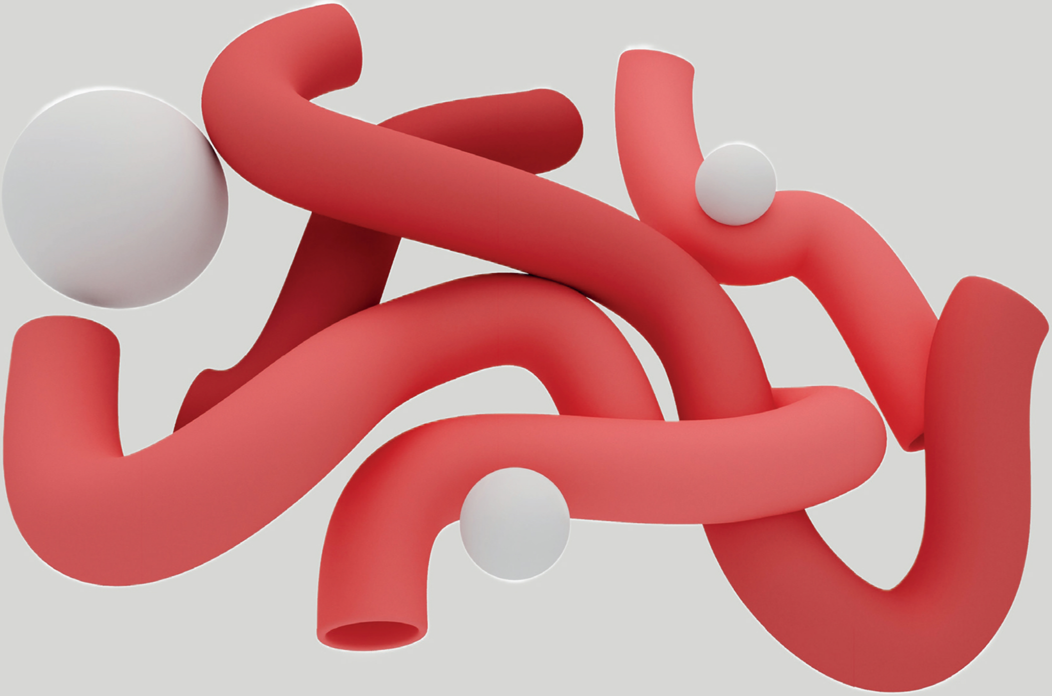

POLITICISING AND GENDERING CARE FOR OLDER PEOPLE

Multidisciplinary perspectives from Europe

EDITED BY ANCA DOHOTARIU,
ANA PAULA GIL AND ĽUBICA VOĽANSKÁ

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Manchester University Press

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Preface

This collective volume was born out of our belief that the topic of care for older people, and the related politicising and gendering processes, cannot be artificially separated from the larger issue of care, understood as a condition of human existence. It is the result of several years of meetings, roundtables and in-depth discussions that took place within the intellectual and organisational framework provided by COST Action CA 18119 *Who Cares in Europe?* (2019–2023).[1] It brought together scholars from a variety of disciplines, including anthropology, gender studies, history, political science, social work, and sociology. Nevertheless it managed to overcome the organisational and disciplinary logics of academic affiliation, inviting us to reflect upon similar epistemological challenges nurtured by the common scientific need to know, to understand, and, above all, to share. We thank all the authors for their firm commitment and outstanding contributions to this editorial project, as well as all those who supported in many different ways the elaboration and the publication of this book.

We would like to express our most sincere gratitude to all the organisations involved in this project, for their financial support – namely, the COST Association (particularly Dr Mickael Pero), the University of Bucharest (particularly Prof. Carmen Chifiriuc, Vice-Rector), the Interdisciplinary Centre of Social Sciences (CICS.NOVA) of the NOVA University of Lisbon (NOVA FCSH), and the Institute of Ethnology and Social Anthropology of the Slovak Academy of Sciences; also, for their academic, administrative, and technical support – the European University Institute (especially Prof. Laura Downs) and Université Paris Cité (especially Prof. Clarisse Berthezene, and Elliana Farazi, European Project Manager).

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As with any other editorial project, this book has not escaped its own ups and downs during the long period of working and waiting for it to be elaborated and completed. We are grateful for all the unexpected challenges that we have encountered and that pushed us towards valuable improvements, and we hope to continue with future publications and enlarge our approaches across time and place.

Anca Dohotariu, Ana Paula Gil and Ľubica Voľanská

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Care for older people through politicising and gendering processes: An introduction

Anca Dohotariu

In the context of recent social and political processes that have affected different countries in Europe to a greater or lesser extent, including the globalisation of care, its neoliberalisation and commodification (Wrede and Nare, 2013; Hoppania and Vaittinen, 2015; Dahl, 2017; Hansen *et al.*, 2022), or other transnational trends such as 'dedomestication' or 'optional familialism' (Leitner, 2003; Zagel and Lohmann, 2020) – care for older people has become the object of intense transformations. These are related to the widespread expectations about the nature of the provision of care, general conditions of paid and unpaid care, and the actors involved – e.g. those who care, those cared for, and those at the interplay between the two. However, while the structure of care for older people has been considerably affected by contemporary transformations, older adults' care as inherently political and gendered, as well as the related processes of politicising and gendering, has remained unevenly tackled and often understudied across Europe. For example, in Scandinavian socio-political settings, care for older people has long been a governmental priority. Therefore, the legitimacy of such an object of study has rarely, if at all, been questioned, while an important strand of research on the political struggles in care has been developed in the Nordic countries (Rostgaard and Zechner, 2012; Vabø and Szebehley, 2012; Dahl, 2017). Also, care for older adults (or different aspects of it) has mainly been investigated in other established welfare regimes in Europe (Degavre and Nyssens, 2012; Ranci and Pavolini, 2013; Frericks *et al.*, 2014; Theobald and Luppi, 2018). However, grouping these publications under a single umbrella is hard, if not impossible. For instance, unlike some cases where care for older people and childcare have been treated as stemming from the general issue of care, in other situations, research on care has particularly focused on childcare while almost completely ignoring care for the older population. Also, the COVID-19 pandemic has drawn particular attention to an important research direction on transversal concerns of care, such as medical, health, or dependency issues (Bodogai and Cutler, 2013; Phellas, 2013; Filipovic Hrast *et al.*, 2013; Numerato *et al.*, 2021;

Bethany, 2023). Nevertheless, in the case of these analyses, the political and gendered dimensions of care are often treated as subsidiary aspects of the investigation.

Why then an interdisciplinary collection of contributions on care for older people as inherently political and gendered and on the related politicising and gendering processes in Europe? The reasons that have constantly stimulated the development of this collective volume are numerous and diverse.

First, this book builds on epistemological issues. Starting from the observation that 'scientific terms emerge in a specific milieu and academic disciplines, including terms describing care' (Dahl, 2022: 20), one needs to investigate analytical concepts before making use of them in research concentrating on specific contexts and socio-political settings. Contributions of this book do not simply seek to 'transfer' context-based framing of politicising and gendering care into other socio-political contexts (Luhtakallio, 2012). On the contrary, one of its main objectives is to interrogate the concept of older adults' care as inherently political and gendered before analysing the ways in which it is connected to various concrete manifestations and understandings in different European countries. However, this book does not aim to answer the questions '*What is* care for older people?' and '*What are* the related politicising and gendering processes?' Rather, its main ambition is to investigate *how to* tackle and analyse older adults' care, understood as inherently political and gendered, and directly related to the processes of politicising and gendering that can be observed and examined in different European/EU settings and societal and political levels. Starting from this analytical approach, the book gathers relevant but not exhaustive perspectives and possible answers. Its contributions are both modest and ambitious, as the volume focuses on a topic that has not been tackled and developed previously.

Secondly, this book brings together contributions from a variety of disciplines, including social anthropology, gender studies, history, political science, social work, and sociology. However, it transcends the disciplinary logic of academic affiliation, inviting us to reflect upon similar epistemological challenges nurtured by the common scientific need to know, to understand, and, above all, to share. Regardless of the academic networks and disciplines they belong to, social science scholars are expected to constantly search for a never fully attainable ideal objectivity while incorporating a certain emotional detachment in relation to their research, particularly important whenever studying sensitive topics – such as children with fatal health conditions, extreme violence, and the topic of care for older people and related aspects. Yet older adults' care is more than just another sensitive object of study; it is a 'condition of our existence [as] we can't live without giving and receiving care' (Dahl and Hansen, 2022: 1). Both caring for our dear older ones or being taken care of when becoming old(er) or frail, are potentially a feature of any personal trajectory, without exception, even in the case of social science researchers. Therefore, this book is more than an inquiry focused on an academic topic – it is, above all, an invitation to reflect upon care for older people as an issue particularly relevant to human existence, of significance at any time, societal level, or socio-political sphere.

Unsurprisingly, this collective volume has its limitations. It is neither comparative nor does it comprise all European countries. It does not include all social science disciplines. And, in a single book, one cannot embrace all aspects of care for older people. This is because, similarly to any other editorial project, this book has a trajectory of its own and has been elaborated in specific conditions.[1] Also, another limitation deserves particular attention. Analysing the process of politicising older adults' care opens additional research directions concerning de/(re)politicisation issues. Depoliticisation as a concept has been addressed by a wide variety of publications from more than a dozen different disciplines in social and political science (Flinders and Buller, 2006: 293) and has received multiple interpretations (Flinders and Buller, 2006; Kauppi and Trenz, 2019; Haapala and Oleart, 2022; Wood, 2015). However, for clarity and coherence, we have chosen to focus on the issue of politicisation (the politicising process) of care for older people, leaving the nexus of de-politicisation/re-politicisation to be analysed in possible future studies. Moreover, in what concerns gendering/degendering, we start from the assumption that both of these processes are relevant to the variety of understandings of gender equality – as sameness, difference, or transformation (Verloo, 2007) – and for the related policy measures that either diminish or reinforce gender inequalities in different socio-political contexts.

Why do we aim at analysing the processes of politicising and gendering older adults' care in Europe rather than other dynamics, such as the professionalising, globalising or neoliberalising trends affecting care? One of the most important reasons informing this choice is that both politicising and gendering care for older people are transversal processes that are also directly connected to inherent features of care, as political and gendered by definition. These characteristics require particular attention considering their pervasive nature compared to other aspects of care. For instance, care for older adults has not always been treated as professional or a commodity. At the same time, care for older adults is directly related to age/generation, class, sexual orientation, race, ethnicity, religion, disabilities, etc. (King *et al.*, 2020; Torres, 2020; Leahy, 2023), which invites us to reflect upon ageing, migration, racialisation, globalisation, etc. (Hyde and Higgs, 2017; Loretto *et al.*, 2022; Vilhelmson *et al.*, 2022; Repetti and Calasanti, 2023). However, each of these processes deserves in-depth investigation.

For instance, ageing is a phenomenon that redirects our attention to current times and the relatively recent increase in life expectancy and changes in conditions of life. Migration has always existed, although, in some socio-political contexts, it opens the discussion about ethnicity, while in other contexts, it draws attention to the racialised other or various shades of whiteness (Kalmar, 2022; Cârstocea, 2023).

Despite the multiple features and interconnected processes that are deeply relevant to the issue of care, we sharpen our attention and dedicate this book to politicising and gendering care for older people. These two processes are prone to interdisciplinary appraisals. They encourage scholars to develop their analyses in various directions between ontological and empirical aspects or regarding any historical, societal, and political level in Europe. In other words, politicising and gendering invite us not only to reflect upon the meaning of care for older people but to examine how care as inherently political and gendered constantly changes over time, and what are the concrete, socio-political effects of these changes. Therefore, the book has a clearly defined focus as all chapters concentrate on politicising and gendering care for older people in different European historical and geographical contexts. At the same time, the book's multidisciplinary contributions do not start from a pre-defined theoretical approach but aim to discuss context-based specificities analysed from various theoretical and methodological angles. Sharing one clearly defined research interest while including a diversity of multidisciplinary analyses – this endeavour has been one of the main challenges stimulating the elaboration of this book. Our aim is also to shift from solely focusing on the concrete effects of politicising and gendering care for older adults towards revealing how these processes developed in different European countries and various historical periods. This research question inspires new analyses of care for older people as both inherently political and gendered, which complement the existing substantial literature on care for older people.

Overall, this book brings together various analytical approaches and research topics concerning care for older persons in Europe. These have been elaborated from the same key concepts to be discussed in the following paragraphs.

Conceptual background

Contributions to this book have been developed around two main aspects of care for older people, or segments of it: the processes of politicising and gendering care for older people. These need further exploration and clarification.

Care for older people …

One cannot grasp the issue of care for older people without paying attention to the fundamental question tackled first and foremost by feminist researchers – what is care? Above all, this question emphasises the need to delimit care as a research topic and to explain what we are studying. However, there is no homogeneous theorisation of care. Over time, the constantly increasing theoretical field of care has become the object of various classifications, developed through diverse angles, and based on different categorisation criteria. For instance, inspired by Barnes (2012), Dahl expands on this British sociologist and political scientist's classification and distinguishes between four strands of feminist research on care: ethics of care, care as reproductive labour, social policy, and the tradition of 'the double perspective of care' (Dahl, 2017: 68). Another example is the study of care through the lens of only two main traditions – one that focuses on care as ethics and another that understands care as a form of reproduction (Hoppania and Vaittinen, 2015: 72–73). Other scholars draw attention to different diachronic stages that correspond to two generations of care theorists (Beasley and Bacchi, 2007; Hankivsky, 2014; Dahl, 2017: 82). These are only some examples that suggest there is no general and clear-cut classification of the scientific literature on care. However, overall consideration of the different strands of care research, elaborated for classification purposes, may be of heuristic value. A better understanding of care as work, care as ethics, and care as a site of political struggles is, in my view, indispensable to achieve more clarification on care for older people, and its related dimensions and (scientific) categories and dichotomies – such as long-term care (LTC), care regimes, formal/informal, paid/unpaid, home-based/institutionalised care, etc.

Research on care as work emerged around the 1970s when it was brought to the fore by feminist theorists, and has been developed in various disciplinary settings. This heterogeneous strand of research has usually developed an understanding of care as an activity, a dyadic relationship, and a process, but also as a moral disposition (Tronto, 2013). Building on care as work, while also questioning it, paved the way towards numerous dichotomies which are still important within current research: informal/formal/'semi-formal' work, unpaid/paid, provided by family members/close others and/or care professionals, within home or public, private, or mixed settings (Ungerson, 2004; Pfau-Effinger and Geissler, 2005). Moreover, care as work has been theorised as a labour of love (Knijn and Kremer, 1997: 330) and a professionalised labour. The latter was either interpreted as a highly desirable process bringing social recognition (Daly and Lewis, 2000) or was drastically criticised for reinforcing gender inequalities (Glenn, 2000). Another significant strand of research on care as work has developed around the concepts of global care chains and care drain, especially in the context of contemporary globalisation, feminised migration, and transformation of welfare states (Hochschild, 2000; Iskasen *et al.*, 2008; Nguyen, Zavoretti and Tronto, 2017). Furthermore, care crisis (Isaksen *et al.*, 2008; Fraser, 2016; Dowling, 2021) is also an important key concept that has been elaborated in relation to care as work, and that is relevant to the differentiation between Anglo-American and Scandinavian approaches to care. Based on both differences and similarities, this delineation has been interpreted as explaining the differences between Western liberal and North European welfare state regimes (Antonnen and Zechner, 2011: 19). Understanding care as work and questioning its (in)visibility is also at the heart of an extensive social policy comparative literature, which has been developed around the nested relationships between the state, the market, and the family, and related gendered dimensions (Orloff, 1993; Daly and Lewis, 2000; Orloff, 2010). Not least, care as work has encouraged research around the care ideals concept. For example, the 'traditional', 'postmodern', 'cold modern', and 'warm modern' ideals of care elaborated by Hochschild (1995) can be considered a classic reference in care research.

Another strand of research particularly relevant to care for older people is related to the feminist literature on *care as ethics*. This research can be considered one of the oldest and most prevalent strands of theorizing care developed around the moral implications of care at all societal levels in the modern age. Two key references that can be seen as major analytical turning points merit special attention. First, one must be reminded of the work by American psychologist Carol Gilligan published in 1982. Her decision to frame care as ethics broke radically with the hegemonic traditional theory of justice (Gilligan, 1982). More precisely, Gilligan made possible the switch from the abstract and formal ethics of justice towards an ethics of care understood as intrinsically connected to concrete situations and the interdependence of human beings (Gilligan, 1982; Paperman and Laugier, 2011). Although criticised for paving the way towards essentialist interpretations of care, Gilligan managed to reveal that there is a normative and, at the same time, contextual dimension to care relations, in accordance with the idea that care ethics is about rules and relationships occurring in specific contexts. Second, the work of the American political scientist, Joan Tronto, is another turning point within care research, as the author redirected attention away from the ethics of care towards an understanding of care as directly related to power. According to Tronto, care is more than taking an interest in another person: it is neither self-referring nor self-absorbing while implicitly leading to some form of action. Following Tronto's approach, care is both an (ethical) disposition and a practice and can be defined in five intertwined phases: ‘caring about’, ‘taking care of’, ‘caregiving’, ‘care-receiving’, and ‘caring with’ (Tronto, 1993, 2013). In Tronto’s view, moral theory is a tool for perpetuating power relations but also for challenging them, as care ethics does. Hence, the concept of care allows us to perceive the shift from autonomy and dependency to a more sophisticated sense of human interdependence.

A more recent theoretical approach to care (for older adults) has been framed by Danish political scientist Hanne Marlene Dahl, who developed previous theorising on care as work and care as ethics (Dahl, 2017, 2022). In line with the premise that scientific knowledge is not positioned in relation to ‘grand meta-narratives’, but is elaborated in different contexts, Dahl chooses to place her analysis between an abstract systemic level and a concrete level of care needs and responsibilities (Dahl, 2017: 72). In doing so, instead of focusing on the foundational question ‘What is Care?’, Dahl invites us to reflect upon ‘How the changing conditions of care and an attention to power and struggles reframe our theorizing about care?’ (Dahl, 2017: 62). In her view, the changing conditions of care practices have been influenced by seven social and political processes of change, including commodifying, professionalising, late-modernising, degendering, globalising, bureaucratising, and neoliberalising (Dahl, 2017: 29). These processes have brought to the fore the fragmentation of care along with other inherent tensions and logics that struggle to become dominant (Dahl, 2017: 62). Overall, according to Dahl, care is more than ethics or work: instead, one can understand care as a site of struggle or ‘an assemblage characterised by contingency and fragmentation of the care provided’ (Dahl, 2017: 62). This perspective invites us to take a closer look at the tensions and struggles over hegemony concerning the issue of care, and consequently, to reconsider care as a matter of power. However, unlike other scholars who previously raised the issue of power in relation to care, especially Tronto, Dahl understands power not solely as dominance and resistance to dominance. Instead, she builds on Foucault’s as well as Arendt’s analytics of power as contingent, pervasive, ambivalent, fluid (difficult to identify empirically), and as collective: ‘Seeing power more broadly, as power-over and power-to, and as everywhere and potentially also as a collective ability, changes the way we think of care. Care becomes traversed by power, and resistance is potentially everywhere’ (Dahl, 2017: 70).

All in all, power is not simply another core concept in relation to analysing care (for older people). It is more than that, as the notion of power invites us to go deeper into studying care as ‘a condition of our existence’ (Dahl and Hansen, 2022: 1) that is political and gendered. However, considering these transversal and interrelated features of care for older adults requires more analytical clarification. These are tackled in the following.

… through politicising

In line with the classical feminist statement that ‘the personal is political’, care for older people can also be seen as political. That being the case, what does this mean from a conceptual perspective? The simple yet complex statement of care as political raises multiple questions at once. However, instead of searching for irrefutable answers, our intention is exploratory and draws attention to three relevant aspects and research directions. First, care for older people as inherently political needs to be examined in relation to the different understandings of politics. Second, although the conceptualisation of politics has a very long tradition that largely exceeds the frame of our analysis, some clarification of the main approaches is indispensable before focusing on the ‘politicisation’ of care for older people, comprehended both as a multi-layered concept and an empirical process (i.e. ‘politicising’). Third, the switch from asking *Why is older adults’ care seen as inherently political?* to *How to tackle and understand politicising care for older people and its implications?* raises further questions around the notion of ‘political problem’ or ‘political concern’. More precisely, the fact that care is inherently political does not necessarily mean that it is automatically transformed into a political problem or political concern, understood as both the topic of political debates and the object of public policies. Hence, one of our main endeavours is to interrogate the different circumstances in which, and how, politicisation processes have contributed (or not) to conceiving care for older people as a political concern in different socio-political settings in Europe. In other words: *How should we tackle and understand the politicisation of care for older people – as already inherently political, and its possible transformation into a political problem?* While the general issues of ‘politics’, ‘politicisation’, and ‘political problem’ have been largely examined within more or less recent, persuasive, interdisciplinary research, the more delineated interest in politicising care for older people has so far rarely been tackled within other social science contributions.

Examples of how politics and politicisation have been understood and used in different historical and socio-political contexts are numerous (Palonen, 2019). However, there seems to be a consensus around the idea that one cannot conceptualise politicisation without referring to the way in which it stems from a certain understanding of politics. Without seeking to elaborate a literature review, a clear-cut definition, or a unique theoretical framework for further investigation of politicising older adults’ care in Europe, in the following, we will try to briefly regroup the main research axes concerning politics and politicisation. This is necessary to elaborate a possible starting point for further interpretations of the precise issue of politicising care for older people in various European contexts – both EU- and non-EU-related.

Starting from the assumption that 'understanding politics predetermines how politicisation is theorised and analysed on every level of its conceptualisation' (Wiesner, 2019: 255), one can observe that there are two opposite strands of research in theorising politics and politicisation: (a) the first refers to politics understood as a *sphere*, or a field, distinct from other societal fields such as social, cultural, economic, etc.; (b) as opposed to the first approach, the second conceives politics as something inherent to human existence, that transcends the rather limited view of politics as a specific *locus*.

First, understanding politics as a sphere is based on the idea of the classical political system, mainly formed by political parties and other political institutions (Easton, 1953). According to this perspective, politicisation means either enlarging the political sphere or shifting 'non-political' issues into the political field or system. Any 'outsider' – i.e. any issue of any kind – is considered 'non-political', at least until it eventually enters the political sphere. Such an approach is also in accordance with a conflict-oriented assessment of politics understood as based on conflicts and strategy, including four dimensions – 'intensity', 'visibility', 'direction', and 'scope' (Schattschneider, 1957). Therefore, if one considers this perspective, the politicisation of care for older people means that this type of care is not inherently political but becomes so if converted into a relevant political struggle within the political system. Otherwise, if struggles in care for older people remain limited to other societal levels (personal, professional, regional, etc.), without entering the political sphere, they cannot be labelled as politicised matters and do not become political concerns.

Secondly, as opposed to conceiving politics as a clearly delimited sphere or societal field, another theoretical option develops a broader understanding of politics, this time as a condition of human existence. For instance, the British feminist and political scientist Laura Jenkins understands politics as a 'realm of contingency', as opposed to the fixity of fatalism and necessity. Furthermore, politicisation represents a strategy that 'entails exposing and questioning what is taken for granted' and occurs in relation to conflicts and struggles in order to open contingency and change (Jenkins, 2011: 159).

Another eloquent approach congruent with the broader understanding of politics is that of the German political scientist Claudia Wiesner. Wiesner builds on the analysis of the Finnish historian Kari Palonen according to whom politics can be seen as an *activity* that embraces four sub-dimensions – 'polity', 'policy', 'politicking', and 'politicisation' as 'the act of making, or naming something as political' (Palonen, 2003; Wiesner, 2021: 21). In accordance with the idea that 'Politicisation is not a fait accompli, nor does it represent a linear process' (Numerato *et al.*, 2021: 2), Wiesner identifies different stages of politicisation that can occur at micro-, meso-, and macro-levels: (a) whenever something is named political, even at a personal level, in ‘private’ conversations; (b) whenever something enters public or semi-public arenas, for example, through media, social media, protests, or campaigns; (c) a third ‘advanced’ stage of politicisation happens whenever an issue enters the public political system and generates institutionalised political conflicts or effects. Accordingly, politicisation can be seen as a multi-directional process related to a variety of positions stemming from both top-down and bottom-up reactions: for instance, once something is named political at the personal or ‘semi-public’ level, it can either reach a higher level of public debate or remain limited to a less advanced or still ongoing stage of politicisation. Therefore, while politicisation may not lead to predictable and measurable outcomes, its nature and impact are not fully captured by conventional metrics: politicisation may occur even if not salient or publicly visible (Wiesner, 2019: 258).

Overall, although these analyses do not focus on the specific process of politicising care for older people, they are at least a starting point for classifying existing theoretical alternatives in relation to how one can understand politicising as a process. Moreover, politicising older adults’ care raises important operational aspects. If the process of politicisation does not transform care for older adults into either a topic of personal or political debate or an object of public policy, it should be considered purely a ‘personal’ matter that is lived and managed without any ‘external’ interference on behalf of personally related others, the local community, or society in general. However, in the context of recent social and political processes that have affected European countries (both EU and non-EU) to a greater or lesser extent, including the globalisation of care, its neoliberalisation and commodification, its over-regulation as a response to the COVID-19 pandemic, etc., it would be hard, or even impossible, to consider that care for older people has completely escaped politically driven managerial, regulatory, and professionalising actions. Therefore, if older adults’ care is inherently political, and if any related action can be considered as potentially part of politicising processes, how can one empirically identify and analyse these? In other words, what are the most relevant indicators of politicising care for older people? What kind of research sources are preferable for such analysis? Without aiming to gather together different papers resulting from clear-cut definitions and answers to these questions, contributors to our book have been invited to proceed the other way around to reveal a variety of possible responses to the above-mentioned questions – i.e. only *after* conducting research on specific manifestations of politicising older adults’ care in different European settings. This choice results from the belief that only a plurality of approaches and interpretations of the politicisation of care for older people can be relevant to the multitude of European contexts, either within or outside the EU.

According to the approach in which 'the personal' becomes debatable and can entail shifts in power relations at any time, older adults' care can be understood as inherently political. This perspective allows us to tackle care for older people not only as something that is 'political' by definition – that is socially constructed and potentially debatable at any level of social life – but also as an issue that can be 'politicised' at any moment – i.e. it can become a subject of personal and/or public debates, and an object of public policies. More precisely, politicising care includes two directions of analysis. The first refers to the extent to which the issue of care (or parts of it) becomes (or not) the topic of personal, semi-public, and political struggles and debates in both bottom-up and top-down directions. The second refers to the ways in which care for older people is being turned into a political problem or political concern understood as an object of public policies or legislative regulations (Bacchi, 1999). Considering that (paid) care for older people constitutes the concrete object of different policies (family policies, care policies, labour policies, health policies, immigration policies, etc.), which are part of the larger frame of public policies at different levels (local, national, supra-national), a 'political problem' can be understood as the object addressed, constructed, and influenced or even transformed by public policies operating at different levels. Therefore, analysing the process of politicising care for older people also refers to the extent to which and how older adults' care becomes, or not, the object of public policies in different European settings.

… and gendering

Nowadays, it goes without saying that one of the most important contributions of feminist research is its revelation of gender as transversal in any human interaction. Care for older people is more than just a (new) social risk covered by social protection systems. It has never ceased to be a social and moral construction shaped by social structures, ideologies, and social contexts. It is related to *power* relations in place at the personal, professional, and other societal levels. Older adults' care is thus not only inherently political but also gendered (Daly and Lewis, 2000). For example, Tronto reminds us that gendered activities in general, and gendered care, strongly associated first and foremost with the feminine, are the result of and the cause of social attitudes, practices, and representations or cultural meanings about the differences perceived in women's and men's capacities to care. Although prone to social altering and change, gendered differentiation gives the impression of being 'universal and timeless' (Tronto, 2013: 72). However, care understood as gendered implies an essentialist perspective on either care or gender. Our book is not about gender as a substantial feature of care. It rather refers to gender as a power relationship,[2] understood as socially instituted and impregnated with meanings, constructed, alive, and constantly changing (Déchaux, 2010).

Considering older adults' care as inherently political and gendered, and gender not as a fixed attribute but as a transversal and fluid aspect of human interactions and ways of being, paves the way towards the second process central to our analysis: that of gendering care for older people. Similar to politicising care for older adults, our aim is not to focus on what gendering is but on how it has been tackled and understood in existing research, before focusing on how to grasp it in different European settings in relation to the issue of care for older people. The existing scholarship provides different ways of understanding and referring to gendering.

First, gendering refers to a pervasive and constantly ongoing societal and political process at all levels (Bacchi and Eveline, 2010). This process means that 'care as gendered' and 'gendering care' share the same meaning, in accordance with 'gender-as-becoming' or 'doing gender'. For instance, Orloff explains that 'The notion of the fixity of gender categories has been replaced by more fluid conceptions of gender, reflected in the phrases "doing" or performing gender (rather than "being" a gender), a transformation from gender to gendering' (Orloff, 2010: 256).

Secondly, gendering is often referred to within feminist analyses on the welfare state and social citizenship, which have paid special attention to the dynamics between social provision and gendered relations (including care and the gendered division of labour). Regarding this, the whole development of feminist welfare state research can be read through the lens of an oscillation between two main perspectives about how to achieve equality concerning the gendered division of labour: for some feminists, women's economic independence or financial autonomy can be achieved first and foremost through paid work; other feminists consider that gender equality can be achieved through social rights attached to unpaid or informal care (Ciccia and Sainsbury, 2018: 94–95). Beyond these two perspectives, Ciccia and Sainsbury do not provide a clear-cut definition of 'gendering'. Nevertheless, their analysis merits particular attention as they refer to '*gendering* welfare state research', understood as the decision to bring gender into welfare state analysis or to scrutinise welfare states through the lens of gender.

This theoretical and methodological choice developed first and foremost by feminist scholars is also related to defamilialisation, another key concept which invites us to reflect upon family dependencies, solidarities, and care and their correlation with achieving a certain level of welfare. Defamilialisation is not only particularly relevant to understanding the dynamics between the process of gendering (older adults') care and the related public policy measures, but also for 'the tendency in mainstream research to consider [informal and/or family] care as subordinate to paid employment rather than incorporating the two on equal terms into social and political citizenship' (Ciccia and Sainsbury, 2018: 98). The concept of defamilialisation also has other meanings in existing scholarship. For example, in Esping-Andersen's view, defamilialisation refers to the availability of care services outside the home, allowing women to enter employment and benefit from the status of paid worker, and thus escape care duties perceived mainly as a burden on families (Esping-Andersen, 2009). Opposed to this perspective and based on an understanding of care as not only an obligation but also a right, feminist researchers have often referred to defamilialisation as synonymous with individualisation of social rights, understood as the possibility of benefiting from social provision independently of one's familial status or family relationships (Ciccia and Sainsbury, 2018: 98). Also, Zagel and Lohmann highlight the multiple meanings and spellings of the term in the literature – ranging from 'defamilialisation' to 'defamilisation', including the possibility to add a hyphen. The two authors prefer 'defamilising', understood as a 'multidimensional concept' which refers to social services and conditions that can relax the economic and social dependence between family members who give and receive care from their relatives (Zagel and Lohmann, 2020: 130–132). Furthermore, defamilialisation brings into discussion two other concepts. First, 'refamilialisation' relates to numerous analyses concerning the recent LTC transformations and reforms (Da Roit and Le Bihan, 2019; Dykstra and Djundeva, 2021). Secondly, 'optional familialism' invites us to reflect upon the extent to which the diversity of personal and family preferences for caring can be subordinated to public policy measures aiming at reducing the burden of care (Leitner, 2003).

However, some scholars have emphasised the need to re-evaluate this concept and its usefulness in analysing gendered relations within social protection systems (Daly, 2011; Kurowska, 2016). For instance, some care policies can be considered familialising and, at the same time, defamilialising public measures when they consist of simultaneous support for both extra-familial care and care provided by family members. In turn, gendering and degendering measures cannot occur at the same time if the former represents policies that explicitly or implicitly encourage women to stay out of the labour market, while the latter represents public action aimed at reducing or eliminating pre-determined gendered roles (Saxonberg, 2012, 2014). For example, Dahl stresses that in the context of the secular 'drive towards equality' that emerged at the time of the French Revolution and has intensified during recent decades, the process of degendering (as opposed to gendering) has been much more visible in the Scandinavian countries compared with the rest of the world, even though these countries still cannot be labelled ‘gender-neutral societies’. According to this perspective, degendering represents a process that has constantly pushed towards equality with various effects on care, especially visible in the case of childcare and less effective in the case of care for older people (Dahl, 2017: 40–41).

Overall, the conceptual background presented above is neither exhaustive nor does it provide a theoretical framework shared by all chapters. The book brings together multidisciplinary and exploratory research without aiming to reach a single analytical perspective on politicising and gendering older adults’ care. It represents neither deductive nor inductive research. The conceptual background regarding politicising and gendering care for older people in Europe is rather indicative and serves as a guide for different analyses concerning different levels – i.e., of EU or country-based analyses. Also, the volume’s conceptual background raises a multitude of further questions. For instance, one can interrogate the relationship between politicising and gendering or degendering care for older people: to what extent do these processes overlap, reinforce, or contradict each other? When and how are they related or separated across time and place? What does the historical perspective allow us to discover in response to these questions? What are the gendered effects of politicising or the political effects of gendering? Furthermore, as the chapters focus on older adults’ care or aspects of it, analysed through the lens of politicising and gendering, what do these processes reveal about who the older people (a heterogeneous category) are or who takes care of them, and what kind of care they receive?

This book brings together multidisciplinary chapters that address only some of these questions, topics, and research directions, depending primarily on the specific and relevant aspects concerning politicising and gendering care for older people and how these take place in different European settings and societal and political levels.

The organisation of the book

This book interrogates politicising and gendering care for older people, or aspects of these processes, as inherently political and gendered in various European socio-political settings. It starts from a conceptual reflection, which does not consist of deductive research based on a pre-established theoretical framework. This book brings to the fore diverse understandings of the two processes concerning care for older people and some of their empirical manifestations in various European societies at different socio-political levels and periods.

Chapter 1 consists of a feminist discourse analysis of the processes of politicising and gendering ageing and care for older people through the lens of the European Union discourse. Hanne Marlene Dahl and Daria Litvina build their inquiry based on EU policy papers elaborated during 2013–2022 and interrogate the problematisation of ageing and care in official EU documents. The Danish authors explore the framing of ageing and care as a political problem at a supra-national level. They focus on the main problematised aspects, tensions, and silenced topics within the EU official discourse of ageing and care for older persons from an intersectional perspective.

The following two chapters of the book interrogate the politicisation of care for older adults from a diachronic perspective. Unlike research that exclusively focuses on the present, Chapter 2 and Chapter 3 allow us to better understand continuities and changes concerning care for older people in the long run in the case of two Western democratic systems. In Chapter 2, Pat Thane explores the history of social care for older adults in Britain through the lens of the formal political orientation of successive governments before and after the foundation of the welfare state to the present day. Thane starts by deconstructing common stereotypes related to golden ageism, or the so-called advantages of multigenerational family cohabitation, before focusing on the never fully accomplished integration of health and social care services for older adults in Britain. The analysis pays particular attention to the pervasive gendered dimension of care and the politicisation of care for vulnerable older adults who are often instrumentalised as an unimportant section of the electorate. The following historical appraisal by Christophe Capuano analyses the social protection system for the older population in France. It relies on secondary sources in public and private archives to interrogate long-term ‘political inconsistencies’ in the absence of a national political project regarding care for older adults over the last decades. Capuano casts light on the importance of family solidarity as a political issue and the highly feminised aspects of professional and informal care activities in France.

The next contributions focus on the issue of care for older adults in two southern European countries. Chapter 4 consists of a critical social policy analysis that considers how public discourses which address the issue of long-term care policies in Spain articulate gender and racial inequalities. Antía Pérez-Caramés focuses on discursive aspects and the actors involved in politicising care for older adults over the last two decades. Pérez-Caramés interrogates the roles of familism and activism concerning this process and examines the issue of politicisation as a modality paving the way toward recognising public responsibility in providing care in Spain. Chapter 5 complements the analysis of the care issue for older people in the Mediterranean region by focusing on recent controversies around care policies and care policy proposals in Portugal. Ana Paula Gil develops a document analysis based on 15 policy proposals elaborated between 2016 and 2022 around the benefits for informal carers and the state co-payment of services for care for older adults. She investigates how the elaboration of the informal carer statute allows us to perceive care for older people as an object of political struggle at different societal and political levels. This analysis is also relevant for familialising and gendering care processes since these reveal the blurred boundaries between formal and informal care predominantly provided by women.

The following three chapters draw attention to Central and Eastern Europe by addressing different aspects of politicising and gendering care for older adults in three countries that were part of the former Yugoslavia: Slovenia, Croatia, and Serbia. These contributions are neither comparative nor developed through similar theoretical and methodological lenses. However, the three chapters combined are particularly relevant to the problem of care for older people. Beyond their contribution to the still limited research on this topic in Central and Eastern European countries, they invite us to critically deconstruct classic dichotomies through the lens of the multiple manifestations of the processes of politicising and gendering care for older people. These include East/West, socialist/post-socialist, and EU/non-EU differentiations in the case of emergent democratic socio-political systems. In Chapter 6, Majda Hrženjak, Jana Mali, and Vesna Leskošek invite us to take a closer look at the post-socialist context in Slovenia, which has witnessed long discussions around the adoption of a Long-Term Care Act over the last 20 years. The authors interrogate the process of politicising care for older adults as closely connected to different societal and political tensions around three main forms of care provision: institutional care, cash-for-care, and family assistance. More precisely, the analysis focuses on the social and political struggles that result from opposite aspirations, as follows: older adults' needs for good care; care workers' rights to better working conditions; the state's interest in controlling public spending; and women's needs for better distribution in managing care burdens. The authors also examine the specific case of politicisation of care for older people in Slovenia as related to other processes that have been at stake over the last decades – i.e. familialisation, institutionalisation, and marketisation of care for older people. In its turn, Chapter 7 complements the Slovenian case while shifting the attention toward the non-profit sector in providing social care for older people in Croatia. Jelena Matančević and Danijel Baturina develop their analysis based on the 'welfare mix' as a conceptual and theoretical framework centred on the interrelation of different sectors in providing social services for older people. The contribution regarding the Croatian case interrogates the politicisation of care for older adults through the lens of the intertwined relationship between formal public care provision and the post-socialist development of non-profit care services. Finally, Chapter 8 draws attention to the Serbian case, where the care issue for older people became particularly salient during the recent COVID-19 pandemic. Ljiljana Pantović, Bojana Radovanović, and Adriana Zaharijević analyse the politicisation of care as a process of political instrumentalisation. Moreover, the authors conduct ethnographic research aimed at mapping the visible and invisible gendered aspects of care for older adults as part of both formal and informal economies in Serbia.

The book's last two analyses consist of two case studies that are particularly relevant for methodological reflection on the care issue for older adults and the related politicising and gendering processes. In Chapter 9, Ľubica Voľanská builds on the case study of a day-care centre for older adults in Bratislava – the capital city of Slovakia – as a topic of broader societal struggles and political decisions. The author develops a bottom-up perspective that allows us to reflect upon more general care regimes in Slovakia through the lens of the actors directly involved in the issue of care and related processes. This analysis consists of ethnographic research conducted between 2017 and 2021, a period of intense care transformations for older adults due to essential negotiations concerning the roles of the family, the state, and communities in older adults' care. Chapter 10, a case study by Simona Ioana Bodogai and Diana Mărgărit, draws attention to the (in)visibility of care for older adults in Romania as a topic of public debate. The two authors interrogate the process of politicising care during the last two decades through the institutional analysis of the National Council of Pensioners' and Older Persons' Organisations (NCPOPO). As a mediator, negotiator, and knowledge provider, this unique institutional actor plays several roles in political issues concerning older adults' problems.

Pat Thane concludes with an Afterword, which offers an overview of the book's main contribution to research on care for older people. This concluding chapter consists of an overall presentation of the main findings and discusses some of the book's limitations and possible further developments.

Notes

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2 The discussion about gender exceeds the framing of our analysis. However, understanding gender as a power relationship is in line with a sociological perspective of symbolism, institution, and social relations (Fougeyrollas-Schwebel *et al.*, 2003; Théry, 2007).

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1

How does the EU frame gender and care of fragile, older people? Polyphony, tensions, and silencing

Hanne Marlene Dahl and Daria Litvina

Introduction

Care for older persons has increasingly become ‘a site of struggle’ (Dahl, 2017) in many places globally, including the EU. There is now more than ever a proliferation of thinking and talking about ageing and old age care in the academic and the EU’s political sphere. The idea of an ageing-related crisis (‘silver tsunami’), along with the idea that age is not necessarily associated with fragility, gave rise to many discussions on ‘ageing society’, demographic crisis, and recently, a care crisis. Care has been a site of struggle at every level – as a personal experience of caregivers (paid or unpaid) and receivers, an institutional field of care work, a national problem, or a global challenge. While this topic has recently received more attention from researchers and policy-makers, some of its aspects remain understudied. In this chapter, we aim to focus on recent policy documents (2013–2022) that concentrate on the proliferation of old age and old age care discourse and relevant rights in the context of the EU from a genderlens. We use old age care and long-term care (LTC) as synonyms for caring for older, fragile people.

In the EU, a new Care Strategy was launched in 2022. The year prior to this launch, the president of the EU, Ursula von der Leyen, announced a new European Care Strategy with the following words:

> If the pandemic taught us one thing, it is that time is precious. And caring for someone you love is the most precious time of all. We will come forward with a new European Care Strategy to support men and women in finding the best care and the best life balance for them. (von der Leyen, 2021)

The president of the EU puts care for our loved ones at centre stage after a pandemic that made us acutely aware of our vulnerabilities, our inabilities to protect older people in nursing homes (Amore *et al.*, 2021), the conditions of care workers (Poulsen *et al.*, 2022), and increasing problems combining caring and paid work. Von der Leyen links care with ‘finding the best care’ and the best work-life balance and explicitly mentions both women and men. But how do these ideals play out in the political problematisation that underlies recent attempts to create common EU welfare ideals concerning old age and old age care?

Social policy-making in the EU since 2020 has been greatly disrupted by the COVID-19 pandemic, which required large investments and resulted in a shift of priorities at the EU level (Vanhercke and Spasova, 2022). Related to the pandemic, there have been several policy responses regarding gender equality, work-life balance, and care (European Commission, 2022c). While realising the effects of some of these changing policies on care, here we focus on how at the present moment old age becomes problematised and fits into the discourse of care in the EU by bringing to the table the need for common ground on ageing and care policies. We observe the process of politicisation of ageing and of care defined as an articulation of them as political. They are contested at different levels of society, but in this chapter, the object of analysis is delimited to the way in which ageing and old age care become a topic of political discourse and thereby are conceived of as an 'object of politicisation' (Dohotariu, 2024). We realise that there are many stakeholders (such as AGE Platform Europe, European Women's Lobby (EWL), etc.). However, our analysis does not cover their role in policy-making. Neither do we address the issues of multi-level governance (municipality, state, and the EU) and the jurisdiction of the various levels in relation to each other. We realise that this is an important context, as it defines the extent to which and how the care for older people becomes the object of public policies (regulation, financing, etc.) in the EU, which is governing in a minefield of opposing logics of national sovereignty and the EU social right §18: 'Everyone has the right to affordable long-term care services of good quality, in particular homecare and community-based services.' The EU consists of different care clusters and care regimes (Bettio and Plantenga, 2004), including a variety of old age care regimes (Theobald and Luppi, 2018; Szweda-Lewandowska, 2022) with different levels of state support, roles of care professionals, family institutions, and migrants. Many sociocultural differences and legislative and economic barriers exist to a common care strategy. While there is a global trend for the acknowledgement of care needs of older people as not just cared for in the family, the ideal of care differs in care regimes, e.g. between the Nordic and the Mediterranean old age care regimes.

However, some researchers argue that EU members have a joint focus on the 'deinstitutionalisation' of care and 'ageing in place' (Szweda-Lewandowska, 2022: 147), where the latter refers to an ability to live in one's home or community as long as possible. An estimated 20 million people across Europe care for older members of their family (Caracciolo di Torella and Masselot, 2020: 87–88), and in this sense, the EU relies heavily on informal caregivers, whom researchers argue need more support (Wieczorek *et al.*, 2022: 145).

Care is a gendered issue in two aspects: its division of labour and its valorisation. Both informal caregivers and the care workforce are made up of women (Eurostat, 2018; European Commission, 2022a), and care as work is typically not recognised as crucial nor sufficiently recognised even in the Nordic welfare regimes (Fraser, 1997; Dahl, 2004, 2009). Therefore, scholars point out an increasing demand for attention to women's needs as informal caregivers concerning issues such as recognition, labour market policies, support of well-being, etc. (Wieczorek *et al.*, 2022). We can see that some of these needs become commonly agreed upon concepts in policies, e.g. work-life balance, gender equality, and 'active ageing' ('as a way to postpone care needs' (Collovà *et al.*, 2022)).

The growing number of policy reports and documents from the WHO, OECD, and recently the EU signal that something novel is occurring concerning ageing and old age care. But what exactly is problematised, and what is offered as a solution? In this chapter, we identify the ways of problematising old age and care for older, fragile people, where problematisation is defined as the result of policies that produce particular types of 'problems' (Bacchi and Goodwin, 2016: 6). In our feminist discursive analysis, we are inspired by Bacchi (2009) and Fraser (1989) and locate elements of silencing in the official EU discourse.

In the following section, we elaborate on our theoretical framework, while in the third section, we outline our feminist, discursive analysis and sources. The fourth section shows the results of the analysis, and finally, we conclude.

Theoretical perspectives: care and EU studies

In our analysis, we mostly draw upon two theoretical perspectives, that of feminist care research and EU studies on care (including LTC). In line with feminist care research, we see caring as a useful concept that highlights its characteristic as a basic human condition, a social phenomenon, and a critical perspective. We supplement feminist care research with specific literature on care for older adults when needed.

Caring – and receiving care – is a basic human condition. We are all vulnerable and need care from others at various points in our lives, such as when we are babies, sick, challenged, or among the oldest old (Tronto, 1993; Fineman, 2008). There is no clear-cut dividing line between those in need of care and those giving care. Even those needing care can sometimes provide care for others (Tronto, 1993; Milligan and Wiles, 2010). Caring is a social phenomenon involving bodily aspects (Twigg, 2000), affective dimensions (Yuval-Davis, 2011; Thelen, 2015), and cognitive elements (Martinsen, 1994; Leira, 1994). Caring is work regardless of whether it is paid or not

(Wærness, 1982). Caring either takes place in relationships (Graham, 1983; Ungerson, 1987) or in more contingent assemblages involving a larger group of care workers, professionals, significant others, and perhaps strangers (Mol, 2008; Milligan and Wiles, 2010; Gherardi and Rodeschini, 2015; Dahl, 2017, 2021). Caring is typically about helping or alleviating pain. It is about trying to do 'good' and a dialogue about what is needed: tinkering with care (Mol, 2008). Caring is embedded in various practices and has increasingly become part of the public sphere either as state regulated, tax financed, or paid for in the market or in the grey economy.

From this general literature on caring, we move on to specify caring for the oldest old as a provision of their various needs over an extended period to enable a dignified life (inspired by Caracciolo di Torella and Masselot, 2020: 83). 'An extended period' is identical with what is elsewhere referred to as 'long-term care'. A dignified life relates to idea(l)s about good care, sufficient resources, knowledgeable care professionals, and noticing the older person's needs. In this definition, we are inspired by Mary Daly and her understanding of care as 'a configuration' involving four aspects: ideas, resources, actors, and perceived needs (Daly, 2021: 114).

But caring is not just about 'doing good', there is also another, darker side to it. Care and caring are also about power. Tronto (1993) argues that caring can be suppressive if there are paternalistic elements, i.e. dominance and control. Recently researchers have argued that idea(l)s of care and cure can be more subtly suppressive as they create normative standards about the recipients, e.g. 'enablement' (Dahl, 2012, 2017; Clare, 2017). Beyond the more general feminist care literature, there are a number of critical voices under the umbrella of 'critical gerontology' (Ray and Cole, 2008; Katz and Calasanti, 2015; Wellin, 2018; Doheny and Jones, 2021). For instance, there is a consistent critique of the idea of 'successful ageing', as it excludes 'unsuccessful agers' and ignores the diversity of the ageing experience. Such a critique aims to draw attention to socially located perspectives of ageing people and point out that certain ways of framing might have practical consequences – 'such labelling deeply affects their treatment by health care regimes in practice' (Katz and Calasanti, 2015).

Caring has also increasingly become a critical perspective to a contemporary, neoliberalised, and capitalist society (Fraser, 2016; Tronto, 2017; The Care Collective, 2020; Dowling, 2021; Dahl, 2022; Lynch, 2022), which shows the inequalities concerning gender, class, and race – to mention a few – that are produced and reproduced by current care arrangements including the misrecognition of care and the depletion of women's resources (Rai *et al.*, 2014; Wieczorek *et al.*, 2022). Part of a critical perspective is to investigate whether and to what extent caring becomes a public issue, i.e. becoming visible through its politicisation, and also to identify the process of gendering care for older, fragile people in EU discourse, whether this reproduces gendered care arrangements or has more egalitarian logics, i.e. contesting care arrangements by acknowledging unequally distributed care work with a transformative aim (Fraser, 1997; Dahl, 2017).

Existing scholarship on care at the EU level, especially for fragile, older persons, is an emerging field where little research has been done (Caracciolo di Torella and Masselot, 2020; Zacharenko and Elomäki, 2022). This lacuna is related to the subsidiarity principle, which used to hinder the role of the EU as a supra-national policy-maker: 'It is based on the idea that decisions should be made at as local a level as possible' (Nousiainen, 2011: 22). According to this principle, matters concerning families and social policies should preferably be the competence of individual member states and not a concern of the EU. For over a decade, social issues have been discussed within the so-called 'open method of coordination' (OMC), typically seen as a forum for learning and transferring best practices. The OMC can be interpreted as a kind of soft law (de la Porte, 2021). Alternatively, it can be seen as a forum containing struggles about a dominant imaginary of good long-term care – or the European social model.

The role of the OMC changed in 2017 with the European Pillar of Social Rights (EPSR) (and the relevant Action Plan in 2021). This became a 'game changer' (Caracciolo di Torella and Masselot, 2020: 98). The EPSR introduced a rights-based language and stated in §18: 'Everyone has the right to affordable long-term care services of good quality, in particular, homecare and community-based services.' This exists alongside the original Treaty of the European Union that codifies basic values of 'human dignity' and 'wellbeing of its people'. Although §18 seems to undermine the principle of subsidiarity, the EU lacks a clear competence to regulate care for fragile, older people (Caracciolo di Torella and Masselot, 2020). However, some scholars argue that despite this lack of supra-national authority, the mantra for this policy field goes like this: 'those who want more do more' (de la Porte, 2021: 71).

Despite the lack of a clear legal authority, some scholars have argued that a discourse about key principles has crystallised in this intergovernmental forum. These are 'access, quality and sustainability' as joint principles (Caracciolo di Torella and Masselot, 2020: 95). Conversely, Zacharenko and Elomäki (2022) argue that there is not one holistic view of care in the EU. Instead, there are contradictory framings of care generally in different policy fields, where gender equality and social policies have been subject to economic policies (Zacharenko and Elomäki, 2022). Simultaneously, they also argue that there are contradictory constructions of caregivers and care. We consequently wonder whether the newly launched Care Strategy is part of a more unified discourse on old age and care for older people.

A feminist, discursive policy analysis

We identified the relevant empirical material in two rounds. The materials originate from 2013–2022. During the first round, we created a list of potentially relevant empirical sources about care for fragile elderly persons at the EU level. It included 28 documents (policies, reports, proposals, communications, etc.) on old age care, long-term care, and relevant topics such as social rights, health care, and gender. Most were by the European Commission, and some by the Council of the European Union and European Parliament. We have also monitored several publications by the EIGE (European Institute for Gender Equality) and NGOs. This round showed that EU discourse about old age and old age care is quite diverse (especially at the level of NGOs and other stakeholders). At the same time, there was an attempt to make it more coherent via the European Care Strategy and other relevant documents. Therefore, during the second round, we narrowed our analysis to documents by the European Commission that have directly addressed long-term care (n=10), among which the European Care Strategy appeared to be one of the most central (because of its unifying attempt). In addition, we aimed to find some intertextuality in this material and identify key terms, boundaries, and silences that the discourse constructs.

In collecting our archive, we aimed to reveal the field of care for older, fragile people that we simultaneously co-constructed as encompassing more than just health issues. There is a choice of boundaries involved in this research process, which implies that another archive collection might give us a different analysis. The collected archive is intended to give us an analysis of the way old age and care for fragile, older people have been problematised in the EU.

We combined elements of discursive policy analysis (Bacchi, 1999, 2009; Bacchi and Goodwin, 2016) with a politics of need interpretation (Fraser, 1989), supplementing it with an attention to something more than gendering and degendering. We also used an intersectionality lens (Crenshaw, 1991). Identifying a problem representation is a difficult task, as it requires a dual process of familiarising oneself with the texts closely and then alienating oneself from the same vocabulary, premises, and understandings in an analytical move (Dahl, 2022). The characteristics of the discursive field created a problem for us in the application of Bacchi, as she moves from the policy solutions to the implicit constructions of the policy problem and, therefore, better fits policy papers. At the same time, our collection of documents seemed to pile up problems with no clear policies at hand, making it difficult for us to work backwards from policies to identify the problematisation.

Bacchi's discursive policy analysis involves seven steps (Bacchi, 2009; Bacchi and Goodwin, 2016): (1) What is the problem represented to be? (2) What assumptions underlie this representation of the problem? (3) How has this representation come about? (4) What is left unproblematic in this representation? (5) What effects are produced? (6) How/where has this representation of the 'problem' been produced – and how could it be disrupted? (7) Self-reflexivity, i.e. how is our analysis itself a representation of the problem? We have pragmatically selected three of Bacchi's seven steps, that is steps one, two, and four. Step one is to identify how the political problem is framed through the solution/policy suggested, i.e. identifying the problematisation. A problematisation is the way problems are produced as a particular type of problem (Bacchi and Goodwin, 2016: 6). Step two is about the underlying dichotomies, key concepts, and categories necessary for constructing the political problem in this way, making it intelligible and natural-looking. Step four is about the limits of what is seen as a political problem, what fails to be problematised (Bacchi, 2009: 12): it is about identifying silences and processes of silencing (Dahl, 2017).

We supplement Bacchi with elements of Fraser's 'politics of need' interpretation to direct attention to the way needs-talk has become a major part of Western political discourse (Fraser, 1989). Fraser stresses that needs are contested and that needs-talk is about a struggle to gain political status, the interpretation and satisfaction of a particular need (Fraser, 1989: 294). Our focus is to identify the kinds of needs articulated and for whom. When identifying the subject positions available in the policy field, it is not just about being fragile, older persons or not, or gendering or degendering taking place, but about various intersecting identities. Here we rely on Kimberle Crenshaw and her concept of intersectionality, which stresses how we must be attentive to identities as a meeting place that combines different categories that are typically assigned different values (Crenshaw, 1991).

Our feminist perspective consists of three key dimensions: an attention to the private-public dichotomy as politicisation (a key object of our study), care as a critical perspective, and self-reflexivity. Feminist research has from its origin been concerned about how some issues are deemed private, whereas others become public and politicised (Fraser, 1989). We draw upon care as a critical perspective that can expose inequalities related to current and future care arrangements. Simultaneously, we reflect upon our positionality as researchers belonging to different generations and welfare regimes and its bearings on our research (Haraway, 1988; Bacchi and Goodwin, 2016). In this way, we acknowledge the politics of location (Braidotti, 2002).

Old age and old age care as a political problem for the EU

The greying of societies and care for fragile, older people have become politicised at the EU level and as a joint problem with common solutions.

The problematisation of old age is mainly based on demographic and economic presuppositions, which can be seen in this quotation: ‘significantly lower working-age population is projected for the EU over the coming decades’ (European Commission, 2018). Ageing is perceived not only as an individual experience, or as a state-level problem, but as an EU region-wide problem that requires a common vision and complex solutions. This alarmist discourse refers to dramatic changes related to an ‘ageing society’: low fertility rates, seniors dropping out of the labour market, rising care needs, etc. While this problematisation addresses crucial problems, such as health care, long-time care, or pensions, it does not suggest concrete solutions.

In this paragraph, we explore how EU documents frame ageing and old age care as a political issue. They create a discursive repertoire, which is, as we find out, not always unequivocal. We argue that the recent Care Strategy, which aims to make a common framework for various care-related issues, including issues of LTC, health care, and work-life balance, remains uprooted and rather insensitive to cultural and political differences. According to our analysis, despite the articulated ideals of care, the discourse remains neoliberal in nature. Older people widely appear in the context of growing alarmism that demographic tendencies will create financial and care deficits and in which economics remains the main rationality for changes in the care sector. We will focus on the key problematised issues, tensions, and silenced topics that constitute the EU’s official discourse of ageing and care for fragile, older people. We realise the limitations of this study – our analysis only sketches the main lines of the problematisation of old age and caring for older, fragile people in common EU policy papers. The practices of its interpretation, implementation, and negotiation between different stakeholders are out of the scope of this chapter.

First, let us answer one of our questions: ‘What deep-seated presuppositions and assumptions underlie this representation of the problem?’ We will start with some basic notions on the nature of political discourse about ageing at the EU level. While the discussions about ageing and care constitute an ongoing debate over the last couple of decades, at the level of the EU, the debate appears in the form of fragmented discourses, which pile up concerns, alarmist prognoses, and rationales. It is made up of a hybrid discourse which operates with rationales from *neoliberal, paternalistic, and feminist discourses*. Neoliberalism is a process of marketising, increasing choice, self-responsibilising, and increasing attention to monitoring (Brown, 2003; Dahl, 2012, 2017). (Supra-)state paternalism is a type of relationship when the government covers some basic needs, but in return, it limits individual autonomy and assumes the right to define aspects of citizens’ personal and public behaviour. Feminist elements of the discourse refer to gender equality, work-life balance, and the need to revalorise care (Tronto, 1993; Fraser, 1997; Lynch, 2022). All these elements can be found in the language of the EU discourse.

An important premise that glues these discourses together is that the EU is discursively constructed as a single space, and therefore, the rising costs of ageing are framed as a common issue economically and morally. Proposed solutions are framed to deal with upcoming challenges in accordance with a 'European way of life'. However, pronounced common values seem to have a rather declarative character that reflects a moral landscape. There is a desired imaginary of a moral society of Europeans: 'It is about living in dignity, upholding human rights, leaving no one behind and providing opportunities for better life and career prospects, the backbone of our European way of life' (European Commission, 2022a).

Such an approach itself has a huge empowering potential. The newly announced European Care Strategy (European Commission, 2022b) and related documents[1] formulate an important framework for a common EU understanding of care. They recognise gender imbalances in care provision and the need for humanising long-term care in accordance with principles of dignity and freedom. It seems to be an attempt to bring together the principles of care at the EU level and put certain moral ideals at the forefront. But what exactly do these documents problematise and bring up as a public issue? And what are the tensions they contain, and what topics remain silenced in the discourse, despite its versatility? So, 'what is the problem' articulated in these documents (Bacchi, 2009)? The concept of care in the discourse seems extremely complex yet fading – it is a floating signifier. Care is a human right, a public issue, a burden, a priority, an instrument, a matter of health, a matter of help with chores, and many more things, but not something concrete. The discourse on old age care seems to be polyphonic in a way that it 'piles up' many care-related issues of different levels, such as the mental health of caregivers, attractiveness of care professions, and the need to support the economy. Some of the rationales are oriented to achieve aims beyond 'care' per se (e.g. sustainability of economy) (e.g. European Commission, 2015, 2018, 2021), while others refer to a humanising discourse (e.g. recognising the needs of informal carers), which is especially evident in documents related to LTC.

But what is relevant for all the documents is that the problematisation of ageing is largely based on the expected economic consequences of an increased proportion of older people in the population. In other words, the society in which older people prevail is expected to be less productive. The insufficient size of the labour force in upcoming years becomes one of the main categories that constitutes the 'ageing society' problem. It is noted that there will be an increased burden on younger generations due to a lack of workforce, extended expenses on health care, and increased informal care duties (especially for women):

> The economic old-age dependency ratio (inactive elderly versus employed people) is projected to rise significantly in all Member States (…). Similarly, the ratio between the total inactive population and employed people (economic dependency ratio) would rise strongly amid demographic ageing with large variability across countries. (European Commission, 2021: 38).

Therefore, the problem of ageing is constructed as a multi-layered issue: care about older people is presented as care about younger generations, which is also about economic sustainability and growth. When older people become vulnerable, the main problematisation (our first question/step one) of old age care focuses on two aspects: (1) insufficient, too expensive, and non-quality care services; and (2) a too high, informal, and gendered care burden that hinders women's participation in the labour market and/or a good work-life balance (see, for example, European Commission, 2022d).

The EU speaks in terms of the unsatisfactory 'resilience of elderly care systems' that was revealed during the pandemic. Resilience is believed to be strengthened through developing a market regulated by general principles and standards for good old age care, collective bargaining, and the monitoring of delivered services. However, old age care is not sufficiently regulated, creating precarious working conditions for those providing the care. According to this rationale, care in the grey economy must be brought under the auspices of unions and employer organisations. However, it remains unclear which are the actors engaged in care networks; in what proportions are care duties proposed to be shared between formal and informal caregivers; what inequalities (including trans-local) can create a redistribution of care; will caregivers and receivers be willing to cooperate (change care and work patterns), etc. The gendered care burden is described in the following way:

> Inadequate care services have a disproportionate impact on women's supplementary or informal care responsibilities as they fall predominantly on them and affect their work-life balance and options to take on paid work. (European Commission, 2022a: 2)

This quotation shows how the issue of gender equality is strongly linked to labour market participation. To increase the number of people available in the labour market, women must be liberated from some of their care obligations. Equality becomes equal participation in the market. Here, a feminist element is articulated.

However, there is also another rationale that could be linked to feminism. This rationale is about the informal carers and recognition of their work. The commission links the potentially detrimental effects of their caregiving to their health, pay and pensions, and their need for support. Support for informal carers is 'through training, counselling, psychological and financial support' (European Commission, 2022b: 2). This support for the informal carers, i.e. 'caring for the carer', is a feminist strategy, but an affirmative one. It is not transformative as it is unlikely to change the gendered division of work. However, the EU also argues that care for fragile, older persons is one of the most gender-segregated sectors and must change to transform its status and recruit more men. This revalorisation of care is supposed to be achieved through campaigns that change gender stereotypes.

Labour shortages related to greying societies can be counteracted through higher wages, better regulation, and migrating care workers. The EU proposes to increase the access of migrating care workers coming from outside the EU. It wants to create 'legal pathways', i.e. fast track systems that have been tried in Italy (Tronto, 2011). This problematisation assumes that there is a large pool of would-be care migrants, and it simultaneously ignores the negative effects upon those left behind by an increasingly feminised migration (Isaksen *et al*., 2008).

It is hard to predict how implementing broad, overall policies would change the situation in the market and in the private sphere due to not seeing gender identities as continuously socially and culturally produced. This perspective is deeply embedded into the sphere of gender relations, as most of the caregivers – both institutionalised and informal – are women. Gendered problems of work-life balance and lack of recognition of care market jobs are mentioned, but the rationale beyond this remains mostly neoliberal: we need women to enter (or not drop out of) the labour market. However, it remains unclear what is the potential of this in reducing the care burden. The care consists of the management of dependents, emotional labour, and constant investments of different kinds into the well-being and development of family members. It can take many forms. However, as we said earlier, despite acknowledging certain gender inequalities, the informal caregivers' lived experiences are only marginally considered in these documents. Instead, more women are expected to join the labour market, related to these shifts in social infrastructure.

If we look closer, the discourse contains some tensions and blind spots. So, following Bacchi, we ask: 'what is left unproblematic in this representation of the problem? Where are the silences? Can the "problem" be conceptualised differently?"

The rationale beneath the proclaimed ethics leans rather not on moral order but on an economic necessity, and appears to be neoliberal in nature. The 'liberating project' in this framework can be interpreted as a form of supra-state paternalism. While it demonstrates solicitude for important and even crucial components of care infrastructure for older people (health care and long-term care), it is eager to dictate its norms in the personal sphere as a reward. This relates to entering – and staying in – the labour market (for women) and 'active ageing' as a way to keep elderly people in the labour market and postpone care needs. The lived effects of implementing this imperative can be both oppressive and liberating – for various groups of men and women, depending on how the hybrid discourse will be put into action.

Old age is framed as a problem which can be solved by a neoliberal project of ageing based on the premise that growing old does not necessarily mean getting more fragile. This is part of the idea that is widely known as "active ageing". Older people are (implicitly or explicitly) expected to make personal efforts or use institutionalised help to get healthier, keep an active social life, and have access to high-quality care, etc. It can be said that an idea of ageing prevails that to some extent ignores elderly people's frail bodies. At the same time, older people are discursively constructed as passive recipients of care or a labour force that can be utilised if managed correctly. It does not seem they are expected to be included in care networks as caregivers. It is as if they only require care, but do not provide it themselves – to their partners, children, grandchildren, or themselves. They seem to become locked into one-sided identities. This is an example of a paternalistic 'state knows better' approach.

'Care needs' are not specified in their heterogeneity. The unifying approach does not consider personal differences or at least adapt the needs according to class, race, family composition, sexuality, religion, and other social dimensions. While intersectionality (Crenshaw, 1991) has become a mainstream concept in gender studies, its potential does not seem to be used in policy discourse. Inequalities related to gender are mentioned, as well as race/ethnicity, when referring to care and domestic workers (e.g. 'with a migrant background'), but separately. The rest are silenced, and there is no visible attempt to get deeper into the intersectional nature of social inequalities (in terms of care needs). As a result, in the configurations of care, situated views of care receivers and givers remain blind spots.

Problematic issues are not addressed or even mentioned, such as the 'darker elements of care' (when care receivers are disciplined and/or subject to institution-based violence and abuse). As mentioned, care as a social phenomenon is theoretically typically imagined as a combination of head, heart, and hand, i.e. cognitive elements, affective dimensions, and bodily aspects. These different dimensions of care are silenced. Care is exclusively seen as a question of sufficient hands – except when there is a mention of a need for the 'up- and reskilling of care workers' (European Commission, 2022a: 15). However, there is no specification of such a strategy, and many questions about its form remain unanswered. Up- and reskilling presumes that care workers are not good enough, and that there is a problem with their qualifications. This framing hides underfunding as a source of the problem of quality, and it also neglects existing bodily and experience-based knowledge.

On a supra-national level, care needs are rather pictured by the 'view from above, from nowhere' (in terms of Haraway, 1988: 589). From such a perspective, caregivers and receivers are mostly objectified and reduced to equalised labour force units or consumers of public goods. The economic approach uses statistical data and economic models to meet its criteria of 'objectivity'. However, 'it says very little about those who provide care (and under what conditions) and those in need of care' (Zacharchenko and Elomaki, 2022: 13). The needs of older, fragile people (from their perspective) are not described in any of the analysed interrelated documents, although it is assumed that the increasing availability of a care market and choice is beneficial for them – or that older people or their families/significant others can navigate in a care market. Another problem with the unifying attempt is that the EU is neither homogeneous in terms of welfare regimes and economic development, nor in terms of uprooted practices of informal care. As well as that, there are notable differences in what 'ageing with dignity' might mean in different cultural, social, and political contexts. The analysed level of EU discourse recognises these differences but does not seem to pay attention to them. For example, a briefing (a pre-legislative synthesis) by the European Parliament claims that:

> There is no standardised definition of LTC, the needs it covers or the quality standards it should fulfil. EU national systems differ in terms of how LTC is organised, delivered (at recipients' homes or in institutions) and financed, and how the resources are generated. (Collova *et al.*, 2022: 3)

The homogenising attempt does not seem to consider how numerous policies, projects, and strategies, created by different stakeholders, coordinate social relations at the local and personal levels and between different levels of governing institutions. Instead, we observe the process of politicisation and Europeanisation of care policies from the perspective of private and national issues, where these issues become a political question at the supra-state level and where policies give way to more general concepts and principles.

The discourse on old age care problematises ageing and care, juggling with neoliberal, paternalistic, and feminist vocabulary. It sounds like a choir of many voices, including the motif of rights and values, with a leading vocal of economic reasoning. The economic approach frames 'ageing society' as an EU and global issue that dramatically challenges the situation in a labour market and therefore requires instruments to improve the situation, which makes the care discourse sound disciplining and paternalising. At the same time, the discourse appeals to a 'European way of life' – an imaginary moral society which treasures the same values. Therefore, it proclaims person-centredness, recognises gendered issues (related to informal and professional caregiving), mentions 'dignity', and includes quality of care in its priorities.

However, the discourse uses a 'god's view' optics – and therefore, the lived experiences and sociocultural differences in the perception of care are not specified. This makes the whole discourse uprooted and uncertain regarding older, fragile people's needs, full of silenced issues (such as 'darker care') and blind to the diversity of caring needs and more specific strategies. The overdetermined concept of care and the declarative character of aims and blurred proposals allow us to draw broad interpretations of how to translate the magic buzzwords and principles nationally and locally.

Conclusion

In this chapter, we aimed to explore the ways of politicisation and silencing in EU discourse about older people and their care from a feminist lens. Our analysis is limited to official EU discourse, including the newly launched Care Strategy and many other documents that frame ageing and care-related issues such as work-life balance. This archive does not allow us to grasp the lived, potentially gendered effects of the politicisation of old age care. Politicisation means visibility and contestation, but it can also mean instrumentalisation of care, such as concerning active ageing. We approached this field as strangers with different academic, generational, and national backgrounds. Using critical and feminist optics, we examined how the problem of ageing and old age care is discursively constructed and what is left unrecognised.

In contrast to the existing literature, we claim that there is an emerging policy field of old age care within the EU based on policy documents from the last decade, including the recently launched Care Strategy. Although there is not (yet) a unified discourse, care has become a floating signifier that weaves together different rationales and policy problems. We saw a fragmented discourse glued together by ideas of an imaginary moral 'European society' and global economic problems of an 'ageing society'. Some scholars argue that the ideas of 'Social Europe', including the EPSR, remain blind to existing political tensions about the locus of authority and responsibility (Vesan and Corti, 2019).

The care discourse, as a part of wider ideas of Social Europe, operates with categories from different logics of care: neoliberal, paternalistic, and feminist. It offers a multi-layered problematisation of both ageing and care, which includes 'piling up' various problems, with economic ones being dominant. The neoliberal element is about increasing labour market participation, economic growth, and creating an enlarged, well-functioning market for care services. Moreover, as other scholars have argued, key principles in the field have crystallised, such as ‘access’ and ‘quality’. Both aims are supposed to be achieved through a regulated market with collective bargaining, increased import of care workers, and monitoring of care services.

Discourse seems multi-vocal, as it speaks about many care-related issues in different tones, however sociocultural differences, inequalities, and intersectional dimensions are left unnoticed. Sometimes migrants and gender issues are mentioned, but not in detail. Therefore, the implementation of policies and their effects on the personal level are unpredictable. Gendered issues are mentioned, but in a conflictual way, as the discourse applies both gendered stereotypes and feminist rationales. The discourse acknowledges the role of women, who reproduce most of the informal and professional care (the care burden). However, it remains unclear whether the existing strongly gendered (and racialised) care for fragile, older persons is proposed to be reframed (degendering by attracting men to the care market, promoting more egalitarian informal care, etc.) or reproduced as a strongly gendered, racialised care market, e.g. by promoting an increased migration of care workers (read: women) from outside the EU. The darker elements of care and of relationships in their complexity are not recognised either.

We observe in the discourse a pluralism of scenarios, blurriness of strategies, and terra incognita of regional differences. The main trend is alarmism about ageing, which is problematised and framed as a shared responsibility (of people, states, the EU, and the global world). Citizens should be more active (to postpone the time when they will leave the market and require care), and there should be improved care services. ‘Active ageing’ serves as an example. However, fragile, older people’s agency, needs, life choices, and political voices seem to be ignored.

Despite the proclaimed social agenda behind the EU discourse, we find declarative statements and silenced topics. Ironically, the documents do not specify care, indicating that many rationales are at play as well as tensions between a more neoliberal part of the discourse and more humanistic ideals. Can EU-wide care policies even exist? Can we bypass situated perspectives and solve care issues ‘from nowhere’? The answer would lie in analysing the lived effects of this care discourse, increasing the visibility of blind spots in existing policies, and voicing the situated perspectives of the ones included in care networks.

Note

1 Full list can be found here: https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=10382&tableName=news&moreDocuments=yes

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2

Social care in Britain: How did we reach the present crisis?

Pat Thane

Did people in the past grow old? Older people and their families

This chapter explores the history of social care for older people in Britain, focusing upon its shifting relationship with formal politics and the persistent gendering of care. To help us understand how the present situation came about, it first examines the long-run history of elder care before the mid-twentieth century.

It is not the case, as is sometimes stated in Britain, that in 'the past' few people lived to be old, and the contemporary world is faced with a wholly unprecedented need to care for older people. Many more people than ever before, though of course not all, do now live to later ages and need care, although many older people do not need care, but the change over time is less dramatic than is sometimes believed. In all known past societies, even in ancient Rome (Parkin, 2003), a significant number of people lived to their sixties and beyond, sometimes well beyond, more often women than men since women have long tended to outlive men and still do in Britain and many other countries. And richer people have always outlived the poor, and still do, as we will see, while in the poorer societies of the past, people often appeared physically old and frail at earlier ages than today[1] (Thane, 2000; Botelho and Thane, 2001).

References to care for older people in 'the past', like many comparisons between 'now' and 'then' in popular discourse, tend to be afflicted by beliefs that things were always better in 'the past', always getting worse in the present. It is said that in the (vaguely defined) 'past', British families normally lived with and looked after older relatives, but now they abandon them in care homes. Similar, contemporary, comparisons are made with other, faraway, countries in Asia and Africa, where family care for older and disabled people is said to be more devoted than in Britain.

These comparisons are highly questionable. It is true that it is not a traditional cultural norm in Britain for older people automatically to live with their adult children as it is, for example, in Japan, although it is a norm for some minority groups who have arrived in Britain since the 1950s, especially those from South Asia. It has not been so in north-western Europe for hundreds of years (Laslett and Wall, 1972). The evidence is rather that for centuries very many older people preferred to live independently in their own homes for as long as possible, valuing the freedom, privacy, and capacity to socialise when and with whom they choose (Arber and Ginn, 1991: 158–159). Today more older people can financially afford this independence. In the seventeenth and eighteenth centuries, 7% of men over 65 and 15% of women lived alone, by the mid-1980s, 20% and 48% respectively (Arber and Ginn, 1991: 24), generally moving to live with relatives only when they became too frail to manage alone (Qureshi and Walker, 1989). Numbers in the 2020s are similar. Before improvements in medicine in the mid-twentieth century, especially the discovery of antibiotics, older people often did not survive long in a frail condition but died quite quickly from infections. Now medical treatment can keep them alive for many years in fragile health, requiring care.

But if in the past, and now, older people have not routinely lived with their families in Britain, this does not mean that they have been more neglected by their families than in cultures where the generations live together. Until World War II, over many centuries, many people in Britain never married and had no children to support them in old age (Schofield, 1985).[2] The numbers, of course, fluctuated over time and from place to place: the census of 1931 still showed that 14% of adult women and 9% of men were never married (Schofield, 1985). Among those who had children, until the early twentieth century high death rates of children and young people meant that many people had no surviving children as they grew older. The latter was true of one-third of women aged 65 and above in sixteenth- and seventeenth-century England because they had no children or their children had died (the precise numbers in each category are uncertain) (Smith, 1987: 261–265). Also, for centuries, young people migrated away in search of work. Communication with their elders was then difficult when transport and other forms of communication were poor or expensive, and they were not highly literate. So, until quite recently, many older people had no close relatives available to care for them.

It is often suggested that older people are more neglected now because members of the younger generation are so busy, so mobile, and women work and no longer have time for family care. But women and men worked hard, travelled, and had stressed lives throughout history. The difference now is that it is possible to live at a distance from relatives but to keep in touch using modern transport and technology. Relatives can travel even from Australia to Britain within 24 hours. And, in the mid-twentieth century, after World War II, marriage rates increased. Most people have since married at least once, or, increasingly, from the 1970s have co-habited stably, and had children, although fewer children were born between the late 1960s and 2001 than in the post-war ‘baby boom’ following the arrival of the birth pill and growing numbers of women in employment. Death rates at earlier ages declined, so, as censuses reveal, in recent decades, almost all ageing adults have at least one surviving adult child. Also, most people (we do not have precise numbers) have close relatives within easy travelling distance, and modern technology – the internet, telephones – enables the generations to keep in touch even over long distances. The evidence is strong that most families do so and provide care for each other when needed, with women always the main providers of care (Arber and Ginn, 1991: 129–157).

Although generations living together has never been the norm in Britain, this does not mean there is no tradition of intergenerational care. The evidence is, rather, that older and younger generations have always supported one another whenever they could, when it was needed. It was always quite common for some close relatives, where they survived, to live close to older people, for adult children, especially daughters, to help ageing parents living nearby, and, as we will see, for ageing parents to help them in return. To live separately but in close contact was often a conscious choice for as long as the older people could manage alone, partly because they preferred to keep their independence; also, they were aware of the tensions that can arise when families share a home (Thane, 2000: 119–146). There were folk tales even in medieval Europe warning older people of the dangers of living with their children, who might marginalise and neglect them, especially if the elders handed over their property to the younger generation (Shahar, 1997: 94–97).

It is important not to romanticise extended family living and assume that it always entails warm, caring relationships. The clearest, alarming, evidence about this comes from Japan where, as already pointed out, it is normal for older people to live with their adult children, but there is evidence of high levels of abuse of elders within families (Hayashi, 2013: 63–64; Hayashi, 2014). One national survey claimed that half of all family carers had subjected frail older relatives to abuse, and other surveys support this.[3] Evidence from other countries suggests that Japan is not unusual in this respect (Acierno *et al.*, 2010; Naughton *et al.*, 2012). In Britain, the Crime Survey for England and Wales reported that in 2019, 278,000 people aged 60–74 experienced abuse from their families. For no clear reason, they do not collect statistics on abused people over age 74, but there is other evidence of abuse (O’Keeffe *et al.*, 2007). Of course, the generations can and often do live together contentedly everywhere, without conflict and abuse. There is much evidence of strong intergenerational support within families in Britain, past and present, even when they do not live together. It is likely to have grown more, not less, prevalent over the past century, especially since World War II (Arber and Ginn, 1991: 130–135), because, as suggested above, although families are smaller than in the past, most older people now have at least one surviving child, most, though of course not all, people are better off, and family members can more often afford the costs and time to help one another, although this has become more difficult for more families since 2010 due to rising levels of poverty.

Until the early twentieth century, adult children were often too poor to help their ageing parents along with supporting themselves and their children, and they might live in such miserable, overcrowded conditions that sharing a home was impossible (Thane, 2000: 119–146, 287–307). Through the twentieth century conditions improved, and, in contemporary Britain, as we will see, very many families (precise statistics are hard to find) – mainly female family members – care for their elders at least as much as in the past, probably more so, even at considerable emotional, physical, as well as financial cost to themselves, and at least as much or more than in countries with traditions of co-residence (Arber and Ginn, 1991: 129–177). It is an essential part of British culture. As we will see, pressure on families to care has grown in the later twentieth and early twenty-first centuries as public care services have declined, especially in the COVID-19 crisis, and there is every sign that very many families have risen to the need despite the considerable strain it can cause.

It is sometimes asserted as evidence of family neglect that more older people in Britain live alone now than in the past. This is partly because there are more older people as average life expectancy has grown, more can afford their own homes, and they still prefer independence whenever possible, as suggested above (Arber and Ginn, 1991: 67–78). They are not necessarily cut off from close contact with friends and family. Some, sadly, are isolated and lonely (again, numbers are uncertain), but throughout history, there have always been some lonely older – and younger – people.

Care services before the welfare state

But what happened to older people who did not have access to family care in the past? What care services existed? At all times until World War II, better-off older people in Britain, whether or not they had, or lived with, families, would generally be cared for at home by servants – untrained, low-paid female carers, as is all too common now, although through centuries they generally lived in the older person's home and provided long-term care. This became much less common after World War II when previously extensive live-in servant-keeping declined except among the very wealthy.

For poorer people without family support, from the seventeenth century, the main form of care was the publicly funded Poor Law, providing minimal cash, food, or sometimes residential support for destitute people throughout Britain, of locally variable quality. This was established in 1601, the first measure by the state to give (very basic) support to the very poor, including older people. For the first time, support for the poor was controlled by state politics due to the government's growing concern about the extent of destitution and the danger that it would incite unrest. It was funded by local taxes. Charities also provided support, generally staffed by women, including care homes, but not everywhere.

By the nineteenth century, for many of the low-income majority of the population, the only resort if their families could not help when they could no longer manage alone was the Poor Law workhouse, an institution which developed from the 1830s, providing grim, basic residential care, if 'care' is the right word, alongside younger destitute residents, generally with untrained staff. From the 1870s, similarly, basic workhouse hospitals were established for the sick poor. Most older workhouse inhabitants lacked close relatives. They were more often men than women since older men were less likely than women to maintain close family and friendship ties if they were unmarried, widowed, or divorced. The poor quality of these institutions was frequently criticised, but the government did not respond with improvements. Successive governments before the mid-twentieth century believed that their responsibility for social welfare was limited to very basic protection against destitution (Thane, 2000: 165–193).

From 1929, all Poor Law services were taken over by local authorities, having previously been separately administered. This was a decision of the Conservative government designed to close the elected Poor Law authorities because they believed that too many had been taken over by the growing Labour Party and were too generous to poor claimants. They introduced stricter central controls over Poor Law administration, including the care of older people, retaining its very basic services. This changeover revealed the large numbers of older and disabled long-stay patients in workhouse hospitals. Older patients were found in often very miserable conditions, receiving little care, with no access to rehabilitation to enable them to leave and live in the community, or staying in hospital because they lacked a home or support in the community. Health care was as inadequate as social care for those who could not afford to pay for care. Discovery of this situation in the mid-1930s led Dr Marjorie Warren, at a London hospital, to experiment successfully with rehabilitation and improvement of the hospital environment and care, enabling many older patients to leave hospital. This led to the emergence and gradual growth of geriatric medicine in Britain (Warren, 1946;

Thane, 2000: 436–438). The government showed no interest in improving social or medical care for older people.

During World War II, official surveys revealed extensive hidden need among older people living in the community with minimal or no health or social care, and there were social and political pressures for reform from a wide range of individuals and groups of voluntary carers and campaigners for improved care for older people, who had become increasingly concerned about old age poverty before the war (Thane, 2000: 356–363; 438–440). State pensions had existed since 1908, but they were very low. British state pensions have always, to the present, been lower than in comparable countries, never providing enough to live on (Thane, 2000: 216–235, 308–332, 364–384; Pensions Commission, 2004). The wartime surveys led the government to introduce some improvements in financial and care support, but the needs of older people did not receive high priority among the extensive wartime proposals for social reform from politicians, liberal reformers, and the wider public, many of whom hoped for no return after the war to the poverty and unemployment of the inter-war years (Smith, 1986; Addison, 1994).

The 'Welfare State' from 1945

In 1945 a Labour government was elected with a large majority because voters expected and wanted it to introduce social reforms proposed during the war and to develop the economy to avoid a return to depression and unemployment. It greatly extended state welfare in what became known as the 'Welfare State'. Among other reforms, in 1948 it introduced the National Assistance Act, which abolished the Poor Law and required and funded local authorities to provide residential accommodation for older and disabled people judged to be 'in need of care and attention not otherwise available to them', and to improve community services for older and disabled people living at home. For the first time, the British government, as part of its wider strategy of social reform for the whole population, required and provided for social care services for older people. Local authorities then gradually provided more services, including social workers and 'home helps', almost invariably female, providing cleaning and other assistance to people in their own homes; and local authorities were empowered to subsidise and supervise voluntary and private, profit-making, residential and community care. Charitable voluntary action, mainly provided by women, had always contributed to the care of older people, and it continued to be important in the post-war welfare state. For example, the Women's Voluntary Service provided free 'meals-on-wheels' to older and disabled people in their homes, until this service declined due to cuts to local authority budgets from 2010.

From 1948 a clear division was established between health care services, provided by the National Health Service (NHS), also founded in 1948, and social care services provided by local authorities, which had previously also provided health care but no longer did so. An important difference between them was that all NHS services were free of charge for everyone while local authority social care, residential or in the community, required payments determined by the recipient's income, 'means-tested' as it was known. Government funding for care services was too low to enable local authorities to provide them free of charge. A major reason was that, in the difficult post-war economic situation, the Labour government could not afford wholly to fulfil its ambitions for a universal welfare state, and it prioritised some needs over others. Services which everyone could use, including the NHS and the education system, were free; those needed only by more restricted populations, who were often regarded as low-status – including older, disabled, or very poor people – were provided by the voluntary sector where possible, or they were means-tested public services with low priority for expansion. However, local services for children improved much faster than those for older people, signifying a certain discrimination against older people. As public provision of care expanded, it became increasingly politicised, shaped by the priorities of successive governments in which the needs of older people were rarely prominent. Universal services freely available to all adults, such as health and education, appealed to more voters than those restricted to smaller groups, including care services for older people, who were not at this time regarded as a large or important section of the electorate.

The Labour government did not attempt to integrate health and social services, and they operated within different administrative boundaries, although older and disabled people often needed both services simultaneously, then as now, and were often disadvantaged by the difficulty of accessing the two separate services. The lack of integration of health and social care was an issue of concern to those actively concerned with the health and social care of older people as care providers or engaged with the growing number of NGOs established at this time to support older people (including Age Concern and Help the Aged), and it was criticised from the beginning. In 1948 leaders of the newly formed British Geriatrics Society produced a report for the British Medical Association, which represented all doctors. The report, 'The Care and Treatment of the Elderly and Infirm', summarised the dismal state of both health and social care for people over 60 and the foreseeable costs of continued neglect as their numbers grew. This was an issue of particular concern at the time because the proportion of older people in the British population had been rising since the beginning of the century due to lengthening life expectancy combined with a declining birth-rate. In 1901, 6.2% of the population were of what by 1945 was pensionable age (men over 65, women over 60), in 1931, 9.6%, 1941, 12%, 1951, 13.5%, and the numbers were expected to continue to rise causing growing demand and costs for pensions and health and care services (Thane, 1990: 283–305). The report recommended coordinated medical and rehabilitation services based in general hospitals and linked with community social services. But geriatric medicine was still in its infancy and had low status, and the report had little impact on policy. The government ignored it, giving no explicit reasons. The post-war rise in the birth-rate – the 'baby boom' – caused the panic about the ageing society to decline until births fell again from the late 1960s and concern revived, as we will see.

The NHS offered no guidelines on the treatment of older people. Many hospitals refused to accept chronically ill older people and gave preference to younger over older patients; some leading hospitals unofficially banned patients aged over 65 (Thane, 2000: 443–452). This was an outcome of widespread scepticism about the cost-effectiveness of health and social care for older and disabled people, given their expected short remaining lives. It was a sign of serious discrimination against older people in health and social services, which unfortunately has never gone away, despite persistent criticism since 1948. A report on the NHS in 1956, set up by the Conservative government in the, unfulfilled, hope that it would recommend the privatisation of health care, cited research demonstrating the poor quality of health and community services for older people. It reported that local social services were too often withheld from older people living with their families on the grounds that families should provide care, despite evidence that families (mainly, of course, women in families) were already doing their best and could do little more to care for frail relatives without specialist support – for example, older people suffering from dementia needed specialist care.

Care in the 1950s and 1960s

Conservative governments from 1951 were not strongly committed to the welfare state, and they made little effort to improve elder care. Local care services were of uneven quality across the country, depending on the priorities and funds of local authorities. Authorities with more socially concerned political leadership, mainly Labour-led, provided better services; and richer areas could raise more income from local taxes to fund services but did not always do so, while the greatest need was in poorer areas with the fewest resources. This inequality has persisted to the present.

In the late 1950s, sociologist Peter Townsend surveyed residential care homes; his findings were published in 1962 as a book, *The Last Refuge*, which severely criticised conditions in very many institutions. Among other things, it revealed how many former workhouses were still in use as local authority care homes, providing the largest number of institutional beds, as can be seen in Table 2.1 below, still with very basic conditions, little improved since 1948. This was because many authorities had no funds for new buildings. Townsend described his first visit to such an institution, which had stimulated the wider study:

> The first impression was grim and sombre … Several hundred residents were housed in large rooms on three floors. Dormitories were overcrowded, with ten or twenty iron-framed beds close together, no floor covering and little furniture other than ramshackle lockers. The day rooms were bleak and uninviting. In one of them sat forty men in high-backed Windsor chairs, staring straight ahead or down at the floor. They seemed oblivious of what was going on around them … They had the air of not worrying much about their problems because of the impossibility of sorting them out, or the difficulty of getting anyone to understand or take notice …
>
> The staff took the attitude that the old people had surrendered any claim to privacy … They also admitted that improvements in staffing standards and in the conditions of the buildings had been small [since the days of the Poor Law]. (Townsend, 1964: 4)

Townsend calculated the extent and variety of institutional provision: see Table 2.1.

He found no evidence for assertions that careless families increasingly abandoned older relatives into care homes. He found that most care home residents had no close relatives, or needed skilled, specialised care beyond the capacity of their relatives to provide (Townsend, 1964: 15–170). When *The Last Refuge* revealed how little had changed in ten years since the system was reformed in 1948, it caused such shock and concern that from 1962 the Conservatives, followed by the 1964–1970 Labour government,

Table 2.1 Number of institutions and homes of various types in England and Wales (Townsend, 1964: 24)

Type of institution	Number of institutions	Number of beds
Former public assistance	309	36,934
Other local authority	1,105	36,699
Voluntary	815	25,491
Private	1,106	11,643
Total	3,335	110,767

provided increased funding for care services. Labour provided more than the Conservatives as part of their aim of general improvement of the welfare state. Publicly provided institutions gradually improved, and there was increased community care provided by social workers to support and encourage independent living, although it remained means-tested, locally variable in quality, and far from meeting the needs of all older people.

In later research, Townsend, with Dorothy Wedderburn, found that still in the early 1960s many older people did not have access to the services they needed. Family and friends provided more support. The researchers again found no evidence for the persistent rumour that the growth of public welfare services had displaced family care; rather, they stated, 'In illness and infirmity the role of the family dwarfs that of the social services' (Townsend and Wedderburn, 1965: 42–43). But families and friends could not always provide adequate care without suitably skilled assistance, and the researchers advocated more intensive inquiry into family care, which their research indicated was of highly variable quality. Better-off people, as ever, could pay for skilled private care in care homes or in their own homes.

Elder care still failed to receive adequate public funding and health and social services remained disconnected. In 1968 an official Committee on Personal Social Services was established by the Labour government to assess the development of social services since 1945 and to recommend improvements where needed. It commented on the slow development of community care and recommended more specialist social workers and methods of assessing local needs and planning to meet them. The report stated: 'Services for old people in their own homes will not be adequately developed unless greater attention is paid to supporting the families who in turn support them …' (Glennerster, 1995: 126–131).

As a result, the Labour government's Local Authority Social Services Act, 1970, established a single social services department in each local authority, emphasising the need for a coordinated and comprehensive approach to social care.[4] The new departments were intended to support families providing care, to detect need and encourage older people and families in need to seek help. They became responsible for residential homes, home helps, social work support, meals, and recreation services for people living in their own homes, for all of which means-tested charges could be made. But these services continued to be unevenly provided across the country and were underfunded by the Conservative government which came into office in 1970. Services suffered persistently from the opposing policies of governments of different political persuasions. Criticism continued of the lack of integration of local authority social and NHS health services to support older people at home.

The 1970s

A succession of measures in the 1970s were designed to assist older and disabled people to remain in the community, partly impelled by increasing campaigns by disabled people of all ages who felt they had been marginalised in the post-1945 welfare reforms. The Conservative Chronically Sick and Disabled Act, 1971, required all local authorities to register disabled people of all ages and to publicise services. It encouraged, but did not require or adequately fund, more community-based services such as home helps and day centres. In 1975 the Labour government introduced Invalid Care Allowance for people of working age (only) acting as unpaid care assistants to older and disabled people, but married women caring for close relatives were excluded from the Allowance because care was assumed to be their natural duty. This indicator of the political belief that responsibility for care should lie primarily with female relatives rather than the state was reversed in 1986 following a judgment by the European Court of Justice in response to an appeal. But people above state pension age were still barred from receiving the Allowance, although they were, and are, a significant proportion of carers (Finch, 1989; Arber and Ginn, 1991: 130–140). In 1985 official statistics showed that 35% of home care for people over 65 was provided by others over 65, often partners, 63% by women, 37% by men (Arber and Ginn, 1991: 135). The Care Allowances were low in relation to average earnings.

Both local government and the NHS were reorganised, in 1973 and 1974, respectively, into larger units. One stated aim was closer integration of preventive and after-care services between the NHS and local authorities. It was recognised, at least in principle, that good preventive services would reduce the need for health care, and good community services enabled people to leave health care faster. But, again, practice was slow to follow. NHS services were run at the local level by new Area Health Authorities established by the government to work together with local government and health authorities to advise on planning and operation of services of common concern. They were recommended to establish joint planning teams to integrate health and social care, especially for older and disabled people. In 1976 the Labour government introduced joint financial arrangements to assist cooperation, enabling NHS funds to be used on collaborative projects with local authorities. But collaboration was never fully effective, partly due to funding cuts following the financial crises of the late 1970s.

Neoliberal cuts to social care

The planned integration was not fully implemented by the time Margaret Thatcher came to power in 1979 as a Conservative Prime Minister strongly committed to neoliberalism and shrinking the welfare state, and her policies did not promote it. As she put it in a speech in 1981:

> it all really starts in the family, because not only is the family the most important means through which we show our care for others, it's the place where each generation learns its responsibility towards the rest of society … I think the statutory services can only play their part successfully if we don't expect them to do for us things that we could be doing for ourselves. (*Woman's Own*, 1987)

Again, political ideology determined care policy. The shift from institutional to cheaper community care moved even faster under Thatcher's governments in the 1980s, along with cutting public spending and services generally, despite the fact that a succession of official documents in the 1980s emphasised the need to improve services for older and disabled people and recommended more and better care services in the community for their growing numbers. Awareness was growing of the speed at which the population was ageing, as life expectancy continued to rise, and the birthrate had been falling again since the late 1960s due to the introduction of the birth control pill and increasing numbers of women in paid employment. In 1988 a report by Sir Roy Griffiths, who was appointed by the government to recommend reforms to the NHS, commented that 'community care is a poor relation; everybody's distant relative but nobody's baby' (Griffiths, 1988). This was a fair characterisation of the low priority given to community care at all levels of administration, and nothing improved thereafter.

Through the 1980s and 1990s, under Thatcher and her Conservative successor, John Major, from 1990, entitlement to care was eroded and poor coordination of health and social care continued, as local authority budgets were cut, and services were increasingly targeted at the most severely disabled and disadvantaged. Local authorities were under central government pressure to transfer responsibility for care services to the voluntary sector or, increasingly, to private, profit-making providers offering services at the lowest cost. There was increasing pressure on users to pay rising fees and the quality of residential and community services widely declined.

Labour and social care, 1997–2010

Shortly after his election as Prime Minister in 1997 the Labour party leader, Tony Blair, proclaimed 'I don't want [our children] brought up in a country where the only way pensioners can get long-term care is by selling their home' (Blair, 1997). A Royal Commission was quickly established by the new government and in 1999 recommended that all long-term personal care should be free of charge. This was adopted in Scotland, which from 1999 gained independence in certain policy areas including welfare, but not in England and Wales. There was increased spending by the Labour government on health and social services in England and Wales until the financial crisis of 2008–2010 held back further spending, but services never matched the need or the recommendations of experts.

The Labour governments of the period repeatedly expressed intentions of wholesale reform, but again the needs of older people took low priority among the extensive weaknesses of state welfare that required remedies following the neoliberal cuts. There was little action until, as late as 2008, the Department of Health announced it would pilot models of closer collaboration between local health and social care services to ensure that all the needs of older people living at home were met. Also, the government put £225 million into support for carers, including family members, recognising and encouraging their continuing importance in providing care when public services were inadequate. But awareness of the willingness of families, especially female relatives, to provide care when needed still motivated officials at all levels to give low priority to improvement of services for older people.

An official document in 2009 proposed a National Care Service, emphasising the importance of prevention, equal and high standards across the country, integration of health and social care services targeted at individual needs, and providing funding for all care users. Under the existing system in England and Wales all users of elder care services with assets above £23,000, including the value of their house, paid for all services, which created major difficulties for many people. However, the document rejected free, tax-funded social care to match health care as financially 'unsustainable', although it was widely supported by experts as the most cost-effective way to provide adequate care. It suggested raising the threshold for qualifying for free care above £23,000, but it made no decisive proposals. The method of funding an improved, reformed, integrated, care system was and is a political choice that successive governments contend to evade. At this time, the serious financial crisis of 2007–2010 constrained expensive government commitments. The proposals were put out for popular consultation, labelled the 'Big Care Debate'. A ministerial Committee on Integration of Health and Social Care Services was established, and legislation promised, but not until after the election due in 2010, which Labour lost, and the 'Debate' was terminated having hardly taken off.

Meanwhile, a committee of the British Parliament, composed of Members of Parliament of all parties, also investigated social care (House of Commons Health Committee, 2010).[5] It was told by the Department of Health in 2009 that improvement and integration of services needed to progress quickly, but that it was 'really very, very complicated', especially concerning sources of funding – not surprisingly in the middle of the financial crisis. Without much hope, the Committee's 2010 report wished the political parties would come together 'to map out a programme of sustainable reform' of social care, since they believed that the quality of care had been much undermined by conflicting party policies (House of Commons Health Committee, 2010: 8, 112). The report, based on extensive evidence from across the country, was highly critical of the inadequacies of existing services and the resulting stresses on older and disabled people and their carers. It argued that thorough reform and integration was needed, and they believed it was manageable, despite probable increased future demand from the still growing numbers of people surviving to old age.

The report spelled out details: it deplored the prevailing pessimism about the impact of population ageing and popular representation and stereotyping of older people as 'burdens', which they believed was holding back reform. It pointed out that longer life did not necessarily mean longer years of sickness – that, in reality, more people remained fit and healthy for longer than ever before. Prevention and public health measures were necessary to encourage this tendency – the report praised the government's recent ban on smoking in public places as a step forward but argued that more was needed. It stated that 'pervading the whole system of social care is a persistent ageism, both overt and covert' (House of Commons Health Committee, 2010: 6). The report supported many of the proposals in the 2009 document and concluded:

> There is still an opportunity … to reform the social care system, achieving consensus and creating a lasting solution that would represent a 'Beveridge' model for our time. Current and future generations will be betrayed if the failure to achieve consensus means that social care is once more left to languish near the bottom of Government's list of priorities for the next Parliament. (House of Commons Health Committee, 2010: 103)

'Austerity', 2010–present

But little changed before the 2010 election. The failures continued, indeed deepened, after Labour lost the election and a Coalition Conservative/Liberal Democrat government took over, led by the Conservatives. It quickly published a document, 'A Vision for Social Care', and appointed yet another Commission, under a respected economist, on 'Funding of Care and Support'. This reported in 2011, proposing a lifetime cap of £35,000 on individual liability for care costs, since it concluded that the existing means-tested system excluded too many people in need from adequate care (Commission on Funding of Care and Support, 2011). This was partly accepted in the 2014 Care Act, but the cap was set at the much higher level of £72,000, and £118,000 for residential care, which would disadvantage many older people. This was due to be implemented in April 2016 – until the new Conservative government elected in 2015 delayed it to April 2020. By this time there was another Conservative Prime Minister and the Covid pandemic had begun, displacing other political issues. It was not implemented and was still not in 2022, although the pandemic made the elder care crisis even more evident and more acute, as we will see.

Meanwhile, from 2010 successive Conservative-led and Conservative governments pursued even more vigorous neoliberal policies than Thatcher, described as 'Austerity', seeking low taxes and a small state sector. They severely cut the budgets of local authorities and the NHS, which suffered persistent funding and staffing shortfalls. There was still no integration of health and social care nationally. Even before the COVID-19 pandemic arrived in early 2020, there was much evidence of the deterioration of community care, following cuts to staff numbers and pay, and deteriorating care in some, though not all, residential homes, which declined in number as private providers closed homes which were not making enough profit. In 2017 there were 11,300 care homes in the UK, with around 410,000 residents. Only 5% of homes were now run by local authorities, most of the remainder being run by for-profit private providers, following Conservative policies since 1979 (UK Government Competition and Markets Authority, 2017). There was a growing shortage of residential care. Increasing numbers of older people were trapped in hospitals because there was no suitable care for them elsewhere. The care system has never been perfect but, at a time when more people were living longer than ever before, it seemed to be reaching a low point, some said on the brink of collapse, even before the pandemic.

However, it is important not to accept the stereotype of older people as only frail recipients of care, as 'burdens', since, as we have seen, they have often also been caregivers and research showed that they continued to do so, probably more than ever. A survey in 2019 by the NGO Age UK, which campaigns on behalf of older people, revealed that one in seven people aged over 80 in Britain provided unpaid care, most often for a husband, wife, partner, or disabled adult child, and 25% of all providers of family care were aged 65 or over (Age UK Org, 2019). Age UK reported that the numbers had shot up in recent years due to the decline in local services. Older people caring for others, old and young, is nothing new, including grandparents looking after grandchildren, whether they share a home or live nearby. It has a long history, but it is rarely acknowledged. As mentioned above, not only are people on average living longer, they remain healthy and active later in life and so can do more for others. The government's Community Life Survey showed that in 2018–2019, the 65–74 age group were the group most likely to volunteer to help family members and others, more women than men, although substantial numbers of both sexes (UK Government Department for Digital, Culture, Media and Sport, 2019). This confirmed a series of official research findings since 2001. The number of grandparents, mostly female but also male, caring for grandchildren while their parents worked, sometimes giving up their own work to do so, had been growing in Britain for some time due to the increasing costs of childcare and the deterioration of services. Also, growing numbers of older people have stayed in the workforce past the conventional retirement age, paying taxes and contributing to the economy.

Far from lavishing their money on selfish pleasures, as much rhetoric about 'intergenerational inequity' would have it (Willetts, 2010), 31% of grandparents save to help grandchildren buy a home; 16% in their sixties and one-third in their seventies give financial support to children and grandchildren (Grundy, 2005: 248–252), although very many older people, especially women (Ginn, 2006), have very low incomes and cannot afford to do this. Older people have always made a significant contribution to their families and communities when they could, and they still do, more than ever. The role of older people as care providers has grown as care services have declined.

The COVID-19 pandemic

The need for care by and for older people grew due to the pandemic, and it made the deficiencies in the public care system, and the importance of family care, better known. It revealed very clearly the deteriorating state of care homes and community services for older and disabled people, who were especially vulnerable to the virus. Serious staff shortages emerged at all levels in the NHS and care services, partly due to Britain's exit from the EU at the end of 2020, which caused many European nurses, doctors, and care workers to leave Britain – British health and care services have always been dependent upon immigrant labour. Others were driven from work by stress due to high workloads. Care homes and services were too often staffed by under-trained, underpaid, increasingly overworked workers – overwhelmingly female – because most of them were run by private companies which put profits before the welfare of their clients and staff. In 2021/22 there were over 150,000 vacancies in the care system and few applications while vacancies continued to grow. Many private care homes collapsed into bankruptcy, further reducing the availability of care. In 2018 more than 100 UK private care home operators collapsed; over the previous five years, a total of 400, under the pressure of funding cuts and rising costs, and older people could not afford the high fees they demanded to maintain profits.

In consequence, families, again mainly female relatives, came under even greater strain as more of them had to provide care, without expert help, including for very frail people who could not find or afford a care home place or a home carer. Also, increasing numbers of families were and are suffering severe poverty due to low pay, precarious employment, and rapidly rising prices, which makes support for relatives even harder. Voluntary action, often by older people, made an important contribution during the pandemic, bringing meals, groceries, medicine, and other essentials to people in need, but it cannot replace good public services.

Government policies made conditions worse. When the pandemic began, very many older people were trapped in hospitals, no longer needing hospital treatment but unable to find a care home place or care in their own homes due to the decline of services. When the pandemic increased demand for hospital beds, they were ejected into care homes, which became overcrowded and over-stretched. They were not tested for Covid after being transferred from hospital and are believed to have carried it into many homes, increasing death rates. The impact was severe as care homes were a low priority for government-directed supplies of protective equipment and it was slow to arrive. Age discrimination persisted. Visitors were banned from care homes, even after testing for Covid, causing desolation for residents and further deaths, especially among dementia sufferers unable to understand why family and friends had deserted them.

Prioritisation in hospitals of the large numbers of Covid cases caused failure to treat other conditions including cancer and heart disease, exacerbated by inadequate government funding, which did not improve in response to the crisis. Older people were especially vulnerable, further increasing deaths. Covid further exposed discrimination in the NHS against older patients who were too often denied treatment due to prioritisation of younger people.

The extent of poverty and poor health care in Britain pre-Covid was signified by the country's lower average life expectancy, and lower expectation of healthy life, than in all other EU countries. Both declined from 2010 after rising steadily for decades, mainly in poorer areas, while continuing to rise among the rich. In 2018/19 average life expectancy fell by about six months. It fell faster among women than among men and fastest in poorer districts, while in richer areas it still rose, mirroring the steady increase in income inequality in Britain from the 1980s. Expectations of healthy life followed a similar trajectory. The UK now has a lower average life expectancy than any other OECD country, with a wide gap – about 17 years – between richer and poorer people. The timing suggests that 'austerity' policies and the resulting decline in services contributed, then decline among poorer people continued due to the pandemic, with major inequalities between ethnic groups (Black and some Asian groups faring worst) and between richer and poorer people growing further (Marmot *et al.*, 2020). Despite widespread publicity for these problems, there is no sign of government plans to improve care services.

Conclusion

When the modern system of health and social care was introduced in Britain in 1948, a period of gradual improvement followed, until the 1980s, but provision was never ideal. Care policy was highly political, driven by the competing priorities of governing parties, and it faced persistent expert criticism. But, to the present, this has been ignored by governments of all persuasions, who have avoided decisive action, despite the issues and possible solutions being repeatedly clearly spelled out by experts. Even before the Covid pandemic, this failure had a serious impact on health and social care provision for older people. The pandemic has made it worse.

It seems clear that discrimination against older and disabled people has been one reason for the failure of governments to respond. Their needs have persistently not received high priority for government action, and frail people cannot launch the protests that have ameliorated other forms of discrimination. Another likely influence upon policy is the belief of successive governments that families, especially women in families, neglect older relatives and should be forced to care for them by restriction of public services. This aroused little publicity or protest pre-Covid, even from feminists, perhaps because many women were socialised into the belief that they should care for older relatives. The assumption that providers of public care services will be women has also led to low pay and poor conditions in the sector, creating staff shortages and deteriorating services. The long history, to the present, of government promises of change but continued underfunding and failure to introduce reforms is a cause for concern. The Covid pandemic has given greater publicity to the severe problems of the care sector while making them still worse. We wait to see whether any improvements in government policy will result from this increased public awareness.

Notes

1 See Thane (2000: 19–28, chapter 1, ‘Did people in the past grow old?’) for a review of the extensive literature on this theme, and also Botelho and Thane (eds) (2001).

2 For the best available statistics, see Schofield (1985).

3 For details of surveys, see Hayashi (2013, 2014).

4 In the early 1970s there were 449 local authorities in England and Wales each serving substantial urban or rural populations.

5 House of Commons Health Committee (2010), 3 volumes.

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3

Waiting for the revolution in care and old age: The missed appointments of a French policy of care for older people

Christophe Capuano

In France, we are struck by the great invisibility of care for older adults and their family carers, as well as the staff working in this professional field. The issue of support for older adults only seems to emerge in public debate on the occasion of health crises and scandals before falling back into oblivion: for example, the crisis of the summer of 2003, which resulted in more than 14,800 deaths in France (Keller, 2015), the tens of thousands of older people's deaths from Covid in 2020–2021, and the scandals formed around the ORPEA group's establishments for older adults, where numerous cases of mistreatment have been confirmed (de Saint-Martin, 2022). What is surprising in the long term is the absence of a large-scale public policy on all aspects of the issue of old age: public measures mainly concern healthy retirees (the active third age) or disabled adults under 60, but not older people with a loss of physical or psychological autonomy (Capuano, 2018a, 2021). An ambitious law on 'Old Age and Autonomy' was announced by President Emmanuel Macron in 2018,[1] but it has not seen the light of day. However, with the increase in life expectancy, this phenomenon concerns a growing proportion of French society (Martin, 2015). The aim is, therefore, to tell the story of a phenomenon that is not really there – the absence of a centralised public policy at the national level – and to examine the particular forms of French politicisation of this aid to older adults.[2] To do this, we need to understand the terms according to which the debate has been posed since the 1950s. By politicisation (Palonen, 2021), we understand the process that transforms a private or public issue into a political issue and object of public policy, invested in by political actors (governmental and parliamentary, supra-governmental or local) at different scales or cause bearers (public, para-public, and private); it also includes the various forms of political uses of these issues. In this contribution, we will focus on the case of older people with disabilities in their daily lives. We will analyse the extent to which the principles that have governed their care have been guided by the budgetary logic of least cost, particularly through promoting home care. We will show the role played by local actors (political and civil society-related), which has resulted in the territorialisation of care policy for older adults and significant contrasts between territories. The issue of gender is a key aspect in analysing the family and professional carers' difficulties in mobilising to claim their rights. In the first part of the chapter, we will see how care for older adults remained an issue for local actors in the 1950s and 1970s, with strong territorial contrasts, based first and foremost on home helpers and families and thus providing the least costly assistance. In the second part of the chapter, we will analyse how the welfare state, in a deteriorating economic situation, politicised this issue in the 1980s and 1990s while seeking to limit the related costs. In the 2000s, we will study how home care – in the wake of crises and scandals – becomes the priority orientation while involving even greater commitments and 'enrolments' (Giraud and Le Bihan, 2022) for women carers and home care professionals.

Keeping older adults at home to limit costs (1950s–1970s)

For the second half of the twentieth century, the French system of care for older adults was based on three pillars that cost the state very little: local public and private actors; families and relatives of the frail – in particular wives, daughters, daughters-in-law; and low-skilled and low-paid employees. Before that, there were no paid home helpers for older adults, as this type of actor did not exist, and those without children asked to be admitted to an institution. The French case is characterised by a strong territorialisation of the issue of care for older adults since the 1950s–1960s – the latter then constituting the poorest part of French society. The measures that were adopted were based mainly on implementations (creation of home help services and recruitment of employees) by local actors. A Commission for the Study of Problems of Old Age, set up by General de Gaulle in 1960, was to define the broad outlines of an ambitious policy for old age, but focusing on the active third age. In practice, the measures were modest; a scheme adopted in 1962 was intended to enable physically independent older people to remain at home, with a very light system: a maximum of 30 subsidised hours per month. And the scheme was adopted without any funding measures for home services. This incentive was part of a process initiated in 1954 to reduce costs and prevent older people from occupying beds and places in institutions: assistance benefits, which became 'social assistance' in 1953, could then be paid in kind in the form of home help to certain sick older people. A circular from 24 August 1954, related to 'Bureaux d'aide sociale' (BAS) encouraged social welfare offices to participate in home care and assistance by organising 'family assistance services' (*Revue de l'aide sociale*, 1958). The circular of 7 October 1957 on standard medical aid regulations encouraged the widespread use of home care services for older people whose 'hospitalisation is not medically necessary' (*Revue de l'aide sociale*, 1958). The Commission for the Study of Problems of Old Age decided to strengthen the possibility of home care, which resulted in the decree of 14 April 1962 (Decree no. 62–439) on the conditions for the allocation of household help. The decree intended to spread the payment of social assistance in the form of household services within the limit of 30 hours per month. This was the first attempt to make a request for household help solvent. However, home-based services needed to be created and employees recruited; the state did not subsidise these because the home had to be an economic solution compared to the placement of older people in institutions (hospices, hospitals, retirement homes), and all financial efforts were made by local players (French National Archives, 1965): municipal councils, departmental councils, social security funds, private associations. Their efficiency would be evaluated in terms of saved days of hospitalisation. These financial arrangements brought together public, para-public (social security bodies), and associative actors, which gave rise to a 'mixed economy of welfare' at the territorial level. The dynamics differed between territories: services were provided in urban areas, but it was more difficult in rural areas. In the early 1960s, around twenty home care services combined with domestic help services (housework, household chores) were also developed and managed by the same association (French National Archives, 1960). This made it possible, as in Limoges, where there was an association aiming at helping isolated and ill infirm people, to relieve the sick person of domestic chores, avoid hospitalisation, and limit the care period.

The Commission for the Study of Problems of Old Age was totally unaware of the requirements of home help for older adults, its specificities, and constraints. Furthermore, the fact that home care was considered to be an economic solution for public finances had long-term effects on the home care professions. From the 1950s–1960s, these activities were seen as subaltern (less important than official professional activities), equated with care work, and as feminised activities. The Commission for the Study of Problems of Old Age saw this unskilled work as an extension of the domestic and free work of the housewife, which tended to undervalue this activity from the outset, and associated it with naturalised female skills and the importance of voluntary work. This representation explains why any training or qualification appeared unnecessary, and the question of salary seemed secondary. We cannot speak about professionalisation because there is no specific training involved. Moreover, its initiators conceived household help as a supplementary activity, in the economic scheme of the breadwinner, where the husband provides the main salary. Designed for married couples, the wife's secondary income would supplement the household resources or provide a small supplement to the retirement pension.

Another source of inspiration for this activity is found in the example of family workers, trained in domestic schools, who supported or assisted mothers of families on an ad hoc basis. A study of the archives of the 'Association d'aide aux vieillards de l'Ain' (which became the 'Association d'aide aux personnes âgées de l'Ain' – ADAPA – in the early 1970s) shows a complex situation. This non-profit organisation was created in 1959, without state aid, to prevent the hospitalisation of older adults and to slow down the number of admissions to the hospice in Bourg-en-Bresse. The skills required to work at the organisation were numerous and demanding: being able to establish a personal relationship with the person being cared for, mastering the technical skills of the housekeeper, and having good time management. The task was difficult because older adults often suffer from physical (rheumatism, difficulty in moving about), mental, or psychological (debility) disabilities. Despite these requirements, wages were low because they were forced to work part-time (most of the staff worked half-time at best), and hourly wages were kept low to keep costs down: due to the absence of national collective agreements, the level of wage was the result of negotiations between the association and the prefecture. These difficult working conditions explain the difficulties in recruiting and the frequent turnover of staff. This problem was found in other European countries, as highlighted in a report by the Council of Europe's Committee of Experts on Public Health in 1964 (Aujaleu, 1965). In the context of home help, the report stressed that home helpers too often worked part-time (the majority were married women of average age) and were temporary staff (40–50% of the staff). The experts proposed to raise salaries and improve their status. To compensate for the lack of home care nurses, the experts also suggested recruiting nursing assistants who could follow a short training course (about 130 hours) to provide care for older adults, as in Denmark and Sweden. This suggestion and its execution are the ancestors of European expertise in home care.

The important consequences of home care on women

During the 1970s, home care services became more widespread, but home care was still seen as a means of achieving 'considerable savings', as the 'Older People' Intergroup pointed out in the context of the work of the

Commissariat du Plan, which was responsible for considering the prospects for development (French National Archives, 1971). The success of the programme of action finalised in preparation for the 6th Plan (1971–1975) was assessed in terms of the number of days of accommodation that were eliminated. However, the public authorities were well aware that an effective home care policy depended on substantial investment; this was the choice made by the municipalities in the Scandinavian countries, which largely financed the public sector. At the end of the 1970s, the coverage of the territory by home help services was still very uneven (10,201 municipalities were not served out of a total of 36,433), with inequalities in access to services. However, the official declarations were encouraging: at the 'Assises du Troisième Age' in Lyon on 9 October 1977, the President of the Republic, Valéry Giscard d'Estaing, promised to double the number of older people benefiting from home help as an 'irreplaceable service', in four years. But the results did not follow. These situations provoked discontent among older adults, who organised demonstrations in several towns to demand an ambitious home care policy, as in Grenoble on 13 November 1979.

These home care arrangements placed a great deal of pressure on families, particularly women, as they were the main carers among their relatives. This situation has been invisible for a long time in terms of statistics and the sociology of the family. Furthermore, this invisibility feeds a whole discourse on the disappearance of family solidarity (Capuano, 2018b). However, since the beginning of the 1960s, certain studies have emphasised the decisive role of these carers, particularly older wives, in maintaining the old couple in their familiar surroundings (Paillat, 1963). These French women found it difficult to escape their isolation and mobilise. In the UK, Mary Webster, a carer for her older dependent parents, succeeded in founding the National Council for the Single Woman and her Dependants (NCSWD) in 1965 (Thane, 2000: 407). This organisation became a powerful lobby with the public authorities and the main advocate for *carers*. In France, nothing similar for carers of older people ever came to exist during the years 1960–1990. The potential for help lies mainly with these women, who are sometimes trapped in family relationships and who have to compensate for the lack of professional carers at the cost of significant sacrifices, as shown by the first survey devoted to them in 1994 (Bocquet *et al.*, 1994). From the 1970s onwards, when women massively entered the labour market seeking individual autonomy, no policy was put in place to reconcile working life with caring for an older parent. This contrasts with the orientation of French birth and family policy during this period, which leaned towards reconciling family and working life.

What are the limits to an ambitious home care policy (1980s–1990s)?

From the 1980s onwards, support for older adults became a political issue for the government, combined with the need to combat female unemployment in a context of economic and social crisis. However, this turning point in the development of the welfare state amidst the socio-economic crisis did not result in a long-term policy change. We will have to analyse the reasons for the lack of a comprehensive and coordinated national policy that undermines the effectiveness of the whole.

The first reason is the successive governmental political orientations that followed one another over a very short period and modified the intensity of intervention by the welfare state and its methods of action: a period of political voluntarism and public finance spending (1981–1983), followed by a period of austerity (1983–1986), then a more liberal period (under the Right (1986–1988)), then the Left (1988–1993), and then the Right again (1993–1997). The arrival of the Left in power with the election of François Mitterrand in 1981 led to a strong commitment on the part of the public authorities to support older adults with the creation of the first Secretary of State for Older People, entrusted to Joseph Francesci. In July 1981, he set out his objectives in terms of home care: ‘on the one hand, it is a question of preventing, delaying and shortening hospitalisation or entry into a public institution, when this is neither desirable nor desired’ (French National Archives, 1981), which implies the spread of home help and home care services.

Secondly, it was necessary to encourage the creation of jobs at a time of rising unemployment, particularly among women, by attracting new workers to the activity of domestic help. To achieve these goals, the government decided for the first time to subsidise the creation of 5,000 full-time equivalent jobs for domestic helpers in a few months and 15,000 in the medium term. To this end, it agreed to make very substantial investments with financial aid for the start-up of new domestic help services, particularly in rural areas that were not covered. Furthermore, the Secretary of State undertook to increase the hourly wage to 110% of the SMIC (Minimum Interprofessional Growth Wage – 18.40 francs per hour in 1981, i.e. 6.75 euros), even though he acknowledged that it was ‘not enough to take into account all qualifications and seniority’ (French National Archives, 1981). A national collective agreement, signed on 11 May 1983, completed the system and defined the function of household help as having the task, according to the terms of the agreement, in addition to household tasks, of ‘performing material, moral, and social work for older adults, contributing to their maintenance at home' (*Convention collective* ..., 1983). The term 'household help' disappeared and was replaced by 'home help'.

The political will was also reflected in other measures in the context of lowering the legal retirement age to 60 (Order no. 82–270). The 8th Plan prepared from 1982 onwards includes special emphasis on the problem of older adults. The circular of 7 April 1982 on social and medico-social policy for the retired and older adults asserts several principles on the guarantee of the lifestyle of one's choice in terms of housing and medico-social services. This was part of a new logic of decentralisation (Law no. 82–213),[3] the adoption of incentive credits (285 million francs in 1981, 505 million francs in 1982) to launch a new dynamic with local authorities, pension funds, and associations, particularly for a whole series of personal services. The state continued to provide massive support for the development of domestic help with substantial financial efforts (credits increased by 70% between 1980 and 1982, from 1.3 to 2.2 billion francs) (French National Archives, 1983). Between 1980 and 1982, the number of household helpers increased by 3,700 (exclusively women),[4] and the number of beneficiaries rose from 320,000 to 400,000. Home care services for older adults were instituted by a decree of 8 May 1981. Financed by the health insurance schemes and created at the instigation of the state, these services experienced strong development from 1981 to 1983 before the rate of creation slowed down (the number of places rose from 3,000 to 13,000 between 1981 and 1983, with 3,000 new services and the recruitment of 730 care assistants).

However, the austerity measures introduced in 1983 led to a sharp slowdown in public investment in home care. For example, a programme to renovate the old housing stock, launched in the early 1980s to create housing adapted to the ageing of older adults, slowed down after 1983. With the victory of the right wing in the 1986 legislative elections and in the context of reduced public spending, the government decided, from a more liberal and less costly perspective, to favour tax incentives for the hiring of home helpers rather than the subsidisation of home services. Employing low-skilled unemployed women as home helpers was still a political objective for the right-wing government of 1986, but it was now a question of combating female unemployment while limiting the costs to public finances. Led by the Ministry of Employment, and without consultation with the Ministry of Social Affairs, this new policy of 1986–1987 targeted older people in the home and was part of the fight against unemployment through market regulation. The Seguin Law of 27 January 1987 introduced a tax deduction on income for expenses incurred for home help (Dherbey *et al.*, 1996: 303–304). The tax deduction for private employers replaced public subsidies. New measures completed the system during the 1990s: the 'chèque emploi-service' instrument, adopted in December 1994, regulated the possibility to hire home helps; it also offered profit-making companies the possibility to reinforce their position within the personal services market (provided they obtained quality approval).

Another limitation to an ambitious home care policy was the increased territorialisation of social policies from the 1980s onwards. The issue of care for older adults became highly politicised at the local level, with the growing role of departments in the context of the decentralisation laws (Law no. 82–213; Law no. 83–663). It is today up to them to finance and pay certain social assistance benefits such as the 'Allocation compensatrice pour tierce personne' (ACTP). This allowance, created in 1975, was intended to finance the assistance of a third party on a daily basis for people with an 80% disability rate, regardless of age. This allowance is allocated according to need by a departmental technical commission ('Commission technique d'orientation et de reclassement professionnel', COTOREP). Created as part of the disability policy (Law no. 75–534), but opened to older people in a 1978 circular (circular no. 61 AS), this scheme is especially interesting because it is paid in cash (according to national scales), without any counterpart, and its use is little controlled. It is more attractive than the medico-social policy for old age and attracts many older people who are rapidly becoming the majority beneficiaries of the ACTP (70% of recipients were over 60 years old in 1994, and almost half were over 75 years old).

With the increase in costs that the payment of the ACTP represented in 1994, the general councils of the departments considered it abnormal that they were not involved in the choice of beneficiaries (they contested the fact that they had to pay without deciding) and above all that there were so many older beneficiaries: this was associated with a form of disempowerment of families, who would be relieving themselves of their family obligations on the basis of public finances and solidarity. This political discourse was favourable to the return to familialising measures that involve families financially and legally. The elected representatives made this a political issue, and their demands were relayed to the Senate, where their representatives were present in force. The general councils won their case. This resulted in the exclusion of older adults from the disability policy and the creation of a specific dependency benefit in January 1997 (PSD) for 'dependent older people' over 60 (Law no. 97–60). This benefit was aimed less at meeting the needs of people with disabilities than at reducing social assistance expenditure in departmental budgets.

From 1997 onwards, the general council took control of the new benefit without any new rights; on the contrary, this social assistance benefit was considered an advance payment to be recovered from the beneficiary's inheritance after his or her death. This system re-establishes the principle of recovery from the estate after death for 'dependent older people', which shows that it is not a matter of social rights, but of social assistance: the benefits are considered as an advance by the general councils of the departments. If the inheritance exceeds 300,000 francs (62,657 euros), the sum of the benefits paid is recovered after the death of the older person. Moreover, it is now the departments that decide on the beneficiaries with a medico-social team of the general council.

It was also in the name of the free administration of local authorities that the Assembly of General Councils obtained their demand that the PSD be modulated within the limit of a ceiling determined by the department's regulations alone, according to the applicant's state of dependence. This new prerogative of the general councils entails the abolition of national scales, with the risk of strong territorial inequalities, which appears to be a step backwards in the universal vocation of the welfare state. The ACTP is now only available to disabled adults under 60. In 2001 (Law no. 2001–647), the PSD was replaced by the 'Allocation personnalisée d'autonomie' (APA), which was paid without any counterpart and depending on the amount of revenues and the types of disabilities involved. However, the system remained the same, and the amounts granted for the same needs were very different from one department to another. This position was further strengthened by another law (Law no. 2004–809), which recognised the role of the general councils in Article 56 as the 'leader' of the joint action of the various components of the public authorities concerning older people. The role of the general councils in deciding whether to grant the APA remained decisive and contributed to the territorialisation of social policies and the decentralisation of social action, with very different provisions depending on the territory. This established the political role of a 'welfare department' (Lafore, 2004).

A third reason for the absence of a comprehensive older people policy is that the state mobilises families even more without helping them. During the twentieth century, families were referred to their legal obligations: because of Article 205 of the Civil Code, they had to provide food and assistance to their ascendants. Public solidarity intervenes in a logic of subsidiarity as a second resort, if the family cannot help, and there is the principle of recovery from inheritance after the beneficiary's death. The role of families as an economic and political issue has been reinforced even more since the 1980s, when home care experienced unprecedented development in all French departments. However, no support system for carers was in place. At the same time, the Council of Europe recommended setting up respite care for carers in a 1974 resolution on health and social care for older adults. In 1982, it was at a supra-national level, in the context of the World Assembly on Ageing organised in Vienna by the United Nations, that various recommendations were proposed in favour of state support for family assistance to older adults (French National Archives, 1982: 23–24).

In France, the lack of support for carers is linked to an attempt to use family solidarity as a political tool. During the 1970s and 1980s, numerous studies in the sociology of the family emphasised the adaptation of family solidarity to changes in the family and mobility (Pitrou, 1978); kinship is studied as a mutual aid network. The public authorities have then relied on this work to reactivate the 'natural' role of 'close protection' of the family (Castel, 1991). In the context of the crisis of the welfare state and the decentralisation of social assistance spending, the public authorities wanted to maintain a ceiling on public social spending that was not supposed to be exceeded. The aim was to offload part of the dependency burden onto family solidarity. Bruno Jobert's analysis of this issue is very interesting and relevant:

> in this way of thinking, public action and private solidarity seem to interact like two communicating vessels: an increase in public action can only lead to the destruction of private solidarity. Conversely, a halt to the expansion of the protective state will make civil society more adult, more inventive in solving its own problems. (Jobert, 1991)

The crisis of the welfare state has also been instrumentalised as an opportunity for some reformers to envisage a withdrawal of the state from the field of social protection, in favour of the market and naturalised family solidarity. This question was raised in the report published in 1986 by the Commissariat général du Plan and resulting from the work of the commission chaired by the demographer Léon Tabah (Tabah, 1986). Others took as their model the British community care system, which partly replaces the support provided by public institutions with support provided by family and informal resources. In France, the mix of the neoliberal and conservative model does not lead to a withdrawal of the state but explains the lack of development of support services for carers in the 1990s.

The 2000s: a turning point for the care of older adults?

From the 2000s onwards, a third phase began, in which public debates and public policies were developed in response to health crises and scandals, but the adoption of a major public policy was still postponed. Families were suspected of abdicating their responsibility of solidarity towards their elder parents. But at the same time, public authorities fear the physical and psychological exhaustion of these families, because they need family carers to look after older adults.

The fear of the disintegration of family ties, which has been at the heart of political discourse since the 1980s and 1990s, regained unprecedented vigour in the early 2000s. Michèle Barzach, Minister for Health and the Family from 1986 to 1988, was indignant in *La paravent des égoïsmes* about a supposed decline in family solidarity that would encourage 'the exclusion of older adults' (Barzach, 1989). This conviction was very strong on the right of the political spectrum, within certain general councils and the Senate, during the 1980s–1990s, and expresses a strong distrust of any measure to support families, as it views such measures as 'disincentives' to look after one's relatives. During the debates on the reconsideration of the ACTP for older adults in the 1990s, some senators suspected families of wanting to 'offload their obligations onto social assistance' (French Senate, 1990: 6). These ideological views on the alleged abandonment of frail older people by their relatives came to the fore during the 2003 heatwave, which caused the death of 14,802 people, including 12,210 aged 75 and over, the vast majority of whom were women. The leaders and the media at the time accused the families of abandoning their loved ones. They reinforced this representation even though 64% of the people died in institutions, particularly in residential institutions for dependent older adults. Moreover, in neighbouring countries, where intergenerational family cohabitation is high, the number of victims was still very high compared to the French case. There were 15,000 and 20,000 deaths, respectively, in Spain and Italy.

In parallel with these discourses, the number of potential carers became a political issue at the turn of the century. The public authorities were uncertain about the number of potential carers in the decades to come, their availability, and their ability to provide help over time: to avoid physical and psychological exhaustion and to maintain their ability to combine the role of carer with their professional obligations. This issue is directly linked to the gendered division of care since there is an unequal sharing of care between the sexes, which makes it more fragile: women are more involved than men in the practice of intergenerational solidarity. However, support for family carers developed quite late in France and under the impetus of private associations such as the French Alzheimer's Association, which was created in 1985 to act as a lobby. This issue has entered the public debate, especially from the point of view of the fight against Alzheimer's disease, which President Jacques Chirac made a national cause with two national Alzheimer's plans in 2001–2005 and 2004–2007 (Ministry of Employment and Solidarity, 2001; Ministry of Solidarity, Health and the Family, 2004). The number of day-care facilities has increased significantly: 187 in 2003, and 741 in 2007 (Dartigues, 2005; Commission nationale ..., 2007). But in this new scheme, family assistance becomes strategic for the welfare state, which involves family members more frequently in the carer position and assigns women this role. Indeed, the orientation adopted by the public authorities does not consist of giving family members the choice of whether or not to help, but of supporting them in their role as carers of a dependent relative; this was the meaning of the First National Family Carers' Day organised on 6 October 2010, which was intended to make carers more visible (carers, both men and women, are estimated to number 11 million people today). The law of 28 December 2015 (Law no. 2015–1776) on the adaptation of society to ageing also goes in the direction of investing in family members, with recognition of the role of family carers of older people with loss of autonomy, the transformation of family support leave into a more flexible family carer's leave, the introduction of a right to respite, and the assumption of responsibility for the beneficiary of the APA when the family carer is hospitalised. With the decree of 1 October 2020 (Decree no. 2020–1208), a daily allowance for family carers came into force (52 euros per day for a single person) in the context of a three-month leave with compensation, renewable up to one year over the entirety of a career. If the measures envisaged are insufficient to reconcile professional life and the role of carer, they risk locking women into the role of carer for years to come.

During the 1990s and 2000s, with the ageing of the population, the question of the risk of the cost of caring for frail older adults became a major political issue. At a time when some countries, such as Germany, were turning to a public insurance system to cover the risk of dependency, the Minister of Social Affairs and Health was attracted by the German choice. The government then discussed the creation of a fifth branch of social security in France and to therefore recognise old age as a new social risk (in addition to sickness and disability, retirement, family, and work-related accidents). The proposal was finally rejected in 1994 for reasons of cost to the social security system, as the public authorities preferred to keep a system based on social assistance that was more financially controllable. At the same time, the general councils, which were not keen to see local social security bodies strengthen their position in this area, lobbied to become the operators of a social assistance dependency benefit that they could manage within their territory. At the end of the 1990s, criticism of the specific dependency benefit (PSD) was once again an opportunity to promote the creation of the fifth risk, which was meant to replace the general councils in this field with social security funds and to manage this new branch for greater equity throughout the country. The introduction of the Allocation personnalisée d'autonomie (APA) in 2001 was preferred.

The health and climatic crisis of the summer of 2003, which claimed thousands of victims (Keller, 2015), led to a new political reflection. The President of the Republic, Jacques Chirac, decided to create a National

Solidarity Fund for Autonomy (CNSA). A public holiday was abolished, as in Germany, and the National Solidarity Fund was funded on a 'social contribution' basis. The functioning of the CNSA differed from that of a social security body and was rather a form of recentralisation, which made it possible to rebalance the power of the general councils somewhat. Still, they continued to play a leading role at the territorial level (Law no. 2004–809: art. 56). In 2021, during the COVID-19 crisis, which particularly affected those over 70 (73% of victims), a new branch of social security was created: the CNSA was integrated into the social security system. Moreover, the 'Old Age and Autonomy Act' announced for 2019 (Libault, 2019), which was supposed to radically transform the care system, has still not been implemented. The main reason for this is the fear of decision-makers in the face of demographic change, as the ageing of the population is automatically associated with an increase in health care expenditure. In 2012, 11.2% of gross domestic product was devoted to health care, compared with 5.4% in 1970; health care now accounts for almost 17% of public spending, compared with 11% in 1970. However, for several years, work in health economics has insisted on the need to dissociate the ageing of populations from the increase in costs. Research shows that the increase in the proportion of the population aged 65 and over has had a very moderate impact on health expenditure since the 1950s (Aziz and Pereira, 2005). The surveys show that whatever the ageing of the population, it plays a minor role in the face of policy choices that have considerable consequences for both public and health expenditure (Tenand, 2014).

The crises and scandals of 2020–2022 are shaking things up and raising awareness. The home care policy[5] – desired by the French – has become a political issue with multiple dimensions. This orientation is based on numerous home services: since the Borloo Plan of 26 July 2005, the law on the development of personal services has liberalised the market. This plan facilitates the development of commercial organisations in the field of home help, even if this leads to strong competition between organisations and, in some cases, high costs and unaffordable services for the average elder. The challenge is now to attract large numbers of staff to an activity that remains underpaid (salary increases are minimal and follow inflation, the hourly wage is set at the level of the minimum wage: 8.74 euros per hour), as shown in the information report on 'Les métiers du lien' by deputy MPs Bruno Bonnell and François Ruffin in 2020 (Bonnell and Ruffin, 2020). The COVID-19 crisis highlighted the essential role of these home care workers, but also the glaring lack of staff and the need to upgrade their profession. This led to social mobilisations of care and home help professionals (97% of employees are women), such as the one held on 23 September 2021 on the initiative of the General Confederation of Labour (CGT). Collectives also carry out lobbying actions in an electoral context. This was the case in June 2022 with the 'Domicile: Making the home a possible choice' collective, which brings together managers and directors of home-based organisations. This group strives to raise awareness among the candidates in the legislative elections; its aim is to put forward 'concrete and urgent proposals that are essential to the organisation of home support for all in France' (*Collectif* ..., 2022).

The choice to remain at home was further reinforced in 2022 by the discrediting of EHPAD institutions. In March 2022, a book by the journalist Victor Castanet, *Les Fossoyeurs* (Castanet, 2022), was published, and had a bombshell effect: it denounced the numerous cases of elder abuse in the EHPADs of the private group ORPEA. The book gathered testimonies that proved that, in order to maximise profits for shareholders and to increase profitability, ORPEA establishments chose to ration food and hygiene products and provided degraded care, sometimes amounting to mistreatment. The scandal was such that a parliamentary commission of inquiry was organised, and it was decided to subject all EHPADs to strict controls. As a result, ORPEA establishments were discredited. In the context of this crisis of mistrust, the home becomes more than ever a priority for political decision-makers. However, in addition to the issue of family carers, home services, and staff, the problem of adapting homes to ageing is also raised: every year, more than 10,000 people over the age of 65 die from falls in the home. This implies a global strategy and a proactive policy of adapting housing, which must become urgent in the coming years: the number of French people aged 75 to 84, who live at home and do not need an EHPAD, will increase by 47% between 2020 and 2030 (Broussy, 2021, 2022).

Conclusion

In France, the issue of care for older adults is marked by the absence of an overall, ambitious, and financed strategy supported by a national political project. This absence can be explained by the fact that the approaches to care for older adults have been guided more by a desire to limit the costs of public finance than by a real societal choice resulting from a debate amongst the French population on this issue. However, even if built by default, it was indeed a political choice to build a welfare state for ageing that relies on family actors (especially women), private players (home help and care organisations, associations, or profit-making companies), and local players, in the departments' case. The issue of care for older adults, therefore, gives rise to various forms of politicisation of aspects and problems related to older people. For the general councils of the departments, intervening in the field of old age by distributing through social assistance instruments, and then becoming the pilot for social action, is an extremely important local power issue in relation to the central government and the social security bodies, but this freedom of the departments leads to major inequalities between the territories and therefore to inequalities in the way people live with old age, depending on local political choices. The question of family solidarity has also become a major political issue in a country that relies on it to make the system work. We have seen the political uses of the myth of the abandonment of older adults by their families to justify the absence of support systems for assisting families. This system is also fragile because it is essentially based on women carers, who have been invisible for a long time and risk becoming physically and psychologically exhausted. We have also shown the extent to which the fact that home help and care activities are carried out by women has prevented these activities, which are considered natural and subordinate, from being valued. The problems are multiplied when these home workers are also carers in their families. Long isolated, these women are now mobilising in the social and political fields, building a class consciousness of personal services that defends their interests, like other employees in the world of work; they are employees who are more aware of the essential role of *care* that they play on the scale of society (Avril, 2009; Tronto, 2009; Jenson, 2011; Plumauzille and Rossigneux-Méheust, 2019).

Notes

1 In the summer of 2022, after the re-election of Emmanuel Macron, it was announced that the Ageing Act might not happen. Instead, the Minister of Solidarity and Autonomy, Christophe Combe, was considering a major national conference on the fight against loss of autonomy and the creation of a body bringing together representatives of older adults.

2 This includes arrangements for older adults regarding the question of institutions and services provided at home, the question of care personnel, but also arrangements for family caregivers.

3 This means a transfer of competences from the state to local authorities. It was completed by Law no. 83–663, which entrusted blocks of competences to the local authorities; for example, social action and the distribution of social assistance services were entrusted to the department, and professional training was entrusted to the region.

4 Some American feminist works denounce this phenomenon as reinforcing gender inequalities (Finch and Groves, 1983).

5 In a mission letter dated 17 September 2018, the Prime Minister asked Dominique Libault to conduct a consultation on the expectations and objectives of a law on old age and autonomy, which was due to be submitted in 2019 (Libault, 2019).

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4

Recent developments in long-term care in Spain: Challenges and competing discourses amidst the global pandemic

Antía Pérez-Caramés

Introduction: main characteristics of the Spanish care regime

In studies on comparative welfare systems, Spain has been included in the so-called Southern European Welfare Model or Mediterranean Welfare State. This category was proposed in the 1990s (Rhodes, 1996; Trifiletti, 1999) in response to Esping-Andersen's now classic typology of welfare models (1990) and to account for, among other aspects, the unique role of the family, compared to other welfare regimes, in the provision of social protection. In states such as Spain, Italy, Portugal, and Greece, the state's role in social assistance is rather subsidiary to that of families (Rodríguez Cabrero, 2005). Moreover, this welfare system is also based on a male breadwinner model with a rigid sexual division of labour in which care work is relegated to within the household and carried out by women (Bettio and Plantenga, 2008).

This context explains the late emergence of dependency as a new social risk in Spain and its politicisation. Indeed, the literature on the so-called new social risks alludes to the implications of various processes as triggers for consensus on the need for care for dependent persons under the umbrella of public policy. Among these processes, we find demographic ageing, the transformation of family forms, the increase in female labour participation, and changing values concerning informal care (Morel, 2006). All of these are at the root of a tension whereby the need for care increases while the availability and willingness of those who have been providing it –women in households – decreases, giving rise to what some authors call a care crisis (Pérez Orozco, 2006; Ezquerra, 2011; Fraser, 2016).

This care crisis emerged during widespread cuts in welfare systems, with the paradox that, in many European countries, the retrenchment of public provision coexists with the deployment of ambitious programmes in the field of long-term care (Ranci and Pavolini, 2013). This is not the case in Spain, which had to wait until 2006 to implement the main legislative initiative in favour of care for dependent persons, Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Persons in a Situation of Dependency (LAPAD, hereafter). The main objective of this legislation was to develop a public long-term care system, prioritising services over financial benefits and recognising the work of informal carers at home. Transitioning from a tradition of care in the family, in which the state played a residual role, to achieving public recognition of the right to care or the conception of dependency as a social risk has been a long and not problem-free journey, as described in the contribution by Rodríguez Cabrero and Marbán Gallego (2013).

However, the LAPAD, which crystallises the first moment of politicisation of long-term care in Spain, reached a broad consensus among all political forces and a large number of social actors. Yet, even if a consensus was reached, some concerns were raised about the economic unsustainability of the intended system of care for dependent adults, as well as the null, if not negative, impact on the objective of equality between women and men through the elimination of the sexual division of labour[1] (Hernando, 2006; Pérez Orozco and Baeza Gómez, 2006).

On the other hand, the implementation of the law took place during the hardest years of economic recession (starting in 2008), and austerity as an economic response certainly did not help to consolidate the care system for dependent adults. From a moment of heightened public and political debate about the response we collectively gave ourselves to the problem of dependency, we moved on to a few years, more than a decade, in which this issue took a back seat on the agenda of public opinion.

It was only during the outbreak of the COVID-19 pandemic that the issue of care for dependent persons, particularly those living in gerontological homes, was brought back into the public arena. However, a debate emerged about the conditions of carers' work, whether in the home (mainly migrant domestic workers) or other types of facilities and services, such as residential homes or home help services (Moré, 2020). This context of re-politicisation of old age care is different from the one that made the approval of the LAPAD possible. This is because the social and political response to the crisis unleashed by the pandemic seems to place more emphasis on the provision of funds for economic recovery than on cutting them, so that a window of opportunity may open up for greater social and collective responsibility for the care of dependent older people in Spain.

In this chapter, I will address the development of long-term care policies in Spain over the last two decades from the perspective of politicisation. I will pay special attention to the critical evaluation of the implementation of the LAPAD, as well as to the new challenges and political discourses that have emerged as a result of the impact of the pandemic. This contribution is framed within a critical social policy analysis that takes into special consideration the particular way in which gender and racial inequalities are articulated in the discourses that are conveyed when addressing issues related to long-term care policies.

The structure of the chapter is as follows. After these introductory notes, the section follows with an analysis of the development, implementation, and current situation of long-term care policies in Spain, with particular emphasis on two more general elements of the social organisation of care in Spain: the role of women in families and the contribution of migrant workers as domestic employees. This will be followed by an analysis of the process of politicisation of long-term care in Spain over the last two decades, focusing on the discursive aspects and the actors involved. Finally, I will present a last reflection and some brief conclusions.

Policies and practices in the organisation of long-term care in Spain

Before LAPAD: a residual and family-based care system

Before the adoption of the LAPAD, the social organisation of care for dependent persons in Spain rested mainly on the shoulders of women in families. That is, of the four actors that make up the care diamond (Razavi, 2007) – families, the market, the state, and civil society – what is characteristic of the Spanish care diamond is the hypertrophy of the family as a care agent and the residual role of the other three actors, especially the state (Pérez-Caramés, 2010).

This system was based on a strict sexual division of labour that assigned women the role of family caregivers and resulted in low female labour participation rates. Underlying these economic aspects was a familialist value system that underpinned the preference of aged people to be cared for at home and by their families. Moreover, accompanying this, public policies on family support, care, reconciliation, and co-responsibility needed to be more developed in contrast to what was happening in other European countries (Flaquer, 2004; Cousins, 2005).

The socio-historical framework that covers this form of social organisation is that of late development of the welfare state, given that Spain did not achieve democracy until the end of the 1970s. Thus, when other European countries, mainly the Nordic ones, were opting in the 1980s for community care formulas, in Spain, efforts were still concentrated on constructing older people's homes. In publications of the time, it is not unusual to find those who argue that pension policy, which was being shored up at that time, constituted the main support for old age. It was therefore assumed that pensions would enable the necessary care services to be purchased on the market and that residential homes and other services would be residual and intended only for the most economically disadvantaged older adults.

It was not until 1993, with the publication of the first Gerontology Plan by the Institute for the Old People and Social Services (IMSERSO, 1993), that the issue of care provision for dependent older people was addressed, albeit hidden in a set of five areas of intervention: pensions, health, social services, culture, and participation. It was in this document that, for the first time, what was then called 'informal support' for older persons by their families was considered in an institutional way (Sancho Castiello and Rodríguez Rodríguez, 2001), although the language used denotes a certain instrumental consideration of women carers in families.

Under the umbrella of the recommendations contained in the 1993 Gerontology Plan, there was a relatively silent movement in public opinion to increase the coverage of available resources for the care of older people, mainly regarding residential homes and home help services, which reached coverage ratios of 3.2% and 2.1%, respectively, in 2000. These levels of coverage are not only an indication of the residual nature of public assistance in terms of support for older people but are also far away from those observed for the same date in other countries (Sancho Castiello and Rodríguez Rodríguez, 2001). On the other hand, as Pérez Orozco and Baeza Gómez (2006) recall, a clear precedent for the LAPAD can be found in the work of the Toledo Pact. This is an agreement signed in the mid-1990s by all parliamentary political forces aiming at establishing mechanisms to guarantee the sustainability and solvency of the pension system in the face of the growing generational imbalance.[2] Within the framework of the recommendations made by this commission in 1994, it is stated that,

> traditionally, care for dependent persons was carried out directly within the family, and more specifically by women as part of their unrecognised work; however, the profound changes taking place in the family and social sphere are putting these traditional models of social protection to the test. (in Pérez Orozco and Baeza Gómez, 2006: 16)

Parallel to this process of incipient consideration of the need to provide a public response to the care demands of aged persons, as well as to recognise and make visible the work carried out in this regard by women in the home, a series of socio-demographic transformations are taking place in Spain which tear at the seams of the care provision model and expose its unsustainability. The main changes have to do with women's participation in the labour market, which is on an unstoppable upward trend (Salido Cortés, 2006), and that will threaten a social protection system that relies on their (almost) full-time availability.

In Spain, as in other southern European countries, this situation has led to the development of the so-called the migrant-in-the-family care model. This expression reflects the process that links the growing participation of women in migratory flows and their insertion into the labour market as domestic and care workers in households to meet the care needs of the aged population without significantly altering the traditional model of family care (Bettio, Simonazzi and Villa, 2006; Da Roit, González Ferrer and Moreno-Fuentes, 2013). In the Spanish case, the development of this model, obviously available only to those families who could afford to hire a migrant domestic worker, was also based on a regulation of domestic employment that considerably curtailed the labour rights of these workers (Díaz Gorfinkiel, 2016). Without the right to receive unemployment benefits, with a verbal contract and free dismissal, without recognition of occupational risks, and with a significant part of the salary that can be paid in kind (for room and board in the employing family's home), domestic employment became accessible to many Spanish families, who enshrine the live-in modality in order to guarantee the permanent care of their family member. Moreover, this system led to the development of what has been called global care chains (Hochschild, 2000). As women migrated from countries in the global south to work as caregivers in countries in the global north, they left the care of their families to other women, reproducing and reinforcing gender and racial axes of inequality in the global distribution of reproductive labour.

These were the fundamental characteristics of the model of care provision in Spain and the main actors involved prior to the LAPAD. But how can it be explained that in a family-oriented country like Spain, a law that enshrines the right to care and aims to develop an ambitious system of services and benefits to cover the needs of dependants is passed with a significant political consensus?

The approval and implementation of LAPAD

In our opinion, the factors that converge in the creation of a political climate favourable to the drafting of this law are, on the one hand, the influence of European and other Spanish policies, social awareness of the unsustainable and even unfair nature of the care provision model, as well as the existence, at that time, of a benign economic climate and a government favourable to pushing for social changes in the direction of greater social equity. In this regard, Rodríguez Cabrero (2009) reports on the influence of the transformations taking place in other European countries on the design of the Spanish model, which is reflected, for example, in the consideration of a subjective right to care, in the establishment of a co-payment system, and a high degree of administrative and budgetary decentralisation.

The LAPAD is oriented towards two fundamental objectives, namely two issues that had been on the public opinion agenda most often up to that point: on the one hand, the issue of so-called informal support for older people, about which there had been a discursive consensus on its lack of recognition, and, on the other, the insufficiency of services and resources and their territorial dispersion (Sarasa, 2007). To address these two issues, the law proposes the development of a system, the System for Autonomy and Care for Dependency (SAAD), which would implement a process of assessing care needs based on internationally standardised scales and deploy a catalogue of services and economic benefits. Among the former are the services for preventing dependency and promoting autonomy, telecare, home help, day and night centres, and residential homes. Given the law's strong emphasis on the development of services, the economic benefits included in the catalogue were of secondary and even exceptional consideration, the use of which was expected to be reduced as the system was consolidated and the necessary public services were created to meet demand. Nevertheless, three benefits were defined in the LAPAD: the service-linked benefit, to pay for a place in a residential or day centre on the market if there are no available public places; the personal assistance benefit, to enable people of working age to continue their studies or participate in the labour market; and the benefit for care in the family environment, considered to be exceptional and intended to remunerate a relative for the provision of care to their dependent relative.

This benefit for care in the family environment had the particular character of a salary, as it implied a contribution to social security and therefore allowed thousands of women who had been carrying out this work for their relatives without any social or economic recognition to generate rights to a future retirement pension. This was the central discursive rhetoric used by the governing party at that moment, the Spanish Socialist Workers' Party (PSOE), to defend this benefit.

Although, as mentioned above, the law had a broad parliamentary and, in general, political consensus, there were critical voices and some alarm about the possible consequences of the law at the time of its approval. Among the most critical voices were those of feminists, both academics and activists, who were deeply critical of supporting the provision of care in the family environment with public funds, considering it a mechanism for perpetuating the sexual division of labour, which also reinforced the idea that care is not a job or, at best, it is a peculiar job since its regulation through this benefit did not imply the recognition of the right to unemployment benefit, nor the establishment of a schedule and minimum working conditions, nor the consideration of the home as a place of work. However, this was not the only target of criticism, as the narrow definition of dependency, practically associated with disability, reduced the universal scope of the right to care and renounced any consideration of interdependence in human life (Hernando, 2006; Pérez Orozco and Baeza Gómez, 2006; Martín Cano and Ruiz Sesidedos, 2010; Barbadillo Griñán and Gómez García, 2011; Serrano Pascual, Artiaga Leiras and Dávila de León, 2013; Artiaga Leiras, 2015). These concerns went beyond the academic-activist framework and spilled over into the gender impact report carried out on the LAPAD by the Ministry of Labour and Social Affairs (2006), which also pointed to the negative implications of the family care benefit on gender equality.

The movements for independent living and, in general, those who advocate for the social recognition of functional diversity were also critical of the concept of dependency contained in the law and of the inadequacies of the figure of the personal assistant (Martín Palomo, 2010).

As for the alarmist voices, they were academic but also political. Concern surrounded the tripartite financing system, which would generate problems for territorial balance and difficulties for implementation in all the Autonomous Communities, since some, those governed by the conservative Popular Party (PP), were beginning to show reluctance to contribute funds. There was also concern about the foreseeable enormous amount of resources that would need to be contributed to the system once the implementation period was over.

Many of these cautions and criticisms became apparent in the first years of the LAPAD's implementation. For example, the development of the public services envisaged was slow and under-resourced, with the result that aid was granted predominantly in the form of economic benefits. Among these, the economic benefit for care in the family environment came to represent half of the aid granted under the law (Pérez-Caramés, 2014), and in some Autonomous Communities this proportion exceeded two-thirds. On the other hand, shortly after the mechanisms for assessing dependency and applying for resources were put into operation, the system's shortcomings in terms of personnel became evident, and a significant delay began to be generated between the application for and granting of aid, known as the 'limbo of dependency' (Trillas Fonts, 2018), which has led to many older persons dying before receiving any aid.

The analyses that were beginning to be made on the implementation of the LAPAD, both from institutions and academia, pointed to a missed opportunity, given that its main consequence was the reinforcement of the already existing familism (Muñoz González, 2015; Moreno-Colom *et al.*, 2016; Spijker and Zueras, 2018). It also reinforced family outsourcing strategies by hiring migrant domestic workers (Martínez Buján, 2011). Finally, it also consolidated the role of the market vis-à-vis public services (Comas d'Argemir, 2015).

The impact of the recession and the pandemic

However, the main stumbling block in the implementation of the dependency care system was not so much in its initial deficiencies, but in the cuts made in response to the Great Recession of 2008, which greatly reduced its intensity of coverage, delayed access to services and benefits for people with moderate levels of dependency, and abolished social security contributions for family carers. The first set of cuts took place in mid-2010, still under the PSOE government, and consisted of the suspension of retroactivity in the granting of aid; a measure that was accompanied in 2011 by a readjustment in the timetable for access to services and benefits that excluded people with moderate and mild dependency from aid for a long time. These two measures, together with the existence of the 'limbo of dependency', led to a significant reduction in monetary funds for dependency, which went on to cover almost exclusively the most severe cases, with delays and without recognition of the right to aid during the time spent waiting for a decision. In the summer of 2012, another package of austerity measures was approved, which, as far as dependency was concerned, consisted of a reduction in the amounts of economic benefits, the establishment of incompatibility in the receipt of services and benefits, and the suppression of the government's social security contribution for family carers (Pérez-Caramés, 2014).

All these cuts and the general austerity climate in recessionary Spain left LAPAD empty of content. The economic crisis (and, only belatedly, the social crisis) was at the centre of the media agenda, so the issue of care again disappeared from public debate, leading to a process of depoliticisation of the issue. As some academics have pointed out (Ezquerra, 2012; Gálvez Muñoz, 2013; Gálvez-Muñoz and Rodríguez-Modroño, 2016), the crisis and the austerity response to it returned women to the home, re-familiarising the care of dependants. Re-familiarisation went hand in hand with the depoliticisation of long-term care, thus ushering in a period in which this issue lost relevance in the public debate.

In a way, it was not until the outbreak of the pandemic that care came out of its political lethargy. The implementation of confinement measures, not only in Spain, brought to light and put the spotlight on the kind of work and therefore jobs that cannot stop because they are necessary for the preservation of life. Thus, the indispensability of these kinds of jobs was revealed, but also the working conditions in which they were being provided (from the health sector to household employment) and the implications this had on the people receiving this care, a case of particular media and political relevance being that of aged residents in care homes (Almeda and Batthyány, 2021; Comas-d'Argemir and Bofill-Poch, 2022). Care was thus once again re-politicised. Among the body of research that has already been done in this regard, two lines of research on the re-politicisation of care stand out: the one that looks at living and working conditions in care and nursing homes (Del Pino *et al.*, 2020; Del Pino *et al.*, 2021; Rodríguez-Rodríguez *et al.*, 2022), and the one that focuses on the regulation and conditions of care workers in general (Hernández-Moreno and Pereira-Puga, 2021; Comas-d'Argemir and Roca-Escoda, 2022; Hernández-Moreno, 2023).

Apart from the practices and social policies on dependency, what have been the relevant discourses and actors in these 20 years of politicisation, re-politicisation, and depoliticisation of the care issue? In the following section, we will address this question in the context of the emerging policy proposals in favour of creating a national care system.

The politicisation of long-term care: competing discourses amongst social actors

The Spanish welfare and care system has a familist character that is structurally based on the sexual division of labour, as we have already seen. However, it also relies on a value system that reinforces the role of the family as a provider of welfare and the responsibility of women within families. In other words, the Spanish welfare state is ideologically underpinned by the hegemonic social preference for family care. In a 2002 survey research study, the preference for family care in Spain exceeded two-thirds of the surveyed population, with 60% indicating that the preferred caregiver was the daughter (Bazo, 2002). However, this inclination towards family care, although still in the majority today, shows signs of receding. The contribution by Fernández-Carro (2018) notes the growing support in surveys for mixed formulas that combine formal and informal care, although the pattern of social desirability around family care remains high. The work of Martínez-Buján (2019) also points in the same direction, although she considers that the outsourcing of care through the hiring of domestic workers does not alter this predilection for family care, as they are incorporated into the home of the person receiving care in a quasi-familial relationship that hides exploitation (Pérez-Caramés and Martínez-Buján, 2015). With a qualitative analysis from the perspective of caregivers in Spanish families, Weiss (2022) highlights how the assumption of care responsibilities towards family members occurs in contexts of extreme capitalist and austerity pressure, something that Narotzky (2021) also pointed out in her work.

How can it be explained that a legislative text such as the LAPAD, which recognises the subjective right to care, could have passed in 2006? It is paradoxical, to say the least, in a country that barely recognises public responsibility in providing care for dependent older people. In the previous section, I referred to a set of social and economic processes that pushed political actors towards the need to provide an institutional response to the growing care needs while recognising the role of women as carers in families. I emphasise now that this discursive framework is mainly characterised by the understanding of women's unpaid work within the family as instrumental and functional to the system, so that, deep down, there was no objective of transformation or overcoming it.

Moreover, the potential gender and generational tensions caused by this organisation of care were cushioned to some extent by the role which migrant domestic workers played in a growing number of Spanish households. Some of these workers began to organise themselves into associations in defence of their rights and to seek alliances with anti-racist movements, organised feminism, and some trade unions (Ruiz García, 2013; Bofill-Poch, 2021). In this way, they articulated an activist agenda and politicisation of their labour condition and status that was oriented around the denunciation of the labour regime of domestic employment and in favour of the approval by Spain of Convention 189 of the International Labour Organization (ILO, 2011)[3] and the recognition of the right to unemployment benefits. Some political parties of the parliamentary left echoed their activism. In 2011 a reform was approved (Ministry of Labour and Immigration, 2011) that introduced some improvements, such as the written formalisation of the contract or the requirement that at least the amount corresponding to the minimum interprofessional wage[4] be paid in cash (and not partially in kind, as with the previous regulation).

The economic crisis of 2008 put a brake on the processes of politicisation of care that were underway at the hands of various social actors in Spain. To a certain extent, debates on social rights were anaesthetised in favour of an overwhelming neoliberal and austeritarian logic that left virtually no room for the survival of alternative discourses. This is in line with Foster, Kerr, and Byrne (2014), who argue that depoliticisation is yet another technique of neoliberal rule.

It was not until the advent of the pandemic that the dormant voices clamouring to circulate concepts such as vulnerability and interdependence in the political (and public policy) debate re-emerged. Bofill-Poch (2021) calls this process the democratisation of care and considers that it is centred on the following axes: (a) promoting the centrality of care and its recognition; (b) socialising care; (c) favouring its distribution between men and women in order to eliminate the sexual division of labour; and (d) understanding the recipients of care as subjects of rights and not as consumers or clients.

Related to these axes, the re-politicisation of long-term care is currently being shaped by the discourse of political actors in three directions. The first direction aims to dignify care, especially care provided in public institutions such as nursing homes. The high number of deaths due to COVID-19 in publicly owned and outsourced care homes has highlighted the need to reconsider the model of service provision, as well as the conditions under which people work in these institutions (Comas-d'Argemir and Bofill-Poch, 2021). The second direction focuses on making the working conditions of those formally dedicated to care decent. Some progress has been made along these lines, such as the Spanish government's ratification of ILO Convention 189 on 9 June 2022 and the approval, on 6 September 2022, of the right to unemployment benefits for domestic workers (Ministry of Labour and Social Economy, 2022). And the final direction is the recovery of public (and community) initiative in the care field.

In relation to this last direction, the emergence of community action and mutual support groups during the pandemic (Diz, Estévez and Martínez-Buján, 2022; Navarro Rupérez, 2021), but also the government's action in favour of the creation of a national care system, stand out. The latter has been significantly influenced by feminist thought and activism, which in late May 2020 presented a proposal to the Commission for Social and Economic Reconstruction of the Congress of Deputies under the title *Towards a state care system* (VV.AA., 2020), some of the main proposals of which were included in the opinion approved by the Plenary of Congress. In fact, in May 2022, the Spanish government approved the Strategic Project for the Recovery and Economic Transformation (PERTE) of the social and care economy, in which one of its main objectives is the 'development and promotion of advanced, accessible, and people-centred care services' (Ministry of Labour and Social Economy, 2022). The European influence also adds to this momentum, as the establishment of the European Care Strategy, which crystallised at the beginning of September 2022, has set up a series of objectives common to all member states that the Spanish government is currently following. In the coming years, we will see to what extent this return to the politics of care has led to significant transformations in its socialisation, recognition, and dignification.

Conclusions

Throughout these pages, we have presented the main characteristics of the organisation of care in Spain based on an approach that considers, in addition to policies, the social practices and discourses surrounding these practices. I have pointed out how the double anchoring of Spanish familism, structurally based on the elements of sexual division of labour and ideological preference for family care, has prevented and delayed the politicisation of the issue of care.

This process of politicisation has had two high points in Spain. One was in 2006, with the approval of the LAPAD, which was the first recognition of public responsibility in the provision of the right to care and the need to make at least visible the role that women were playing as carers in the home. The second came in the wake of the coronavirus pandemic and has had, for the moment, implications for improving the working conditions of domestic workers, many of whom are migrants, and for the development of work towards the implementation of a national care system.

European influence, the relevance of certain actors (such as, currently, feminism and organised domestic workers), as well as the existence of progressive governments in relatively expansive economic periods, seem to be conditions that go hand in hand with the politicisation of care, at least in the Spanish case.

Notes

1 The concept of 'sexual division of labour' is used in social sciences to explain the unequal distribution of work between men and women in society as a result of differential socialisation and the patriarchal structure of society (see, inter alia, Benería, 1979; Ferguson, 2013; Nuño Gómez and Pérez-Caramés, 2022).

2 Given the evident imbalance between the size of the generations for demographic reasons, the Toledo Pact aims to guarantee the pay-as-you-go nature of the pension system and thus avoid further reform of the system (Blanco Ángel, 2002).

3 ILO *C189 Domestic Workers Convention* was adopted in 2011 as a document of proposals to states for the improvement of the recognition of domestic workers' rights (ILO, 2011).

4 In December 2022, the minimum interprofessional wage in Spain was 1,000 euros gross per month.

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5

Ambivalences around family care: The rhetoric of a family policy in Portugal

Ana Paula Gil

Introduction

This chapter focuses on family care provided at home by family members. Informal care refers to the unpaid care provided to older and dependent people by family members and friends (namely neighbours), either full-time or part-time, and which includes daily life activities related to health care and well-being (Comas-d'Argemir, 2019; Cès *et al.*, 2019).

Due to demographic changes and labour market demands, uncertainty about family care is expected to create a significant deficit of carers by 2060, leading to unmet care needs and a widening of the so-called 'caring gap' (OECD, 2014). The 'caring gap' describes the disproportion between the demographic growth of the older population, especially at advanced ages (> 80 years), and the reduction of future cohorts of potential carers, composed of younger generations (Bonnet *et al.*, 2021). This phenomenon raises the question, 'who will care for the older people?', a central issue for long-term care (LTC) policy.

Two dimensions should be considered to respond to this issue: the availability of potential informal carers and their willingness to provide care. According to the European Commission (2021a: 143), key variables affecting the future availability of potential informal carers are the future number of older people who have children who live near enough to provide care (i.e. co-residence or geographical proximity), and the future number of people living with their spouse. The second dimension is how the willingness to provide care will be affected by participation in the labour market (particularly that of women, who tend to be the main carers), as well as the ability/willingness to provide care. A third dimension is the citizens' right to receive formal care and to have easy access to institutional care. This preserves their right not to perform care, as well as the right to be protected by the state in the case of caring full-time for a family member (Comas-d'Argemir, 2019).

With the demographic changes we have been witnessing in Europe, care has emerged as an analytical concept (São José, 2016) and a political category (Casas-Cortes, 2019). This means that care today is understood as a broader category, seen not only as belonging to the private and domestic sphere but also to the public sphere. Care has gone public, becoming a matter of public and civic interest (Fine, 2007). This is expressed through the emergence of what some researchers have called a 'care deficit' (Hochschild, 1995). Care is conceived as a necessary social response to human frailty and vulnerability at different points in the life course. The form taken by the response, which we refer to as 'care', is not a fixed or self-sustaining autonomous practice. Rather, as Mary Daly has put it, 'care is produced as an ethical commitment, a set of actions and increasingly as a policy good within complex economic, social and political contexts' (Daly, 2002, cited by Fine, 2007: 144).

Care has become a new social risk covered by public social protection systems in several countries. However, it is also a social and moral construct shaped by social structures, ideologies, and contexts. The way care is constructed socially and politically has a significant impact on how it is provided and received (Weicht, 2015). When conceiving care as a social construct, the concept of care has become an object of sociological analysis (Weicht, 2015) and a political category (Casas-Cortes, 2019; Comas-d'Argemir, 2019; Soeiro and Araújo, 2020), passing through a process of birth, genesis, and legitimisation, through its institutionalisation. As an object of public intervention, the reconstitution of the process of institutionalisation of care brings us back to the concept of social construction (Berger and Luckman, 1985; Stiker, 1996). Henri-Jacques Stiker defines the concept of social construction as the way in which a society establishes and processes or handles a domain of life, a population, or a type of social relations, according to the representation it holds and the categories it uses. This representation and these categories are themselves dimensions of practices and cultural frameworks. Thus, all these notions are a constructed 'result of antagonisms, struggles, categorisations and political strategies' (Stiker, 1996: 311). Until the recognition of care as work (Pfau-Effinger, 2014; Frericks *et al.*, 2014; Dykstra, 2019), its institutionalisation goes through a process of politicisation, which means that care becomes a political struggle within the political system (Palonen, 2021).

An overview of the long-term care context in Portugal is given, and the new legal framework in force concerning informal care is presented to show how informal care has become the object of public policy, and, therefore, subject to a formalisation and regulatory process.

(In)formal care: complementarities

Researchers have theorised care in various disciplines involving new forms of employment and different mixes of paid and unpaid care, reflecting deeper processes of social and economic change. Michael Fine identifies three elements in the care concept:

> First, care entails *a disposition, a concern for others or another*. This element is the intangible, mental aspect of care that involves a cognitive, rational and emotional concern for the wellbeing of others. Second, care is given expression as a form of work that takes place as the activity of providing practical assistance to another. These actions involve the physical provision of support to another over time, and demand competence of practitioners. (…) The third element acknowledges care as a social and personal relationship, concerned essentially with interpersonal support. (…) Care must be understood as a fluid and variable expression of the most intense forms of social support. (Fine, 2007: 143–144)

The concept of care has been replaced by another concept, care work, which a group of feminists proposed in the late 1980s and early 1990s (Guberman *et al.*, 1992; Twigg and Atkin, 1994). This broke away from the concept of care as an essentially female practice. This movement drew attention to how essential care is a process involving an organisational system, resources, and skills. Care is analytically broken down into formal care (paid) and informal care (unpaid). The unpaid care of carers is conceived as *a burden* in the domestic context (Pearlin *et al.*, 1990), and the care debate increasingly came to focus on the work conditions and career development in the field of paid care (Ungerson, 1990).

The complexity and the interdependences in care arrangements require a conceptual approach, such as formal and informal care, or familialisation/defamilialisation. These concepts derive from feminist work (Lister, 1994), although they are now present in comparative welfare state studies:

> While it has different usages, through a feminist lens, the concept seeks to theorise the role of social policy in affecting women's dependence on the family, on the one hand, and the state's construction of family responsibilities and roles, on the other. (Daly and León, 2022: 24)

Policies that support extrafamilial care are categorised as defamilialising, aiming to promote gender equality, and policies that promote informal care provision by relatives are categorised as familialising, placing these policies in logics that fall into one extreme or the other (Eggers *et al.*, 2020). Saraceno and Keck (2010) distinguish three patterns in familialisation of care: *option familialism*, *supported familialism*, and *defamilialisation*. The concept *option familialism* is based on the understanding that caring preferences do not need to conflict with policies lowering the burden of care. In *option familialism*, families can choose between provision of services and cash for home care, whereas *supported familialism* allows access to services and public support for leaves. *Defamilialisation* implies good access to institutional care for older people through different actors: public, third sector services, and the market.

Some authors have stressed the increased blurring of boundaries in welfare regimes: ‘The rise in a varied mix of care which includes a plurality of care providers, from public services to private profit services and subsidised third-sector services and unpaid and paid informal caregivers’ (Naldini *et al.*, 2013: 173). In order to understand diversity in care arrangements, Daly and Lewis (2000) propose the concept of social care to overcome the dichotomies that have fragmented the concept of care, such as public-private, informal-formal, and paid-unpaid. Care is an activity and set of relations at the intersection of state, market, and family (and voluntary sector) relations, including three dimensions:

> care as labour/work, a form of work that is carried out under certain conditions; care as an activity located within a normative framework of obligation and responsibility; and care as an activity with costs, both financial and emotional, which cross the public/private boundaries. (Daly and Lewis, 2000)

In his turn, Fine proposes a broader perspective, which he has termed the ‘social division of care’ (Fine, 2007). The concept is based on the recognition of care as a form of work, which includes: (1) the relationship between paid and unpaid care (2) the relationship between different forms of paid care staff, and (3) the relationship between care staff and care recipients, this last relationship as an active subject, not simply as the object of care. According to Fine, the concept is intended to provide a simple framework for the study of care as an increasingly complex form of work, drawing attention to how responsibility for different aspects and stages of care processes is being reapportioned between different social actors through the development of innovative hybridised forms of practices and responsibilities (Fine, 2007: 138). One such development that has significantly blurred the boundaries between paid and unpaid care in the informal sphere in several countries is the introduction of direct payments to family carers for the work they undertake. There is a need for more detailed and extensive research that explores the impact of these policies on families.

Processes of familialising and gendering care through the lens of the Portuguese case

1. *Who provides care to older people in Portugal?*

A longer life expectancy and low fertility rates are among Europe’s most significant issues raised by demographic ageing. In 2013, 5% of the

Portuguese population were 80+, and demographic projections suggest a significant growth in people over 80 by 2060 to reach 16% (EU, 12%). The increase in people aged 80 and older and the projected increase in life expectancy (Eurostat, 2015) suggest that more older people will require care. In Portugal, the projected 'support ratio', i.e. the ratio of women aged 45–64 years old per person aged 80 years and older, has already diminished in the period 1990–2030 from five to two caregivers (Hoffmann and Rodrigues, 2010: 5).

The reduction in this ratio was also confirmed by the European study Felicie (Gaymu *et al*., 2007), in which nine European countries participated, including Portugal. This study had the objective of analysing the availability of family care for older people in a situation of dependency based on demographic projections until 2030. The study concluded that with the closeness of life expectancy between men and women, women might rely more in the future on the presence of a spouse. This trend is particularly strong among Europeans over 85 years old since the presence of a spouse will be three times more frequent in 2030 than in 2000 (22% compared with 9%). It means that if the Portuguese population continues to age and the birth-rate falls, family care for older people will not seriously decline. However, care will be provided by other older people (a rise from 7% to 16% in 2030), which also increases the need for paid and formal care.

On average, across OECD countries, around 13% of people aged 50 and over reported providing informal care at least weekly in 2019. According to data from the Survey of Health, Ageing and Retirement in Europe (SHARE), 2.3 carers in Europe care for older parents or spouses, and as the age of the carer increases, more time is spent in caring. Two patterns of carers were identified: (1) younger carers (50–65 years) caring for older parents, usually daughters (gender differences are exacerbated); (2) older carers (above 65 years) caring for a spouse, who provide more intensive care (round-the-clock care). In this last pattern, gender differences are reduced (OECD, 2020). The proportion of the Portuguese population aged 50 and over providing informal care was 9%, 8% for those who provide care daily, and 1% every week (OECD, 2020). According to SHARE, 70% of informal care in Portugal is provided daily by women over 50 years old (OECD, 2020).

A survey of 846 families who provided care to older people in Portugal revealed that the direct family (spouses, both men and women) and daughters were the main sources of support whenever illness and disability arose (Gil, 2010). Although women were the dominant figures, the survey also uncovered the role of male carers (in old age and retired), revealing men's contribution to the family sphere. In this survey, sons (5.7%), extended family members, neighbours, and friends, irrespective of gender, had relatively minor importance.

The two patterns of care across OECD countries are also in line with the Portuguese Time Use Survey (Perista *et al.*, 2016), which concluded that the gender gap is smaller in the older population (of advanced age and with chronic illness). Although the patterns of participation of women and men in the labour market have been progressively convergent, they still show significant asymmetries and a greater feminisation in care (Perista *et al.*, 2016). Women tend to be the main providers of informal care, and a large part of care is provided by unpaid women who are fully or partly pulled out of the labour market to provide care to relatives (Gil, 2010; Carvalho *et al.*, 2021). Gender inequality emerges as the central issue in paid and unpaid care and a central axis for public policies.

COVID-19 further aggravated the situation of many Portuguese carers, isolating them and negatively affecting their performance (Henriques *et al.*, 2022) regarding the number of hours of caring, physical and mental health, social isolation, and employment. In addition, access to services in the community (home-based services and day centres) was denied to many families (Carvalho *et al.*, 2021).

2. *Portuguese long-term care system*

There are several studies (Hespanha, 1995; Adão e Silva, 2002; Soeiro and Araújo, 2020) on the integration of Portugal into a familistic regime. The arguments put forward include the late creation of a welfare state, the role of Catholicism's social doctrine, and the role of the *welfare society* (Hespanha, 1995). Portugal had a rudimentary social assistance system until the creation of a corporative welfare model, of Bismarckian inspiration, in 1935. The few institutions were public, and the situation in the 1960s until the early 1970s was chaotic. The living conditions in these asylums were inhuman, with cohabitation of older people, beggars, children, and prostitutes in the same space. It was in the 1970s that the Portuguese government began to show some concern for improving the living conditions of these institutions. This concern was framed in a European context, namely France and England, with the studies by Peter Townsend and Marcel Drulhe, who criticised the asylum institutions which explicitly contributed to the stigmatisation and isolation of individuals (Gil, 1998).

The process of modernising economic structures came about very late (in the late 1970s) when the fascist regime ended, and the fragility of the social sector and its underdevelopment made it unavoidable to resort to informal support systems. According to Hespanha (1995: 211), the vitality of the *welfare society* is a social force compensating for the deficits in services coverage, where the family, mainly women, have historically played a central role in care.

In recent decades, Portuguese public policies have been developed in the social sector through two fundamental axes (Lopes, 2017). The first concerns the direct monetary transfers from the state to families to promote family care and to support the care recipient, as in the case of the 'attendance allowance' (for disabled people) and the 'dependency pension complement' ('complemento por dependência') [1] (i.e. the first generation of LTC policies for older people). The second pillar is based on the provision of care by public services (the National Health Service), particularly in primary health care and community care teams, and by the non-profit sector, led by the Private Institutions of Social Solidarity (IPSS) (83% of care services are part of the non-profit sector). They are non-profit, oriented towards social solidarity, and are recognised by the state, to which they may apply for funding (cooperation agreements). The services and facilities for older adults are included in a social network (*Rede de Serviços e Equipamentos Sociais* – RSES) (GEP, 2019).

From 2000 to 2019, there was an 84% increase in the number of users of nursing homes (from 55,523 to 101,919 (GEP, 2019)) included in this social network. In 2019, there were 11,500 facilities for older people (GEP, 2019), and the number of users also increased in home care services (112,272 users, and 64,338 were integrated into day centres). The capacity of these services in 2018 was 93% full in the residential facilities for older people, 70% in home care services, and 64% in day centres (GEP, 2019).

This Social Response Network (RSES) is distinguished from the National Network of Integrated Continuous Care (RNCCI) (which serves mainly convalescence, medium-term, and rehabilitation units), with services that are more health-oriented. In 2018, 48,677 users were assisted in the RNCCI, 4.6% more than in 2017, and 9.6% more than in 2015. The typology according to which most users were assisted in 2018 was integrated continued care teams, followed by long-term maintenance and medium-term rehabilitation units (National Health Service, 2019).

In 2019, only 1.9% of people aged 65 and over received formal LTC (from RNCCI) in Portugal (OECD, 2020), of which 1.2% received care in an institution and 0.6% received care at home. The low capacity of the Portuguese long-term care system is confirmed by the estimates from the European Institute for Gender Equality (EIGE, 2019). In the European Union, 29% of households reported unmet needs for professional home care services. Some of the most common reasons reported were affordability and lack of available care services (EIGE, 2019: 8). For example, among the member states, this figure ranges from 12% in Sweden to 86% in Portugal. According to the European Commission (2021b), 39% of the population over 65 years old that needs long-term care in Portugal does not have access to it. The low number of people aged 65 and over receiving formal LTC may be linked to the shortage of LTC workers (OECD, 2020). Numbers are much lower in Portugal (less than one worker per 100 people over 65), leading to waiting lists for access to care and insufficient capacity to meet needs (OECD, 2020; Gil, 2021).

Lopes (2017) underlines that although Portugal has seen some convergence towards the EU average in coverage rates for formal care provision, it should be noted that coverage rates alone do not necessarily correspond to an appropriate coverage. Some factors are pointed out in the formal care sector: 'excessive workloads and long working hours', 'poor working conditions are coupled with high rotation of staff', and poorly trained and remunerated staff members (Gil, 2021). Lopes considers that 'the non-profit sector itself, either because it operates as a monopoly or because of ideological orientations towards care, is still very embedded in the Christian doctrine of charity and assistance and not in a culture of social rights' (Lopes, 2017: 71).

Despite public investments in the long-term care system, in the last decades, Portugal allocated 0.9% of its gross domestic product to the public provision of LTC, less than the average across OECD countries (1.5%) in 2019 (OECD, 2020) and, therefore, considered a limited state intervention model (Pavolini, 2021).

A number of consequences emerged from the inadequate coverage of LTC, such as the reliance on an informal care work market, the increase in unlicensed homes, and a higher responsibilisation of the family, particularly of women (Gil, 2019), as well as continued demand for domestic and care workers, mostly immigrants. This unqualified work, which includes mainly domestic work, cleaning services, and social care for the older population, is performed by African (Cape Verde, Angola) and Brazilian immigrant groups (Oliveira, 2022). In recent decades, there has been a segmentation of the labour market in Portugal, including a segregated immigrant labour force, particularly in the least qualified professional groups, with precarious jobs, more exposure to instability in the labour relationship, lower pay, and a higher incidence of labour accidents (Oliveira, 2022). Immigrant carers work mainly in the informal market, often as live-in carers in private households or non-licensed private nursing homes. Sometimes they are vulnerable to exploitation, discrimination, and abuse (Figueiredo *et al.*, 2018, cited by Gil, 2021: 6) due to the insecurity surrounding their immigration status. Thus, they are exposed to the vulnerability of their unqualified work and also to racial inequalities related to their immigration status.

3. *(Re)familialisation: a policy to support informal carers*

The visibility of informal carers in the public arena

Some studies (Soeiro and Araújo, 2020; Canha, 2020) were conducted to understand the context and the conditions that allowed the issue of informal care to enter the political agenda between 2016 and 2019, which led to the entry into force of the Law of Informal Care in Portugal.

The first carers' meeting was held at the Catholic University in 2016, at which some public figures from left-wing parties were present. After the first National Meeting of carers in June 2016, there was a clear motivation to bring attention to their cause in the public arena, using two key mediation channels for this purpose: the media and the political authorities. The media space contributed to bringing into the public sphere the biographical narratives of carers and their needs. In this process, different political parties (especially the left-wing political parties) and civil society actors (the Portuguese Association of Family and Friends of Alzheimer's Patients and associations for disabled people) reflected different political-ideological perspectives on the role of informal care in society. The main goal of this social movement was to remove this reality from invisibility, socially and legally. This demand was articulated through claims that, in essence, relied on the categories of Nancy Fraser (2008), the *struggle for recognition and the struggle for redistribution*:

> The struggle for recognition of a segment of the population whose work was not identified as such and which, until then, did not have access to forms of collective representation of their interests as carers. The struggle for redistribution, that is, social policies capable of valuing informal care and making it a platform for access to rights and social protection. (Soeiro and Araújo, 2020: 58)

The informal carers' movement included carers of all ages (such as disabled and old people and carers for young children with health problems), which triggered political and public attention, providing an opportunity for legislative regulation. With public and political pressure to recognise an informal care policy in the face of demographic ageing and changes in family structures, care emerged as an object of public policy. One of the public figures who supported this movement was the Portuguese President. According to Marcelo de Sousa, 'the law signified the possible consensus to follow up a great movement of the Portuguese society, in some cases related to some principles, in others going further in terms of implementation' (Jornal de Notícias, 2022). The pandemic of COVID-19, he added, made the process difficult, but in any case, a 'historic step' was taken, the result of the 'merit of those who fought for the law, coming from the base', i.e. 'informal carers, but also some protagonists', such as the BE Marisa Matias (member of the left-wing political party and member of the European Parliament). More than a simple object of public policy, care was the subject of a visible and debated process in the public arena (contested, negotiated, and emerging from struggles), which became relevant in the process of politicisation.

The regulation of the Informal Carer Statute

The recognition of the need for measures to support informal carers emerged following the Resolution of the Portuguese Parliament 129/2016. The Informal Carer Statute (ICS) was approved in July 2019 and regulated the rights and duties of carers (Ordinance 2/2020: 5).

The primary informal carer is a family member living in the same household as the person being cared for, providing care permanently without any salary. A secondary carer is a family member providing care on a regular but non-permanent basis, with or without compensation. There was a split in this policy, which resulted in the exclusion from the designation of all those who provide daily support, namely non-family members, friends, neighbours, and formal carers paid by families, who are also sometimes secondary carers (Ordinance 2/2020: 6). All family members, regardless of gender, who accompany and provide care regularly but not permanently, are excluded.

Before the institutionalisation of the support for family carers within the social security system was extended to the entire country, which took place in 2022, authorities had implemented pilot projects lasting for 12 months, from 1 April 2020 to May 2021, which covered 30 Portuguese municipalities (Ordinance 64/2020: 5). According to a national report, until June 2021, the status of the informal carer was recognised for 977 people in the 30 municipalities where the pilot project took place, with 83% of these being women, which shows a significant feminisation of care. The carer's allowance covered only 352 people in the country, with a monthly average below the poverty threshold (281.96 euros per month) (CAMAI, 2021).

In 2022, the Regulative Decree 1/2022 established the terms and conditions for recognising the status and the support measures for informal carers. In order to receive cash benefits for family care, care has to be provided by a family member (aged 18 years or older) who is either a spouse or unmarried partner, kin up to the fourth degree of the direct or collateral line of the person being cared for, and who lives in the same household. More precisely, there are strict eligibility restrictions with regard to specifying a family carer:

> a) living in the same household as the person cared for; b) providing care permanently; c) not having a paid professional activity or any other type of

> activity incompatible with the provision of permanent (24/7) care to the person being cared for; d) not receiving unemployment benefits; e) not being remunerated for the care they provide to the person being cared for. (Regulative Decree 1/2022: Art. 6)

The family carer must qualify and attest through health services to his/her health status to become a family carer.

Generic and demagogic measures have been laid down, without any budgetary reinforcement to implement them, either in terms of access to services or in terms of hiring human resources. In Art. 11, the legal document stipulates that the assigned reference health professional is to be responsible, namely within the context of the health team centre, for advising, accompanying, empowering, and training the informal carer, to develop skills in caring for the person being cared for. Art. 13 regulates the Carer-Specific Intervention Plan, a document resulting from the diagnosis and person-centred planning needs in terms of health and social services. In Art. 15 participation in support groups and psychosocial support are regulated together with respite care for the carer following the diagnosis made by the reference professional, for a period of up to 30 days per year, due to the informal carer's need for respite and depending on the availability of a vacancy for respite care in the RNICC.

The informal carer support allowance ('Subsídio de apoio ao cuidador informal principal') is a cash benefit from the social security system. The allowance and the amount awarded depend on the income of the entire household of the informal carer (their income as well as the dependency benefits of the person being cared for), which means that household income must be less than 576.16 euros (1.2 times the value of the Social Support Index – IAS). The reference amount of the support allowance is 443.20 euros (month). In Portugal, this amount is meagre and below the poverty line since the income relates to the entire household (in Portugal, the minimum wage was 740.83 euros in 2022). The allowance cannot be received along with the following benefits: unemployment benefit, dependency pension complement, invalidity pension, and old age pension, except for early pensions (before retirement age). The primary informal carer can benefit from social security insurance for providing informal care – the Non-Compulsory Social Insurance Regime ('Seguro Social Voluntário') – by paying a contribution rate of 21.4% of the informal care allowance. Under this scheme, the protection covers invalidity, retirement, and death. This insurance, although voluntary, corresponds to the lowest contribution and can be considered the first recognition of family care as a form of work.

The law defines work-life balance policies for a non-primary informal carer as the following: parenting scheme, remote work regime, and measures promoting reconciliation between professional activity and care, by agreement with the employer or by the provisions of the applicable collective labour regulation instrument. Other policies strengthening the labour protection of a non-primary informal carer include a scheme for absences: the right to 15 days of unpaid absence; leave (annual leave of five days, without pay, and the obligation to notify the employer ten days before the leave); organisation of work hours (flexible working hours, part-time work for up to four years); and legal protection in case of dismissal (Law 13/2023 of 3 April, which amends the Labour Code and the related legislation, within the scope of the Decent Work Agenda).

Measures to promote a return to the labour market after the main carer's work ends are also unclear. The law includes measures for an unemployed person, provided that he/she is enrolled in an employment centre. The only specific measure after the cessation of the provision of care is recognising and validating the carers' competencies through a Portuguese Entity ('Centro Qualifica'). This public recognition of the carer's skills and his/her certification through the national entities is an indirect way of forwarding carers to the formal care sector, which is characterised by a shortage of LTC workers (OECD, 2020; Gil, 2021).

From contestation in the public arena to proposed regulatory change

The movement of informal carers, after the legal regulation, has used different forms of collective action in civil society. The National Association of Informal Carers, as the representative body of its members, emerged from the social movement ('O movimento dos cuidadores informais'). Today, the association acts as a source of support and information on the rights of informal carers and, recently, the promoter of a citizens' legislative initiative.

The citizens' legislative initiative proposed in the Portuguese Parliament to change Law 100/2019 on the Statute of the Informal Carer and Regulative Decree 1/2022 is underway. This initiative, for which 20,000 signatures are needed (from Portuguese voters), is currently collecting signatures before it comes up before Parliament for discussion. The proposal was based on the following demands:

- Extending the recognition of the status of the informal carer to people who, not being a spouse, unmarried partner, relative or kin, demonstrate ties of affection and/or closeness with the person cared for and prove that they effectively exercise the role of informal carer.
- Extending the recognition of the status to children under the age of 18 who are caring for their parents, provided they are referred to as effective carers by the social or health services, even if they are not entitled to an informal carer's allowance.

- The recognition of the status no longer being dependent on the eligibility of the person being cared for to access the *dependency pension complement* or the *attendance allowance*.
- Changing the term 'informal primary carer' and 'informal secondary carer' to 'full-time informal carer' and 'part-time informal carer', respectively.
- Recognising the right to rest for the carer for no less than 58 days per year.
- Exempting the cared-for person from fees on admission to units within the RNCCI in cases where it is intended to ensure rest for the carer.
- The informal carer's allowance no longer depending on the income of the entire family household of the informal carer.
- Increasing the informal carer support allowance, corresponding to 100% of the value of the contributions that fall into the first level of the Non-Compulsory Social Insurance Regime.
- Providing a labour regime that protects the informal carer, ensuring absences and leaves, regulating flexible working hours, and extending the parental leave of up to one year for holders of parental rights.

Conclusion

Portugal has implemented policies to support informal carers to promote family care. The issue of informal care was politicised at the time of its legal regulation. However, the movement that surfaced in civil society has lost strength in terms of contestation in public space. The primary demand of this social movement was to remove the carers from social invisibility, but today there is a general dissatisfaction among informal carers (Gil, 2022, 2023). The *struggle for recognition* (Fraser, 2008), in the public arena, through the social movement turned into a struggle to change the law, mobilising civil society. This policy has been challenged for perpetuating the invisibility of care since many women are excluded from such recognition without any social protection mechanism.

First, one can wonder why only 11,080 carers (of which only 2,767 receive allowances) (CAMAI, 2021) benefit from official recognition, out of the presumed 827,000 Portuguese carers. It also merits reminding that 207,000 were estimated to work full-time (Eurocarers, 2017). Secondly, the idea of family obligation remains associated with the policies to support informal carers, based on the value of family solidarity and an absence of discussion around gender inequality. This law gives the family a central role in care, without this being matched by compensation for that care, particularly in terms of social transfers (Soeiro, 2022) or more accessible access to support services (i.e. domiciliary services with nursing care, medical assistance, respite care).

Formally, the Portuguese government has come to recognise that family care is work that can be stressful and needs support. However, it only gives minimal support to a selected group of carers. There is no real committed defamilialisation by the state. There is a rhetorical discourse on the status of the informal carer that does not coincide with practice, that is, with concrete measures that minimise costs associated with care.

The main characteristic of the Portuguese care regime is the prevalence of a *familistic model*, in which care is seen as a family obligation (mainly female) and not as a social right (Gil, 2021). The carers do not see their citizenship rights recognised for their work, and neither the carers nor the persons cared for benefit from formal care conceived as a social right related to citizenship. The support, at the level of monitoring, training, psychosocial support, and respite care proposed by the Regulative Decree 1/2022, can only be practical for carers with increased coverage in the formal sector. Despite an improvement in the availability of social services and facilities for older people, the social response network and the user capacity are insufficient to cover all those in need, and the formal support network has not kept pace with the demographic ageing of the Portuguese population. Since the 1990s, Portugal has seen an expansion in the coverage of services for older people, although far below the real needs emphasised by the accelerated ageing pattern of the Portuguese population. Furthermore, there are no vacancies in nursing homes in the non-profit sector because of the limited number of places available (RSES and RNCCI). For the (licensed) private sector, families cannot afford care home fees, which are outside the reach of the majority of the Portuguese population (Gil, 2019), and often employ African and Brazilian immigrant care workers in the informal market, often as live-in carers in private households (Gil, 2021) in precarious labour situations and without social protection.

The Informal Carer Statute was a great step in the recognition of family care. However, more responsibilities are assigned to carers under a discourse of support and recognition (Canha, 2020) without this discourse being accompanied by effective measures that minimise the impacts on carers. The way the care relationship is legally framed causes distinct contradictory interests within the family, i.e. the family carer is legally in a precarious position. Family carers only receive an allowance if they provide full-time care to a family member with severe care needs, and live in a cohabitation regime, and they cannot have a paid professional activity, or receive unemployment benefits or a pension.

Informal carers become an object of social policy in which there is a risk of perpetuating their burden and associated gender inequality. There is no explicit gender differentiation in the law, but informal care inevitably emerges from a family obligation, and a naturalisation process is attributed to women. Rather than a universal policy that recognises the social rights of informal carers (Comas D'Argemir, 2019), it is a policy against poverty, reduced to an allowance limited to a social group in a vulnerable situation (Gil, 2023). Therefore, it cannot be said that families are relieved or less burdened than before or that the law can be considered a form of *supported familialism* (Saraceno and Keck, 2010) since the allowance only applies in situations of extreme poverty and depends on the household's resources. The low amounts of care allowances, which had created expectations in carers, have ended up not valuing and not providing real compensation for care. At the same time, these care allowances can lead to an early exit from the labour market or greater dependence on other family members. The value of informal care is recognised, but measures that can ease the burden, particularly in the context of work-life balance policies, remain to be defined. The effects of these measures are still weak regarding gender differences, age, education, and racial discrimination, which are still predominant.

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[1] The dependency pension complement ('Complemento por dependência') is awarded to a person requiring permanent assistance from a third person to perform daily life activities. First degree: people who cannot perform, with autonomy, basic needs of daily life (acts related to nutrition, locomotion, or personal hygiene care) (106.96 euros); second degree: people who are bedridden or suffer from serious dementia (192.52 euros).

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6

Policy controversies in the Long-Term Care Act in Slovenia

Majda Hrženjak, Jana Mali and Vesna Leskošek

Introduction: politicising and gendering the long-term care regulation

In Slovenia, care for older people entered the policy agenda and public discussion as a salient political topic relatively late, only in the first decade of the new millennium, when the ageing of the population started to show its effect on the care deficit, labour market, and public budget. The state is now rushing to find policy solutions for the care of older people, primarily within the long-term care (hereafter LTC) system. Indeed, it was through the policy regulation of the LTC system that care for older people, including its gendered consequences, has been transformed into a political problem and become the subject of political party programmes, election campaigns, and the topic of political struggles over the design of regulation. Although LTC is a broader concept, as it addresses all persons aged 18+ who are dependent on the help of others because of illness, frailty, injury, disability, and lack or loss of intellectual capacity, it has become synonymous with care for older people in policy debates.

Political pressure from international organisations, in particular the European Commission and the OECD, who estimated that Slovenia is poorly prepared for ageing, has raised the political profile of older people's care as an issue of the LTC regulation, too. The OECD estimated that "long-term care spending covers 11.5% of the older population, well below perceived needs. The supply of long-term care is fragmented, with different legislation and eligibility criteria" (OECD, 2020: 5–6).

The LTC system has also been the subject of vibrant politicising in civil society in the last decade. Employers' organisations, trade unions, and the Union of Pensioners' Associations of Slovenia organised several public discussions on LTC's systemic financing and type of service provision. NGOs such as Amnesty International Slovenia and the Silver Thread Association – an association for a dignified old age – warned of the dangers of the mixed economy, privatisation, and limited access to services. Evidence about introducing the social work approach and innovation in the medicalised model of care homes for older people was provided by academia (Flaker *et al.*, 2008; Mali *et al.*, 2018; Mali, 2019). The Association of Social Institutions highlighted poor working conditions. Care workers' trade unions struggled with the government regarding the improvement of normative standards in care work (Hrženjak, 2017, 2019).

The general belief within policy-making in Slovenia that gender equality has already been achieved, which is supposed to be evident from a high share of women's full-time employment and the comprehensive public network of childcare, has for a long time made the gender effects of LTC polices (or their absence) irrelevant for policy-makers. However, this has changed, at least on the rhetorical level, in the last decade of intense public debate. In 2018, Women's Lobby Slovenia founded the Long-Term Care Coalition, an alliance of civil society organisations, including trade unions. In addition to advocating for an urgent adoption of an LTC Act that establishes care as a universal right provided by public services, the Coalition has drawn the attention of policy-makers and media to the gender impact of LTC regulation. With these messages, the Coalition engaged in the 2018 election campaign, publicly commented on the LTC Act drafts, communicated their views to relevant ministries and media, etc. The last two LTC Act drafts, including the adopted one, explicitly addressed the impact of LTC regulation on the situation of women as constituting the majority of informal and formal caregivers in the Act's preliminary assessment, yet, as we argue, this was not done in the design of the policy measures.

The LTC Act, which has been under preparation since 2002, was shaped by different governmental coalitions and different actors, most notably by the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MoLFSA), and the Ministry of Health. A decisive push that made the right-wing government finally adopt the LTC Act in 2021 was the COVID-19 pandemic and the related European Union Recovery and Resilience Plan. The European Commission has conditioned the use of grants for post-pandemic recovery on the adoption of the LTC Act (Zakon o dolgotrajni oskrbi, 2021).

In this chapter, we focus on the analysis of the implications of three core care services, i.e. institutional care, family carer, and cash benefit, offered to older people by the LTC Act as the outcome of long political struggles. We reflect on them through three key concepts, i.e. (de)familisation, (de)institutionalisation, and public provision. The LTC Act's preliminaries emphasise deinstitutionalisation as an important principle of care of older people, which stresses their right to live at home for as long as possible. The gendering of care is recognised by the principle of defamilisation and the provision of universal, formal, public care services to prevent burdening women with informal care as a necessary condition for their integration into the labour market and gender equality. The Act's preliminaries also pay attention to market anomalies in care work, such as precarious work and the grey economy. In this way, the Act's preliminaries explicitly emphasise the responsibility of the state over the responsibility of the family and the market in the provision of care and the importance of social care innovation in care homes for older people with the aim to support deinstitutionalisation. Our aim is to critically discuss inherent controversies and contradictions of the LTC Act's specific policy solutions for strengthening the public network, deinstitutionalisation, and defamilisation in care for older people, which are established as the guiding principles of the modern organisation of care for older people in the Act's preliminary assessment.

Our discussion is based on an analysis of the adopted LTC Act and its previous versions, as well as on the related national and international policy documents, reports, and current research. The authors have also been actively engaged in public discussion over the different versions of the LTC Act drafts and have argued against privatisation, for social innovation, and for considering the gender impact of the concrete policy solutions for care of older people within the framework of the LTC system regulation.

First, we briefly outline the historical and contextual features of the Slovenian regime of care of older people and how the LTC Act intervenes. In what follows, we analyse the three main care services as designed in the new Act in such a way that we first discuss the relevant concept for the analysis of a particular service and then reflect on the concrete service arrangements. We analyse the institutional service through the concept of deinstitutionalisation, the family carer service through the concept of defamilisation, and the cash benefit through the concept of cash-for-care. In the conclusion, we point to potentially controversial effects of the design of these three policy measures for the principles of deinstitutionalisation, defamilisation, and public services.

Contextualisation of care for older people in Slovenia

As in most Eastern European countries and despite the normatively public and universalistic principles, the Slovenian regime of care for older people can be, in practice, described as familialist by default (Gábriel, 2022), in which the state provides low financial support for care and does not offer a wide variety of publicly available services. With the motive of 'free choice and plurality' of services, and because the state estimated that it could not cover the growing needs through the public network, a mixed economy of care provision was introduced in 2000 without extensive public discussion (Hrženjak, 2019).

In contrast with the comprehensive public childcare system, in Yugoslav socialism, care for older people complied much more with the traditional pattern of intergenerational solidarity within the family, which was complemented by institutional care based on the social-gerontological model provided by the state (Mali, 2008). When the burden of care becomes severe, the families turn to residential services, which provide institutional care for 4.5% of older people (Community of Social Institutions of Slovenia, 2021a). While in the last decade the health profile and dependency of residents has worsened, demanding more intensive care, the standards regarding the number and skills of care workers have remained unchanged over the past 30 years. This accelerates high work intensity and poor working conditions, which, accompanied by low pay, contribute to staff shortages (Hrženjak, 2017).

After the disintegration of Yugoslavia and at the beginning of the transition from socialism to capitalism, in the 1990s, home-based care services were launched as a form of public work, due to the high unemployment rate among women caused by the transitional restructuring of the economy. In 2000, the service was professionalised and subsidised by the municipalities, but its expansion remained limited, relatively expensive,[1] and regionally uneven (Hlebec *et al.*, 2014a, 2014b). In 2019 only 1.8% of seniors aged 65+ received this service (Kovač *et al.*, 2019), while the EU average was already between 8 and 12% in 2010 (Bettio *et al.*, 2010).

The bulk of informal care is placed on women, but due to a dual-breadwinner family model, family care is not sustainable. Families are pushed to organise home-based care as a 'care puzzle' (Widding Isaksen and Näre, 2019) in which care is provided by a diversity of actors that can change over time, and in which care is constituted by parts that can fit well or less well together. Members of the extended family, mostly women, alternate in care provision. Public homes for older people and social work centres provide home delivery of food, transport services, and socialising in day centres. The informal care market is flourishing, where primarily local early-retired women, but also migrant women from former Yugoslav countries, mostly from Bosnia and Herzegovina and Serbia, offer casual services of cleaning and respite care (Hrženjak, 2019).

One of the salient problems in the existing system of care for older people is that while seniors are the most vulnerable group for living under the poverty threshold in Slovenia (Leskošek, 2019), the LTC insurance is not yet in place and care costs put a huge strain on the family budget as well as on the service providers. The Act was intended to finally introduce LTC insurance and regulate care provision in a comprehensive and systematic way. However, the adopted Act has postponed a regulation of systemic financing to 2025 and to a future government, which was a major disappointment and the most important reason why it was strongly criticised by all stakeholders. In addition, the Association of Social Institutions of Slovenia (representing the views of 86 out of 102 care homes), the Social Chamber of Slovenia, the Union of Pensioners' Associations of Slovenia, and many other civil society organisations publicly declared that they do not support the LTC Act due to its "many shortcomings, ambiguities and because it does not bring better and more accessible services to users" (Community of Social Institutions of Slovenia, 2021b).

The Act was due to enter into force in 2023 and to be fully in force in 2024. However, in the meantime, elections and a change of government took place. The new left-wing government has postponed its implementation, arguing that it was flawed. It announced a revision of the Act and sustainable financing based on progressive property taxation and other budgetary resources. It promises to increase funding for the expansion of the public network of home-based care services and care homes for older people as well as periodic independent assessment of the quality of life in care homes for older people. In parallel, a modernised system of professional social and community care services is foreseen as well as the promotion of the use of ICT to make care more efficient and help older people to live independently (Government of the Republic of Slovenia, 2022). While the previous right-wing government is calling for a referendum to prevent the postponement of the LTC Act's implementation, the majority of citizens support it. The regulation of care for older people remains an open space for political struggles. However, criticisms about the lack of regulation regarding the financing of LTC and general criticisms about the Act's vagueness have overshadowed more specific reflections on the potential dilemmas raised by the concrete measures that the law brings.

Controversial policy solutions

In its preliminaries, the Act recognises that too much emphasis placed on institutional and family care is a problem in the current system, and promises deinstitutionalisation, defamilisation, and a comprehensive public network of formal service provision.

> Increased involvement of women in informal care has a negative impact on their labour market participation, increasing their risk of economic dependency, poverty, and social exclusion. The availability, accessibility, and affordability of LTC services is therefore crucial to enabling choice, especially for women, to enter the labour market and to enhance the possibility of reconciling work and family responsibilities. Therefore, the LTC system in Slovenia must be based on formal care provided through accessible, plural, and publicly

> funded services, while informal care merely complements these services in a way that enables people in need of LTC services to benefit from them in a familiar home environment, both physically and socially, at least until a period of high dependency on the help of others. (LTC Act; Zakon o dolgotrajni oskrbi, 2021)

To reduce familisation and institutionalisation and strengthen the public network of care services, the LTC Act offers publicly co-financed care services of institutional or home-based care, family carers, and cash-for-care benefit, which are mutually exclusive, i.e. the user may choose only one and cannot combine them. In the following, we discuss the proposed policy solutions in terms of their controversial potentials for strengthening the public network, deinstitutionalisation, and defamilisation in care for older people.[2]

Backlashes in institutional care

One of the reasons for the emergence of LTC is the process of deinstitutionalisation – that is, the closure of large institutions and the restructuring of their services into different community-based services, which has fundamentally changed the way care is delivered (Flaker *et al.*, 2008; Leichsenring *et al.*, 2013; Rafaelič, 2015; Flaker and Ramon, 2016). This has changed the long-established models of care provision and focused attention on people's right to live outside of institutions, within a community, and their right to make independent decisions about their lives.[3] The paradigm of care has also changed accordingly – the focus is now on the person and their needs, and assistance is considered effective when it meets a person's needs according to their expectations and levels of distress.

Institutional care remains an integral part of LTC under the new Act. In 2008, Slovenia reached the target of 5% of people aged 65+ in institutional care (Community of Social Institutions of Slovenia, 2021a). The highest share of people aged 65+ in institutional care was in 2012 (5.2%), but today this share has decreased to less than 4.5% because of the increase in the number of older people, especially those aged 80+, who are potential users of institutional care. Their number has increased by 72% in the last decade (Mervic *et al.*, 2021).

Homes for older people are part of both the public and private sectors, but are absent from the non-governmental sector. The number of homes has doubled in 20 years, and in the private sector their number has been increasing rapidly since 2008 (see Table 6.1). There are inequalities in access to institutional care between small rural and larger urban municipalities (Hlebec and Mali, 2013: 375; Community of Social Institutions of Slovenia, 2022).

Table 6.1 Older people's homes and number of residents from 2001 onwards in Slovenia

Year	Number of older people's homes	Number of public older people's homes	Number of private older people's homes	Number of residents
2001	55	50	5	12,346
2002	58	50	8	13,051
2003	61	50	11	13,498
2004	63	52	11	13,098
2005	66	52	14	13,641
2006	69	52	17	13,699
2007	69	52	17	13,856
2008	84	56	28	15,235
2009	84	56	28	15,994
2010	89	55	34	17,571
2011	92	56	36	18,030
2014	95	54	41	18,621
2015	95	54	41	18,601
2016	97	54	43	18,854
2017	97	54	43	19,054
2018	99	54	45	19,318
2019	99	54	45	19,488
2020	99	54	45	19,568
2021	99	54	45	19,723
2022	101	55	46	20,039

Source: Hlebec and Mali (2013); Community of Social Institutions of Slovenia (2022).

The LTC Act encourages the trend of increasing the private sector witnessed over the last 16 years. In this way, the state has reduced geographic distances and increased the geographic coverage of homes. However, financial barriers to accessing institutional care have increased, as care in private homes is more expensive. Since 2008, co-payment for institutional care by municipalities and family has been increasing (Mervic *et al.*, 2021: 229). Until the adoption of the new LTC Act, private homes were bound to provide institutional care according to the same rules and standards as public homes (Hlebec and Mali, 2013). The new Act, however, does not explicitly define such a similarity between the content and type of services.

The LTC Act does not significantly change access to institutional care. What has changed is the possibility for municipalities to establish homes by strengthening the presence of the private sector. According to the Slovenian Institute of Health Insurance (2022), by the beginning of 2023, the capacity of institutional care would increase by 1,129 places, all in the private sector and owned by an Austrian private company.[4] However, for users, this does not mean an improvement in accessibility of services. Financial barriers to accessing institutional care have increased in past years as private care is more expensive, and this trend will continue in the future as the poverty rate among older people increases (Mervic *et al.*, 2021: 229). An additional problem is that in the last three years interest in working in homes has decreased because of bad working conditions. Over one-half of job announcements did not receive a single application in 2019. Due to staff shortages, some homes are not accepting new residents despite vacancies. Some workers leave the care sector entirely; however, many seek better-paid jobs in neighbouring Italy and Austria where home-based care is supported by the state with generous cash-for-care benefits. Homes strive to fill the care deficit with migrant care workers from former Yugoslavia countries, where the pool of available care jobs is limited and the working conditions even worse (Hrženjak and Breznik, forthcoming).

The concept of Slovenian homes for older people has taken the form of medical hospitals since the 1990s, visible in the employment of mainly medical staff. However, since 2005, homes have been systemically integrated into the social care system, and most homes have begun to introduce elements of social orientation with a special role for social work. They employ social workers too, but only one social worker per 150 residents. The emphasis in social orientation is on an individualised approach to the person, the development of individualised care plans, and the development of opportunities for equal collaboration between health and social care given the importance of the concept of long-term care. For institutional care, this approach opens up the possibility of working more flexibly with residents, developing services tailored to users' needs, and beginning the process of deinstitutionalisation (Mali, 2008).

Social orientation in homes has been at the forefront of the integrated development of care for older people in the community, including those still living at home. Homes not only provide institutional care in the narrow sense (residential and institutional care), but also support older people in their home environment and in the community by organising day-care, home-based care services, social services, assisted living, respite care, etc. Mali *et al.* (2018) note that homes are implementing a number of innovations in

LTC that have the character of a paradigm shift in care, as the focus is on exploring the needs of users and finding the type of support that effectively meets their needs.

The social orientation of the homes was shaken by the COVID-19 pandemic. Mali and Penič (2022) note that social work strengthened its autonomy in some homes and developed new practices and areas of work, while its role was not recognised in other homes, which created many ethical dilemmas for social work. In the crisis situation, social work in some homes, especially those with a paradigm of social orientation (Mali, 2010), proved to be able to react quickly and act efficiently, for the benefit of the residents.

However, the LTC Act does not encourage social orientation and the development of an innovative approach to homes. Instead, it introduces the transformation of existing social care homes into 'nursing homes', whose operation is not precisely defined. The Act only stipulates that they must devote at least 80% of their capacity to the care of the neediest users and that they may carry out curative health activities (LTC Act, 2021: Art. 58, fourth paragraph). The Act introduces another type of home, the care home. These are smaller homes where care like that in assisted living facilities is provided; however, the question is whether social workers will be allowed to work in these homes. Given the current norm of one social worker per 150 residents, it is highly probable that the legislature will not provide for social workers in these homes, nor will it provide for a social care model.

It can be concluded that the LTC Act promotes the medical model of nursing homes and ignores the specificity of social orientation and the development of community forms of care in which social work has its place. This makes the role of social workers in the homes unclear. From the perspective of supporting deinstitutionalisation and developing innovation in care for older people, the LTC Act's regulation of homes represents a backlash for innovative, community-based and social forms of care, as it has been the profession of social work that has initiated most of the innovations so far (Mali *et al.*, 2018).

Cash-for-care benefit: towards a marketisation of care

Although the LTC Act defines care for older people as a public concern, to be guided by the principle of universality, what is important is not only the extent to which the state takes over the responsibility for care, but also the form in which it carries out its responsibility. Meagher and Szebehely (2013) showed that the neoliberal restructuring of the universalistic welfare state involves processes of marketisation, i.e. a turn towards markets as the source of welfare instead of the state. They argue that these processes typically involve the implementation of cash-for-care models in the public care system.

Studies observe many controversial effects of the cash-for-care policy mechanism (Ungerson and Yeandle, 2007). Depending on how cash payments are regulated, they can have different effects on the formal–informal division of care and on its (de)familisation (Macdonald, 2021). The rules range from cash benefits paid to the user with no control over whether the money is spent on care services at all (Austria, Czech Republic, Germany, Italy), to the market or family carer signing a formal employment contract with either the user (France and the Netherlands) or with the municipality (Sweden) (Da Roit and Le Bihan, 2010; Da Roit, 2010).

Although it is recognised that, overall, the emphasis of cash-for-care benefit reinforces family obligations to provide care, when strictly regulated, the use of cash benefits may encourage a formal care market and the complementary use of formal care services. On the other hand, research shows that favouring unregulated cash-for-care benefit promotes the development of a particular form of home-based, often 24/7, low-paid, precarious, and commodified care accessed privately through informal care markets, including migrant care work (Williams, 2011; Van Hooren, 2014). Alternatively, unregulated cash-for-care benefit which permits payment of relatives may also create ‘incentive traps’, where family carers, often women, are encouraged to take over care work (León, 2014). In both cases, cash-for-care enlarges the pool of care labour at very low cost, because it enables the state to reduce the employment and organisational costs by shifting them to the users or their families. Hybridisation of work and care, as well as deprofessionalisation, are two further controversies, as distinctions between formal and informal, paid and unpaid, skilled and unskilled care are becoming increasingly blurred in cash-for-care schemes (Macdonald, 2021).

Like in most Eastern European countries, cash-for-care benefit is a novelty in the Slovenian system of care for older people and contains all the above-mentioned controversies. The LTC Act does not specify how the cash-for-care benefit is to be used, but only provides for monitoring its use with periodic visits by the LTC coordinator (LTC Act, 2021: Art. 43 and 66). However, monitoring is intended only to check the adequacy of care, while it does not involve the protection of care workers who provide care through the social security systems and employment law. The cash benefit can be used to pay a family member, or to buy services on the grey or formal market, or not be used at all if unpaid care can be obtained. Such regulation sets the conditions for the informalisation and familisation of care, or, alternatively, the precarisation of care in the irregular market.

The Slovenian cash benefit is also controversial from the perspective of the principle of equality laid down in the Act stipulating equal access and quality of services for equal needs. Namely, its value is only 38% of the value of in-kind public and formal home-based or residential care services (compared to, for example, Germany, where cash benefit reaches approximately 70% of in-kind services (Zigante, 2018)). On the one hand, the legislator claims that the Act eliminates inequalities in care between diverse care arrangements and makes it possible for those who want to stay at home to do so. On the other hand, it explicitly allocates less resources to those who prefer home-based private care arrangements. The low value of cash benefit indicates a devaluation of care work provided within the privacy of the family domain and stimulates its use to purchase cheap services in the irregular market, where care workers compensate with their precarity for the low price of services compared to formal markets or public services.

While one might guess that the intention of the legislator in setting up the low value of cash benefit is to discourage its use and encourage instead the take-up of formal, public, in-kind services, Article 34 raises doubts about this. Article 34 stipulates that even if a user chooses formal home-based or residential care services, but they are not available in the public network, a cash benefit shall be granted as compensation. In the context of the existing shortage of public services and the state's vague commitments to expanding the public network, this lays the ground for transforming cash benefit from a 'free choice' into a 'forced choice'. There is a risk that a large share of users will have no other option than to settle for a low cash benefit and organise the needed care privately, either within the family or on the (grey) market, due to the lack of public services. In this way, the state in effect establishes a legal basis for not expanding the existing public network despite increasing demand. Given the low value of cash benefit compared to co-financing formal home-based or residential services in the public network, this could indeed provide for cost containment in LTC. The key danger of the cash-for-care benefit mechanism as set out in the Act is that it effectively opens the door to informal, low-paid, family, or (grey) market care, expansion of precarious forms of care work, pressure to lower wages, and the deprofessionalisation and informalisation of care work. Given that informal and formal care work is feminised, it will be mostly women who will bear the effects of these potentially negative developments.

Family carer: towards the familisation of care

The concept of defamilisation reveals the contradictions of the service of family carer as regulated in the LTC Act. The concept closely relates to the welfare state, specifically to the *care regime* established in a particular cultural and social framework according to historically constructed gender order (Connell, 1987). It is used as an analytical tool to study social policies, more specifically the arrangements of care in the context of relations between state, market, and the family (Hobson *et al.*, 2002; Bettio and Plantenga, 2004). These relations are built on an ideological assumption of what care is, how it should be organised, and who should manage it (Sevenhuijsen, 1998). Despite the change in employment patterns towards greater involvement of women in paid work, equality policies, and the involvement of men in caring responsibilities in Europe, there is a growing tendency for current care regimes to be based on women's unpaid or paid but precarious work (Hrženjak, 2010; Daly 2001). This points to re-familisation policies that are based on the expectation that women will respect the traditional caring roles assigned to them in the past, which reinforces gender inequalities (Rune *et al.*, 2015). The family carer can also be understood in the context of the right to care, but we argue that in Slovenia the intention was merely the reduction of state responsibilities and costs for care.

Domestication policies (Allen, 2012) are a response to the care deficit that began to emerge in Slovenia in the late 1990s and early 2000s. The lack of space in homes for older people, combined with a weak network of home-based care or other more innovative forms of care, has led to the idea that the family should take on the bulk of care, with the state stepping in only when the family cannot, for legitimate reasons, shoulder the burden. The most visible measure of this policy was the introduction of the service of the family assistant, which was enacted through disability care in 2004 by the Social Assistance Act (hereafter SAA). In the adopted LTC Act this service was expanded under the modified name family carer to also include care for older people (LTC Act, 2021: Art. 19 to 30).

The service of family assistant was primarily intended for persons with disabilities who believe that institutions cannot offer adequate intimacy, individuality, solidarity, homeliness, and conviviality (OHCHR, 2022). The family assistant was a service provided by a family member or other person that permanently resided with a disabled person. A person can become a family assistant if she/he has left employment with the intention of becoming a carer or is a part-time employed person for the same purpose (Act Amending the Social Assistance Act, 39/2016). The service is paid primarily by the municipality as partial payment for lost income, and amounts to below the minimum wage (751.77 euros per month in 2022, that is around 522 euros net per month (MoLFSA, 2022a)), but family members, including the disabled person, must remunerate the costs according to their income or property ownership (MoLFSA, 2022b). The family assistant must contribute to the adequate care or appropriate satisfaction of the needs of the person with disability by carrying out the tasks of personal care, medical care, social care, and domestic help (European Commission, 2021).

The SAA is gender-neutral, which is in line with the declared gender equality legislation in Slovenia. But in practice, in 2016 there were 166 male and 711 female family assistants (Leskošek, 2016). Their number has declined in recent years, with only 429 family assistants in 2022 (MoLFSA, 2022a), not least because of the precarity of the status. The most obvious effect of the family assistant status is the impoverishment resulting from low income, which is further reduced because family assistants cover the costs of the person they care for, such as transport, additional physiotherapy, medical devices, special diets, and leisure activities. Family assistants are also likely to experience poverty in old age because they will receive a low pension. The exclusion from the paid labour market is a measure of female domestication and the most obvious reflection of familisation policies. It is also irrational in the context in which the employment of both partners is important for the survival of families (Leskošek, 2016).

The service of family assistant was problematised in academia and in public discussion based on an empirical study that pointed to the multiple precarisation of family assistants (Leskošek, 2016). The study showed that due to being poorly paid, the status often leads to the pauperisation of the carer. Due to exemption from labour rights, such as paid leave, sick leave, and defined working time, the status often results in work overload and social isolation. The study pointed to its gendered and class controversy too, as mainly low-income women exit the labour market and take over the status of family carer (Leskošek, 2016; Hrženjak, 2017). Despite that, in the new LTC Act, the service of family assistant has been extended to the care of older people under the amended name of family carer. Some positive developments can be noted. The partial payment for lost income will increase to 1.2 times the minimum wage, which will be paid from the newly introduced compulsory LTC insurance. An annual leave of 21 days is guaranteed, during which the care recipient is provided with institutional care. Under the LTC Act, the family carer is also entitled to unemployment insurance benefits in case of lost status.

However, a close reading of the Act also shows several controversies. The Act stipulates that only persons in categories 4 and 5 of LTC beneficiaries, i.e. those who are no longer able to care for themselves and are totally dependent on the care of others, have the right to a family carer (LTC Act, 2021: Art. 12). This provision seems irrational, as care for the most dependent care receivers is physically and mentally exhausting for carers, and it also demands professional skills. Family carers will have to attend 30 hours of training, and 20 hours of refresher training every five years, and the process of their professionalisation should be supervised by the coordinator of the long-term care who is also in charge of making the care plan. Family assistants will also have to keep a care diary recording all daily services, observed changes, and peculiarities in care and the way in which they manage them. This can be seen as a quasi-professionalisation reinforced by the Act as well as an additional bureaucratic burden for carers. The basic intention of the legislator is to merge or meliorate the family care with institutional rules and institutional standards and norms, as this is needed to justify public spending. All public spending has to be controlled and objectified to be seen as just and rational.

We can conclude that the service of family carer enables cost containment because it is much cheaper than the potential cost of care for the most dependent in formal care settings. Family carers are thus becoming part of the market of services and are normalised in the system because they are proving to be the most cost-effective version of care. The care provided by the family is institutionalised with the new LTC Act and becomes part of a system which is increasingly marketed and monetised. What matters is cost-effectiveness regardless of gender equality and personal consequences for carers themselves.

Conclusion

In this chapter, we have shown how care for older people has been politicised and gendered within the framework of 20-year-long processes of policy regulation of LTC in Slovenia. Gendered consequences of policies for the care of older people are closely linked to the issues of deinstitutionalisation, defamilisation, formal/informal care, public/private provision, provision of services/cash benefits, and working conditions in care. We point out that the legislator recognises these connections at the level of the Act's preliminary assessment; however, it does not translate this recognition into concrete policy measures. Moreover, the LTC Act formulates concrete policy solutions in a way that is controversial in relation to the principles of deinstitutionalisation, defamilisation, and the establishment of a formal, public network of services and, at the same time, raises several new dilemmas.

Concerning deinstitutionalisation, we argue that the Act does not promote innovative forms of care that homes for older people have used in the past to demonstrate the potential for the development of community-based LTC. The LCT Act itself does not contain specific provisions for the development of community-based care, which calls into question the prospects for realising the deinstitutionalisation of LTC for older people and the further development of community-based forms of assistance previously referred to as home-based care. The introduction of the low and uncontrolled cash-for-care benefit opens the door to informal, low-paid, family, or (grey) market care, expansion of precarious forms of care work, pressure to lower wages, and the deprofessionalisation and informalisation of care work. The service of family carer, while recognising the right to care, simultaneously contributes to gender inequality in care and to the domestication of women. Introducing defeminisation measures and improving working conditions in care, support for social innovation in care homes for older people, and expanding the public network of home-based formal care services as an alternative to institutional, family, and informal care are largely absent from the politicising and gendering of the LTC Act.

We see one of the reasons for such a situation in the tensions and contradictions that are inherent to each form of organisation of care, which represents an arena where the conflicting aspirations of different actors collide. To name but a few of these aspirations: older people's right to quality and plural care, care workers' demands for good working conditions, the state's intention to contain costs, and women's claims to justice in sharing care burdens. This turns the principles of deinstitutionalisation, defamilisation, and public services into potentially mutually controversial and contradicting trends. Deinstitutionalisation may strengthen the role of the family and informal care, as states tend to reduce the costs of care. Instead of providing public and formal services, they offer cash benefits, which may stimulate irregular care markets and migrant care. The states may outsource the services to private non-profit or for-profit providers chosen through competitive tendering, thus creating a quasi-market which puts downward pressure on wages etc. (Ungerson and Yeandle, 2007; Macdonald, 2021). The first step towards resolving inherent contradictions in the organisation of care is precisely to politicise them, i.e. to openly discuss them in a broad public debate.

Notes

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1 Municipalities subsidise the service to a very different extent. The analysis by the Social Protection Institute of the Republic of Slovenia (2020) shows that subsidies are highest in the rich municipalities and lowest in the poor ones. This results in inequalities and in re-familisation of care in poor households, as women take over the care when the family is not able to pay for it. Consequently, women from low-income families are more burdened with care responsibilities, which is also a class issue.

2 The LTC Act also introduces a modest co-funding of e-care for beneficiaries living at home and, for all beneficiaries, co-funding of services to strengthen and

maintain independence within their respective eligibility category (Article 16), but these services are outside the scope of our analysis.

3 Paradoxically, in Slovenia institutional care also ensures deinstitutionalisation, as homes for older people also provide community services such as home care, day-care, respite care, etc. (Mali, 2019).

4 Deinstitutionalisation is obviously a political struggle in which private institutional development is very strongly supported.

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7

Older people's care in Croatia: Struggles between public and private sectors

Jelena Matančević and Danijel Baturina

Introduction

The shift from industrial to post-industrial societies, changes in employment towards more unstable employment patterns, and decreasing capacities of families to provide care, coupled with demographic challenges that come from the ageing of European societies, have put the future of personal social services at the heart of social policy debates. Care for dependent older people is conceived as a new social risk (Bonoli, 2006) and a rising issue for contemporary welfare states (Greve, 2017). Pressures for reducing welfare state spending, expectations from the service's quality (and size), and the use of new technologies have become challenges for organising and financing formal care (Greve, 2017). Older people's care as a social policy concern can be viewed as a part of the broader concept of long-term care (LTC). According to Pavolini and Ranci (2013), it is one of the most rapidly developing policy areas in Europe, with significant institutional change and innovation, testing the innovative capacities of the European welfare systems.

The needs for older people's care are pressing, and the capacities of the state and public providers to meet them have become insufficient. Therefore, the question of shared responsibility between the state, market, and the third sector (non-profit organisations) in the framework of welfare mix (or welfare pluralism) has been central in many scholarly works, notably since the 1990s – see, for example, Evers (1993). Also, some suggest public policy debates on older people's care emerged in the 1990s as a response to the 'care deficit' (Pavolini and Ranci, 2013).

Countries in the region share a socialist legacy of a relatively strong focus on policies aimed at facilitating women's employment and providing, during socialist times, significant state support for families (Hrast and Dobrotić, 2022). Social policy in post-socialist countries has been shaped by a combination of Bismarckian tradition, neoliberal influences, and often lower levels of social spending and scope of rights as well as familialism in care arrangements (Kuitto, 2016; Stambolieva, 2016). However, it is difficult to establish which welfare models they adhere to. Most likely, they do not embody any specifically Western models and have 'hybrid' or 'mixed' characteristics of Central and Eastern European (hereafter CEE) welfare regimes (Kuitto, 2016).

The Croatian welfare state best fits the definition of hybrid welfare regimes, comprising attributes of the continental model of social insurance, the communist legacy, and recent privatisation processes, individualisation, and clientelism. The earliest schemes of Bismarckian provenance and limited scope gradually extended to different social risks and categories of workers in the socialist period, when some universal rights were introduced (e.g. in education and health care). Social infrastructure was built (e.g. establishment of centres for social work and employment offices), and during that time, progressive and rather liberal reproductive rights and family policy instruments were developed (Puljiz, 2008). The present condition of the welfare state is characterised by low social spending, constant reform attempts (especially of the pension and health system) (Bežovan *et al.*, 2019), and underdeveloped social services (Matančević, 2014). Generally, social programmes for various vulnerable groups in Croatia focus on addressing 'old' social risks. The welfare state relies more on passive benefits and money transfers than on social investments in services, education, and programmes that could foster the social integration of vulnerable groups (Bežovan, 2019a).

On the other hand, when we look at the non-profit or third sector, post-socialist countries have a small non-profit sector in size and workforce, low levels of professionalisation within the sector, and the legacy of statism in social service provision (Salomon *et al.*, 2004; Salmon and Sokolowski, 2018). The 're-discovered' world of civil society and the third sector in Croatia coincided with society's broader political and economic transformation in the early 1990s. In the first half of the 1990s, the policy and sociocultural environments for third sector developments were somewhat unfavourable as legal and policy frameworks were not developed, and there were negative attitudes of the state towards civil society (Bežovan, 2008; Baturina *et al.*, 2019). In the past two decades, there has been a significant improvement in the legal and policy framework, with new laws regulating the sector's work and several supportive institutions and policies developed (Baturina *et al.*, 2019). However, the paternalistic attitude of the state actors towards the third sector (Matančević and Bežovan, 2013) is still relevant. The centralised and paternalistic state has over-regulated the development of services and social programmes. On the other hand, the development of local social programmes is not coordinated and well-planned (Stubbs and Zrinščak, 2012). Clientelism still plays a role in shaping the sector. This is especially the case in the social welfare domain, which is also related to the care for older people.

Looking specifically at older people's care and the position of older people in Croatian society, we may state that an intense process of population ageing characterises Croatia. According to Eurostat projections, the share of people over 65 will reach 27% in 2040, and the overall population drop will be significant, making the population's ageing the most striking socio-demographic trend in Croatia (Bežovan *et al.*, 2020). Older people in Croatia face multiple economic and social vulnerabilities (Baturina, 2021). Recent data show many functionally dependent persons (European Commission, 2015). In Croatia, 83.5% of people who need help with everyday activities are in the 50+ age group (Strmota, 2017). It is estimated that the number of people who depend on other people's help in their daily activities in Croatia will increase further (Bađun, 2019).

Overall, it is not surprising that there is a noticeable trend of increasing demand for social care services for older people (both institutional and non-institutional), which is influenced by the ageing of the population. Researchers suggest the inadequacy of social care for the elderly (Dobrotić, 2016; Babić, 2018). However, long-term care issues are not on the agenda of public political debates (Bađun, 2019). The European Commission (2016) assesses that Croatia's LTC is characterised by almost exclusive informal care orientation and low formal care accessibility.

At present, social care service delivery, including home care, is based on the 'welfare mix' principle. Unmet and growing needs concerning older people's care and limited state capacities for care provision have opened space for private (profit and non-profit) initiatives in service provision.[1]

This chapter overviews the current policy and institutional changes and developments in older care in Croatia. The Croatian social care system, with care services for older people being a hallmark of those processes, has been characterised by the growing demand for services, privatisation, marketisation, and deinstitutionalisation, i.e. the shift from institutional to community-based social services (Matančević, 2014; Šućur, 2019). The chapter specifically focuses on the role of the private not-for-profit and profit sector in providing care for older people and their relations with the government and public service providers. The chapter uses the welfare mix as a conceptual and theoretical framework. The welfare mix is a system in which the government, local government, civil society organisations (third sector), companies (profit sector), family (informal sector), and other stakeholders act in place of the state's position as the main provider of the services (Evers, 1995; Bežovan, 2008). In addition, the welfare mix emphasises the pluralisation, not only of service providers but also their regulation and financing.

After presenting dynamics and changes related to the regulation of care for older people (with a particular focus on the legislative framework regulating private social services providers), the characteristics of the welfare mix model are explored from two key aspects: *financing* (changes in responsibility for financing services, trends of marketisation, the structure of financing – state subsidies vs. out-of-pocket, etc.), and *service provision* (trends regarding the composition of providers: state – profit – non-profit, changes in types of services, deinstitutionalisation, quality of services, etc.). Finally, the results of the analysis will be put in the broader context of the dynamics of the welfare state in Croatia.

Characteristics of care for older people in Croatia

Croatia is characterised by early public intervention in the field of care for older people, where a more comprehensive policy framework started to develop in the mid-twentieth century (Dobrotić, 2016). During the later socialist period, older people's care became more formalised, with a dominant role of the state; however, the formal care system remained rather residual as a part of overall social programmes and on the margins of the social policy agenda (Dobrotić and Zrinščak, 2022). According to the same authors, changes that followed the 1990s, after the dissolution of the communist regime, were not accompanied by reforms concerning the care for older people (such as in the pension system). However, the older adults' care system continued to operate on the foundations built in the communist period. Moreover, a neo-conservative agenda in the 1990s weakened the defamilialising potential of policies inherited from the socialist period, leaving care predominantly to the family (women) (Dobrotić and Zrinščak, 2022).

At present, older people's care services in Croatia are primarily regulated by the Act on Social Care, which was first introduced in 1997. It reaffirmed the principle of subsidiarity in the social care system and, importantly, opened the space for greater decentralisation of service provision, welfare pluralism, and private initiative in social service provision. This change was based on the premise that non-state actors' involvement in care provision will relieve the state of the growing social costs of institutional care (Balaband, according to Dobrotić and Zrinščak, 2022). Accordingly, as well as the central government, the regional and local government could also provide certain institutional and community services, religious organisations, associations, and other profit and non-profit organisations, and individual professionals (Šućur, 2019). It can be said that older people's care services are one of the most prominent areas of welfare mix development in Croatia; as Jurčević (2005) noted, the greatest interest of private service providers after the Act on social care was adopted was directed towards opening private residential homes for older people.

In 2001, ownership of public homes for older people was decentralised from the national to the regional (county) government. Žganec *et al.* (2007) stated that already in the 2000s there was a certain diversification of care services for older people, both in terms of providers and types of services, examples of which were the opening of day-care centres for older people, the so-called gerontological centres, and organising help and care services at home, which brought institutional fragmentation of elderly care regulation and provision (Dobrotić, 2016).

Generally, the older people's care system in Croatia is underfinanced, underdeveloped, and fragmented between the social and health care sectors, as well as between different levels of government (Bežovan *et al.*, 2020), with services remaining on the margins of the social policy agenda (Dobrotić and Zrinšćak, 2022).

In order to illustrate those changing dynamics between different sectors and their impact on services, after presenting current social policy measures aimed at older adults, the text that follows focuses specifically on institutional care services for older people and analyses welfare mix arrangements in financing and service delivery.

Social policy measures aimed at older people

In a broader sense, the current formal support system for older adults in Croatia generally consists of different income support and services programmes. Recently, there were policy attempts to introduce the status of informal caregiver to older adults;[2] however, this right has yet to be introduced (Vlada RH, 2021).

Alongside the work-related old age pension scheme in 2020, the government adopted the Act on National Benefit for the Older People (in force since the beginning of 2021), a scheme of income support aimed at older adults (65+) who do not meet requirements for work-related pensions. Other income support and services programmes are mainly regulated by the Act on social care (OG 18/22, 46/22, 119/22). Income support schemes include general social assistance benefits, which are mostly income/means tested (such as guaranteed minimum income, housing allowance, personal disability benefit, one-time benefit, and benefits for personal needs of beneficiaries in residential care), and those targeted at older persons (and other dependent persons), namely, allowance for assistance and care, which is based on the principles of income and needs testing.

Social services for older people include institutional care in residential homes or care in a foster family and other out-of-family services such as daily care, supported housing, or in-home services (home care).

Residential homes for older people can be public (founded by the regional government) or private (founded by private persons on a not-for-profit basis). However, care services for older people can be provided in other less institutionalised organisational settings, run by associations, for-profit entities, or physical persons. Public and private non-profit residential homes imply higher organisational, professional, and physical prerequisites than elderly care settings.

In 2019, around 10% of the older population (aged 65+) were recipients of the social rights envisaged by the Act on Social Care. Social assistance (called 'guaranteed minimal income') was used by 1% of older adults, 5.9% were users of the allowance for assistance and care, 1.3% were users of the personal disability benefit, 0.5% received in-home care, and 1% were using residential care in homes for the elderly[3] (Vlada RH, 2021).

Financing

In 2016, Croatia's overall spending on LTC was approximately 0.9% of GDP, which was below the EU average (1.6% of GDP) (Bežovan *et al.*, 2020). Concerning the structure of LTC spending, Croatia had a higher share of cash benefits (50%) in comparison to the EU average (15.6%), while 47.4% was allocated to institutional care and only 2.6% to home care services, which was the lowest spending on home care in the EU (Bežovan *et al.*, 2020).

The financing of older people's care services relies on mixed financing from public sources (state budget) and private sources (out-of-pocket). Public institutional care (older people's homes), dominantly owned by the regional government, is subsidised by the state, and the prices are set below the total economic price (Stubbs and Zrinščak, 2018). This means the government covers the cost of subsidies for all beneficiaries in public homes, regardless of their purchasing power, which results in an 'advantageous' position of public homes in the institutional care system. Consequently, accessibility and affordability of services differ between private and public service providers, where the cost of services for users in private homes can be twice as high. Moreover, whereas beneficiaries in public institutions are paying subsidised prices, those in private institutions are paying market prices (Bađun, 2017; Šućur, 2019; Bežovan *et al.*, 2020). Alongside the state budget, costs for vulnerable groups are covered based on the administrative procedures and decisions of centres for social care.[4] These costs can be paid for users in public homes, but also in private ones, based on the practice of social contracting (the respective ministry contracts private service providers, sets prices, and covers costs for several users) (Šućur, 2019; Bežovan *et al.*, 2020).

Therefore, the financing of the LTC system in Croatia is a rather complex system with blurred roles and inequality between public and private service providers, a lack of transparency, and a bad practice of social contracting between the government and private providers, resulting in territorial inequalities in access to services and significant price differences between services provided in public and private older people's homes (Matančević, 2014). It also challenges the principle of the needs test, keeping in mind that the centre refers only 20% of service users in public institutional care for social care (based on needs and income testing) (Stubbs and Zrinščak, 2018; Šućur, 2019).

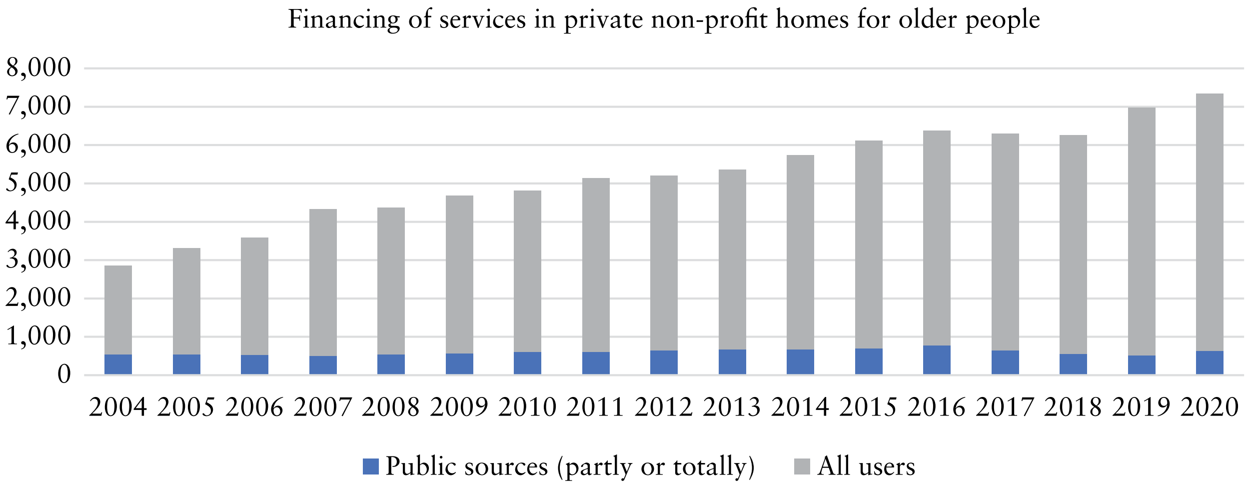
The other significant characteristic of the care system for older people in Croatia is marketisation. Parallel to the trend of privatisation, i.e. the increase in the number of private non-profit older people's homes, there has been a trend of increase in the number of service users who pay for their service, in contrast to those users whose service is (fully or partially) paid from the state budget. While in 2004, 23% of service users in private non-profit homes for older people were subsidised by the state, in 2020, only 9.5% of service users were subsidised. In contrast, the vast majority of users paid the total price of the service (Graph 7.1).

Service provision

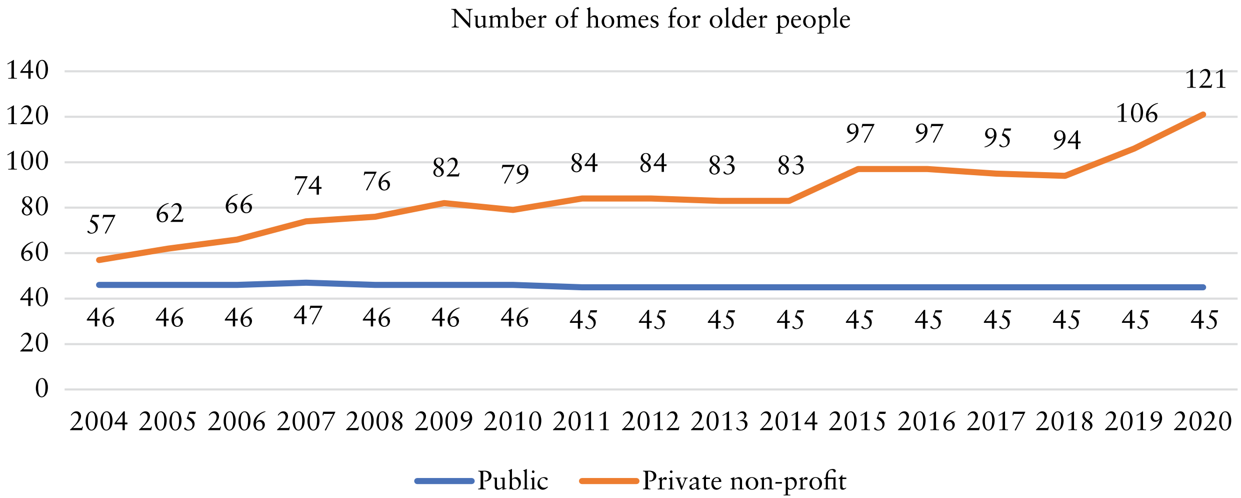
Due to the growing and unmet needs of older people's care and limited capacities in public institutional care, the Croatian social care system is characterised by an intense privatisation trend. As a result, since 2000, there has been a strong growth of private homes for older people founded by private persons and religious or humanitarian organisations or associations (Šućur, 2019).

For illustration, during 2003–2015, the capacities of public institutional care increased by 10%, whereas the capacities of private institutional care more than doubled (Šućur, 2019). In the early 2000s, private homes for older people already outnumbered public ones. In 2005, private non-profit homes constituted 57% of the total number of homes for older people, while in 2020, already 73% of homes for older people were private non-profit (Graph 7.2)

As one of the priority goals of the development of the social care system, the government of the Republic of Croatia has emphasised stopping the trend of institutionalisation and implementing deinstitutionalisation and



Graph 7.1 Financing of services in private non-profit homes for older people in Croatia

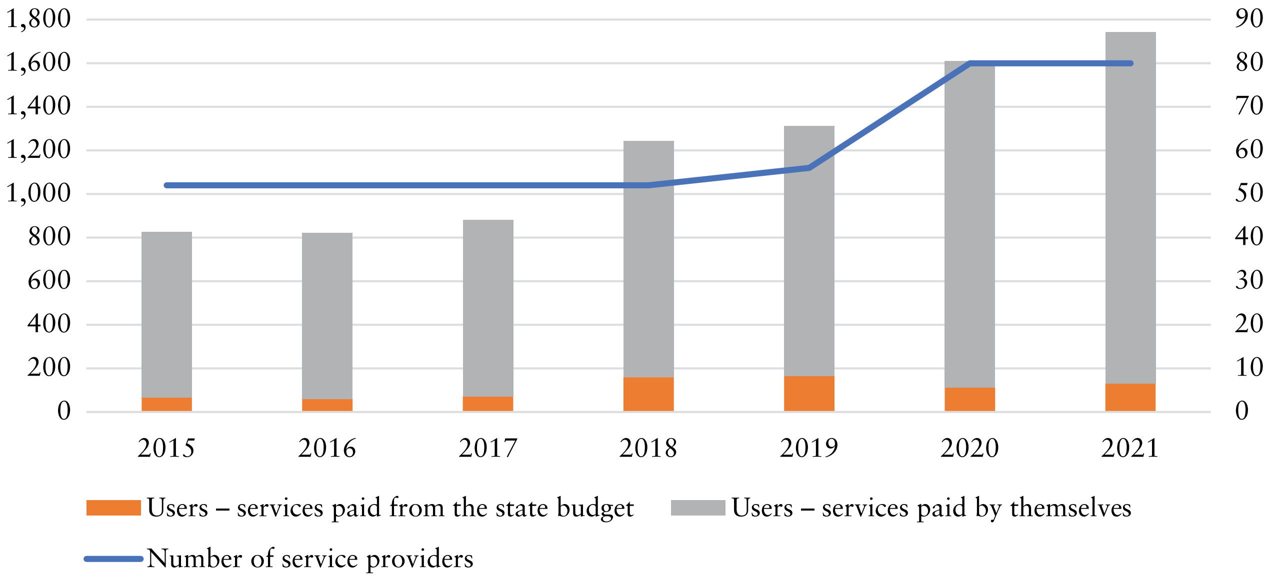


Graph 7.2 Number of homes for older people in Croatia

transformation of homes for older people and other legal entities (Jedvaj *et al.*, 2014). After the decentralisation process, almost no new public homes were opened in Croatia (Babić, 2018).

Similar trends of privatisation and marketisation (shifting the responsibility for the financing of the services to service users or family members) are noticeable when examining out-of-home care services for older people provided by other private service providers (e.g. associations, religious organisations, for-profit organisations) (Graph 7.3). Whereas in 2015, there were 52 such service providers in Croatia, in 2021, there were 80 providers. There has also been a significant increase in the number of service users cared for by such private service providers; in 2021, the number of service users more than doubled. The share of service users whose service was paid (in total or partly) from the state budget was around 8% throughout the observed period, while most of them paid for the service themselves (or it was paid for by other family members).

When it comes to home care services, they are the least developed and most fragmented part of the LTC system in Croatia (Stubbs and Zrinščak, 2018; Bežovan et al., 2020). Knezić and Opačić (2021) found that existing home care services are insufficient to meet the needs of citizens. The development of home care services reveals several problems: (lack of) continuity, parallelism in programmes, and financing. The Act on social care encompasses home care services (named 'home assistance') for frail older adults or disabled persons. Additionally, since 2000, there have been several parallel home care programmes where the provision is decentralised to the local government (usually contracted on a project basis), resulting in varying capacities to organise the service and significant differences in users' coverage. For example, at the end of the 2000s, the home care service was organised by the former Ministry of Family, War Veterans, and Inter-Generational Solidarity as projects in cooperation with local governments (Stubbs and Zrinščak, 2018). A more recent example is the 'Wish for – Women's Employment Programme', launched in 2017 and funded by the European Social Fund. It is intended for the employment of disadvantaged women to work on support and care for the disadvantaged older people in their communities, with a special focus on rural and remote areas. The local government or associations administer the programme at decentralised levels in cooperation with other local stakeholders. While the programme has improved the supply of care services for older people, especially in rural areas, it is problematic, from the gender perspective, in pushing long-term unemployed women exclusively towards the precarious and undervalued care sector (Dobrotić and Zrinščak, 2022).



Graph 7.3 Other private (non-state) service providers for older people's care in Croatia

Discussion

Older people's care and growing needs in that field are pressing issues that all welfare states will need to address now and in the future. However, policy and institutional change differ among countries, ranging from abrupt change to incremental innovation or continuity and mere adaptation to previous solutions (Pavolini and Ranci, 2013). In the CEE region, public social services play only a marginal role and, to a great extent, are either transposed to market-based solutions or back to the responsibilities of families (Kuitto, 2016).

The need for changes in the older people's care and services system in Croatia is evident. For example, Dobrotić (2016) emphasises that the absence of a clear state policy and coordination leads to a 'blurred' network of services. Even the Ministry of Demography, Family, Youth and Social Policy[5] (2018) cites the problem of the availability of services for older people and underdeveloped community services, especially regarding in-home care and day-care services. On the other hand, the necessity for long-term care is not recognised. As a result, the long-term care system faces several challenges, such as fragmentation, which leads to inefficiency (Bađun, 2019).

Older people's care has become the object of political debate, and, in the process, it has been actively politicised (Dahl, 2017). The older people's care system has not received adequate attention from policy-makers (Bežovan, 1998; Dobrotić, 2016), so it can be argued that some aspects of depoliticisation are in place in the Croatian context. For example, Kekez (2018) found that institutional care for older people, deeply embedded in the traditional social care system, is marked by formalism and the domination of experts and thus is more resistant to reforms and politicisation. In contrast, in-home care services have been less standardised and professionalised, with a minimal institutional framework, and thus more prone to political control over service provision and clientelist practices in which political actors (especially at local levels) politicised the reform process.

We can discuss aspects of politicisation from different perspectives, comparing politicisation via policy and public discourse lenses. First, looking at policy changes in the last two decades normatively, the government is currently orientated towards developing services for older people to keep them in their homes via the development of community-based services (Ministry of Labour, Pension System, Family and Social Policy, 2021). These changes followed previous ones in which pluralisation of providers was introduced in a partly neoliberal perspective, with the rationale of private service providers relieving the state from the high cost of residential care (Dobrotić, 2016; Dobrotić and Zrinščak, 2022).

Politicisation can be seen in the welfare mix aspect as different modes of governance, as a process through which something is added (such as responsibility or agency) (Flinders and Buller, 2006). The non-state actors in Croatia were given a new agency and the opportunity to be important stakeholders in the care of older people. It was shown (Poškutė *et al.*, 2021) that having well-coordinated efforts among different actors from different sectors is often a prerequisite that can satisfy the increasing demand for care and ensure system efficiency. However, there are several challenges to implementing the welfare mix principle. Previous research shows that Croatia's LTC system is underdeveloped, with little or no coordination of separate systems: social welfare, health, and war veterans (Stubbs and Zrinščak, 2018). Against the background of the welfare mix principle, the system is characterised by the lack of coordination and cooperation between different levels and stakeholders (national, county, and local administration, public and private – profit and non-profit – service providers) (Bežovan, 2010; Matančević, 2014; Stubbs and Zrinščak, 2018; Bežovan *et al.*, 2020).

Services for beneficiaries are largely subsidised, and the government is not prepared to introduce economic prices for those services. In such circumstances, public homes have a kind of 'monopolistic' position, which means that private providers cannot compete with them (Bežovan *et al.*, 2020).[6] However, it seems that there is a lack of political will to improve the financial framework for institutional care for older people, which at present puts citizens in an unequal position and results in the problem of affordability of institutional care for many older people.

In addition, the system of financing institutional care is found to be clientelist and discriminatory towards service users. Despite several attempts to deliver a unified methodology for calculating costs and users' fees in institutional older people's care, such documents have never been adopted. Therefore, the access to institutional older people's care does not support the principle of social citizenship as there is no equal access to social rights, which is an important pillar of Croatia being a welfare state as proclaimed by the Constitution (Republic of Croatia, 1990).

Also, the use of EU funds shows a 'patch' pattern, as EU resources are often used to patch the welfare state's weakened ability to respond to growing social pressures. EU funds are part of the perspective on the Europeanisation process, and their usage is a political issue in Croatia (Baturina *et al.*, 2019; Bežovan, 2019a; Hrast and Dobrotić, 2022).

From the public discourse perspective, the question is posed as to whether care for older people is defined and discussed as a 'political problem' or 'political concern'. Politicisation was maybe an issue of the standards of provision of services (in case of unfortunate accidents in private homes[7]) or sometimes regarding the topic of violence towards older people (Baturina, 2021). However, there is a general lack of politicisation of this topic, especially from older people as agents of political mobilisation. Older people have some political power. For example, the Croatian Party of Pensioners is a widely recognised party with experience in participating in government coalitions, and there is also the National Pensioners' Convention of Croatia with a broad base of members.[8] However, they are mainly mobilised around issues related to the financial position of older people or pension reform.[9]

The care system for older people is not only inherently political, but also gendered (Daly and Lewis, 2000). For example, the SHARE study shows that across Europe, women are more likely to care for family members (Bethmann *et al.*, 2022). In Croatia, this is notably the case. We can mainly reflect on the services provided in families and communities. Research (Klasnić, 2017) shows levels of gender inequality in doing housework and caring for the family, in which women, in a large number of cases, are involved in care more than men.[10] In addition, previous research (Kamenov and Jugović, 2011) indicates that an unequal division of responsibilities between women and men characterises family relations. Looking longitudinally, Leinert Novosel finds that in the private sphere, 'in home', there is stagnation, even deterioration of the woman's position in the family (Leinert Novosel, 2018). She even notes aspects of 'returning' patriarchal models of gender roles, especially those related to raising children and caring for older people, as well as household duties.

For care in institutions for older people, we do not have research on the gendered division of labour. Still, we can make a reasonable assumption that most of the carer staff are women as gender division is highlighted in the national statistics in the category of 'human health and social work activities' (in 2020, 79% of those employed were women) (Croatian Bureau of Statistics, 2021).[11] In addition, aspects of politicisation and gendering can be discussed in the implementation of the welfare mix model in the Croatian care system for older people.

Additionally, looking at the gender aspects of care from the welfare mix perspective, pluralisation of the provided services for older people has not changed the gender dynamic in care delivery. Reaffirming the traditional gender roles in providing care is maybe best demonstrated by the above-mentioned 'Wish for' programme. Therefore, the familial perspective of women's roles in care is still a mark of the development of the welfare mix in care for older people in Croatia.[12]

Regarding the process of gendering care, there is also a potential issue of feminised immigration in the context of care for older people. In the last several years, there has been a significant rise in foreign workers in Croatia. Most of them come from the former Yugoslavia countries and work in fields such as tourism and hospitality, industry, transport and communication, and agriculture and fishing.[13] There might be a growing trend of care workers, especially women, coming to Croatia (working in the formal or informal economy), but there is not sufficient data available on that issue.

How the 'struggle' between public and private subjects has been related to processes of politicisation could also be discussed from the broader view of the development of the welfare mix in Croatia as well as some trends of the welfare state.

Bežovan (1998) claims that the non-profit sector in Croatia was not part of the concept of social policy reform and the construction of a new social regime. The development of the third sector since the early 1990s was explained by the theory of demand for social services, i.e. needs that the state could not respond to.[14] Today third sector organisations still occupy a residual role in the social service system.[15] Third sector and public organisations providing social services do not enjoy equal financial and tax status treatment, which results in discrimination amongst service users (Baturina *et al.*, 2019). Therefore, the question arises as to what place and what role private non-profit and for-profit initiatives occupy in the welfare mix model. Research (Bežovan and Zrinščak, 2001; Bežovan and Zrinščak, 2007; Bežovan, 2010) identifies various obstacles to the development of a welfare mix. The research (Matančević, 2014) talks about some minor developments, but the main findings of the research point to the absence of a socio-political orientation towards strengthening the welfare mix model.[16] In the development of the welfare state, there is an overall system barrier in terms of a lack of strategic orientation towards the development of the model based on the welfare mix and pluralism of service providers (Bežovan, 2010). The COVID-19 pandemic has highlighted the vulnerabilities of older people even more. Insights from the pandemic show that civil society organisations proved flexible and able to respond quickly to emerging social needs, including those related to various vulnerable groups like older people (Baturina, 2022). However, these external shocks did not cause closer collaboration between the welfare state and the third sector in the field of care for older people. The issue of transformation of care for older people according to the principles of co-production and co-management (Pestoff and Brandsen, 2008) of social services remains open. The practice of co-management and co-governance based on more significant involvement of third sector organisations is still in its early phase in Croatia. Future development depends on policy improvements, but maybe even more so on the potential for democratisation and changes in the sociocultural environment (Bežovan *et al.*, 2019). The legacy of the paternalistic social policy is still visible, with low degrees of openness to change and innovations (Bežovan *et al.*, 2019; Baturina, 2019). The same applies to social entrepreneurship in general as a concept (Baturina and Babić, 2021), but also specifically in the field of care for older people.

Conclusion

The ageing of societies as a trend includes not only questions about the various social aspects of demographic changes but also cultural and social perceptions of the age structure of a given society and the basis for formulating social responses (Zrinščak and Lawrence, 2014). Older people's care has become the object of intense transformations related to the conditions of care, the expectations about how it should be provided, and the actors involved.

It is becoming increasingly clear that the welfare state alone does not have sufficient capacity to deal with the challenges of ensuring adequate and affordable care for older people and that it has turned to non-profit and other private actors for 'help'. The role of the third sector and other stakeholders within the welfare mix model depends, on the one hand, on the processes in their environment – state policies, governance, and regulatory system – and on the other hand, on the goals and strategies of their stakeholders (Svetlik, 1991; Evers and Laville, 2004). As such, the welfare mix model in older people's care negotiates and balances different forces.

From the politicisation point of view, there is a duality between policy developments and framing care for older people as a political issue in public discourse. The policy trend towards opening more space to private and non-profit actors in the welfare mix development is noted. In Croatia, the decentralisation of institutional care for older people was followed by the limited process of privatisation and pluralisation of this sector. Normatively, the government is orientated towards developing services for *older people* to keep them in their homes (Ministry of Labour, Pension System, Family and Social Policy, 2021). However, there is a lack of political capacity to address the changes in social structure with demographic trends and new social risks that are arising. On the other hand, depoliticisation of the topic of care can be noted in public discourse as it appears on the public agenda in discussions on the future of the welfare state or the position of older people in society.

In the context of post-socialist countries, as is the case in Croatia, there is a certain colonisation of the social sphere by the public and political sectors. This also shapes (welfare) state modernisation capacities. Finding a balance between the state and private sectors in the welfare mix model would be significant in addressing the care needs of older people. The welfare mix approach could lend a 'helping hand' as it could foster the political transformation of *older people's* care from a personal/familial issue to a proper social right in Croatia as an ageing society. A special focus could be put on degendering care work as there is currently a substantial status quo in perceiving it as a female profession, and there are noticeable patterns of unequal distribution of care work in families.

Notes

1 The care diamond, proposed by Razavi (2007), is also frequently used to analyse the role of the different stakeholders and to compare care arrangements in different countries. It considers different institutions involved in providing care in the form of a care diamond, including the family/household, markets, the public sector, and the not-for-profit sector. We will partly reflect on this throughout the chapter but give primacy to analysing the welfare mix model.

2 It was foreseen in the Social Care Strategy for the Elderly in the Republic of Croatia 2017–2020 (Vlada RH, 2017). As stated in the Strategy, the rationale behind introduction of the right to status of informal caregiver was the argument of insufficient capacities in residential care, which undermines the principle of equal rights in access to care (Vlada RH, 2017).

3 This only encompasses older people whose right to residential care in homes for the elderly was awarded by the centre for social care and excludes users who contracted their service directly and who pay out-of-pocket.

4 Based on income and needs test; for users with income below the service price. Cost of care is covered entirely by the state budget or partly, depending on the level of users' income.

5 Afterwards, it changed its name to 'Ministry of Labour, Pension System, and Family and Social Policy'.

6 Currently reform of the payment method for long-term accommodation services for older people who are placed in public homes is foreseen, which would introduce a unique financing model based on payment for the service performed (Ministry of Labour, Pension System, Family and Social Policy, 2021).

7 For example, see a mass-media article: www.index.hr/vijesti/clanak/inspekcija-dorhu-kazneno-prijavila-vlasnike-doma-u-kojem-su-izgorjeli-starci/2150832.aspx

8 They include 278,000 members. In total 359 organisations and over 811 pensioner branches and clubs from all municipalities, cities, and counties operate within it. See www.muh.hr/o-nama/about-us.

9 Bežovan (2019b) analyses public debates related to pension system reforms.

10 A Council of the European Union (2020) report noted that when looking at direct care (childcare and LTC), in Croatia the gender gap in time spent on care did change during 2005–2015.

11 The Ombudsman for Gender Equality (2022) warns on the examples of the different types of issues connected to gender segregation in the labour market. Moreover, most of the complaints they received were in the area of social security, including the area of social care.

12 The 'Wish program' was recently criticised from the perspective of the state's perception of the role of older women in the labour market. See: www.telegram.hr/politika-kriminal/vlada-ocito-misli-da-zene-starije-od-50-mogu-samo-posprematі-kuhati-cajeve-i-mijenjati-pelene-i-da-s-time-trebaju-biti-sretne/

13 Croatia issued residence and work permits for 124,121 foreign workers in 2022, which is 42,166 more permits than were issued and extended in 2021. Most of the workers come from Bosnia and Herzegovina and Serbia (followed by Nepal, North Macedonia, and Kosovo). More information can be found

at: https://lidermedia.hr/biznis-i-politika/rekordan-broj-stranih-dozvola-u-2022-najvise-iz-zemalja-u-okruzenju-i-nepalaca-148385

[14] The experiences of some other post-socialist countries show that the legacy of the former system, reflected in the dominance of the state, was slowly discarded and had far-reaching implications for the development and consolidation of the non-profit sector (Potuček, 2000; Rymsza and Zimmer, 2004). Recent analyses state that in post-socialist Central Europe the non-profits in welfare provision have not been able to maintain a secure independent role in the face of fluctuating government attitudes to their role and growing competition (Cox, 2020).

[15] Research also shows that private non-profit service providers have contributed to and made a certain impact on access to social services (Matančević, 2014).

[16] Path dependence is used as one of the key explanations for the characteristics of welfare mix, recognising the influence of sociocultural heritage, which is reflected in the dominant role of the state and distrust of the state, other stakeholders, and citizens in private initiatives in social services (Matančević, 2014).

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8

Caregiving for older adults in times of the COVID-19 pandemic in Serbia: A gendered perspective

Ljiljana Pantović, Bojana Radovanović and Adriana Zaharijević

Introduction

Care implies taking into account the voices of those cared for – apprehending their reality, understanding their needs and desires, and seeing to them (Noddings, 2013). Care is central to what makes us human, yet it is too often treated as a marginal part of existence (Tronto, 1993), as something consigned to the exigencies of life rather than having meaning and value in itself. Coupled with work, especially paid work, care merits even less importance. Not only are caregiving positions poorly paid and unprestigious, but the association of people with bodies lowers their value (Tronto, 1993). Furthermore, care seems to lose even what little worth it customarily has when it is linked with older people. This speaks volumes about the position of the older person in contemporary societies but also says something about those who give or provide care, as the burden of care often falls on the shoulders of those who are themselves marginalised and devalued (Tronto, 1987; Gerstel, 2000; Parreñas, 2000; Zimmerman, Litt, and Bose, 2006; Noddings, 2013; Hochschild, 2015).

Tronto suggests that any democratic politics needs to build on ethics of care, on values such as 'attentiveness, responsibility, nurturance, compassion, meeting others' needs – traditionally associated with women and traditionally excluded from public consideration' (Tronto, 1993: 2–3). In this chapter we show how the Serbian government *re-read* 'ethics of care' during the COVID-19 pandemic. Under the guise of care for 'grandpas and grandmas', the government enforced policies, measures, and protocols that severely impacted the already fragile system for the care of older adults in Serbia, at the same time creating a situation in which those older persons who were previously independent turned completely dependent, while those who were truly in need of care were unable to get it.

On the other hand, the underpaid, undervalued caregivers – the main subjects of this chapter – bore the greatest brunt of the pandemic-induced politicisation of care for older adults in Serbia. In this sense, we use the term *politicisation of care* to denote the situation when caring for older adults is either the direct object of public policies or is indirectly affected by the policies, and we approach it through policies introduced during the COVID-19 pandemic.

We first map the system of care in Serbia and introduce the relevant actors in the field, through analysis of the normative and public policy framework. We then focus on how the pandemic-driven public policies affected the frail and denigrated care system. In the last section, we present the findings of our exploratory empirical research based on ethnographic methods which included unstructured and structured interviews with both providers and beneficiaries of care. Our aim is to demonstrate the gendered aspects of care work which the pandemic, and the policies introduced to stop the spread of the virus, only made more overt.

Perišić and Pantelić (2021) showed that there are four types of care providers in Serbia: (1) informal caregivers in the household; (2) state-funded care (care homes and professional caregivers at home whose services are financed by the local municipalities); (3) market-based care (privately owned care homes, brokering agencies offering home care services by professional caregivers, and paid professional caregivers working in the grey economy); and (4) civil society (formal and informal civil society organisations providing care for older adults). In this research, our gaze was on the gendered aspects of paid care work provided at the intersections of the state and the market. In order to understand the specificities of paid care work in Serbia we will now turn to a brief discussion of its mixed social welfare system and crisis of care.

Socialist Yugoslavia created an inclusive welfare model (Radovanović, 2022). However, caring for older adults has never been a political priority:

> In contrast to the comprehensive public care for children, care for older persons in socialism complied much more than in the West with traditional cultural patterns of informal care in the form of intergenerational solidarity within family. (Hrženjak, 2019: 641)

After the wave of transitional reforms introduced in Serbia since the 2000s, the welfare model moved towards privatisation and pluralisation of service providers, widening the responsibilities of individuals and their families (Pantović, 2018, 2022). The result of these parallel processes is a mixed welfare system in which the state and the private (both for-profit and non-profit) sectors provide social welfare (Radovanović, 2019a, 2019b; Radovanović and Simeunović, 2020). The earlier concept of the state taking care of every individual from the beginning to the end of their life has been abandoned, based on the criticisms of state-paternalism, the inefficiency of such a model, and the belief that the individual is sovereign in deciding about their own life (Rašević and Mijatović, 2004). What was once considered as common good moved into the private domain (Radovanović and Prodanović, 2023). Almost overnight, older adults turned into sovereign and active 'decision-makers', whose sphere of decision in fact revolves around reliance on the support of their family members or seeking care services on the market. 'Active ageing' travelled to Serbia, mostly in its consumerist form, as part of the economic transition. In reality, however, the transformation of the labour market, together with low fertility rates and high migration of youth, led to 'a crisis of care with more older adults living alone that are not capable of taking care of themselves' (Antonijević, 2015: 407). The burden of care, more often than not, falls on women (Pantović and Zarić, 2022).

In Serbia, women are responsible for the majority of formal and informal caregiving (Babović, 2010). Compared to men, women spend twice as much time in informal care work, regardless of their employment status (SORS, 2020), and, on average, older women spend more time caring for others than younger women (Babović *et al.*, 2018). Older women are most often the informal care providers – following both the socialist pattern and early transition models – for their adult children, grandchildren, and other family members, especially spouses (Babović *et al.*, 2018).

To place this in a wider socio-economic context, the employment rate of women is 41.9%, which is lower than the employment rate of men (56.6%) (SORS, 2020). The inactivity rate for women is higher than for men (52.9% vs. 37.3%) (SORS, 2020). The largest gender gap considering inactivity occurs in the age group 55 and older, where the inactivity rate for women is 78.4% (SORS, 2020). 'The data leave the impression of a society in which the burden of caring for the family falls disproportionately on women, and, from a generational perspective, this burden falls most precisely on older women' (Babović, 2010: 47).

The same pattern is discernible in the sphere of paid care. Even before the pandemic, caregiving in Serbia has been described as a woman-specific concept (Babović *et al.*, 2018). The majority of those employed in public care homes are middle-aged to older women, between the ages of 40 and 60. The average nurse's salary in Serbia is quite low – in 2022, it was approximately 60,000 dinars (c. 500 euros) which is below the average salary of around 75,000 dinars (c. 600 euros). Like most other women in Serbia, when they finish their paid jobs, they are expected to start their 'second shift' and provide unpaid care at home. Some of the women we spoke to were already grandmothers, who told us how after work they would take care of their grandchildren.

Taking a closer look, care is not just gender-specific, but sits at an important intersection between gender, age, and class. Nurses and caregivers for older adults are in high demand in Serbia. However, their social status and remuneration do not correspond to this societal need, which is why most of them seek to migrate to Western Europe and work there, a trend noted in other parts of post-socialist Central and Eastern Europe as well (Carlson and Idvall, 2015; Bajt, Leskošek and Frelih, 2018; Bahna and Sekulová, 2019; Hrženjak, 2019). In search of financial stability, many skilled and unskilled caregivers from Serbia make use of the 90-day visa-free Schengen regime to travel to EU countries like Germany, Austria, or Italy. They provide paid care work in the informal economy (Hooren, 2014; Léon, 2014; Ambrosini, 2015; Lutz, 2016; Triandafyllidou and Marchetti, 2017). While in Serbia there are no studies to confirm it, it is logical to assume that due to the migration of skilled informal caregivers, or 'care drain' (Lutz and Palenga-Möllenbeck, 2012; Dumitru, 2014), there is a shortage of skilled caregivers at home.

Institutional and legal framework of care for older adults in Serbia

According to the official data, 21% of the population of Serbia are people over the age of 65, and the average age of the population is 43.4 years, while the retirement age for women is 63 (SORS, 2020). The monthly pension is on average 30,000 dinars (c. 250 euros), which is less than a minimum consumer basket, reduced to basic foodstuff. Even when the older population is mentioned in strategic documents as a vulnerable group, there are no action plans to improve the position of older persons or provide them with adequate support.

The Law on Social Protection (24/2011) is not only the most important document regarding the care of older adults, but it can also function as a template for the application of the notion of older individuals as 'decision-makers'. The Law on Social Protection was passed in 2011, at the time when the effects of the belated Serbian transition were in full swing, entailing significant and progressive reduction of welfare provisions, additionally fortified by the 2013 ban on new hires in the public sector.

This law regulates all areas of social protection, which includes services intended for the older person. According to it, an individual older than 65 can be a beneficiary of social protection services in cases where their safety, well-being, and productivity are compromised due to age, illness, or disability. State-provided social protection services for older adults are organised partly at the national level (institutional accommodation – care homes) and to a greater extent at the local level for day and home care services in the community (Babović *et al.*, 2018). In the market there are both care homes and home care services. While both the state and the market, at least on paper, provide substitutions for informal care provided by family members, children are still seen as the ideal care providers for their ageing parents (Milosavljević and Antonijević, 2015). In Serbia, consignment to the care of 'strangers' is largely understood as the worst scenario, a form of crude abandonment by the closest of kin, who are taken to be the natural carers – usually unpaid, outside a professional or formal setting, and predominantly women. However, informal care is not an option for everyone. Considering that there is a need to give older people the opportunity to continue living in their own home, provision of paid home care in their own homes is a preferred option for many.

Home care (often referred to as 'help at home', *pomoć u kući*) is provided by paid caregivers in the formal and grey economy. This preference provided the state with an opportunity to attempt to solve two social issues at one blow – care for older adults and employment for middle-aged women aged 55+, a part of the population with the highest long-term unemployment and inactivity rates (SORS, 2020). Since 2006, home care for older adults has been provided by trained or formally employed professional caregivers called *geronto domaćice* (a literal translation would be geronto housewives).

Geronto housewives' services are provided either through public or private institutions. The public ones, social work centres, provide free services for older adults who meet certain criteria. By supplying hefty documentation, a person can obtain help at home for up to two hours a day, except on weekends, for three or five days during the week. When determining the real needs of their potential beneficiaries, as well as the expediency of providing help, the social work centre is obliged to assess whether the person has family and relatives who can provide them with this help instead. This rigorous caution is vindicated by the limited number of social work centres. From this perspective, the state actively discourages its interference into the well-being of its older citizens, so long as there is a familial structure they could, at least in theory, turn to.

The other option is provided by the private sector through private brokering agencies that provide geronto housewife services at market prices. It needs to be underlined that the services of paid caregivers are reserved for those with better financial standing, typically the parents of children working abroad or older persons that worked abroad and have foreign pensions, for that reason called *foreign currency pensioners* or *devizni penzioneri* (Milosavljević and Antonijević, 2015). Geronto housewives can also be associated not only with a for-profit but also with a non-profit organisation, an intermediary organisation between the beneficiary and the caregiver.

However, the greatest number of paid caregivers work in the grey economy. This work is disproportionately done by women, to the point that in the grey economy these caregivers are colloquially referred to simply as 'women' (*žene*) (Milosavljević and Antonijević, 2015). The caregivers working in the grey economy are paid solely out-of-pocket. In some cases, these are women with no professional background in care work, while in other cases they are working or retired nurses who thereby supplement their income. In 2018, 3,854 persons worked in health care and home help, 58.8% of whom worked in the informal economy (Đorđević, 2020). In addition, as in Slovenia, there is a quiet tolerance of the grey market for care work.

> Quite often, the contact between clients and informal care workers is established through public services: homes for older adults, social work centres, or public services for home assistance that redirect applicants for home assistance to the informal care market. (Hrzenjak, 2012: 43)

Our research shows that nurses in public hospitals supplement their income in the grey economy and establish connections with their patients within the public health care sector.

Care homes represent an institutional form of providing support to older citizens who are unable to take care of themselves and need round-the-clock care. Absence of direct carers or their inability to fully devote themselves to the care of the older person, especially if they live in separate households or abroad, is the primary reason for families to opt for care homes (Milosavljević and Antonijević, 2015). As social institutions, care homes are licensed to provide housing and offer day-care services and 'clubs for active ageing'. Their users are provided with health care, maintenance of personal hygiene, proper nutrition, psychological support, and cultural and entertainment facilities – the last three being, according to our interviewees, the most vital and the first to experience cuts through the pandemic-induced restrictions. Care homes operate both in the public and private sector and require prior licensing for their work, which is carried out by the Ministry of Labour, Employment, Veterans, and Social Affairs.

According to official data, in December 2019, state- and privately-owned care facilities together had the capacity to accommodate 21,211 users (60% of the total capacity in the public sector, 40% in the private). The capacities of the private care homes have of late seen some expansion, which does not apply to the state-owned homes. State care facilities are working at maximum or near maximum capacity, and there are waiting lists to enter them.

One of the existing problems for older citizens who are alone and do not have close relatives who could take care of them is that most of them do not have the financial means to be placed in state or private care homes. For example, in one of the state care homes in Belgrade, the type of accommodation differs in relation to the category of beneficiaries; therefore, the service of a double or triple room with a shared bathroom is the cheapest and costs 32,939 dinars (c. 200 euros), while the most expensive one-bed apartment is for users who need the help of another person in the majority of daily life activities, and this service costs 60,391 dinars (c. 500 euros). It clearly follows that the majority of users with monthly incomes of 250 euros cannot pay the entire cost of the accommodation service in any of the state homes for older adults, so the state's help is needed to cover the difference. Far too often, people resort to informal practices, such as 'connections', to be placed or to place their parents in state-owned care homes. What the data presented makes clear is that care services are not readily available to those who, sooner or later, will need to 'use' them.

The COVID-19 pandemic and politicisation of care

On 15 March 2020 the Serbian government declared a state of emergency, a legal measure to respond to conventional threats of a military nature, neither specifying reasons for its introduction nor its intended duration. The state of emergency lasted for 53 days and entailed a heavy presence and active deployment of the army across the country. The Serbian way of waging 'war against the virus' involved measures that derogated constitutionally guaranteed human rights. The measures were introduced by non-competent bodies, in a non-transparent way, and without a clear plan for tackling the crisis.

A strict curfew was imposed on all citizens during the night-time and during the day at weekends (only persons with official permission, among them medical workers with a valid licence to practice, were allowed to be outside during the curfew). Citizens older than 65 (in places with more than 5,000 inhabitants) and older than 70 (in places with less than 5,000 inhabitants) found themselves in a total lockdown. In the first weeks of the crisis, this entire category of people were prevented from leaving their homes at all times. Gradually, they were authorised to go to select grocery stores once per week on an appointed day, from 4–7am, while yet later they were allowed to have a 30-minute walk three times per week.

The older adults turned into a homogeneous category overnight. Those who were hitherto independent and active became completely dependent on somebody else's support and care. Certain groups of people 'turned old' and vulnerable almost by decree, while those who were truly in need of care were unable to get it, as physical proximity was no longer possible. The state proclaimed that we protect 'our grandmas and grandpas' by staying put and distant from them.

Policy measures meant to protect 'our grandparents' were, however, incomprehensive, and at the beginning, they pertained only to a specific portion of those 'most in need' – to the residents of care homes. Initially, they were not allowed to leave their rooms, later the premises. Visits were not allowed. All extracurricular activities, psychological support, physical therapy sessions, creative, cultural, and entertainment workshops were stopped, and any activity that entailed a gathering of more people within care homes was banned. New admissions were not allowed. The current residents of care homes – if they were 'Covid positive' they were discharged from hospital – were occasionally turned away from care homes, sometimes with nowhere to go. The care homes were divided into zones: green ('Covid negative'), orange ('Covid suspect'), and red ('Covid positive'). The typical 12-hour work shifts for the nurses and caregivers became 24-hour work shifts for ten days straight. The nurses who worked for ten days in the red zones spent their shifts in full protective gear, risking daily exposure to the virus. These were centralised recommendations, while additional recommendations, occasionally unclear or inconsistent, left the staff in care homes confused about how best to proceed.

The state of the care system, as described in the previous section, revealed its utter frailty through the public policies aimed at suppressing the pandemic. The Citizens' Association Amity Report (Amity, 2022) shows that the majority of services, including emergency accommodation in care homes, as well as home care services, were suspended during the state of emergency or were provided with significant restrictions when the state of emergency ended.

Caregivers at home were only allowed to come to the door of their users' apartments to make purchases and pay bills for them (and, since we may surmise that there were cases in which this type of care was simply insufficient, we might conjecture that the caregivers were often left to their own devices and were possibly acting against the law if they did pass the threshold to change a diaper, reposition their 'grandpa', or treat the decubitus ulcer of their 'grandma'). In some municipalities, the work of home services was normalised only in May or June 2021 (Amity, 2022). It also needs to be stressed that after the lifting of the state of emergency, the restrictions in care home institutions were in place for almost two years, even though most of their residents were vaccinated.

Caregiving during the pandemic: empirical findings

In this section we take a closer look at the experiences of women who provided paid care for older people during the pandemic to understand the visible and invisible gendered aspects of care. We focus on three categories of paid caregivers: (1) nurses providing care in care homes, (2) those providing care at home as geronto housewives, and (3) nurses working as caregivers (*žene*) in the grey economy.

The experiences we look at have been collected through semi-structured interviews, 35 in total, with both providers and beneficiaries of care. We conducted ten in-depth semi-structured interviews with paid professional caregivers. During these interviews, the participants were asked to describe their typical (work)day before the pandemic, during the state of emergency, in the first year following the pandemic, and today. The semi-structured interviews were audio-recorded and transcribed, while the ethnographic observations and unstructured interviews were jot-noted. The transcriptions were analysed using the qualitative data software MAXQDA.

Before the pandemic, the working day of a medical nurse in care homes was far from easy. Taking care of older patients, especially those who are ill, is both physically and emotionally taxing. Medical nurses usually work more than 40 hours a week, and their workdays sometimes last 12 hours with night shifts or even 24 hours due to understaffing. Owing to the austerity measure ban on new hires in the public sector, the care homes were continuously understaffed long before the pandemic. If a nurse retired or decided to quit in search of better-paid work elsewhere, her place could not be filled. When the pandemic started and both staff and residents began to fall ill, it could easily happen that the care of around 100 patients was left in the hands of one or two nurses.

During the pandemic, especially during the lockdown, the older patients and employees were sequestered in care homes and even guarded by armed military patrols at the gates. Nurses who previously worked already tiring and long shifts were not allowed to leave until their ten-day shift ended. The already understaffed care homes also began losing their staff to COVID-19, to which those working in the 'red zones' were particularly exposed:

> There should have been at least five of us, and that would have been the minimum! However, when we got to that red zone, only me and two caregivers remained. For ten days straight, it was me and two caregivers because there was no one else. (Nurse, 54 years old)

> With full protective gear, masks, visors, suits … that was the hardest for me … that was the most difficult for me. I was sweating all over. (Nurse, 55 years old)

During the lockdown, only essential personnel with passes, like nurses, were allowed to be outside during curfews. This was particularly hard for the nurses who after a ten-day shift had to walk home or wait for organised transportation.

> I don't remember anymore, I know that I cried when I left work, there was not a living soul around. Afterwards, I got used to it. Then I caught myself at the traffic lights, standing and waiting for the green light, and then I realised what I was doing – who was it that I was waiting for? … at this point, people on the terraces of the buildings were looking at me, and they must have been thinking: 'look how nice, she is walking'; and they had no idea where I was going. (Nurse, 54 years old)

This new and demanding work schedule also took a toll on caregivers' family relationships:

> I noticed with my grandson, when he came to see me with my son, that he turned away from the door and did not approach me. He turned around and wouldn't come in. Usually, he would run into my arms. And, after they brought him in, when I was with him, he didn't want to leave me, so I connected it to the fact that he might have thought that I had left him for those ten days. (Nurse, 55 years old)

As already mentioned, home care is provided by paid caregivers in the formal economy (*geronto domaćice*) and grey economy (*žene*). The geronto housewives provide care for older adults that is paid out-of-pocket and for those supported through the local municipality and social work centres.

Geronto housewives during the pandemic

A formally employed geronto housewife usually has between 12 and 14 users she visits daily. The users who pay market price for her services have a choice in the type and quantity of care they receive and can opt for round-the-clock care. On the other hand, others who receive this type of assistance through public institutions usually have little room for negotiation and can expect to be visited for two to three hours per week. This means that before the pandemic, a geronto housewife would spend on average two to four hours 'supporting older people to continue an independent life', as advertised by a Belgrade-based agency.

This work is, at its core, basic housework (washing dishes, cleaning, cooking, ironing, etc.), with the addition of monitoring that the older person takes their prescribed medication and buying or procuring prescribed medications for them. Two of the three geronto housewives we spoke to even went so far as to underline that they were housekeepers rather than caregivers, thus potentially trying to detach their work from the emotional or intimate aspects present in care work.

> Geronto housekeepers provide exclusively the services of geronto jobs. We are not caregivers. Everything that is necessary for the daily normal activities of our users. (Geronto housewife, 50 years old)

> Well, those are the jobs in the house that they can't do on their own. We don't bathe them. Washing and basic hygiene we do. Then nutrition, yes, preparing meals, buying food, medicine, paying bills, everything that one needs – just like us except they are old so they can't do it all. (Geronto housewife, 44 years old)

When the pandemic started, the agencies (intermediary organisations) that these women worked for did not get any recommendations from state officials. During the first two to three weeks of the state of emergency, all services were completely suspended. In other words, along with freedom of movement, the older individual who relied on help from their caregivers lost all support for two whole weeks.

With the new, belated protocols, the agencies supplied the caregivers with passes and personal protective equipment (masks and gloves). They could therefore restart working with their users, on the condition they signed an agreement with the new rules that ordained compulsory masks for all involved and keeping two metres' distance. If someone, either the user or caregiver, did not adhere to these rules, they could be reported. The pandemic disconnected most of the users from their families, so the only help and support they had for weeks, or even months, was that of the geronto housewives. This fact imposed itself on caregivers who acknowledged the emotional labour they provided as well (Hochschild, 1983).

> So, we used to only come to the door. Most of them (users) didn't have that help and support from relatives, friends, and children because of Corona. I was able to give them a warm word and a smile. They would smile when they saw me, I got that smile in 90% of those houses. (Geronto housewife, 48 years old)

> I was the only one who showed up at the door, and then I went and bought them what they needed, came back, then stood at a distance again, and we talked. I just knew to ask them about their flowers. It was the only thing they had contact with in that moment. I deliberately led such conversations to divert their attention. I just really think it was important to give them that little bit of love if we were with them at that distance, and it was important that they didn't get sick, and they didn't really get sick. (Geronto housewife, 44 years old)

According to one psychological research study on the effects of lockdown on quality of life and mental health, the urban middle-class older person managed to maintain a subjective feeling of well-being despite the restrictive measures (Džamonja-Ignjatović, Stanković and Klikovac, 2020) because of help from their immediate social environment. This was widely related to former overall quality of life (Džamonja-Ignjatović, Stanković and Klikovac, 2020). However, having paid caregivers who provided emotional support during the lockdown was a privilege that not everyone could afford.

Caregivers in the informal economy during the pandemic

As in Slovenia, we can also trace hierarchisation in the informal economy of care work (Hrzenjak, 2012, 2019). Milosavljević and Antonijević (2015) note that in rural areas in particular, unskilled women provide care work, especially for the older population whose children work abroad or who were themselves at one point guest workers abroad (*gastarbajteri*). However, in most cases the older adult or their children are disappointed with the care these women (*žene*) provide, especially in cases where medical care (making sure they take their medication) is also necessary.

In that regard, women who are skilled current or retired nurses are highly sought-after. We spoke to two nurses who work together in a public hospital in Belgrade, where they typically attend to patients who have suffered strokes or other neurological illnesses. In addition, they both informally work for an older married couple (mostly taking care of the husband) who worked in the UK and retired to Serbia.

Similar to the geronto housewives who presented themselves as housekeepers, the nurses highlighted the medical aspects of their work. They focused on particular aspects, such as measuring blood pressure, and used the term ‘patient’ to refer to the older person they looked after. If the pandemic drew out the emotional aspects of care work for the geronto housewives, the nurses discovered that their role was a very gendered care, that would typically be described as provided by *domaćice* (housewives).

> I would look around the apartment and see what they had in their fridge, if it was eggs, flour, or sometimes I would make them pancakes … I would do some light cleaning, so that they felt ‘the touch of a housewife’s hand’ … it was the humane thing to do, it made their day. (Nurse, 51 years old)

Before the pandemic, these women would sometimes work for 24 hours. Like the nurses in the care homes, they also had 12-hour shifts in the public hospital a couple of times per week, except they did not go home afterwards for their second shift as informal caregivers. Instead, twice a week they went from their eight- or twelve-hour workday to another eight to twelve hours of care work at the home of their ‘patient’. According to the women we spoke to, at least twice a week they would have one 24-hour workday and one 12-hour workday due to their supplemental work in the grey economy. While this additional work provided a much-needed income boost in their household, all the women we spoke to noted it took a toll on their own informal care duties and relationships with their families.

> Well, maybe it’s a bit ugly to say this, but primarily the financial situation, that’s the key factor. I mean, time and private life suffer there, of course, but you have to live. (Nurse 2, 52 years old)

Mostly due to the nature of their employment, the women we spoke to decided not to work, as they say, ‘privately’, which meant they ceased to provide paid home care during the state of emergency. While this had a big impact on their finances, it did mean that they had more time to spend in doing unpaid work at home as regular housewives. For them it was in a certain sense the reverse situation of the care home nurses before the pandemic.

> This ‘private work’ is beneficial financially, but our family suffers, especially since we are women. [During the lockdown] we had more time for our family, I could be a housewife (*domaćica*) 100%. (Nurse, 51 years old)

When the lockdown ended, they could resume care work. However, unlike the geronto housewives who had to sign contracts with their users that guaranteed adherence to COVID-19 protections, these women had no contracts to count on. Prior to the pandemic, they were the most coveted form of caregivers, as they were skilled and agreed to provide medical and emotional care work typically associated with housewives. But the pandemic laid bare all the risks and uncertainties of providing paid care work in the grey economy, because these nurses risked personal exposure to the virus and infecting others they cared for in the public hospitals. Therefore, their stories show most blatantly how interconnected paid and unpaid care work performed by women is, who during the pandemic remained invisible to the state and outside of its regulations.

Conclusion

The institutional and legal framework we discussed in the second section of this chapter showed that a variety of care options exist for the older population in Serbia. In cases where family is not readily available to do the care work – however desirable this option may be – the state and the market provide alternatives. The mixed welfare model introduced a commodification of care, where the best of care – in terms of intensity, quantity, and variety of its types – also requires adequate means to procure it. The system, fragile and foundering due to the financial undervaluing of those who *do* the caring, showed its overall frailty in the moment when the state stopped and locked itself down precisely to protect those most in need of protection.

The COVID-19 politicisation of care, the repercussions of which we attempted to capture through the experiences of women who are paid to care, revealed how unstable the care system in Serbia really is.

Our research shows that older individuals were faced with a troubling lack of care during the pandemic, particularly during the state of emergency.

The haphazard and inconsistent introduction of public policies, in fact, deprived many of care, while putting additional pressure on caregivers who were already strained.

Both during the state of emergency and after, the pandemic-induced measures produced overwhelmingly hard working conditions for the nurses who worked in public care homes. The new protocols and work schedules meant that they not only had to manage their own anxieties about heightened exposure to the virus but also guilt and anxieties about not infecting others around them, together with feelings of guilt for being separated from their family for long periods. While the nurses were near the older person they cared for, even to the detriment of their own personal lives and health, the caregivers who provided care at home could not come close enough to provide adequate care. As policies and recommendations were missing or ambiguous when it came to home care, it meant, especially for women working in the grey economy, either risking their health and the health of the person they were caring for, or the loss of (possibly their only) income.

During the pandemic, the double role of caregivers who provide home care became evident. Furthermore, it is interesting that the pandemic created some space for these women to negotiate their roles. While they were usually expected to provide both nursing services and help with the housework, the caregivers we spoke to made it clear that they did not provide the housework services (in the case of nurses) or the nursing services (in the case of geronto housewives). However, as they were often the only ones in direct contact with the older person, many of the caregivers, rather than distancing themselves from some types of work, in fact, worked additionally, providing much needed emotional support to the older person.

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9

‘This old town is not for old people’: (Un)successful community activism in Slovakia

Ľubica Voľanská

In Slovakia, nobody expects older adults to be involved in public affairs to a significant extent. Their voice is usually not heard, even in the area that probably affects them the most – caring for them. However, this does not mean that the topic of caring for the older generation is not politicised in Slovakia. However, its politicisation rarely occurs at the community level and hardly ever respects the ‘giving voice’ perspective – offering opportunities for older adults to express themselves.

In this chapter, I focus on a case study of community activism that emerged around a senior day-care centre in the city centre of Bratislava as an example of politicisation of the topic of care for older people and intergenerational relationships on many levels of society. The quotation in the title frames the situation: “This Old Town is Not for Old People” was written on one of the banners used by the residents of the senior centre and their family members, employees, and other members of the neighbouring community during a demonstration for the preservation of the centre. This happened in spring 2017, when the centre became a subject of political debates at the communal level in the City Administrative District of Bratislava-Stare Mesto/Old Town. I use their perspective, description, and interpretation of the actions and reactions of the actors involved in these debates to understand the impact of the wider public setting and public policies on the regimes of care and the senior citizens in an era of intense transformation (Dahl, 2017), when the roles of the family, the state, and the communities in care were negotiated.

To better understand the care regime in Slovakia, it is necessary to introduce and explain the country-specific context in general (Giordano, 2022). Demographers have long warned that as a result of the ageing of the population, Slovakia is changing from the youngest population to the oldest in the European Union (Káčerová and Ondačková, 2015; Káčerová and Nováková, 2016). It is happening for various reasons: change in reproductive behaviour and declining birth-rates, emigration, a relatively closed immigration policy, and the rather lukewarm attitude of the majority of the population to the integration of foreigners (Káčerová, Mládek and Kusendová, 2022). Moreover, healthy life expectancy is relatively low compared to other EU countries. In Slovakia, it roughly overlaps with the retirement age, and the need for care gradually increases after reaching retirement age (Bútorová *et al.*, 2022).

Despite this development, in the political environment in Slovakia, this long-standing topic is still underestimated and pushed aside – as is the unfinished pension insurance reform. In addition, there is still a prevailing attitude towards older people as passive, as people who need to be protected as if they were just objects of care.

The most recent example is related to the development and manifestations of the relationship with the oldest generation in Slovakia during the COVID-19 pandemic (Gyarfáš Lutherová *et al.*, 2020; Voľanská *et al.*, 2020; Gyarfáš Lutherová and Voľanská, 2023). The exceptional situation and the fear of the unknown, which the virus represented at that time, further sharpened ageist expressions associated with paternalism, a protective but superior approach. Associated with it is the ethical dilemma of whether one has the right to care for those that one thinks need care, even at the cost of restricting their freedom. Paternalism towards older adults during the COVID-19 pandemic was present at both levels, the family and the state, leading to political decisions limiting the rights of older adults based simply on their chronological age. The restrictions were most pronounced against those who were residents of long-care facilities, assuming that the institution multiplies risks (e.g. due to the inflexibility of large-scale facilities to separate pavilions, thus allowing only partial containment and quarantine).

The perception of older adults as passive objects of care is also reflected in the care regime in Slovakia. The size, structure, and spatial distribution of social care facilities related to the preference of the form of care for older adults mirror the development of society in connection with the historical heritage going back centuries, giving priority to family care (Voľanská, Majo and Káčerová, 2021). However, a specific development occurred in the second half of the twentieth century in connection with the socialist regime. In former Czechoslovakia, social services for seniors mostly took the form of facilities with a large capacity, where the recipients of care only had minimal space for individual plans and needs. In the present, the dominance of these large-scale institutions is only slowly giving way to deinstitutionalisation and the revival of community care, an example of which was the senior day-care centre at the centre of this case study. At the same time, the majority of long-term care workers provided care informally (Radvanský and Lichner, 2013).

There exist various categorisations of care systems for older adults. Based on the responsible actors of long-term care, Virpi Timonen (2005) identified three groups, the main actors being: the state, the families, and a mixed model. In the third model, the state provides financial support, whereas other actors provide care services. According to Gábor Szüdi and his colleagues,

> Slovakia falls into the third group, as elderly care is predominantly financed by the municipalities through transferred state taxes, local taxes, state grants, and client co-payments, while municipalities, authorities of the self-governing regions, and, to a lesser extent, third sector organizations provide elderly care services. The main responsibility is officially borne by municipalities, but the system can be considered to be oriented toward informal care, because a substantial (not easily quantifiable) responsibility lies with the families. (Szüdi *et al.*, 2016, 2)

Municipalities have a great deal of decision-making power in the field of formal care for older adults in Slovakia. In contrast, family members can minimally intervene in political decisions regarding institutional care. In this respect, the senior centre in our case study was an exception, as the younger generations of family members of its residents were part of the events in the senior centre and later also part of the community that formed around it.

When describing the care regime in Slovakia, Gábor Szüdi and his colleagues suggest the term rudimentary system. It is prevalent in Central European countries that, from an economic aspect,

> have a relatively low GDP per capita and a higher unemployment rate, as well as a low care allowance, caregiver's allowance, and old-age pension. From a demographic perspective, these countries are characterised by low labour market participation of women and a relatively younger (but increasingly ageing) population. (Szüdi *et al.*, 2016: 4)

According to their prognosis, the Slovak social care service for older adults may become more similar to the advanced Central European systems: the availability and variety of formal social care services will increase. In this context, the case study of the senior centre is an example of the opposite development, when the trend of variability and providing care in different types of facilities was not considered. The overall context of decision-making power at the level of towns or city districts is shown to be important. Administrators and decision-makers always have to deal with considering the needs of several parties when making administrative and political decisions and try to combine the often-conflicting requirements – in the case of our senior centre – of two generations requiring care.

As Marcela Káčerová and her colleagues write (Káčerová *et al.* 2021: 137), according to the Central Register of Social Service Providers in Slovakia, there are almost three thousand entities registered that offer various care services intended for seniors. Four entities out of ten provide field-based services, which is in line with the trend to deinstitutionalise social care and support communities. An equally significant proportion of the entities provide the residential form of social services. In addition, 13% provide outpatient/ambulant forms of care. Only a small fragment (below 3%) provide a rare form of weekly boarding.

In general, there is limited availability of care services for older adults, manifested in the small portion of seniors receiving formal home care. Moreover, in the past few years, residential facilities for seniors or municipalities have had difficulty finding workers for these positions. According to the statistical data (Statistical Office of the SR, 2023), in Slovakia, as elsewhere in the world, it is primarily women who work in the field of care, experiencing the high demands of this work, low remuneration, and – as is repeatedly underlined in research conducted by Martina Wilsch and Mădălina Rogoz – low social status (Rogoz and Wilsch, 2021; Wilsch, 2023). Thus, informal family care often has to complement formal care methods. However, shortages and changes related to the demographic structure are also felt in the area of informal care in the family environment, fully exposing the gendered character of care for older adults in this area as well.

Given the above, it can be concluded that, in Slovakia, we are also observing a deepening of the care crisis (Dowling, 2021). The aforementioned variability of available forms of long-term care for older adults and the need to support community-based care such as our day-care centre with political decisions will be all the more important.

The care crisis has led to global care chains (Hochschild, 2000), where the responsibilities for caring for those in need are delegated to migrant women from economically less developed countries, most often from Central and Eastern Europe. Slovak women are also a part of the care industry, working mostly in Austria, Germany, and Switzerland. However, in Slovakia, research has not confirmed chaining in the sense of hiring a person from another country (Sekeráková Búriková, 2023). Informal care remains the most important: family or household members are cared for by other persons in a close relationship, relatives or neighbours, and, very exceptionally, a paid caregiver (mostly a retired woman). Women only leave their home or their country when they do not have children or older adults to care for. If such intensive obligations in care for their loved ones arise, they usually stop migrating for work (Rogoz and Sekulová, 2019).

The migration of Slovak care workers in the area of care for older adults is well described in the work of Miloslav Bahna and Martina Sekulová (2019) which provides a historical overview since the fall of the Iron Curtain, enabling the work migration of carers, foremost to Austria. The authors also provide a comparison with other care regimes in Central Europe. Questioning the use of some concepts developed based on research in the Western part of Europe and the USA in the area of post-socialist countries, they stress the necessity to look beyond the prevailing traditions in the research of care for older adults, for example, the care-chains framework (Lutz, 2018) and the 'care regime' (Betio and Plantenga, 2004), or the 'gender regime' (Lutz, 2008). Moreover, their work focuses on the sending country perspective and the agency of the care workers themselves.

After having presented the overall context in the field of care for the older generation in Slovakia in connection with the demographic situation and social services in this introduction, I will describe in the next part of the text my field research and working with interviews and other sources. In the following section, in five subsections, I will recall the story of the day-care centre and the community that formed around it in connection with the concepts of active ageing, ageing in place, and 'ageivism'. In the end, I will return to the idea of politicisation of care for older adults as it is manifested at the communal level in the local environment.

Bottom-up perspective from the interviews: methodological aspects

When assessing the agency of those who are directly affected by public policies and how they contest the efficiency of public policies in the case study of the senior centre in Bratislava, I used ethnographic research: participant observation and in-depth interviews with the centre's residents, their relatives, personnel, and a broader community of neighbours, between 2017 and 2021. However, due to the COVID-19 pandemic, other methods, besides the standard ethnological/anthropological ones, were also necessary.

Goekce Günel and her colleagues (2020) described a new research approach that has gained prominence recently. They based their ideas on a feminist and decolonial critique of anthropology and its methods regarding certain aspects and practices related to the (qualitative) research field. The authors, therefore, propose the procedure they call patchwork ethnography. Patchwork ethnography represents a methodological and theoretical framework for ethnography and field research that focuses on how changing living and working conditions irrevocably transform knowledge production in anthropology or other related disciplines. In such an approach, researchers prefer to undertake short-term field visits and use fragmentary, yet still rigorous and accurate data, as well as various innovative techniques that ultimately defy established practices in field research.

It should be noted that patchwork ethnography does not represent a methodology characterised by short and instrumental visits to the field without establishing stronger relationships with the participants or the community in which the research takes place. On the contrary, it primarily supports establishing and building lasting relationships in the field and acquiring contextual knowledge in local communities, which are also characteristic of 'traditional' field research.

I started interviewing the residents of the senior centre and prepared small biographical 'blurbs' to get to know the people most involved, in 2017. Then I continued interviewing the family members and the centre's staff, and finally, I got in touch with the local MPs and the representatives of the municipality. Getting in touch with the local administration took me the most time. This time was probably necessary, so that the strong emotions related to the whole process of abolition and the actions evolving around the senior centre could settle. However, finally, members of the local administration were also willing to tell me their side of the story. Moreover, at the time of the interviews, many were no longer part of the local political sphere. Also, communication was easier compared to the period of their active involvement in local politics, especially shortly before the communal elections in the autumn of 2018.

Altogether, I collected 19 interviews, where women dominated as employees and primary caregivers in the formal and informal spheres. In contrast, the male research participants were, in addition to family members, mainly members of the neighbourhood community and local deputies.

The interviews lasted from tens of minutes to several hours and offered an exciting and colourful mosaic of opinions and views. I conducted more than one interview with the main actors and compared the text versions. The views of the same people on the same events often differed, which, according to Gabriele Rosenthal, is not only related to the time gap, since there is no structural difference between the individual noemas of memories (from a year ago or 40 years ago) (Rosenthal, 1994: 133). They were influenced by the context of the origin of the interview, by the interview situation, and closely related to the development of the situation around the senior centre. Thus, in (auto)biographical research, whether memories are true or 'correct' is irrelevant. As Jana Nosková states, a biography should be viewed as a reflection of 'how someone experienced something, processed it and based their daily actions on it – then omissions, embellishments, etc. are allowed' (2006: 96). The presence, stories, and presentation of the stakeholders' opinions and comments of the wider public in the local press and online social networks were also a valuable source.

When analysing the sorts of texts produced by the people I interviewed live or online, I was inspired by the approach of Gabriele Rosenthal (2018, 2019).[1] First, the way a person talks about specific events is important. While the events of life have a certain chronological order, the story's sequences may not be so clear anymore. Different themes can overlap, and sequences can take various forms. The second thing I noticed in the analysis was the types of texts that talked about the various topics. As Gabriele Rosenthal suggests, when analysing narratives, we can ask why the narrators chose this type of text and not another. It has a meaning if they express themselves angrily or argue with the social discourse. They can discuss one topic in detail and talk very broadly, but they might barely mention others, using only brief descriptions (Rosenthal, 2004: 57).

Similarly, I analysed the recordings and transcripts of the minutes of the city council meetings, where the fate of the senior centre was decided.

The story of a senior centre

The beginning – active ageing and ageing at home as basic principles

Corresponding to the change in the demographic situation in Slovakia, the senior centre was founded by the City Administrative District of Bratislava-Stare Mesto/Old Town on the site of the former crèche in 1994. At that time, demographic development was characterised by a very low birth-rate due to the radical political and social changes after the fall of the Iron Curtain and the Velvet Revolution in then Czechoslovakia. The gradual decline led to the number of children in the Slovak population reaching a historic low in 2010, resulting in a bottom-up ageing process (Káčerová *et al.*, 2022: 117).

When the senior day-care centre was established, it was the only institution of its kind not only in Bratislava, but also in Slovakia.[2] For more than 20 years of its existence (1994–2017), the centre provided older adults with a 'home-like' environment (as described by them and their relatives), providing care and meaningful activities, as well as social contacts with non-relatives.

The day-care centre for seniors was created in the premises of the former children's crèche on the ground floor of a residential building and it had two separate parts, which had separate entrances. This spatial arrangement allowed for the variability of the activities. One part was occupied by the day-care centre for seniors, and in the other part, there were regular activities of the seniors' club and various other clubs for people with disabilities or mental disorders. When an interesting lecture or art therapy activity was held in one of the clubs, the activities of both groups (members of the clubs and the day-care centre) could be connected. In addition to the barrier-free entrance, a significant asset of the premises was a small garden with a hedge and plants, which the senior centre residents took care of. The garden was set in a quiet courtyard next to the children's playground, providing plenty of opportunities to interact with the outside world.

Although from an administrative perspective the premises and financing for the staff members were provided by the city district, the initiative to establish a day-care centre came from its founder and the first director of the centre, psychiatrist Eva. In her ambulance at a nearby clinic, she met with the neighbourhood inhabitants who visited the ambulance because they were assigned to it according to their residential address. She felt the need to solve the problem of the lack of care for the oldest generation in the neighbourhood. Demographically, the population of Bratislava has been ageing significantly since the 1990s. From 1992 to 2011, the population ageing index more than doubled (Bleha *et al.*, 2013). In addition, the Old Town district was then and still is one of the oldest districts in Bratislava.

The progressiveness of the senior centre lies in its character at the time it was founded in 1994. At the time of the prevailing objectifying approach towards seniors in public policies, the centre's director relied on two up-to-date approaches, not very well-known in Slovakia or widespread: ageing in place and active ageing.

Environmental gerontologists already in the 1970s suggested that as people age, their attachment to their place of living increases. Conversely, they become more sensitive to their living conditions related to place and community. Ageing in place as a term started to gain importance in the literature regarding social policies and gerontology in the 1990s (Pastalan, 1990; Pynoos, 1990; Tilson, 1990). Despite some criticism (related, for example, to the gentrification of some urban environments – Vidovićová and Gregorová, 2010; Slezáková and Temelová, 2014), it still presents the best way to grow old (Andrews *et al.*, 2006), or to prolong a person's life in a satisfactory way (Wahl and Oswald, 2010; Rogers *et al.*, 2020). It represents an arrangement in which older adults live out their lives in the place where they have lived a large part of their lives, where they have established social networks and a functioning infrastructure and are a part of their community. Ageing in a place familiar to us is important because, in addition to the community, it is also tied to life stories, and the home thus plays an essential role in maintaining the continuity of the life cycle (Sixsmith *et al.*, 2014: 7).

The activities in the centre corresponded with the idea of active ageing as a process of optimising opportunities for health, participation, and security to enhance the quality of life as people age, which has become part of the current mainstream social policy framework within social gerontology (Walker, 2002). Unfortunately, the whole topic in Slovakia has had a slow start. Actual actions on a large scale and public discourse related to this concept were silenced by the disinterest of relevant decision-makers. Thus, the centre was presented in the 1990s rather as an exception.

The first attempt related to the active involvement of older adults in public life was the national project Strategy of Active Aging (ended in 2013), which aimed at detailed elaboration of the connections between demographic ageing and the labour market and the pension system, including the incorporation of strategic goals in this area and the proposal of measures by which said goals should be fulfilled. The strengthening of the approach occurred more or less as an inspiration from the European Year of Active Ageing and Solidarity between Generations in 2012. European resources brought the implementation of projects related to the way the older inhabitants of Slovakia live. The first significant policy document, the National Program for Active Ageing for 2014–2020 (Národný program, 2013), was also created. Although many scholars in the field of social gerontology already criticised the concept of active ageing for its imperative character (Lamb, 2017), it became a political priority. The Government Committee for Seniors, which dealt with the situation and rights of seniors, was renamed the Council of the Government of the Slovak Republic for the Rights of Seniors and the Adaptation of Public Policies to the Process of Population Ageing. The current version of the National Program for Active Ageing for 2021–2030 continues to emphasise the need to change the approach to the issues of population ageing and the status of older people and their care (Národný program, 2021). However, the fact that the National Program was under negotiation for quite a while and was not approved by the Slovak government by the end of 2021 is evidence of the lack of interest of political actors and institutions. Moreover, although the National Program has been updated, it has not been incorporated into the life of local governments and communal politics. Some cities, such as Bratislava, are at least interested in having a similar plan inspired by this. However, the Ministry of Labour, Social Affairs and Family of the Slovak Republic did not specify how it should be implemented. Local governments are therefore trying to realise it from below through activities, the organisation improvement system, and the subsidy programme.

From this it follows that the concept of active ageing has not yet been established in Slovakia on a broad level. Even more so, its promotion and implementation have been frozen by developments associated with social isolation and the restrictions related to the COVID-19 pandemic.

Various forms of community engagement

The director of the senior centre managed to build a community of friends around the centre. In her first optimistic interview, in spring 2017, she described it in the following way:

> Because we have many friends, we all mobilised them, including our families, and we ordered furniture and built it during weekends. My friend sewed the curtains. We brought all sorts of Legos, crayons, watercolours … we stole

> everything from our kids, of course … And we actually arranged it so there was always something to do, yes … ordinary things to make the program valuable … (Eva, director, interview spring 2017)

For family members of the residents, the existence of the centre meant the opportunity to leave the care of their relatives to someone else, at least for a certain period of the day, and all for a reasonable level of financial contribution. Moreover, they felt the time their relatives spent in the senior centre was quality time. Several times the community described the environment and the overall atmosphere in the centre as respectful and pleasant: 'When English lords can go to the club, so can our mother …' (Peter, son of a resident, 2017).

The capacity of the centre was 20 people. However, it was not obligatory to visit the centre every day, one could pay only for the time spent in the centre and the lunch during the days of visiting. The centre's residents were mostly older adults from the surroundings, having different abilities and needs regarding levels of care. They also had different educational and social backgrounds and different life stories. Among the last generation of residents who participated in my research were a former director of a national company, a doctor's wife who helped him all his life as a housewife, two teachers, one administrative worker, and one scholar, primarily people with high school and university education. Regarding the staff members – all women – two cooks and two nurses were employed permanently in a full-time job. The director and psychiatrist (in one person) visited them regularly. However, the main content of the director's work remained associated with her psychiatric practice/ambulance in the nearby clinic.

In 2011, independently of the functioning of the day-care centre, the civic association Susedia na dvore (Neighbours in the Yard) was founded, based on a personal initiative of a few neighbours, contributing to initiating community activism in the surrounding houses in the courtyard of the place where the senior centre was located. The founder, Dušan, explains in his blog:

> We started the Susedia na dvore (Neighbours in the Yard) community, also because I'm gay … I have a strong need to live in a place that is open and where people know each other. In a place where I don't just have to swim quickly with a mask created by the expectations of others. In a place where I can boast that the handsome man who takes pictures of us at every neighbourhood event is my partner. Where public space is also my space. (Martinčok, 2015)

Thus, intergenerational communication and cooperation were not primarily the focus of the initiative Susedia na dvore (Neighbours in the Yard). It was just one of the agendas they felt it was necessary to start being actively engaged with. As Dušan continues, creating one community from the previously anonymised neighbours was a way to deal with several issues, such as support of the homeless and overall tolerance in relationships among neighbours, intergenerational tolerance included.

As a result, the local community members from Susedia na dvore (Neighbours in the Yard) started to visit the senior centre and its residents in 2014. In the beginning, there was some hesitation from the side of the senior centre's staff. They could not precisely understand the reason or intention of the unexpected visitors, that they were not selling any goods or trying to evangelise the centre's inmates. Over time, in the framework of the activities related to the senior centre, they organised several events: preparing coffee, baking cakes, quizzes, reading books and memoirs by the members, or simply listening to their stories with some old photographs. The activities were organised with the idea of supporting intergenerational communication.

Later some well-known personalities of Slovak cultural life, for example, actors, activists, and writers, living in the surroundings, became community members. They also visited the activities with their children and thus contributed to promoting the agenda of the necessity of intergenerational communication as one of the focuses of the initiative Susedia na dvore (Neighbours in the Yard). Thus, the functioning of the senior centre within the community challenged the idea of the post-socialist syndrome (Molzahn *et al.*, 2011). Under its influence, citizens are often unable to identify with citizenship and community fully. Instead, they are confined to the privacy of the family. Part of the post-socialist legacy may be the principle of mistrust of public institutions, which, in addition to social services, also include health care and care for older adults in general.

Dark clouds over the senior centre

At the beginning of 2017, rumours started about a decision to abolish/ remove the senior centre and to use its premises for its original purpose – a crèche. Again, this decision seemed to correspond with the present demographic situation in Bratislava and other Slovak cities: the strong generation born in the 1970s and at the beginning of the 1980s (as a result of a supporting family policy of the then socialist Czechoslovakia) demanded the provision of social services for their children (under 18).

> The mayor also came by in January, looked around and told us that there would be a crèche. That's when I asked him if they would cancel us, and he told me that no, why would they do that? We were supposed to go to a better place … (Milka, staff member, interview 2018)

With the decision to replace the senior centre with a crèche, two groups were pitted against each other, which made the whole political discussion on the municipal level as well as the public discussion about the continuation of the senior centre or its abolition extremely complicated and with no real solution.

> The City District of Bratislava-Staré Mesto solved one problem by producing another … (Dušan, founder of Susedia na dvore – Neighbours in the Yard)

According to the minutes of the city council meetings, which were devoted to the issue of cancelling the day-care centre for older people and replacing it with a crèche, the situation was even more complicated. The mayor's office solved the problem of where to move a nursery from another part of the same city district. After reconstruction of the nearby hospital for oncology patients, the premises of this particular nursery would not suit their purpose due to the reduced amount of daylight that would shine into the premises. At the same time, another organisation, the NGO Prešporkovo Family Centre, also asked for new premises. It is a non-profit organisation providing a meeting place and activities for parents on parental leave with their children, mostly of preschool age. Until then, the Prešporkovo Family Centre had been located in the building of an elementary school in the neighbourhood, whose founder was in the same city district. The reason for Prešporkovo's request was that the elementary school had demanded that these premises be returned, to provide space to open another class for the increasing number of schoolchildren, fulfilling the parents' needs. Prešporkovo, as a civic association that did not have to meet the demanding hygiene and daylight requirements that apply to state and municipal care facilities, was to be moved to the premises which were unsuitable for a nursery school because of the future hospital renovation. At first glance, this game of 'musical chairs' appeared as a win-win situation, except for the fact that it completely excluded the residents of the senior day-care centre since there were no more chairs left for them.

The mayor did offer them the opportunity to move into another facility in another part of the district, as the former day-care centre was actually an administrative part of this facility. However, this new facility had a completely different structure. It is today a facility with many residents in an old building that is also a national cultural monument and was built for purposes other than the provision of social services and care. The facility for senior citizens provides a social service with a year-round stay, meaning many residents usually live in this facility for several years, even decades. It is not barrier-free, and there is no garden or yard near it which would allow for staying outside and having some intergenerational interaction with the surroundings.

In her second interview, which took place after the senior centre was already closed, former director Eva expressed her dissatisfaction with the development very emotionally. Compared to the first interview situation in spring 2017, the whole conversation was conducted in a gloomy, angry mood.

> Well, the institutions [meaning the officials from the city district, Ľ. V.] have never appreciated this effort enough … They asked: Why do we need this place, right? We could make an office here, or we only need a gym … So, it hurt a lot, and when the officials came to check the place: 'What? Paintbrushes? And why should paintbrushes be good for older adults?' So, we said to ourselves that we would not discuss it with them anymore. This trend continued, and, unfortunately, they decided that there was no need for professional guidance in the centre. And they fired some staff. (Eva, director, early summer 2017)

The closure and replacement of the senior centre by a crèche reveals many characteristic features of developments in society in Slovakia nowadays. There exist ageist stereotypes that are connected to both symbolic and cultural injustices, such as being perceived and politicised as a burden on society by demanding care (Voľanská, Káčerová and Majo, 2020).

With the background of the care crisis, the two age groups requiring care were pitted against each other. Competencies regarding care decisions for those who need it fall under individual city districts, but these institutions often lack the funds to operate the facilities. Although there exist models of good practice in the world combining institutional care for the oldest generation with care for the youngest, in this case, the founder of the senior centre – the City District of Bratislava-Stare Mesto/Old Town – was not inspired by a similar example. The community gathered around the senior centre and the civic association founded by Dušan discussed this possibility with the mayor as well. There was no will and time to explore this possibility. The political decision was made in favour of the youngest generation, which prevailed in numbers: in 2017, there was an average of ten seniors in the centre (the number varied on individual days), who, according to the debates during the city council meeting, could not even compete with the 30 places for children in the future crèche and approximately 30 other schoolchildren in the new primary school class, which the city district was able to set up in the vacated premises. The satisfaction of the demands of the parents of small children took place less than a year before the elections to the city council in 2018, and the crèche was finally opened after the reconstruction a few months before the elections.

Moreover, during the debates at the city council meetings, the centre's residents were often objectified. There was a clear tendency of the decision-makers to decide about matters concerning seniors without their participation.

Unprecedented reaction – community fights back

The report on plans for the centre's abolition in spring 2017 triggered an unprecedented reaction in Slovakia, initiated by the centre's senior clients themselves and the community concerned – challenging the idea of seniors being passive and not interested in the *res publica*. The active involvement in local politics began by attending the city council meetings, where the residents and their relatives tried to explain the rationale for the existence of their senior centre and the importance of its ties to the community.

After these visits and explanations at the city council meetings, it became clear that the cancellation of the senior centre was more or less already decided (by the mayor's decision). The city council only had to fine-tune the details and the conditions under which the representatives of the oncology hospital would ensure the reconstruction and rebuilding of the premises to be suitable for the crèche. The next meeting with the mayor ended in a fiery discussion making clear there was no chance of saving the senior centre, with his main argument being its unused capacity. However, the residents and the community concerned continued their activities in the form of a petition (online and offline) supported by personalities of social and cultural life. They gathered several hundred signatures supporting preserving the senior centre at its original premises.

This bottom-up initiative showed the strength of the community that had formed around the senior centre, including well-known personalities of cultural life in Bratislava. At the same time, the power of Dušan's character as the driving force behind the Susedia na dvore (Neighbours in the Yard) initiative was indispensable.

Finally, the seniors and community members organised a demonstration, with the idea mainly coming from one of the oldest members of the centre – Ms. P. The protest took place in front of the local office of the municipality – the City District of Bratislava-Stare Mesto/Old Town. The residents carried banners proclaiming the participants' dissatisfaction with the situation, and they were joined by their relatives, the employees of the senior centre, and members of the neighbourhood community. They even alerted the press and some members of the local parliament. When the mayor unexpectedly met the demonstrators, he was extremely surprised by the event. In the end, he cited unsuccessful communication as the reason for the conflict, which, according to him, was due to time stress and the need to quickly resolve the situation of a lack of premises for the nursery.

The unprecedented political activism started with the idea of the senior residents themselves. Thus, it goes beyond the notion of active ageing. In the framework of critical gerontology, Israel Doron suggests introducing the concept of 'ageivism', referring to:

> An ideology which serves as the basis for calls for social action (echoing similar 'isms', e.g. feminism, or socialism) on the protection and promotion of the rights of older persons based on the grounds of political, social and economic principles of identity, dignity and social justice. (…) It opposes any attempt to eliminate older persons as a distinct social group, or eradicate old age as a unique human experience. Ageivism, as an ideology, encourages older persons to self-identify as such, and to actively resist the attempts to ignore their unique subjective social experiences of being old in modern and post-modern societies. (Doron, 2018: 35)

Also, Doron stipulates that 'ageivism' embraces social activism within the framework of identity politics while aiming to promote the rights and interests of older persons as a distinct but not homogeneous social group (Doron, 2018). As such, ageivism is breaching the rules and queering the norms concerning the biographic and sociocultural orders of ageing.

Aftermath

However, the efforts of the older adults from the centre and the community of neighbours and relatives that evolved around the centre were unsuccessful. The centre was closed after more than 20 years of its existence and rebuilt into a crèche for more than 30 children, which opened its doors in April 2018.

Moreover, the then mayor of the City District of Bratislava-Stare Mesto/Old Town got an award appreciating the community development, titled 'Oscar without barriers', presented annually by the Association of Towns and Communities of Slovakia.

> It is a satisfaction for me regarding everything that accompanied the implementation of this project. We managed to move the day care centre, improve the working conditions of the staff and build a new crèche for 30 children. They are barrier-free and meet the strict conditions of the new 'Crèche law'. We have shown other towns and villages that it makes sense to break down architectural and interpersonal barriers, even concerning young families. Not only the old and the disabled people need our help, but also young families. (Radoslav Števčík, 2018)

Residents of the senior centre, their relatives, and its employees were faced with the task of looking for other ways to replace this service, this place, and not all went the way they hoped. Some of the people who visited the centre on a regular basis had already passed away or died shortly after the replacement of the senior centre.

The wider community responded to its abolition in several ways. For about a year, they organised regular meetings once a month in the nearby café. However, this activity stopped as the former residents gradually passed away. Dušan and some community members created a civic association titled Zrejmé (a play on words combining the words 'let us mature' and 'apparently'), still in existence today, which addresses intergenerational communication and the importance of supporting the debate on this topic in the broader society. The civic association has for five years organised an intergenerational festival with a programme for all generations, slightly interrupted only by the COVID-19 pandemic. The activities also include intergenerational book clubs, storytelling sessions, using the possibility to meet in the yard, and opportunities for dancing and other activities.

The community activism related to the senior centre brings us back to the values of interdependence, reciprocity, and cooperation among generations. And as a community may be defined by social rather than physical boundaries presented by a specific territory, locality, or district of the city, it can include those with whom we share interests, identities, and/or interactions (Robert, 2002: 579). Nowadays, the community that emerged around the senior centre continues on a symbolic level (Cohen, 1985). The basic characteristic features include shared memory – the community is experienced by its members, although it does not consist of a social structure or in 'the doing' of social behaviour. It inheres, rather, in 'the thinking' about it. The past is used here as a resource during the organised festival and during the regular minor activities and functions, rather than as a repository of meaning for its members, or a set of mechanical linkages. Although the senior centre was abolished or moved to another place, it is still the place, the spatial identity, or belonging to a place that forms one of the pillars of its identity. The community members named the platform for their recent activities after the place, the street's name, where the centre was located.

However, the activities of the civic association are not connected to one place anymore. It is a 'nomadic' platform. Events or activities always occur in different spots – the book club in the local library, the intergenerational quizzes in local pubs, and dance lessons in the local park. During the COVID-19 pandemic, they often occurred in the virtual environment. Moreover, the activities also attract more people with different backgrounds, and the community expands and represents a different kind of activism. Its agenda is similar – to foster intergenerational communication and cooperation. Yet, the ageivistic aspect related to self-definition and fighting for the right to decide about political issues and, as such, challenging the presentation of seniors as passive beneficiaries, has gradually disappeared.

Conclusion

Population ageing is often seen as a victory for humanity, providing unprecedented opportunities to live longer. However, it also leads to concerns about the future development and economic sustainability of current systems due to the ratio of too few children or people of ‘productive age’, who would have to take care of the burden of too many older people, within the framework of the intergenerational contract. This idea was also implicitly present in this case study’s political decision to cancel the senior day-care centre. Its residents had to leave its premises to provide space for a crèche. In the decision-making process, two generations both requiring care were put on the scales, and the younger one was given priority. Usually, the idea of being a burden is additionally enhanced by various manifestations of ageism. The most direct and visible forms of ageism in society are usually presented through lack of voice – the ability to express oneself, be heard – lack of respect or esteem, and limitation of one’s own space or place.

All the more interesting is the politicisation of the development that evolved around the fate of the senior centre on the part of the residents themselves and the community that formed around them and the centre. As the residents themselves first politicised the abolishment issue, we return to the concept of active ageing. Among other things, within the public sphere, active ageing supports greater participation of older adults in other areas of public life in society – by participating in the life of the neighbourhood community or getting involved in civic and political events.

At the same time, the engagement of older adults was enabled and enhanced via community care, which was not based on formal care provided by the (female) employees of the institution. It is necessary to constantly renegotiate the potential of forms of care relating to local contexts and traditions. And although the seniors’ day-care centre could not be saved, returning to the title of this chapter, it can be concluded that the community’s efforts were not entirely unsuccessful. Its members brought and emphasised in the public debate related to care the need for broader intergenerational cooperation between family members and a wider circle of acquaintances, neighbours and sometimes complete strangers.

It can be assumed that due to the rapid ageing of the population, the care crisis, e.g. the gap between care needs in society and the resources available to provide them, will widen in the future. Thus, community social services that combine state, municipality, and family resources, as in the senior day-care centre, contribute to the best possible care. However, the political enforcement of the concept of community services is conditional on the implementation of the legal measures, for example, the approved community plan of social services and the overall concept of developing social services in Slovakia.

Notes

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1 As I have written about the approach elsewhere (Voľanská, 2017), I would like only to mention the basic principle of the work with the material from the biographical interviews.

2 At its establishment, it represented a relatively unique institution with an international response. There was even a report/article published in the journal *National Geographic* in the 1990s.

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10

Politicising older persons' care in Romania: An institutional approach

Simona Ioana Bodogai and Diana Mărgărit

After the fall of communism in 1989, Romania was subject to significant changes that had to reconcile the dictatorial past and its cultural and social background with the Western political and economic model. The free market, privatisation in different industry branches, and legal provisions in terms of human rights accompanied the institutional reconfiguration of the newly democratic state. In addition, by following a global trend (Lutz *et al.*, 2008; Spijker and MacInness, 2013; Beard and Bloom, 2015; Sander *et al.*, 2015), improvements in terms of medical services and quality of life have determined radical structural transformations within the social balance. However, massive economic migration, which involved the exodus of active categories of citizens towards Western countries, combined with access to contraceptive methods – considered illegal during communism, more precisely between 1966 and 1989 – and the rise in living standards led to population ageing. Even though population ageing is a globally widespread phenomenon, especially in post-industrialised countries, Romania is facing one of the most accelerated cases of ageing among the member states of the European Union; it is estimated that people aged 65+ will make up 30% of the population by 2050 (Teşliuc *et al.*, 2015: 101).

The post-communist governments have had to deal with the economic, political, and cultural consequences of ageing (Caragea and Alexandru, 2017) by creating a care system that could address older people's challenges as a vulnerable social category. However, reforms in social services sometimes go against the grain of how society deals with integrating and assuming the responsibility of taking care of them. Ageism, a discriminatory attitude towards older persons, has become a widespread phenomenon, including in Romania (Stanciu, 2012). However, Romania shares a common feature with other neighbouring countries of Central and Eastern Europe, namely the acceptance of ageism as inherent to the evolution of society (Trusinova, 2014). People tend to tolerate age-based discrimination, even though they disagree with it. In this context, the marginalisation and exclusion of older persons from active life or social and medical care may have some roots in the local culture (Chelcea, 2015; Precupetu *et. al.*, 2019).

The economic crises during the early 1990s and, more recently, the global economic crash in 2008–2009 influenced the government to implement austerity measures and make significant cuts at the level of public expenditure that eventually affected older adults. These policies generated a widespread nostalgia for communism (INSCOP, 2013), similar to that in Central and Eastern countries with a recent dictatorial history. Nevertheless, over the years, Romania made considerable progress in economic and social terms. Moreover, European Union membership in 2007 stimulated Romanian society and successive governments to speed up the process of development to reduce the gap between Romania and other member states. Despite all this, Romania occupies first place, with a figure of 34%, in terms of people exposed to poverty and social exclusion at the European Union level (Eurostat, 2022). Compared to other age categories, older people are the most vulnerable (NIS, 2022: 61).

Older age categories were the most vulnerable compared to the rest of society during the COVID-19 pandemic. Isolation, lack or scarcity of medical assistance, inadequacy or inefficiency of social aid, economic precarity, and digital exclusion deepened the social cleavages and exposed older people to a higher degree than before. Medicine shortages and reallocation of hospital resources, especially for COVID-19 patients, to the detriment of chronic illnesses, contributed to the decline of their quality of life. In addition, mortality due to the SARS-CoV-2 virus was among the highest among all the world's nations, and it dramatically impacted those aged 65+ and, to a greater extent, those with comorbidities (Pop, 2021).

Even though legal provisions and policies dealing with different aspects related to older persons have been subject to many amendments over the past few years, they have yet to generate public debates and consultation processes at the societal level. In this context, our chapter provides an overview of the legal framework and the dynamics between public and private institutionalised care services. We hypothesise that an idea becomes an efficient piece of law or a policy if it emerges from consistent societal debates and consultations. In other words, it needs to go through the complex process of politicisation, which we further define as the set of activities through which a topic relevant to society later transforms into a policy or a law. Mutatis mutandis, political decisions on older people's care should be part of politicisation. Based on this assumption, our analysis focuses on an institution that is essential in politicising older people's issues, including care, in Romania. By considering the structure and repertoire of the actions of the National Council of Pensioners' and Older Persons' Organisations (hereafter NCPOPO), our chapter questions its agency in the process of politicisation of older persons' care.

The threefold structure of this study consists of: (a) a theoretical framework on the meanings of politicisation and an overview of the Romanian literature on social care; (b) a presentation of the defining aspects of the older persons' care system in Romania; and (c) an institutional analysis of NCPOPO, through the lens of the process of politicisation of care for older people. From a methodological point of view, we analyse primary sources such as legislation, reports, and other information retrieved from the official websites of relevant institutions, as well as secondary literature in the field of older people's care.

Theoretical framework

References to politicisation have revealed two opposite tendencies, one favouring a depreciative connotation and the other a positive understanding of it. The negative meaning of politicisation presupposes its equivalation with instrumentalisation or manipulation to serve the interests and goals of different (political) actors (Graff and Korolczuk, 2022: 117). A politicised issue or a domain is thus compromised and transferred into the vicinity of corrupted subjectivity.

In contrast, politicisation may also mean an opportunity for public debate and social change that can improve certain domains or issues neglected before (Palonen, 2019: 250–252). Thus, politicisation refers to "the process of opening an arena of political action or raising an issue to political debate. (…) (It) can be either inventive or disruptive: the construction of entirely new chances, or the detection of political potential" (Luhtakallio, 2012: 4–8). In other words, the positive connotation of politicisation implies the rise of an issue from oblivion to relevance for the public space. Being in the spotlight may meet the majority's expectations or contradict what society expects. Politicisation may be an answer to grievances and claims expressed by different civic groups or, on the contrary, may have a disruptive effect. Nevertheless, politicisation results from opportunity structures generated by the political environment on social grounds that open the floor for public debate, contestation, social mobilisation, civic synergies, and so on (Wiesner, 2019: 257; Numerato *et al.*, 2021).

This positive connotation allows us to tackle the issue of older people's care as inherently political while also inviting us to focus on the process of its politicisation. In Romania, the issue of care for older people as a topic of debate and deliberation does not reach high levels of notoriety. However, related topics such as pensions, health care, shortages of pills in pharmacies, or the risk of poverty sometimes make headlines in television news and newspapers.

Older persons' care in Romania is also subject to different public policies – health and disability policies, family- or pension-related. Even though pieces of legislation and executive decisions made by central and local authorities address the topic of care for older adults, it remains marginal at the level of public debate. The limited popularity of this topic is evident from the scarce studies conducted so far in Romania on the social protection of this category compared to other fields in social studies.

Even though scholars from different fields of studies have tackled the issue of care for older people in Romania, the social work perspective has prevailed. Those affiliated with social work have mainly analysed different aspects of the organisation of the older people's care system and specific policies without necessarily considering how political issues affect the public space in general and the political decision-making processes in particular. Research in social work has either focused on diagnosis of the challenges that older categories of the population have to face (Bălașa, 2003; Gal, 2003), be they material or symbolic (Stanciu, 2008), their needs (Bodogai, 2009a, 2009b), or on different types and levels of solutions – medical and social (Șoitu and Rebeleanu, 2011; Băjenaru *et al.*, 2020; Bodogai, 2020; Stanciu, 2020; Șoitu, 2021), institutionalised and non-institutionalised forms of older persons' care (Gîrleanu-Șoitu, 2006; Caciula *et al.*, 2019).

The assumption tested within social work research is that efficient policies are the consequence of an adequate, nuanced, and complex knowledge of, on the one hand, the needs and struggles of older adults as a social category and, on the other, the formal and informal elements that shape the specialised care system (Bodogai, 2020; Popescu *et al.*, 2020). The need for adequate medical care, together with the problems of material deprivation, isolation, dependence, limited capacity for self-management, lack of information, inefficient and insufficient institutional mechanisms, spiritual needs (Bodogai, 2020), and inadaptability to social, cultural, and technological changes (Popescu *et al.*, 2020), are all aspects that push older people even further to the edge of vulnerability, marginalisation, and social exclusion.

An overview of the Romanian care system for older persons

The social protection system in Romania has a four-level structure: public goods, social insurance, universal categorical transfers, and social assistance. Older persons, almost four million (NCPOPO, 2022a), benefit from protection at all the levels mentioned above (Costăchescu, 2015; Jimon *et al.*, 2019), at least from a formal point of view. The main level of protection, which supports those who have lost their ability to work due to old age, disability, or death, concerns social insurance – pensions. The Romanian social protection system provides the possibility to benefit from: (a) public pensions, based on compulsory contributions; (b) compulsory private pensions that are obligatory but invested in privately managed portfolios; and (c) optional private pensions, which give those with higher incomes the possibility of extra insurance. Until now, the retirement age has differed depending on gender: men – 65; women – 62. However, due to the increasing pressure of ageing, Romania is facing a debate on raising and equalising the retirement age of women and men to 65. This measure intends to ease public expenditure for older persons, among others.

In terms of health insurance, pensioners have the right to receive health care in outpatient clinics and hospitals that have contracts with health insurance funds, access to medicines, medical supplies, and medical devices, annual preventive examinations, emergency medical services, some dental care services, physiotherapy treatment, rehabilitation, and last but not least, home health care services (Bodogai, 2020). As for the third level of social protection (i.e. the universal categorical transfers), it is worth mentioning the allowance for people with disabilities. This allowance induces the idea that the older persons' health problems are not strictly related to age, but to a disability. Therefore, older people facing health issues are considered disabled and benefit from the so-called 'allowance for people with disabilities' (Abrudan and Oprea, 2004).

The last level of social protection for older people is the social assistance intervention. This aims to catch, like a safety net, those who fail to ensure a decent standard of living on their own. Law 17/200, republished in 2007, provides the legal framework for social assistance for older people. It stipulates different types of formal and informal caregiving establishments that offer a wide variety of services – health, assistance, financial support, etc. Moreover, social assistance is under the authority of the Ministry of Labour and Social Security (hereafter MLSS), which is the public institution that synthesises and coordinates strategy and government policies in the areas of work, family, and social protection. One of the tasks of this ministry is to identify, develop, and promote public policies and legislation by different government provisions and in line with Romania's obligations arising from membership in the EU and international organisations.

Since the fall of communism, Romanian society has been subject to demographic ageing. According to the National Institute of Statistics, the share of the population aged 65+ is 19.5%, while the population aged 0–14 is 15.8% (NIS, 2022). This unbalanced age structure reveals an issue that Romania has already started to face, namely the decreasing proportion of the young and active population, which will soon be unable to support the social protection system. Moreover, the Romanian social system has been chronically underfinanced, whilst the number of social workers is constantly in deficit (Lazăr *et al.*, 2020: 12–20). This challenges even more the social system that must deal with a significant category of society that is increasingly dependent on it.

Romania also occupies a low position in terms of public spending on long-term care compared to most of the other European states – less than 0.5% of GDP, compared to Norway which spends almost 4%, or to the average of the EU member states which is not far off 2% (NCPOPO, 2017: 12). Until recently, it has managed to organise different specialised institutions and services, namely residential centres, residential centres of a 'respiro' type, reception centres for emergency but temporary protection, day-care centres for care, rehabilitation, and socialisation, home care services, counselling and hotline support, medical and social care centres, hospice-type nursing centres for those terminally ill, and protected housing and social canteens (Bodogai, 2020). However, the number of residential care centres is insufficient to meet the existing demand. In addition, the employees in geriatric institutions are often insufficient and overloaded (Ungureanu *et al.*, 2020). Also, the quality standards established by the legislation are hardly satisfied by the existing centres, and the solution of residential care is insufficient with respect to the high demand. Moreover, the Romanian system has difficulties finding solutions that would shift the focus from residential care to home care services, and dealing with geographic challenges. The almost total lack of home care services in rural areas, the insufficient budget funds, and the development of social policies without consulting practitioners and scholars deepen the gap between political decisions and social reality.

Even though Romania has a long history of centralised organisation, the care system has evolved following regional and local trends. There are discrepancies between different counties, such as for instance Transylvania and Banat, where the proportion of licensed home care services is higher than in southern Romania (MLSS, 2022a). The private sector also plays a vital role in providing care. The private sector manages 68% of the existing home services, while the public sector is responsible for only 32% (MLSS, 2022b). In addition, the involvement of the non-profit sector in developing all types of residential centres has risen to 83% (MLSS, 2022c). The disproportion between public and private is significantly in favour of the former only in the case of 'respiro'/crisis centres and medical and social residential centres. Other types of care institutions – residential centres, protected housing, and residential palliative care centres – are mainly the result of private initiatives. Another relevant detail concerns the complete absence of publicly funded palliative care centres (MLSS, 2022d). Private initiatives try to fill the gap created by the lack of consistent public funding for care, but they cannot fully meet the existing high demand. Waiting lists are constantly drawn up in residential centres because the existing places are insufficient. These waiting lists would be shorter if day-care or home care services were privileged over institutionalised care.

Overall, in Romania, there are three main types of care institutions for older people: day-care centres, home care, and residential care establishments. Most day-care centres focus on socialising and spending free time while ignoring early intervention and recovery services. At the same time, the narrative of the care system seems outdated in contrast to the European trend. Romania keeps encouraging residential care over the development of the home care system – only 24.3% of the care services (MLSS, 2022d) – even though it would entail lower financial and social costs.

The fragility and scarcity that characterise the home care system is also closely connected to the traditional gendered division of labour and the prohibitive costs of institutionalised care. In rural and peri-urban areas, women are primarily responsible for caring for older persons, especially in the familial context. Since care for older people is mainly perceived as a moral obligation, it lacks financial remuneration. At the same time, despite slight recent improvements in care policies, women often perceive ageing and care for older people as one of their burdens, since most often they are the main care providers (NCPOPO, 2017: 15).

During the last two decades, economic migration of Romanian women to Western European countries, especially to Italy, Spain, Austria, and Germany, has had significant consequences for local informal care. For example, more than half a million Romanian women have permanent jobs as home caregivers in Italy (Țoc and Guțu, 2021: 3). In this respect, economic migration of Romanian women has adverse effects on the situation of older family members who are left behind, which results in the reconfiguration of the domestic informal care system. Thus, family members provide care for older people if their female relatives working abroad do not earn enough to financially support residential centre services in Romania. However, 'this produces the paradox that many migrant women who work as caretakers for older people in Italy are not able to meet the care needs of their own older parents' (Vianello 2016: 791).

Overall, Romania has made considerable efforts to synchronise with the Western narrative on dealing with ageing. In 1999, Romania ratified the Revised European Social Charter which promotes a perspective of older people as active members of society and the responsibility to take care of them when they can no longer do so themselves (Abraham, 2000: 298–299). Moreover, it developed its own National Action Plans that could address specific ageing problems. The National Strategy for Promoting Active

Ageing and Protecting Older Persons for 2015–2020 aimed at improving their quality of life and active participation, care, and health services (Government Decision 566/2015). Another strategy is currently in force until 2030 (Government Decision 1492/2022).

Nevertheless, many of the commitments made by the Romanian government still lack necessary funding and political engagement. Promoting social inclusion, active participation of older adults, fighting discrimination, and reforming the entire care system are long-term measures. Moreover, educating society against ageist stereotypes and raising awareness of older persons' struggles requires sustained financial and human efforts and consistency. In this regard, the National Council of Pensioners' and Older Persons' Organisations (NCPOPO) enters the scene.

Agency for politicisation? The NCPOPO case

The history of NCPOPO goes back to 2000 when the institution was born under the name the National Council of Older Persons (NCOP). An autonomous and consultative body, yet partly financed by the state, NCOP aimed primarily at offering assistance in terms of policies and recommendations to different state institutions dealing with older people's needs. Second in the hierarchy of its responsibilities, as stated in article 4 of Law no. 16/2000, came the role of representation of older people in different associative contexts. Through a legal lens, NCOP should have helped the state evaluate older people's struggles and, consequently, provide recommendations that would eventually reflect in the political decisions. Specifically, NCOP intended to reduce the distance between the arena of political decisions and the complex, multifaceted aspects of older people's daily life. At the same time, NCOP represented the voice of civil society and different levels of older persons' associations within the process of social dialogue with the centralised political authorities. Finally, NCOP would have supported and watched over state compliance with the recommendations issued at the World Assembly on Ageing.

The law was adopted two years before the United Nations World Assembly on Ageing in Madrid – which took place on 12 April 2002. Even though the Madrid International Plan of Action on Ageing was a non-legally binding document, the governments attending the assembly proved their enthusiasm in openly addressing issues such as old age rights, the risk of poverty, the ageing population, the welfare of older persons, building national and international framework capacity to assure them a more inclusive and active life, and gender equality (United Nations, 2002). Healthy and active ageing, work integration even after retirement, and reducing social isolation were some of the recommendations made by the Plan. However, governments implemented these differently based on the particularities of the domestic social system, culture, and economic development.

Over 20 years later, there is room for improvement (Zaidi, 2018). For instance, Romania has low employment rates among people aged 55+ compared to other member states of the European Union, which is correlated with a high risk of poverty in later life (Formosa, 2023: 42–44). In response, the Strategic Plan for Active Ageing and Long-Term Care adopted in December 2022 by the Romanian government seems to offer solutions to the deficit of jobs due to high rates of emigration by stimulating employment among older persons, preventing health-related issues, and other initiatives (Government Decision 1492/2022).

During the last 20 years, NCOP has passed through several processes of legal transformation, with many amendments to the initial law and an addition to its name, becoming thus the National Council of Pensioners' and Older Persons' Organisations (NCPOPO). Furthermore, the word 'pensioners' was added recently, before the word 'organisations', to encompass all older adults. In this way, NCPOPO becomes representative not only of those older persons who are beneficiaries of a state system pension but of all those included in the age category of older adults. Thus, age is privileged over integration within the social system. Moreover, the Council represents especially organisations following a federative model – local autonomy and central representation.

NCPOPO has a president and two vice presidents elected for four years, forming the Permanent Commission. Next to it, there is the Council of Pensioners and Older Persons' Organisations, which has two types of members: (a) one representative for each of the following institutions: the General Union of Pensioners from Romania, the National House of Public Pensions, the National House of Health Insurance, the National Institute of Statistics, the Ministry of Work and Social Solidarity, the Ministry of Internal Affairs, the Ministry of Health, the Ministry of Finance, the National Authority for the Rights of Disabled Persons, Children, and Adults, the National Association of Military Personnel in Reserve and Withdrawal, the National Association of War Veterans, the Union of War Veterans and Veteran Survivors, and the Association of War Veterans of the Ministry of Internal Affairs; and (b) one representative for each of the 41 County Councils of Pensioners and Older Persons – including the capital city, Bucharest. The composition of the Council shows NCPOPO as a forum where a plethora of political, civil, and military actors, on the one hand, and representatives of local branches of NCPOPO, on the other, meet and negotiate (NCPOPO, 2023a).

NCPOPO highly connects to local organisations for older persons (Bodogai, 2020), which are represented in the decision-making process by the Civic Dialogue Consultative Committee for the Problems of Older Persons. This structure is a specialised service within the Prefectures (Government Decision 499/2004). The Committee includes representatives of all local institutions whose activities regard older people. Its activity consists of mutual information, consulting the representatives on the draft normative acts to be initiated, analysing and elaborating legislative proposals, and suggesting solutions to the authorised institutions (Government Decision 499/2004).

Within the institutional structure of NCPOPO, the Office for Analyses and Studies is responsible for researching different topics related to older people. Writing reports and scientific papers is one of the main functions of NCPOPO, according to the law. On the website, one can find 165 studies on different topics related to ageing, chronologically organised, from 2007 till now (NCPOPO, 2023b). More specifically, they tackle aspects directly or indirectly connected to older people's lives, such as health, economic life and social protection, the gender gap, and social dialogue. The authorship of the analyses either involves members of the Office, called 'experts', or researchers from academia. The analyses and studies realised under the auspices of the Office offer a complex and insightful overview of the multiple struggles of the older generations, as well as progress and recommendations for institutions involved in the decision-making processes. The assumption on which the research is based is that understanding reality should constitute the basis for all specific policies and inform all decision-making actors, be they central or local. At the same time, these studies are helpful to everyone outside the political spectrum interested in the topic. Unfortunately, they are published only in Romanian, considerably reducing the audience.

Starting with 2020, NCPOPO has also become an aggregator of information, mainly statistical data on the number of beneficiaries of pensions, correlated with different relevant aspects – inflation, purchasing power, previous domains of activity, social insurance, and others. Nevertheless, such data are insufficient to get a complex perspective on the social system unless correlated with other reliable sources such as those provided by the Ministry of Work and Social Solidarity, the Research Institute for Quality of Life, subordinated to the Romanian Academy, specific research conducted by professors in sociology and social work in university departments, local specialised institutions, and so on.

Regarding the repertory of actions, NCPOPO uses various instruments to interact with different actors: meetings, conferences, press releases on trending topics, and proposals. As an illustration, the 2021 report lists requests addressed to: (a) the Ministry of Health concerning the price of medicines, developing a national dental programme and financing emergency dental services, and increasing the number of rural pharmacies; (b) the Ministry of Labour and Social Solidarity concerning the development of the home care system, as well as the provision of facilities for care in one's own family, as an alternative to institutionalisation, the set-up of social canteens throughout the country in order to support disadvantaged older people, and free public urban transportation; and (c) the Parliament, to amend the law by forcing the local public administration to assign to the County Councils of Pensioners and Older People the appropriate premises necessary for carrying out their activity and an annual amount for office expenses (NCPOPO, 2022b).

NCPOPO and affiliated member county organisations are engaged in direct action activities such as sit-ins in public squares for issues primarily related to pensions, or letter writing addressed to key institutional representatives. Concerning the latter, the Actions section on the website (NCPOPO, 2023c) mentions some notable examples: an open letter to the General Inspector of the Romanian Police asking for public campaigns on the prevention and punishment of violence against older persons; in 2019, an open letter to the Director of Romanian Television asking for the introduction of informative shows dedicated to the older audience; in 2019 again, an open letter to the Minister of European Funds requesting funds for the installation of elevators in four-level blocks of flats.

As shown above, NCPOPO plays diverse, often overlapping roles: (1) negotiator with policy-makers – central executive and legislative bodies. From a legal point of view, the presence of NCPOPO at the negotiating table is a *sine qua non* condition in all decisions and laws that regulate domains related to older categories; (2) *porte-parole* of the pensioners' and older persons' organisations at the national and local levels. The legitimacy of NCPOPO derives from public trust and specific procedures that allow affiliated organisations to delegate members in the internal structures. Adhesion to NCPOPO may be a source of representation for civic older people's organisations. For instance, in 2021, the Solidarity National Federation of Pensioners of Romania organised a protest at the Ministry of Work and Social Protection by claiming, among other things, its adhesion to NCPOPO (Nica, 2021); (3) generator of knowledge through analyses and reports, available on the website; and (4) knowledge dissemination agent through conferences and debates where academia and civil society take part, as well as meetings with specialised state institutions.

We have enumerated these four hypostases following the order suggested by the law. We assume that the order of these elements in the law reflects the hierarchy of their relevance according to the legislation. However, concrete social life does not entirely correspond to the normative narrative. NCPOPO privileges generating and diffusing information or offering help in kind over legislative proposals (Enache, 2021: 3). There have been situations in which it drew attention, through the media or its website, to the fact that critical central institutions failed to invite it for consultations during the drafting of laws that directly concerned older persons, such as the Pensions Law. In the 2016 report on the activity of its members, the institution criticised situations where ministries proposed draft normative acts without the approval of NCPOPO, which was a mandatory step according to the legislation in force (NCPOPO, 2017: 4). The deficiency in communication was confirmed six years later in the 'National Strategy for Long Term Care and Active Ageing, 2023–2030', issued by the Ministry of Work and Social Solidarity. In the section referring to the institutional arrangements for long-term care, the document mentions improvement of collaboration between the ministry and the NCPOPO as one of the strategy's goals (Government Decision 1492/2022).

In this context, to what extent is NCPOPO an effective agent for politicising older people's care in Romania? Before answering this question, a few short clarifications are necessary. As stated in the theoretical framework section, we privilege the positive connotation of politicisation, meaning the process through which a topic becomes relevant for public opinion, subject to debates, antagonism, or consensus. At the same time, politicisation presupposes using different formal and informal mechanisms that transform ideas that society agrees upon into policies. These mechanisms involve the implication of different collective actors that strive to raise an opinion – even though shared by a group – to the level of a widely accepted idea or at least relevant to society.

From a normative point of view, NCPOPO should fulfil the task of an agency for the politicisation of older people's needs, including care. All along, it has managed to improve and diversify instruments that contribute to raising awareness of the difficulties of this specific category and consolidating its status as a negotiator with political actors. In addition, the legislation regulating NCPOPO has changed over time, allowing improvements in financial and logistical resources – remuneration for its members, funds for different activities, offices, etc.

From a descriptive perspective, it is premature to conclude that NCPOPO is an effective agent for politicisation. In this regard, analysis of the institution's functioning reveals some pertinent information. As long as political institutions and other actors petitioned by NCPOPO simulate consultation or ignore its claims, the politicisation of a topic such as older persons' care remains an uncertain goal. After all, the credibility and prestige of an institution rely, among others, on its interaction with other essential actors in the public arena. Its recognition as an agent of politicisation should not be reduced only to the bare existence of a law. On the contrary, it involves creating different mechanisms that could ultimately favour compliance with the law and improving it, if necessary.

At the same time, the composition of the council of NCPOPO, which includes political actors and civic organisations, may cause organisational identity problems and long-term strategic difficulties. Moreover, considering the repertoire of actions, NCPOPO assumes the role of a vector for social dialogue on behalf of older persons' organisations. In dissension between civil society and the government, it would be hard to make decisions because state secretaries from four ministries are part of the council. Paradoxically, an agency for politicisation does not suppose party membership or membership in other political institutions. On the contrary, it requires autonomy, free will, responsibility, consistency, and a certain degree of spontaneity (Barnes, 2000: 25–29, 91). Supposing that NCPOPO remains active in raising awareness of older persons' issues and influencing the legislative process that deals with them, a more precise separation between political and civic membership might be a solution.

Conclusions

Despite improvements, the Romanian social protection system for older persons faces many difficulties due to scarcity of funding and specialised human resources, overload with demands, political unpredictability, etc. Unfortunately, prevention and early intervention often need more attention, and late intervention involves much higher costs and only covers part of the demand. Moreover, the issue of caring for older people is not reflected in a coherent set of policies, and the political response is far from being immediate and effective even though the process of demographic ageing is deepening. The non-profit sector strives to meet the needs not covered by the state – e.g. palliative care – but also needs help from the perspective of the sustainability of specific initiatives.

The Romanian care system has witnessed some improvements over the past years. Even though long-term care for older people is a topic of legislation and governmental reports, it still requires more coherent and adequate policies. Diversifying institutionalised care and prioritising home-based care services should become attainable goals in the foreseeable future. At the same time, hybrid solutions that mix formal and informal care elements could prove viable.

As shown above, care is highly gendered. On one side, informal care provided by family members, especially women, keeps being preferred. On the other, the formal care system has its deficiencies, starting with the undervaluation reflected in low salaries, lack of public expenditure, and staff shortages. Moreover, during the past decades, the care drain associated with Romanian women's economic migration has challenged the traditional model. They choose remunerated jobs as caregivers abroad at the price of leaving behind their older relatives.

Unfortunately, older persons' struggles are rarely the topic of debates and consultations with specialised organisations and public opinion. Lack of communication between political actors and beneficiaries or personnel in the social care field have consequences on the specific policies and regulations. In this context, NCPOPO is a crucial actor. Our analysis emphasises that it not only plays the role of a mediator and negotiator but also wears the shoes of a generator of knowledge and knowledge diffusion agent. At least from a normative perspective, NCPOPO acts as an agent for politicisation in that it seeks to make older people's issues visible within society and influence the political decision-making processes. However, from a practical point of view, its agency has to deal with different institutional and political obstacles, which makes its task even harder. Even so, just as one swallow does not a summer make, similarly, the NCPOPO cannot run a one-person show in the process of politicisation of older people's care in Romania.

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Afterword: Care for older people in Europe

Pat Thane

Introduction

The most striking, and depressing, feature of the national case studies in this volume is the generally poor quality of care, by public and private providers, for the needs of older people, with only occasional, sporadic improvement. This has been so, even, indeed especially, as their numbers have grown and as knowledge of their needs and effective methods of care has expanded. It is also striking that political discourse about elder care has taken similar paths over time even in apparently very different socio-political contexts. Equally evident is the significance everywhere of family care for (and by) older relatives, generally provided by women (as is most formal care), seeking, often struggling stressfully, to compensate for the inadequacy or absence of formal care services, in the face of widespread, persistent, wholly inaccurate, popular rhetoric about growing family neglect of older relatives. Indeed, the belief of politicians internationally that women in families will – and in their view should – take over when public policy fails can be suggested as a reason for their failures to make adequate public provision for needs in later life: they know that women will take over.

Another likely reason, less often discussed in these chapters, is age discrimination, ageism, the belief that the needs of older people should have low priority for governments compared with those of the rest of their populations, especially children, because it is less urgent for the economy and society to keep older people healthy and active: they have limited futures and can contribute little in return; the more they are neglected, the sooner they will die. Also, frail older people in need of health and social care are less likely to vote or to protest against neglect compared with younger groups, so politicians can ignore them. Such shameful sentiments are rarely explicitly expressed, if at all, but it is hard to believe that they do not lurk behind much government, and wider, thinking in most societies, deeply embedded in our cultures. A rare explicit statement came in William Beveridge's official report on social insurance in 1942, which did much to influence the post-war UK welfare state: “It is dangerous to be in any way lavish to old age until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young” (Beveridge, 1942: 92). Similar principles seem to have long (silently) guided policy concerning older people in the UK and other countries.

This volume includes studies of a wide range of European societies, but not all. Notably absent are any of the Nordic countries which since the mid-twentieth century have developed and largely sustained the most comprehensive welfare states. Although these have undergone some erosion in recent years, as occasional remarks in this volume indicate, they continue to offer more effective public provision for the needs of older people than other countries. Other north European countries, including France and the United Kingdom (UK), which are discussed here, initially aspired to emulate them but have lost momentum, especially since the 1980s. Similarly, Spain and Portugal in southern Europe developed state welfare systems after their emergence from fascism in the 1970s, but they have since declined. The volume also valuably surveys many features of the similarities and differences in patterns of elder care in several former communist countries of Central and Eastern Europe, which have been much less studied in this context. Many of the studies are innovative and incomplete, but they raise important questions for discussion and further research. So, what can we learn from them?

The European Union (EU) and care

All countries surveyed in this volume are currently members of the EU, except the UK, which left in 2020, having been a member since 1973. The EU gradually developed principles of care for older people which it recommended to member states as desirable ways forward, although it has no power to impose them, and they can, and often do, ignore them. Hence it has tended to confine its recommendations to general statements of principle rather than describing specific care policies, which would not necessarily be appropriate for the very different structures and needs of each member state. Relevant to older people’s care, in 2017 its European Pillar of Social Rights promoted the principle that ‘everyone has the right to affordable long-term care services of good quality’, in particular community-based home care services. This built upon the original Treaty of the European Union (1957), which upheld the basic values of ‘human dignity’ and the desire to promote the ‘wellbeing of its people’.

The EU gave attention to the care of older people only several decades after it started to urge care for the needs of children in their early years.

Children form the future of every state, as older people, it is widely believed, do not. The shift came about as EU policy-makers recognised that populations throughout Europe were ageing due to declining births and growing life expectancy, which became especially evident in the 1980s. They noted the inadequacy of public services to meet the needs of older people, which they feared would decline further as their numbers grew. They were also influenced by growing awareness of the diversity of later life, stimulated by scholarly studies which revealed that not all older people matched the commonplace stereotype of 'dependent burdens', but many were capable of 'active ageing', as it became known, of independent living, even of continuing in paid work and learning new skills, which the EU became keen to encourage as a means to offset the expected growth in costs of pensions and other services for frail older people. However, there was a danger, as the authors of the chapter on the EU point out, that this approach could encourage another form of negative ageism, disparaging those incapable of activity in their later years.

The EU was also keen to draw women into the labour market to expand the shrinking younger workforce and assist economic growth. Also, it was under constant pressure from feminists throughout Europe to improve gender equality. It was increasingly aware of the degree to which care of older people was left to families, especially unskilled, unpaid women in families, increasingly including older women; there are now an estimated 20 million informal carers for older relatives in the EU. It recommended relieving them by facilitating the immigration of care workers from outside the EU while improving the training and support for all carers, paid and unpaid, including 'informal' family carers.

Along with other international bodies, the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD), the EU became increasingly concerned to establish the best type of care for the growing numbers of frail older people, and how to provide it. It was further influenced by the Covid pandemic, to which older people were especially vulnerable, which deepened and exposed the inadequacy of services in many countries, further increasing pressure upon family carers. The crisis led to a more detailed EU strategy document in 2022. This recognised that, throughout Europe, even paid care work was not valued and was highly precarious, with inadequate pay and conditions, and it was highly gendered, confined overwhelmingly to women, which helps to account for its low status, given women's internationally low status in workforces. The recommendations included improved services provided through a publicly regulated and monitored market in which unionised workers would negotiate improved pay and conditions. Also, men should be encouraged to take up care work – more likely if pay and conditions improved – along with importing workers from outside the EU to fill shortages. In 2024 it is, of course, unclear to what extent, if at all, member states have followed EU advice while recovering from the shock of COVID-19.

Care in the UK and France

Seeking what we can learn from experiences of care for older people across the EU, I will begin in northern Europe with the UK, which I know best. The Labour government elected with a large majority in 1945, after the war, aimed to revive the economy, creating growth and full employment, and to introduce a comprehensive welfare state, which together would revolutionise living standards, especially for working-class people, and greatly extend political involvement in the management of society and the economy. It prioritised economic policy and successfully achieved full employment and economic growth, which did much to raise general living standards for three decades after the war. It began to develop an extensive welfare state, in particular a National Health Service, invaluably providing the first state-funded free health care for the whole population, also free education with higher standards, and universal pensions and other benefits funded by workers' and employers' social insurance contributions.

Social services were also expanded. Elected local authorities were delegated to provide services, including for children and young people and residential care homes and community social services for older and disabled people. They could provide these directly, funded by local taxes, or delegate them to charitable or profit-making providers whom they were required to supervise and regulate and could subsidise. But local funds were rarely adequate to provide high-quality services, including care homes, and they received inadequate state funding. Consequently, services for older and disabled people, unlike those for children and young people and the universal state services, required means-tested fees from users. Hence older people received free health care but, apart from the poorest, had to pay for social care whilst often needing both. Also, as was evident in most countries surveyed in this volume, services delegated to local authorities were highly variable in extent and quality from district to district depending upon local finances and the decisions of local politicians. In the UK, health care, initially at least, was more uniform across the country because it was centrally administered. Also state old age pensions, first introduced in 1908, were universalised and raised, although they remained, as they had always been, too small to live on, contrary to expert recommendations, so were of little help to pay fees for services. Almost one million poorer pensioners had to apply for a means-tested supplement to the pension in order to survive.

The fact that charges were confined to services for older and disabled people suggests a certain age discrimination, which had long been a feature of British culture (Thane, 2000). Another persistent feature of the culture was stereotyping of people past a certain age as dependent 'burdens', ignoring the real diversity of this large age group. At this time, it was intensified by fears in government and wider circles that the pre-war situation of steadily falling births combined with lengthening life expectancy would revive after the war, creating a shrinking younger workforce required to pay for health care, pensions, and other needs of the growing older population. This ageing of the population began earlier than in many other European countries, from the beginning of the twentieth century, mainly due to the UK's greater prosperity at this time. A positive outcome of the panic it aroused was innovative research demonstrating that many older people could be active, effective workers, capable of learning new skills even past the official retirement ages of 65 for men and 60 for women. In fact, there was an unexpected post-war 'baby boom' which balanced the population. This was not recognised until the 1950s, when the fears receded, and the positive discoveries of the diversity of later life were forgotten until the birth-rate declined again from the later 1960s when, as the chapters show, the population panic emerged in many European countries (Thane, 1990).

Despite economic recovery and increased taxation, the Labour government believed it could not immediately afford to provide all welfare services free of charge, although it hoped to do so in future following further economic growth. This was despite the considerable funding given to the UK and other Western European countries by the US from 1948 – known as Marshall Aid – to help them revive their economies, institute welfare services, raise living standards, and demonstrate that liberal democracies could be more successful than communist countries in the emerging cold war. But Labour was unable to fulfil its ambitions for a welfare state, including care services for older people wholly free of charge, because in 1951 they lost an election to a Conservative government less committed to state welfare, including older people's care, which was in office until 1964. The competing ideologies of competing politicians were powerful influences upon welfare services throughout the EU.

Another feature the post-war UK welfare state shared with others was dependence upon female and immigrant labour. As the economy grew after the war, a labour shortage emerged as industries and services, including state services, expanded. The government responded by encouraging older women, whose children were no longer dependent, to enter the labour market – not younger women, who were under strong social pressure to raise the birth-rate and care for their children at home. To give them little alternative, publicly funded childcare, which had expanded during the war when labour was required from women of all ages, contracted, and has remained very limited and expensive in the UK ever since. Before the war, middle-class women were prohibited from working after marriage in professions and other skilled occupations. This 'marriage bar', as it was known, died out during the war. After the war, middle-aged, middle-class women were welcomed into expanding teaching, health care and other public, private, and charitable services, always fields perceived to lie particularly within 'women's sphere' because they were assumed to have a natural capacity for caring. In 1955, after long campaigns, they gained equal pay in the public sector for the first time, but not equal opportunities for promotion to senior posts, and women tended to be confined to lower-paid, lower-status roles. Care work, including social work, was almost exclusively female, low-paid and low-status, as it has remained.

The rapid expansion of the National Health Service (NHS) after its foundation in 1948 soon led to an acute shortage of skilled doctors, nurses, and other practitioners. The government responded to this and other labour shortages by calling for immigrant labour. They looked first to Ireland. The Republic of Ireland had become independent from the UK in 1922, but its economy remained weak, and many people migrated to find work, including in Britain, which especially attracted female nurses. The government also appealed to Europeans displaced by the war, thousands of whom migrated in the immediate post-war years. By 1948 the supply dried up, and the government looked to its colonies for labour at a time when there were few restrictions upon migration to the UK. At first, they were reluctant to call on people of colour for fear of arousing racism, but then felt that the shortage was such that they had no alternative to inviting nurses and other workers from the Caribbean, where unemployment was high. And increasingly, they looked to South Asia, mainly the former colonies of India and Pakistan, which became independent in 1947, for skilled doctors. The NHS has always, to the present, been highly dependent on immigrant staff, at all levels, along with other services, including care of older people. In the following decades, care staff came from many poorer countries, including in Europe, and including Eastern and Central Europe after the end of communism, until the UK left the EU in 2020, when many left the country. It continues to be difficult to recruit care workers from native British people because the work continues to be low-status, low-paid, and precarious.

Care for older people in the UK was highly politicised in the immediate post-war years, as it has since remained. It also became the subject of scholarly study. My chapter discusses the influential work of sociologist Peter Townsend (1964). His well-publicised revelations of the poor state of underfunded public residential care for older people in the 1950s were promoted especially by NGOs founded during and after the war to speak and lobby for the needs and interests of older people, who they felt were neglected compared with others in the growing welfare state. The shock of Townsend's revelations persuaded central and local government through the 1960s and 1970s to build comfortable, publicly managed care homes, expand community services for older people in their own homes – as older people preferred and which cost the government less – and create sheltered housing where older people could live independently with resident support and communal services. The outcome was far from meeting all needs, and there were still charges for services, but improvements were real.

Townsend and colleagues also revealed to the public that, contrary to prevailing myth, families provided more care for needy older people than public services (Townsend and Wedderburn, 1965). It was widely believed that, as more women worked and younger people moved away, sometimes far away, for work, families abandoned responsibility for their elders. Research showed this was decidedly not so. This information had a mixed impact. It may have encouraged the public sector further to withhold services when there was a (female) family member at hand to provide care. This certainly occurred in the 1960s, 1970s, and later, but it was never official policy and there is no means of measuring its extent. It also stimulated campaigns, especially from NGOs, to fund unpaid family carers for their considerable, often stressful, disregarded work. They were supported by feminists who had long campaigned for women's unpaid work in the home to be respected as 'work' because caring for children and other relatives and freeing men for employment was as arduous and vital to the economy and society as paid work. The outcome, as my chapter shows, was the very gradual provision of inadequate allowances to some, but not all, family carers. Politicians remained, and remain, reluctant to treat care of older people, formal or informal, with generosity and to give it priority for welfare funding.

This approach became even more prominent in the 1980s, in the UK as elsewhere, when Margaret Thatcher's neoliberal Conservative governments continued to uphold the myth of family neglect of older relatives. She asserted strongly that families and individuals should take primary responsibility for their own needs, without looking to the state. When they could not provide, they should look to the market and the charitable sector, paying fees as necessary. Public services were severely cut, becoming fewer and of lower quality, replaced increasingly with private, market-based services providing 'care' at higher cost for poorer quality. There was some improvement under Labour governments from 1997, especially in Scotland, which gained greater devolved powers from 1999 following its demands for independence from the UK. It introduced free personal care for older people, including in residential homes. England did not. Then came the international financial crisis of 2008–2010, and Labour lost the election in 2010. The 'austerity' policies of successive Conservative governments which followed brought further cuts to services and marketisation, despite repeated expert criticism and government promises to improve services for older people, which never happened. They remained of low priority. The growing relative deprivation of many older people in the UK was evident when, from 2012, their life expectancy began to decline after rising for a century while still rising among the better-off and in most other high-income countries (Marmot *et al.*, 2020).

The Covid pandemic, in the UK as elsewhere, made conditions even worse. Older people had relatively high death rates, especially those from the most deprived backgrounds. The most deprived communities with the highest death rates from Covid were of Bangladeshi and Pakistani origin, who suffered from poor housing, working, and living conditions at all ages. Unfortunately, little information is available about the access of these and other ethnic minority communities to elder care services – an under-researched field in a country with a large population of diverse immigrant origins. The pandemic brought the experiences of frail older people of all backgrounds to public notice as never before, spreading knowledge of the poor quality of services and the stress on (mainly women in) families who came under even greater pressure to care for older relatives. Publicity brought no evident political action to improve services, despite repeated promises.

I have discussed the UK situation at some length because it raises issues relevant to all the countries discussed in this volume. In post-1945 France, successive governments, whatever their ideologies, took a different approach to welfare from Labour in the UK. They appear to have paid even less attention to the needs of older people and provided few services at low cost to the state. France suffered considerably during the war due to the German occupation from 1940, and recovery took some time. Christophe Capuano describes how, from the 1950s to 1970s, the state focused on keeping older people in their homes, cared for by their families, supplemented by locally funded public and private, profit and non-profit, services employing low-skilled, low-paid, mainly female staff. It aimed to keep older people independent for as long as possible and to save on state funding by avoiding institutional care. But, as ever, locally based services were uneven in numbers and quality. By the 1970s, there were none in one-third of French municipalities. Poor services, of course, put pressure on women in families that could not afford expensive private services. The pressure intensified in the 1980s when, as in the UK and elsewhere, public policy was increasingly driven by neoliberalism, and there were further cuts and privatisation.

The 2000s was a time of health crises and scandals in France, arousing public debate about care of older people but no public policy response at a time of growing concern about the ageing of society. Here too, families were accused of negligence. But there was increasing pressure for support for older people and family carers from NGOs, which led to some improvement in day-care services, mainly providing support for female family carers. From 2020 they were paid a small daily allowance. But increasingly support services for older people and family carers were provided by profit-making companies, whose fees few of those in need could afford, while, again, staff were low-paid and overworked. Whether or to what extent the exploited staff were immigrants, or from the substantial racial minority population in France, we are not told.

Again, the Covid pandemic brought these problems to greater public attention, as it increased pressure upon services and families. There were demonstrations by care professionals against increasing pressure at work without improved conditions and evidence of abuse of older people in institutions. This led to a parliamentary inquiry and increased state monitoring of private institutions, but still no overall strategy to improve services. Government policy continued to be guided more by the desire to limit costs than by care for older people. Little changed in France after COVID-19. Care continued to be provided primarily by families and local authorities, the latter highly variable in quality and cost.

Care in Portugal and Spain

Portugal and Spain were both ruled by fascist dictatorships from the 1930s to the mid-1970s. Neither regime promoted welfare services, for older people or others, but they were succeeded by more democratic governments who joined the EU and aimed to emulate developments in EU countries, while long-established traditions of family care continued. In Portugal family carers were either daughters or older people themselves, caring for their spouses. However, as elsewhere, care by younger people was assumed to be declining in the 1970s due to the ageing of the population, emigration of younger people to more liberal environments, and more women in employment. These shifts made care for older people a public and political issue for the first time. Care was provided at the intersection of the state, families, the market, and voluntary action. Family care remained at the heart of state policy, but for the first time, it provided unpaid carers with (small) attendance allowances and support from a national health service and social services provided by NGOs recognised and funded by the state. From 2000, health and social services were increasingly integrated, and more nursing homes were established. But still by 2019 Portuguese state spending on care for older people was well below the OECD average; only 1.9% of over-65s received publicly funded long-term care, 1.2% in institutions, 0.6% at home, and it was not always of good quality. Private businesses provided residential and home care, but it was too costly for most older people and families and often of poor quality.

Informal carers of all ages campaigned for greater recognition of their work, supported by NGOs and left political parties, further politicising the needs of older people. This led in 2019 to a statute recognising the rights and duties of family carers, but only if they were full-time, unpaid, and living in the same household as the person cared for. They were granted training by health professionals, respite support, and means-tested cash allowances, but they were very small and paid to only 2,767 of 827,000 carers. They continued campaigning, with little effect. In Portugal also, despite protestations of concern for older people by successive governments, there was little effective political action and responsibility for care remained predominantly with women in families.

The story was similar in Spain and in other southern European countries, including Italy and Greece, which had strong traditions of intergenerational co-residence and care and a strict gender division of labour in households dependent upon male 'breadwinners'. In Spain, like Portugal, by the 1980s, there was concern about the combined effects of lengthening life expectancy and increased female employment. All political parties then focused upon providing care homes and pensions, the latter intended as the state's main source of support in old age, enabling purchase on the market of services providing support at home, while the state provided care homes and services for the poorest. By 2000, 3.2% of over-65s were care home residents, and 2.1% received community services. As more women worked, a high proportion of home care, in families that could afford it, was provided by immigrant employees from Eastern Europe and further afield, who had few labour rights or access to benefits and were paid partly in food and accommodation, at low cost to employers.

There was a growing awareness of the unfairness of this model to mainly female paid and unpaid carers and to poorer older people, and of the need to recognise, support, and fund informal care at a time when the economy was doing well and the government claimed to favour social equity. The Spanish government was influenced by EU recommendations to improve elder care, leading to legislation in 2006 designed to provide long-term care by prioritising services over benefits and recognising the services of home carers. It proposed a process of assessment of care needs according to international standards, with a catalogue of services and benefits, including day and night centres, home services, residential homes, increased benefits enabling payment for places in profit-making institutions if no public places were available, and remuneration of some family carers. Unfortunately, implementation began in 2008, along with the international crisis and national recession, 'austerity' followed, and the new system was underfunded and introduced slowly and incompletely. Services were delegated to local authorities and implemented unequally, with poorer services in Conservative-controlled districts. Dependence upon female family care, migrant labour, and the market was reinforced.

As elsewhere, the Covid pandemic revived public debate in Spain about care for older people, revealing the extent of home care provided by low-paid, low-skilled migrant workers, the weaknesses of residential care, and the high death rate of older people. Again, this led to pressure for change, and in May 2022 the government approved advanced, accessible, and people-centred care services, influenced by the EU's 2022 post-Covid Care Strategy. The outcome is unclear.

Care in former communist Europe

The remaining chapters discuss countries of Eastern and Central Europe that were communist-controlled until the early 1990s. Romania, like the others, aimed for greater democracy after communism and improved public services, including for older people. But a declining birth-rate plus extensive emigration and growing life expectancy created one of the fastest ageing populations in Europe and increasing need for a public care system as sources of informal care dwindled. The authors stress, as other chapters do not, the extent of ageism in Romania, which held back public action to provide care. So also did economic crises in the early 1990s, then the international crisis of 2008–2010, and the austerity policies that followed, as elsewhere, bringing significant cuts to public spending. Romania joined the EU in 2007, which stimulated economic growth, but in 2020 it had the most people in poverty (34%) of any EU country, among whom older people were the most vulnerable. Despite the efforts of the National Council of Pensioners' and Older Persons' Organizations (NCPOPO), to politicise the issues, at no point does there appear to have been significant public debate about policies to meet their needs and there were few academic studies.

Private provision has failed to meet older people's needs and demands, as elsewhere leaving unpaid female family members mainly responsible for what is often a considerable burden of care. The supply of family carers has declined as more Romanian women have migrated to richer countries in Western Europe, often as care workers. From 2015 to 2020 the government responded with a National Strategy for Promoting Active Ageing and Protecting Older Persons, designed to improve their quality of life and access to health and care services. But it lacked adequate funding or the necessary effort to fight discrimination against older people and educate the public against stereotypes. NCPOPO tries to promote these issues and has some state funding to do so, while lobbying government and the media demanding more state-funded provision, on behalf of local authorities and NGOs, but with little effect.

In 2022 there were about 4 million over-65s in Romania. They qualified for contributory pensions and had the right to health care, dentistry, and home care. There is a state allowance for people with disabilities at all ages, and social assistance for older people who cannot afford a decent standard of living or to pay for health care. Employment of over-55s is low by EU comparisons, increasing the risk of poverty in later life. But state spending on long-term care is low compared with other European states: 0.5% of GDP compared with an EU average of 2%, and 4% in Norway, which is not an EU member, with its leading welfare state. Residential centres are few, overloaded, and of poor quality, 83% provided by the non-profit sector. Funding and provision of home care services are devolved to local authorities with highly variable outcomes and almost totally lacking in rural areas, which have limited local funding. The profit-making private sector manages 68% of home services, 32% are public. Most crisis and medical centres are publicly run. Currently, Romanian care for older people is very limited and coherent public policies are lacking. Female family care is still prioritised. The issues are rarely publicly debated.

The situation in Croatia is little better. The authors point out that the former socialist countries share a legacy of strong policies to facilitate women's employment and provide state support for families. Under socialism, there were universal rights to education and health care, and supportive infrastructure was created, including centres for social work and employment. Formal elder care expanded in the late socialist period, although it remained residual and on the margins of the state agenda. Post-socialist countries inherited small non-profit sectors and they remained limited thereafter. After socialism, pensions increased but care services did not. Social spending and social rights declined, and responsibility for care was placed on women in families. The system came to rely more on benefits and cash transfers than services and the social integration of vulnerable groups.

The Croatian state was reluctant to spend limited funds on expanding state services. Increasingly, like other European countries, it developed a mixed welfare system composed of the state, the market, and a growing non-profit sector. Legislation in 1997 increased decentralisation and private provision of services which were locally devolved and community-based, but not coordinated or planned. Residential services were run almost wholly by private providers, with little regulation and low standards. Increasing numbers of dependent over-55s have since needed care, but home care services, in particular, are fragmented and inadequate. From 2003 to 2015 public residential care increased by 10%; private provision doubled, providing 73% by 2020; 8% of residents had their services funded by the state, the remainder were funded by residents or their families. In 2016 state spending on long-term care in Croatia was 0.9% of GDP, compared with the EU average of 1.6%. From 2017 programmes to improve older people's care services were funded by the European Social Fund, but still, in 2019, only 1% of over-65s received the government's minimum income, and 5.9% the allowance to pay for care services; 1% were in residential homes. The government covers all residents' costs in the minority of homes run by local government. Costs are twice as high in private homes: most residents pay the full price, and the state helps only the most vulnerable. Care work has been allocated to disadvantaged unemployed women who support older people in their communities, especially in rural areas. As elsewhere, it is precarious, undervalued work, but it has increased services. As this inadequate system continues in Croatia, as elsewhere, older people have not campaigned for improvement, and most care is provided by women whose social position has deteriorated.

In post-socialist Slovenia older persons' care entered the policy agenda and public debate in the 2000s, when, as elsewhere, the ageing of the population exposed the care deficit. The number of dependent older people in poor health grew, increasing the workload of care workers whose pay and conditions were poor, and staff shortages grew as precarious conditions drove them from the work or from the country. In socialist Yugoslavia, there had been a comprehensive public childcare policy, while care for older people followed the traditional pattern of intergenerational solidarity within the family. When the burden of care became too severe, families could turn to state-provided residential services which cared for 4.5% of older people. In Slovenia in the post-socialist period in the 1990s public home-based services were expanded partly to counter high unemployment among women. In the 2000s the state sought more developed policy solutions primarily for long-term care, under pressure from the EU and the OECD, both of which judged Slovenia poorly prepared for the ageing of society, with inadequate, fragmented care services. There was pressure also from employers' organisations, trade unions, and NGOs warning of the dangers of privatisation if the state did not act, and care workers' unions struggled with the government over standards of work and care. The Women's Lobby of Slovenia pointed out that women formed the great majority of formal and informal care providers experiencing these poor standards. They joined the campaigns advocating urgent action to establish long-term care as a universal right provided by well-funded public services.

In response, through the 2000s, services were professionalised and devolved to municipalities who funded them, but this again led to regional inequalities in services, which were relatively expensive. In 2019 only 1.8%

of seniors received publicly provided care compared with the EU average of 8–12%. Family members still provided care when possible. Public childcare continued, and a high proportion of women with children were employed. Other, often older, family members took over, or paid carers were employed. From 2016 paid daily carers who shared a home with the cared-for received a low fee from the municipality, below the minimum wage, and the family was expected to provide for all their needs. Pay rose under legislation in 2021 but remained low. Paid carers received specialist training and some respite, but the work was exhausting. They and family carers were assisted by public care homes and social work centres which provided home deliveries of food, transport, and day centres. Some early retired local women provided casual cleaning and respite care, but the costs of care strained family budgets. Left-wing politicians promised increased funding for care homes and professional services to help older people live independently, but right-wingers opposed the required higher taxation. Political struggle between opposing ideologies and successive governments blocked reforms.

A Long-Term Care Act was in gradual preparation from 2002, delayed by such political conflicts. It was finally adopted in 2021 under pressure from the impact of Covid and assisted by the EU Recovery and Resilience Plan, which provided grants to help post-Covid recovery. The Act promised reduced dependence upon institutional and family care and a comprehensive network of public services providing care in older people's homes, stressing their right to live in the community and make their own decisions about care. It provided support for the remaining family carers. Large institutions were closed and replaced by community services, but many older people needed residential care, due to frailty or lack of family support, and the number of homes continued to grow, especially in the profit-making sector. The costs were shared between municipalities and families. Geographical coverage improved following the legislation, but costs increased, there was no regulation of private homes, work conditions remained poor, and staff shortages continued. Carers migrated, including to Austria and Italy where the state funded care more generously. More older people in Slovenia were now poor and could not afford private homes. Public care homes provided social and medical care tailored to users' needs, but they remained a minority and community services remained limited. To cut its costs, the state gave low 'cash-for-care' benefits to families, encouraging them to provide care or employ low-paid, unskilled carers, now often migrants from outside Europe. This continued to be the only support available in many areas. Family care continued to predominate as the state failed to meet needs. Effectively state services for older people declined in Slovenia from the 1990s as needs grew.

The situation was no better in Serbia. As elsewhere in the former Yugoslavia, in socialist times there was an inclusive welfare system but, unlike childcare, care for older people was never a priority. Here also it was delegated to families, continuing after socialism, increasingly from the 2000s as services were privatised and more costly. A mixed system emerged of state-funded care homes, professional home care funded by local authorities, family care, and market-based and NGO-provided care homes and home services. Again, women in families provided most care and mainly female professional carers were poorly paid and of low status. As elsewhere, growing life expectancy, low fertility, more women working, high emigration of younger people, and care workers seeking higher pay in Western Europe left more older people living alone. Official policy encouraged active ageing, enabling older people to decide on their own needs in their own homes, as many older people preferred, but it was not always possible. Informal care was still needed by frail older people, often provided by older women caring for their spouses. From 2006 much formal care, public and private, was provided by women over 55 trained and employed in care work by the state because they were the largest group in long-term unemployment. They formed 58.8% of low-paid professional carers in 2018.

Currently, about 21% of the population of Serbia is aged 65+. The monthly state pension of 250 euros is below the minimum wage, and inadequate for healthy living. The care system is poor. A law in 2011 significantly reduced welfare provision. In 2013 new hirings were banned in the public sector. In principle, public services were available for over-65s whose safety, well-being, and productivity were compromised by age, illness, or disability and who had no family care, but they were limited. Care homes were administered at the national level, community day and home care services at the local level, the work often performed by retired or working nurses supplementing their low incomes. Publicly funded social work centres provided free services for up to two hours per day for three or five days per week, but the number was limited. Care homes, public and private, licensed by the government provide sheltered housing, day-care, and ‘clubs for active ageing’, but they are also limited. In 2019, 60% of care homes were publicly provided, 40% private, but both required fees and private homes especially were too expensive for most people, with long waiting lists for public homes.

The care system deteriorated further in Serbia following the COVID-19 pandemic. Everyone over 65, in some places 70, was placed in total lockdown, although gradually they were allowed to leave home briefly to buy groceries or take walks. Active older people needed help, inactive people lacked care because close personal contact was forbidden, and home care services were suspended, then allowed only in very restricted forms, in some places for as long as two years, although most older people were protected by vaccination against COVID-19. Care home residents were isolated even from fellow residents, and no visitors were allowed or new admissions. Pressure on staff intensified, and many left due to suffering Covid or overwork, required to stay on duty for ten-day shifts, away from their families. There was increased public awareness of the weakness of care provision in Serbia but no official suggestions for improvement.

The chapter on Slovakia focuses on a case study of a successful care home ultimately closed by the state. This occurred in a context similar to that of other countries in the former Yugoslavia. Here too, the population aged, shifting from the youngest to the oldest society in the EU due to declining births, increasing emigration, and very limited immigration. Again, the needs of older people had low priority in public policy, and ageist perceptions of older people were pervasive, especially following COVID-19. Care was left to women in families in a society in which relatively few women were employed.

Under socialism, the main state provision for older people was large institutions which minimally met their needs. After socialism, these gradually gave way to community services, mainly provided by local authorities, and funded by local taxes with central government subsidies. Some services were provided by NGOs, but responsibility remained primarily with families. National GDP was low, unemployment high, pensions, care allowances, and caregivers' allowances low. Workers for home and residential services were as elsewhere female, low-paid, low-status and in low supply since they could gain better-paid work abroad. There were and are major deficits in health and social care, increasingly replaced only by the private market at fees too high for most people, leading to major social, regional, gender, and race inequalities in access to care.

Against this background, the chapter surveys the history of a senior centre established by the city administration in the capital, Bratislava, in 1994 at a time of growing concern about falling births and the growing older population. Inspired by a woman psychiatrist who was in advance of her time in her interest in and desire to promote active ageing, it was the only such institution in the city, possibly in Slovakia. The author talked to people involved, discovering that the centre provided residential care in a home-like atmosphere for 20 people, plus, for a larger population of older people, day-care centres, low-cost lunches, clubs providing meaningful activities and social contacts, and a garden where people could work and sit. The centre also welcomed people with physical and mental disabilities. The staff were wholly female. Relatives could leave family members for at least part of the day in a respectful and pleasant atmosphere. Over time neighbours drew the institution into their community, providing activities and contacts, including with children.

Then in 2017 the city decided to close the centre and replace it with a crèche. Older users, employees, and neighbours campaigned against this, with petitions, demonstrations, and fiery exchanges with the mayor, who argued that with only 20 residents, the building was under-used, despite its other activities. The building could provide space for more children. He rejected a suggestion to combine care for children and older people in the building. The campaign failed to win wider support, the building closed, and the crèche and a primary school opened. Neighbours continued to organise activities for older people, including a book club, dance lessons, and quizzes, but they were unfunded, and there was little formal care. The Slovak government continued to show little interest in older people, stereotyping them as less worthy of state support than children with futures before them. Their care was formally the responsibility of city districts, but they had little funding. As in other post-communist countries, services for older people were poor.

In discussing these societies, I have tried to convey the effects of political systems providing in diverse ways essentially token support to a social group they did not prioritise, aware that most older people would be protected from the worst outcomes by highly gendered family support.

Conclusion

I have discussed the case studies in this volume in some detail because they illustrate the diverse care services for older people that were provided, although often in limited quantity and in different combinations in different contexts. In all the countries surveyed, elder care was politicised, and patterns of care were determined above all by political decisions, including decisions to cut public funding and encourage market-based or family-based care. Similarly, in all countries, families have been the most reliable care providers, which is possible because care is highly gendered. Women have long been expected to provide care and have done so everywhere, no matter how difficult the circumstances, as during the pandemic.

It would be interesting to know more about the feelings of women carers about this generally unpaid and undervalued work. Perhaps they are driven by feelings of attachment, affection, and responsibility, often for parents who once cared for them. Much as it is discussed, it is surprising how little this relationship is explored from the perspectives of carers and cared-for. Its very existence is surely one explanation for the limited state support everywhere for older people's needs: politicians know that women will fill gaps they create or tolerate. Many women feel the same commitment to caring for their children, but this does not provoke comparable withdrawal of state services for children. Politicians believe they have much to gain by encouraging mothers to contribute to the economy, while enabling them to combine employment with raising children – much-needed future workers. They have incentives to fund childcare as they do not for elder care since they feel they have nothing to gain from enabling people to live longer, other than more obligations and costs. They happily embrace the alternative of free, gendered care. Such attitudes appear deep-rooted in all the cultures considered here.

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