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Mixed Care for Elderly People in Spain and France: A Comparative Analysis

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Abstract

The aim of this paper is to make a comparative analysis of the factors influencing the receipt of mixed care in over 65's in France and Spain who receive informal care. As a data source we used the SHARE w4 for 2011. We applied binary logistic regression models for the analysis of the factors predicting the use of mixed care. The main results are gender is a significant factor in Spain but not in France. The income and the receipt of additional regular state subsidies or benefits increase the use of mixed care in both countries. Our findings suggest that the dynamics of spatial proximity to their social network are different. In France the social network is more dispersed in the territory, while in Spain it tends to be concentrated within less than 1 km. It was confirmed that mixed care is an additional complement for those receiving informal care.

Keywords: mixed care, informal care, social networks, proximity, gender, age.

Introduction

The EU member states are committed to providing long-term health care. This commitment has transformed the traditional notion in which the care of an individual was a family problem into a social problem requiring state support (Due, Holstein, Lund, Modvig, & Avlund, 1999; Pavolini & Ranci, 2008).

Long-term care systems in Europe have a common structure in terms of services (old people's care homes or care in the home and in terms of the financial benefits that can be used to pay for informal care or offset its costs (Rodrigues, Huber, & Lamura, 2012). Even though the structure is similar, the principle of universal health cover and the levels of protection regarding the treatment of

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people in dependency situations varies a great deal from one country to the next (OECD, 2005).

This scenario is producing changes in the implementation of social policies and an important process of budgetary reform in most countries (OECD, 2005; Pickard *et al.*, 2007; Pavolini & Ranci, 2008; Huber, Rodrigues, Hoffmann, Gąsior, & Marin, 2009; Kraus *et al.*, 2010; Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). These changes are likely to have far-reaching effects on the social protection schemes for the elderly and for dependent people in Spain and France.

In Spain, there are two key moments in the development of the social protection system for elderly and dependent people. The first was at the end of the 1980s in which there was an increase in institutionalization via the creation of psychiatric hospitals and high capacity care homes. In 1992 the State Gerontology Plan defined the impact of ageing, its economic, social and political implications and its role in the transformation of family customs and structures.

This provoked a new debate about the care of elderly people with needs in their everyday lives (Sancho Castiello & Diaz Martin, 2006) and helped visualize the family care traditionally provided within the privacy of the home.

The second key period began in the year 2002 with the renovation of the *Pact of Toledo* cross-party pensions agreement and the emergence of a new generation of social rights in the EU as a result of socio-demographic changes (Rodriguez Cabrero, 2011). This culminated with the publication and implementation of the Law of Dependence in December 2006. The basic pillars of this law were the principles of universality, accessibility and fairness which together produced a new subjective right, the right of people in a situation of dependence to receive care. This gave rise to the *Sistema de Autonomia y Atención a la Dependencia (SAAD)* (System for the Promotion of the Personal Autonomy and Care of People in a Situation of Dependence) which was established as a new form of social welfare protection, extending and complementing the protective work conducted until then by the health and social security system. The SAAD offers a series of economic benefits in terms of personal care, care within the family and support to non- professional carers, along with services such as telephone help lines, home help service, day and night centers, and residential care services. These mixed care services have grown in recent years but there are still big differences in provision around the country (Garcia, Prieto-Flores, & Rosenberg, 2008).

The SAAD has two main sources of funding: public and private. Public funding comes from central government and local councils and is insufficient to cover all needs (Camacho, Rodriguez, & Hernández, 2008). Private funding involves either the beneficiaries paying the full cost of their treatment or a joint payment system in which the amount beneficiaries have to pay for the service varies according to their economic capacity to pay for it.

In France policies relating to the care of elderly and dependent people have appeared relatively recently. They did not enter the political agenda until the mid-1980s due to the fact that care was traditionally provided within the family. Until 1994 there was no real social policy aimed at dependent people, just political debate and a few reports from experts. Social cover for elderly dependent people was associated with disabled status via a compensatory allowance for those requiring help from outside the family (*Allocation compensatrice pour tierce personne*) (Martin & Le Bihan, 2007).

In 1997 the French Government set up the specific dependence provision or PSD (*Prestation Specifique Dependance*) created to provide cover for disabled elderly people and managed at a local level. This scheme received numerous criticisms because of its restrictive access criteria (Da Roit, Le Bihan, & Osterle, 2007). As a result in 2002 a system of universal cover (known as *Allocation perssonalisèe á l'autonomie or APA*) based on the provision of long-term care was established. This allowance was aimed at over-60s living at home or in an institution who needed help with everyday activities. An income threshold was established to calculate the contribution that each user had to make towards the cost of the service. Those people whose income was below the established threshold did not have to pay, while for those with higher incomes there was a joint payment system in which the richest participants paid up to 90% of the monthly cost of the service provided (Bihan & Martin, 2013). The system was implemented and managed at local level and the State guaranteed the same level of access to these services all over the country.

With the basic premise of keeping the person at home for as long as possible, in the year 2003 numerous plans and a varied range of services (home care services, nursing care services, temporary accommodation, day care services) were established, leading to an increase in the presence of formal careers and services (Le Bihan, 2012).

In France the care of dependent people has consolidated its position as the fifth risk (the others are health, pensions, family and accidents at work) in the state-family-market triangle and the funding system is under debate.

Spain and France both have welfare state models in which personal care has been and continues to be viewed within the context of the family and is considered a natural resource in which the State has tended to play a subsidiary role (Geerts & Van, 2012). Today the traditional system of care is undergoing a process of transition for the following reasons: the ageing of the population, the increase in dependency situations and the demand for care, the progressive reduction in the availability of informal carers with the increasing participation of women in the labour market, changes in family structures and dynamics and an increase in the mobility of the members of family units (European Commision, 2012; Rechel *et*

al., 2013). The object of our study is to make a comparative analysis of the factors that predict the use of mixed care amongst over 65s in France and Spain.

Sample and Methods

Our analysis uses data from the Survey of Health, Ageing and Retirement in Europe (SHARE) release 1.0.0 of wave 4 for the year 2011. SHARE is a multi-disciplinary survey which analyses the state of health, the socioeconomic level and the social and family networks of over 50s in 16 European countries.

We made a comparative analysis of the factors that influence the reception of mixed care in over 65s in Spain and France who receive informal care. Informal care is provided by members of the family or by friends and/or neighbours within the elderly person's closest circle. Mixed care is a combination of informal care and professional care and services provided by public or private bodies. It is based on a complex system which combines family action with that of the market and the state (Le Bihan & Martin, 2010).

The sample group was constructed on the basis of the following questions from the SHARE survey: Thinking about the last twelve months has any family member from *outside the household*, any friend or neighbor given you personal care or practical household help?, *Which family member or other from outside the household*, friend or neighbor has helped you in the last twelve months? and Is there *someone living in this household who* has helped you regularly during the last twelve months with personal care, such as washing, getting out of bed, or dressing? Who is that? Those who simultaneously answered that they receive help from professional care providers, who identified family members from older generations and replied "no" when asked if they received informal care were excluded from the analysis.

The sample group is therefore made up of those who answered yes to the question about receiving informal care. These questions help establish the type of care received by over 65s in Spain (N329) and France (N401).

Method

The objective of our statistical analysis was to estimate the factors that predict receipt of mixed care in over 65s in Spain and France who receive informal care. The model used was a binary logistic regression. The dependent variable *receives personal care* has two categories: mixed care (value 1) as a reference and informal care (value 0). The exploratory variables are divided into four groups: personal factors, health factors, economic factors and socio-territorial factors. The IBM SPSS version 20.0 statistical software package was used.

Measures

Personal factors: The personal characteristics of receivers of personal care include gender, age over 65 and the binary variable 'living in a couple'.

Health factors: The number and degree of the limitations that older people experience in their daily lives determines the need for personal care and the type received. SHARE classifies everyday activities into two large groups according to their difficulty and purpose (see, *Table* 1*): Activities of Daily Living (ADL)* essentially those activities involving care of oneself, and *Instrumental Activities of Daily Living (IADL)* more complex activities that generally involve a relation between a person and their environment. These activities help the person adapt to or deal with their surrounding environment.

Table 1. Classification of Basic and Instrumental Activities of Daily Living. Adapted (Chan, Kasper, Brandt, & Pezzin, 2012)

Dimensions	Activities
Activities of Daily Living (ADL). Number of limitations: 0 to 6.	Dressing, including putting on shoes and socks. Walking across a room. Bathing or showering. Eating, such as cutting up your food. Getting in and out of bed . Using the toilet, including getting up or down.
Instrumental Activities of Daily Living (IADL). Number of limitations: 0 to 7.	Using a map to figure out how to get around in a strange place Preparing a hot meal Shopping for groceries Making telephone calls Taking medication Doing work around the house or garden Managing money, such as paying bills and keeping track of expenses

Economic factors. Annual household income (*thinc* variable) is classified bearing in mind the average income for EU 27, which in 2011 was 16,618 euros (Eurostat, 2015), producing a new binary variable: income lower than or equal to the average and above average. Spain and France have a system of *periodic public economic benefits* such as retirement pensions, early retirement, sickness benefit, disability pensions and social welfare benefits. SHARE allows us to group them together and create a binary variable 'receives' or 'does not receive' regular public economic benefits.

Socio-territorial factors. In our research we consider the proximity of the *elderly person's social network* to be a territorial factor. This network can be defined as the group of people and the family relations and/or affective bonds between them. This means that the social network is made up not only of family

members but also of friends, neighbours, colleagues, ex-colleagues etc. (Due, Holstein, Lund, Modvig, & Avlund, 1999; Puga, Rosero-Bixby, Glaser, & Castro, 2007)

Recent studies on the structure, type and implications of the social networks of elderly people include among others (Litwin, 1996; Mutchler & Burr, 2003; Garcia *et al.*, 2005; Fiori, Antonucci & Cortina, 2006; Choi, Burr, Mutchler & Caro, 2007; Litwin, 2009; Fiori, Consedine & Merz, 2011). SHARE w4 includes a new module called social networks, which contains the main variables that describe and characterize the elderly person's social network. As a result in our research we use the *size of the social network* made up of those people who are emotionally close or very close as identified by the person being interviewed (see more in McPherson, Smith-Lovin & Brashears, 2009; Litwin, Stoeckel, Roll & Shiovitz-Ezra, 2013).

The *territorial perspective* is included in our study through the question, where does member X of the social network live? The geographical proximity between the person being interviewed and each member of their social network is classified into a maximum of seven categories. Each category was then awarded a score of between nine and one with the highest scores going to the members with maximum proximity (Table 2). As a result we obtained a variable called *maximum geographical proximity,* which identifies the member who is physically closest to the person being interviewed without going into more detail as regards the internal characteristics of the social network.

Table 2. Scoring system used in the calculation of the maximum geographic proximity variable

Categories	Score
Same home/ same building	9/8
Less than 1 km	7
Between 1 and 5 km	6
Between 5 and 25 km	5
Over 25km/ Between 25-100km/ 100-500km/ Over 500km/ Specify country.	4/3/2/1
Missing, Refusal and Don't Know	Not recorded

Results

Table 3 shows the results for the variables used in the analysis. The first thing we observe is that the use of mixed care is much lower in Spain at around 15%, compared with France where 32.4% of the population of 65 or over receives it. Within the over 65s, the groups that receive most personal care in both countries are octogenarians and women (about 68%).

In France 66.8% of the over 65s who receive personal care do not live in a couple. In Spain by contrast over half live with their spouses or partners.

The economic asymmetries between Spain and France are also very significant. 69.3% of Spanish seniors have an income level which is lower than the average for EU 27. And only half of them receive regular public economic benefits compared to 90% in France.

If we analyse social networks and their proximity to the elderly person (Figure 2), we find that the size of the social network is similar in France and Spain. However there are substantial differences in terms of proximity. In Spain two thirds of the care is provided inside the home while in France this figure is only one third. The numbers within 1 km are similar, while the social network between 1km and 25 km is significantly larger in France than in Spain.

Table 3. Descriptive analysis of the variables involved in the study on the basis of the SHARE data

	Spain	France
Informal care (%)	85.1	67.6
Mixed care (%)	14.9	32.4
Age (average) (SD)	79.4 (7.6)	80 (7.7)
Gender		
Men (%)	31.9	32.4
Women (%)	68.1	67.6
Live in a couple		
Yes (%)	55	33.2
No (%)	45	66.8
ADL (average)(SD)	1.7 (2.1)	0.9 (1.5)
IADL (average)(SD)	2.4(2.5)	1.5 (1.9)
Annual income		
Less than or equal to EU 27 (%)	69.3	45.6
Above average EU 27 (%)	30.7	54.4
Periodic public economic benefits		
Does not receive (%)	50.5	9.9
Does receive (%)	49.5	90

	Spain	France
Size of social network (average) (SD)	2.3 (1.5)	2.5(1.6)
Member of the social network with greatest geographical proximity		
Same home (%)	60.2	35.4
Less than 1 km (%)	24	27.4
Between 1 and 5 km (%)	6.7	16.4
Between 5 and 25 km (%)	3.6	10.5
Over 25 km (%)	0	5.5
N/A (%)	5.5	4.7

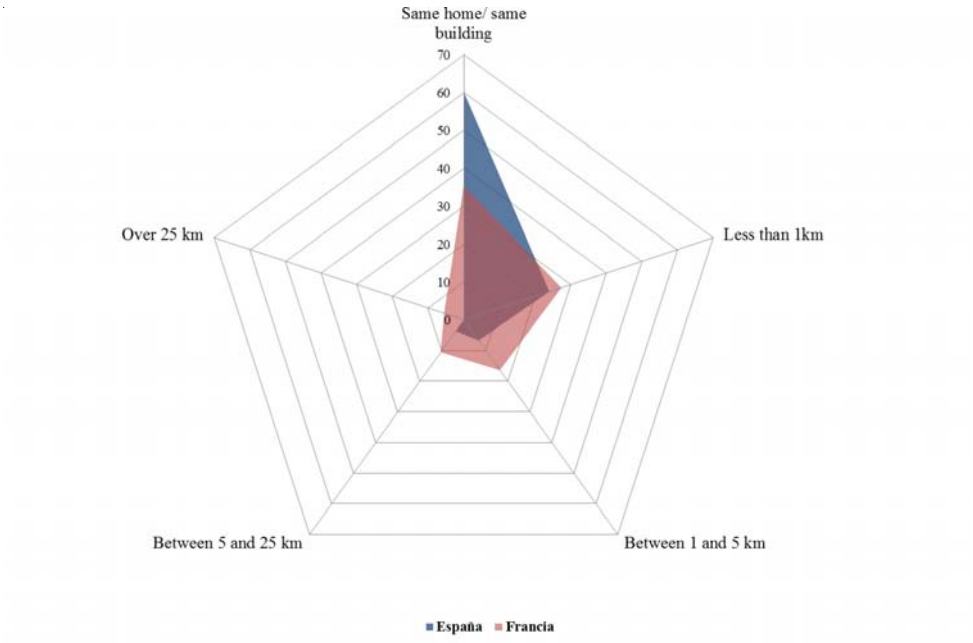

Figure 1. Maximum proximity between the elderly person who receives personal care and the geographically closest member of their network

We used a binary logistic regression model to determine the factors that could predict the use of mixed care amongst over 65s in Spain and France who are receiving informal care (Table 4). For this we used the corrected version of the Cox-Snell R square, and the Nagelekerke R^2 square to find out the goodness of fit of the model. Here the Spanish case was significant (x^2, $p<0,001$) with a Nagelkerke R^2 of 0.206 that correctly classifies 85.10% of cases. The French model was also significant (x^2, $p<0,001$) with a Nagelkerke R^2 of 0.163 that correctly classifies 70.3% of cases. We then analysed the probabilities of change using the odds ratio.

Of the various personal factors, the age of those interviewed was an important factor in both countries, in determining the probability of receiving mixed care. The main differences within this group appear in gender with Spanish women 3.13 times more likely to receive mixed care than men. In France however gender is not a significant factor. In addition the probability of receiving mixed care increases in France when the person does not live in a couple, while in Spain this variable is not significant.

Factors related with the elderly person's health follow a similar trend in both countries, in that the probability of receiving mixed care increases as the person's limitations with instrumental activities of daily life (IADL) increase. By contrast basic activities of daily life are not a significant factor either in Spain or in France (*Table 4*).

As regards economic factors, in both countries the probability of receiving mixed care increases the higher the level of income (Spain OR 1.64 and France OR 1.80). In addition elderly people in Spain who receive a regular economic benefit payment are 1.5 times more likely to receive mixed care, a situation that is repeated in France albeit at a lower level (OR 1.15).

Lastly the *socioterritorial perspective* of mixed care shows that the size of the elderly person's social network is a factor that predicts the use of this kind of care in both Spain and France (Table 4). Combined with this factor, maximum geographical proximity shows significant differences in both countries. In Spain the probability of receiving mixed care is 2.3 times higher when the closest member of the social network is less than 1 km away. In France however when the member of the social network is at a distance of between one and 5 km the probability of receiving mixed care increases (OR 2.5). Both in Spain and in France a high percentage of the care is given in the home itself, in which proximity is at a maximum, which is why this was used as the reference distance for this category.

Table 4. Binary logistic regression model for mixed care in over 65s

	SPAIN				FRANCE			
	B	p-value	Exp(B)	OR (IC 95%)	B	p-value	Exp(B)	OR (IC 95%)
Age	.087	.002	1.091	1.031 to 1.154	.040	.018	1.041	1.007 to 1.076
Gender								
Men (ref.)								
Women	1.141	.028	3.130	1.134 to 8.637	.098	.716	1.103	0.650 to 1.870
Living in a couple								
Yes (ref.)								
No	-.370	.353	.691	0.317 to 1.507	.926	.030	1.031	0.543 to 1.957
ADL	-.027	.826	.973	0.762 to 1.242	-.062	.550	.940	0.768 to 1.151
IADL	.170	.024	1.185	0.955 to 1.470	.213	.011	1.237	1.049 to 1.459
Annual income								
Below average or average for EU 27 (ref.)								
Above average for EU 27	.494	.046	1.639	0.712 to 3.773	.589	.026	1.803	1.072 to 3.031
Periodic Public Economic Benefits								
Does not receive (ref.)								
Receives	.449	.047	1.567	0.733 to 3.353	.138	.025	1.148	0.532 to 2.479
Size of social network	.367	.001	1.444	1.172 to 1.779	.154	.054	1.166	0.997 to 1.364
Member of the social network with greatest geographic proximity.								
In the same home (ref.)		.210				.004		
Less than 1 km	.812	.050	2.251	0.989 to 5.128	.136	.681	1.146	0.598 to 2.196
Between 1 and 5 km	.769	.238	2.158	0.601 to 7.745	.923	.012	2.518	1.223 to 5.159
Between 5 and 25 km	1.236	.109	3.442	0.761 to 15.580	-.767	.115	.464	0.179 to 1.206
More than 25 km	-.360	.675	.698	0.130 to 3.750	-.979	.161	.376	0.095 to 1.478
No record	.494	.246	1.639	0.712 to 3.773	.353	.544	1.423	0.455 to 4.449
Constant	-11.726	.000	.000		-5.216	.000	.005	

Note: Spain (N 329). Percentage predicted correctly by the model: 85.10%. Nagelkerke R2: 0.206. France (N 401). Percentage predicted correctly by the model: 70.3%. Nagelkerke R2: 0.163.

Discussion and Conclusions

The provision of care in Spain and France has traditionally been a legal and moral obligation of the family with the state performing a subsidiary role (Due *et al.*, 1999; Geerts & Van, 2012; Courtin, Jemiai, & Mossialos, 2014). Governments have shown an increasing interest in responding to the progressive ageing of the population and the entry of women into the Labour market. Through the *Ley de dependencia* of 2006 in Spain and the Allocation *perssonalisèe á l'autonomie* in France in 2002, they have responded to the growing social demand for care of dependent people, a problem now considered as a social risk (Pavolini & Ranci, 2008). These advances mark the beginning of the socialization of this risk characterized by intensive intervention by the state through universal access to a series of basic services, the growing responsibility of the individual for the cost of the service on the basis of their economic capacity to pay and respect for family practices. There has also been an expansion of the network of public and private care services (formal care) (Rodriguez Cabrero, 2011).

Our research has revealed that there are significant differences between Spain (14.9%) and France (32.4%) in the proportion of over 65s that receive mixed care (formal and informal care). In France there is a greater consolidation of formal care and of its combined use with informal care (Fontaine, 2012; Suanet, Van Groenou, & Van Tilburg, 2012).

In Spain and France dependence situations and the use of mixed care have certain common denominators in factors such as age and limitations in the instrumental activities of daily living (Colombo *et al.*, 2011). Mixed care is a complement to informal care, due to the complexity of these activities (IADL). This does not mean that those who suffer limitations in activities of daily living (ADL) do not use mixed care but rather that these needs tend to be catered for by informal careers.

The socio-territorial perspective we incorporated into our study is a key factor for predicting the use of mixed care, and helps maintain the elderly person in his or her home, one of the basic pillars of government policy for care of dependent people in both countries. Although it is true that the size of the social network implies a greater likelihood to use this kind of care in France and in Spain, the dynamics of the elderly person's maximum proximity to their social network are different. In France the social network is normally larger and more disperse, while in Spain it tends to be concentrated within less than 1 km from the elderly person. The presence of members of the social network in the home of the dependent person is significantly higher in the case of Spain than in France, a fact explained by the higher proportion of dependent elderly people who live in a couple.

From an economic perspective the results of the model point to a similar pattern in that the likelihood of receiving mixed care is higher amongst elderly people with high incomes or who receive regular public economic benefits.

In spite of the fact that France and Spain are close neighbours, important differences have been identified in the way public policies on dependence are implemented. Mixed care has become society's means of responding to what is an important growing need, with a geographically close network of informal support allowing elderly people to remain in their own homes for as long as possible.

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