Did austerity affect long term care?

Investigating micro data spanning the Greek crisis

by:

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Contents

ABSTRACT

Social protection in Greece is provided by an amalgam of formal and informal welfare systems – a hybrid system. This paper investigates how the combination of two – formal and informal – fared through the unique circumstances of the Greek crisis, between 2007 and 2015.

Focusing on dimensions related to elderly care (such as personal care and practical help), the empirical investigation lies in three directions. First, it examines evidence on the demand side of care (in terms of health-related outcomes'). Then, by providing evidence on the diverse institutional and social contexts across Europe, it examines the role of the family in providing care on: i) the substitutive and the complementary role of informal welfare state to the formal state and ii) the role women played role in care provision. To serve this purpose, it presents comparable evidence on Greece vis-à-vis other Southern and other European countries, by using microdata from SHARE wave 6 (Survey of Health, Ageing, and Retirement in Europe) for persons aged 50+ conducted in 2015 in 18 European countries.

1. INTRODUCTION

Why should knowing what happened to Long Term Care (LTC) in the Greek crisis be of interest *beyond* Greek social policy? The Greek crisis that began at 2008 is the deepest and longest in the postwar developed world. There is much a priori thinking; little hard evidence. A number of crisis narratives make analyzing what *actually* happened to LTC interesting:

a) **The austerity narrative**. Retrenchment of social expenditure; personal incomes and pensions suffer large and uneven reductions. –The supply of LTC has been negatively affected.
b) **The Ageing narrative**. The crisis years correspond to a period of accelerating ageing trends –The demand for Long term care (needs) rise**.**
c) **The gender narrative.** Women fill the gaps of a stunted welfare state, which still relies on the family as the provider of (first and) last resort. Women take on any slack generated in the LTC nexus.

The Greek crisis is an area where conclusions run ahead from observations. What we think *ought to have happened* takes precedence over what *actually happened*. The return of Greece to wave 6 of SHARE (the Survey of Health, Ageing and Retirement in Europe), after a four year hiatus, means that there now exists a rich new source of data, which allows the investigation and consistent comparison of 2007 with 2015 for the 50+ population. Those years span the course of the crisis and hence create the possibility to approach questions with a new light. This paper addresses the following issues:

1. Why is the course of LTC in the Greek crisis interesting? Are there *general* lessons to be drawn?
2. Some necessary background and Greek idiosyncrasies: Attitudes to care; LTC; gender and cohorts.
3. What happened between 2007 and 2015, when GDP per head fell by 25% and public expenditure was slashed? Uncovering paradoxical findings, both negative and positive.
4. Why? Explanations? What does gender contribute?

2. LITERATURE REVIEW

The Greek crisis was uniquely long and uniquely deep. (Meghir et al 2017, Lyberaki and Tinios 2017). GDP is falling continuously from 2008 to 2016, GDP per head is now 25% lower are simply some of the indicators documenting unprecedented individual hardship. The elderly are thought to have been hit especially hard, both by pension cuts and cuts in health care, both necessitated by austerity economics (Lyberaki 2017).

The crisis. Much of the literature on the Greek crisis is dominated by apriori theorizing. On the one hand is the anti-austerity narrative. This builds on the fiscal story to underline cuts in entitlements and dramatic falls in welfare. On the other hand are other narratives stressing implementation and reform ownership problems (IMF article 4, Meghir et al 2017). A common observation is that press reports of hardship frequently overdramatized reality, essentially playing out a priori expectations.

What we need to keep as stylized facts are (a) formal provision of social services was curtailed (b) pensions were cut repeatedly, but by less than working incomes (c) health care expenditure fell, but chiefly due to retrenchments on pharmaceuticals and cuts in salaries of health staff (d) there was a wave of young people leaving, as well as many of the first immigrant wave of the 1990s. (e) that a common response to unemployment among women was to step in and try to find employment; this 'added worker effect' could be seen to compensate for the non-existence of a social safety net. (Lyberaki and Tinios 2016).

Lyberaki (2017) using SHARE data shows that solidarity remained strong, though it had changed direction: From being directed *towards* the old in 2007, it shifted towards children in need, probably due to rampant unemployment.

Family ties and care: Earlier findings on family dynamics reported in the First Results Book of SHARE (Kohli, Kühnemund & Ludicke, 2005; Attias-Donfut, Ogg & Wolff, 2005) demonstrate a *North-South gradient in family structure*, as reflected in the frequency of contact and the rates of co-residence (Kohli, Kühnemund & Ludicke, 2005; Lyberaki & Tinios, 2005; Lyberaki *et al.* 2013). High rates of co-residence in Greece (Lyberaki & Tinios 2010) imply that family support is focused around the immediate kin group inside the household and is *performed almost exclusively by women* (Attias-Donfut, Ogg & Wolff, 2005; Lyberaki, 2008, 2011). With respect to *intergenerational financial transfers*, he there exists a North/south variation in the composition of the networks of support recipients: *while younger respondents receive more in the North, older respondents receive more in the South, reflecting the differences in welfare systems.* Help in cash is important towards older households in Greece, compensating for a *pensions adequacy problem* (COM, 2012; Figari *et al.* 2013; Lyberaki and Tinios, 2005; Zaidi, 2010).

At the same time, the elderly family members (and primarily women) offer abundant and frequent childcare and child-minding services to working parents (Lyberaki 2009; Lyberaki & Tinios, 2016). This is true also during the summer holidays (longer stays of grandparents with their grandchildren). All in all, the picture emerging suggests that care provision to grandchildren in Greece is more intensive than elsewhere in Europe. In Greece, one out of three women aged 50+ (31%) provides childcare to grandchildren almost daily.

Examining how the needs for care are met across the SHARE countries Lyberaki *et al.* 2017 as well as Tinios et al. 2017, distinguish between *informal* and *formal* care:. Informal networks fulfill an important role in providing care to persons aged 75+ in Greece as in other Southern countries, while there is a marked North-South gradient. This corroborates other findings (Bettio, Simonazzi & Villa 2006; Lyberaki 2011).In contrast, formal (paid) care dominates in Northern and Continental countries.

Using data from the Time-Use Study (conducted for first time in 2014 in Greece) Lyberaki and Tinios (2016) discuss time use allocation by gender in different age categories. As compared to the rest of Europe men devote far less time in Greece to caring and to core housework. Working women have to deal with almost the same amount of care as non-working women, in sharp contrast to what is the case in Europe.

3. METHODOLOGY AND DATA

The current paper uses SHARE data[1] (The Survey of Health Ageing and Retirement in Europe) using the last pre-crisis data (Wave 2 -2007) and the latest available data (Wave 6 -2015).

The Survey of Health Ageing and Retirement in Europe (SHARE) is well suited to track the fortunes of people aged 50+ over the crisis. It contains interdisciplinary, comparable panel data, adapted to the difficulties of sampling an older population.

Greece had participated in the first three waves (2004, 2007, 2009) -pre crisis. It then dropped out in w4 (2011) and w5 (2013). It finally rejoined in w6 (2015) and with an enlarged sample. It was possible to revisit the 3,500 respondents who had participated in the first waves. Hence we have a full longitudinal interdisciplinary picture of what happened to these people covering their finances, social relations, health, cognitive status and psychological well-being from 2007 to 2015. This was a time when GDP per capita fell by 25% and pensions were cut at least 12 times (Panageas and Tinios 2017).

The sample size of W6 of those aged 65+ which will be used in the analysis, is shown in the following Table.

Table 1: SHARE Sample size per country 65+, per age categories and per gender, Wave 6

country	men 65-80	women 65-80	Total 65-80	men 80+	women 80+	Total 80+	men 65+	women 65+	Total 65+
SE	1,037	1,202	2,239	280	306	586	1,317	1,508	2,825
DK	746	763	1,509	149	220	369	895	983	1,878
DE	1,038	943	1,981	183	207	390	1,221	1,150	2,371
BE	1,051	1,215	2,266	311	453	764	1,363	1,668	3,031
LU	307	284	591	57	84	141	364	368	732
FR	726	904	1,630	232	408	640	958	1,312	2,270
CH	648	702	1,350	172	210	382	820	912	1,732
AT	785	1,017	1,802	161	267	428	946	1,284	2,230
IT	1,207	1,320	2,527	275	301	576	1,484	1,622	3,106
ES	1,203	1,315	2,518	462	657	1,119	1,665	1,972	3,637
GR	**1,001**	**1,090**	**2,091**	**254**	**328**	**582**	**1,257**	**1,418**	**2,675**
PT	409	435	844	67	102	169	476	537	1,013
CZ	1,072	1,512	2,584	220	300	520	1,292	1,812	3,104
PL	339	418	757	79	122	201	418	540	958
SI	856	1,039	1,895	204	318	522	1,061	1,357	2,418
EE	996	1,556	2,552	258	522	780	1,254	2,078	3,332

[1] *This paper uses data from SHARE Waves 2 and 6 (DOIs: 10.6103/SHARE.w2.600, 10.6103/SHARE.w5.600, 10.6103/SHARE.w6.600), see Börsch-Supan et al. (2013) for methodological details.*(1)

The SHARE data collection has been primarily funded by the European Commission through FP5 (QLK6-CT-2001-00360), FP6 (SHARE-I3: RII-CT-2006-062193, COMPARE: CIT5-CT-2005-028857, SHARELIFE: CIT4-CT-2006-028812) and FP7 (SHARE-PREP: N°211909, SHARE-LEAP: N°227822, SHARE M4: N°261982). Additional funding from the German Ministry of Education and Research, the Max Planck Society for the Advancement of Science, the U.S. National Institute on Aging (U01_AG09740-13S2, P01_AG005842, P01_AG08291, P30_AG12815, R21_AG025169, Y1-AG-4553-01, IAG_BSR06-11, OGHA_04-064, HHSN271201300071C) and from various national funding sources is gratefully acknowledged (see www.share-project.org).

HR	475	521	996	61	109	170	539	632	1,171
IL	447	563	1,010	153	194	347	600	757	1,357
TOTAL	**14,343**	**16,799**	**31,142**	**3,578**	**5,108**	**8,686**	**17,930**	**21,910**	**39,840**

Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017).

4. ANALYSIS & DISCUSSION

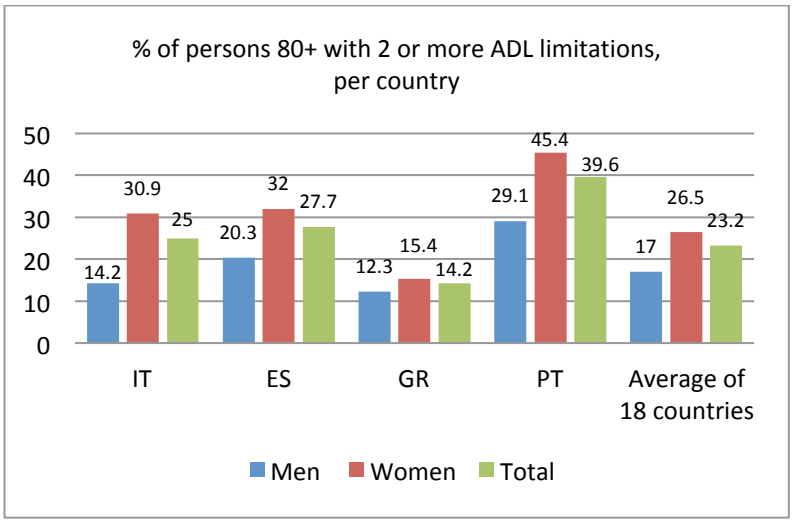
4.1. The need for care: The Demand side

The need (demand) for care is approached in the conventional way – by examining reported ADL limitations. This is done for 18 countries (Sweden, Denmark, Germany, Belgium, Luxembourg, France, Switzerland, Austria, Italy, Spain, Greece, Portugal, Czech Republic, Poland, Slovenia, Estonia, Croatia, Israel), for persons age 65+ and for a more focused group of persons of age 80+. We separate the number of reported ADLs into two categories: those with only 1 ADL limitation and those with 2 or more ADL limitations. Results are shown in Table 1 where we compare Greece with the other Southern European countries and with the Average of the above mentioned 18 countries.

As a general conclusion, it can be said that for all countries, care demand is higher for women than for men,. More specifically, 12.1% of women of age 65+ reported two or more ADLs compared to 8% of men, while when focusing on age 80+, the percentage of women reporting two or more ADLs climbs to 26.5% and is significantly larger than the respective 17% of men (see Table 2 for details).

Regarding the country dimension, contrary to expectations, Greece has lower percentages of persons with ADL limitations than the European average, practically for all categories (men, women, age). When comparison is focused to other Southern European countries, another impressive finding appears; in Greece, only 12.3% of men and 15.4% of women of age 80+ appear to have more than 2 ADLs, while the respective numbers for Italy are 14% and 30.9%, for Spain 20.3% and 32% and for Portugal 29.1% and 45.4%! (Figure 1). Greece in terms of ADL limitations is closer to Sweden and Denmark than to Italy and Spain.

Figure 1



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017).

Table 2: ADL limitations per country, per age category and per gender

Percentage of persons 65+ with ADL limitations							Percentage of persons 80+ with ADL limitations					
	Percentage (%) of persons 65+ with 1 ADL limitation			percentage (%) of persons 65+ with 2 or more ADL limitations			Percentage (%) of persons 80+ with 1 ADL limitation			percentage (%) of persons 80+ with 2 or more ADL limitations		
Country	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
IT	5.6	7.9	6.9	7	14.9	11.5	12.7	13.4	13.1	14.2	30.9	25
ES	6.1	7.0	6.6	9.3	14.3	12.1	9.8	9.5	9.6	20.3	32	27.7
GR	**4.3**	**8.2**	**6.4**	**6.4**	**7.8**	**7.2**	**8.1**	**13.6**	**11.3**	**12.3**	**15.4**	**14.2**
PT	11.5	14.0	13.0	10.9	20.5	16.5	19.0	18.5	18.7	29.1	45.4	39.6
Average of 18 countries (%)	**7.6**	**9.2**	**8.5**	**8**	**12.1**	**10.3**	**13.5**	**13.2**	**13.6**	**17**	**26.5**	**23.2**

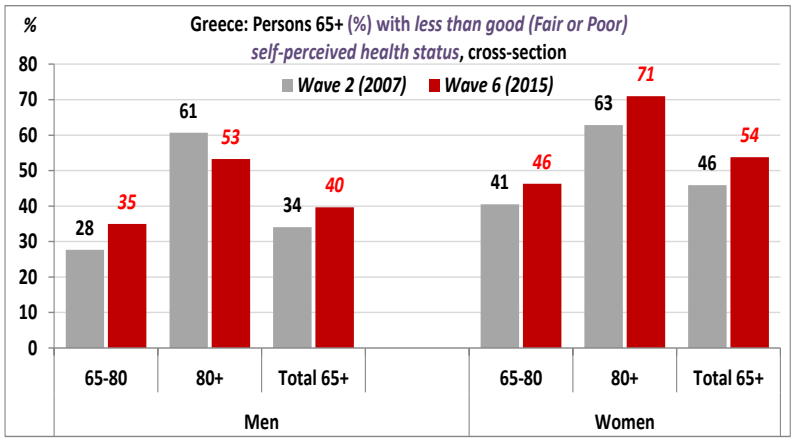
Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017).

Greece is ageing fast after the mid-2000s (Tinios 2010). Given this, plus the austerity narrative, one would expect to see a rise in the demand for care. However, what we see is the *opposite*: needs as measured by ADLs *drop* in Greece over the crisis, **especially among women 80+.** For other groups they remain largely unchanged. More specifically, a cross-section analysis between wave 2 (2007, before economic crisis) and wave 6 (2015, after economic crisis), showed that 20% of men age 80+ reported ADL limitations in 2015 -a decrease of 5% in percentage points compared to 2007-, while the percentage for women of age 80+ was 29% in 2015 from 38% in 2007 (see Figure 2).

ADLs should be, at least roughly, related to health status. Yet, if one considers that for the same group and for almost all others (except men of age 80+), overall **self perceived health** is worse in 2015 than 2007 (Figure 2). This leads us to a first 'paradox': although ADL limitations are lower, self perceived health is worse. Self perceived health 'less than good' reached 35% in 2015 for men of age 65-80 (compared to 28% in 2007) and 46% for women of the same age group compared to 41% in 2007. For the age 80+, then the self perceived health went separate ways for the two genders: 'less than good' dropped from 61% to 53% for men and increased from 63% to 71% for women.

The overall conclusion for both waves and for all age categories, remains: women report ADL limitations in higher percentages than men, while their health is worse. This applies even if one controls for age.

Figure 2

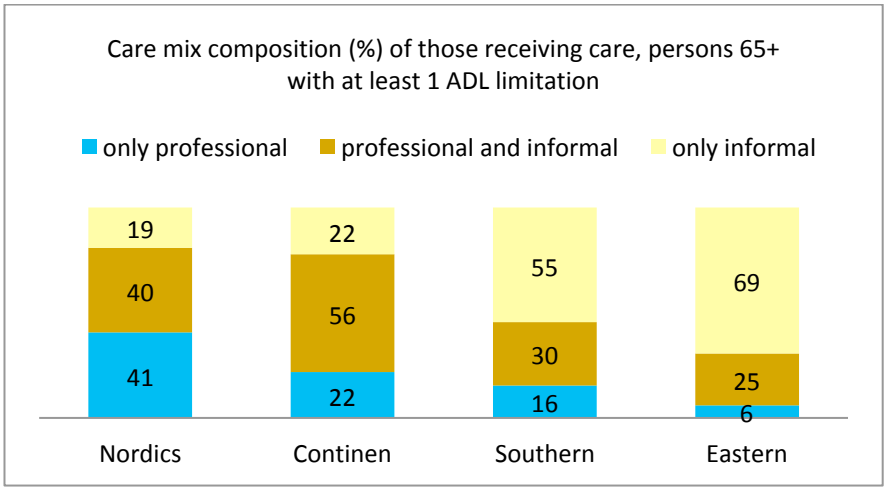


Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017).

4.2. The supply side: informal care provision

The role of family and friends in Southern and Eastern countries is significantly more crucial in the provision of care to the elderly compared to Continental and Nordic countries (based on Wave 6 data). In Southern countries, 55% of persons in need of care that receive care, receive only informal care when the respective number in the Nordics is 19% and in Continental countries 22%. Receiving *both* (Combination of professional and informal care) is significant in Continental countries (56%), while in the Nordics 41% receive only professional care. The role of the family in care provision differs per country group due both to cultural differences as well as differences in the level of development of public policies. Informal care is important even in countries relying on social protection for most care.

Figure 4



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017).

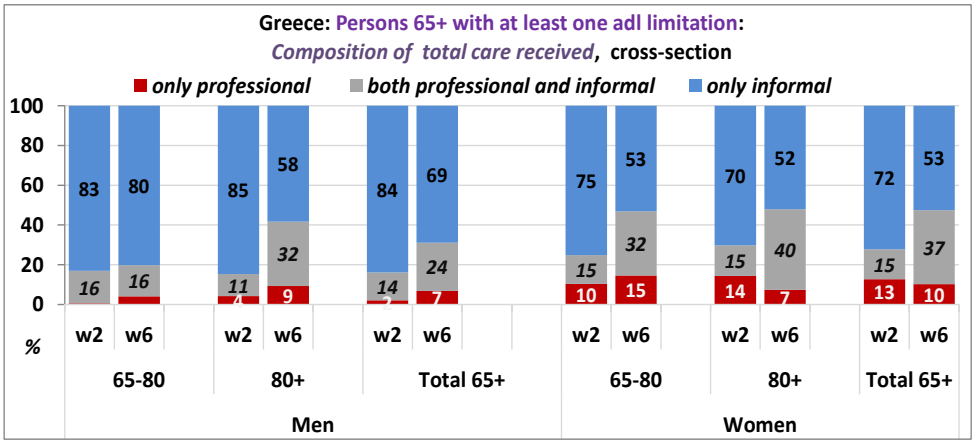
Does the care mix change over the crisis in Greece? The austerity narrative predisposes that formal care should be lower – as family incomes are squeezed and state provision is threatened. Again, the opposite holds. The mix between formal and informal care is shifting i*n favour* of *formal* care. This is defined as professional care – in the sense that it is delivered by a person who was paid to do so, who may or may not be a specialist[2]). The category

[2] ***Professional care****: Includes any professional or paid services received in own home s: i. Help with personal care, (e.g. getting in and out of bed, dressing, bathing); ii. Help with domestic tasks (e.g. cleaning, ironing, cooking); iii. Meals-on-wheels (i.e. ready made meals provided by a municipality or a private provider); and iv. Help with other activities (e.g. filling a drug dispenser.*

'professional' includes those paid for by others (e.g. State formal bodies, social insurance) or engaged by the family from the open market for a fee. This is particularly marked for people over 80 and for women.

Even so, the bulk of provision is still provided by informal help – either on its own or in conjunction with professional help (Figure 5). More specifically, for women 80+ receiving care, 47% of them received formal care (7% only formal care and 40% both formal and informal) in 2015, while in 2007 only 29% of those receiving care were receiving formal care (14% of which were receiving only formal care and 15% were receiving both formal and informal care).

Figure 5

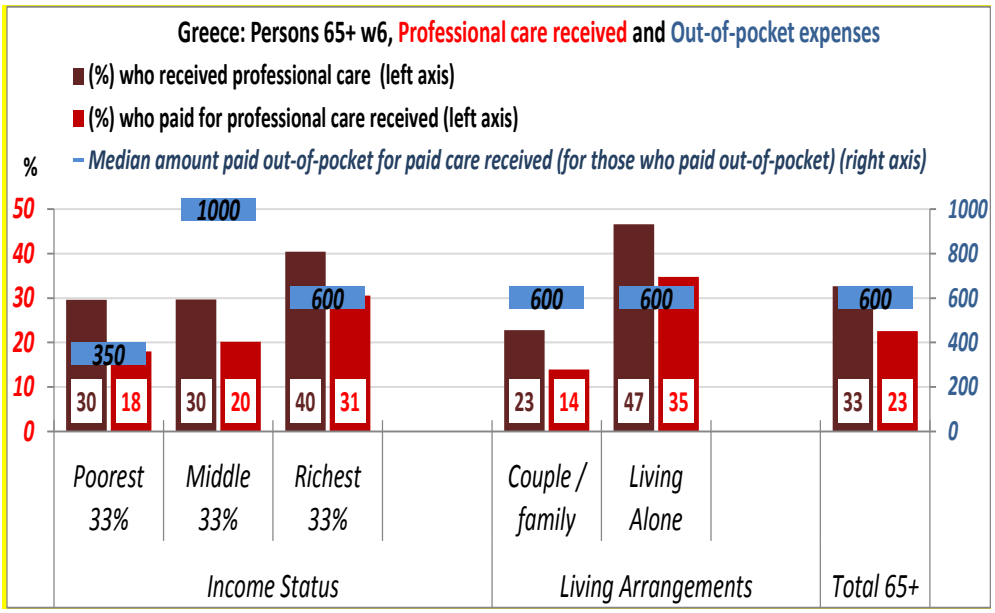


Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

Professional care is bought in. SHARE w6 includes a question for out of pocket expenses for care. This can act as a lower bound for this part of the population who have to pay to secure LTC services. Approximately two thirds of professional care is accompanied with out of pocket expenses; the remainder may be either be delivered free by municipalities or paid for by family members not part of the household. The ratio is higher for the richer groups and for those living alone (Figure 6). Median amounts of out-of pocket expenditure are approximately €500/year, an amount not small at all for the Greeks in the midst of austerity. (based on the Ministry of Social Insurance, Dec 2016, the average gross pension €890 per month and minimum pensions are €384 per month.). Of those received professional care in 2015, only 13.0% (with 95% confidence interval lying in between 9.3% to 17.9%) was provided by the municipalities through the so-called 'Help at Home' program, while the respective percentage in 2007 was 15.9% (with 95% confidence interval lying in between 8.67% to 27.28%), indicating that during the economic crisis, municipalities did not increase long term care provision to the frail despite the income decrease.

Figure 6

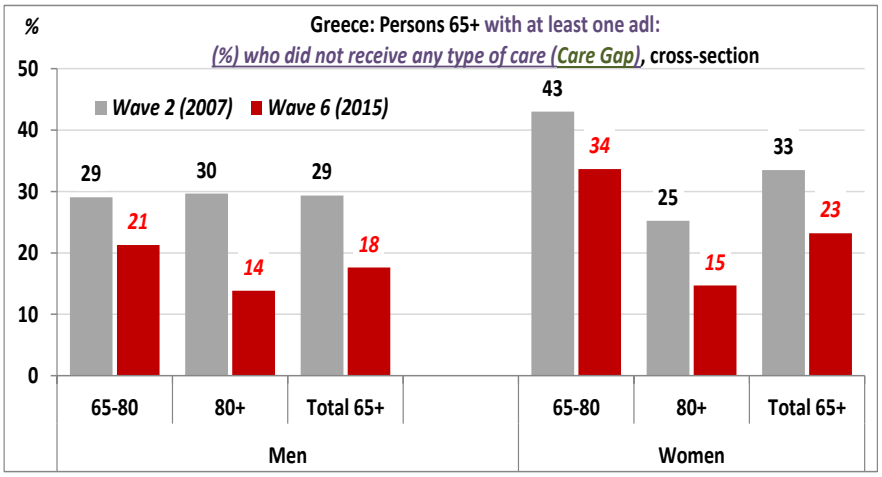
***Informal care/help**: This indicator equals one if a person either receives informal care/help from outside the household on a daily or weekly frequency or/and receives personal care regularly from someone in the household.*



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017)

The austerity narrative often bemoans the plight of those left uncovered. This in the case of LTC should be measured by the Care Gap – those people with an expressed need for care but whose need, nevertheless, remains unanswered. Again, despite the austerity narrative, care gaps in Greece, *fall* in all cases. Though gaps are *still* large (especially for younger women), they appear to be shrinking, especially among the older group –more so for men than for women (Figure 7).

Figure 7



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

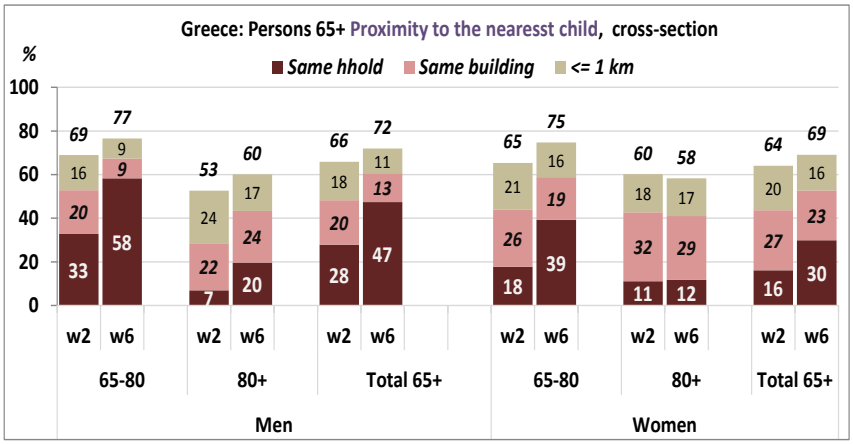
When measuring the life satisfaction indicator, we do not see significant differences between those receiving care and those not receiving care, while there exists a slight difference between waves. More specifically, analysis for Wave 2 showed than on a scale 0 to 10 (where 0 represents lowest life satisfaction and 10 highest life satisfaction), persons 65+ with at least 1 ADL that did not receive any care had an average life satisfaction rate of 5.77 (st.dev. 2.35), while those that were receiving care had a slightly lower, statistically non important, rate of 5.53 (st. dev. 2.02). Respectively in Wave 6, persons 65+ with at least 1 ADL that did not receive any care had an average life satisfaction rate of 6.28 (st.dev. 2.43), while those that were receiving care had a slightly lower rate of 6.04 (st. dev. 2.05).

Although at a first glance, this may seem paradox, a logic explanation could be that those receiving care are those with more serious problems in daily activities, thus those with lower life satisfaction rate due to higher dependence on others.

The puzzle is completed when we look at family consolidation. As a coping strategy during the crisis, family members moved together. Either children moved in with elderly parents or parents move in with their working children. This is captured by Figure 8. In the younger groups (65-80) there is a movement from the same building to the same household. This is more marked for men, than for women. While in 2007, 28% of men older than 65 years-old were living in the same household with a child, the percentage in 2015 increased dramatically to 47%. The respective shift for women was from 18% to 30%.

Family consolidation could result from two mechanisms: a. Income consolidation (take advantage of pensions) or b. Care consolidation (make looking after needy parent easier). The first applies chiefly to men 65-80, rather than women – which is the pattern we see.

Figure 8

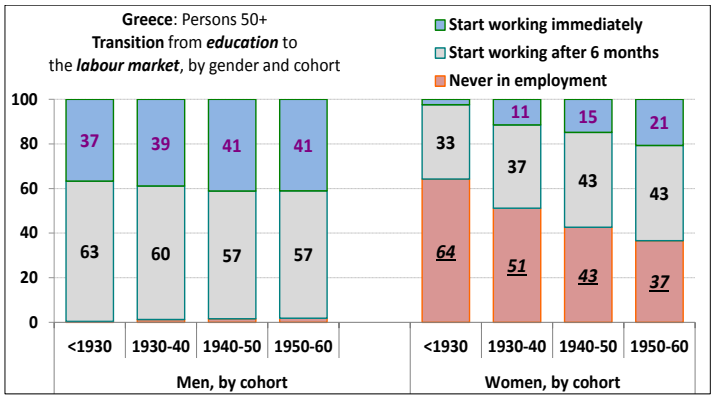


Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

The gender dimension: Women, work and care

Greece is one country where the older generation of women is being rapidly transformed, as younger cohorts with much more active paid work involvement enter retirement. This transformation is evident in the reduction of women who have never worked in each successive birth decade. In figure 9, we see that women born after 1950 are more involved in the labour market. Women born before 1930 were never in employment at a percentage of 64%, while the respective percentage for women born between 1930 and 1940 is 51%, for women born between 1940 and 1950 is 43% and for those born between 1950 and 1960 drops to 37%.

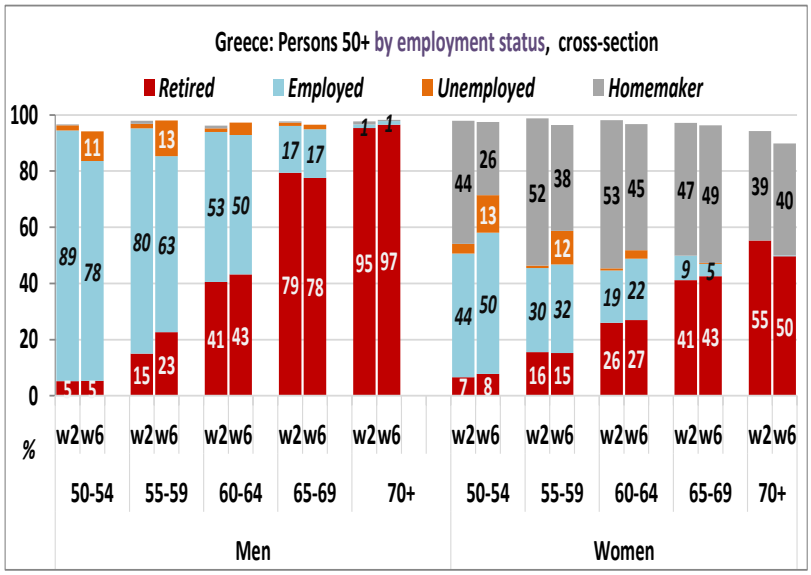
Figure 9



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

A key reaction to the crisis was the added worker effect. Women entered the labour market in large numbers to make up for unemployment hitting male members, partly to make up for the deficiencies of social safety nets in Greece. This is confirmed by SHARE data. While employment of men 50+ for all age group categories decreased in 2015 as compared to 2007 (especially for those between 50 and 54 years old that decreased from 89% to 78%), employment in women 50+ for all age group categories *has increase*d. Their involvement is even more marked in activity rates, which also factor in the increased unemployment. This is mirrored by the number of women reporting 'Homemaker' as employment status. In 2007, 44% of women of age 50-54 reported that, while that percentage in 2015 dropped to 26% (Figure 10).

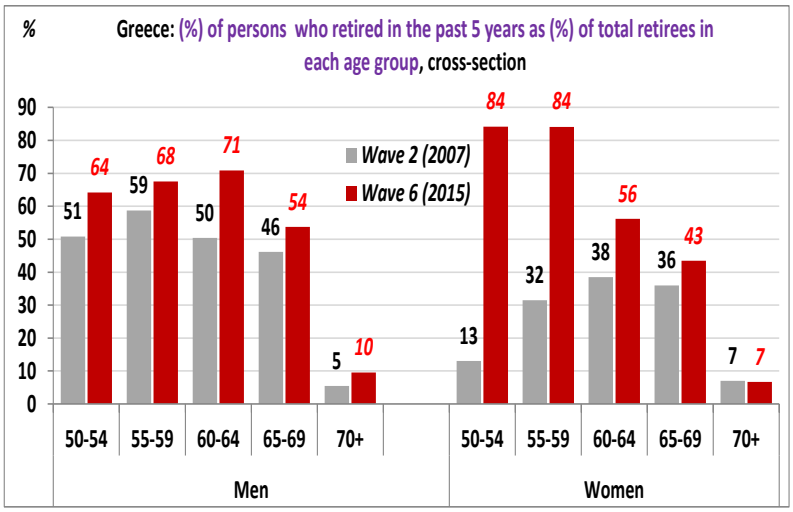
Figure 10



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

Increased activity, paradoxically, went hand in hand with early retirement which increased during the crisis, especially in the public sector. This came as a result i) of the need to reduce the number of civil servants and ii) of the (untimately doomed) attempt to escape pension cuts by taking advantage of grandfathering clauses in pension legislation (Panageas and Tinios 2017). This was more marked for women rather than men. (Figure 11 documents the 'waves' of retirement in the five years previously).

Figure 11

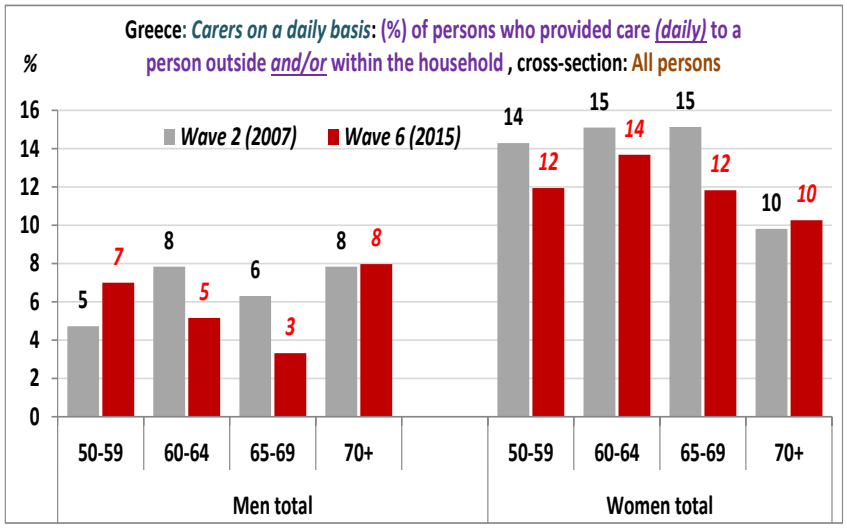


Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

So, women work more, they are looking for more work and are also retiring earlier. Who provides the extra care that corresponds to the lower care gaps?

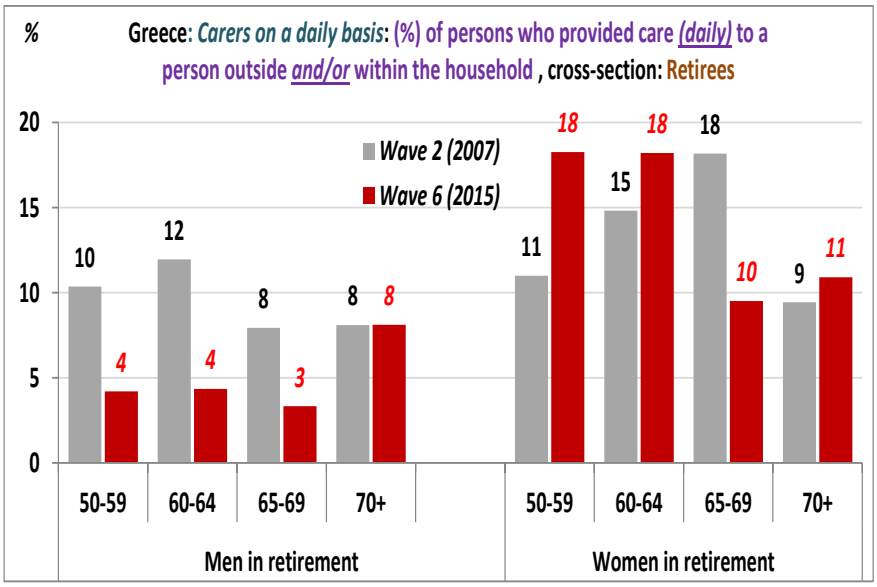
In Figure 12, women over 50 years old provide informal care much more than men, *but* slightly less so than in 2007. An approximate 10% to 14% (depending on age category) of women 50+ provided care to a person on a daily basis, while the respective percentage of men was 3% to 8% (depending on age categories). The opposite holds for recent younger retirees (under 65), where care is provided in higher percentages in 2015 compared to 2007. The opposite holds for men, who provide less care when retired (Figure 13).

Figure 12



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

Figure 13



Source: SHARE, wave 6, (release 6.0.0: March 31st, 2017), wave 2 (release 6.0.0: March 31st, 2017)

5. KEY FINDINGS & CONCLUSIONS

Our findings can be summarized as a tangle of five paradoxes:

1. Care needs are stable or falling, despite ageing and worsening self perceived health, especially among older women
2. The Care gaps are shrinking, despite limited public provision, which has been retrenched.
3. This is due to an increase in professional care (shift from informal only to combination of professional and family care).
4. The results are more surprising given that there is family consolidation – pulling incomes and care resources together.
5. The incidence of out-of-pocket payments for care, are growing across the income spectrum and despite falling incomes.

Those paradoxes however can be interpreted both in family consolidation terms as well as in financial terms:

- The deep crisis has encouraged reactions of stoicism – LTC needs are stressed less, as *other* unmet *needs* (mainly financial and employment) are rising rapidly.
- Families are consolidating – mainly to combine income rather than informal care resources.
- It is professional out-of-pocket (and not public) care that is filling the gap.

Despite pension cuts, pensioners are better off than those employed and certainly families with unemployed members. Wages – and one imagines wages of carers – have fallen by more than pensions. Hence pensioners have greater access to paid care – which is thus able to shrink the care gap.

- Care provision is still largely outside the reach of the tax authorities – its relative price is falling.

- Women 50+ as pensioners help in informal care and work (both over and under 50 years old) work as carers in unregulated formal care in the grey economy.

The key message is that, despite the deep crisis, and the absence of public provision, families *are appearing to be coping* – with social indicators apparently improving (or at least not deteriorating as much as financial indicators).

However, this resilience does not mean that there is no need for a formal system of LTC provision: Out of pocket expenses can prove a drain on family resources. It is an open question whether they can keep up for long. If (as is due to happen in 2019) pensions fall further – there might be a conflict between income and care consolidation for the family. We really do not know what will happen when pension cuts reach lower pensions? – LTC is a major determinant of well-being especially for the over 80 generation.

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A further point to note is that the *quality* of care is not measured. Unregulated affordable care is likely to raise issues of quality. These are more likely to affect the widespread cases where formal and informal care appear together.

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