pension or health), public intervention in LTC is still relatively underdeveloped even in the most advanced countries (Pavolini *et al.*, 2013). Total public spending on LTC in OECD countries is on average 1.2 % of GDP. The analysis at country level confirms the well-known differentiation in terms of generosity of welfare systems: the Scandinavian countries plus France and Belgium devote more than 2% of their GDP to the LTC system; Slovenia, Germany, Spain, UK and Italy spend between 1 and 2% of their Gross Domestic Product; finally,

[7] These figures do not take into consideration the role played by informal care.

the block of Eastern countries spends less than one point of GDP (SHA, 2010; ESPROSS 2010). The same picture emerges if we analyze the countries from the point of view of per capita spending corrected for the population aged over 65.

Public expenditure in LTC can be considered as a measure of LTC system generosity (Kraus, 2010). This is confirmed by the clear correlation between the share of GDP devoted to LTC and the degree of accessibility to the formal in-kind services (0.712) (Figure 5).

Figure 5: generosity and accessibility: LTC public expenditure in GDP and population over 65 receiving formal services



Although, we could not find a similar correlation with the degree of accessibility to cash benefits (0.211): a high public expenditure in LTC tends to correspond to a limited use of cash benefits. As highlighted before, a greater use of in-kind services, relative to monetary subsidies, tends to be linked with a more limited family involvement in the care process, both in economic terms and in time. Thus, the ratio between spending devoted to in-kind services and cash benefits can be of relevance for the private cost of care. Italy and the Eastern countries are the only countries that

spend more on cash benefits than on services, (twice as much on cash than on services). On the contrary, Belgium, UK and Sweden are the most services-oriented countries. In Belgium the expenditure for monetary subsidies is less than 2% of the expenditure on services.

We can conclude that, although it is obviously true that differences in public expenditure allocated to LTC are directly related to the level of development of the care services, which in turn implies a lower level of private expenditure (European Commission 2009), the relation is a complex one. This has not only to do with the difficulties encountered in defining the amount of public expenditure which we mentioned above (cross-countries differences in the levels of government, in terms of kind/intensity and access to the services), since the relation between public financing and the level of generosity of the LTC system is affected by all the factors that we have examined above. Thus, an understanding of the relation between the characteristics of the LTC system and the family involvement in care can be achieved only by taking into account all the different aspects of the system.

2.3 CLUSTER ANALYSIS

As the different features impact private expenditure, the objective of this section is to present how the selected EU countries are grouped on the basis of the indicators related to the LTC system characteristics presented above. The purpose of this exercise is to define groups of countries based on the features of their LTC systems, in order to understand if similar characteristics of elderly care sectors require a similar level of family's private resources for the care of the dependent elderly. In other words, we want to investigate whether the selected LTC system characteristics can define the degree of involvement of families in the care process.

In the next sections we present: *i)* the outcome of the Principal Component Analysis, used in order to obtain a proper grouping of countries; *ii)* and the outcome of the cluster analysis.

2.3.1 Principal component analysis

In view of the quantity of variables used (12) and the number of European countries for which it was possible to obtain data (14[8]), we decided to construct indicators that would make it possible to summarise the characteristics of the LTC systems, without involving a reduction of the information provided by the data collected. The Principal component analysis (**PCA**) technique was used for this purpose. The PCA is a statistical procedure that uses orthogonal transformation to convert a set of observations of possibly correlated variables into a set of values of linearly uncorrelated variables called principal components. The number of principal components is less than or equal to the number of original variables. Based on the research design this technique is applied to the 12 variables that represent the four aspects affecting the level of family's involvement in the care process[9], leaving aside the two variables that directly indicate the two dimensions of private care resources required by each LTC system, namely, informal care (label: *infocare*) and out-of pocket expenditure (label: *priv_exp*).

[8] These countries are Spain, United Kingdom, Germany, France, Austria, Poland, Estonia, Belgium, Italy, Czech Republic, Slovenia, Finland, Sweden and Denmark. The selection criterion is the availability of comparable data for all the variables considered.

[9] The explanation of the variables is provided in appendix A2.

As Table 3 shows, 3 indicators were identified with an explained variability of about 79%. The outcome presented in the table is coherent with the analysis presented in the previous section. In the following, we briefly explain the relation between factors and variables.

Table 3 Pattern matrix of Principal Component Analysis, Oblimin rotation, variability explained 78,98, KMO test=0.556.

variables	factor 1	factor 2	factor 3
GDP_LTC	,907	-,011	,132
Per_cap	,903	-,009	,177
Formal_dep	,871	,104	,017
Home_rec	,832	-,169	,029
Institut_rec	,634	,184	-,512
Public_prov	,030	,974	-,056
MT_exp	,041	-,840	-,091
Forprofit_prov	,237	-,810	-,358
Notprofit_prov	-,220	-,588	,509
Cash_dep	,166	,279	,899
Cash_rec	,468	,007	,778
Cash_Kind	-,554	,124	,591

Sources: Author's elaboration.

The first factor represents the variables related to the public expenditure, accessibility and coverage level of services in-kind, and it confirms the existence of a positive relation between these aspects. The second factor is a summary index of the care market dimension variables and of the rate of means-tested expenditure for services in-kind, and it attests that the public operator is inversely correlated not only with the private fro-profit and not-for-profit actors but also with means-tested expenditure. In other words, the share of means-tested services tends to be higher in countries in which the public operator is not the main actor in the market. The last factor is the index of the three variables that reconstruct the features of the LTC system's cash benefits schemes, and it is not surprising that these variables are related together in a positive manner: the more the public expenditure is allocated to cash benefit schemes, the more the latter will be accessible.

The Principal Component Analysis selects those factors that enable a feasible and proper cluster analysis. However, in order to clarify the results of the cluster process, in the next paragraph we explain its results through the (original) variables used in the previous section.

2.3.2 Results

Table 4 summarizes the characteristics of the identified clusters[10]. Attention should be paid in interpreting this clustering exercise: it is not an attempt to update taxonomies of care regimes if anything, because we are referring to only one category of population, the dependent elderly, and not to the overall care sector. It rather offers an opportunity to summarize the findings on the availability and accessibility of care services and complementarity among providers, while also capturing some of the changes that care regimes are undergoing.

As indicated in Table 4, we obtained four clusters[11] that differ little from other works on different types of LTC systems (Kraus et al, 2010; Poomer *et al.*, 2007 Bettio and Verashchagina, 2010).

Table 4. Cluster identified

LTC system dimensions	CLUSTER / VARIABLES	CLUSTER 1 SE, FI, DK, SI	CLUSTER 2 IT, PL, EE, CZ	CLUSTER 3 FR, AT	CLUSTER 4 ES, BL, UK, DE
Service delivery	home care +65	+	--	++	=
	istitut. Care + 65	++	--	=	=
	cash ben. + 65	=	+	++	--
Market structure	Public prov.	++	+	-	-
	not for profit prov.	--	+	++	=
	private prov.	-	-	=	++
Entitlement for care	Formal in kind on dep. pop.	+	--	++	=
	Cash ben. on dep. Pop.	+	+	++	--
	% of exp. in kind mean tested	--	-	+	++
Public expenditure	per capita pub. exp. Pop +65	+	--	++	=
	LTC/GDP	+	--	++	=
	Cash in kind exp. Rate	-	++	-	--

Source: Author's compilation; Note: + or - indicate cluster average value including between the mean of all countries and 1 standard deviation of the variable: ++ or - - indicate a value higher or lower than 1 standard deviation.

It is not surprising that the Nordic countries cluster together with Slovenia. This cluster is characterized by a high level of provision, accessibility and funding, and the delivery of LTC

[10] Some countries (e.g. The Netherlands) have been left out due to the difficulty in collecting data that would allow an acceptable level of comparability.

[11] In order to have a proper subdivision into groups we decided to repeat the clustering operation using the different methods and compare the results. The methods used were: Complete linkage method, Average linkage method, Ward's method and Centroid method. The results of the cluster analysis were tested through R^2 ,Semi Partial R^2 and pseudo t^2. The methods used produced similar results. In any case, the best distribution that we found was the subdivision into 4 groups. See the dendrogram in the Appendix.

services is almost exclusively of public relevance. Somewhat more unexpected is that Sweden still belongs to this cluster. As a consequence of the reduction of service provision and budget cutbacks that have interested this country in the past years, research findings (Meagher and Szebehely, 2013; Szebehely and Trydega°rd, 2011) show that the Swedish LTC system is no longer so close to the Scandinavian characteristics. This is also confirmed by our data: Sweden shows a public spending, both as percent of GDP and per capita, which is lower not only than the Nordic countries' average, but also with respect to the mean of our selected countries.

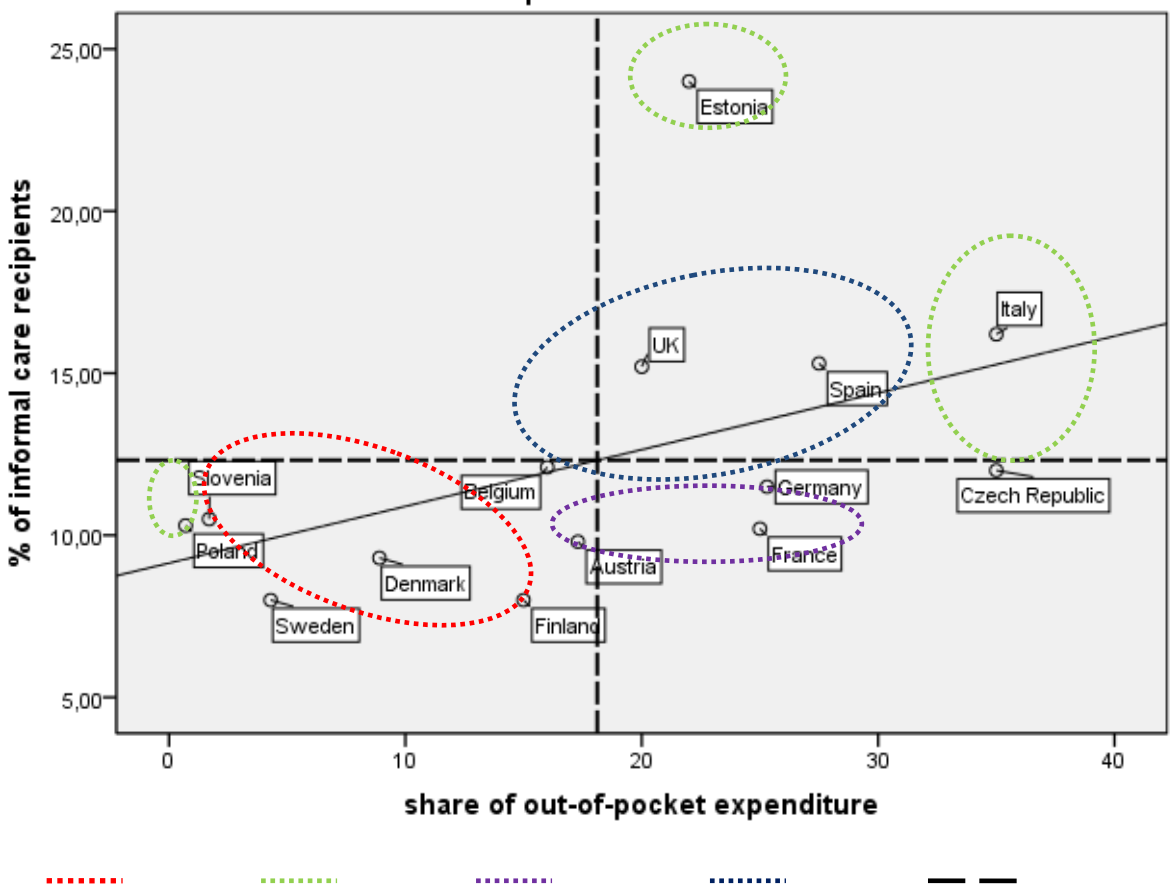
The novelty with respect to the past clustering is the position of Italy and Spain, which do not belong to the same cluster. Italy is placed in the same cluster as the Eastern countries, (even if it shows a higher level of generosity and accessibility than Poland and Estonia). Spain appears to have moved towards more performing countries, like Belgium, UK and Germany. The common feature between these four countries is the composition of the care market, namely the common high share of private operators with respect to public and not-for- profit providers[12]. Another incongruity in relation to our expectations is the position of Belgium in this cluster, which, based on the literature, does not fully represent the characteristics of its LTC system. As we have seen - and as we shall see in the next paragraph - the Belgian LTC system presents several features similar to the French LTC model, such as a high level of public expenditure and a high coverage level of home care services. Therefore, we would have expected that these countries clustered together. Instead, France forms a group with Austria, generating a cluster that seems to be formed by two of the top performing countries. In fact, the latter are characterized by a generous funding of the LTC system, and, consequently, they show a high coverage of home care, as well as cash benefits. Moreover, even if they tend to allocate a substantial share of their expenditure to means-tested services, the degree of accessibility to services is high. Finally, in both of them the not-for-profit operators provide more than half of the LTC services.

[12] It should be considered that our data mainly refer to 2010 and do not reflect the budget cuts and 2011 and 2012 government reforms that reduced the capacity of the Spanish LTC system (Observatorio Estatal De La Dependencia 2012)(refer to thesis).

2.4 A TYPOLOGY OF LTC SYSTEMS BASED ON THE RELIANCE ON PRIVATE CARE RESOURCES

This section focuses on the analysis of the relation between the characteristics of the national LTC systems and the level of private resources that the families devote to care, in order to understand the role of the factors described above in determining the involvement of the family in care. In other words, we want investigate whether countries with similar characteristics of national LTC systems tend to present similar distributions of the cost of care, with specific reference to private care resources. To this end, we analyze the outcome of the cluster analysis under the two dimensions of private care resources: reliance on informal care and out-of pocket expenditure. The result is shown in Figure 6.

Figure 6, Association between percentage of population 65+ that receives informal care and percentage of out-of-pocket expenditure on total LTC expenditure



= **cluster 1**; = **cluster 2**; = **cluster 3**; = **cluster 4**; = mean value

Source: Author's calculations based on: informal care, OECD 2011; out-of-pocket expenditure, SHA and ESPROSS, 2010 reference year.

There is positive correlation (0.643) between the two dimensions of private care resources, which means that there is not a trade-off between the them. Countries are distributed along a line going from those with a limited family involvement in care, to countries that depended heavily on family resources for the care of the elderly. A possible explanation for this positive correlation could be offered by a third variable: the level of public spending. In fact, with the only exception of Sweden and Poland, the level of private care resources increases with the decrease in public expenditure (figure 2, appendix A.3). Moreover, Figure 6 shows another important element - with the exception of cluster 2 -: the distribution of countries reflects the outcome of the cluster analysis based on LTC system characteristics. This pattern suggests that even if public expenditure tends to determine the private care resource level, the elements described above contribute to determine the degree of family's involvement in care.

Considering the fit line as a proxy of the level of development of national LTC system, we can say that the need for private resources decreases with the increase in LTC "quality". It is not surprising that the first cluster is placed in the lower left quadrant, where family involvement in care is lowest. Italy and the Eastern countries (with the exception of Poland) are placed in the opposite quadrant, which is characterized by a high level of both dimensions of private care resources. The fourth cluster is placed in an intermediate position, but slightly toward the top right quadrant. It presents an average value of informal care and a substantial level of private spending. The cluster of France and Austria is characterized by a similar level of out-of-pocket expenditure, but by a lower share of elderly receiving care from relatives or friends.

On the basis of the cluster outcome and the countries' distribution in relation to the level of private care resources, it is possible to identify four types of LTC system.

"Self-sufficiency model"

This model represents the LTC systems able to ensure a suitable level of formal services and adequate financial support to the dependent elderly: they do not depend heavily for they sustainability, on the recourse of the family of the frail elderly. This model identifies the characteristics of Cluster 1. In fact, on average, less than 9% of the older population receives care from relatives, partners or friends. This may be a consequence of the fact that in these countries the

care of the dependent elderly is a direct responsibility of the State. The public operator is the main actor, providing more than 80% of the services, ensuring the highest level of coverage and accessibility. Moreover, this cluster combines a high public spending and an extremely low share of means-tested services expenditure, integrated by a fair level of coverage and expenditure for cash benefits. The result is that the cluster average percentage of private expenditure on total LTC spending is about 8%, less than half the average value of all countries.

"Family-centred model"

The second cluster (cluster 2) identifies the polar model, in that it indicates countries in which the care of the dependent elderly is tightly dependent on family involvement. The characteristic feature of this model is the subsidization of care. About 70% of total LTC expenditure is devoted to cash benefits, with in-kind services that covering only a small part of the dependent elderly. As a consequence, more than 15% of the older population has to rely on their family's assistance. Moreover, although the public operator is the main provider of services and there is a fair share of means-tested services expenditure, the insufficient public resources devoted to the LTC imply that about a quarter of total LTC expenditure derives from cost-sharing or private expenses.

"Cash for care / economic involvement model"

The third cluster identifies a model of LTC that requires a limited involvement of the family in terms of informal care, and moderate reliance on private financing. This model presents some of the characteristics of the Scandinavian countries. In France and Austria the LTC system receives a generous public funding (more than 2 points of GDP) and is characterized by a virtuous sector of home care services, and a broad coverage level of cash benefits. So it is not surprising that in this model there is a limited recourse to the use of informal care. At the same time, despite the high public spending, more than 30% of the expenditure for in-kind services is subject to means-testing, and the public operator provides only a quarter of services, leaving to not-for-profit actors more than half of the delivery of LTC benefits. With respect to the self-sufficient model, these differences involve a heavier economic burden for the families of the dependent elderly, reaching about 22% of the entire LTC expenditure.

“Family integration model”

In this model the formal care sector is able to take care of the dependent elderly, but needs the integration of the family, both in terms of direct support to care (informal care) and cost-sharing (private expenditure). Figure 6 shows that the fourth cluster is placed between the two identified extreme models. In fact, this cluster is characterized by average level of coverage and public expenditure in services, which results in a slightly above average use of informal care (13.5% of the older population). Moreover, this model combines a limited financing and use of cash benefits, with a strict income assessment for the access to in-kind services that are mainly provided by private operators. Although expenditure on services is twice the amount spent on cash benefits, the broad use of mean-testing, together with the limited role played by public providers, seem to generate a negative effect for the dependent elderly and their families, namely, a significant level of cost-sharing and private expenditure: more than 22% of LTC funding derives from household incomes.

These types of models should be considered as ideal-typical models of the relation between LTC system characteristics and the needs for private care resources. Unfortunately, macro data can provide only a general view of these relations, and cannot provide information on how the different models affect the economic condition of the dependent elderly and their families. Since our research is aimed at understanding whether the LTC reforms affect the risk of poverty for the dependent elderly and their families, we extend the analysis to the micro level. To this end, we shall consider only a limited number of countries, selected on the basis of the results obtained in the cluster analysis. The countries we are going to analyse are the following:

Sweden: we decided to choose this country from the "Self-sufficient" model, because, as already mentioned, following an intense process of reform, the country is now moving away from the characteristics of the Scandinavian LTC system; *Italy* and *Poland*: were selected from the "Family-centred model”, since though presenting similar characteristics of their LTC systems, they are placed at the opposite ends of the diagonal of figure 6; *Belgium* and *Spain* too: are interesting case: they belong to the “Family integration model” bur they are placed in the two opposite quadrants in figure 6, and they belong to the same cluster, but present substantial differences as regards the characteristics of LTC systems; *France:* this country was selected from the “Cash for care model” because it requires a higher level of private care resources than Austria, and, compared to the

average characteristics of the model, it is more oriented to a LTC system based on services provided by non-public providers.

Before presenting the results of the analysis on the relation between risk of poverty and elderly care, in the next section we provide a brief overview on how the LTC reforms have influenced the (family) care for the dependent elderly in the last ten years. In particularly, we analyze, from the point of view of dependent elderly, how the provision of LTC services and cash benefits have changed over this period, and what consequences that these changes have caused on the families of frail elderly, in terms of both financial costs and time-to-care.

CHAPTER 3

THE IMPACT OF REFORM PROCESSES IN SIX NATIONAL LTC SYSTEMS[13]

As mentioned earlier, all EU countries were tackling the problem of sustainability of their LTC systems in different ways: the recent economic crisis has directly affected the reform guidelines that have interested this sector. As argued by Pavolini and Ranci (2013), since the beginning of the early 1990s up to 2008, the spending dynamics in various countries have highlighted a growing public expenditure in care sector. However, positive trends can hide important variations in the spending programs aimed at the older population. In general, in spite of a growing demand for LTC services, overall public spending did not rise at the same pace. Institutional reforms in this sector have been addressed at trying to meet the growing demand for services, while simultaneously containing public spending. This section is aimed at understanding the consequences of these policies on the dependent population.

In the following paragraphs the research will focus on schemes that provide home care services or cash to support dependent older people aged 65 and over, living in their homes, leaving aside the schemes of residential and semi-residential services. This decision derives from data constraints: the only survey that provides information on income, health status, LTC services, and health expenditure, for both dependent elderly and their adult children is the "Survey of Health, Ageing and Retirement in Europe" (SHARE), and its samples represent the non-institutionalized population aged 50 and older of each country. In this research we use three waves of this survey: the first refers to the years 2004 and 2005, the second to 2006 and 2007, and the fourth wave 2011 and 2012. Due to the different purpose of the third wave, the data of this wave cannot be used in our research. In fact, SHARELIFE - the third wave of SHARE- focuses on people's life histories. Its questionnaire links individual micro data over the respondents' entire life with institutional macro data on the welfare state; and does not provide information of elderly disability level, families care expenditure or informal care provided or received.

[13] This chapter and the next one are based on the use of SHARE data, a multidisciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks, with a sample representing the non-institutionalized population aged 50 and older.

3.1 SERVICES PROVISION

3.1.1 Cash benefit

In last 15 years there has been a considerable increase in the use of cash-based schemes to support to disable people (Ungerson, Yeandle et al., 2007), and this paragraph starts by looking how the reforms and accessibility characteristics have influenced the provision of cash benefits for the over 65 population. We use a broad definition of "cash transfers", one which encompasses both LTC benefits and disability allowances. This decision was suggested by the scarce homogeneity across countries both, in the definition of services packages for the dependent population, and in the identification of beneficiaries. Figure 7 reports the percentage of dependent elderly that have received cash benefits in the survey's years, and their average annual amount (green triangles). Although the trends over the 3 years are largely negative, in terms of both coverage level and average amount, in 2012 in five out of the six selected countries, at least 8% of the dependent population had received this benefit

In Belgium the two major cash benefits are targeted at supporting financial costs of nonmedical care-related expenses, and they are means-and needs-tested. The financial evaluation is related to the family income, including every relative living with the dependent elderly (Meulders, 2010). They are strictly targeted on the neediest old people living at home, but they do not require the agreement of a particular care plan and recipients are free to spend the money as they want[14]. Figure 7 shows that one of the consequences of the 2004 home care reform, in particular the reallocation of public resources towards the services in-kind and resort to different financial instruments - such as the tax deduction - has been the reduction of the average annual amount of cash benefit, from around 7,000 € in 2004 to about 5,000 € in 2012. In 2012 the effect of the increase in public expenditure in the LTC sector was detectable, leading the number of users close to 10% of the dependent population.

The economic compensation for dependent elderly and/or for family carers is not particularly common in Sweden (Socialstyrelsen & Linköpings universitet 2007). The main forms of

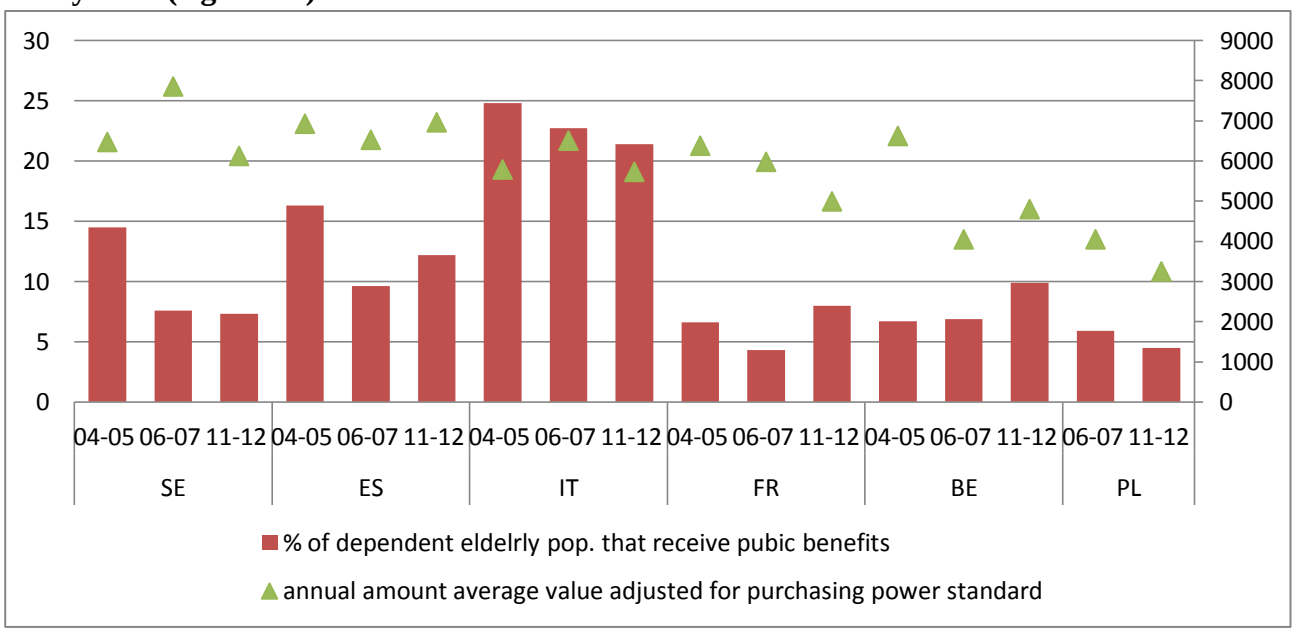
[14] Moreover, Flemish older people receive a flat cash allowance of €30 (2009) from the Flemish Long –Term Care Insurance (Vlaamse zorgverkering). This entitlement program is not means-tested and is targeted on people from above a certain level of dependency living in residential facilities or at home (CROME 2012).

compensation are a home nursing grant (hemsjukvårds¬bidrag) and a family carer grant (anhörigbidrag). The former is a compensation from the local authority or the county to a person close to the dependent person for nursing work in the home. A family carer grant is a cash compensation to help a person in ordinary house working, i.e. elderly people who can use the grant to pay a relative for help in the home (Nyberg, 2010). The amount of these benefits is rather small in relation to the cost of living (ibidem): the care grant is comparable to a nurse's aide, while the latter is equivalent to sickness allowance. In 2012 the annual base amount of the family care grant was 48,000 SEK, around € 5,500 (Försäkringskassan, 2012). Between 2004 and 2012 the number of recipients of cash benefits decreased from around 15% to 7.3% (but also annual amounts decreased on average by around 2,000 € from 2007 to 2012)(figure 7). This can be explained with the reforms undertaken by the Swedish government, in order to reduce public spending on LTC: between 2000 and 2009 the latter decreased not only in relation to the ageing population, but also in absolute terms (by 6%) (Szebehely 2011). In addition to a deep process of market reorganization in favour of non-public operators, budged reductions have led to the narrowing of the definition of public responsibility (Nyberg, 2010), translated into the decision of concentrating available resources on the population with a high level of disability (Szebehely 2011).

On 1 January 2007 a new law regulating the services provided to dependent people became effective in Spain: "Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia - LAPAD" (Dependency Act). This law has radically changed the characteristics of the Spanish LTC system, creating a new citizenship right that tries to meet the dependent people's care needs (Gutiérrez, 2010). The reform has a service-oriented philosophy and establishes that the use of cash benefits is allowed only when the equivalent services in-kind are lacking, or is bound to purchase specific services. In fact, after 2007, the two main benefits introduced by the law are granted only when it is not possible to access a public service (Prestación económica vinculada al servicio) or, exceptionally, if beneficiaries are being cared for by their families in their own homes (Prestación económica para cuidados en el entorno familiar y apoyo a cuidadores no profesionales). Moreover, like all the services and benefits established by LAPAD, access to the cash benefits is regulated on the basis of a disability evaluation and on the beneficiary's economic status. In spite of its brief history, the Dependency Act is already experiencing severe difficulties for its full implementation, and as claimed by Gutiérrez, in 2010 more than 45% of the benefits were of a financial nature. As a consequence, despite the significant reduction of recipients of cash benefits which occurred after the introduction of the LAPAD, - by

around a quarter during the eight years considered (figure 7) - there is still a high use of cash benefits, the second highest coverage level of financial benefits among our 6 countries in 2012.

Figure 7. % of dependent elderly that receive public cash transfer for LTC or disability, on total dependent population aged over 65 (left axis), annual average amount of cash benefits, at family level (right axis)



Source: Author's compilation on the basis of SHARE data, waves 1-2-4.

Italy is the country that presents the highest level of cash benefit recipients. As highlighted by Gori (2012), the main instrument at the core of the Italian LTC system, together with the role played by the families and by the private caregiver, is the disability allowance - "indennità di accompagnamento" -. This cash benefit, unlike in other OECD countries, is a fixed lump-sum and is not means-tested (Colombo et al. 2010). It is subject to certification of a (severe) disability issued by the Health authorities and can be freely spent (Bettio and Verashchagina 2010). The second major cash transfer, is the care allowance that plays a minor role in terms of public financing and share of users, and is financed by municipalities or National Health Service Units. It is paid either in cash or tax credit, it is means and needs tested, and unconstrained in its use. According to SHARE data, between 2004 and 2012, more than 20% of dependent elderly people received cash benefits The observed reduction in share of users is mainly explained by the increase in the population with LTC disabilities, unmatched by a proportional increase of public expenditure (Gori, 2012). The average monthly amount is stable over the years, with a slight increase, from € 436,7, in 2004, to €

492,9 in 2012[15]. Figure 7 allows us to understand the effects of the Italian (lack of) reforms that have maintained a cash-oriented system: in 2012 the Italian share of recipients of cash benefits is almost double the Spanish one. Specifically, in Italy, the shift towards untied cash transfers, together with the family's legal obligation to provide care to its relatives in need, result in a increase in care responsibility of the family. In particular, cash transfers are often used by Italian elderly to buy services from private providers or to compensate the care provided within family.

The aim of the 2002 French reform was clear: to move away from the previous cash scheme (Prestation spécifique dépendance), based on a cost containment objective, and to increase the number of recipients. The Personalised autonomy allowance ("*Allocation personnalisée à l''autonomie"*) (APA), was therefore created, based on a universal principle, (Martin, 2003). According to Campéeon *et al.* (2008), the French long-term care policy is based on a specific scheme – the APA – which is organized around three main elements. Firstly, the APA is a benefit given to the elderly people who live at home and in institutions, according to their level of dependency. As the French scheme is a national scheme implemented at the local level, and in order to guarantee access to the same services across the country, care packages are defined according to the level of dependency, and give rights to a certain amount of benefit. Secondly, a main characteristic of the French scheme is that the benefit is paid to finance a precise care package, determined by professional teams, according to the needs of the recipient. The use of the benefit is therefore controlled, and can only finance the services identified as necessary by the professionals. Finally, France has adopted a mixed system for the funding of the care packages. At the lower end of the income scale care is provided on an assistance principle: under a fixed income threshold - €669.89 in 2010 -, recipients do not contribute at all to the funding of the care package. Above the threshold, a user fee or co-payment system is introduced: the recipient contributes to the cost of the care package, according to his/her level of income. According to data of the Ministry of Social Affairs and Health (Ministère des affaires sociales et de la Santé)[16], between 2002 and 2010 public resources devoted to APA increased at an annual rate of 5.9%, while users increased at a rate of 8.8%. Although figure 7 captures only the non institutionalized users, this positive trend is clearly visible. The share of user increases over the period considered from about 5% of the dependent population to 8% in 2012. The higher increase of users compared to resources leads to a constant reduction in the average amount, passing from 6,200 € in 2004 to around 5,000 € in 2012.

[15]This figure could be a further confirmation of the predominance of the disability allowance among disability cash schemes: the average annual amount detectable by SHARE data is very close to the annual amount of the disability allowance, respectively 492,9 € and 495€(http://www.inps.it/portale/default.aspx).

[16] http://www.social-sante.gouv.fr/

The limited presence of in-kind services (figure 10) and cash benefits in the Polish LTC system can be explained by the fact that the development of a formal, non-family based LTC system is in its initial stage (Golinowska, 2010). At present, there is no specific regulation that comprehensively covers the issues of care services for the elderly, the institutions providing these services, the rules of access or the ways of financing . The majority of LTC services is provided by the Health sector, under a chronic shortage of public fund (ibidem). As reported by Szwałkiewicz (2007), the financing of elderly care and LTC services remains a major policy concern in Poland, which involves all kinds of provisions and providers. According to the national consultant on nursing and care of chronically ill and disabled, LTC facilities in the health sector are increasingly indebted due to insufficient funding from the health fund (NFZ). As a result, the recent system reforms, further reduced the availability and affordability of the LTC services and benefit provisions (Golinowska, 2010). Figures 7 and 8 confirm this picture: the percentage of dependent elderly that receive cash benefits is around 5% of the dependent population, and the annual average amount of these benefits decreased by one-third between 2006 and 2012. Moreover, although there is a limited system of formal in-kind LTC services, in the first wave of the survey covering Poland (the 2nd wave) no one aged over 65 declared to receive this kind of services (figure 10).

In order to understand how the characteristics of the cash schemes (and the related reforms) have affected the care conditions of the dependent elderly it can be useful to analyze, in a diachronic perspective, the average amount that the elderly receive, on the basis of their disability level. Excluding Spain, in 2004 the annual amount of cash benefits received by elderly people with a moderate level of disability does not vary significantly across countries, and it ranges between4000 € to 5200 €. Conversely, table 5 shows that the compensation to severely dependent elderly people varies considerably. In 2004 in Italy, Spain and France this category of population received, on average, around 6500 € per year, in Sweden 4700 €, and only 3500 € in Poland; completely different is the Belgian scenario, where the public economic support is close to 9000 € per year. The change in the absolute values of cash benefits between 2004 and 2012 demonstrate the impact of the reforms on the dependent elderly. One of the consequences of the economic crisis on the welfare policies is the narrowing or reduction of public services; in the LTC sector, this mechanism has affected primarily the elderly with a low level of disability: all countries show a negative differential for this category of population. As for the elderly with severe disabilities, the figures suggest that in Italy, France and Poland the amount has remained more or less stable during the years, while in Spain, thanks to the reform introduced in 2007 which linked the amount of benefit to the level of disability, the situation has changed completely, leading to an increase of 2000 €.

Table 5. Average annual amount of LTC cash benefits in 2004-05 and absolute change in 2011-12, by disability level

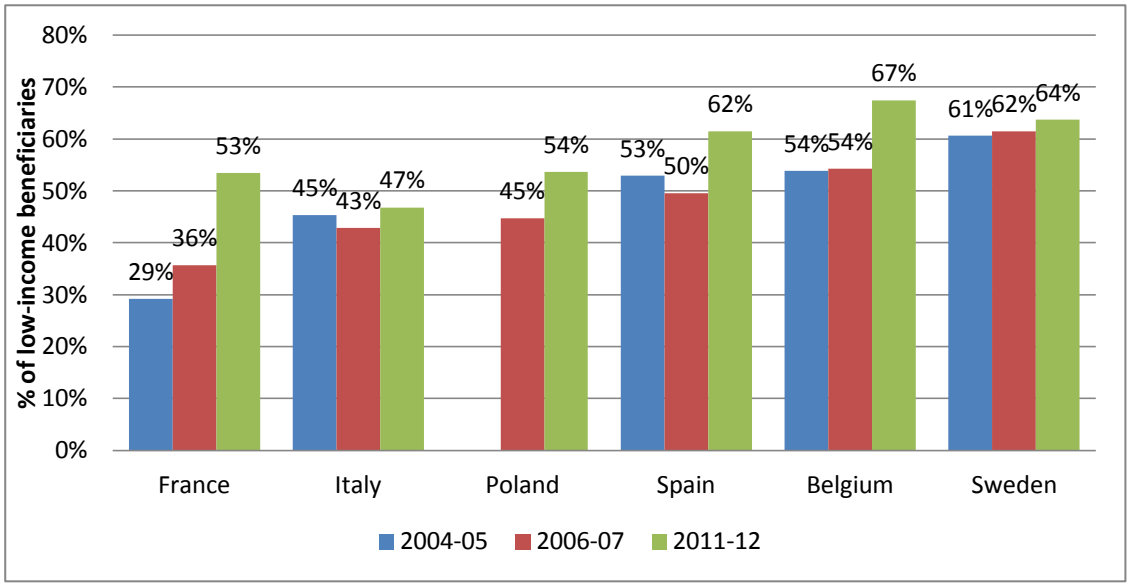
	average annual amount €*		**differential between years €***	
	2004-05		2004-05 / 2011-12	
	moderate	*medium or severe (difference)*	*moderate*	*medium or severe*
Italy	5203	6123 (920)	-37	+ 359
Spain	7246	6620 (-636)	-604	+ 2003
France	3980	6887 (2907)	-753	-68
Belgium	4201	8858 (4657)	-678	-2269
Sweden	4665	4705 (90)	-499	+ 1227
Poland (06-07)	4165	3512 (-653)	-5	-271

Source: Author's compilation on the basis of SHARE data, waves 1-2-4.; *= adjusted by purchasing power standard

Another country in which the process of focusing on the neediest is more evident, is Sweden. The category of population with moderate disability receives 500 € less, while the benefit for the more severely dependent has increased by 1200 €. In Belgium the decision to reallocate the expenditure towards different care services has affected both categories , with the neediest suffering the larger reduction.

The main goal of cash benefits is to support, through a public transfer, the income of the family of disabled people, so that they can face the related care expenditure. Cash benefits perform a dual role: care and assistance , and income support . If viewed as an income support instruments, their amount should be adjusted to the recipients' economic resources. Since the main goal of this research is to understand the relation between poverty and the condition of dependency, it is important to asses the degree of redistribution achieved by these services in the selected countries. Figure 9 shows the share of low-income recipients of cash benefits, in total beneficiaries; low-income refers to a family equivalised income included in the first two quintiles of the income distribution. In those countries where access to cash benefits is based on disability and family's economic resources - Belgium, Spain and Sweden - more than half (and more than 60% in 2012), of cash benefits receivers live in a low-income family. In Italy and Poland, where the public transfers do not require a means-tested assessment, this percentage presents lower values.

Figure 9. Percent of low-income recipients of cash benefits in total recipients



Source: Author's compilation on the basis of SHARE data, waves 1-2-4.
Note: Low-income recipients: first two quintile of the income distribution.

In France, the means-tested evaluation does not limit the access to the services, but reduces or excludes the user's co-payment for in-kind services. This can explain the low share of benefits bestowed to the poorest elderly in 2004 and 2006. All in all, these figures give an idea of the impact of the current economic crisis on the families of the dependent elderly: regardless of the evaluation criteria, in all countries the share of low-income beneficiaries of public transfers reaches a peak in 2012.

3.1.2 Services in-kind

Figure 10 reports the percentage of the dependent population aged over 65 that receives formal LTC services, where for formal services it is intended all LTC services provided by professional workers through private, public or not-for-profit operators, in 2004-05 and in 2006-07. Due to changes in the questions in the fourth wave, it was impossible to obtain information on type, coverage level and number of hours of formal LTC services received by the elderly for 2011/12.

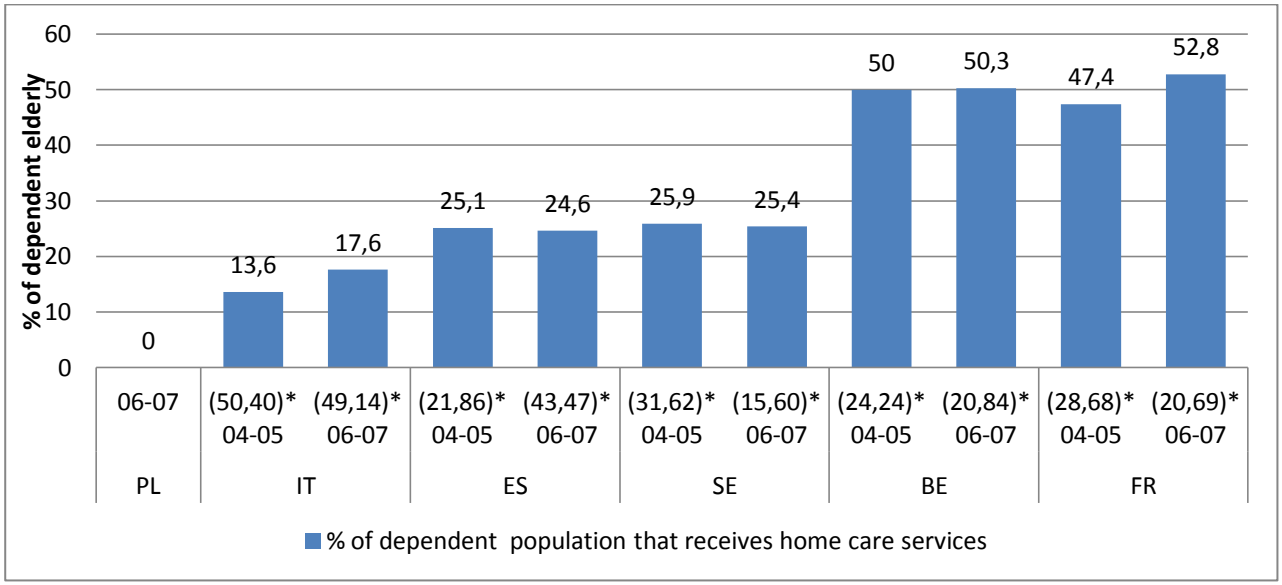
The first important element is the difference between the macro and micro data in relation to the Swedish case. In the previous paragraph Sweden was grouped together with countries with a medium-low level of use and accessibility to cash benefit schemes, but with a very high level of

coverage, accessibility and expenditure for formal in-kind services. However, the micro data provide a different indication. According to the SHARE data, for the period between 2004 and 2007, only about 25% of the dependent population aged over 65 received formal LTC services, and the monthly average number of hours was reduced by half, from 31 to 15. The Swedish decline in home care coverage is also noted by Szebehely (2012) who stated that the share of elderly population that received home care in 1980 was above 16%, while it was 8% in 2008 . This situation derives from the processes of reform and from the demographics changing which occurred in the last 20 years. During the 1990s economic crisis the resources allocated to elderly care by the municipalities decreased. Also the resources in the counties to health and medical care were cut and the number of places in emergency health care was almost halved between 1992 and 2003 (Socialstyrelsen, 2005). During the same period the number of persons 80 years and older increased by 22 percent. The declining number of places of care in combination with the increased number of elderly in the population resulted in more elderly people being checked out to go home, though stilling need of nursing and rehabilitation. As a consequence, the municipalities choose to concentrate resources on those persons with the greatest needs, so that elderly people with less severe care needs are often not taken care for by the municipalities. This development has generated a more narrowly defined concept of public responsibility and more responsibility has been shifted on persons in need of care. (Larsson & Szebehely, 2006). Additionally, regarding the intent to reduce or redirect the public responsibility of care, the government, during the last two decades, has implemented a packet of reforms with the goal of broadening recipients' freedom of choice through the increase of privatisation in the elderly care sector. From the new Local Government Act of 1992 the municipalities are able to out-source provision of tax-financed care services to non-government actors, both for-profit and non-profit. Since then, there has been a growth in the proportion of services provided by for-profit organisations, and, in 2007, nearly 11% of people over the age of 65, who were granted home help service, had these benefits provided privately (Socialdepartementet, 2008). A consequence of this policy of austerity is that more elderly today than 10-15 years ago receive help from family members: between 1994 and 2003 the percentages of female relatives that provide help to dependent elderly (over 75 years) grew of 10 points, and specifically the percentage of adult daughter caregivers pass from 22% in 1994 to 35% in 2003 (Socialstyrelsen, 2004).

France and Belgium have moved in a different direction, developing a variety of instrument to support elderly care. Since 1990 various measures have been taken in France to facilitate home care (Le Bihan, 2012): tax deduction, introduced to encourage home employment; 'service employment vouchers', to simplify the procedure for paying people working in the home; and in 2005 the

'Cheque emploi service universel' (universal service voucher), created with the purpose to simplify and extend the access to private/public formal services. A similar reform process has interested the Belgian LTC system, with the introduction of voucher schemes as *Titre-Service*, and tax reduction to support home care services. The main goal of this process has been to strengthen the already high degree of development of the public in-kind services (Willemé, 2010). As a consequence of these interventions on home care, in France and Belgium these services meet the needs of a large share of dependent elderly, reaching, in both countries in the period under examination, around half of the dependent population (Figure 10). As mentioned earlier, in these countries the intensity of cash and in-kind services is based on the disability level of the recipient. Here too, however the increase in the share of recipients was not matched by an increase in the average number of hours. Between 2005 and 2007, in both countries, this indicator decreased, respectively, by 4 hours in France and 8 hours in Belgium. Yet, in 2006 a French or Belgian dependent elderly person receives, on average, around 20 hours of service per month, that, compared with the other countries, seems to be an acceptable intensity of care.

Figure 10. % of dependent elderly that receive professional nursing care at home, on total dependent population aged over 65,(*=monthly average number of hours received)



Source: Author's compilation on the basis of SHARE data, waves 1-2.

SHARE data allow to analyse only the initials effect of the introduction of the Spanish constitutional reform implemented on 1 January 2007. On the basis of the information provided by figure 10, it seems that this reform has significantly affected the intensity of services but not the level of coverage. This partial increase may be considered a consequence of the implementation of

the first phase of the reform, whereby, in compliance with the law, the right to care is progressively based on the users' level of dependency (Gutiérrez, 2010). In 2007 the implementation schedule planned the introduction of services for persons with high/very high disability, that required a high number of hours of professional care. Thus the doubling of the monthly number of hours between 2004 and 2007 (from 21 to 43 hours), might derive from an increase of the share of dependent elderly with high or very high disability among recipients of services.

Since the '90s the Italian LTC sector has been characterized by an institutional inertia and, in spite of several attempts at institutional reforms[17], no change has been introduced in the national Italian LTC system over the last 10-15 years. All attempts stumbled against two main difficulties. The first is financial: the country's public debt is high and the level of taxation on wage income is also high (Bettio and Verashchagina, 2010). The second has to do whit the low priority assigned to care, given the widespread feeling that 'the family can fix it', which tends to hinder any major social policy reform until the status quo turns into a state of emergency (ibidem). This inertia has generated a situation in which regional and municipal authorities are proceeding in a random fashion, accentuating the existing fragmentation across regions and municipalities (Gori, 2008). In this scenario the Italian home care sector is doubly penalized. Historically this sector has suffered from a subordinate position with respect to the cash benefits. Between 2005 and 2011 more than half of the increase in public financing (amounting to 0.21percente of GDP) is devoted to cash scheme (58%), and only around 35% is intended to services in-kind provided at home (ibidem). Additionally in Italy, unlike France, Sweden and Belgium, there is no legal obligation on the part of public authorities to deliver care to old people in need, and the responsibility falls on the families (Bettio and Verashchagina, 2010). Therefore, the insufficient public resources devoted to formal in-kind services, the limited involvement of the national government in the management of this sector, and the absence of a public commitment to service provision can explain why the home care services sector is undersized (Gori, 2012). With the exception of Poland, Italy has the lowest home-care services coverage ratio among the selected countries (Figure 10). Despite the increase in

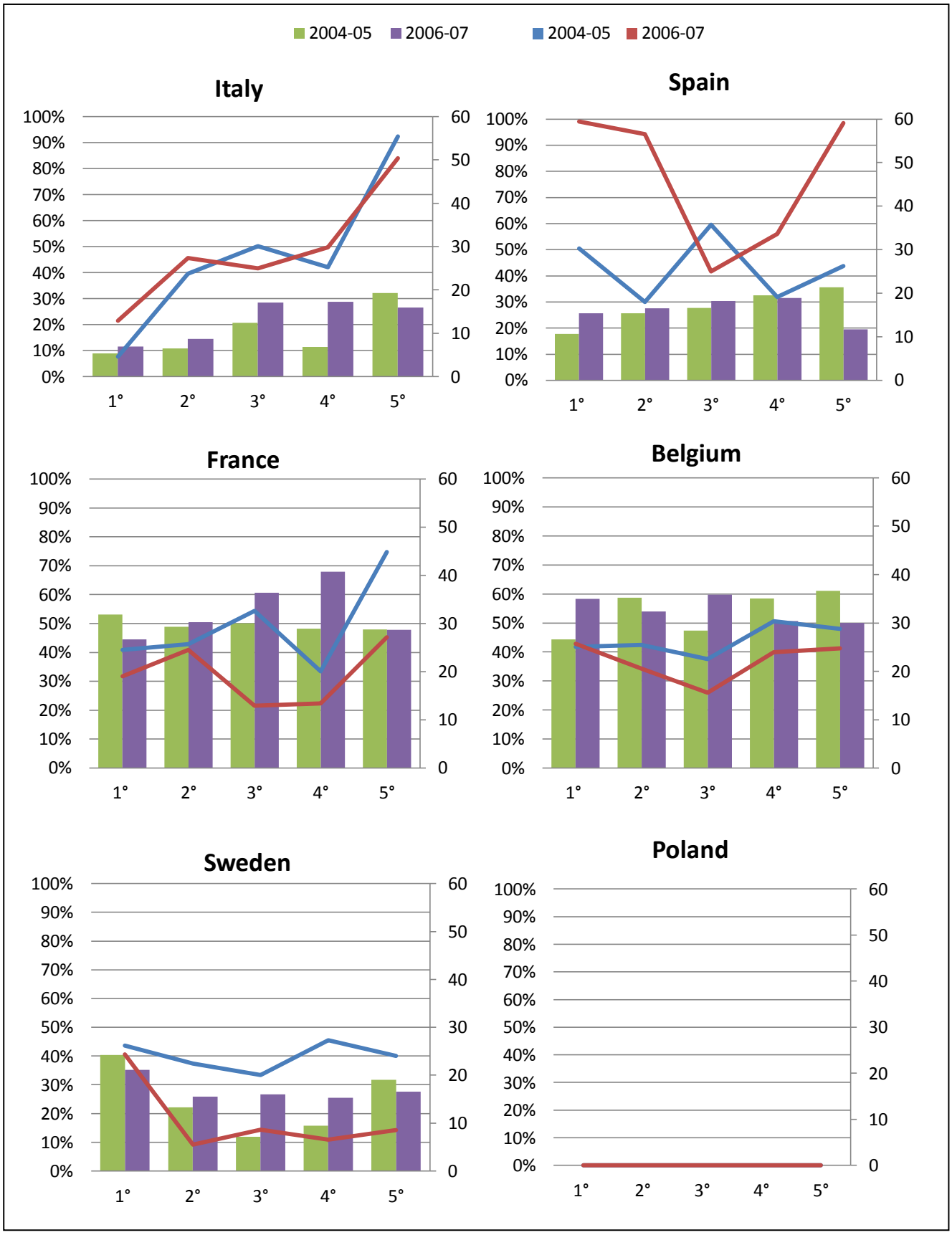
[17] In 1997 the Commissione Onofri proposed to institute a national fund for the disabled financed with a dedicated tax. In 2002 the then Health Minister Sirchia advocated a mandatory fund partly financed out of workers' contributions. In 2003 the Commissione Affari Sociali put forward a draft legislation instituting a fund for the care of disabled persons that would pay for residential care and home care services; the idea was to finance the fund mainly out of general taxation and to leave to families the option between existing cash transfers and fruition of services. Since its existence this fund has suffered several cutbacks, and the second-last Italian government had almost canceled the financial resources from the expenditure budget. In 2006 the Prodi government begun to draft a bill purporting to enact perhaps the most complete reform envisaged to date. The main pillar of the reform was the individual right to so-called 'basic levels of care' (livelli essenziali di assistenza). The expansion and reorganization of publicly financed services, as well as the setting up of a machinery to monitor outcomes and quality, would be geared to implement this right. The government fell before any such bill was passed.

recipients by of 4% in the two years under examination, more than 80% of the potential beneficiaries of these services do not receive professional care at home.

According to the results of the Eurobarometer survey conducted in 2007, almost a half of Italian interviewees (43% of the answers including the 'Don't know') declared that home care (but also residential care, 49%) is not affordable. The average European citizen held slightly more positive views, with a 32%, but, excluding Poland (47%), this figure significantly decreases if we look at the other examined countries, respectively France 20%, Spain 23%, Sweden 9%, and Belgium 33%. The results of this survey are in accordance with the graphs presented in figure 11. The only country in which both the percentage of beneficiaries and the average number of hours are proportional to the family income is Italy: only about 10% poor elderly (first quintile of income distribution) receives professional care at home, with an intensity, that despite the increase of 2007, was under 15 hours per month; while for better-off population, these figures reach respectively around 30% and more than 50 monthly hours. In Italy a scarce presence of public home services and a broad supply of private carers, together with cash benefit amount usually lower than the cost of care, mean that the possibility to access to the home care services is strictly related to the possibility to pay for them. In Spain the reception of services is proportional to family income, but with a less intensity compared to the Italian case. In 2007, the gap in the share of beneficiaries between the first and the fourth income quintile in is limited to 5%. Additionally in Spain, between 2004 and 2007, the intensity of services significantly increases for the extreme groups of the population: the dependent elderly included in the two first quintile of income distribution, on average, receive the same intensity of care of the wealthy population. In France, the strong correlation between income and share of beneficiaries in 2007, suggests that the financial incentives introduced in the early 2000 have generated a broadening of the home care sector driven by the middle-income households[18]. However, in this country a high public spending for the home services sector together with the "subsidization" of private operators, ensure a fairly access to the care: around a half of the dependent elderly that live in a low-income family has access to the home care services and receive an intensity of care equal or higher than the rest of the population.

[18] In 2005, the tax deduction for employing help at home is more affordable for middle-income family; considering the most dependent people this instrument involves a cost reduction equal to 77% for those on high pay (€ 43200 annual), while this discount reaches the 23% for those on low pay (€ 7756 annual) (Cour des comptes, 2005).

Figure 11, monthly average number of hours (line, right axis) and percentage of recipients of formal services in-kind (bar, left axis), by quintile of household equivalised income.



Source: Author's compilation on the basis of SHARE data, waves 1-2.

The most appropriate LTC system in relation to accessibility level seems to be the Belgian one. The share of recipients of home services is higher than the half of the dependent population, and the 2007 the low-income family benefited of an increase of services provision, reaching a level of coverage close to 60%. Additionally, the reduction of number of hours occurred between 2004 and 2007 affected especially the middle-income families, leaving almost unaltered the benefits' intensity of the low-income households. The capacity of the Swedish home care sector to meet the dependent elderly needs is fairly limited, and is similar to the Spanish one. Unlike the latter, however, the figure shows that the perception of services is evenly shared across income groups, and the poorest elderly receive the highest share of services as well as the greater intensity of care compared to the entire population.

3.2 PRIVATE CARE RESOURCES

The last part of this chapter is dedicated to the analysis of how the LTC characteristics affect, at the individual level, the two dimensions of private care resources: informal care, both received and provided; and the incidence of care costs on the family's equivalized income.

3.2.1 Private expenditure

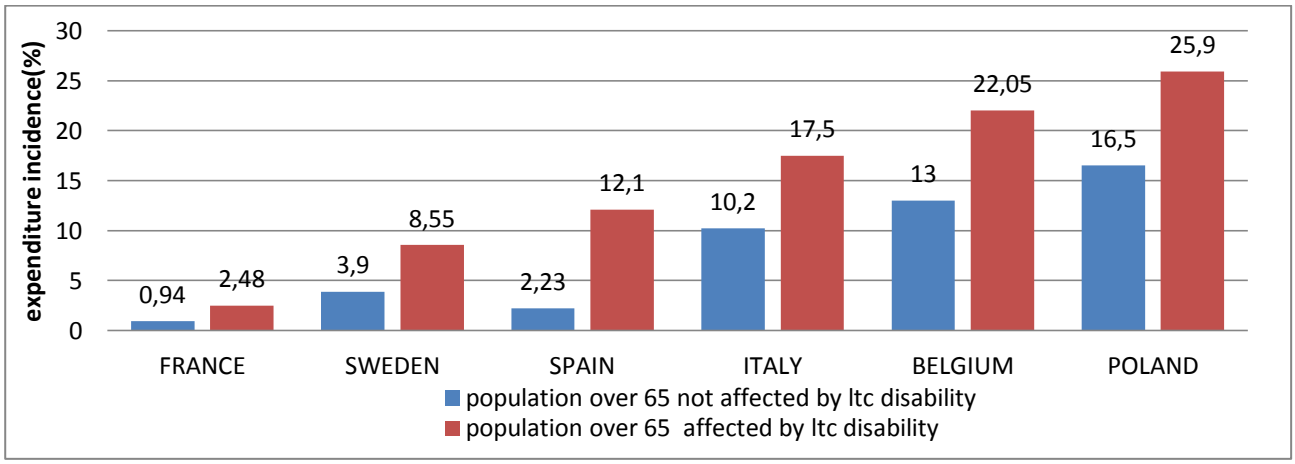
Figure 12 shows the average annual values (first and second wave of SHARE) of the incidence of families out-of-pocket expenditure for care and health on the household's equivalised available income[19]. In the micro analysis phase of this research we consider both the expenditure devoted to LTC services, and health expenditure. In fact in all countries the basket of LTC services includes both medical and social treatments, that are managed by different sectors, and elderly care requires a wide variety of treatments, ranging from domestic help to specific medical and physiotherapy treatments. Thus, the basket of services which, includes expenditure for health, hospitalization and drugs, in addition to the LTC services, provides a more correct definition of the "economic dimension" of private care resources. Indeed, the use of this indicator gives a completely different picture of Poland and, to some extent, Belgium, compared with the distribution obtained through aggregate data. In Poland, where, due to the lack of private supply of formal services, private expenditure for LTC services is necessary low, the inclusion of health expenditure completely changes the scenario. This country shows the highest incidence of health expenditure on household income for the two groups of population examined in figure 12 (dependent elderly and older population not affected by disabilities). Similarly, in Belgium where the private LTC expenditure is slightly below average (figure 6), when health expenditure is included we find that on average a dependent elderly person has to devote a quarter of his/her household's income to care and health expenditure.

The level of public spending devoted to the LTC system helps understand the countries' distribution. Excluding Belgium, in the countries with the highest public expenditure, France (where the elderly care sector receives approximately 2% of GDP), and Sweden (in which the

[19] The equivalised disposable income is the total income of a household, after tax and other deductions that is available for spending or saving, divided by the number of household members converted into equalized adults. A detailed description of this indicator is presented in the next section.

overall social protection expenditure is one of the highest among EU countries, reaching more than 30% of GDP), the incidence of care and health expenditure does not exceed 8% of household's income. On the contrary, in countries where the public intervention is more limited, like Italy and Poland, the dependent elderly devote on average a quarter or a fifth of their household's income to care and health expenditure.

Figure 12 Incidence of care expenditure on equivalised disposable household income by country, average annual values (mean between 1° and 2° wave)



Source: Author's compilation on the basis of SHARE data, waves 1-2.

In analysing the relation between risk of poverty and private care resources it is important to note that a common element is represented by the greater incidence of care and health expenditure of the dependent elderly, compared with the older population not affected by disabilities. This is particularly true for Spain that presents the broader gap between these two categories of population. A crucial issue affecting the incidence of care costs is given by the criteria for the definition of the degree of co-payment which are adopted by each country. These criteria vary from country to country, but also at sub-national level. Moreover, as already pointed out, they can consider only the dependent elderly, his/her family income, or the families' availability in terms of financing and support to care.

The introduction of the family co-payments for care home services was seen as a 'revolution' in the Polish social system. Before 2002 the evaluation criterion that regulated the access to care was based only on the recipient income, while after the introduction of this reform the co-payment level is determined taking into account the income of partner and/or children. Additionally, recently the Polish government reduced the income threshold for the services' accessibility evaluation,

establishing a ceiling rather low, equal to 316 PLN (which amounts to about 10% of the average earnings in the economy). This lowering of ceiling implies that also less well-off families have to face necessary payments (several hundred PLN) for the care of their family members in social services (Golinowska, 2010). These changes can in part explain why, in 2007, none dependent elderly interviewed by SHARE survey declared to receive home care services (figure 10-11). According to Kotowska and Woycicka (2008) the changes in the responsibility for payment, and the lowering of income threshold may have been associated with a falling demand for services[20]. Indeed, the cost and quality of formal care for the elderly is seen as a substantial barrier to a wider use.

In Italy the co-payment, based on family income, instead of the recipient's wealth, and the direct expenditures for the care of the dependent elderly represent a significant cost for the family. The *Centro Studi Investimenti Sociali* CENSIS (2013), estimates that an Italian family spend annually on average € 8488 for services, € 1297 for drugs not reimbursed by the health system, and € 3178 for other related activities to care (i.e. specific visits or rehabilitation). Despite this, in Italy the co-payment level represents only a minor part of the private home care sector expenditure, as the majority of services is provided outside the public domain. An estimation of the cost to the user for home basic home care[21], states that, including the social security contributions and of the meal allowance, this cost amount to 987 € per month[22] (N.N.A, 2009). Considering that the average net wage earnings for 2003 were € 1228 per month, and the average pension for ex-employees is € 612 per month (average for men and women) and € 464 per month for women only, the home care (an in-living assistant) would prove unaffordable for the average holder of a pension with no other source of income, and even more so for women pensioners.

In Spain the dependent person's income level and also that of their relatives and the cost and nature of the care services provided are considered to determine the private level of contribution. Criteria determining the amount of co-payments to be paid have recently been defined, and for the public services an estimation of the average co-payment level amounts to around 17% of total SAAD

[20] Referring to the residential sector in 2003 about 19 800 persons were awaiting placement, while in 2008 the number was much lower at 9 600 persons (GUS 2009).
[21] Where by basic home care we mean the combination of home help and of personal care delivered by family assistants (considering the minimum contractual rates for a low-skilled assistant, € 5,13). The estimation uses data provided by National Institute for Statistic INPS and Bank of Italy, and is based on 2003.
[22] The figure refer to a services provided an in-living assistance (around the clock), while for a regularly employed assistant on a part-time basis (4 hours, 30 days per month) the price is € 616 , and for the same assistant employed on a full-time, but daily schedule (8 hours, 30 days per month) the cost is € 1231.

expenditure in 2009 (Asociación Estatal de Directores y Gerentes en Servicios Sociales, 2009). This figure does not consider the private expenditure that the families sustain for the services out of the public domain. This expenditure might explains the difference between this data and the figure used in the macro analysis (28% of total LTC expenditure, see Table 2, cap. 2.1). This differential allows to define the cost of the private services sustained by the families, which can be estimated around 11% of total LTC spending[23]. Despite the fact that at current stage of implementation of reform define the private care cost sustained by the families is really difficult (Gutierrez, 2010), Gonzales Gago (2010) suggests that main concern regarding elderly home care is not the type of provisions, but the availability and affordability of the existing ones. In fact, from the second question of Eurobarometer survey related to the affordability of home care services, emerges that in Spain only 18% of citizens - the lowest percentage of the whole European Union - thinks that professional care at home is available at an affordable cost.

In France, for health home and home care, in 2007, families paid € 650 million in co-payments. For a very dependent person the private cost for home services ranges from € 1500, for around 60 hours of care per month, to € 4000, per 250 hours per month (Gisserot, 2007; Cour des comptes, 2005); and on average, cost-sharing for home services amount to € 88 per month (Joël *et al*, 2010), equal to the 18% of the average value of APA (Prevot, 2009). As mentioned earlier the APA benefit is not means-tested but the amount is reduced progressively (from 0% to 80%) for recipients who have resources in excess of € 677.25 a month (in 2008). Moreover the amount of this benefits is related to the level of disability of the elderly and in 2008, the maximum monthly amount of APA for a very dependent elderly person living at home was about € 1,209, while for a less dependent person, it was about € 518 (Joël *et al*, 2010). From these figures it can be assumed that the care cost for an elderly with moderate or medium disability it equal or slightly higher than the benefits that he/she receives, while for very dependent elderly people the maximum amount of APA does not cover the total cost, and the difference fall back on the families.

In Sweden taxes and general allowances finance the majority of total costs for care of the elderly, and the share of out-of-pocket expenditure is the lowest among the examined countries, reaching, in 2006, only the 4% of LTC spending (SKL, 2007). In 2002, a new fee system was introduced for elderly and disabled care, establishing that the highest fee the municipal authorities may charge for

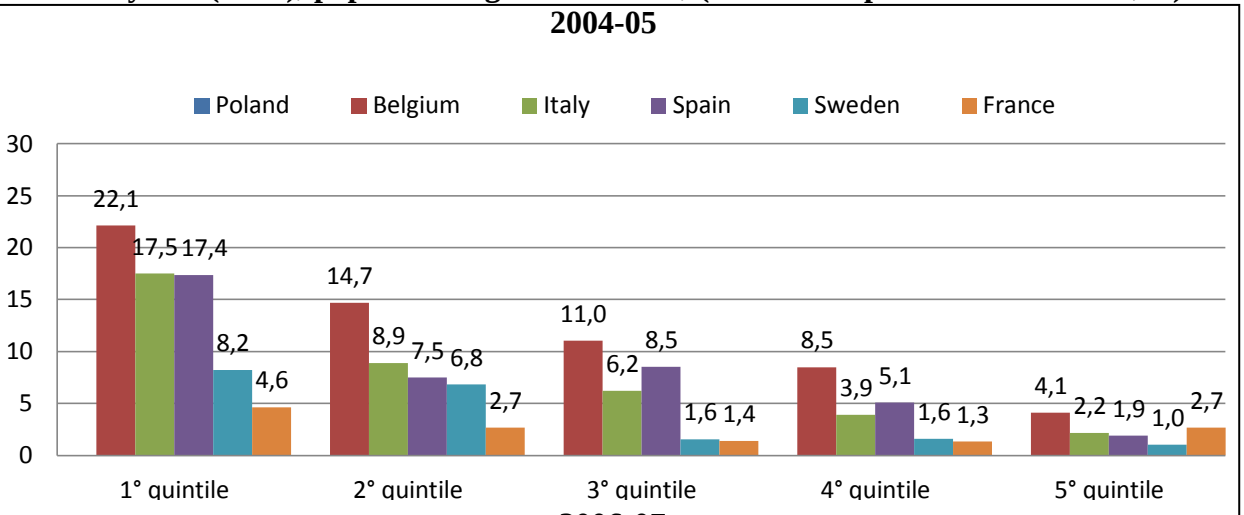
[23] In the interpretation of this figure it have to consider that the estimation is based on different sources of data and different reference years (respectively 2009 and 2010 for macro analysis); additionally the data reported in this paragraph refers both to residential services and home care services.

home care services was around € 170 per month in 2010 (Socialstyrelsen 2010). The purpose of the new system was to protect the individual from excessively high costs for municipal care (maximum rate or high cost insurance), and to ensure that all individuals have a minimum sum for living expenses once all fees are paid, known as a reserve sum (förbehållsbelopp) (Socialstyrelsen 2002). In 2010, the reserve sum is around € 475 per month for single people and around € 400 per person for married or common-law spouses living together (Socialstyrelsen 2010). It follows that in Sweden the majority of expenditure are sustained by public resources and the families face only a very small part of the general cost. Nevertheless, the National Board of Health and Welfare (Socialstyrelsen) has in reports from 2004 and 2005 shown that elderly with home help services have lower incomes and less often private means than people at the same age without home help. The income of more than a fourth of the care receivers is so low that they do not cover the average living costs in spite of the fact that they do not pay any home care fee. Additionally, in 2005 slightly less than half of the care receivers who do not pay any fee do not have capital above around € 9900 (Socialstyrelsen 2007).

Given the organisation of the Belgian LTC system, with its division of responsibilities between the federal and the regional levels, it follows that the financial flows are rather diverse and complex. Total LTC expenditures were approximately € 5.7 billion in 2006, of which almost 98% was financed by a combination of social security contributions (59%) and taxes (39%). This figure does not include out-of-pocket payments for accommodation in residential care (approximately €2.3 billion), while the co-payment expenditure for home care services was around € 1 million. It should be noted that not all out-of-pocket expenditures for LTC are known, since elderly persons who are not eligible for subsidised home care can and do buy these services privately, mainly by using *'service cheques'*. These are vouchers that can be purchased to pay for domestic services provided by public bodies or private firms who employ - usually low-skilled - personnel. The services provided under this scheme are paid in large part by government subsidies - around €13 per hour -, with the balance paid by the user (€7.5 per hour). This amount covers the hourly wage of the employee, including social security contributions, and a profit for the employer. The money spent on *service cheques* is tax-deductible by users up to a certain limit - implying that the government intervention is even greater than the subsidy - . In 2008 the system cost around €1.3 billion (Willemé, 2010). The amount spent on LTC is unknown, unfortunately, because the vouchers are used rather extensively to pay for domestic help other than help for elderly persons with IADL limitations. Nevertheless for define the cost borne by families it can be useful utilize the estimate provided by the Flemish Agency for Care and Health. Considering the overall provision of services,

in 2006, the private services offered close to 12 million hours of help and the 80.52% was consumed by population aged over 65, that has contributed with an amount of user fee of about € 38 million; while the public services offered 2 million hours of help in 2006 and 83.15% was used by users aged 65 or over, and the co-payment level was close to € 7 millions[24].

Figure 13, average annual values of Incidence of care expenditure on equivalised disposable household income, by year and quintile of income distribution; differential between years (table), population aged 65 or over; (left axis: expenditure incidence, %)



	1° quintile	2° quintile	3° quintile	4° quintile	5° quintile
Bl	-3,59	-4,45	-3,82	-3,2	-1,4
IT	1	0,6	-0,3	-0,7	0,13
ES	2,14	-1,04	-1,96	-1,26	-0,48
SE	-1	-1,53	0,11	0,03	-0,21
FR	-0,87	-0,29	0,1	-0,31	-1,46
PL	-	-	-	-	-

Source: Author's compilation on the basis of SHARE data, waves 1-2.

The analysis by income groups tends to reflect the results presented in figure 12: the Italian, Belgian and Polish families bear, on average, a greater incidence of care costs compared to the other three countries. Additionally, in all countries the incidence of expenditures is inversely proportional to

[24] http://www.zorg-en-gezondheid.be/topPage.aspx?id=11418

household income: with the exception of France, the incidence of care costs for the families included in the first income quintile is about five or six times that of the richest population (families with a disposable income included in the last quintile of the distribution). When considering all the income groups we find that in Spain the incidence of the care costs for the low- and middle-income families is closer to the Italian and Belgian case than to the more egalitarian countries, namely Sweden and France. Moreover the differential between 2004 and 2007, shows that the Belgian reforms seem to generate a beneficial effect on the "care cost", producing an evenly reduction of the families economic burden close to 4 percentages points.

Notwithstanding the SHARE data do not allow to monitor all the indirect economic effects of the dependent condition, it must be observed that the reforms and characteristics of LTC systems affect the care process not only in terms of informal care provided by the family (analyzed in the next section), but also in financial terms. Moreover the Eurobarometer survey (2007) confirms that the economic care burden can exceed the dependent elderly family income and falls back on the financial resources of their relatives, namely their adult children: the majority of Europeans who pay for their parents' care spend less than 30% of their income on the service (68%), but one respondent in twenty who paid in the past or who is paying for his or her parents' care spends more than half of the household income, and close to one respondent in ten spends between 31% and 50% of the household income. To this end the dependent elderly as well as their adult children can be considered categories exposed to financial impairment, and the last chapter is dedicated to figure out if the dependent condition can lead to an increase of the risk of poverty for both these population groups.

3.2.2 Informal care

As argued by OECD (2011), informal carers are the backbone of long-term care systems in all OECD countries. On average, in 2007 in the OECD area, one-in-nine people aged 50 and over gives care and ADL assistance to a dependent relative (ibidem). Form this it seems evident that the EU countries, alongside the development of formal services sector, have to recognize the importance of the informal carers and provide them the necessary support in order to ensure a fair balancing between care, work and private life. The six selected countries, even if with significant differences, guarantee a financial sustain for the informal carers, in form of allowance (for the not active workers) or in terms of parent leave. Although In Italy no leave scheme is explicitly and solely

devoted to elderly care, use can be made of two schemes motivated by 'serious and specific family reasons'. The first (Permesso retribuito) is modest as it entitles employees to a maximum of 3 days per year, or an equivalent reduction in working hours. It is fully paid in case of medically certified severe disability or death of a family member and unpaid for other family reasons. The second scheme is the 'Congedo per gravi e documentati motivi personali' or leave for serious and certified personal reasons. Under this scheme employees of private and public concerns are entitled to leave that can be taken up in whole or in parts for a maximum of 2 years in a lifetime. The leave is unpaid except in the specific cases[25] (the amount is proportional to the carer wage). There are some restrictions as to whom the applicant may care for, but they are not too severe when the leave is unpaid. Unfortunately, there are no publicly available figures on the take up rate of these leaves and this suggests that currently the use of these time off is somewhat limited. Additionally, Italy is the only country that does not provide allowance or a direct economic support to the family carer[26].

In Belgium the family of frail elderly can benefit of two leave schemes. The first (Leave for medical assistance) may be taken to take care of a household (each person living under the same roof) or family (to the second degree) member with a serious illness. The length of this leave is minimum 1 month and maximum 3 months. It can be extended to 12 months when leave is taken full-time (full career interruption) and to 24 months when it is taken half-time or at a rate of 1/5. The leave for palliative care, instead, regards who is approaching the end of his/her life. Any form of assistance (medical, social, administrative and psychological) and caring for a person with an incurable disease in the terminal phase, is considered palliative care. There does not necessarily need to be a family tie with the person cared for. The length of this leave amounts to 1 month and it can be extended with another month. This leave can be taken full-time, half-time or at a rate of 1/5. During each of these leaves a lump-sum allowance is granted to compensate for foregone earnings. The amount of these allowances vary according to the type of leave taken, the sector of economic activity and, in a number of cases, the age or seniority of the worker (the amount is higher for workers above 50 years of age). Additionally, the Flemish region's citizen can benefit from a informal care allowance aimed to reduce the burden of care, that in 2008 was about € 115 per month.

[25] According to Law 104/92 revised in light of the judgment recently made by the Constitutional Court (Sentenza 19/2009), some beneficiaries of the 2 years leave are also entitled to full pay provided they are: *i)* the co-residing spouse of the disabled elderly; *ii)* the brother or sister of the disabled elderly, subject to both parents having died or being seriously disabled themselves; *iii)* and a child co-residing with the disabled elderly subject to the fairly restrictive condition that there are no suitable carers to replace her or him.

[26] An additional allowance aimed to sustain the dependent elderly and to compensate the caregiver effort has been introducted in the last year in some Italian Regions,mainly in the North Italy. The availability and amount of this allowance ("*Assegno di cura*") significantly vary across regions and even among local community.

In France, as claims Joël (*et al., 2010*), the issue of reconciling life times regards primarily the child care, while, at current stage, the support for informal caregivers seems to be underdeveloped. As mentioned earlier, the APA beneficiaries can employ their relatives to care for them, and use the amount of the cash benefit for pay the assistance received. The restriction in its use, the elderly - cannot use this benefit to hire the partner or a cohabitants to care for them - implies that only the 8% of the APA receivers employ their relatives, mostly their daughter or daughter-in-law. The only leave measure intended for the care of an needy elderly is the Family Solidarity Leave (*Congé d'accompagnement de fin de vie*) available for all employees, whose ascendant, descendant or someone sharing their home suffers from a life-endangering pathology. This leave lasts for a maximum of 3 months, which is renewable once, and does not recognize any compensation to the applicant[27].

The Spanish elderly care sector recognizes two different measures of reconciling life times. A targeted leave is available for all workers in order to take care of a dependent relative. Under this scheme employees of private and public concerns are entitled to an unpaid leave for a maximum of 2 years, and the social security contributions are recognized during the first year. Additionally, the carers can take advantage of a flexible time arrangements, that allows the family members to reduce their working hours by 1/3 and up to 1/2 to take care of a dependent relative, with the proportional reduction of their pay (Gonzales Gago, 2010). The compensation for the family carers, that derives from the care allowances received by severely disabled elderly, is granted if there are no public alternatives. The elderly are entitled to use the amount for pay the related care expenses; and this benefit usually goes to family carers and implies the inclusion of the carer in the social security system[28].

As we have seen before (¶ 3.1.1) in Sweden, the economic compensation for family members providing help and care to elderly is not especially common (Nyberg, 2010). Nevertheless, each Swedish cash benefit examined previously is directly targeted to sustain the family carers. The family carer grant and the home nursing grant are compensations to a person closely related for nursing work in the home or for help in ordinary housing. Additionally, two further measures are recognized by the Swedish LTC system: family members can be employed to care

[27] http://www.e-sante.fr/ (last access November 2013)

[28] Also in Italy the care allowance (*Indenntà di accompagnamento*) is usually used to compensate both the family caregiver or the private carers directly employed by the family. The feature that differs Italy from Spain and France is that, in this case, the mechanism of subsidization of care is not regulated by any national, regional or local law.

(anhöriganställnig), and an allowance for care of close relatives (närståendepenning) (Nyberg, 2010). The latter is a benefit from Försäkringskassan (the Swedish Social Insurance Agency), which can be used for a maximum of 100 days as of 1 January 2010 (earlier it was 60 days) if a person stays home from work in order to nurse a closely related person who is seriously ill, and the beneficiaries receive approximately 80 per cent of their salary[29].

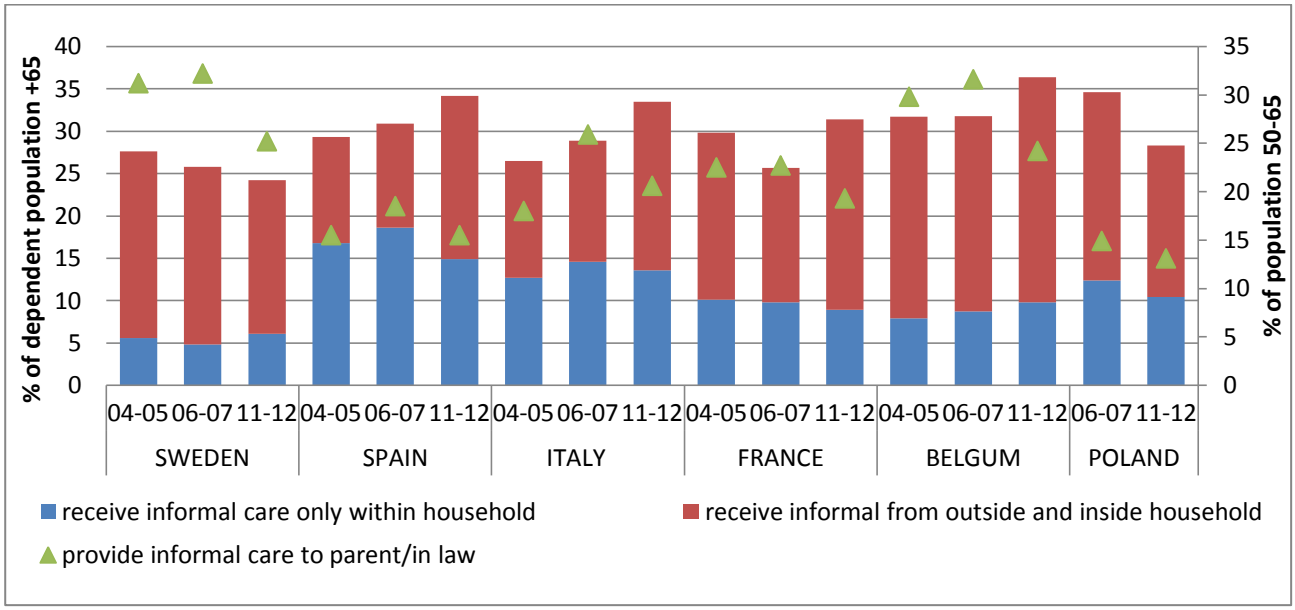
Somewhat contrasting with the characteristics of Polish LTC system previously presented is the nursing benefit (świadczenie pielęgnacyjne) available since 2003. This measure is a payment to a person - parent or child - who resigned from paid employment to care for a disabled person (child or adult) certified as in need of permanent or long term care or assistance based on severely limited ability to function independently. Since January 2010 the benefit is independent of family income (previously means tested) and the current level is € 133 per month. Carers who are entitled to any pension or to social assistance benefits are not eligible to receive the nursing benefit. Also, benefit is not paid if the cared-for person is married or is a resident in a facility providing round the clock care. The Polish system does not provide a targeted leave scheme for long-term care, but recognizes the right to leave from work to care for a family member, whatever his/her age. This leave is accompanied by care allowance (zasiłek opiekuńczy) funded by the Social Insurance, that is granted for the duration of the leave, but no longer than 14 days in a calendar year at the level of 80% of pay.

To sum up, all countries provide a form of sustain for the informal caregivers, but the majority of these measures do not concern the non-working population, and generally have a limited length. Additionally, where the caregivers are entitled to receive a economic compensation for the assistance provided, generally, the compensation derives from a redirection of the cash benefit received by the elderly.

Figure 14 shows the degree of importance of informal care in all countries according to SHARE data: from 25% to 35% of the elderly population receives informal care from relatives or friends, and with the exception of Sweden and Poland, the recourse to this kind of help increases over the period between 2004 and 2012.

[29] https://www.forsakringskassan.se/ (last access January 2014).

Figure 14. % of population over 65 that receive informal care on total population of over 65 (left axis); and % of population aged 50-65 that provide informal care to parents/in law on total population aged 50-65 (right axis),

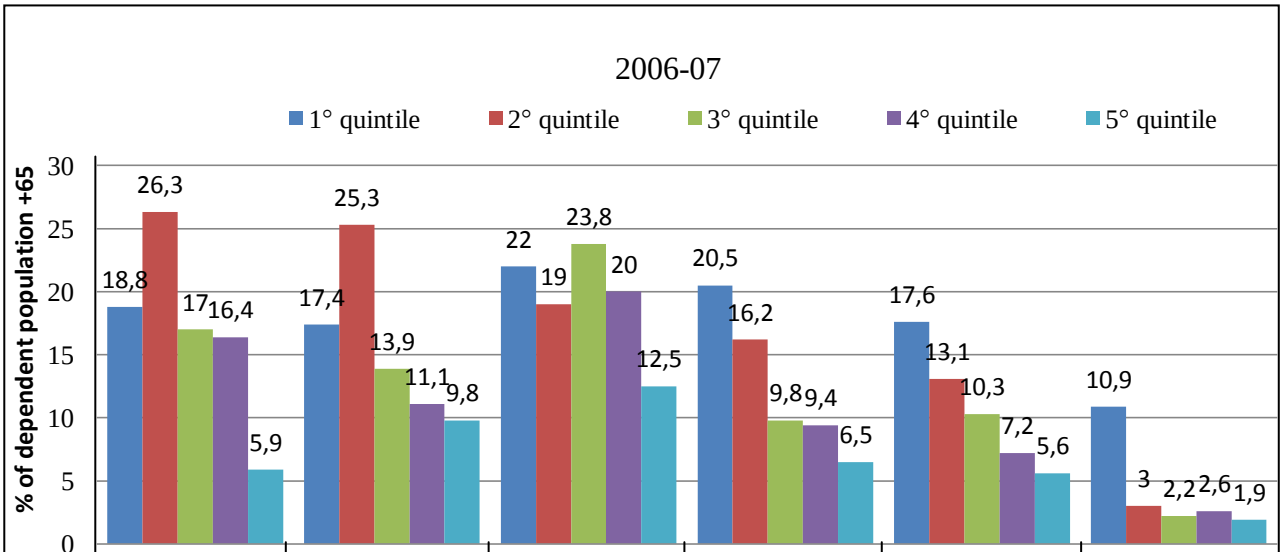


Source: Author's compilation on the basis of SHARE data, waves 1-2-4.

Although there is little difference in terms of share of older population receiving informal care, Spain, Italy and Belgium show the highest degree of reliance on this help. Moreover, in the two Mediterranean countries roughly half of the help that a dependent elderly person receives is provided by a cohabitant, in most cases his/her partner or adult child. The green triangles report the share of population aged between 50 and 65 not living with parents but providing informal care to them or in-laws (we have identified this type of population as the "adult children") with respect to the total population of the same age. In all countries a significant share – about 15% - of this population category is involved in the care of parents or in-laws.

The income groups analysis suggests that the degree of informal care received by the elderly is related with the household's economic resources. Focusing on the dependent population that receives assistance from relatives or friends on a daily basis, figure 15 shows that the share of elderly that relies or needs this help decreases with the increasing of household income. In 2006, in France, Belgium and Sweden the relation between informal care and family income is clear and almost linear: in the first two countries the ratio between the share of the first income quintile and the percentage of the last income quintile is equal to 3,1; while in Sweden this form of help regards almost exclusively the poorest dependent population.

Figure 15. Share of dependent population aged 65 or over that receive informal care almost daily or daily on total dependent population aged over 65 by quintile of household income, in 2006-07; differential between years 2006-07/2011-12.



	Italy	Spain	Poland	France	Belgium	Sweden
1° Q	13,5	5	4,5	-4,1	1,2	-2,1
2° Q	1	1,6	5,1	1,4	4,1	1,2
3° Q	9,5	3,4	4,4	1,7	-0,2	4
4° Q	-1,8	4,4	-5,4	1,5	2,4	-0,3
5° Q	-0,6	2,7	2,2	2,4	2,9	0,6

Source: Author's compilation on the basis of SHARE data, waves 2-4.

In the other three countries the situation is slightly different. First of all, on average, each income groups, present the highest percentages of elderly that receive assistance every day among the examined countries. Additionally, in Spain and Italy the second income quintile shows a significant trend reversal, and respectively 25.3% and 26.3% of dependent population of this income group, rely on daily informal care. After controlling for the socio-demographic variables[30], this aspect suggests that for the low-income families that have the possibility to chose to reduce or leave work in order to take care of a relative, the care opportunity cost boost the caregiver toward this alternative. In Poland, instead, the absence of a developed system of formal services implies that informal care tend to be slightly correlated to the family income, and an important share of population receives this kind of help regardless their wealth. Another difference between the latter countries and France Belgium and Sweden is the impact of the economic crisis on the recourse to

[30] Value of the socio-demographic characteristics considered respectively, % of female; % of elderly that live in a family with 2 or more members; average age: Spain first quintile: 80%; 75%; 78.02; Spain second quintile=65%; 68.8; 78.1; Italy first quintile: 84%; 69.2%; 77.07; Italy second quintile: 65; 55,2%, 78.3.

informal care. Although all countries, after 2007, show a general increase in the share of dependent elderly population that receives help on a daily basis (figure 15), in the two Mediterranean countries and in Poland this rise is more evident and affects especially the lower income groups. In Italy the first income quintile presents a differential of 13,5%, and in 2011-12 around one in three dependent elderly of this income group receives informal care every day. Although in Poland and Spain the increase is milder, in 2012 about a quarter of the low-income elderly family relies on daily assistance of friends and relatives.

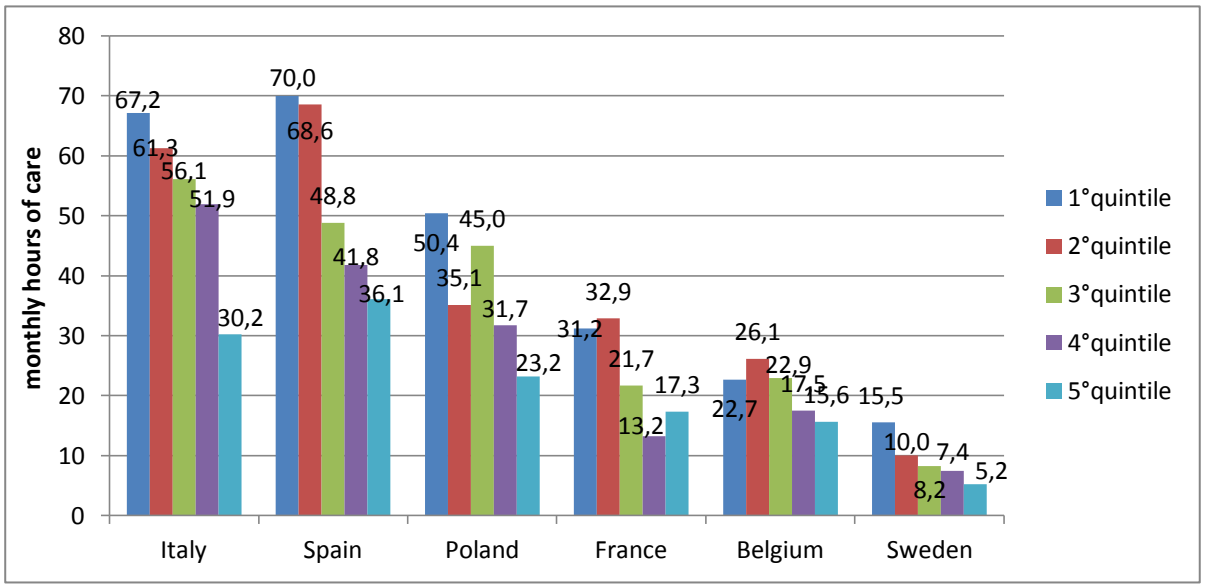
Nevertheless, the interpretation of the population share providing informal care requires a careful analysis. Even if this indicator confirms that providing and receiving care within families is a common aspect in all countries, it does not give a direct information on the intensity of this practice. The number of monthly hours of received and provided care[31] also allows us to understand the reliance of the LTC systems for this kind of help. The intensity of informal care received by dependent elderly for Italy, Spain and Poland, on average, exceeds 70 monthly hours (respectively 80.6, 87.5 and 69.9); and proportionally the care intensity provided by adult children is extremely high. Respectively on average, an adult children dedicates in Italy 63.1, in Spain 73.6, and in Poland 41.8 monthly hours in providing help and assistance to their parent or in-law. In the other three countries, both the categories analyzed show values of intensity considerably lower. The Swedish elderly population receives on average 13,9 hours of informal care per month, and the France and Belgium values are respectively 31 and 22,8. In these countries the intensity of care provided by adult children does not exceed the 27 monthly hours - France 21,8; Belgium 27; and Swedish 8,2 -. In light of the results shown in the first paragraph, this indicator confirms that the need for informal care is directly related to the degree of LTC system development, and to the public expenditure allocated to elderly care. In fact, figure 10 suggests a clear division of the LTC systems. On the one hand, we find countries in which the informal care plays a fundamental role in the care of the elderly, Italy, Poland, and also Spain. On the other hand, we find countries like France, Belgium and Sweden where families provide help and assistance to the elderly for 5-6 hours a week on average, instead of 20 hours or more

The intensity and share of informal care provided by adult children in all countries suggest that a large part of elderly care is provided by this category of population. If we exclude the care provided

[31] Due to the changes occurred in the structure of the SHARE's questionnaire, in the fourth wave, the intensity of informal care is collected only through a categorical variable, and no data is available of the monthly numbers of hours for this wave.

by cohabitants, according to SHARE data, in all countries more than 75% of informal care, both in terms of intensity and quantity, regards the adult children.

Figure 16, number of monthly hours of informal care provided by adult children to their parents or in-law, by income quintile, in 2006-07.



Source: Author's compilation on the basis of SHARE data, waves 2

The figure 16 help to understand the impact of the informal care on the adult children's working life. Not surprising that the countries respect differentiation presented above, and that the burden of care is considerably heavier in Spain, Italy and Poland. In these countries, for those in the bottom half of the income distribution provide informal care to a dependent parents or in-laws severely limits the possibility of a full-time regular job. In Italy and Spain this population offers on average, between 15 and 20 hours of care per week. While in the other three countries the care burden of the low-income population is at most, on average, 1 hours for day. Currently, the caregiving impact is already straining the (women) carers' employment situation. According to Eurofamcare survey, in Italy, 13.5% of the family carers of disabled elderly in employment reduced hours of work in order to care, an additional 5.5% worked only occasionally and a slightly higher share (6.5%) experienced career problems. Additionally, about 8% of the non employed carers had to give up work altogether (Lamura 2008). Without adequate support, informal care giving might exacerbate employment and health inequalities (Colombo et al., 2011). For this reason, in the next chapter, the relation between private care resources and risk of poverty has been analysed for two specific categories: people aged over 65 affected by LTC disability and the adult children of parents with a fair or poor health status.

CHAPTER 4

DEPENDENCY, PRIVATE CARE RESOURCES AND RISK OF POVERTY

4.1 POPULATION AT RISK OF POVERTY

Figure 17 shows the distribution of the population at risk of poverty for the two age groups under examination (non-self-sufficient elderly people and their adult children). The indicator used to define the population at risk of poverty is the at-risk-of-poverty variable, that indicates the share of people with an equivalised disposable income below the at-risk-of-poverty threshold, which is set at 60% of the national average equivalised disposable income after social transfers. The poverty threshold used in this research is estimated on the basis of the Eurostat data (EU-Silc data), while the equivalised disposable income is calculated in the following three steps:

- all monetary incomes received by any source by each member of the household are added up; these include income from work, investment and social benefits, plus any other household's income, excluding income from rents; taxes and social contributions are also deducted;

- in order to adjust for differences in households' size and composition, the total (net) household income (adjusted to the standard purchasing power) is divided by the number of 'equivalent adults', using the modified OECD scale[32];

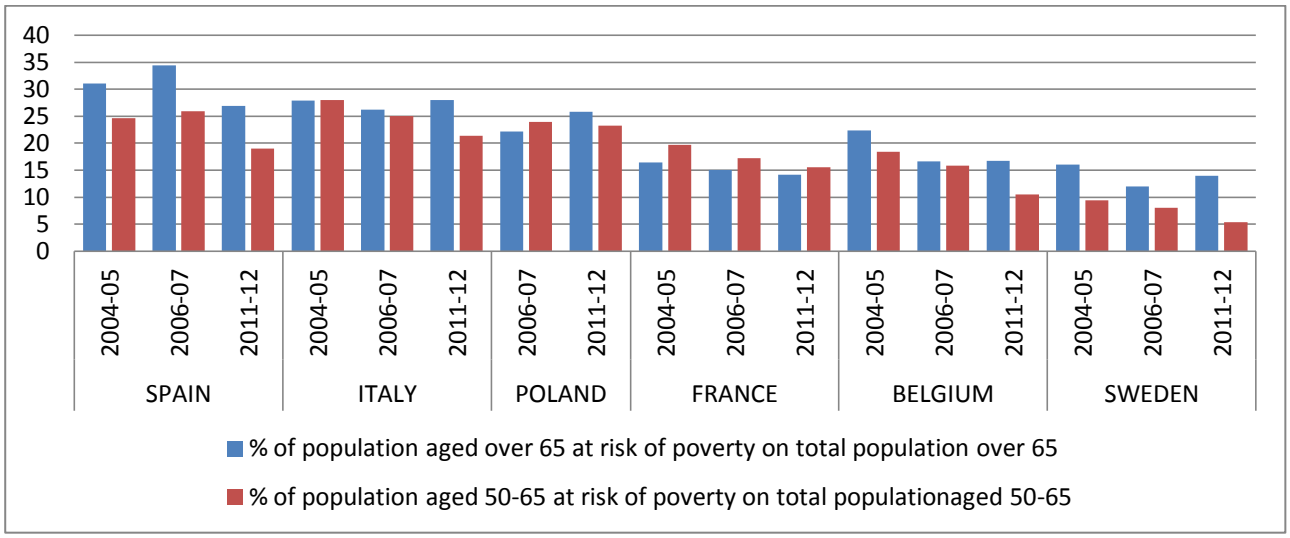
- the resulting figure is called equivalised disposable income, and is equally attributed to each household member.

During the period covered by SHARE data, in all countries, with the only exception of France (and Poland in the 2006-7 wave), the elderly population shows a higher percentage of individuals living in a family with a disposable income below the poverty line, compared with the population aged between 50 and 65 (figure 11). Italy, Spain and Poland are the countries more exposed to the risk of poverty. In these countries, at least 20% of the population of both age groups can be considered at

[32] This scale gives a weight to all members of the household (and then adds these up to arrive at the equivalised household size): 1.0 to the first adult; 0.5 to the second one and each subsequent person aged 14 and over; 0.3 to each child aged under 14.

risk of poverty. On the other hand, in France, Belgium and especially Sweden, the risk of poverty affects only a reduced share of the population. Furthermore, France and Belgium are characterized by a positive trend in the reduction of the risk of poverty concerning both age groups

Figure 11. % of population at risk of poverty by age groups.



Source: Author's compilation on the basis of SHARE data, waves 1-2-4.

Sweden and Spain show a significant difference in the risk of poverty of the two groups: in the three periods, the elderly population has a higher probability (at least five percentage points) to be exposed to the risk of poverty than the other group. This disparity is only partly explained by differences in welfare policies across countries and in relation to the different age groups. In fact, it may simply result from the features of the indicator. First of all, the at-risk-of-poverty defines poverty as the economic inequality within the place or society where people live (World Bank, 2011). Furthermore, in a context of economic growth, characterized by an average increase of wages, this indicator tends to emphasize the risk of poverty of the population with a more stable revenue, such as pension income. This last factor can partly explain the large gap between the two age groups presented in the second wave in Spain, the most dynamic economy in the Euro zone in the decade 1998-2008.

All in all, figure 11 shows a picture in line with the studies on the poverty risk for older people (Zaidi 2008, 2010). Although no single explanation can fully account for the differentiation across countries, differences in welfare states can provide a part of the story. In general, the risk of poverty of both age groups tends to increase across countries: starting from Sweden, characterized by a

Nordic welfare state, through those countries featuring a continental welfare state - France and Belgium- , reaching the highest share in the Mediterranean countries or in countries with a less developed welfare state (the Eastern countries). In the next sections we investigate whether the condition of dependency and the private care resources can play a role in the explanation of the risk of poverty for the two groups of population under consideration: the dependent elderly and their adult children.

4.2 SAMPLE, MODELS AND VARIABLES

The datasets of the first, second and fourth wave of SHARE have been divided in two subsamples on the basis of the age of the interviewed people: persons aged between 50 and 65 and persons aged over 65. For the definition of the level of disability of people aged 65 or more, the SHARE survey uses two common indicators: *Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)*. The population aged between 50 and 65 has been characterized on the basis of the parent's health status, using the variable "health of parent (mother/father)". Although this variable is not based on a specific scale of LTC problems, it can be considered a good proxy for the health status of the parent[33].

In order to assess whether the condition of dependency and the amount of private care resources affect the probability to be at risk of poverty for the two population categories, a logistic regression analysis has been used. The data has then been analyzed using SPSS. The "recoding into different variables" function and the creation of new variables have been necessary procedures in order to test the research hypothesis in a more adequate way.

We use two models, one for the population aged over 65 and one for that aged between 50 and 65. The dependent variable is a binary variable created on the basis of the at-risk-of-poverty indicator. The value is equal to 1 when a person lives in a family with a disposable equivalized income below the poverty threshold, and 0 otherwise. In terms of our predictor (independent) variables we provide some transformations to the original ones in order to meet the requirements of a logistic regression analysis and offer a more comprehensive inferential analysis of their statistical effect over the outcome (dependent) variable. All variables used in the models and their categories are shown in table B1.2 of the Appendix. The models that are used in this study consist of a dependent variable (E) as a function of several variables, respectively:

Dependent Elderly= nine independent variables. Where P is poverty risk, I is the intensity of informal care received, C is the incidence of the care costs, D is the level of disability, F is the

[33] Appendix B1 reports a summary table of the samples by countries, age groups, disability level and parent health status and table B1.2 reports an explanation of the indexes used.

family dimension, A is age, G is sex, B is the amount of cash benefits, S is the intensity of home care services, E is the employment situation at family level.

$$P_i = f\ (I_i, C_i, D_i, F_i, A_i, G_i, B_i, S_i, E_i)$$

Statistically, where a and b (b1…b9) are parameters to be estimated and ε_i is the error term, for agent I it has been estimated:

$$P_i = a + I_i b1 + C_i b2 + D_i b3 + F_i b4 + A_i b5 + G_i b6 + B_i b7 + S_i b8 + E_i b9 + \varepsilon_i$$

Adult children of dependent elderly= eight independent variables. Where P is poverty risk, H is the parent's health status, I is the intensity of informal care provided, F is the family size, A is age, G is sex, B is the number of siblings, T are the financial transfers within family, E is the employment situation at family level.

$$P_i = f\ (H_i, I_i, F_i, A_i, G_i, B_i, T_i, E_i)$$

Statistically, where a and b (b1…b8) are parameters to be estimated and ε_i is the error term, for agent I it has been estimated:

$$P_i = a + H_i b1 + I_i b2 + F_i b3 + A_i b4 + G_i b5 + B_i b6 + T_i b7 + E_i b8 + \varepsilon_i$$

These models allow to reject or accept our hypothesis:

- -in relation to the dependent elderly' model, if bi, b2, b3, are greater than 0, then there is a positive relationship between the private care resources, the elderly disability level and their risk of poverty;
- -in relation to adult children of dependent elderly' model, if bi, b2, are greater than 0, then there is a positive relation between the parent's health status and the care provided to them with the risk of poverty of adult children.

4.3 RESULTS

The risk of poverty related to the condition of dependency is a concern which is widely shared by the majority of European citizens. According to the Eurobarometer survey (2007), about seven in ten respondents think that dependent elderly people are exposed to a high risk or some risk to live in poverty. This section aims at investigating whether this general concern has an empirical confirmation, and to understand if this risk can be partly explained by the amount of private care resources demanded from the family.

In the previous chapter, the descriptive analysis of the main predictor variables explained how the characteristics of each LTC system affected the provision of services and the need for private care resources. In the following we analyse how these aspects can influence the risk of poverty for the two groups, focusing in particular on the predictor variables concerning the disability level , parent's health status and private care resources.

Table 3. Values of Nagelkerke R Square and Hosmer-Lemeshow test of each logistic regression model used

	SWEDEN		SPAIN		ITALY		FRANCE		BELGIUM		POLAND	
	R Square	HL test	R Square	HL test	R Square	HL test	R Square	HL test	R Square	HL test	R Square	HL test
Population over 65 years												
Wave 1	0,225	0,895	0,154	0,445	0,269	0,541	0,133	0,825	0,197	0,226	-	-
Wave 2	0,285	0,211	0,222	0,092	0,184	0,066	0,216	0,225	0,225	0,766	0,593	0,328
Wave 4	0,214	0,061	0,094	0,231	0,149	0,375	0,139	0,671	0,286	0,278	0,124	0,499
Population aged between 50-65 years												
Wave 1	0,224	0,903	0,179	0,589	0,313	0,151	0,381	0,991	0,231	0,666	-	-
Wave 2	0,155	0,963	0,207	0,206	0,241	0,08	0,339	0,314	0,207	0,708	0,343	0,709
Wave 4	0,37	0,985	0,221	0,097	0,311	0,06	0,216	0,23	0,309	0,137	0,272	0,502

Source: Author's elaboration

To account for the effects of the characteristics of the national LTC systems on the probability to be at risk of poverty we run the models at the national level for each wave of the SHARE survey. Thus we obtained 34 models: three for each country, (only 2 for Poland since it did not participate in the 2004-05 wave). Table 3 reports the values of each model for Nagelkerke R Square, and for Hosmer-Lemeshow test. Due to the size of the samples, the models can be used in a descriptive way. Regarding the H.-L. Test, the models present statistical significance showing p values over (in some case slightly over) the confidence interval used (95% i.e. p value < .005). Tables B1.3-B1.8 in

appendix report the statistical significance and the Exp(B) values of the main predictor variables presented, while due to excessive size we cannot report the overall analysis outcomes[34].

The main outcomes are reported in the following figures, which are created in the same way: on the vertical axis are reported the odds ratio values for the wave or category which is presented in the horizontal axis. Odds ratio values higher than 1 (dotted red line) indicate a greater probability to be at risk of poverty in relation to the reference category.

4.3.1 DEPENDENT ELDERLY PEOPLE

i)Disability level

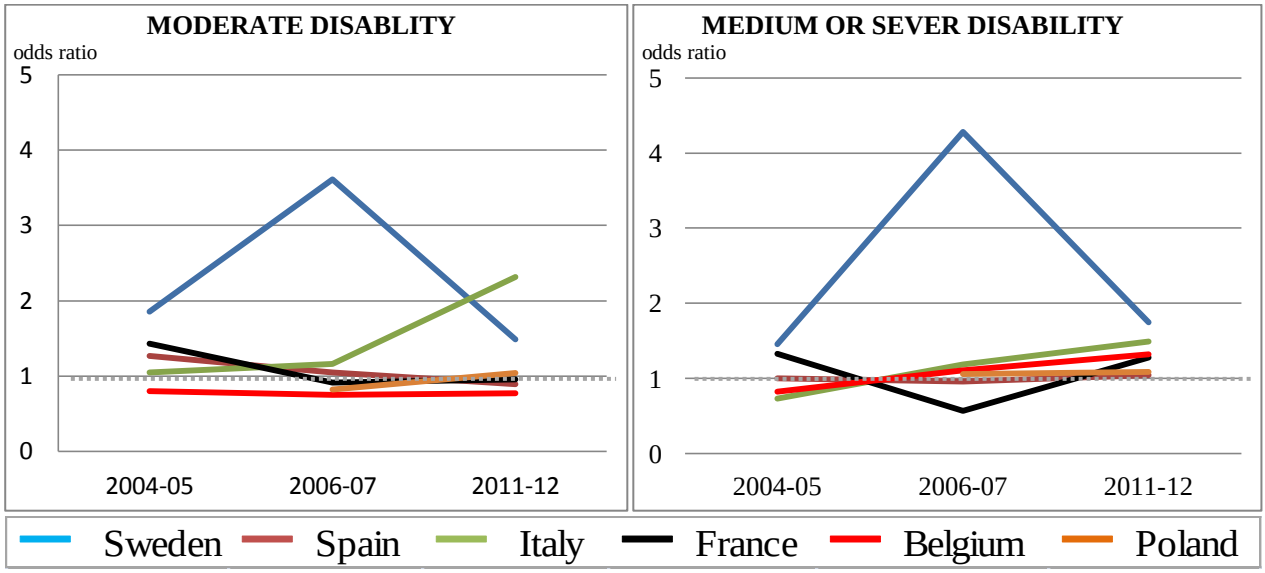
Figure 18 presents the odds ratio to be at risk of poverty in relation to the disability level of the elderly compared to the older population with no disabilities. In Belgium, France, Poland and Spain it seems that a moderate level of disability does not increases the probability to be at risk of poverty for the dependent elderly. In fact Spain and France present a negative trend of the odds ratio between 2004-2012, while all countries show values close or below one. Conversely, the graph on the right suggests that, even in those countries with the most developed LTC systems, a severe disability level can affect the old person's probability to be at risk of poverty.

In France and Belgium the elderly people with medium or severe disability are more exposed to the risk of poverty compared to the dependent elderly population with a lesser degree of disability. Nevertheless it seems that the quality of these LTC systems is able to limit the economic incidence of the condition of dependency: in the last wave, the increment of the risk of poverty generated by the condition of medium or severe disability is limited to an increase in the probability between 20% and 30%, with respect to the older population without any disabilities. Conversely, it is a bit surprising to see that Spain and Poland are the only countries in which, a medium or severe level of disability has a minor impact on the probability to be at risk of poverty for the dependent population. This result contrasts with the limited capacity of their LTC systems and their path of reform. In the case of Spain, the result could be partly explained by the fact that the introduction of

[34] For the detailed outcomes of the regression refer to appendix B3.

the LAPAD targeted the neediest among the dependent population, so that this category might have benefited from the huge increase in the amount of cash benefits (€ 2000) between 2004 and 2012.

Figure 18. Odds ratio to be at risk of poverty by disability level , population over 65, reference category= population over 65 without LTC disability.



Source: Author's compilation on the basis of SHARE data, waves 1-2-4.

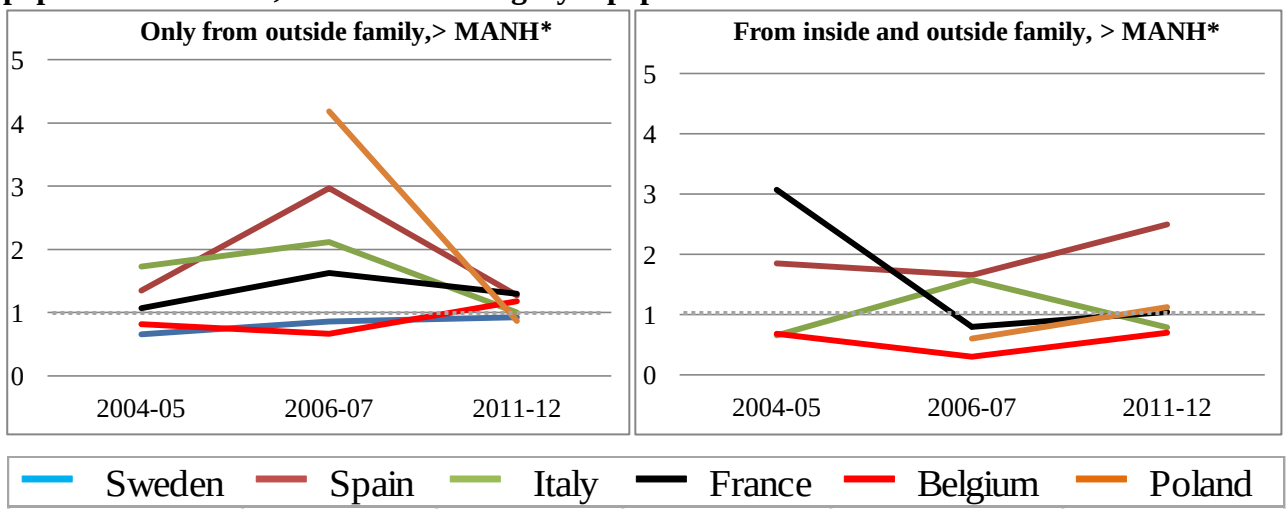
In Sweden and Italy the condition of dependency seems to affect the elderly population's risk of poverty. In Sweden both categories of dependent elderly have odds ratio values greater than 1,5 in all three waves, with a peak in 2006. This seems to indicate that the Swedish system has difficulty to offset the effects of the reduction of the (high) level of social protection which was provided to the dependent people, who seem to pay a higher cost for the government's strategies compared with the self-sufficient older population. In Italy the odds ratio of elderly with moderate disability increases from a value close to 1 in 2004, to a value of 2,316 in 2012; and we observe the same trend as regards the population with medium or severe disability which, in 2012, presents a odds ratio equal to 1,489. These outcomes seem to be in line with the findings of the previous phases of our research. As we have seen, the Italian LTC system requires a substantial level of private care resources, and, at the same time, provides only a limited support in terms of home care services. Moreover, the greater exposure to the risk of poverty of the elderly with moderate disabilities compared with those more severely impaired can derive from the characteristics of the main cash benefit (indennità di accompagnamento). In fact, the absence of a relation between the value of the benefit and the level of disability seems to generate a lose-lose situation: the elderly people with severe disabilities tend to receive a monthly amount that does not fully compensate for the cost of care, while those with moderate disabilities have to rely wholly on their financial resources until they satisfy the standard of access to the allowance .

In general, even if the countries differ for the risk of poverty in relation to the disability level, it is possible to maintain that the condition of dependency can be considered a factor affecting the risk of poverty, which is increasing with the degree of disability. In fact, in all countries in 2012, the elderly with a medium or severe level of disability have a greater probability to be at risk of poverty compared to the total population aged 65 or over (see tables in appendix B2).

ii)Informal care

Figure 19 presents the odds ratio to be at risk of poverty in relation to the type and intensity of informal care received compared to the overall older population. We present the outcomes for the two categories of the variable that represent the highest level of informal care received: only from outside the household; and from inside and outside the household, for a monthly number of hours higher than the national average.

Figure 19. Odds ratio to be at risk of poverty by type and intensity of informal care received, population over 65, reference category= population that does not receive informal care.



Source: Author's compilation on the basis of SHARE data. *= Monthly average number of hours at national level

From the graph on the left we can see that, until 2006, in Italy, Spain, Poland, but also France receiving informal care only from outside the household increases the risk of poverty of elderly compared to older population that does not receive informal care; and, with the exception of Poland, their odds ratio values grow between the first and second wave, and are steadily higher than 1. Conversely, during the same period of time, Belgium and Sweden present stable values of probability to be at risk of poverty slightly below the poverty line. In 2012 the odds ratio of all countries converge to value close to 1, indicating a small probability to be at risk of poverty

compared to the reference category. This can suggest that, in a period of economic crisis, the dependent elderly may limit the burden of care through the help of relatives (and in a small percentage from the help of friends), that, compared to the previous years, allows the probability of risk of poverty to decrease for some countries (IT, FR, ES and PL), or to slightly increase in other countries (BL and SE). Those who receives informal care only from outside the family are usually elderly women living alone, that is, a group already highly exposed to the risk of poverty regardless its health status or the intensity of help and/or assistance received.

In France (with the exception of the first wave) and in Belgium receiving informal care at the higher intensity level (graph on the right), does not increase the probability of risk of poverty for the elderly. In fact in these countries the intensity of informal care received by the elderly population (on average, around 6 hours per week) indicates that this kind of help plays only a small role in the overall care of the dependent elderly, and from this we can suppose that their risk of poverty is primarily affected (or prevented) by the characteristics of the formal services, and by the private expenditure that the family has to sustain. Similarly in Sweden, in the first two waves of SHARE, it is not possible to identify an increment of the risk of poverty in relation to either receiving informal care or its intensity, but the outcomes of the last wave seem to suggest a different interpretation. Almost all the categories of the variable used to define the provision and the intensity of informal care received by the elderly, have odds ratio values higher than 1 (see table 3 in appendix B2). This seems to confirm the aspects emerged in the previous figure (18): the reform processes of the LTC system undertaken by this country seem to affect directly the economic situation of the dependent elderly. The reduction of public responsibility and financing in LTC sector, which occurred in the last decades, together with the impact of the economic crisis have generated a situation in which the low-income family of a dependent elderly person do not receive enough support and do not have enough resources to deal with the dependent condition. This aspect is also confirmed by the analysis for income groups. In Sweden the family support and assistance is almost exclusively a practice that concerns the poorest elderly population.

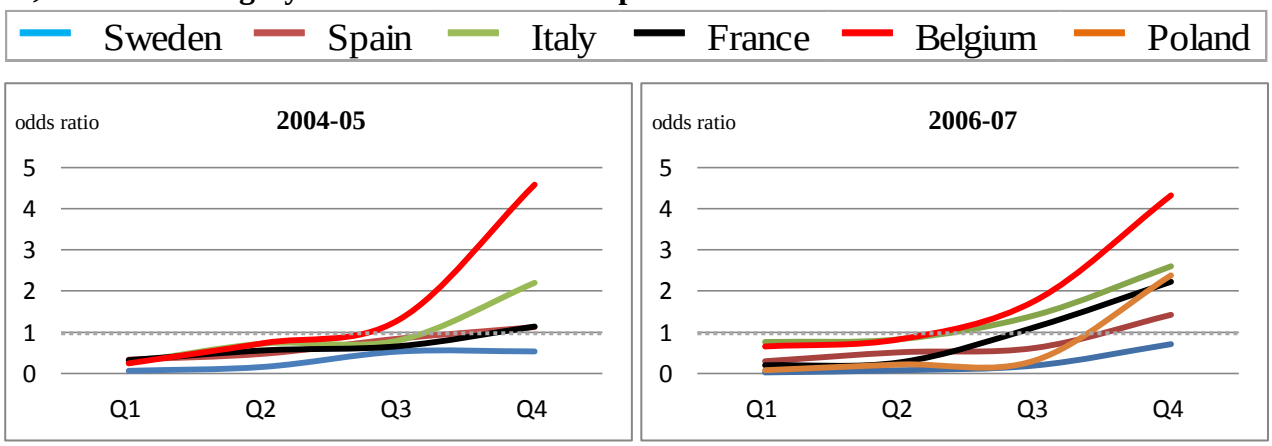
In Italy, Poland and Spain to receive informal care, especially only from outside household, rises the probability to live in a family with an income below to the poverty threshold. However, it seems that in Spain the elderly that receive informal care are more exposed to the risk of poverty. If we look at the overall outcomes of this variable (tables B2 in appendix) it emerges that the receiving informal care increases the risk of poverty of the elderly also in Italy and Poland; but, in 2012, in

Spain, all the categories of this variables have odds ratios values higher than 1. In Spain, Italy and Poland, informal care is a widespread practice that involves not only the low-income families, but in the latter two countries the economic crisis has generated a significant increase in the share of the middle-income families that receive this kind of help, while in Spain this rise was milder. Despite these differences, a common feature can be identified. In these three countries the elderly that do not benefit of a direct support from their family network, namely those that receive informal care only from outside the household, are seriously exposed to the risk of poverty.

iii)Private care expenditure

Figure 20 presents the odds ratio to be at risk of poverty in relation to the incidence of care and health expenditure in the household's income by quartiles. The risk of poverty increases steadily with the increase in the incidence of care expenditure. Except for Sweden, in all countries the incidence of these expenditure on household income is directly related to the risk of poverty, and in France, Italy and especially Belgium this risk is particularly relevant. In these countries, in 2006-07, even an incidence of the care cost included in the third quartile of the distribution increases the probability to be at risk of poverty. Moreover, if we exclude Poland (that did not participate to the first wave) in 2006, each category of the variable presented in figure 20 (namely, each quartile of the distribution of the variable) has a greater value of odds ratio than to 2004 (Table B1.3-4 in appendix).

Figure 20 Odds ratio to be at risk of poverty by incidence of care expenditure, population over 65, reference category= no care and health expenditure.



Source: Author's compilation on the basis of SHARE data, waves 1-2.

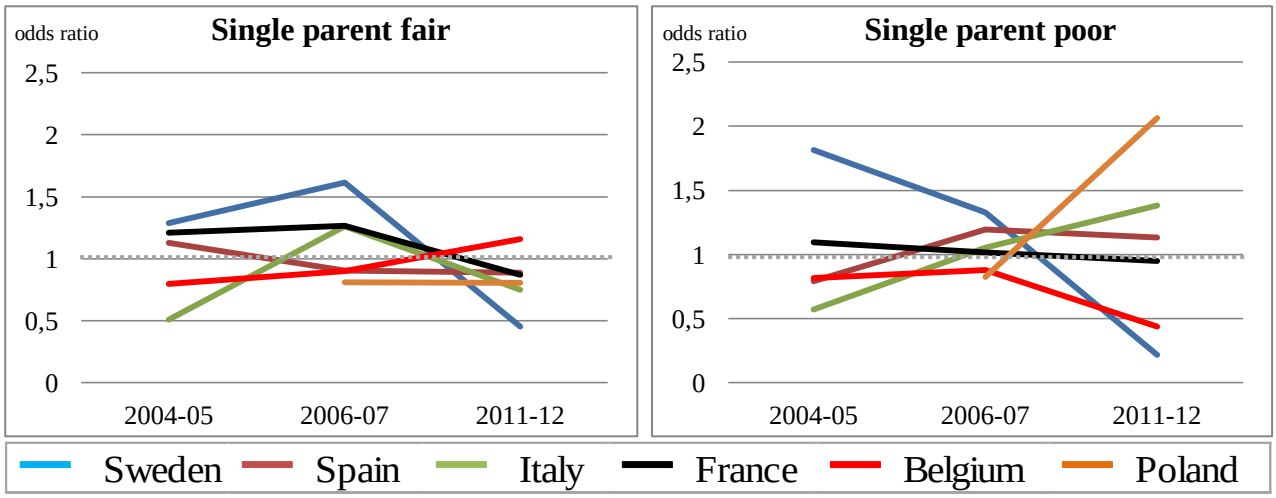
The result for France in 2012 is puzzling: in fact, as we have seen above, in this country the incidence of private expenditure is generally fairly low, and extremely low for the low-income families. In fact, in 2004, even the fourth quartile of the distribution had an odds ratio value slightly above 1. Special care should be paid in interpreting the results at the light of the role played by co-payment in the private cost of care. In some countries - France and Belgium - the elderly people with moderate disability receive a benefit equal to or slightly lower than the cost of care, in all countries a severe disability requires that families shoulder a significant share of the total cost, an amount that, in some cases, can be two or three times the cash benefit. Thus, in those countries where access criteria are not need and means-tested (IT and PL); and/or where a scarce provision of public services shifts on the families the majority of the cost (IT, ES and PL), the severely dependent elderly people are likely to be particularly exposed to the risk of poverty, and this risk can involve directly their adult children.

4.3.2 ADULT CHILDREN OF DEPENDENT ELDERLY

The next step considers the population aged between 50 and 65 years, specifically, the adult children who provide informal care to their parents or in-laws. We analyse the effects of the health status of the parents - fair (left) or poor (right) – on their adult children economic conditions when the parent lives alone (the most taxing conditions for the adult children).

Figure 21 shows that in all countries a "fair" health status of the parent has a small effect on the risk of poverty of his/her adult children. With the exception of Sweden, fair health conditions increase the probability to be at risk of poverty for a maximum factor of 1,3 compared to the reference category, and the odds ratio values tend to decrease between 2006 and 2012. This result suggests that fair health conditions require only a limited involvement of the adult children in the care of the elderly, and it is not to be considered a primary cause of their risk of poverty. Likewise, a poor health condition of the parent seems to have an impact on the risk of poverty of the adult children which is similar to the previous case; except for Poland and Sweden, the odds ratio values are equal to or below 1.5.

Figure 21. Odds ratio to be at risk of poverty by parent's health status, population 50-65 years, reference category= population with no parents alive



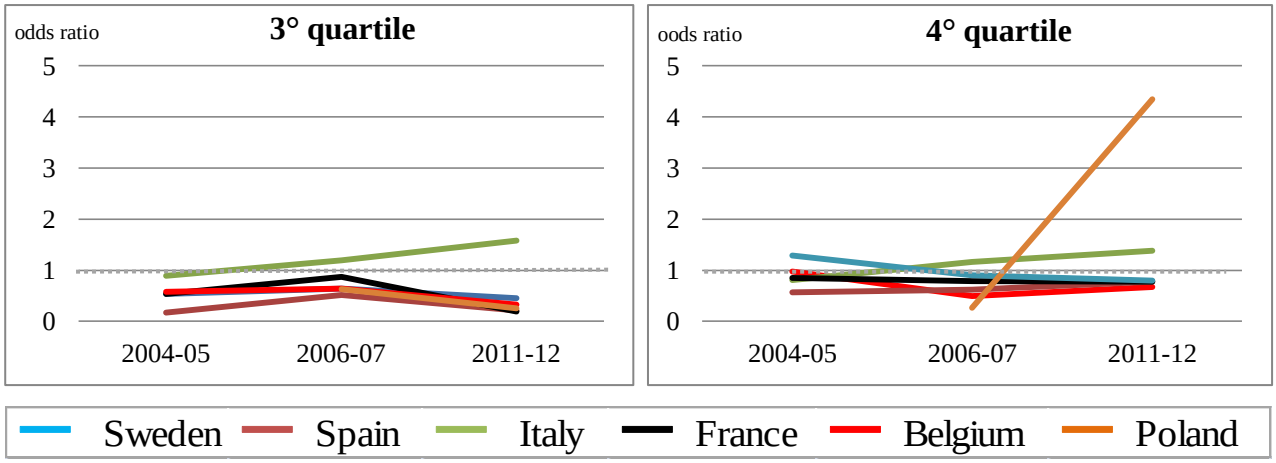
Source: Author's compilation on the basis of SHARE data, waves 1-2-4.

However, it is possible to identify two different trends. In France and Belgium the odds ratio values are close or below the dotted line, and it seems that in these countries the health status of parents does not affect the economic condition of their adult children. In Italy, Spain and Poland the parent's poor health increases, year by year, the probability to be at risk of poverty of their adult children, peaking in 2012. In these countries care responsibility falls on the family, both in terms of assistance and in terms of legal obligations, so that a reduction in the public efforts is directly translated in an increase in the private burden for care. Adult children's families facing economic difficulties are thus exposed to the risk of poverty. Sweden represents an anomaly compared with the other countries. In 2006 there is a peak of odds ratio, followed by a significant decrease of the probability of risk of poverty for the adult children of a single parent with a fair health; conversely, the children of a parent in poor health show a steady decrease in their risk of poverty. All in all, in this country the condition of dependency seems to affect directly the risk of poverty of the elderly population, as well as the economic situation of the adult children.

The last figure (22) allows to see if the involvement of the adult children in the elderly care increases their probability to be at risk of poverty. We focus on the third and fourth quartiles of the distribution of hours of informal care provided, since we suppose that a substantial engagement in term of hours can reduce the working capacity and working possibility of the adult children, increasing their probability to be at risk of poverty.

From the figure (22) emerges that the only country in which providing assistance to their parents, regardless of the intensity, increases the probability to be at risk of poverty for the adult children, is Italy. In this country, in the last two waves and for both the categories presented, the odds ratios are higher than 1; and the risk of poverty increases steadily during the period under examination.

Figure 22. Odds ratio to be at risk of poverty by intensity of informal care provided, population 50-65 years, reference category=adult children that do not provide informal care



Source: Author's compilation on the basis of SHARE data, waves 1-2-4; ref. cat.= no informal care provided.

Conversely, if we exclude the odds ratio value of 2012 of the fourth quartile for Poland (even if it is particularly high), for the other countries, providing care to parents does not seem to represent a cause of the risk of poverty. This result may reflect the absence of measures in support of the caregiver. In fact, Italy is the only country among those under study that does not provide any form of direct economic support allocated to the family carers: the beneficiaries of the main cash benefits (indennità di accompagnamento) are the dependent elderly, not the family caregivers. In Sweden allowances related to a condition of dependency are directed to the family caregiver; in Spain the law recognizes the possibility to redirect the cash benefit to the informal carers and provides them with social security; even in Poland, where the formal LTC system is almost non-existent, the family member taking care of the elderly can benefit from a monthly allowance.

4.3 CONCLUSION

In this chapter we studied whether the condition of dependency and the private care resources can play a role in the explanation of the risk of poverty for two specific groups of the population: the dependent elderly and their adult children.

For the first group of the population, we have analysed the risk of poverty in relation to the following variables: LTC disability level; type and intensity of informal care received; incidence of care expenditure on equivalised disposable household income; formal home care services received; public cash transfers for LTC or disability. Our results suggest that Italy and Poland are the two countries in which the risk of poverty for the old population with disabilities is more evident: for all the aspects analyzed, the probability, in general, is higher than 1. Although with minor intensity, also in Spain the condition of dependency entails a higher probability of risk of poverty for the elderly population, and receiving a high level of informal care is also correlated with an increase in the risk to fall into poverty. The amount of private resources committed to care seems to have different effects across countries. In Sweden the private cost of care does not seem to be a direct cause of family financial impairment, in spite of the high risk of poverty which affects the dependent population, regardless of the disability level. In France and Belgium, viceversa, the risk of poverty, even if with a limited probability, concerns the elderly with moderate or severe disability, and, with a greater intensity, the population with high care expenditure. In all countries receiving home care services lowers the probability to be at risk of poverty while this does not apply to cash benefits[35]. This can explain the results of France and Belgium. In fact, the features that can limit the private cost of care derive, on the one hand, from the degree of development of the formal home care sector, and on the other hand from the accessibility of care. In France and Belgium more than half of the dependent population receives formal services at home, and the accessibility of services (in-kind and cash) is related to both the level of disability and the individual income, and these aspects ensure a fair and high coverage from poverty risk.

The analysis of the adult children population has highlighted the differences in the LTC systems under study. In fact while the French and Belgian population over 65 is only touched by the risk of

[35] For all countries the dependent elderly that receive formal home care services, in the first and second wave of SHARE, have odds ratio values almost lower that 1, regardless the intensity of the services. The same does not happen for the dependent population that receives cash benefits (see Table B1.3-4 in appendix).

poverty caused by the condition of dependency , this risk disappears altogether when the analysis focuses on their adult children. Conversely, in the other countries, in general the parent's dependent condition transcends generations and involves the adult children's life. There is room for differentiation, of course. In Sweden the adult children's risk of poverty seems to be smaller and decreases over the period; moreover the Swedish welfare state has the capacity to limit the effects. In Spain, even if the risk is concrete and it affects both the categories examined, the situation elicits lesser optimism: the Spanish government's attempt to intervene in the LTC by introducing a constitutional reform, was blocked by the financial and fiscal crisis. What is surprising in Poland, is that the situation is not dramatic. In fact, even if this country shows the highest odds ratio values in several categories examined, the risk of poverty for both groups is almost in line with Italy and Spain. It must be considered that the Polish family structure can still help the elderly and their relatives to reduce the economic impact of dependency. Considering that on average the Polish families are formed by 3.2 members, it is possible to argue that the care burden can be more easily shared within the family. Finally, the analysis provides a disturbing scenario for Italy, where there hasn't been a real reform of the LTC system in the last 20 years, and the fiscal crisis is diverting the scare public resources to other social needs.

CONCLUSION

This work aimed at investigating the existence of a relation between the condition of dependence of elderly people and the risk of falling into poverty for them and their adult children. We started from the premise that the dependence –risk of poverty relation might have been strengthened by the re-definition of public responsibility in the LTC, which affected the characteristics of the LTC systems and the role of the family as care provider. For this purpose, we have brought together two levels of analysis that have been usually considered separately in social policy studies: we analyzed the relation between the process of reform of the LTC systems at the macro level with their economic impact at the micro/ individual level. We proceed in two logical steps: first, to investigate the relation linking the reforms of the LTC systems to the amount of private resources required from the dependent elderly people and their families; second, to assess the impact of the cost of care born by families on the risk of poverty.

To this end, we have divided our research in two phases. In the first phase, we have identified four macro aspects of LTC national systems that may affect the private involvement in the care of elderly people. The result of the first phase, obtained through a cluster analysis, is a division of the European countries on the basis of those characteristics of their LTC systems that affect the level of private resources (time and money) that dependent elderly people and their family members devote to care. In particular, the results suggest the existence of a relation between the level of public spending on LTC and the private resources that must be devoted to care: increases in public financing correspond to reduction in family involvement, both in terms of money and in time. It is possible to identify four typologies of LTC systems in relation to their degree of family involvement in care. Moreover, the macro analysis highlights the existence of a complementarity between the two dimensions of private care resources (time and money), showing that the LTC systems are distributed on a continuum, from countries in which the families are scarcely involved in the care process, to countries in which the elderly care is almost exclusively a private matter. The micro analysis integrates and to some extent qualifies the macro analysis, allowing a deeper understanding of the consequences of the reform processes on the services provision in the various countries and on private cost of care. In the case of Sweden, for instance, the analysis on the basis of the micro data highlights how the LTC system of this country is moving away from the Scandinavian model, a result that was not so evident in the macro-analysis.

The purpose of the second phase was to ascertain a possible connection between the level of private care resources and the risk of poverty, at an individual level (dependent elderly people) and at the family level (spouse and adult children). On the basis of the results of the cluster analysis we selected a number of countries in order to estimate the impact of the private resources allocated to care on the elderly person and its family's income. In this phase we used logistic regression models to estimate the relationship between the risk to fall in poverty, the private resources allocated to care, the individual and family characteristics and the benefits that the dependent elderly people receive from the LTC system. The analysis confirmed the existence of a relation between the level of private resources that the family of a dependent elderly devotes to care, and the probability to fall into poverty, and the probability increases in periods of economic crisis (2011-12). While a high share of care and health expenditure in the household's income is generally associated with a risk of poverty, this risk is especially high in those countries where the elderly care sector has experienced a reduction of public funding –Sweden-, and where the public LTC system is under-developed - Italy and Poland. Although high levels of informal care help the older population to limit the burden of care, the recipients of this kind of assistance are exposed to the financial impairment, specially, in those countries where this practice is limited -Sweden - or mainly concerns – Spain and Italy - the low income families.

The analysis of the risk of poverty of the adult children of a dependent old person supported the hypothesis that dependency has an intergenerational impact: in LTC systems with limited capacity, the parent's dependent condition affects the economic condition of his/her adult children. Narrowing public responsibility unsupported by an appropriate reorganization and funding of LTC translates in an increase in the risk of poverty also for the adult children of the dependent elderly person.

However, the risk of poverty is affected by the different features that constitute the various LTC systems. A greater recourse to services in-kind as opposed to cash benefits, a fair access to services obtained through means and needs testing, a high share of beneficiaries of home services, are the main features that ensure a limited economic impairment for the dependent elderly people and their families. Also the process of marketization of care is not in itself a factor that increases the risk of poverty, as the comparison between Sweden and France shows. High public spending together with policies directly aimed to support the dependent person, allow the French LTC system to rely on a high share of private operators with a limited risk of poverty. On the other hand, the growing process of marketization of care, in combination with the reduction of public funding, has generated

a widespread increase of the risk of poverty in Sweden. Finally, the comparison between Italy and Poland suggests that the risk of poverty can increase substantially in the transitional phase from a familistic organization towards one based on a nuclear family, and from a male breadwinner towards a two-earners families, and the risk can be quite substantial if the state does not intervene with public provision to reduce the extent of private care resources demanded from families.

The results on the risk of poverty of the adult children must be interpreted with a view to the future. Because of their aging population, the European economies will experience an increase in the dependency ratio (the ratio of the old population over active population), with a consequent increase in the share of care that families will have to shoulder: an increasing financing of care, both private and public, will impinge on a shrinking active population. Moreover, family care falls still mostly upon women, who are penalized in the market, and suffer a gender wage and pension gap, thus running the greatest risk of poverty in old age. In those countries where old people's dependence already threatens the economic situation of their adult children, the government might face a double responsibility: sustain and protect the elderly population from the disability risk; and prevent the risk of poverty of their adult children.

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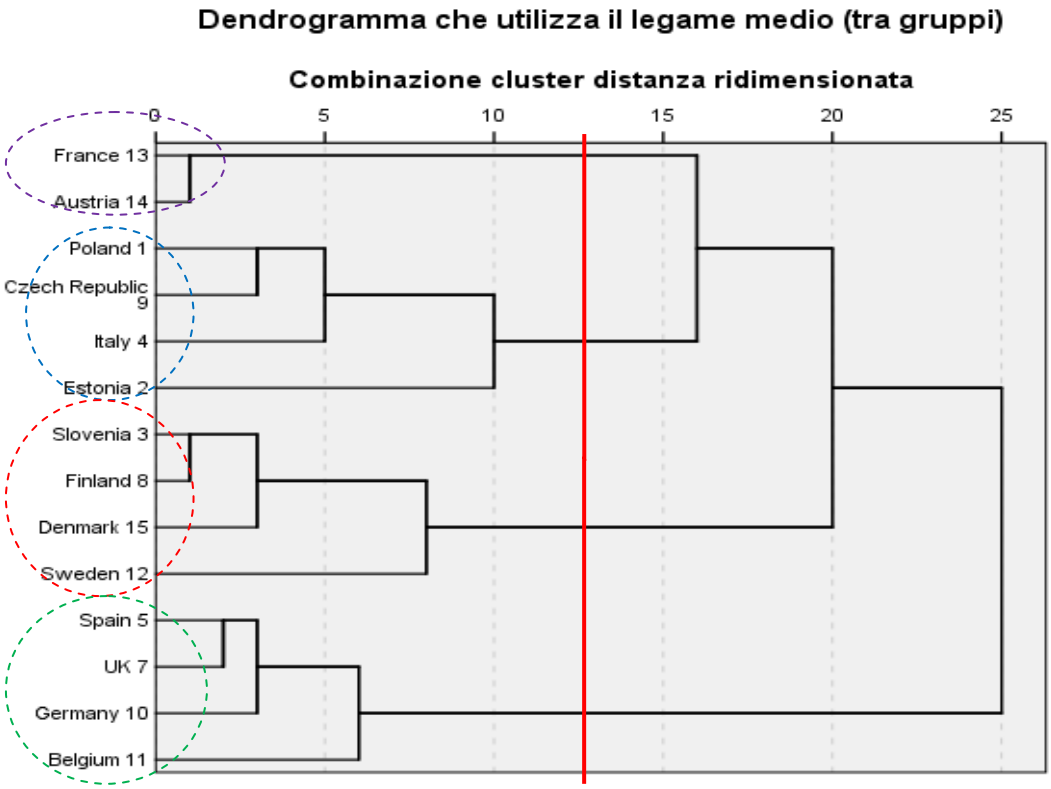
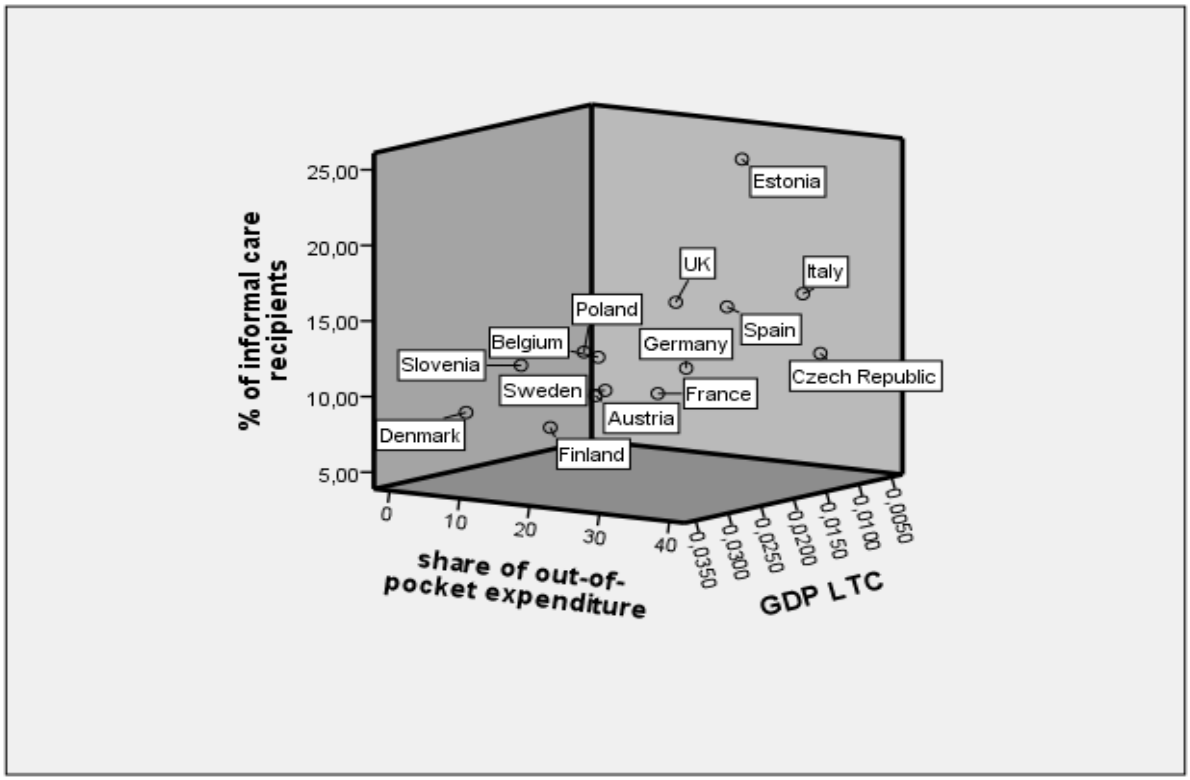
APPENDIX A

Dendogram of cluster analysis



Fiugure 7, Association between the two dimension of private care resources and the public expenditure in GDP



Correlation matrix of the variables used in macro analysis

Matrix correlation variables used for cluster analysis and private care resources

Pearsons's R	Care_rec	Institut_care_rec	Cash_rec	Public_prov	Notprofit_prov	Forprofit_prov	l_Care_dep_	Cash_dep_pop	mean_t_in_k	Pub_expen_corr	GDP_LTC	CASH_KIND	informal care	p_totexp
Home_Care_re	1	0,598	0,443	-0,100	-0,124	0,303	0,722	-0,011	0,094	0,556	0,570	-0,429	-0,429	-0,084
Institut_care_r	-	1	-0,09	0,232	-0,491	0,193	0,697	-0,324	-0,007	0,381	0,469	-0,512	-0,516	-0,152
Cash_rec	-	-	1	0,114	-0,001	-0,119	0,271	0,760	0,001	0,389	0,358	0,275	-0,198	0,125
Public_prov	-	-	-	1	-0,684	-0,744	0,123	0,323	-0,703	0,060	0,045	0,066	-0,318	-0,611
Notprofit_prov	-	-	-	-	1	0,039	-0,116	0,200	0,241	-0,172	-0,177	0,340	0,138	0,555
Forprofit_prov	-	-	-	-	-	1	0,017	-0,571	0,763	0,135	0,162	-0,428	0,167	0,310
Formal_Care_d	-	-	-	-	-	-	1	0,122	-0,150	0,718	0,700	-0,462	-0,673	-0,211
Cash_dep_pop	-	-	-	-	-	-	-	1	-0,281	0,246	0,211	0,458	-0,335	-0,032
mean_t_in_k	-	-	-	-	-	-	-	-	1	-0,040	-0,049	-0,182	0,247	0,429
Pub_expen_co	-	-	-	-	-	-	-	-	-	1	0,846	-0,491	-0,485	-0,241
GDP_LTC	-	-	-	-	-	-	-	-	-	-	1	-0,493	-0,510	-0,183
CASH_KIND	-	-	-	-	-	-	-	-	-	-	-	1	0,409	0,512
infocare_overl	-	-	-	-	-	-	-	-	-	-	-	-	1	0,463
privexp_totexp	-	-	-	-	-	-	-	-	-	-	-	-	-	1

Appendix B1

B1.Descriptive analysis of variables disability level and parent's health status . Distribution of frequencies, by waves of SHARE survey

Table B1.1

	Population over 65 years			Population 50-65 years		
		% of persons affected by LTC disability			% of adult children with parents that with health problems	
	tot pop.	moderate	medium or severe	tot pop.	Fair	Poor
WAVE 1						
Sweden	1408	9,4	9,8	1761	8,3	19
Spain	1275	11,7	17,5	1174	11,9	14,5
Italy	1166	9,3	13,8	1497	7,6	15
France	1425	11,7	15,5	1852	13,1	19,4
Belgium	1752	12,7	12	2172	13,7	17,2
WAVE 2						
Sweden	1413	8,3	8,4	1432	15,8	11,2
Spain	1224	7,4	17,7	1077	14,8	7,8
Italy	1562	8,3	12,9	1521	13,2	11
France	1333	10,4	13,6	1702	16,1	13,9
Belgium	1470	10,3	13,9	1786	16,4	6,6
Poland	1074	12,8	30	1456	13,4	12,2
WAVE 4						
Sweden	1422	10,1	12	708	12,8	12,8
Spain	2159	10,9	22,5	1531	11,2	5,6
Italy	2135	9,6	16,8	1602	9,5	6,9
France	3023	11,9	15,8	3035	15,9	13,9
Belgium	2541	13,9	21,4	2926	8,5	4,6
Poland	1099	10,2	22,4	707	12,1	11,4

B1.2 Variables used in the logistic regression models

VARIABLES USED	CATEGORIES
Predictor variables used in the model for the population aged 65 years or over	
LTC disability level at individual level	- No LTC disability*
	- Moderate disability
	- Medium severe disability
Type and intensity of informal care received aggregated at the household level	- no informal care received*
	- only from outside family, < average national monthly number of hours (ANMNH)
	-only from outside family, > ANMNH
	-only from inside family
	-from inside family, and outside family < ANMNH
	-from inside family, and outside family > ANMNH
Health and care expenditure aggregated at the household level	- no care and health expenditure*
	- first quartile of distribution of the incidence of care and health expenditure at family level, on equivalised disposable household income
	- second quartile of distribution
	- third quartile of distribution
	- fourth quartile of distribution
Public cash transfer for LTC or disability received aggregated at the household level	- no public transfer received
	-amount of transfer below the national mean
	-amount of transfer above the national mean
formal home care services received aggregated at the household level	-no services received*
	- < ANMNH
	- > ANMNH
Age	- 65-69*
	-70-74
	-75-79
	->=80
Predictor variables used in the model for the population aged 50-65 years	
Parents health status	- no parents alive or both parents with health status excellent/very good/good*
	-both parents alive, one parent fair
	-single parent fair
	-both parents alive one parent poor
	-single parent poor
Intensity of informal care provided aggregated at the household level	-no informal care provided*
	-first quartile of the distribution of number of hours of informal care provided at family level
	- second quartile of distribution
	-third quartile of distribution
	-fourth quartile of distribution

Economic transfers between parents and adult children aggregated at the household level	-no financial transfer from parents to adult children*
	-family that receives financial transfer from parents
	-no financial transfer from adult children to parents*
	-family that provides financial transfer to parents
Age	-30-50*
	-51-55
	-56-60
	-61-65
Predicted variables used in both models	
Household dimension	-single*
	-couple
	-3 members
	-4 or more members
Gender	-male*
	-female
Employment condition at family level aggregated at the household level	-at individual level the original variables used (EP005-EX103) provide six types of response: Retired / Employed or self-employed / Unemployed / Permanently sick or disabled / Homemaker / other. At household level this variables provides the combination between of the employment situations of each person who cohabits in the same dwelling. (over 65*=family with two pensioners/pop 50-65*= family with two workers).

***=reference category**

B2 Statistical, table 1: significance and the Exp(B) values of the main predictor variables used, population over 65, wave 1

VARIABLES	elderly with LTC disability, (ref. Cat.= no LTC disability)		type and degree of informal care received (ref. cat.= pop over 65 without LTC disability)					gender (ref. cat.= male)
	moderate disability	medium or severe deisability	only from outside family,< MANH***	only from outside family,> MANH	only from inside family	from inside and outside family (< MANH)	from inside and outside family (> MANH)	Female
SWEDEN	1,856**	1,453**	2,749**	,651**	,371**			1,348**
SPAIN	1,268**	1,003**	1,354**	1,347**	1,294**	1,042**	,813**	-
ITALY	1,048**	,730**	,739**	1,728**	,993**	2,244**	1,272**	,155**
FRANCE	1,429**	1,330**	1,491**	1,071**	1,576**	,835**	,971**	,964**
BELGIUM	,802**	,,825**	,501*	816**	,747**	676**		1,266**

VARIABLES	Total annual care expenditure on family equivalised income, quartiles of distribution (ref. cat.= no care expenditure)				Public cash transfer received for disability allowance or LTC schemes (ref. cat.=no public transfer received)		Formal professional care received (ref. cat.=no prof. care received)	
Categories	Q1	Q2	Q3	Q4	< national mean	> national mean	< MANH	> MANH
SWEDEN	0,071	0,167	,537**		,515**		,582*	,247*
SPAIN	0,34	0,482	,847**	1,123**	1,665*	,108*	0,569*	,229*
ITALY	0,258	,728**	,807**	2,204	1,048**	,730**	,475*	
FRANCE	,326*	,561**	,662**	1,133**	,817**	,565**	1,369**	1,191**
BELGIUM	0,249*	0,741**	1,312**	4,583	0,450*	0,068*	0,564	0,307

Pop. Over 65, wave 1*=sig between 0.001 and 0.05, **= sig. more than 0.05, ***= Monthly average number of hours at national level

Table 2: Population over 65, wave 2

VARIABLES	elderly with LTC disability, (ref. Cat.= no LTC disability)		type and degree of informal care received (ref. cat.= pop over 65 without LTC disability)					gender (ref. cat.= male)
	moderate disability	medium or severe deisability	only from outside family,< MANH***	only from outside family,> MANH	only from inside family	from inside and outside family (< MANH)	from inside and outside family (> MANH)	Female
SWEDEN	3,614*	5,378	,855**	,873**	,104*			1,526**
SPAIN	1,046**	,960**	1,672**	2,970**	,968**	1,777**	1,142**	,758**
ITALY	1,159**	1,182**	,874**	2,117**	,672**	2,057**	1,089**	,744**
FRANCE	,913**	,566**	2,012*	1,629**	1,683**	,789**		,788**
BELGIUM	,746**	1,110**	1,028**	,665**	,500*	,296*		2,633**
POLAND	,817**	1,058**	2,059**	4,188*	,890**	,595**		,343**

VARIABLES	Total annual care expenditure on family equivalised income, quartiles of distribution (ref. cat.= no care expenditure)				Public cash transfer received for disability allowance or LTC schemes (ref. cat.=no public transfer received)		Formal professional care received (ref. cat.=no prof. care received)	
Categories	Q1	Q2	Q3	Q4	< national mean	> national mean	< MANH	> MANH
SWEDEN	0,031	0,083	0,2	,715**	2,207**	1,172**	,301*	,476**
SPAIN	0,297	,515*	,623**	1,427**	1,280**	0,204	,795**	1,044**
ITALY	,767**	,836**	1,420**	2,603	1,282**	0,06	,608*	,670**
FRANCE	0,195	0,268	1,130**	2,230**	,932**	1,563**	,889**	,809**
BELGIUM	,654**	,832**	1,772**	4,321	,988**	,356**	,619*	,627**
POLAND	0,078	0,217	0,32	2,384*	2,500**	,732**	-	-

*=sig between 0.001 and 0.05, **= sig. more than 0.05, ***= Monthly average number of hours at national level

Table 3:Population over 65, wave 4

VARIABLES	type and degree of informal care received (ref. cat.= pop over 65 without LTC disability)						
	only form outside family, almost every month/less often	only form outside family, almost every week	only form outside family, almost daily	only from inside family	from inside and outside family, almost every month/less often	from inside and outside family, almost every week	from inside and outside family, almost daily
SWEDEN	,990**	,923**	1,260**	1,247**	2,081**	5,728	1,403**
SPAIN	1,040**	1,820*	1,269**	1,329**	2,030*	1,657**	2,497
ITALY	,965**	1,192**	,953**	,845**	1,406**	,879**	,788**
FRANCE	,599*	1,056**	1,295**	1,852	1,312**	1,055**	1,040**
BELGIUM	,556*	,611**	1,180**	,965**	,899**	,882**	,692**
POLAND	1,836**	,826**	,864**	1,241**	1,348**	1,304**	1,124**

VARIABLES	Public cash transfer received for disability allowance or LTC schemes (ref. cat.=no public transfer received)		gender (ref. cat.= male)	elderly with LTC disability, (ref. Cat.= no LTC disability)	
Categories	< national mean	> national mean	Female	1 moderate disability	1 medium or severe disability
SWEDEN	1,663**		1,394*	1,488**	1,747*
SPAIN	1,827*	,940**	,925**	0,89**	1,046**
ITALY	,661*	0,415	,914**	2,316	1,489
FRANCE	,818**	2,019**	1,127**	,952**	1,277**
BELGIUM	,846**	1,532**	1,170**	,773**	1,320**
POLAND	,815**	1,514**	1,223**	1,038**	1,086**

*=sig between 0.001 and 0.05, **= sig. more than 0.05, ***= Monthly average number of hours at national level

Table 4:population between 50-65 years, wave 1

VARIABLES	Parents health status (ref. cat.= no parent alive)				gender (ref. cat.= male)	
Categories	both parent alive, one parent fair	single parent fair	both parent alive, one parent poor	single parent poor	Female	
SWEDEN	5,440**	1,289**	,997**	1,815**	1,562**	
SPAIN	,693**	1,128**	,812**	,793**	,980**	
ITALY	,516**	,508**	,444**	,572**	,890**	
FRANCE	,138**	1,211**	1,025**	1,095**	1,329**	
BELGIUM	1,174**	,797**	,550**	,815**	1,211**	
VARIABLES	Quartile of distribution of monthly hours of informal care provided to parents/ in-laws (ref cat.: no informal care provided)				Financial transfer (ref. cat.= no financial transfer)	
Categories	Q1	Q2	Q3	Q4	give financial transfer to parent	receive financial transfer from parent
SWEDEN	-	-	,539**	,976**	2,737**	2,225**
SPAIN	,239*	,640**	,165**	,563**	,953**	1,972**
ITALY	,796**	1,487**	,888**	,810**	,770**	1,046**
FRANCE	1,255**	,601**	,531**	,847**	0,142	,479**
BELGIUM	1,033**	1,258**	,576**	1,288**	,870**	1,300**

*=sig between 0.001 and 0.05, **= sig. more than 0.05.

Table 5:population between 50-65 years, wave 2

VARIABLES	Parents health status (ref. cat.= no parent alive)				gender (ref. cat.= male)	
Categories	both parent alive, one parent fair	single parent fair	both parent alive, one parent poor	single parent poor	Female	
SWEDEN	,292**	1,613**	,979**	1,330**	1,214**	
SPAIN	1,163**	,903**	1,096**	1,197**	,836**	
ITALY	,693**	1,262**	1,485**	1,054**	1,051**	
FRANCE	,801**	1,267**	,355*	1,016**	1,247**	
BELGIUM	1,004**	,902**	,454**	,877**	1,177**	
POLAND	,823**	,810**	,168*	,825**	1,121**	
VARIABLES	Quartile of distribution of monthly hours of informal care provided to parents/ in-laws (ref cat.: no informal care provided)				Financial transfer (ref. cat.= no financial transfer)	
Categories	Q1	Q2	Q3	Q4	give financial transfer to parent	receive financial transfer from parent
SWEDEN	,696**	1,274**	,637**	,493**	,886**	,532**
SPAIN	1,351**	,317*	,514**	,617**	3,274*	,387**
ITALY	,827**	1,355**	1,193**	1,160**	,588**	1,263**
FRANCE	,924**	0,152	,869**	,787**	,551**	1,841**
BELGIUM	,697**	1,164**	,641**	,896**	,987**	,512**
POLAND	0,096	,577**	,626**	,267*	,733**	1,318**

*=sig between 0.001 and 0.05, **= sig. more than 0.05.

Table 6: population between 50-65 years, wave 4

VARIABLES	Parents health status (ref. cat.= no parent alive)				gender (ref. cat.= male)	
Categories	both parent alive, one parent fair	single parent fair	both parent alive, one parent poor	single parent poor	Female	
SWEDEN	1,568**	,452**	2,109**	,219**	1,849**	
SPAIN	,685**	,888**	,290**	1,131**	1,064**	
ITALY	,417**	,749**	1,715**	1,383**	1,242**	
FRANCE	,909**	,872**	,712**	,950**	1,205**	
BELGIUM	,560**	1,157**	2,404**	,439**	1,566	
POLAND	,351**	,807**	,128*	2,062*		
VARIABLES	Frequency informal care provided to the parents / in-laws (ref cat.: no informal care provided)				Financial transfer (ref. cat.= no financial transfer)	
Categories	about once a month	Almost every month	Almost every week	Almost daily	give financial transfer to parent	receive financial transfer from parent
SWEDEN	-	-	,451**	,668**	2,159**	1,62**
SPAIN	,730**	,895**	,213**	,779**	,940**	,527**
ITALY	,943**	0,405*	1,583**	1,386**	2,234**	1,368**
FRANCE	,825**	,470**	,191**	,777**	1,116**	1,453**
BELGIUM	,675**	,578*	,322*	,799**	1,181**	,912**
POLAND	1,134**	,222**	,258**	4,343**	,620**	,856**

*=sig between 0.001 and 0.05, **= sig. more than 0.05.

B3. Outcomes of the regression analysis, for each countries examined and for both the categories under studies, wawe 1-2-4

BELGIUM, WAVE 1, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			34,596	6	0			
condlav_ricod(1)	1,109	0,3	14,128	1	0	3,031	1,7	5,403
condlav_ricod(2)	1,076	0,73	2,148	1	0,14	2,933	0,696	12,37
condlav_ricod(3)	0,995	0,19	26,68	1	0	2,704	1,854	3,944
condlav_ricod(4)	1,188	0,93	1,63	1	0,2	3,281	0,53	20,329
condlav_ricod(5)	3,024	1,1	7,595	1	0,01	20,57	2,395	176,736
condlav_ricod(6)	1,036	0,41	6,319	1	0,01	2,819	1,256	6,325
Qexpt_y_w1			103,52	4	0			
Qexpt_y_w1(1)	-1,39	0,66	4,461	1	0,04	0,248	0,068	0,904
Qexpt_y_w1(2)	-0,3	0,58	0,275	1	0,6	0,738	0,238	2,296
Qexpt_y_w1(3)	0,263	0,56	0,22	1	0,64	1,301	0,433	3,916
Qexpt_y_w1(4)	1,511	0,56	7,294	1	0,01	4,532	1,514	13,569
hh_infocare_ricod			7,177	4	0,13			
hh_infocare_ricod(1)	-0,66	0,26	6,589	1	0,01	0,519	0,315	0,856
hh_infocare_ricod(2)	-0,15	0,39	0,152	1	0,7	0,86	0,401	1,841
hh_infocare_ricod(3)	-0,24	0,29	0,678	1	0,41	0,787	0,446	1,391
hh_infocare_ricod(4)	-0,33	0,43	0,584	1	0,45	0,721	0,311	1,67
hhsize_cl			12,998	3	0,01			
hhsize_cl(1)	0,332	0,3	1,222	1	0,27	1,394	0,774	2,51
hhsize_cl(2)	1,206	0,38	10,116	1	0	3,34	1,589	7,022
hhsize_cl(3)	0,429	0,83	0,266	1	0,61	1,536	0,301	7,848
ltc_prob_w1			1,87	2	0,39			
ltc_prob_w1(1)	-0,29	0,25	1,386	1	0,24	0,745	0,457	1,216
ltc_prob_w1(2)	-0,26	0,27	0,899	1	0,34	0,775	0,457	1,313
hh_M_pub_bft_w1			6,236	2	0,04			
hh_M_pub_bft_w1(1)	-0,81	0,59	1,885	1	0,17	0,447	0,142	1,411
hh_M_pub_bft_w1(2)	-2,68	1,24	4,663	1	0,03	0,068	0,006	0,781
hh_M_hpr_w1			16,805	2	0			
hh_M_hpr_w1(1)	-0,57	0,21	7,172	1	0,01	0,564	0,371	0,858
hh_M_hpr_w1(2)	-1,19	0,33	13,108	1	0	0,306	0,161	0,581
gender_w1(1)	0,276	0,16	2,96	1	0,09	1,317	0,962	1,803
Costante	-3,22	0,66	24,042	1	0	0,04		

BELGIUM, WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
age_classi_w2			4,293	3	0,23			
age_classi_w2(1)	0,263	0,22	1,407	1	0,24	1,301	0,842	2,011
age_classi_w2(2)	0,31	0,23	1,817	1	0,18	1,363	0,869	2,139
age_classi_w2(3)	0,484	0,24	4,204	1	0,04	1,623	1,022	2,579
gender_w2(1)	0,358	0,17	4,598	1	0,03	1,43	1,031	1,984
Mhh_pub_bft_ltc			1,162	2	0,56			
Mhh_pub_bft_ltc(1)	-0,01	0,43	0,001	1	0,98	0,988	0,424	2,299
Mhh_pub_bft_ltc(2)	-1,03	0,96	1,16	1	0,28	0,356	0,054	2,332
pr_careM_w2			4,626	2	0,1			
pr_careM_w2(1)	-0,48	0,24	4,156	1	0,04	0,619	0,39	0,982
pr_careM_w2(2)	-0,47	0,35	1,811	1	0,18	0,627	0,317	1,238
Qtotcarexp_y			72,57	4	0			
Qtotcarexp_y(1)	-0,43	0,45	0,906	1	0,34	0,654	0,272	1,568
Qtotcarexp_y(2)	-0,18	0,44	0,172	1	0,68	0,832	0,349	1,981
Qtotcarexp_y(3)	0,572	0,43	1,758	1	0,19	1,772	0,761	4,126
Qtotcarexp_y(4)	1,463	0,43	11,35	1	0	4,321	1,844	10,123
hh_size4cat			46,79	3	0			
hh_size4cat(1)	1,534	0,3	26,13	1	0	4,635	2,574	8,344
hh_size4cat(2)	2,676	0,4	45,48	1	0	14,53	6,677	31,639
hh_size4cat(3)	1,872	0,95	3,905	1	0,05	6,504	1,015	41,668
hh_infocare4cat			9,84	5	0,08			
hh_infocare4cat(1)	0,027	0,26	0,011	1	0,92	1,028	0,621	1,7
hh_infocare4cat(2)	-0,41	0,43	0,913	1	0,34	0,665	0,288	1,535
hh_infocare4cat(3)	-0,69	0,34	4,062	1	0,04	0,5	0,254	0,981
hh_infocare4cat(4)	-1,22	0,47	6,596	1	0,01	0,296	0,117	0,749
hh_infocare4cat(5)	-0,38	0,3	1,646	1	0,2	0,685	0,384	1,221
ricod_cond_lav_1			79,52	7	0			
ricod_cond_lav_1(1)	1,776	0,32	31,12	1	0	5,909	3,165	11,029
ricod_cond_lav_1(2)	0,584	0,64	0,838	1	0,36	1,793	0,514	6,262
ricod_cond_lav_1(3)	2,286	0,79	8,465	1	0	9,832	2,108	45,852
ricod_cond_lav_1(4)	1,141	0,91	1,586	1	0,21	3,131	0,53	18,499
ricod_cond_lav_1(5)	1,414	0,21	45,19	1	0	4,111	2,722	6,208
ricod_cond_lav_1(6)	2,67	0,37	52,5	1	0	14,44	7,013	29,738
ricod_cond_lav_1(7)	2,589	0,5	27,09	1	0	13,32	5,023	35,299
ltc_prob_w2			1,935	2	0,38			
ltc_prob_w2(1)	-0,29	0,31	0,879	1	0,35	0,746	0,404	1,377
ltc_prob_w2(2)	0,105	0,29	0,128	1	0,72	1,11	0,625	1,972
private_ltc_service_w2(1)	0,968	0,75	1,688	1	0,19	2,633	0,611	11,341
Costante	-4,62	0,59	61,87	1	0	0,01		

BELGIUM, WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hhsize_cl_w4			100,42	3	0			
hhsize_cl_w4(1)	1,578	0,24	45,233	1	0	4,845	3,059	7,675
hhsize_cl_w4(2)	2,608	0,31	73,202	1	0	13,569	7,466	24,66
hhsize_cl_w4(3)	3,584	0,48	56,912	1	0	36,004	14,191	91,348
age_clas_over65			18,076	3	0			
age_clas_over65(1)	0,379	0,2	3,788	1	0,05	1,46	0,997	2,139
age_clas_over65(2)	0,697	0,19	12,917	1	0	2,007	1,373	2,934
age_clas_over65(3)	0,739	0,19	14,665	1	0	2,094	1,434	3,056
ltc_prob_w4			6,195	2	0,05			
ltc_prob_w4(1)	-0,26	0,23	1,273	1	0,26	0,773	0,494	1,209
ltc_prob_w4(2)	0,277	0,2	1,959	1	0,16	1,32	0,895	1,946
hh_infocare_w4			7,723	7	0,36			
hh_infocare_w4(1)	-0,59	0,32	3,443	1	0,06	0,556	0,299	1,034
hh_infocare_w4(2)	-0,49	0,29	2,975	1	0,09	0,611	0,349	1,069
hh_infocare_w4(3)	0,166	0,31	0,291	1	0,59	1,18	0,647	2,154
hh_infocare_w4(4)	-0,04	0,23	0,025	1	0,88	0,965	0,621	1,5
hh_infocare_w4(5)	-0,11	0,66	0,026	1	0,87	0,899	0,245	3,299
hh_infocare_w4(6)	-0,13	0,42	0,092	1	0,76	0,882	0,391	1,987
hh_infocare_w4(7)	-0,37	0,44	0,698	1	0,4	0,692	0,291	1,643
Mhh_pub_bft_ltc_w4			0,938	2	0,63			
Mhh_pub_bft_ltc_w4(1)	-0,17	0,29	0,336	1	0,56	0,846	0,481	1,488
Mhh_pub_bft_ltc_w4(2)	0,426	0,6	0,499	1	0,48	1,532	0,47	4,996
condlav_ricod			226,12	9	0			
condlav_ricod(1)	0,896	0,22	17,417	1	0	2,45	1,608	3,731
condlav_ricod(2)	-1,21	0,75	2,568	1	0,11	0,299	0,068	1,309
condlav_ricod(3)	-0,21	0,82	0,065	1	0,8	0,812	0,164	4,025
condlav_ricod(4)	1,339	0,57	5,458	1	0,02	3,815	1,241	11,731
condlav_ricod(5)	1,304	0,16	70,624	1	0	3,683	2,718	4,992
condlav_ricod(6)	1,226	0,86	2,049	1	0,15	3,407	0,636	18,246
condlav_ricod(7)	1,037	0,33	9,844	1	0	2,821	1,476	5,393
condlav_ricod(8)	1,748	1,2	2,117	1	0,15	5,741	0,545	60,44
condlav_ricod(9)	4,895	0,39	158,84	1	0	133,66	62,428	286,164
no_infocare(1)	0,374	0,21	3,275	1	0,07	1,453	0,969	2,177
gender_w4(1)	0,157	0,13	1,524	1	0,22	1,17	0,912	1,502
Costante	-4,34	0,32	189,66	1	0	0,013		

BELGIUM, WAVE 1, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			194,148	15	0			
condlav_ricod(1)	1,702	0,467	13,3	1	0	5,487	2,198	13,7
condlav_ricod(2)	0,834	0,509	2,68	1	0,102	2,302	0,848	6,244
condlav_ricod(3)	2,819	0,482	34,148	1	0	16,759	6,511	43,137
condlav_ricod(4)	2,216	0,6	13,641	1	0	9,175	2,83	29,744
condlav_ricod(5)	2,851	0,39	53,478	1	0	17,303	8,059	37,15
condlav_ricod(6)	0,547	0,455	1,443	1	0,23	1,727	0,708	4,215
condlav_ricod(7)	1,762	0,456	14,963	1	0	5,827	2,386	14,232
condlav_ricod(8)	0,433	0,792	0,299	1	0,585	1,542	0,327	7,273
condlav_ricod(9)	0,959	0,659	2,118	1	0,146	2,609	0,717	9,493
condlav_ricod(10)	0,921	0,462	3,97	1	0,046	2,512	1,015	6,218
condlav_ricod(11)	3,406	0,615	30,618	1	0	30,133	9,019	100,675
condlav_ricod(12)	3,724	0,448	69,173	1	0	41,435	17,228	99,659
condlav_ricod(13)	3,483	0,403	74,893	1	0	32,57	14,798	71,686
condlav_ricod(14)	1,833	0,504	13,255	1	0	6,254	2,331	16,778
condlav_ricod(15)	2,738	0,463	35,002	1	0	15,45	6,238	38,265
gender_w1(1)	0,192	0,156	1,507	1	0,22	1,211	0,892	1,646
salute_gen_individ			2,849	4	0,583			
salute_gen_individ(1)	0,16	0,489	0,107	1	0,743	1,174	0,45	3,059
salute_gen_individ(2)	-0,227	0,271	0,703	1	0,402	0,797	0,469	1,355
salute_gen_individ(3)	-0,597	0,461	1,68	1	0,195	0,55	0,223	1,358
salute_gen_individ(4)	-0,205	0,264	0,603	1	0,437	0,815	0,486	1,367
Q_infocare_dato_w1			4,026	4	0,402			
Q_infocare_dato_w1(1)	0,032	0,327	0,01	1	0,922	1,033	0,543	1,962
Q_infocare_dato_w1(2)	0,23	0,342	0,451	1	0,502	1,258	0,643	2,463
Q_infocare_dato_w1(3)	-0,552	0,364	2,302	1	0,129	0,576	0,282	1,175
Q_infocare_dato_w1(4)	0,253	0,269	0,885	1	0,347	1,288	0,761	2,18
n_fratelli_cl			3,657	5	0,6			
n_fratelli_cl(1)	0,152	0,267	0,325	1	0,569	1,164	0,69	1,964
n_fratelli_cl(2)	0,253	0,27	0,877	1	0,349	1,288	0,758	2,188
n_fratelli_cl(3)	0,307	0,292	1,107	1	0,293	1,36	0,767	2,41
n_fratelli_cl(4)	0,152	0,269	0,318	1	0,573	1,164	0,687	1,973
n_fratelli_cl(5)	0,568	0,327	3,021	1	0,082	1,764	0,93	3,347
hhsize_cl			19,08	4	0,001			
hhsize_cl(1)	-0,34	0,266	1,636	1	0,201	0,712	0,423	1,198
hhsize_cl(2)	-0,23	0,294	0,612	1	0,434	0,794	0,446	1,414
hhsize_cl(3)	0,513	0,326	2,483	1	0,115	1,671	0,882	3,163
hhsize_cl(4)	2,748	1,121	6,004	1	0,014	15,604	1,733	140,503
age_clas			2,344	3	0,504			
age_clas(1)	0,189	0,338	0,312	1	0,577	1,208	0,623	2,343
age_clas(2)	-0,113	0,346	0,106	1	0,745	0,894	0,454	1,759
age_clas(3)	-0,021	0,371	0,003	1	0,955	0,979	0,474	2,024
ftgiv_w1(1)	-0,139	0,577	0,058	1	0,809	0,87	0,281	2,695
ftrec_w1(1)	0,262	0,49	0,287	1	0,592	1,3	0,497	3,397
Costante	-4,049	0,572	50,182	1	0	0,017		

BELGIUM, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
ricod_cond_lav			150,024	18	0			
ricod_cond_lav(1)	1,512	0,397	14,508	1	0	4,534	2,083	9,868
ricod_cond_lav(2)	0,112	0,339	0,109	1	0,741	1,119	0,575	2,175
ricod_cond_lav(3)	1,535	0,42	13,331	1	0	4,642	2,036	10,583
ricod_cond_lav(4)	0,944	0,539	3,069	1	0,08	2,571	0,894	7,392
ricod_cond_lav(5)	0,641	0,33	3,768	1	0,052	1,898	0,994	3,626
ricod_cond_lav(6)	1,357	0,328	17,057	1	0	3,883	2,04	7,392
ricod_cond_lav(7)	-0,149	0,416	0,128	1	0,72	0,862	0,381	1,947
ricod_cond_lav(8)	0,373	0,407	0,842	1	0,359	1,452	0,655	3,222
ricod_cond_lav(9)	0,772	0,37	4,342	1	0,037	2,163	1,047	4,471
ricod_cond_lav(10)	0,897	0,274	10,732	1	0,001	2,451	1,434	4,191
ricod_cond_lav(11)	2,312	0,533	18,831	1	0	10,099	3,554	28,701
ricod_cond_lav(12)	0,487	0,803	0,368	1	0,544	1,628	0,337	7,861
ricod_cond_lav(13)	4,323	0,588	54,113	1	0	75,402	23,833	238,556
ricod_cond_lav(14)	2,612	0,384	46,313	1	0	13,627	6,422	28,913
ricod_cond_lav(15)	2,241	0,402	31,036	1	0	9,4	4,273	20,678
ricod_cond_lav(16)	2,661	0,504	27,826	1	0	14,307	5,323	38,449
ricod_cond_lav(17)	0,598	0,822	0,528	1	0,467	1,818	0,363	9,111
ricod_cond_lav(18)	2,819	0,473	35,528	1	0	16,763	6,634	42,358
gender_w2(1)	0,163	0,149	1,2	1	0,273	1,177	0,879	1,575
salute_gen_individ			1,997	4	0,736			
salute_gen_individ(1)	0,004	0,348	0	1	0,99	1,004	0,508	1,985
salute_gen_individ(2)	-0,103	0,236	0,19	1	0,663	0,902	0,567	1,434
salute_gen_individ(3)	-0,789	0,59	1,789	1	0,181	0,454	0,143	1,444
salute_gen_individ(4)	-0,131	0,359	0,134	1	0,715	0,877	0,433	1,774
Q_infocare_dato			3,556	4	0,469			
Q_infocare_dato(1)	-0,361	0,311	1,349	1	0,245	0,697	0,379	1,282
Q_infocare_dato(2)	0,152	0,277	0,301	1	0,583	1,164	0,676	2,004
Q_infocare_dato(3)	-0,445	0,331	1,809	1	0,179	0,641	0,335	1,226
Q_infocare_dato(4)	-0,11	0,303	0,132	1	0,716	0,896	0,495	1,621
n_fratelli_cl			3,712	5	0,592			
n_fratelli_cl(1)	-0,289	0,239	1,468	1	0,226	0,749	0,469	1,196
n_fratelli_cl(2)	-0,129	0,239	0,293	1	0,588	0,879	0,55	1,404
n_fratelli_cl(3)	-0,395	0,273	2,093	1	0,148	0,674	0,395	1,15
n_fratelli_cl(4)	-0,084	0,235	0,127	1	0,722	0,92	0,58	1,459
n_fratelli_cl(5)	-0,408	0,354	1,33	1	0,249	0,665	0,333	1,33
hhsize_cl			57,134	4	0			
hhsize_cl(1)	0,883	0,287	9,469	1	0,002	2,419	1,378	4,246
hhsize_cl(2)	1,536	0,319	23,19	1	0	4,647	2,487	8,683
hhsize_cl(3)	2,284	0,353	41,963	1	0	9,811	4,917	19,578
hhsize_cl(4)	3,646	1,118	10,629	1	0,001	38,315	4,28	342,968
age_clas			3,883	3	0,274			
age_clas(1)	0,171	0,331	0,268	1	0,605	1,187	0,62	2,272
age_clas(2)	0,287	0,343	0,7	1	0,403	1,333	0,68	2,612
age_clas(3)	0,574	0,37	2,405	1	0,121	1,775	0,86	3,667
ft_giv_cat(1)	-0,013	0,625	0	1	0,983	0,987	0,29	3,357
ft_rec_cat(1)	-0,669	0,603	1,232	1	0,267	0,512	0,157	1,669
Costante	-3,848	0,493	60,87	1	0	0,021		

BELGIUM, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod_1			277,29	18	0			
condlav_ricod_1(1)	2,162	0,375	33,177	1	0	8,685	4,162	18,123
condlav_ricod_1(2)	0,046	0,438	0,011	1	0,916	1,047	0,443	2,473
condlav_ricod_1(3)	2,531	0,404	39,185	1	0	12,568	5,69	27,761
condlav_ricod_1(4)	2,357	0,288	66,755	1	0	10,557	5,998	18,582
condlav_ricod_1(5)	1,395	0,293	22,652	1	0	4,034	2,271	7,165
condlav_ricod_1(6)	0,397	0,523	0,576	1	0,448	1,487	0,534	4,147
condlav_ricod_1(7)	1,795	0,332	29,24	1	0	6,02	3,141	11,54
condlav_ricod_1(8)	1,274	0,389	10,729	1	0,001	3,575	1,668	7,66
condlav_ricod_1(9)	1,907	0,286	44,593	1	0	6,735	3,848	11,788
condlav_ricod_1(10)	4,026	0,539	55,724	1	0	56,055	19,476	161,336
condlav_ricod_1(11)	1,253	0,825	2,307	1	0,129	3,5	0,695	17,626
condlav_ricod_1(12)	4,731	0,471	100,883	1	0	113,454	45,066	285,621
condlav_ricod_1(13)	3,297	0,339	94,753	1	0	27,021	13,913	52,479
condlav_ricod_1(14)	1,418	0,83	2,92	1	0,088	4,128	0,812	20,989
condlav_ricod_1(15)	4,088	0,496	67,907	1	0	59,641	22,555	157,706
condlav_ricod_1(16)	2,644	0,455	33,79	1	0	14,066	5,768	34,299
condlav_ricod_1(17)	3,65	0,335	119	1	0	38,461	19,964	74,098
condlav_ricod_1(18)	3,731	0,496	56,667	1	0	41,725	15,794	110,226
gender_w4(1)	0,449	0,141	10,057	1	0,002	1,566	1,187	2,067
ftgiv_w4(1)	0,166	0,662	0,063	1	0,802	1,181	0,323	4,323
ftrec_w4(1)	-0,092	0,366	0,063	1	0,801	0,912	0,445	1,868
n_fratelli_cl_w4			1,972	5	0,853			
n_fratelli_cl_w4(1)	-0,052	0,239	0,048	1	0,827	0,949	0,594	1,515
n_fratelli_cl_w4(2)	-0,002	0,237	0	1	0,993	0,998	0,628	1,586
n_fratelli_cl_w4(3)	0,201	0,25	0,644	1	0,422	1,222	0,749	1,995
n_fratelli_cl_w4(4)	0,11	0,234	0,22	1	0,639	1,116	0,706	1,766
n_fratelli_cl_w4(5)	0,189	0,298	0,404	1	0,525	1,209	0,674	2,167
infocare_dato_hh_w4			10,24	4	0,037			
infocare_dato_hh_w4(1)	-0,393	0,329	1,426	1	0,232	0,675	0,355	1,286
infocare_dato_hh_w4(2)	-0,547	0,26	4,435	1	0,035	0,578	0,348	0,963
infocare_dato_hh_w4(3)	-1,133	0,485	5,446	1	0,02	0,322	0,124	0,834
infocare_dato_hh_w4(4)	-0,225	0,376	0,358	1	0,55	0,799	0,382	1,668
age_clas_w4			1,47	3	0,689			
age_clas_w4(1)	-0,063	0,34	0,035	1	0,853	0,939	0,482	1,828
age_clas_w4(2)	0,123	0,35	0,124	1	0,725	1,131	0,57	2,244
age_clas_w4(3)	0,158	0,37	0,183	1	0,669	1,171	0,568	2,417
hh_size_ricod			169,369	3	0			
hh_size_ricod(1)	0,639	0,24	7,119	1	0,008	1,895	1,185	3,031
hh_size_ricod(2)	1,583	0,266	35,542	1	0	4,871	2,894	8,198
hh_size_ricod(3)	3,08	0,283	118,213	1	0	21,752	12,485	37,897
salute_gen_individ			7,708	4	0,103			
salute_gen_individ(1)	-0,58	0,502	1,335	1	0,248	0,56	0,209	1,498
salute_gen_individ(2)	0,146	0,275	0,282	1	0,595	1,157	0,675	1,983
salute_gen_individ(3)	0,877	0,489	3,221	1	0,073	2,404	0,922	6,265
salute_gen_individ(4)	-0,824	0,517	2,544	1	0,111	0,439	0,159	1,208
Costante	-5,32	0,485	120,197	1	0	0,005		

FRANCE, WAVE 1, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			18,31	4	0			
condlav_ricod(1)	0,219	0,35	0,404	1	0,53	1,245	0,634	2,446
condlav_ricod(2)	1,292	0,79	2,644	1	0,1	3,639	0,767	17,269
condlav_ricod(3)	0,845	0,29	8,559	1	0	2,327	1,322	4,099
condlav_ricod(4)	1,135	0,43	6,839	1	0,01	3,111	1,329	7,282
Qexpt_y_w1			9,546	4	0,05			
Qexpt_y_w1(1)	-1,12	0,49	5,356	1	0,02	0,326	0,126	0,842
Qexpt_y_w1(2)	-0,58	0,35	2,681	1	0,1	0,561	0,281	1,121
Qexpt_y_w1(3)	-0,41	0,33	1,52	1	0,22	0,662	0,344	1,275
Qexpt_y_w1(4)	0,125	0,27	0,218	1	0,64	1,133	0,671	1,912
hh_infocare_w1			4,954	5	0,42			
hh_infocare_w1(1)	0,4	0,31	1,65	1	0,2	1,491	0,81	2,745
hh_infocare_w1(2)	0,068	0,58	0,014	1	0,91	1,071	0,343	3,341
hh_infocare_w1(3)	0,455	0,37	1,528	1	0,22	1,576	0,766	3,243
hh_infocare_w1(4)	-0,18	0,82	0,049	1	0,83	0,835	0,169	4,13
hh_infocare_w1(5)	1,122	0,64	3,053	1	0,08	3,072	0,872	10,823
hhsize_ricod			44,09	3	0			
hhsize_ricod(1)	-0,12	0,37	0,113	1	0,74	0,885	0,433	1,809
hhsize_ricod(2)	1,014	0,45	5,098	1	0,02	2,756	1,143	6,646
hhsize_ricod(3)	2,452	0,48	25,89	1	0	11,62	4,517	29,877
ltc_prob_w1			1,177	2	0,56			
ltc_prob_w1(1)	0,357	0,36	0,993	1	0,32	1,429	0,708	2,883
ltc_prob_w1(2)	0,285	0,33	0,749	1	0,39	1,33	0,697	2,537
hh_M_pub_bft_w1			0,581	2	0,75			
hh_M_pub_bft_w1(1)	-0,2	0,81	0,063	1	0,8	0,817	0,167	3,997
hh_M_pub_bft_w1(2)	-0,57	0,77	0,551	1	0,46	0,565	0,125	2,553
hh_M_hpr_w1			1,726	2	0,42			
hh_M_hpr_w1(1)	0,314	0,24	1,725	1	0,19	1,369	0,857	2,187
hh_M_hpr_w1(2)	0,174	0,4	0,193	1	0,66	1,191	0,547	2,591
gender_w1(1)	-0,03	0,22	0,018	1	0,89	0,971	0,638	1,479
private_ltc_service_w1(1)	-0,04	0,43	0,007	1	0,93	0,964	0,417	2,229
no_infocare_w1(1)	-0,3	0,39	0,577	1	0,45	0,742	0,343	1,603
Costante	-2,86	0,42	46,23	1	0	0,057		

FRANCE, WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
gender_w2(1)	0,386	0,24	2,664	1	0,1	1,472	0,925	2,34
age_classi_w2			1,585	3	0,66			
age_classi_w2(1)	0,329	0,29	1,252	1	0,26	1,389	0,781	2,47
age_classi_w2(2)	0,028	0,32	0,008	1	0,93	1,029	0,553	1,915
age_classi_w2(3)	0,107	0,31	0,116	1	0,73	1,113	0,602	2,057
hhsize_w2			44,35	3	0			
hhsize_w2(1)	-0,57	0,38	2,294	1	0,13	0,567	0,272	1,182
hhsize_w2(2)	1,276	0,53	5,723	1	0,02	3,582	1,259	10,188
hhsize_w2(3)	2,847	0,61	21,5	1	0	17,23	5,172	57,387
hh_infocare_prova			5,721	5	0,33			
hh_infocare_prova(1)	0,699	0,32	4,791	1	0,03	2,012	1,076	3,763
hh_infocare_prova(2)	0,488	0,61	0,645	1	0,42	1,629	0,495	5,358
hh_infocare_prova(3)	0,521	0,45	1,34	1	0,25	1,683	0,697	4,063
hh_infocare_prova(4)	-0,24	1,08	0,048	1	0,83	0,789	0,095	6,557
hh_infocare_prova(5)	0,588	0,38	2,341	1	0,13	1,8	0,848	3,822
Mhh_pub_bft			0,165	2	0,92			
Mhh_pub_bft(1)	-0,07	0,69	0,011	1	0,92	0,932	0,244	3,564
Mhh_pub_bft(2)	0,447	1,14	0,154	1	0,7	1,563	0,168	14,585
pr_careM_w2			0,336	2	0,85			
pr_careM_w2(1)	-0,12	0,28	0,178	1	0,67	0,889	0,514	1,538
pr_careM_w2(2)	-0,21	0,43	0,246	1	0,62	0,809	0,35	1,869
Q_spesecare_y			21,12	4	0			
Q_spesecare_y(1)	-1,64	0,5	10,86	1	0	0,195	0,074	0,516
Q_spesecare_y(2)	-1,32	0,47	8,055	1	0,01	0,268	0,108	0,665
Q_spesecare_y(3)	0,122	0,23	0,284	1	0,59	1,13	0,721	1,772
Q_spesecare_y(4)	0,802	0,74	1,174	1	0,28	2,23	0,523	9,513
prova_condlav			24,65	7	0			
prova_condlav(1)	0,52	0,37	2,017	1	0,16	1,682	0,821	3,445
prova_condlav(2)	-1,78	1,12	2,526	1	0,11	0,169	0,019	1,514
prova_condlav(3)	2,901	1,21	5,768	1	0,02	18,19	1,705	194,116
prova_condlav(4)	1,318	1,12	1,375	1	0,24	3,736	0,413	33,821
prova_condlav(5)	0,506	0,4	1,641	1	0,2	1,659	0,765	3,6
prova_condlav(6)	1,154	0,87	1,765	1	0,18	3,171	0,578	17,397
prova_condlav(7)	1,598	0,47	11,62	1	0	4,941	1,972	12,382
ltc_prob_w2			2,3	2	0,32			
ltc_prob_w2(1)	-0,09	0,37	0,059	1	0,81	0,913	0,439	1,901
ltc_prob_w2(2)	-0,57	0,4	2,023	1	0,16	0,566	0,258	1,24
private_ltc_service_w2(1)	-0,24	0,62	0,149	1	0,7	0,788	0,235	2,645
Costante	-2,78	0,46	36,51	1	0	0,062		

FRANCE, WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hhsize_cl_w4			43,471	4	0			
hhsize_cl_w4(1)	0,323	0,18	3,247	1	0,07	1,382	0,972	1,964
hhsize_cl_w4(2)	1,324	0,27	23,309	1	0	3,757	2,195	6,43
hhsize_cl_w4(3)	1,721	0,38	20,941	1	0	5,588	2,674	11,675
hhsize_cl_w4(4)	2,712	1,22	4,969	1	0,03	15,07	1,388	163,594
age_clas_over65			27,2	3	0			
age_clas_over65(1)	0,313	0,16	3,806	1	0,05	1,368	0,999	1,873
age_clas_over65(2)	0,659	0,16	17,684	1	0	1,932	1,422	2,627
age_clas_over65(3)	0,719	0,15	22,037	1	0	2,052	1,52	2,77
ltc_prob_w4			3,641	2	0,16			
ltc_prob_w4(1)	-0,05	0,18	0,073	1	0,79	0,952	0,668	1,358
ltc_prob_w4(2)	0,245	0,16	2,293	1	0,13	1,277	0,93	1,753
hh_infocare_w4			19,137	7	0,01			
hh_infocare_w4(1)	-0,51	0,27	3,537	1	0,06	0,599	0,352	1,022
hh_infocare_w4(2)	0,054	0,19	0,085	1	0,77	1,056	0,735	1,517
hh_infocare_w4(3)	0,259	0,24	1,121	1	0,29	1,295	0,802	2,09
hh_infocare_w4(4)	0,616	0,18	12,054	1	0	1,852	1,308	2,622
hh_infocare_w4(5)	0,271	0,5	0,29	1	0,59	1,312	0,488	3,522
hh_infocare_w4(6)	0,054	0,34	0,025	1	0,88	1,055	0,542	2,054
hh_infocare_w4(7)	0,039	0,37	0,011	1	0,92	1,04	0,502	2,153
Mhh_pub_bft_ltc_w4			2,91	2	0,23			
Mhh_pub_bft_ltc_w4(1)	-0,2	0,26	0,591	1	0,44	0,818	0,49	1,366
Mhh_pub_bft_ltc_w4(2)	0,702	0,47	2,241	1	0,13	2,019	0,805	5,064
condlav_ricod			67,935	9	0			
condlav_ricod(1)	0,515	0,18	8,624	1	0	1,673	1,187	2,359
condlav_ricod(2)	-0,79	0,4	3,902	1	0,05	0,456	0,209	0,994
condlav_ricod(3)	-1,75	1,06	2,724	1	0,1	0,175	0,022	1,387
condlav_ricod(4)	0,584	0,19	10,032	1	0	1,794	1,25	2,576
condlav_ricod(5)	0,773	0,61	1,606	1	0,21	2,167	0,655	7,164
condlav_ricod(6)	1,885	1,3	2,09	1	0,15	6,59	0,511	84,92
condlav_ricod(7)	0,743	0,74	1,015	1	0,31	2,102	0,496	8,917
condlav_ricod(8)	1,189	0,27	19,145	1	0	3,284	1,928	5,594
condlav_ricod(9)	4,572	0,75	37,032	1	0	96,75	22,188	421,893
no_infocare(1)	0,231	0,18	1,687	1	0,19	1,26	0,889	1,784
gender_w4(1)	0,119	0,1	1,357	1	0,24	1,127	0,922	1,377
Costante	-2,52	0,24	115,01	1	0	0,08		

FRANCE, WAVE 1, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			161,981	15	0			
condlav_ricod(1)	1,53	0,48	9,98	1	0	4,619	1,788	11,938
condlav_ricod(2)	0,669	0,53	1,615	1	0,2	1,953	0,696	5,481
condlav_ricod(3)	1,43	0,84	2,887	1	0,09	4,177	0,803	21,731
condlav_ricod(4)	2,042	0,83	6,11	1	0,01	7,707	1,526	38,913
condlav_ricod(5)	2,355	0,43	30,332	1	0	10,536	4,557	24,356
condlav_ricod(6)	0,876	0,41	4,535	1	0,03	2,4	1,072	5,373
condlav_ricod(7)	0,699	0,59	1,387	1	0,24	2,011	0,629	6,43
condlav_ricod(8)	2,424	0,45	29,438	1	0	11,289	4,703	27,097
condlav_ricod(9)	2,822	0,51	31,263	1	0	16,807	6,25	45,192
condlav_ricod(10)	1,224	0,41	8,937	1	0	3,402	1,524	7,592
condlav_ricod(11)	3,473	0,48	52,933	1	0	32,218	12,643	82,106
condlav_ricod(12)	4,857	0,62	60,744	1	0	128,6	37,916	436,184
condlav_ricod(13)	2,899	0,59	23,946	1	0	18,157	5,685	57,989
condlav_ricod(14)	4,654	0,65	52,07	1	0	105,03	29,669	371,831
condlav_ricod(15)	2,472	0,45	30,128	1	0	11,841	4,899	28,62
gender_w1(1)	0,268	0,19	1,949	1	0,16	1,307	0,898	1,903
salute_gen_individ			4,127	4	0,39			
salute_gen_individ(1)	-1,99	1,05	3,553	1	0,06	0,137	0,017	1,082
salute_gen_individ(2)	0,189	0,31	0,38	1	0,54	1,208	0,663	2,2
salute_gen_individ(3)	0	0,39	0	1	1	1	0,468	2,139
salute_gen_individ(4)	0,088	0,28	0,099	1	0,75	1,092	0,631	1,891
Q_infocare_dato_w1			3,353	4	0,5			
Q_infocare_dato_w1(1)	0,227	0,43	0,277	1	0,6	1,255	0,539	2,923
Q_infocare_dato_w1(2)	-0,51	0,46	1,212	1	0,27	0,601	0,243	1,487
Q_infocare_dato_w1(3)	-0,63	0,47	1,8	1	0,18	0,531	0,21	1,339
Q_infocare_dato_w1(4)	-0,17	0,47	0,124	1	0,72	0,847	0,337	2,128
hhsize_cl			104,959	4	0			
hhsize_cl(1)	-1,41	0,34	16,899	1	0	0,244	0,124	0,478
hhsize_cl(2)	-0,5	0,37	1,809	1	0,18	0,608	0,294	1,256
hhsize_cl(3)	1,187	0,35	11,691	1	0	3,276	1,659	6,468
hhsize_cl(4)	2,463	0,67	13,621	1	0	11,743	3,174	43,44
age_clas			4,229	3	0,24			
age_clas(1)	-0,31	0,3	1,056	1	0,3	0,734	0,407	1,324
age_clas(2)	-0,25	0,33	0,552	1	0,46	0,782	0,409	1,495
age_clas(3)	0,212	0,39	0,295	1	0,59	1,237	0,574	2,663
ftgiv_w1(1)	-1,95	0,61	10,366	1	0	0,142	0,043	0,466
ftrec_w1(1)	-0,74	0,66	1,268	1	0,26	0,479	0,133	1,726
Costante	-3,37	0,53	41,036	1	0	0,034		

FRANCE, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
ricod_cond_lav			163,23	16	0			
ricod_cond_lav(1)	2,225	0,468	22,63	1	0	9,252	3,699	23,137
ricod_cond_lav(2)	0,528	0,475	1,235	1	0,266	1,696	0,668	4,306
ricod_cond_lav(3)	1,582	0,812	3,8	1	0,051	4,865	0,991	23,87
ricod_cond_lav(4)	1,922	0,738	6,781	1	0,009	6,837	1,609	29,054
ricod_cond_lav(5)	2,507	0,378	43,874	1	0	12,264	5,841	25,748
ricod_cond_lav(6)	1,504	0,358	17,611	1	0	4,501	2,229	9,087
ricod_cond_lav(7)	0,914	0,531	2,956	1	0,086	2,493	0,88	7,063
ricod_cond_lav(8)	1,516	0,469	10,438	1	0,001	4,554	1,815	11,426
ricod_cond_lav(9)	3,132	0,416	56,673	1	0	22,912	10,138	51,78
ricod_cond_lav(10)	2,342	0,341	47,035	1	0	10,4	5,326	20,308
ricod_cond_lav(11)	3,262	0,641	25,921	1	0	26,111	7,437	91,676
ricod_cond_lav(12)	4,262	0,55	60,045	1	0	70,951	24,143	208,512
ricod_cond_lav(13)	3,635	1,091	11,109	1	0,001	37,889	4,47	321,18
ricod_cond_lav(14)	4,168	0,691	36,402	1	0	64,611	16,681	250,259
ricod_cond_lav(15)	3,414	0,536	40,529	1	0	30,401	10,626	86,983
ricod_cond_lav(16)	3,249	0,522	38,818	1	0	25,77	9,273	71,619
gender_w2(1)	0,221	0,183	1,454	1	0,228	1,247	0,871	1,784
salute_gen_individ			5,991	4	0,2			
salute_gen_individ(1)	-0,221	0,395	0,314	1	0,575	0,801	0,369	1,739
salute_gen_individ(2)	0,237	0,261	0,822	1	0,365	1,267	0,759	2,114
salute_gen_individ(3)	-1,037	0,497	4,347	1	0,037	0,355	0,134	0,94
salute_gen_individ(4)	0,016	0,308	0,003	1	0,959	1,016	0,556	1,857
Q_infocare_dato			8,786	4	0,067			
Q_infocare_dato(1)	-0,079	0,405	0,038	1	0,845	0,924	0,418	2,042
Q_infocare_dato(2)	-1,885	0,647	8,496	1	0,004	0,152	0,043	0,539
Q_infocare_dato(3)	-0,14	0,376	0,139	1	0,709	0,869	0,416	1,816
Q_infocare_dato(4)	-0,24	0,422	0,323	1	0,57	0,787	0,344	1,799
n_fratelli_cl			2,185	5	0,823			
n_fratelli_cl(1)	0	0,33	0	1	0,999	1	0,524	1,909
n_fratelli_cl(2)	-0,268	0,314	0,726	1	0,394	0,765	0,413	1,416
n_fratelli_cl(3)	0,384	0,379	1,028	1	0,311	1,468	0,699	3,083
n_fratelli_cl(4)	0,139	0,303	0,21	1	0,647	1,149	0,634	2,081
n_fratelli_cl(5)	0,047	0,404	0,014	1	0,907	1,048	0,475	2,312
hhsize_cl			69,372	4	0			
hhsize_cl(1)	-0,48	0,312	2,36	1	0,124	0,619	0,335	1,142
hhsize_cl(2)	0,393	0,365	1,159	1	0,282	1,482	0,724	3,03
hhsize_cl(3)	1,468	0,355	17,138	1	0	4,342	2,166	8,7
hhsize_cl(4)	2,391	0,73	10,712	1	0,001	10,92	2,609	45,705
age_clas			5,258	3	0,154			
age_clas(1)	0,112	0,284	0,156	1	0,693	1,119	0,641	1,953
age_clas(2)	0,015	0,317	0,002	1	0,962	1,015	0,545	1,891
age_clas(3)	-0,573	0,394	2,115	1	0,146	0,564	0,26	1,221
ft_giv_cat(1)	-0,596	0,49	1,48	1	0,224	0,551	0,211	1,439
ft_rec_cat(1)	0,61	0,452	1,822	1	0,177	1,841	0,759	4,466
Costante	-3,75	0,506	54,992	1	0	0,024		

FRANCE, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod_1			206,542	16	0			
condlav_ricod_1(1)	1,422	0,292	23,668	1	0	4,146	2,338	7,352
condlav_ricod_1(2)	0,536	0,218	6,044	1	0,014	1,709	1,115	2,62
condlav_ricod_1(3)	1,163	0,426	7,474	1	0,006	3,201	1,39	7,369
condlav_ricod_1(4)	2,04	0,368	30,658	1	0	7,691	3,736	15,835
condlav_ricod_1(5)	1,91	0,267	51,327	1	0	6,755	4,006	11,392
condlav_ricod_1(6)	1,07	0,223	23,032	1	0	2,914	1,883	4,511
condlav_ricod_1(7)	1,14	0,261	19,072	1	0	3,126	1,874	5,215
condlav_ricod_1(8)	1,167	0,258	20,384	1	0	3,212	1,935	5,331
condlav_ricod_1(9)	0,983	0,298	10,903	1	0,001	2,671	1,491	4,787
condlav_ricod_1(10)	1,823	0,251	52,862	1	0	6,192	3,788	10,123
condlav_ricod_1(11)	2,009	0,681	8,714	1	0,003	7,459	1,965	28,32
condlav_ricod_1(12)	2,501	0,537	21,666	1	0	12,19	4,253	34,939
condlav_ricod_1(13)	2,718	0,296	84,329	1	0	15,148	8,481	27,058
condlav_ricod_1(14)	3,883	0,568	46,71	1	0	48,59	15,955	147,981
condlav_ricod_1(15)	2,032	0,464	19,146	1	0	7,633	3,071	18,97
condlav_ricod_1(16)	2,679	0,339	62,399	1	0	14,577	7,498	28,339
gender_w4(1)	0,186	0,113	2,727	1	0,099	1,205	0,966	1,502
ftgiv_w4(1)	0,11	0,471	0,054	1	0,816	1,116	0,443	2,809
ftrec_w4(1)	0,373	0,318	1,378	1	0,24	1,453	0,779	2,71
n_fratelli_cl_w4			14,094	5	0,015			
n_fratelli_cl_w4(1)	-0,047	0,186	0,064	1	0,8	0,954	0,662	1,375
n_fratelli_cl_w4(2)	0,186	0,173	1,154	1	0,283	1,204	0,858	1,69
n_fratelli_cl_w4(3)	0,308	0,192	2,583	1	0,108	1,361	0,935	1,981
n_fratelli_cl_w4(4)	0,285	0,168	2,884	1	0,089	1,33	0,957	1,848
n_fratelli_cl_w4(5)	0,665	0,21	9,973	1	0,002	1,944	1,287	2,937
infocare_dato_hh_w4			20,179	4	0			
infocare_dato_hh_w4(1)	-0,193	0,315	0,374	1	0,541	0,825	0,445	1,529
infocare_dato_hh_w4(2)	-0,755	0,268	7,917	1	0,005	0,47	0,278	0,795
infocare_dato_hh_w4(3)	-1,657	0,47	12,421	1	0	0,191	0,076	0,479
infocare_dato_hh_w4(4)	-0,253	0,296	0,728	1	0,393	0,777	0,435	1,388
age_clas_w4			1,856	3	0,603			
age_clas_w4(1)	0,226	0,24	0,889	1	0,346	1,254	0,784	2,006
age_clas_w4(2)	0,096	0,244	0,155	1	0,694	1,101	0,683	1,775
age_clas_w4(3)	0,014	0,274	0,003	1	0,959	1,014	0,593	1,734
hhsize_cl_w4			107,415	4	0			
hhsize_cl_w4(1)	-0,12	0,199	0,365	1	0,546	0,887	0,6	1,311
hhsize_cl_w4(2)	0,789	0,222	12,596	1	0	2,201	1,424	3,402
hhsize_cl_w4(3)	1,425	0,234	36,977	1	0	4,157	2,626	6,581
hhsize_cl_w4(4)	3,539	0,878	16,26	1	0	34,443	6,166	192,409
salute_gen_individ			1,722	4	0,787			
salute_gen_individ(1)	-0,096	0,299	0,103	1	0,748	0,909	0,506	1,633
salute_gen_individ(2)	-0,137	0,18	0,58	1	0,446	0,872	0,612	1,241
salute_gen_individ(3)	-0,34	0,307	1,227	1	0,268	0,712	0,39	1,299
salute_gen_individ(4)	-0,052	0,19	0,074	1	0,786	0,95	0,655	1,378
Costante	-3,332	0,356	87,386	1	0	0,036		

ITALY, WAVE 1, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			46,6	8	0			
condlav_ricod(1)	0,701	0,26	7,327	1	0,01	2,016	1,213	3,35
condlav_ricod(2)	-0,88	1,06	0,687	1	0,41	0,416	0,052	3,314
condlav_ricod(3)	1,698	0,74	5,274	1	0,02	5,461	1,283	23,253
condlav_ricod(4)	1,284	0,24	29,54	1	0	3,61	2,272	5,735
condlav_ricod(5)	-0,64	1,08	0,354	1	0,55	0,526	0,063	4,368
condlav_ricod(6)	-1,39	1,16	1,432	1	0,23	0,249	0,026	2,426
condlav_ricod(7)	0,855	1,21	0,503	1	0,48	2,352	0,221	25,011
condlav_ricod(8)	1,359	0,3	20,07	1	0	3,893	2,148	7,056
Qexpt_y_w1			55,38	4	0			
Qexpt_y_w1(1)	-1,36	0,3	19,86	1	0	0,258	0,142	0,468
Qexpt_y_w1(2)	-0,32	0,25	1,595	1	0,21	0,728	0,445	1,192
Qexpt_y_w1(3)	-0,21	0,26	0,685	1	0,41	0,807	0,486	1,341
Qexpt_y_w1(4)	0,79	0,26	9,293	1	0	2,204	1,326	3,663
hh_infocare_w1			5,674	5	0,34			
hh_infocare_w1(1)	-0,3	0,35	0,761	1	0,38	0,739	0,374	1,459
hh_infocare_w1(2)	0,547	0,5	1,18	1	0,28	1,728	0,644	4,637
hh_infocare_w1(3)	-0,01	0,33	0	1	0,98	0,993	0,521	1,894
hh_infocare_w1(4)	0,808	0,54	2,269	1	0,13	2,244	0,784	6,421
hh_infocare_w1(5)	-0,43	0,83	0,268	1	0,61	0,65	0,127	3,324
hhsize_ricod			52,86	3	0			
hhsize_ricod(1)	-1,16	0,25	22,02	1	0	0,314	0,194	0,509
hhsize_ricod(2)	-0,72	0,29	6,144	1	0,01	0,487	0,276	0,86
hhsize_ricod(3)	0,531	0,3	3,141	1	0,08	1,701	0,945	3,061
ltc_prob_w1			1,528	2	0,47			
ltc_prob_w1(1)	0,047	0,33	0,02	1	0,89	1,048	0,548	2,001
ltc_prob_w1(2)	-0,31	0,32	0,986	1	0,32	0,73	0,393	1,358
hh_M_pub_bft_w1			3,356	2	0,19			
hh_M_pub_bft_w1(1)	0,193	0,35	0,298	1	0,59	1,213	0,607	2,424
hh_M_pub_bft_w1(2)	-0,62	0,37	2,852	1	0,09	0,54	0,264	1,104
hh_hprcare_ricod(1)	-0,75	0,42	3,2	1	0,07	0,475	0,21	1,074
gender_w1(1)	0,241	0,17	1,901	1	0,17	1,272	0,904	1,79
private_ltc_service_w1(1)	-1,86	1,15	2,62	1	0,11	0,155	0,016	1,481
no_infocare_w1(1)	0,663	0,32	4,413	1	0,04	1,94	1,045	3,6
Costante	-1,29	0,36	12,92	1	0	0,277		

ITALY, WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
age_classi_w2			5,937	3	0,12			
age_classi_w2(1)	0,158	0,17	0,902	1	0,34	1,171	0,845	1,623
age_classi_w2(2)	0,435	0,18	5,911	1	0,02	1,545	1,088	2,194
age_classi_w2(3)	0,226	0,21	1,191	1	0,28	1,253	0,836	1,879
gender_w2(1)	0,085	0,14	0,391	1	0,53	1,089	0,834	1,422
hh_infocare_w2			13,65	5	0,02			
hh_infocare_w2(1)	-0,14	0,26	0,273	1	0,6	0,874	0,527	1,449
hh_infocare_w2(2)	0,75	0,43	2,993	1	0,08	2,117	0,905	4,951
hh_infocare_w2(3)	-0,4	0,26	2,326	1	0,13	0,672	0,403	1,12
hh_infocare_w2(4)	0,721	0,41	3,152	1	0,08	2,057	0,928	4,562
hh_infocare_w2(5)	0,452	0,48	0,886	1	0,35	1,571	0,613	4,028
Mhh_pub_bft_ltc			14,84	2	0			
Mhh_pub_bft_ltc(1)	0,248	0,25	0,997	1	0,32	1,282	0,788	2,085
Mhh_pub_bft_ltc(2)	-2,81	0,79	12,65	1	0	0,06	0,013	0,283
pr_careM_w2			3,236	2	0,2			
pr_careM_w2(1)	-0,5	0,29	2,922	1	0,09	0,608	0,343	1,076
pr_careM_w2(2)	-0,4	0,51	0,606	1	0,44	0,67	0,245	1,835
hhsize_4cat			44,13	3	0			
hhsize_4cat(1)	0,35	0,26	1,819	1	0,18	1,42	0,853	2,362
hhsize_4cat(2)	0,883	0,29	9,564	1	0	2,417	1,382	4,229
hhsize_4cat(3)	1,625	0,31	27,16	1	0	5,078	2,756	9,357
Q_totexpcare_y			53,06	4	0			
Q_totexpcare_y(1)	-0,27	0,22	1,407	1	0,24	0,767	0,494	1,189
Q_totexpcare_y(2)	-0,18	0,22	0,654	1	0,42	0,836	0,541	1,291
Q_totexpcare_y(3)	0,35	0,21	2,723	1	0,1	1,42	0,936	2,152
Q_totexpcare_y(4)	0,957	0,21	21,87	1	0	2,603	1,743	3,887
ricod_cond_lav_3			58,33	7	0			
ricod_cond_lav_3(1)	1,173	0,24	23,49	1	0	3,233	2,011	5,196
ricod_cond_lav_3(2)	-0,42	0,56	0,561	1	0,45	0,66	0,222	1,959
ricod_cond_lav_3(3)	1,042	0,4	6,672	1	0,01	2,836	1,286	6,256
ricod_cond_lav_3(4)	0,664	0,16	17,5	1	0	1,943	1,423	2,653
ricod_cond_lav_3(5)	0,273	0,62	0,197	1	0,66	1,314	0,393	4,395
ricod_cond_lav_3(6)	2,857	0,74	14,97	1	0	17,41	4,095	73,979
ricod_cond_lav_3(7)	1,861	0,31	36,34	1	0	6,43	3,511	11,775
ltc_prob_w2			0,468	2	0,79			
ltc_prob_w2(1)	0,148	0,28	0,288	1	0,59	1,159	0,676	1,988
ltc_prob_w2(2)	0,167	0,26	0,4	1	0,53	1,182	0,704	1,983
private_ltc_service_w2(1)	-0,3	0,64	0,217	1	0,64	0,744	0,214	2,583
no_infocare_w2(1)	-0,63	0,29	4,783	1	0,03	0,533	0,303	0,937
Costante	-2,59	0,34	58,34	1	0	0,075		

ITALY, WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hhsize_cl_w4			27,156	3	0			
hhsize_cl_w4(1)	-0,06	0,2	0,083	1	0,77	0,945	0,644	1,388
hhsize_cl_w4(2)	0,31	0,22	2,074	1	0,15	1,363	0,894	2,077
hhsize_cl_w4(3)	0,945	0,26	13,262	1	0	2,572	1,547	4,276
age_clas_over65			6,548	3	0,09			
age_clas_over65(1)	-0,15	0,14	1,078	1	0,3	0,861	0,65	1,142
age_clas_over65(2)	0,205	0,16	1,75	1	0,19	1,227	0,906	1,662
age_clas_over65(3)	0,114	0,16	0,486	1	0,49	1,12	0,814	1,542
ltc_prob_w4			15,976	2	0			
ltc_prob_w4(1)	0,84	0,21	15,707	1	0	2,316	1,529	3,508
ltc_prob_w4(2)	0,398	0,18	4,769	1	0,03	1,489	1,042	2,129
hh_infocare_w4			2,23	7	0,95			
hh_infocare_w4(1)	-0,04	0,3	0,014	1	0,91	0,965	0,536	1,739
hh_infocare_w4(2)	0,176	0,27	0,434	1	0,51	1,192	0,707	2,009
hh_infocare_w4(3)	-0,05	0,24	0,038	1	0,85	0,953	0,591	1,537
hh_infocare_w4(4)	-0,17	0,19	0,832	1	0,36	0,845	0,588	1,214
hh_infocare_w4(5)	0,341	0,78	0,192	1	0,66	1,406	0,306	6,475
hh_infocare_w4(6)	-0,13	0,43	0,09	1	0,76	0,879	0,377	2,048
hh_infocare_w4(7)	-0,24	0,29	0,683	1	0,41	0,788	0,447	1,387
Mhh_pub_bft_ltc_w4			10,209	2	0,01			
Mhh_pub_bft_ltc_w4(1)	-0,41	0,21	3,793	1	0,05	0,661	0,436	1,003
Mhh_pub_bft_ltc_w4(2)	-0,88	0,3	8,405	1	0	0,415	0,229	0,752
condlav_ricod			124,87	14	0			
condlav_ricod(1)	0,451	0,18	6,527	1	0,01	1,57	1,111	2,219
condlav_ricod(2)	-0,98	0,54	3,281	1	0,07	0,374	0,129	1,084
condlav_ricod(3)	1,51	0,84	3,231	1	0,07	4,527	0,873	23,487
condlav_ricod(4)	1,813	0,36	25,211	1	0	6,131	3,021	12,444
condlav_ricod(5)	1,141	0,13	75,392	1	0	3,13	2,419	4,05
condlav_ricod(6)	-1,08	1,06	1,041	1	0,31	0,34	0,043	2,703
condlav_ricod(7)	0,916	0,63	2,085	1	0,15	2,5	0,721	8,669
condlav_ricod(8)	2,021	1,25	2,616	1	0,11	7,544	0,652	87,332
condlav_ricod(9)	2,833	1,13	6,281	1	0,01	17	1,854	155,799
condlav_ricod(10)	1,035	0,59	3,072	1	0,08	2,815	0,885	8,953
condlav_ricod(11)	1,353	0,53	6,49	1	0,01	3,869	1,366	10,956
condlav_ricod(12)	1,272	0,24	29,082	1	0	3,569	2,248	5,668
condlav_ricod(13)	2,547	1,18	4,667	1	0,03	12,76	1,266	128,626
condlav_ricod(14)	1,721	0,51	11,351	1	0	5,59	2,054	15,214
no_infocare(1)	-0,01	0,2	0,002	1	0,96	0,99	0,666	1,473
gender_w4(1)	-0,09	0,11	0,663	1	0,42	0,914	0,737	1,134
Costante	-1,45	0,25	35,257	1	0	0,234		

ITALY, WAVE 1, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			161,5	11	0			
condlav_ricod(1)	1,127	0,6	3,486	1	0,06	3,087	0,945	10,08
condlav_ricod(2)	0,52	0,7	0,554	1	0,46	1,682	0,428	6,618
condlav_ricod(3)	1,518	0,93	2,691	1	0,1	4,564	0,744	27,996
condlav_ricod(4)	2,958	0,55	29,43	1	0	19,27	6,616	56,102
condlav_ricod(5)	1,428	0,58	6,139	1	0,01	4,172	1,348	12,915
condlav_ricod(6)	1,719	0,59	8,614	1	0	5,581	1,77	17,592
condlav_ricod(7)	2,757	0,55	25,13	1	0	15,75	5,36	46,297
condlav_ricod(8)	4,598	0,63	53,37	1	0	99,27	28,915	340,841
condlav_ricod(9)	3,547	0,9	15,5	1	0	34,7	5,937	202,796
condlav_ricod(10)	3,307	1,03	10,32	1	0	27,3	3,629	205,32
condlav_ricod(11)	3,293	0,56	34,56	1	0	26,93	8,982	80,72
gender_w1(1)	-0,12	0,16	0,505	1	0,48	0,89	0,645	1,228
n_fratelli_cl			9,225	5	0,1			
n_fratelli_cl(1)	-0,28	0,27	1,124	1	0,29	0,753	0,445	1,273
n_fratelli_cl(2)	0,017	0,27	0,004	1	0,95	1,018	0,603	1,716
n_fratelli_cl(3)	-0,24	0,29	0,672	1	0,41	0,788	0,446	1,392
n_fratelli_cl(4)	0,281	0,26	1,147	1	0,28	1,324	0,792	2,214
n_fratelli_cl(5)	0,305	0,33	0,841	1	0,36	1,357	0,707	2,605
salute_gen_individ			9,768	4	0,05			
salute_gen_individ(1)	-0,66	0,73	0,818	1	0,37	0,516	0,123	2,163
salute_gen_individ(2)	-0,68	0,36	3,51	1	0,06	0,508	0,25	1,032
salute_gen_individ(3)	-0,81	0,52	2,412	1	0,12	0,444	0,159	1,237
salute_gen_individ(4)	-0,56	0,25	5,156	1	0,02	0,572	0,354	0,927
Q_infocare_dato_w1			1,704	4	0,79			
Q_infocare_dato_w1(1)	-0,23	0,48	0,225	1	0,64	0,796	0,31	2,042
Q_infocare_dato_w1(2)	0,396	0,39	1,038	1	0,31	1,487	0,693	3,187
Q_infocare_dato_w1(3)	-0,12	0,43	0,075	1	0,78	0,888	0,379	2,078
Q_infocare_dato_w1(4)	-0,21	0,42	0,253	1	0,62	0,81	0,357	1,839
hhsize_ricod			55,32	3	0			
hhsize_ricod(1)	-1,44	0,31	21,21	1	0	0,237	0,129	0,438
hhsize_ricod(2)	-0,71	0,31	5,166	1	0,02	0,492	0,267	0,907
hhsize_ricod(3)	-0,01	0,31	0,001	1	0,97	0,988	0,536	1,823
age_clas			5,747	3	0,13			
age_clas(1)	-0,67	0,33	4,095	1	0,04	0,512	0,267	0,979
age_clas(2)	-0,31	0,33	0,886	1	0,35	0,736	0,39	1,392
age_clas(3)	-0,48	0,35	1,871	1	0,17	0,619	0,311	1,231
ftgiv_w1(1)	-0,26	0,59	0,199	1	0,66	0,77	0,245	2,422
ftrec_w1(1)	0,045	0,46	0,01	1	0,92	1,046	0,429	2,552
Costante	-2,36	0,68	12,18	1	0	0,095		

ITALY, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
ricod_cond_lav_1			155,45	16	0			
ricod_cond_lav_1(1)	1,284	0,47	7,605	1	0,01	3,612	1,45	8,999
ricod_cond_lav_1(2)	-0,01	0,32	0,002	1	0,97	0,987	0,53	1,838
ricod_cond_lav_1(3)	1,86	0,65	8,136	1	0	6,422	1,789	23,048
ricod_cond_lav_1(4)	0,804	0,48	2,829	1	0,09	2,235	0,876	5,703
ricod_cond_lav_1(5)	1,578	0,26	36,496	1	0	4,846	2,904	8,087
ricod_cond_lav_1(6)	1,368	0,44	9,737	1	0	3,926	1,663	9,269
ricod_cond_lav_1(7)	0,141	0,32	0,194	1	0,66	1,152	0,614	2,16
ricod_cond_lav_1(8)	2,516	0,45	31,766	1	0	12,37	5,159	29,674
ricod_cond_lav_1(9)	1,948	0,52	14,085	1	0	7,015	2,536	19,401
ricod_cond_lav_1(10)	1,895	0,24	62,518	1	0	6,652	4,159	10,641
ricod_cond_lav_1(11)	2,186	0,45	23,199	1	0	8,895	3,655	21,648
ricod_cond_lav_1(12)	2,827	0,92	9,406	1	0	16,9	2,774	102,925
ricod_cond_lav_1(13)	2,563	1,29	3,961	1	0,05	12,98	1,04	161,943
ricod_cond_lav_1(14)	1,88	0,71	6,994	1	0,01	6,555	1,627	26,407
ricod_cond_lav_1(15)	2,078	0,4	26,474	1	0	7,991	3,621	17,636
ricod_cond_lav_1(16)	3,446	0,91	14,388	1	0	31,37	5,287	186,126
gender_w2(1)	0,05	0,14	0,127	1	0,72	1,051	0,8	1,381
salute_gen_individ			3,389	4	0,5			
salute_gen_individ(1)	-0,37	0,39	0,875	1	0,35	0,693	0,321	1,494
salute_gen_individ(2)	0,233	0,22	1,12	1	0,29	1,262	0,82	1,942
salute_gen_individ(3)	0,395	0,36	1,197	1	0,27	1,485	0,731	3,016
salute_gen_individ(4)	0,053	0,25	0,046	1	0,83	1,054	0,65	1,709
Q_infocare_dato			2,091	4	0,72			
Q_infocare_dato(1)	-0,19	0,31	0,383	1	0,54	0,827	0,453	1,509
Q_infocare_dato(2)	0,304	0,3	1,051	1	0,31	1,355	0,758	2,423
Q_infocare_dato(3)	0,177	0,28	0,4	1	0,53	1,193	0,69	2,062
Q_infocare_dato(4)	0,149	0,27	0,314	1	0,58	1,16	0,69	1,95
n_fratelli_cl			23,662	5	0			
n_fratelli_cl(1)	0,377	0,24	2,473	1	0,12	1,458	0,911	2,333
n_fratelli_cl(2)	0,514	0,25	4,397	1	0,04	1,672	1,034	2,702
n_fratelli_cl(3)	0,083	0,26	0,1	1	0,75	1,087	0,648	1,824
n_fratelli_cl(4)	0,871	0,25	12,579	1	0	2,39	1,477	3,869
n_fratelli_cl(5)	0,964	0,31	9,753	1	0	2,621	1,432	4,798
hhsize_cl			41,046	4	0			
hhsize_cl(1)	0,339	0,38	0,788	1	0,38	1,404	0,664	2,966
hhsize_cl(2)	0,803	0,39	4,288	1	0,04	2,232	1,044	4,772
hhsize_cl(3)	1,386	0,4	12,341	1	0	4	1,846	8,67
hhsize_cl(4)	1,368	1,11	1,519	1	0,22	3,928	0,446	34,608
age_clas			0,97	3	0,81			
age_clas(1)	0,028	0,31	0,008	1	0,93	1,028	0,559	1,891
age_clas(2)	-0,05	0,32	0,02	1	0,89	0,956	0,509	1,794
age_clas(3)	0,118	0,35	0,116	1	0,73	1,126	0,569	2,229
ft_giv_cat(1)	-0,53	0,55	0,936	1	0,33	0,588	0,2	1,724
ft_rec_cat(1)	0,233	0,42	0,302	1	0,58	1,263	0,55	2,9
Costante	-3,46	0,55	39,659	1	0	0,031		

ITALY, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod_1			198,07	16	0			
condlav_ricod_1(1)	0,667	0,39	2,887	1	0,09	1,948	0,903	4,206
condlav_ricod_1(2)	-0,39	0,3	1,656	1	0,2	0,676	0,372	1,227
condlav_ricod_1(3)	1,246	0,5	6,33	1	0,01	3,476	1,317	9,175
condlav_ricod_1(4)	1,73	0,24	52,622	1	0	5,639	3,534	8,999
condlav_ricod_1(5)	0,378	0,3	1,549	1	0,21	1,459	0,805	2,646
condlav_ricod_1(6)	0,366	0,3	1,492	1	0,22	1,441	0,802	2,592
condlav_ricod_1(7)	2,079	0,37	31,966	1	0	7,995	3,889	16,436
condlav_ricod_1(8)	1,617	0,2	64,837	1	0	5,037	3,399	7,467
condlav_ricod_1(9)	1,272	0,79	2,564	1	0,11	3,567	0,752	16,911
condlav_ricod_1(10)	1,082	1	1,178	1	0,28	2,95	0,418	20,81
condlav_ricod_1(11)	2,934	0,44	44,612	1	0	18,8	7,947	44,455
condlav_ricod_1(12)	1,797	0,59	9,284	1	0	6,03	1,898	19,156
condlav_ricod_1(13)	3,216	0,83	15,046	1	0	24,93	4,908	126,588
condlav_ricod_1(14)	2,01	0,32	38,62	1	0	7,462	3,959	14,066
condlav_ricod_1(15)	3,532	1,14	9,65	1	0	34,2	3,683	317,664
condlav_ricod_1(16)	2,886	0,62	21,786	1	0	17,91	5,333	60,172
gender_w4(1)	0,217	0,14	2,484	1	0,12	1,242	0,948	1,627
ftgiv_w4(1)	0,804	0,72	1,24	1	0,27	2,234	0,543	9,195
ftrec_w4(1)	0,313	0,44	0,515	1	0,47	1,368	0,581	3,22
infocare_dato_hh_w4			8,145	4	0,09			
infocare_dato_hh_w4(1)	-0,06	0,24	0,063	1	0,8	0,943	0,595	1,495
infocare_dato_hh_w4(2)	-0,9	0,35	6,637	1	0,01	0,405	0,204	0,806
infocare_dato_hh_w4(3)	0,46	0,55	0,696	1	0,4	1,583	0,538	4,66
infocare_dato_hh_w4(4)	0,326	0,43	0,565	1	0,45	1,386	0,592	3,243
age_clas_w4			3,032	3	0,39			
age_clas_w4(1)	0,316	0,34	0,844	1	0,36	1,372	0,699	2,694
age_clas_w4(2)	0,513	0,34	2,265	1	0,13	1,671	0,856	3,262
age_clas_w4(3)	0,384	0,36	1,119	1	0,29	1,469	0,721	2,994
hhsize_cl_w4			86,387	4	0			
hhsize_cl_w4(1)	0,255	0,36	0,503	1	0,48	1,29	0,638	2,606
hhsize_cl_w4(2)	1,255	0,36	12,35	1	0	3,508	1,742	7,064
hhsize_cl_w4(3)	1,844	0,36	25,626	1	0	6,32	3,095	12,904
hhsize_cl_w4(4)	1,355	0,87	2,423	1	0,12	3,879	0,704	21,372
salute_gen_individ			6,848	4	0,14			
salute_gen_individ(1)	-0,88	0,56	2,419	1	0,12	0,417	0,138	1,255
salute_gen_individ(2)	-0,29	0,24	1,41	1	0,24	0,749	0,464	1,207
salute_gen_individ(3)	0,539	0,47	1,343	1	0,25	1,715	0,689	4,268
salute_gen_individ(4)	0,324	0,27	1,401	1	0,24	1,383	0,808	2,367
n_fratelli_cl_w4			27,624	5	0			
n_fratelli_cl_w4(1)	0,335	0,22	2,321	1	0,13	1,398	0,909	2,15
n_fratelli_cl_w4(2)	0,477	0,22	4,54	1	0,03	1,611	1,039	2,498
n_fratelli_cl_w4(3)	0,66	0,25	7,209	1	0,01	1,935	1,195	3,134
n_fratelli_cl_w4(4)	0,905	0,23	15,247	1	0	2,472	1,569	3,892
n_fratelli_cl_w4(5)	1,327	0,32	17,641	1	0	3,771	2,03	7,007
Costante	-3,89	0,54	51,504	1	0	0,02		

SPAIN, WAVE 1, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			57,5	8	0			
condlav_ricod(1)	0,836	0,313	7,149	1	0,01	2,307	1,25	4,257
condlav_ricod(2)	-0,723	1,075	0,452	1	0,5	0,485	0,059	3,99
condlav_ricod(3)	0,672	0,863	0,607	1	0,44	1,958	0,361	10,616
condlav_ricod(4)	1,092	0,475	5,288	1	0,02	2,98	1,175	7,557
condlav_ricod(5)	1,659	0,291	32,51	1	0	5,256	2,971	9,297
condlav_ricod(6)	-0,134	0,822	0,027	1	0,87	0,874	0,175	4,376
condlav_ricod(7)	1,517	0,542	7,842	1	0,01	4,559	1,577	13,183
condlav_ricod(8)	1,677	0,32	27,41	1	0	5,351	2,856	10,025
hh_infocare_w1			2,693	5	0,75			
hh_infocare_w1(1)	0,303	0,31	0,952	1	0,33	1,354	0,737	2,488
hh_infocare_w1(2)	0,298	0,472	0,399	1	0,53	1,347	0,534	3,397
hh_infocare_w1(3)	0,258	0,247	1,09	1	0,3	1,294	0,798	2,1
hh_infocare_w1(4)	0,041	0,458	0,008	1	0,93	1,042	0,425	2,556
hh_infocare_w1(5)	0,612	0,493	1,543	1	0,21	1,844	0,702	4,845
Qexpt_y_w1			20,15	4	0			
Qexpt_y_w1(1)	-1,079	0,301	12,81	1	0	0,34	0,188	0,614
Qexpt_y_w1(2)	-0,73	0,265	7,583	1	0,01	0,482	0,287	0,81
Qexpt_y_w1(3)	-0,166	0,236	0,495	1	0,48	0,847	0,534	1,345
Qexpt_y_w1(4)	0,116	0,229	0,256	1	0,61	1,123	0,717	1,757
ltc_prob_w1			1,053	2	0,59			
ltc_prob_w1(1)	0,237	0,269	0,779	1	0,38	1,268	0,749	2,146
ltc_prob_w1(2)	0,003	0,249	0	1	0,99	1,003	0,616	1,635
hhsize_ricod			19,84	3	0			
hhsize_ricod(1)	0,533	0,225	5,616	1	0,02	1,704	1,097	2,649
hhsize_ricod(2)	0,416	0,259	2,578	1	0,11	1,516	0,912	2,519
hhsize_ricod(3)	1,181	0,274	18,6	1	0	3,257	1,904	5,57
hh_M_pub_bft_w1			8,881	2	0,01			
hh_M_pub_bft_w1(1)	0,51	0,258	3,906	1	0,05	1,665	1,004	2,762
hh_M_pub_bft_w1(2)	-2,225	1,05	4,489	1	0,03	0,108	0,014	0,846
hh_M_hpr_w1			9,368	2	0,01			
hh_M_hpr_w1(1)	-0,542	0,261	4,317	1	0,04	0,582	0,349	0,97
hh_M_hpr_w1(2)	-1,398	0,57	6,014	1	0,01	0,247	0,081	0,755
gender_w1(1)	-0,207	0,154	1,811	1	0,18	0,813	0,601	1,099
private_ltc_service_w1(1)	-19,75	10538,2	0	1	1	0	0	.
no_infocare_w1(1)	0,062	0,265	0,055	1	0,82	1,064	0,633	1,788
Costante	-2,479	0,366	45,96	1	0	0,084		

SPAIN, WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
pr_careM_w2			0,752	2	0,69			
pr_careM_w2(1)	-0,23	0,28	0,681	1	0,41	0,795	0,462	1,37
pr_careM_w2(2)	0,043	0,34	0,016	1	0,9	1,044	0,538	2,024
Mhh_pub_bft_ltc			9,76	2	0,01			
Mhh_pub_bft_ltc(1)	0,247	0,4	0,385	1	0,54	1,28	0,587	2,79
Mhh_pub_bft_ltc(2)	-1,59	0,52	9,208	1	0	0,204	0,073	0,57
Qspesecare_y			22,45	4	0			
Qspesecare_y(1)	-1,22	0,34	13,04	1	0	0,297	0,153	0,574
Qspesecare_y(2)	-0,66	0,29	5,311	1	0,02	0,515	0,293	0,906
Qspesecare_y(3)	-0,47	0,27	3,036	1	0,08	0,623	0,366	1,061
Qspesecare_y(4)	0,356	0,27	1,79	1	0,18	1,427	0,848	2,404
ltc_prob_w2			0,106	2	0,95			
ltc_prob_w2(1)	0,045	0,27	0,028	1	0,87	1,046	0,618	1,77
ltc_prob_w2(2)	-0,04	0,25	0,026	1	0,87	0,96	0,586	1,574
gender_w2(1)	0,132	0,14	0,906	1	0,34	1,142	0,869	1,5
hhsize_w2			39,77	3	0			
hhsize_w2(1)	0,88	0,27	10,34	1	0	2,411	1,41	4,123
hhsize_w2(2)	1,431	0,3	22,67	1	0	4,183	2,321	7,539
hhsize_w2(3)	1,808	0,33	30,38	1	0	6,095	3,205	11,592
eta_3calssi			13,02	2	0			
eta_3calssi(1)	0,526	0,15	13,02	1	0	1,692	1,272	2,252
eta_3calssi(2)	0,303	0,24	1,531	1	0,22	1,353	0,838	2,185
hh_infocare_w2			10,07	6	0,12			
hh_infocare_w2(1)	0,514	0,32	2,658	1	0,1	1,672	0,901	3,1
hh_infocare_w2(2)	1,089	0,5	4,657	1	0,03	2,97	1,105	7,982
hh_infocare_w2(3)	-0,03	0,24	0,019	1	0,89	0,968	0,609	1,538
hh_infocare_w2(4)	0,575	0,4	2,043	1	0,15	1,777	0,808	3,908
hh_infocare_w2(5)	0,504	0,58	0,767	1	0,38	1,656	0,536	5,12
hh_infocare_w2(6)	0,036	0,26	0,02	1	0,89	1,037	0,627	1,715
ricod_cond_lav_3			91,31	11	0			
ricod_cond_lav_3(1)	1,248	0,28	19,95	1	0	3,484	2,015	6,024
ricod_cond_lav_3(2)	0,138	0,6	0,053	1	0,82	1,148	0,355	3,712
ricod_cond_lav_3(3)	1,73	0,21	66,88	1	0	5,639	3,725	8,535
ricod_cond_lav_3(4)	1,984	0,41	23,87	1	0	7,274	3,281	16,124
ricod_cond_lav_3(5)	-0,03	0,75	0,001	1	0,97	0,973	0,223	4,245
ricod_cond_lav_3(6)	0,766	1,05	0,535	1	0,47	2,151	0,276	16,774
ricod_cond_lav_3(7)	0,688	0,59	1,34	1	0,25	1,989	0,621	6,374
ricod_cond_lav_3(8)	1,199	0,79	2,306	1	0,13	3,317	0,706	15,592
ricod_cond_lav_3(9)	1,301	0,59	4,795	1	0,03	3,672	1,146	11,766
ricod_cond_lav_3(10)	2,596	0,79	10,85	1	0	13,4	2,861	62,787
ricod_cond_lav_3(11)	2,1	0,32	44,2	1	0	8,17	4,398	15,175
private_ltc_service_w2(1)	-0,28	0,93	0,088	1	0,77	0,758	0,121	4,731
Costante	-2,89	0,35	68,48	1	0	0,056		

SPAIN, WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			139,1	17	0			
condlav_ricod(1)	1,44	0,47	9,296	1	0	4,22	1,672	10,648
condlav_ricod(2)	0,087	0,49	0,032	1	0,86	1,091	0,42	2,834
condlav_ricod(3)	2,387	0,45	28,779	1	0	10,88	4,548	26,013
condlav_ricod(4)	0,936	0,63	2,185	1	0,14	2,549	0,737	8,815
condlav_ricod(5)	1,93	0,29	43,835	1	0	6,888	3,891	12,196
condlav_ricod(6)	0,565	0,37	2,37	1	0,12	1,76	0,857	3,614
condlav_ricod(7)	0,913	0,61	2,27	1	0,13	2,492	0,76	8,174
condlav_ricod(8)	0,884	0,31	8,087	1	0	2,421	1,316	4,454
condlav_ricod(9)	0,858	0,4	4,557	1	0,03	2,358	1,073	5,182
condlav_ricod(10)	1,273	0,26	24,679	1	0	3,572	2,161	5,902
condlav_ricod(11)	2,755	0,43	41,575	1	0	15,73	6,806	36,335
condlav_ricod(12)	2,166	0,72	8,956	1	0	8,723	2,112	36,034
condlav_ricod(13)	3,169	0,35	80,919	1	0	23,78	11,924	47,441
condlav_ricod(14)	1,432	0,54	6,975	1	0,01	4,187	1,447	12,119
condlav_ricod(15)	2,112	0,44	23,368	1	0	8,262	3,51	19,451
condlav_ricod(16)	1,588	0,41	14,758	1	0	4,893	2,177	11,001
condlav_ricod(17)	1,446	0,43	11,328	1	0	4,247	1,83	9,861
gender_w4(1)	0,062	0,14	0,188	1	0,66	1,064	0,805	1,406
ftgiv_w4(1)	-0,06	0,96	0,004	1	0,95	0,94	0,143	6,189
ftrec_w4(1)	-0,64	0,86	0,557	1	0,46	0,527	0,098	2,831
n_fratelli_cl_w4			9,983	5	0,08			
n_fratelli_cl_w4(1)	0	0,26	0	1	1	1	0,597	1,675
n_fratelli_cl_w4(2)	0,279	0,25	1,214	1	0,27	1,322	0,804	2,174
n_fratelli_cl_w4(3)	0,559	0,26	4,572	1	0,03	1,749	1,048	2,919
n_fratelli_cl_w4(4)	0,345	0,25	1,939	1	0,16	1,412	0,869	2,293
n_fratelli_cl_w4(5)	0,599	0,32	3,528	1	0,06	1,821	0,974	3,404
infocare_dato_hh_w4			3,076	4	0,55			
infocare_dato_hh_w4(1)	-0,32	0,34	0,876	1	0,35	0,73	0,377	1,412
infocare_dato_hh_w4(2)	-0,11	0,36	0,096	1	0,76	0,895	0,442	1,809
infocare_dato_hh_w4(3)	-1,55	1,08	2,037	1	0,15	0,213	0,025	1,782
infocare_dato_hh_w4(4)	-0,25	0,64	0,154	1	0,69	0,779	0,224	2,71
age_clas_w4			2,999	3	0,39			
age_clas_w4(1)	-0,49	0,35	2,007	1	0,16	0,611	0,309	1,208
age_clas_w4(2)	-0,59	0,35	2,932	1	0,09	0,554	0,282	1,089
age_clas_w4(3)	-0,5	0,36	1,923	1	0,17	0,609	0,302	1,228
hhsize_cl_w4			37,684	4	0			
hhsize_cl_w4(1)	-0,52	0,35	2,161	1	0,14	0,597	0,3	1,187
hhsize_cl_w4(2)	0,369	0,35	1,114	1	0,29	1,446	0,729	2,87
hhsize_cl_w4(3)	0,446	0,35	1,615	1	0,2	1,563	0,785	3,11
hhsize_cl_w4(4)	2,032	0,98	4,349	1	0,04	7,632	1,13	51,542
salute_gen_individ			3,273	4	0,51			
salute_gen_individ(1)	-0,38	0,46	0,672	1	0,41	0,685	0,278	1,692
salute_gen_individ(2)	-0,12	0,25	0,221	1	0,64	0,888	0,54	1,46
salute_gen_individ(3)	-1,24	0,81	2,347	1	0,13	0,29	0,059	1,413
salute_gen_individ(4)	0,123	0,34	0,13	1	0,72	1,131	0,58	2,207
Costante	-2,3	0,54	18,098	1	0	0,1		

SPAIN, WAVE 1, POPULATION AGED BETWEEN 50 AND 65 YEARS

	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			69,113	18	0			
condlav_ricod(1)	1,796	0,67	7,304	1	0,01	6,029	1,638	22,183
condlav_ricod(2)	0,486	0,75	0,416	1	0,52	1,626	0,371	7,117
condlav_ricod(3)	0,425	1,14	0,139	1	0,71	1,529	0,164	14,228
condlav_ricod(4)	2,527	0,66	14,691	1	0	12,51	3,437	45,551
condlav_ricod(5)	1,495	0,5	9,07	1	0	4,458	1,685	11,79
condlav_ricod(6)	0,993	0,48	4,205	1	0,04	2,7	1,045	6,976
condlav_ricod(7)	1,394	0,53	6,891	1	0,01	4,03	1,423	11,409
condlav_ricod(8)	0,836	0,88	0,909	1	0,34	2,307	0,414	12,868
condlav_ricod(9)	1,63	0,65	6,265	1	0,01	5,106	1,424	18,302
condlav_ricod(10)	1,582	0,48	10,854	1	0	4,866	1,898	12,474
condlav_ricod(11)	4,162	1,19	12,146	1	0	64,17	6,179	666,42
condlav_ricod(12)	4,067	0,99	16,966	1	0	58,41	8,432	404,577
condlav_ricod(13)	2,888	0,7	16,973	1	0	17,96	4,546	70,978
condlav_ricod(14)	3,063	0,6	25,994	1	0	21,39	6,589	69,436
condlav_ricod(15)	2,246	0,66	11,443	1	0	9,453	2,572	34,738
condlav_ricod(16)	1,641	0,48	11,48	1	0	5,158	1,997	13,324
condlav_ricod(17)	3,096	0,81	14,784	1	0	22,1	4,562	107,103
condlav_ricod(18)	2,159	0,56	14,761	1	0	8,663	2,88	26,061
gender_w1(1)	-0,02	0,19	0,012	1	0,91	0,98	0,683	1,408
n_fratelli_cl			2,837	5	0,73			
n_fratelli_cl(1)	-0,12	0,33	0,127	1	0,72	0,889	0,465	1,699
n_fratelli_cl(2)	0,03	0,32	0,009	1	0,93	1,031	0,551	1,929
n_fratelli_cl(3)	0,242	0,33	0,529	1	0,47	1,274	0,663	2,449
n_fratelli_cl(4)	0,178	0,31	0,329	1	0,57	1,195	0,65	2,195
n_fratelli_cl(5)	0,306	0,39	0,623	1	0,43	1,358	0,635	2,903
salute_gen_individ			1,368	4	0,85			
salute_gen_individ(1)	-0,37	0,65	0,318	1	0,57	0,693	0,193	2,48
salute_gen_individ(2)	0,12	0,29	0,169	1	0,68	1,128	0,636	2
salute_gen_individ(3)	-0,21	0,49	0,178	1	0,67	0,812	0,309	2,135
salute_gen_individ(4)	-0,23	0,29	0,636	1	0,43	0,793	0,449	1,402
Q_infocare_dato_w1			7,711	4	0,1			
Q_infocare_dato_w1(1)	-1,43	0,77	3,478	1	0,06	0,239	0,053	1,076
Q_infocare_dato_w1(2)	-0,45	0,55	0,664	1	0,42	0,64	0,219	1,872
Q_infocare_dato_w1(3)	-1,8	1,06	2,89	1	0,09	0,165	0,021	1,317
Q_infocare_dato_w1(4)	-0,57	0,57	1,006	1	0,32	0,563	0,184	1,729
hhsize_ricod			35,203	3	0			
hhsize_ricod(1)	0,253	0,43	0,356	1	0,55	1,288	0,561	2,961
hhsize_ricod(2)	0,523	0,42	1,549	1	0,21	1,686	0,74	3,841
hhsize_ricod(3)	1,389	0,42	11,141	1	0	4,009	1,774	9,06
age_clas			11,341	3	0,01			
age_clas(1)	-0,15	0,34	0,208	1	0,65	0,858	0,444	1,659
age_clas(2)	0,315	0,33	0,897	1	0,34	1,37	0,714	2,627
age_clas(3)	0,645	0,35	3,38	1	0,07	1,905	0,958	3,788
ftgiv_w1(1)	-0,05	0,49	0,009	1	0,92	0,953	0,363	2,503
ftrec_w1(1)	0,679	0,48	1,968	1	0,16	1,972	0,764	5,094
Costante	-4	0,7	32,594	1	0	0,018		

SPAIN, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			139,1	17	0			
condlav_ricod(1)	1,44	0,47	9,296	1	0	4,22	1,672	10,648
condlav_ricod(2)	0,087	0,49	0,032	1	0,86	1,091	0,42	2,834
condlav_ricod(3)	2,387	0,45	28,779	1	0	10,88	4,548	26,013
condlav_ricod(4)	0,936	0,63	2,185	1	0,14	2,549	0,737	8,815
condlav_ricod(5)	1,93	0,29	43,835	1	0	6,888	3,891	12,196
condlav_ricod(6)	0,565	0,37	2,37	1	0,12	1,76	0,857	3,614
condlav_ricod(7)	0,913	0,61	2,27	1	0,13	2,492	0,76	8,174
condlav_ricod(8)	0,884	0,31	8,087	1	0	2,421	1,316	4,454
condlav_ricod(9)	0,858	0,4	4,557	1	0,03	2,358	1,073	5,182
condlav_ricod(10)	1,273	0,26	24,679	1	0	3,572	2,161	5,902
condlav_ricod(11)	2,755	0,43	41,575	1	0	15,73	6,806	36,335
condlav_ricod(12)	2,166	0,72	8,956	1	0	8,723	2,112	36,034
condlav_ricod(13)	3,169	0,35	80,919	1	0	23,78	11,924	47,441
condlav_ricod(14)	1,432	0,54	6,975	1	0,01	4,187	1,447	12,119
condlav_ricod(15)	2,112	0,44	23,368	1	0	8,262	3,51	19,451
condlav_ricod(16)	1,588	0,41	14,758	1	0	4,893	2,177	11,001
condlav_ricod(17)	1,446	0,43	11,328	1	0	4,247	1,83	9,861
gender_w4(1)	0,062	0,14	0,188	1	0,66	1,064	0,805	1,406
ftgiv_w4(1)	-0,06	0,96	0,004	1	0,95	0,94	0,143	6,189
ftrec_w4(1)	-0,64	0,86	0,557	1	0,46	0,527	0,098	2,831
n_fratelli_cl_w4			9,983	5	0,08			
n_fratelli_cl_w4(1)	0	0,26	0	1	1	1	0,597	1,675
n_fratelli_cl_w4(2)	0,279	0,25	1,214	1	0,27	1,322	0,804	2,174
n_fratelli_cl_w4(3)	0,559	0,26	4,572	1	0,03	1,749	1,048	2,919
n_fratelli_cl_w4(4)	0,345	0,25	1,939	1	0,16	1,412	0,869	2,293
n_fratelli_cl_w4(5)	0,599	0,32	3,528	1	0,06	1,821	0,974	3,404
infocare_dato_hh_w4			3,076	4	0,55			
infocare_dato_hh_w4(1)	-0,32	0,34	0,876	1	0,35	0,73	0,377	1,412
infocare_dato_hh_w4(2)	-0,11	0,36	0,096	1	0,76	0,895	0,442	1,809
infocare_dato_hh_w4(3)	-1,55	1,08	2,037	1	0,15	0,213	0,025	1,782
infocare_dato_hh_w4(4)	-0,25	0,64	0,154	1	0,69	0,779	0,224	2,71
age_clas_w4			2,999	3	0,39			
age_clas_w4(1)	-0,49	0,35	2,007	1	0,16	0,611	0,309	1,208
age_clas_w4(2)	-0,59	0,35	2,932	1	0,09	0,554	0,282	1,089
age_clas_w4(3)	-0,5	0,36	1,923	1	0,17	0,609	0,302	1,228
hhsize_cl_w4			37,684	4	0			
hhsize_cl_w4(1)	-0,52	0,35	2,161	1	0,14	0,597	0,3	1,187
hhsize_cl_w4(2)	0,369	0,35	1,114	1	0,29	1,446	0,729	2,87
hhsize_cl_w4(3)	0,446	0,35	1,615	1	0,2	1,563	0,785	3,11
hhsize_cl_w4(4)	2,032	0,98	4,349	1	0,04	7,632	1,13	51,542
salute_gen_individ			3,273	4	0,51			
salute_gen_individ(1)	-0,38	0,46	0,672	1	0,41	0,685	0,278	1,692
salute_gen_individ(2)	-0,12	0,25	0,221	1	0,64	0,888	0,54	1,46
salute_gen_individ(3)	-1,24	0,81	2,347	1	0,13	0,29	0,059	1,413
salute_gen_individ(4)	0,123	0,34	0,13	1	0,72	1,131	0,58	2,207
Costante	-2,3	0,54	18,098	1	0	0,1		

SPAIN, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			139,1	17	0			
condlav_ricod(1)	1,44	0,47	9,296	1	0	4,22	1,672	10,648
condlav_ricod(2)	0,087	0,49	0,032	1	0,86	1,091	0,42	2,834
condlav_ricod(3)	2,387	0,45	28,779	1	0	10,88	4,548	26,013
condlav_ricod(4)	0,936	0,63	2,185	1	0,14	2,549	0,737	8,815
condlav_ricod(5)	1,93	0,29	43,835	1	0	6,888	3,891	12,196
condlav_ricod(6)	0,565	0,37	2,37	1	0,12	1,76	0,857	3,614
condlav_ricod(7)	0,913	0,61	2,27	1	0,13	2,492	0,76	8,174
condlav_ricod(8)	0,884	0,31	8,087	1	0	2,421	1,316	4,454
condlav_ricod(9)	0,858	0,4	4,557	1	0,03	2,358	1,073	5,182
condlav_ricod(10)	1,273	0,26	24,679	1	0	3,572	2,161	5,902
condlav_ricod(11)	2,755	0,43	41,575	1	0	15,73	6,806	36,335
condlav_ricod(12)	2,166	0,72	8,956	1	0	8,723	2,112	36,034
condlav_ricod(13)	3,169	0,35	80,919	1	0	23,78	11,924	47,441
condlav_ricod(14)	1,432	0,54	6,975	1	0,01	4,187	1,447	12,119
condlav_ricod(15)	2,112	0,44	23,368	1	0	8,262	3,51	19,451
condlav_ricod(16)	1,588	0,41	14,758	1	0	4,893	2,177	11,001
condlav_ricod(17)	1,446	0,43	11,328	1	0	4,247	1,83	9,861
gender_w4(1)	0,062	0,14	0,188	1	0,66	1,064	0,805	1,406
ftgiv_w4(1)	-0,06	0,96	0,004	1	0,95	0,94	0,143	6,189
ftrec_w4(1)	-0,64	0,86	0,557	1	0,46	0,527	0,098	2,831
n_fratelli_cl_w4			9,983	5	0,08			
n_fratelli_cl_w4(1)	0	0,26	0	1	1	1	0,597	1,675
n_fratelli_cl_w4(2)	0,279	0,25	1,214	1	0,27	1,322	0,804	2,174
n_fratelli_cl_w4(3)	0,559	0,26	4,572	1	0,03	1,749	1,048	2,919
n_fratelli_cl_w4(4)	0,345	0,25	1,939	1	0,16	1,412	0,869	2,293
n_fratelli_cl_w4(5)	0,599	0,32	3,528	1	0,06	1,821	0,974	3,404
infocare_dato_hh_w4			3,076	4	0,55			
infocare_dato_hh_w4(1)	-0,32	0,34	0,876	1	0,35	0,73	0,377	1,412
infocare_dato_hh_w4(2)	-0,11	0,36	0,096	1	0,76	0,895	0,442	1,809
infocare_dato_hh_w4(3)	-1,55	1,08	2,037	1	0,15	0,213	0,025	1,782
infocare_dato_hh_w4(4)	-0,25	0,64	0,154	1	0,69	0,779	0,224	2,71
age_clas_w4			2,999	3	0,39			
age_clas_w4(1)	-0,49	0,35	2,007	1	0,16	0,611	0,309	1,208
age_clas_w4(2)	-0,59	0,35	2,932	1	0,09	0,554	0,282	1,089
age_clas_w4(3)	-0,5	0,36	1,923	1	0,17	0,609	0,302	1,228
hhsize_cl_w4			37,684	4	0			
hhsize_cl_w4(1)	-0,52	0,35	2,161	1	0,14	0,597	0,3	1,187
hhsize_cl_w4(2)	0,369	0,35	1,114	1	0,29	1,446	0,729	2,87
hhsize_cl_w4(3)	0,446	0,35	1,615	1	0,2	1,563	0,785	3,11
hhsize_cl_w4(4)	2,032	0,98	4,349	1	0,04	7,632	1,13	51,542
salute_gen_individ			3,273	4	0,51			
salute_gen_individ(1)	-0,38	0,46	0,672	1	0,41	0,685	0,278	1,692
salute_gen_individ(2)	-0,12	0,25	0,221	1	0,64	0,888	0,54	1,46
salute_gen_individ(3)	-1,24	0,81	2,347	1	0,13	0,29	0,059	1,413
salute_gen_individ(4)	0,123	0,34	0,13	1	0,72	1,131	0,58	2,207
Costante	-2,3	0,54	18,098	1	0	0,1		

SWEDEN WAVE 1, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod			46,6	8	0			
condlav_ricod(1)	0,701	0,26	7,327	1	0,01	2,016	1,213	3,35
condlav_ricod(2)	-0,88	1,06	0,687	1	0,41	0,416	0,052	3,314
condlav_ricod(3)	1,698	0,74	5,274	1	0,02	5,461	1,283	23,253
condlav_ricod(4)	1,284	0,24	29,54	1	0	3,61	2,272	5,735
condlav_ricod(5)	-0,64	1,08	0,354	1	0,55	0,526	0,063	4,368
condlav_ricod(6)	-1,39	1,16	1,432	1	0,23	0,249	0,026	2,426
condlav_ricod(7)	0,855	1,21	0,503	1	0,48	2,352	0,221	25,011
condlav_ricod(8)	1,359	0,3	20,07	1	0	3,893	2,148	7,056
Qexpt_y_w1			55,38	4	0			
Qexpt_y_w1(1)	-1,36	0,3	19,86	1	0	0,258	0,142	0,468
Qexpt_y_w1(2)	-0,32	0,25	1,595	1	0,21	0,728	0,445	1,192
Qexpt_y_w1(3)	-0,21	0,26	0,685	1	0,41	0,807	0,486	1,341
Qexpt_y_w1(4)	0,79	0,26	9,293	1	0	2,204	1,326	3,663
hh_infocare_w1			5,674	5	0,34			
hh_infocare_w1(1)	-0,3	0,35	0,761	1	0,38	0,739	0,374	1,459
hh_infocare_w1(2)	0,547	0,5	1,18	1	0,28	1,728	0,644	4,637
hh_infocare_w1(3)	-0,01	0,33	0	1	0,98	0,993	0,521	1,894
hh_infocare_w1(4)	0,808	0,54	2,269	1	0,13	2,244	0,784	6,421
hh_infocare_w1(5)	-0,43	0,83	0,268	1	0,61	0,65	0,127	3,324
hhsize_ricod			52,86	3	0			
hhsize_ricod(1)	-1,16	0,25	22,02	1	0	0,314	0,194	0,509
hhsize_ricod(2)	-0,72	0,29	6,144	1	0,01	0,487	0,276	0,86
hhsize_ricod(3)	0,531	0,3	3,141	1	0,08	1,701	0,945	3,061
ltc_prob_w1			1,528	2	0,47			
ltc_prob_w1(1)	0,047	0,33	0,02	1	0,89	1,048	0,548	2,001
ltc_prob_w1(2)	-0,31	0,32	0,986	1	0,32	0,73	0,393	1,358
hh_M_pub_bft_w1			3,356	2	0,19			
hh_M_pub_bft_w1(1)	0,193	0,35	0,298	1	0,59	1,213	0,607	2,424
hh_M_pub_bft_w1(2)	-0,62	0,37	2,852	1	0,09	0,54	0,264	1,104
hh_hprcare_ricod(1)	-0,75	0,42	3,2	1	0,07	0,475	0,21	1,074
gender_w1(1)	0,241	0,17	1,901	1	0,17	1,272	0,904	1,79
private_ltc_service_w1(1)	-1,86	1,15	2,62	1	0,11	0,155	0,016	1,481
no_infocare_w1(1)	0,663	0,32	4,413	1	0,04	1,94	1,045	3,6
Costante	-1,29	0,36	12,92	1	0	0,277		

SWEDEN WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
cond_lav_ricod			13,47	3	0			
cond_lav_ricod(1)	1,948	0,55	12,63	1	0	7,014	2,396	20,533
cond_lav_ricod(2)	0,73	0,57	1,615	1	0,2	2,075	0,673	6,395
cond_lav_ricod(3)	0,555	0,9	0,383	1	0,54	1,742	0,3	10,106
Q_totexpcare_y			42,3	4	0			
Q_totexpcare_y(1)	-3,47	0,82	17,8	1	0	0,031	0,006	0,156
Q_totexpcare_y(2)	-2,49	0,61	16,68	1	0	0,083	0,025	0,273
Q_totexpcare_y(3)	-1,61	0,49	10,88	1	0	0,2	0,077	0,52
Q_totexpcare_y(4)	-0,34	0,43	0,601	1	0,44	0,715	0,306	1,671
hh_infocare_3cat			9,734	4	0,05			
hh_infocare_3cat(1)	-0,16	0,41	0,149	1	0,7	0,855	0,387	1,892
hh_infocare_3cat(2)	-0,14	0,62	0,048	1	0,83	0,873	0,26	2,93
hh_infocare_3cat(3)	-2,27	1,11	4,147	1	0,04	0,104	0,012	0,918
hh_infocare_3cat(4)	-1,27	0,57	4,936	1	0,03	0,281	0,092	0,861
hhsize_3cat			5,377	2	0,07			
hhsize_3cat(1)	0,506	0,56	0,812	1	0,37	1,659	0,552	4,985
hhsize_3cat(2)	1,946	0,86	5,101	1	0,02	7	1,293	37,886
ltc_prob_w2			10,99	2	0			
ltc_prob_w2(1)	1,285	0,53	5,863	1	0,02	3,614	1,277	10,226
ltc_prob_w2(2)	1,682	0,51	10,74	1	0	5,378	1,967	14,709
Mhh_pub_bft_ltc			1,517	2	0,47			
Mhh_pub_bft_ltc(1)	0,792	0,64	1,517	1	0,22	2,207	0,626	7,779
Mhh_pub_bft_ltc(2)	0,159	0,82	0,038	1	0,85	1,172	0,237	5,798
pr_careM_w2			5,862	2	0,05			
pr_careM_w2(1)	-1,2	0,51	5,662	1	0,02	0,301	0,112	0,809
pr_careM_w2(2)	-0,74	0,89	0,704	1	0,4	0,476	0,084	2,699
gender_w2(1)	0,423	0,29	2,078	1	0,15	1,526	0,859	2,712
private_ltc_service_w2(1)	-0,38	1,22	0,095	1	0,76	0,686	0,062	7,546
Costante	-3,2	0,64	25,28	1	0	0,041		

SWEDEN WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hhsize_cl_w4			35,77	3	0			
hhsize_cl_w4(1)	-1,57	0,29	29,39	1	0	0,209	0,118	0,368
hhsize_cl_w4(2)	0,016	0,59	0,001	1	0,98	1,016	0,321	3,211
hhsize_cl_w4(3)	0,078	1,18	0,004	1	0,95	1,081	0,106	10,996
age_clas_over65			11,87	3	0,01			
age_clas_over65(1)	0,336	0,27	1,547	1	0,21	1,399	0,824	2,374
age_clas_over65(2)	0,64	0,27	5,512	1	0,02	1,897	1,112	3,238
age_clas_over65(3)	0,818	0,26	10,22	1	0	2,266	1,372	3,742
ltc_prob_w4			4,127	2	0,13			
ltc_prob_w4(1)	0,398	0,31	1,64	1	0,2	1,488	0,81	2,735
ltc_prob_w4(2)	0,558	0,28	4,075	1	0,04	1,747	1,016	3,002
hh_infocare_w4			9,643	7	0,21			
hh_infocare_w4(1)	-0,01	0,29	0,001	1	0,97	0,99	0,563	1,741
hh_infocare_w4(2)	-0,08	0,35	0,051	1	0,82	0,923	0,462	1,845
hh_infocare_w4(3)	0,231	0,51	0,202	1	0,65	1,26	0,46	3,452
hh_infocare_w4(4)	0,221	0,38	0,334	1	0,56	1,247	0,59	2,638
hh_infocare_w4(5)	0,733	0,74	0,972	1	0,32	2,081	0,485	8,93
hh_infocare_w4(6)	1,745	0,61	8,225	1	0	5,728	1,738	18,878
hh_infocare_w4(7)	0,339	0,88	0,149	1	0,7	1,403	0,251	7,849
riceve_transfert_w4(1)	0,509	0,36	1,973	1	0,16	1,663	0,818	3,381
condlav_ricod			9,806	3	0,02			
condlav_ricod(1)	-0,21	0,29	0,529	1	0,47	0,813	0,465	1,421
condlav_ricod(2)	-2,69	1,03	6,835	1	0,01	0,068	0,009	0,51
condlav_ricod(3)	1,151	0,73	2,508	1	0,11	3,16	0,761	13,129
no_infocare(1)	0,21	0,31	0,465	1	0,5	1,234	0,675	2,255
gender_w4(1)	0,332	0,17	3,996	1	0,05	1,394	1,007	1,93
Costante	-1,53	0,38	16,15	1	0	0,217		

SWEDEN, WAVE 1, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
RICOD_CONDLAV_1			10,67	6	0,1			
RICOD_CONDLAV_1(1)	1,722	1,055	2,661	1	0,1	5,594	0,707	44,276
RICOD_CONDLAV_1(2)	1,449	0,806	3,23	1	0,07	4,261	0,877	20,699
RICOD_CONDLAV_1(3)	0,063	0,841	0,006	1	0,94	1,065	0,205	5,535
RICOD_CONDLAV_1(4)	1,359	0,96	2,003	1	0,16	3,894	0,593	25,582
RICOD_CONDLAV_1(5)	2,076	0,969	4,593	1	0,03	7,975	1,194	53,258
RICOD_CONDLAV_1(6)	0,671	1,274	0,278	1	0,6	1,957	0,161	23,786
gender_w1(1)	0,446	0,439	1,035	1	0,31	1,562	0,661	3,691
n_fratelli_cl			2,891	5	0,72			
n_fratelli_cl(1)	-0,885	0,669	1,749	1	0,19	0,413	0,111	1,532
n_fratelli_cl(2)	-0,461	0,656	0,494	1	0,48	0,631	0,174	2,281
n_fratelli_cl(3)	-0,251	0,658	0,145	1	0,7	0,778	0,214	2,828
n_fratelli_cl(4)	-0,956	0,765	1,565	1	0,21	0,384	0,086	1,719
n_fratelli_cl(5)	-0,095	0,89	0,011	1	0,92	0,909	0,159	5,205
salute_gen_individ			2,543	4	0,64			
salute_gen_individ(1)	1,694	1,227	1,905	1	0,17	5,44	0,491	60,275
salute_gen_individ(2)	0,254	0,818	0,096	1	0,76	1,289	0,26	6,403
salute_gen_individ(3)	-0,003	1,131	0	1	1	0,997	0,109	9,15
salute_gen_individ(4)	0,596	0,588	1,027	1	0,31	1,815	0,573	5,745
Q_infocare_dato_w1			0,331	4	0,99			
Q_infocare_dato_w1(1)	-17,08	3050,55	0	1	1	0	0	.
Q_infocare_dato_w1(2)	-17,17	2683,93	0	1	1	0	0	.
Q_infocare_dato_w1(3)	-0,619	1,076	0,33	1	0,57	0,539	0,065	4,44
Q_infocare_dato_w1(4)	-0,024	0,681	0,001	1	0,97	0,976	0,257	3,708
hhsize_ricod			18,15	3	0			
hhsize_ricod(1)	-2,412	0,581	17,26	1	0	0,09	0,029	0,28
hhsize_ricod(2)	-1,411	0,698	4,084	1	0,04	0,244	0,062	0,958
hhsize_ricod(3)	-0,663	0,836	0,628	1	0,43	0,515	0,1	2,654
age_clas			4,919	3	0,18			
age_clas(1)	-1,545	0,753	4,214	1	0,04	0,213	0,049	0,933
age_clas(2)	-0,627	0,722	0,755	1	0,39	0,534	0,13	2,198
age_clas(3)	-1,122	0,817	1,885	1	0,17	0,326	0,066	1,616
ftgiv_w1(1)	1,007	1,124	0,802	1	0,37	2,737	0,302	24,78
ftrec_w1(1)	0,8	0,828	0,934	1	0,33	2,225	0,439	11,269
Costante	-2,494	1,142	4,775	1	0,03	0,083		

SWEDEN, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
ricod_cond_lav			39,93	12	0			
ricod_cond_lav(1)	2,056	0,63	10,712	1	0	7,814	2,281	26,763
ricod_cond_lav(2)	1,063	0,44	5,979	1	0,01	2,896	1,235	6,789
ricod_cond_lav(3)	1,684	1,12	2,264	1	0,13	5,388	0,601	48,325
ricod_cond_lav(4)	1,672	0,82	4,187	1	0,04	5,321	1,073	26,381
ricod_cond_lav(5)	3,157	0,91	11,928	1	0	23,51	3,918	141,027
ricod_cond_lav(6)	1,69	0,5	11,545	1	0	5,42	2,045	14,369
ricod_cond_lav(7)	1,327	0,51	6,824	1	0,01	3,77	1,393	10,205
ricod_cond_lav(8)	2,273	0,61	13,687	1	0	9,712	2,912	32,384
ricod_cond_lav(9)	0,946	0,68	1,944	1	0,16	2,576	0,681	9,742
ricod_cond_lav(10)	2,175	0,67	10,591	1	0	8,806	2,376	32,639
ricod_cond_lav(11)	3,338	0,8	17,495	1	0	28,16	5,893	134,527
ricod_cond_lav(12)	2,657	0,93	8,224	1	0	14,26	2,319	87,663
gender_w2(1)	0,194	0,26	0,557	1	0,46	1,214	0,729	2,022
salute_gen_individ			3,545	4	0,47			
salute_gen_individ(1)	-1,23	1,07	1,311	1	0,25	0,292	0,036	2,4
salute_gen_individ(2)	0,478	0,36	1,729	1	0,19	1,613	0,791	3,288
salute_gen_individ(3)	-0,02	0,67	0,001	1	0,97	0,979	0,262	3,661
salute_gen_individ(4)	0,285	0,45	0,404	1	0,53	1,33	0,552	3,201
Q_infocare_dato			2,954	4	0,57			
Q_infocare_dato(1)	-0,36	0,48	0,571	1	0,45	0,696	0,272	1,782
Q_infocare_dato(2)	0,242	0,42	0,339	1	0,56	1,274	0,564	2,875
Q_infocare_dato(3)	-0,45	0,64	0,494	1	0,48	0,637	0,181	2,243
Q_infocare_dato(4)	-0,71	0,57	1,534	1	0,22	0,493	0,161	1,51
n_fratelli_cl			4,519	5	0,48			
n_fratelli_cl(1)	0,208	0,45	0,21	1	0,65	1,231	0,506	2,993
n_fratelli_cl(2)	0,398	0,46	0,754	1	0,39	1,489	0,606	3,659
n_fratelli_cl(3)	0,644	0,47	1,842	1	0,18	1,904	0,751	4,824
n_fratelli_cl(4)	0,789	0,47	2,834	1	0,09	2,202	0,878	5,519
n_fratelli_cl(5)	0,121	0,84	0,021	1	0,89	1,128	0,218	5,843
hhsize_cl			25,505	3	0			
hhsize_cl(1)	-0,17	0,47	0,132	1	0,72	0,844	0,339	2,104
hhsize_cl(2)	1,059	0,57	3,486	1	0,06	2,883	0,949	8,762
hhsize_cl(3)	1,825	0,58	9,886	1	0	6,205	1,989	19,358
age_clas			3,42	3	0,33			
age_clas(1)	0,289	0,81	0,126	1	0,72	1,335	0,271	6,571
age_clas(2)	0,852	0,81	1,108	1	0,29	2,345	0,48	11,466
age_clas(3)	0,89	0,83	1,148	1	0,28	2,436	0,478	12,422
ricod_ft_giv(1)	-0,12	1,07	0,013	1	0,91	0,886	0,108	7,241
ricod_ft_rec(1)	-0,63	0,59	1,149	1	0,28	0,532	0,168	1,686
Costante	-5,41	1,06	26,166	1	0	0,004		

SWEDEN, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod_2			43,89	7	0			
condlav_ricod_2(1)	2,335	0,771	9,17	1	0	10,33	2,279	46,826
condlav_ricod_2(2)	4,281	0,941	20,71	1	0	72,316	11,442	457,055
condlav_ricod_2(3)	0,174	0,695	0,063	1	0,8	1,19	0,305	4,646
condlav_ricod_2(4)	2,908	0,849	11,74	1	0	18,317	3,47	96,692
condlav_ricod_2(5)	1,482	0,83	3,191	1	0,07	4,403	0,866	22,395
condlav_ricod_2(6)	3,041	0,878	11,99	1	0	20,936	3,743	117,113
condlav_ricod_2(7)	3,796	0,878	18,72	1	0	44,537	7,976	248,701
gender_w4(1)	0,615	0,465	1,75	1	0,19	1,849	0,744	4,599
ftgiv_w4(1)	0,77	1,497	0,264	1	0,61	2,159	0,115	40,639
ftrec_w4(1)	0,483	1,261	0,147	1	0,7	1,62	0,137	19,167
n_fratelli_cl_w4			6,016	5	0,31			
n_fratelli_cl_w4(1)	-0,142	0,687	0,042	1	0,84	0,868	0,226	3,337
n_fratelli_cl_w4(2)	0,55	0,697	0,623	1	0,43	1,734	0,442	6,802
n_fratelli_cl_w4(3)	-0,816	0,838	0,949	1	0,33	0,442	0,086	2,283
n_fratelli_cl_w4(4)	0,708	0,736	0,925	1	0,34	2,03	0,48	8,594
n_fratelli_cl_w4(5)	1,042	1,144	0,83	1	0,36	2,834	0,301	26,659
infocare_dato_hh_w4			0,594	4	0,96			
infocare_dato_hh_w4(1)	-19,41	15520,85	0	1	1	0	0	.
infocare_dato_hh_w4(2)	-18,31	4393,802	0	1	1	0	0	.
infocare_dato_hh_w4(3)	-0,797	1,113	0,512	1	0,47	0,451	0,051	3,996
infocare_dato_hh_w4(4)	-0,404	1,177	0,118	1	0,73	0,668	0,067	6,702
age_clas_w4			0,687	2	0,71			
age_clas_w4(1)	0,518	1,186	0,191	1	0,66	1,679	0,164	17,146
age_clas_w4(2)	0,158	1,197	0,017	1	0,9	1,171	0,112	12,224
hhsize_cl_w4			14,25	3	0			
hhsize_cl_w4(1)	-0,792	0,62	1,633	1	0,2	0,453	0,134	1,526
hhsize_cl_w4(2)	1,22	0,692	3,109	1	0,08	3,388	0,873	13,155
hhsize_cl_w4(3)	1,665	0,925	3,242	1	0,07	5,286	0,863	32,383
salute_gen_individ			3,206	4	0,52			
salute_gen_individ(1)	0,45	1,303	0,119	1	0,73	1,568	0,122	20,138
salute_gen_individ(2)	-0,795	0,891	0,795	1	0,37	0,452	0,079	2,592
salute_gen_individ(3)	0,746	1,316	0,322	1	0,57	2,109	0,16	27,814
salute_gen_individ(4)	-1,517	1,107	1,877	1	0,17	0,219	0,025	1,921
Costante	-4,477	1,493	8,994	1	0	0,011		

POLAND, WAVE 2, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hh_size4cat			214,31	3	0			
hh_size4cat(1)	2,035	0,42	23,291	1	0	7,656	3,35	17,498
hh_size4cat(2)	2,831	0,47	36,434	1	0	16,957	6,763	42,513
hh_size4cat(3)	6,053	0,49	152,15	1	0	425,36	162,576	1112,876
Qtotcareexp_y			87,142	4	0			
Qtotcareexp_y(1)	-2,55	0,45	32,169	1	0	0,078	0,032	0,188
Qtotcareexp_y(2)	-1,53	0,43	12,461	1	0	0,217	0,093	0,506
Qtotcareexp_y(3)	-1,14	0,41	7,869	1	0,01	0,32	0,144	0,709
Qtotcareexp_y(4)	0,869	0,37	5,416	1	0,02	2,384	1,147	4,955
hh_infocare_prova			12,62	5	0,03			
hh_infocare_prova(1)	0,722	0,42	2,896	1	0,09	2,059	0,896	4,731
hh_infocare_prova(2)	1,432	0,59	5,916	1	0,02	4,188	1,321	13,283
hh_infocare_prova(3)	-0,12	0,44	0,072	1	0,79	0,89	0,379	2,089
hh_infocare_prova(4)	-0,52	0,54	0,944	1	0,33	0,595	0,209	1,696
hh_infocare_prova(5)	0,22	0,39	0,322	1	0,57	1,246	0,583	2,665
ltc_prob_w2			0,526	2	0,77			
ltc_prob_w2(1)	-0,2	0,42	0,231	1	0,63	0,817	0,358	1,865
ltc_prob_w2(2)	0,056	0,35	0,026	1	0,87	1,058	0,537	2,085
age_3cat			0,679	2	0,71			
age_3cat(1)	0,057	0,24	0,055	1	0,81	1,059	0,657	1,707
age_3cat(2)	0,331	0,4	0,674	1	0,41	1,392	0,632	3,066
hhpub_bftltc_M			2,118	2	0,35			
hhpub_bftltc_M(1)	0,916	0,65	1,974	1	0,16	2,5	0,696	8,972
hhpub_bftltc_M(2)	-0,31	1,01	0,096	1	0,76	0,732	0,102	5,266
gender_w2(1)	0,211	0,23	0,822	1	0,37	1,235	0,782	1,949
condlav_fam_prova			58,027	6	0			
condlav_fam_prova(1)	2,03	0,3	47,001	1	0	7,613	4,261	13,602
condlav_fam_prova(2)	2,341	1,02	5,283	1	0,02	10,388	1,412	76,446
condlav_fam_prova(3)	-2,07	0,86	5,772	1	0,02	0,126	0,023	0,683
condlav_fam_prova(4)	1,229	0,42	8,643	1	0	3,419	1,506	7,758
condlav_fam_prova(5)	1,466	1,03	2,029	1	0,15	4,33	0,576	32,532
condlav_fam_prova(6)	1,459	1,25	1,353	1	0,25	4,302	0,368	50,27
private_ltc_service_w2(1)	-1,07	1,38	0,605	1	0,44	0,343	0,023	5,098
Costante	-4,9	0,57	74,639	1	0	0,007		

POLAND, WAVE 4, POPULATION OVER 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
hhsize_cl_w4			58,81	4	0			
hhsize_cl_w4(1)	-0,56	0,28	3,942	1	0,05	0,573	0,331	0,993
hhsize_cl_w4(2)	-0,26	0,32	0,683	1	0,41	0,768	0,411	1,436
hhsize_cl_w4(3)	0,624	0,27	5,167	1	0,02	1,866	1,09	3,195
hhsize_cl_w4(4)	1,348	0,4	11,58	1	0	3,851	1,771	8,372
age_clas_over65			2,248	3	0,52			
age_clas_over65(1)	0,114	0,23	0,252	1	0,62	1,12	0,719	1,746
age_clas_over65(2)	0,322	0,23	2,011	1	0,16	1,38	0,884	2,154
age_clas_over65(3)	0,237	0,23	1,067	1	0,3	1,267	0,809	1,985
ltc_prob_w4			0,109	2	0,95			
ltc_prob_w4(1)	0,037	0,33	0,013	1	0,91	1,038	0,547	1,968
ltc_prob_w4(2)	0,083	0,26	0,106	1	0,75	1,086	0,659	1,791
hh_infocare_w4			3,322	7	0,85			
hh_infocare_w4(1)	0,608	0,46	1,768	1	0,18	1,836	0,75	4,497
hh_infocare_w4(2)	-0,19	0,49	0,15	1	0,7	0,826	0,315	2,17
hh_infocare_w4(3)	-0,15	0,35	0,172	1	0,68	0,864	0,434	1,721
hh_infocare_w4(4)	0,216	0,3	0,509	1	0,48	1,241	0,686	2,247
hh_infocare_w4(5)	0,299	0,77	0,149	1	0,7	1,348	0,296	6,144
hh_infocare_w4(6)	0,266	0,68	0,154	1	0,7	1,304	0,346	4,921
hh_infocare_w4(7)	0,117	0,46	0,066	1	0,8	1,124	0,46	2,747
Mhh_pub_bft_ltc_w4			0,473	2	0,79			
Mhh_pub_bft_ltc_w4(1)	-0,2	0,52	0,154	1	0,7	0,815	0,294	2,263
Mhh_pub_bft_ltc_w4(2)	0,415	0,81	0,26	1	0,61	1,514	0,307	7,464
condlav_ricod			2,792	6	0,83			
condlav_ricod(1)	0,151	0,22	0,474	1	0,49	1,163	0,756	1,789
condlav_ricod(2)	0,677	0,67	1,01	1	0,32	1,969	0,525	7,38
condlav_ricod(3)	0,219	0,55	0,16	1	0,69	1,245	0,425	3,646
condlav_ricod(4)	-0,15	0,38	0,153	1	0,7	0,86	0,406	1,825
condlav_ricod(5)	0,767	0,68	1,283	1	0,26	2,154	0,571	8,125
condlav_ricod(6)	0,189	0,55	0,117	1	0,73	1,208	0,409	3,572
no_infocare(1)	-0,47	0,28	2,863	1	0,09	0,627	0,365	1,077
gender_w4(1)	0,201	0,16	1,613	1	0,2	1,223	0,896	1,669
Costante	-1,05	0,32	10,63	1	0	0,35		

POLAND, WAVE 2, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
ricod_cond_lav			164,44	17	0			
ricod_cond_lav(1)	1,978	0,39	25,945	1	0	7,231	3,378	15,483
ricod_cond_lav(2)	0,362	0,44	0,686	1	0,41	1,436	0,61	3,377
ricod_cond_lav(3)	0,98	0,57	2,964	1	0,09	2,664	0,873	8,127
ricod_cond_lav(4)	0,738	0,4	3,456	1	0,06	2,092	0,961	4,555
ricod_cond_lav(5)	1,804	0,41	19,694	1	0	6,077	2,739	13,483
ricod_cond_lav(6)	1,797	0,42	18,728	1	0	6,029	2,672	13,603
ricod_cond_lav(7)	0,147	0,39	0,139	1	0,71	1,158	0,535	2,507
ricod_cond_lav(8)	1,778	0,45	15,808	1	0	5,92	2,464	14,226
ricod_cond_lav(9)	-0,09	0,45	0,041	1	0,84	0,913	0,379	2,199
ricod_cond_lav(10)	0,925	0,48	3,653	1	0,06	2,521	0,977	6,505
ricod_cond_lav(11)	2,468	0,64	14,85	1	0	11,8	3,363	41,423
ricod_cond_lav(12)	2,79	0,48	34,318	1	0	16,29	6,403	41,425
ricod_cond_lav(13)	3,053	0,46	44,984	1	0	21,19	8,68	51,703
ricod_cond_lav(14)	2,02	0,44	21,512	1	0	7,539	3,211	17,705
ricod_cond_lav(15)	3,855	0,69	31,265	1	0	47,21	12,225	182,327
ricod_cond_lav(16)	1,654	0,94	3,112	1	0,08	5,228	0,832	32,846
ricod_cond_lav(17)	3,746	0,48	61,006	1	0	42,36	16,547	108,457
gender_w2(1)	0,114	0,17	0,472	1	0,49	1,121	0,81	1,551
salute_gen_individ			5,205	4	0,27			
salute_gen_individ(1)	-0,2	0,58	0,112	1	0,74	0,823	0,263	2,579
salute_gen_individ(2)	-0,21	0,27	0,628	1	0,43	0,81	0,481	1,364
salute_gen_individ(3)	-1,79	0,85	4,409	1	0,04	0,168	0,032	0,888
salute_gen_individ(4)	-0,19	0,27	0,521	1	0,47	0,825	0,49	1,391
Q_infocare_dato			13,013	4	0,01			
Q_infocare_dato(1)	-2,34	0,87	7,216	1	0,01	0,096	0,018	0,531
Q_infocare_dato(2)	-0,55	0,53	1,079	1	0,3	0,577	0,205	1,628
Q_infocare_dato(3)	-0,47	0,52	0,823	1	0,36	0,626	0,227	1,723
Q_infocare_dato(4)	-1,32	0,62	4,6	1	0,03	0,267	0,08	0,892
n_fratelli_cl			8,132	5	0,15			
n_fratelli_cl(1)	0,35	0,33	1,123	1	0,29	1,419	0,743	2,713
n_fratelli_cl(2)	0,367	0,33	1,267	1	0,26	1,443	0,762	2,735
n_fratelli_cl(3)	0,351	0,34	1,071	1	0,3	1,42	0,731	2,761
n_fratelli_cl(4)	0,466	0,33	2,001	1	0,16	1,593	0,836	3,038
n_fratelli_cl(5)	1,283	0,47	7,578	1	0,01	3,609	1,447	9
hhsize_cl			118,54	4	0			
hhsize_cl(1)	0,226	0,34	0,445	1	0,51	1,254	0,645	2,438
hhsize_cl(2)	1,068	0,35	9,195	1	0	2,91	1,459	5,804
hhsize_cl(3)	2,111	0,34	38,042	1	0	8,257	4,222	16,149
hhsize_cl(4)	3,014	0,43	49,937	1	0	20,36	8,827	46,968
age_clas			4,599	3	0,2			
age_clas(1)	-0,57	0,35	2,634	1	0,11	0,567	0,285	1,125
age_clas(2)	-0,51	0,37	1,895	1	0,17	0,601	0,291	1,241
age_clas(3)	-0,22	0,41	0,296	1	0,59	0,8	0,358	1,787
ft_giv_cat(1)	-0,31	0,67	0,214	1	0,64	0,733	0,197	2,73
ft_rec_cat(1)	0,276	0,61	0,206	1	0,65	1,318	0,4	4,341
Costante	-3,73	0,6	39,21	1	0	0,024		

POLAND, WAVE 4, POPULATION AGED BETWEEN 50 AND 65 YEARS

							95% CI per EXP(B)	
	B	E.S.	Wald	df	Sig.	Exp(B)	Inferiore	Superiore
condlav_ricod_1			63,293	16	0			
condlav_ricod_1(1)	1,961	0,54	13,244	1	0	7,106	2,472	20,43
condlav_ricod_1(2)	0,463	0,61	0,582	1	0,45	1,589	0,483	5,22
condlav_ricod_1(3)	1,402	0,68	4,226	1	0,04	4,065	1,068	15,479
condlav_ricod_1(4)	1,888	0,54	12,428	1	0	6,606	2,312	18,869
condlav_ricod_1(5)	1,694	0,74	5,28	1	0,02	5,441	1,283	23,076
condlav_ricod_1(6)	0,913	0,59	2,386	1	0,12	2,492	0,782	7,941
condlav_ricod_1(7)	1,432	0,51	7,934	1	0,01	4,189	1,546	11,35
condlav_ricod_1(8)	1,907	0,61	9,651	1	0	6,732	2,022	22,419
condlav_ricod_1(9)	1,741	0,53	10,795	1	0	5,703	2,019	16,112
condlav_ricod_1(10)	1,48	0,72	4,24	1	0,04	4,393	1,074	17,974
condlav_ricod_1(11)	3,347	0,63	28,144	1	0	28,42	8,252	97,875
condlav_ricod_1(12)	2,571	0,71	13,08	1	0	13,08	3,247	52,713
condlav_ricod_1(13)	3,911	0,77	25,547	1	0	49,96	10,963	227,64
condlav_ricod_1(14)	2,442	1,05	5,401	1	0,02	11,49	1,466	90,093
condlav_ricod_1(15)	2,8	0,64	19,051	1	0	16,44	4,677	57,817
condlav_ricod_1(16)	1,77	0,73	5,924	1	0,02	5,871	1,412	24,421
gender_w4(1)	-0,06	0,21	0,084	1	0,77	0,94	0,62	1,425
ftgiv_w4(1)	-0,48	1,16	0,171	1	0,68	0,62	0,064	5,97
ftrec_w4(1)	-0,16	0,82	0,036	1	0,85	0,856	0,172	4,249
n_fratelli_cl_w4			6,959	5	0,22			
n_fratelli_cl_w4(1)	0,227	0,3	0,573	1	0,45	1,254	0,698	2,255
n_fratelli_cl_w4(2)	0,233	0,3	0,598	1	0,44	1,262	0,7	2,277
n_fratelli_cl_w4(3)	-0,26	0,34	0,583	1	0,45	0,774	0,4	1,495
n_fratelli_cl_w4(4)	0,509	0,34	2,278	1	0,13	1,663	0,859	3,219
n_fratelli_cl_w4(5)	-0,93	0,86	1,167	1	0,28	0,395	0,073	2,132
infocare_dato_hh_w4			7,547	4	0,11			
infocare_dato_hh_w4(1)	0,125	0,53	0,057	1	0,81	1,134	0,405	3,174
infocare_dato_hh_w4(2)	-1,51	0,84	3,192	1	0,07	0,222	0,043	1,157
infocare_dato_hh_w4(3)	-1,35	0,97	1,963	1	0,16	0,258	0,039	1,716
infocare_dato_hh_w4(4)	1,469	0,99	2,217	1	0,14	4,343	0,628	30,018
age_clas_w4			2,431	3	0,49			
age_clas_w4(1)	-0,32	1,24	0,066	1	0,8	0,726	0,064	8,286
age_clas_w4(2)	-1,15	1,04	1,221	1	0,27	0,316	0,041	2,438
age_clas_w4(3)	-1,1	1,05	1,085	1	0,3	0,334	0,042	2,629
hhsize_cl_w4			35,793	4	0			
hhsize_cl_w4(1)	-0,19	0,43	0,202	1	0,65	0,824	0,354	1,917
hhsize_cl_w4(2)	1,032	0,44	5,479	1	0,02	2,807	1,183	6,662
hhsize_cl_w4(3)	1,154	0,43	7,074	1	0,01	3,172	1,355	7,424
hhsize_cl_w4(4)	1,398	0,63	5,008	1	0,03	4,049	1,19	13,781
salute_gen_individ			10,441	4	0,03			
salute_gen_individ(1)	-1,05	1,08	0,943	1	0,33	0,351	0,042	2,905
salute_gen_individ(2)	-0,22	0,35	0,383	1	0,54	0,807	0,409	1,592
salute_gen_individ(3)	-2,06	1,13	3,334	1	0,07	0,128	0,014	1,163
salute_gen_individ(4)	0,724	0,32	5,01	1	0,03	2,062	1,094	3,887
Costante	-2,2	1,22	3,262	1	0,07	0,111		