
Career - Employee or Beneficiary? Implications of Careers' Status on Public Finance - Case of the European Union

Submitted 27/03/21, 1st revision 20/04/21, 2nd revision 28/05/21, accepted 30/06/21

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Abstract:

Purpose: This paper aims to indicate the critical role as an important actor of public policy and the undervalued entity with an essential impact on public finance.

Design/Methodology/Approach: The article employs document analysis, desk research, statistical analysis of the caregiver's households' budgets from a nationwide questionnaire survey in 2015 and 2020.

Findings: The empirical results show that in countries with underdeveloped care infrastructure, the lack of caregivers' input can induce considerable increases in public burdens within the next 50 years. As the group of caregivers is not (economically) homogeneous, public actions should aim to prevent the impact of pandemic risk and provide caregivers with adequate income for the activities performed, treated, or as an employee or as an allowance.

Practical Implications: The ongoing (although very late) process of reforms on long-term care within UE should be more evidence-based to avoid further income stratification between caregivers households and a rapid increase in public finance expenditure.

Originality/value: The article presents the original concept of the classification of caregivers' income, changes taking place over the last five years in the forms of careers' income in the EU, and the selected results of the author's research on the budgets of caregivers' households in Poland in 2015 and 2020.

Keywords: Caregiver, long term care, public finance.

JEL classification: H44, H55, H68, I38.

Paper Type: Research study.

Acknowledgment: The project is financed within the framework of the Minister of Science and Higher Education program under the name „Regional Excellence Initiative” in the years 2019 - 2022; project number 001/RID/2018/19; the amount of financing PLN 10,684,000.00. The usual disclaimer applies.

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1. Introduction

Custody regulation issues have a history as long as family regulation. Duties of caring for loved ones appeared in the codex records of ancient Rome and Greece. They were mainly related to family responsibilities. Along with the change in the model of family, the growing role of the state in the regulation of social relations and, above all, development of feminism (Finch and Groves, 1983), discussions on the commodification and decommodification of care (Esping - Andersen, 1990; 2002), the trend of research on theoretical interpretations of care was initiated. With the changes taking place in the socio-economic environment, these studies increasingly take into account economic elements as a factor that both limits activity and, at the same time, induces changes. This approach resulted in the development of four research schools: the American school - work focused on the liberal model, where all care is provided by the family or the market (Glen, 2010), the Austrian school - care should not be included in the system provided by the state but financed by the market (Evers, Pijl, and Ungerson, 1994), the British school - providing care is the responsibility of the state (Glendinning and Kemp, 2006; Philips, 2007; Barr, 2011), Scandinavian school - providing care is the responsibility of local authorities (Kröge, 2009). The long-term care (LTC) and the care patterns were also the objectives of studies of international institutions (WHO, 2016; OECD, 2011) as well as the European Union (Ageing Report, 2018).

Along with society aging, all developed countries started to focus on the core problem as the most demanding challenge of subsequent decades. This same refers to Central East European countries where similar demographic patterns were accompanied by fuzzy public systems and traditionally high society expectations. This pace was brutal in Poland, where the strong (religiously based) family position was reflected in unconditional code obligation of care over family members together with communistic experience with a well-developed system of institutional support. This is still not a very exploited area of scientific research, but some investigations were done (Golinowska, 2010; Bakalarczyk, 2013; Jurekm, 2016).

2. Literature Review

Phillips (2007) analyzed that the word "care" has many different meanings, dimensions, and values attached to it. "Until recently, care has been seen as an impediment to work, restricting women to the domesticity of home or, if they were performing 'cate' in the workplace, to low-status, oppressive care work jobs. [...] A right-based approach supported the more positive definition of care". The term 'career' (or caregiver in the United States of America (USA), Canada, and elsewhere) is used profusely in health- and social care research and practice (Fine, 2004). In 90-ies "career" was presented in opposition to a volunteer. A career was supposed to have a personal relationship with the person in need, initiated before the beginning of caregiving, and the length and intensity of care were usually unpredictable. Among carers, the most important group were spouses, daughters and daughters-in-law, and

other relatives. Volunteers did not usually know the person they were going to help; they were not motivated by existing relationships but by their motives. The evaluation of care understanding led to the new attitude that the word caregiver implied "a free and willing service based on choice" (Harrington, 2000), which would exclude many kinds of paid services. The research is done in the first decade of XX-ties shown that there is a huge lack of identification with the term 'carer' also because of its association with the role of paid professionals employed to provide support beyond that of informal or family 'careers' (Molyneaux *et al.*, 2011)

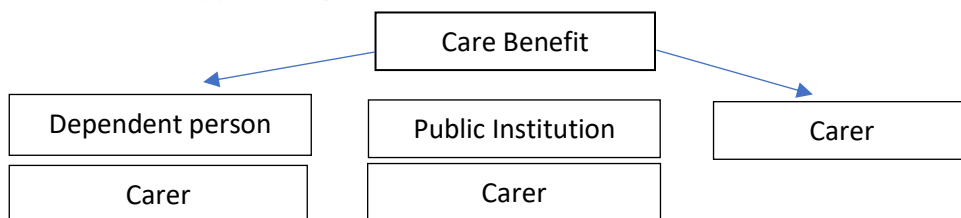
Regardless of the structure of the long-term care system or the reasons for dependency, caregivers play a vital role in the lives of their charges. Long-term care (LTC) summarizes both care in institutions (nursing and residential homes) and at home and is mainly concern with personal care (everyday activities), nursing, and rehabilitation. As research on the sources of care financing are not yet developed, the model of care continues to be debated - from the domination of institutional (promoted in the 1980s and 1990s) to the promotion of home (supported now thanks to technological advances and pressure to reduce costs of public systems). Moreover, although home care does not always reduce costs on a macro scale, it often increases patients' quality of life and satisfaction. In a situation where a dependent person needs continuous (daytime) or permanent (24/7) care, the help provided by informal caregivers - relatives, friends, neighbours, and volunteers are no longer sufficient. It is necessary to give this care standard features (through an agreement, granting status, registration in the database). Not only to pay the caregiver or compensate him/her lost time but also to enable him/her to carry out everyday activities on behalf of the person under his/her care.

A career's situation is usually classified as individual or institutional (such as NGO, hospitals, care houses, or other providers). According to the legal relationship, careers have formal or informal status, depending on the formal entitlement. Recognition of what is formal or not is also not unified. In some countries, family members helping without any contracts or remunerations are considered informal careers, wherein in other countries, family members are legally expected to be careers, and the single "blood" relations constitute formal and obligatory status. Therefore, when looking at the initial requirements necessary to receive any career's benefit, they are sometimes contradictory to obtain a benefit, a person must be a family member (Hungary, Poland) or does not need to be a family member (France, Germany), sometimes must give up a previous occupation (Cyprus, Poland) and sometimes the system provides benefits or support only for careers of children. The benefits offered to careers are diverse, in cash (often with the status of remuneration), in kind, tax reliefs or tax credits, social contribution coverage, social (security) privileges as paid leave, or a flexible work schedule.

The analysis of solutions used in the European Union countries shows several paths to formalizing the care of a non-institutional caregiver. First of all, there is a difference in the approach to transferring funds to the guardian. The critical point is to distinguish

whether the funds paid are remuneration for the work performed by the caregiver (where he/she replaces the state), or whether they are compensation for lost earnings as an effect of performing social obligation, which is the obligation to take care of a relative. This difference results from the tradition and the model of the family characteristic for a given country, but it is also a manifestation of appreciating the caregiver's work through commodification, and thus - the valuation of care. Another difference concerns the entity responsible for defining the terms of the contract concluded with the guardian. In all European Union countries, when appointing a caregiver, the preferences or indications of a dependant are considered, but only in some of them he/she determines the rules on which care, financed from public funds, will be provided. In most countries, the contracting party is an administrative entity (at the national or local level) that qualifies, registers, and frequently supervises and supports the work of a caregiver.

Figure 1. *Paying-for-care patches*



Source: Own compilation.

As the increasing need for care forced the development of support methods, different delivery patches were created. The beneficiary of care allowances can be either a dependent person or a carer (Figure 1). In the case of a direct payment to a caregiver, this benefit might take the form of remuneration (with all consequences as paid holiday or similar) or support or allowance coverage. In France, Germany, or Great Britain, the dependent person decides what form of care is wanted or who the carer is. Hence, the dependent person can pay directly or through a supervisory institution (a local social agency or public insurer). In some countries, even the carer's choice belongs to dependent persons; the carer has a legal entitlement to a local administration, social security program, or similar. This path helps avoid abuse, fraud, and low-quality care, and in general, allows control of the care delivered.

In 2020 in every EU country, the carer's services were in some way included in the public system. It reflects the ongoing changes because four EU members have not acknowledged "a carer" as a co-performer within the system just five years ago. The characteristics of long-term care solutions for each of the 27 countries of the European Union and the UK are presented below - based on, among other things, on the EU Mutual Information System on Social Protection (MISSOC) - as of June 2020.

In a situation where an employer is a natural person, the provision of care acquires the characteristics of a private service, even though it is financed (in part or whole) from

public funds. A public institution (local government) is the party determining the terms of employment; there may be restrictions resulting from formal rules or the manner of decisions' making, which awards this type of care provides the characteristics of public service. Where the carer's benefit is paid as an allowance, it takes the form of a transfer (private or public). However, the allowance granting involves several requirements to be fulfilled by the caregiver (i.e., there is a something-for-something relationship), at no stage is the "value" of the care provided, as is the case with employment. The summary of the information presented above shows that each of the 24 EU Member States that provide direct or indirect caregiver services can be assigned to one of the four types of care (Table 1).

Table 1. *Types of benefits for carers*

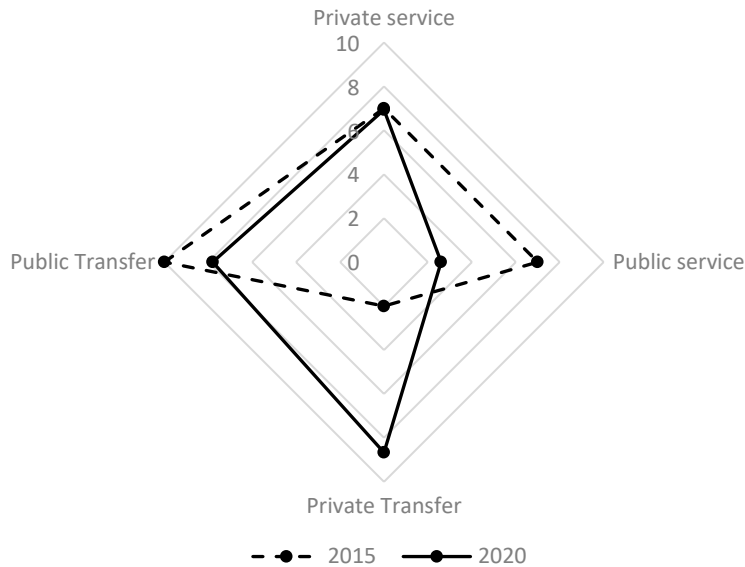
Features of the decision relationship (decision maker)	Features of the legal relationship	
	Employment	Allowance
Individual (decision of a dependent person)	Private service Austria, France (I), Belgium, Luxembourg, Denmark, Czech Republic, Latvia, Slovenia	Private transfer Estonia, Bulgaria (II), Cyprus, France (II) Germany, Ireland, Lithuania, Portugal (I), Slovakia, the Netherlands
Institutional (decision of a legal entity)	Public service Bulgaria (I), Romania, Spain	Public transfer Croatia, Poland, Hungary, Malta, Great Britain, Finland, Italy, Portugal (II), Sweden

Note: *the distinction between I and II means that there are two forms of caregivers' income in the country.*

Source: *Own compilation based on the EU Mutual Information System on Social Protection (MISSOC).*

Looking at the difference in the changes in the distribution of the occurrence of each of the four forms between the year 2015 and 2020, one can notice a rapid increase in the importance of private transfers, i.e., public funds like allowance, which are sent as decided by a dependent person. Very often, changes leading to the introduction of private transfers are carried out under the slogan of "free choice," enabling individuals to select the method of providing care themselves. However, this choice in most cases does not increase the quality of their lives- on the contrary - when choosing suppliers in the open market, the dependent person is forced to pay additionally from private sources to obtain a satisfactory level of service. In addition, private transfers are much easier and cheaper to provide for public institutions than the development of care service infrastructure. This trend is reflected in Figure 2, which shows an apparent decline in the share of public services among financing methods and organizing the work of caregivers. In those countries where the income level is relatively low, the necessary amount of care is often supplemented by informal (unpaid, unregistered) care of family members and friends - mainly spouses and children - making systems extremely extensive. This refers especially to Greece, Bulgaria, Romania, Cyprus, Latvia, Poland, Croatia Portugal - where the level of public spending on LTC is below 0,5% of GDP.

Figure 2. Distribution of four types of benefits for carers in the EU in 2015 and 2020.



Source: Own compilation.

The 2018 EU Ageing Report in Chapter "Long-term projections of age-related expenditure on long term care" clearly presented how important it is for public finance to maintain or develop the position of informal carers within the system of care support. As the care will be permanently based on human resources, the projections for 2070 take into account the future availability of potential informal carers (there may be an increase in the availability of informal caregivers) and their propensity to provide care (increasing labor-participation by women and new family structures may mean that providing informal care may become more complex as well as providing care may have negative consequences for the carer's health and career).

Table no 2 presents the impact of two scenarios of changes on public finance spending between 2016 and 2070. The "shift to formal care scenario" policy-change scenario is run to assess the impact of a demand-driven increase in the (public) provision of proper care, replacing care provided in an informal setting. The "coverage convergence scenario" assumes that growing expectations of the populations and the exchange of best practices will lead to an expansion of publicly financed formal care provision into those groups of the population that relied on informal care until then. The "cost convergence scenario" is a policy change scenario that models upward convergence to the EU average of the relative cost profiles for those countries that in the base year are below the EU average. The "cost and coverage convergence scenario" combines the coverage convergence scenario and the cost convergence scenario, as described in the sections above.

Table 2. *Shift from informal to formal care scenario and cost and coverage convergence scenario projected public expenditure on long-term care as % of GDP*

	Shift from informal to formal care scenario				Cost and coverage convergence scenario	
	2016 as % of GDP	2070 as % of GDP	Change 2016-2070		Change 2016-2070	
			pp.	In %	pp.	In %
BE	2.3	4.6	2.3	100%	3.9	167%
BG	0.4	0.9	0.5	125%	1.1	272%
CZ	1.3	3.6	2.3	169%	2.7	200%
DK	2.5	5.8	3.3	129%	5.2	205%
DE	1.3	3.6	2.3	178%	2.3	182%
EE	0.9	1.7	0.8	84%	3.2	358%
IE	1.3	3.9	2.5	189%	3.7	280%
EL	0.1	0.2	0.1	121%	5.1	5145%
ES	0.9	2.5	1.6	167%	3.7	395%
FR	1.7	3.1	1.3	76%	3.0	173%
HR	0.9	1.8	0.9	101%	1.3	151%
IT	1.7	3.5	1.8	104%	2.4	140%
CY	0.3	0.7	0.4	132%	3.1	1019%
LV	0.4	0.9	0.5	105%	2.8	649%
LT	1.0	2.3	1.3	127%	4.1	404%
LU	1.3	4.7	3.5	271%	5.6	436%
HU	0.7	1.5	0.8	114%	4.5	647%
MT	0.9	2.5	1.6	179%	3.6	400%
NL	3.5	7.2	3.7	104%	5.5	155%
AT	1.9	4.9	3.0	157%	3.7	196%
PL	0.5	2.1	1.6	320%	1.8	358%
PT	0.5	3.0	2.5	458%	2.8	515%
RO	0.3	0.8	0.5	166%	4.7	1578%
SI	0.9	2.2	1.3	137%	3.7	397%
SK	0.9	2.2	1.3	149%	2.3	255%
FI	2.2	4.9	2.7	124%	3.2	145%
SE	3.2	6.1	2.9	90%	2.9	90%
UK	1.5	3.5	2.0	132%	2.0	132%
EU*	1.6	3.6	2.0	129%	3.0	187%

Note: EU* - 28 EU member countries.

Source: *Compilation based on: The 2018 Ageing Report Economic & Budgetary Projections for the 28 EU Member States (2016-2070), The European Commission, Institutional Paper 079, 147-148.*

The presented Table 2 allows us to draw several conclusions important for public finances: replacing informal caregivers with institutional care is expensive, primarily where the concept of support is based on the family and its (unpaid) activity, the level of care provided from public funds can be used as an element of quality-of-life assessment, showing then much more significant differences between the EU Member countries than those assessed solely with the use of GDP per capita. However, the fundamental question concerns the possibility of assessing the base scenario - in many of the countries for which growth rates are very high - Poland, Portugal, Romania or Greece, the actual expenditure covered by, for example, families on care services falls within the gray zone and are unregistered. It often results from legal restrictions (no possibility of agreeing with natural persons or administrative and tax difficulties).

Consequently, the demand for public funding can be much higher, but the cost profile might be more favorable. In countries where formalities have been simplified, e.g., the Czech Republic, the starting values are higher, and thus the incremental indicators are close to the EU average. Therefore, simplifying the employment or payment of the caregiver is in the interests of both the dependent person and the state budget.

3. Results and Discussion

The need to provide care is often accompanied by the so-called pandemic risk (Bakalarczyk, 2016) - in economic meaning - the financial situation of the caregiver depends on the status of the dependent person. The most critical factor turns out to be the age of the dependant. The research in this area was conducted in Poland by the author in 2015 and 2020 on 88/130 caregivers of children and 296/300 caregivers of adults. In Poland, a carer may receive one of the three types of care allowance.

However, the conditions for receiving it are being the closest family and resignation of employment or unemployment. The support system for children's caregivers is much more developed in Poland (especially in benefits in kind). It offers a higher care allowance (PLN 1,800) since it is assumed that the carer covers his/her and the child's expenses. In addition, from 2016, parents receive a child benefit of PLN 500 for each child. Carers of adults receive a special care allowance in one-third of the child's caregivers (PLN 620), provided that they are family, do not work, and have no other income (e.g., retirement pension). It is an amount lower than the statutory income entitling to social assistance.

The analysis of caregivers' budgets shows that in the case of carers of children, the primary source of income is increasingly the care-allowance. Additionally, the carers undertook work (unregistered). The income distribution clearly shows a parallel shift in the income distribution in connection with introducing the 500+ family allowance and the increase in the primary care allowance. The income of caregivers was close to the average monthly disposable income per person in Poland in 2015 (PLN 1,386.16) -2019 (PLN 1,819.14) (GUS).

The situation of caregivers of adults is different. In 2015, more caregivers made a living from illegal employment than from the care allowance. In the 2020 study, the situation begins to normalize, but the care allowance still accounts for only 30% of the basic income of care. They often have income from retirement or disability pensions (a growing phenomenon of older adults caring for the elderly in the same household). However, there are also caregivers, mainly adults, who do not have any income. Research has shown that they may be distant family members with little potential in the labor market, who are "delegated" to care by families and supported by these families (Jurek, 2016). The distribution of income over five years shows the growing share of people receiving special care allowance. This means a stratification into two groups: caregivers of adults who were granted the benefit in the childhood of their charges and caregivers of people who became dependent as adults. If the person's

death is under care, caregivers only receive a transitional benefit for six months; then, they are expected to return to the open labor market.

Figure 3. Income distribution and selected sources of income for carers of children (up to 16 years old) and carers of adults in Poland in 2015 and 2020



Source: Own research financed by National Science Centre (2012-2015) and by „Regional Excellence Initiative” of the Minister of Science and Higher Education (2019-2020).

4. Conclusions

No matter the age and reason of dependency, a career plays a vital role in a dependant's life. The support of a career is also the most heterogeneous element of social integration. As there are different statuses or forms of careers and different ways of delivering benefits, in every European country, the implemented solutions differ. The safety net for careers reflects the social perception of their work importance and the level of LTC policy development. Interviews with caregivers show that received incomes they primarily use as a source of funding care for the dependant and not as an income for their disposal. The ability to maintain caregivers' households remains

a statistical phenomenon. Organizations of caregivers started to notice the need to treat their work (including work performed at home) as a high market value by granting a special status and guaranteeing at least the minimum wage. In the author's opinion, creating a coherent public long-term care system with a strong position of an informal carer is indispensable for further development in the conditions of the aging society.

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