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Care arrangements and social integration: The concept of social exclusion and empirical findings in five European countries

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Issues of social integration in old age, care-dependency and care arrangements build the focus of this paper. On a theoretical basis it draws on the concept of social exclusion developed within welfare state research and transfers it to the area of old age and care. In old age risks of social exclusion are strongly related to health problems and corresponding difficulties to perform daily functions, which impede the participation in social activities and maintaining social relations. In contrast, on the basis of accessible and adequate care resources the elderly may counteract social exclusionary processes. Empirically, the research is based on an investigation into care arrangements and the social situation of care dependent elderly in five European countries, i.e. Austria, Belgium, Germany, Italy and the United Kingdom (Northern-Ireland). The findings reveal country-specific care arrangements and patterns of social integration, which put certain groups among the elderly and their informal carers at the risk of social exclusion. The development of risks is connected to the mode of funding of care services, restrictions existing on care provision and unmet expectations with regard to the role of the family. Patterns of social integration and psychological well-being are influenced by formal and informal care provision, but are also related to a complex interplay of the living-situation, social contacts and related expectations as well as the level of care dependency.

1. Introduction: Social exclusion and care dependency in old age [1]

Since the 1990s the concept of social exclusion has gained significance in the scientific and political debate in Europe as a tool to analyse exclusionary processes in society. Research guided by the concept began within the areas of unemployment and poverty and was only recently transferred to the areas of old age and care. The issues of social exclusion in old age related to care dependency as well as the accessibility of care resources in European countries with different elderly care approaches are the focus of this paper.

I commence with a discussion of the basic assumptions of the concept of social exclusion, as well as its transfer to the area of old age, care dependency and elderly care. As prerequisite, the dimensions of the ageing process are worked out, which allows us to analyse causal factors and processes of social exclusion in old age. Social exclusionary processes become manifest in everyday situations, where actors encounter problems and develop action strategies. A positive self-concept based on notions of belonging, trust and access to relevant resource structures are defined as a prerequisite to counteract social exclusionary processes (see Wessels/Mediema 2002 below). In case of care dependency in old age access to adequate care resources enable the elderly or their family members to maintain social integration.

On the basis of an investigation in five European countries, I compare care arrangements related to different social and care situations as well as patterns of social contacts and psychological well-being of the elderly. The selected countries – Austria, Belgium, Italy, the United Kingdom (Northern Ireland) and Germany – represent countries with different approaches with regard to elderly care. The influence of the country-specific approaches is shown in the care arrangement and patterns of social integration of the country samples, which differ for certain groups among the care-dependent elderly and informal carers.

[1] The article is based on an investigation carried out within the framework of the EU-project "Care For The Aged At Risk Of Marginalization (CARMA)" (QLK6-CT-2002-02341). Funding from the European Commission within the 5th Framework programme is gratefully acknowledged but the views remain those of the author alone. I would like to thank the research teams who, through their commitments to this project, generated the rich data, some of which is analysed here:
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2. Conceptual framework: Social exclusion in old age and care

2. 1 Dimensions of social exclusion in old age

Despite various attempts for clarification, the concept "social exclusion" is still criticized as incoherent and elusive, which diminishes its analytical capacity (see e.g. Room 2000). Nevertheless, some basic assumptions of the concept are outlined in the following as a prerequisite for the discussion of the issues of social exclusion in old age related to care dependency and elderly care (see e.g. Jordan 1996; Littlewood/ Herkommer 1999).

A pivotal characteristic of the concept is its assumption of multidimensionality. Kronauer (1997), for example, lists different dimensions, in which processes of social exclusion may occur:

- economic exclusion, e.g. lack of an adequate standard of living
- institutional exclusion, e.g. lack of access to public institutions
- cultural exclusion, e.g. due to expectations towards certain groups in a society
- social exclusion, e.g. lack of social relationships
- spatial exclusion, e.g. local segregation of living areas

The multiplicity of the concept pertains to its cumulative nature. Social exclusion is viewed as a continuum of combined and accumulated disadvantages, which gradually emerge in a process of reduced social participation. The term 'marginalization' was coined to define this gradual process of becoming detached from the organization and the communities of which a society is composed, as well as from the rights and obligations that it embodies. Marginalization focuses on relational issues, such as inadequate social participation, lack of social integration and lack of power. Thus, it is closely connected to a denied access to the principal social areas and, on the basis of this, to processes of multidimensional and cumulative disadvantage. The described patterns of multidimensional disadvantages enable the identification of vulnerable groups in a society (Room 1995).

The assumption of the multiple and cumulative nature of the concept raises the question of how the various dimensions reinforce each other. Whelan and Whelan (1995) describe this as the "need for conceptual clarity". From their perspective, simply identifying dimensions of social exclusion does not allow conclusions to be drawn on their significance and their interplay. "If the identification of distinct dimensions of exclusion is to be fruitful we must direct our attention to the somewhat different factors that are

involved in producing different types of deprivation and consider the variable consequences of specific types of exclusion" (Whelan/Whelan 1995: 37). In their view, distinguishing between determinants and outcomes seems to be fundamental in order "to understand the dynamics of social change and processes by which certain social groups are excluded" (Whelan/Whelan 1995:37). As a consequence, systematic analysis enables the identification of the (cumulative) factors that trigger an entry to and an exit from situations of social exclusion.

Blackman et al. (2001) transferred the concept of social exclusion to the issue of old age and elderly care. The starting point of their analysis is the definition of an ageing process as the interaction of genetic, environmental, cultural and social factors reflecting the multidimensional and cumulative character of the concept. The complex and still elusive nature of their definition enables us to re-evaluate the interplay of the different dimensions related to care provision on the basis of further empirical findings and conceptual approaches.

The findings of the European project "OASIS" confirm the broad approach for an analysis of the ageing process. The researchers emphasize economic situation, educational background and health status as decisive for the degree of autonomy in old age (Tesch-Römer et al. 2003). An overview of European socio-gerontological research proves the importance of a poor health status, which is associated with both a lack of social support and material resources, as a key risk factor in old age (Grundy 2006). In a representative questionaire survey carried out in Germany the elderly themselves view health problems and economic constraints as major risk factors for a lack of social integration (Böhnke 2006). In an interview study in Sweden the elderly themselves stress health status, functional abilities, social activities and social relations as the most important components of their quality of life (Wilhelmson et al. 2005). Findings of the Berlin Aging study can provide a starting point for the interplay of different dimensions. In this study the health status was revealed as decisive for the performance of daily functions**.** The maintenance of these functions forms a precondition for the involvement in social and leisure activities, whereas the participation in such activities is further determined by the status and income mediated by personality and cognitive competences (Baltes/Mayer 1999).

Social activities and social relations also correlate positively with quality of life as far as health is concerned (George 2001). Strong networks of families, friends and neighbours are regarded as vital for older people and have been revealed to be a significant source of social integration (Scharf et al 2001; Böhnke 2006). Conversely, social

integration may be impeded by ideological aspects that reflect cultural expectations in relation to elderly people within a society (Bytheway 1995). Welfare state arrangements also influence the development of risks in old age. A comparison between Nordic, Mediterranean and transitional eastern European countries finds lower rates at risk of social exclusion among the elderly in more highly developed welfare states (Ogg 2005).

All of the disadvantages within the different dimensions outlined above contribute to a gradual process of social exclusion in old age. Blackman et al. (2001) define social exclusion of the aged as a lack of participation in social life, as well as a lack of autonomy in daily life due to the ageing process. Social exclusion occurs when an old person cannot control the resources needed to meet the demands of an everyday life of autonomy that most take for granted. Life situations, which may counteract processes of social exclusion, depend on the provision of the elderly with basic needs, such as nutrition, housing, social support, etc., and are all strongly connected to socio-economic class or gender (Baltes/Mayer 1999; Grundy 2006). Consequently, changes inherent to the ageing process not only affect the elderly at different rates and in different ways, but according to the degree of vulnerability of the elderly themselves.

Schröder-Butterfill and Marianti (2006) define vulnerability as "the incremental outcome of a set of distinct but related risks, namely: the risk of being exposed to a threat, the risk of a threat materialising, and the risk of lacking the defences to deal with a threat (Schröder-Butterfill/Marianti 2006: 11). In the concept threats are defined as specific events that may propel people towards bad outcomes, e.g. social exclusion, if they cannot fall back on resources to alleviate the situation. Two sides of vulnerability are emphasized, i.e. the structural dimensions of vulnerability, which is based on inequalities, lack of power and lack of access to social protection as well as an agency dimension, where individuals negotiate the challenges and mobilise resources. In old age vulnerability arises from the interaction between advantages and disadvantages accumulated over the life-course, the experience of threat in later life and the adequacy and mobilisation of coping resources.

2.2 Situations, dependency and care

An analysis of the development of processes of social exclusion in greater detail requires an investigation into the situations in which they occur. The situational dynamic of processes of social exclusion builds the focus of an analysis from Wessels and Mediema (2002). In their approach they turn the attention to situations where the dynamics of exclusion materialize and the actors involved encounter problems, analyse their situation

and develop action strategies. Agency, ability and the competence of the actors, as well as the domain of exclusion and the available resource structures provide the framework of action. Wessels and Mediema emphasize a positive self-concept based on notions of belonging, trust and access to relevant resource structures as a prerequisite for the development of successful action strategies. If one of these notions is lacking, effective action-strategies are impeded and processes of social exclusion can ensue.

In their research work they analyse the notions of belonging, trust and accessibility of resources on three levels, on a micro-level, i.e. individual biography, on a meso-level, i.e. in close environments such as neighbourhoods, networks etc, and on the macro-, the societal, level. The positive function of belonging refers to integration and participation on all three levels; by contrast the absence of belonging refers to societal fragmentation, social disorganization and feelings of loneliness. Trust - or a lack of it – can be manifested towards authorities or institutions, as well as towards others in the social environment. Finally, accessible and adequate resources form the basis for social empowerment, personal development and social participation.

In Gibson`s analysis of the situation of care-dependent elderly the exercise or lack of power and control related to adequate care resources are treated as key issues (Gibson 1998). Lack of power and control are defined as negative dimensions of dependency or, in her terms, "negative dependency", which may occur in the life situation of care-dependent elderly people. This can develop on a micro level as a part of a care relationship and can be closely linked to the organisation of care processes on a meso-level. The micro and meso perspectives must be extended to the macro-level – to the societal level - to enable an analysis of socially constructed forms of dependency. Society may cause and strengthen this by direct means, e.g. accessibility to adequate resources or by indirect means in the exclusion from various social responsibilities and activities by social attitudes towards what is or is not appropriate for care-dependent elderly people.

As a result of her analysis, Gibson (1998) identifies the enhancement of access to power or control on the micro, meso and macro levels as the central challenge towards the avoidance of negative dependency. She defines the criteria that determine the degree of powerlessness an individual is likely to experience. From her point of view, the asymmetry of dependency and the lack of mutuality lead to the potential of exploitation. She develops three criteria to define the extent of negative dependency in a given situation:

- the extent to which the dependent individual needs the required services,
- the availability of alternative resources and,

- the level of discretion of the resource holder in providing the required assistance.

The relationship of care is characterised by risks of vulnerability and disempowerment for both care receivers and informal carers. The vulnerability of the informal carer arises from the social position and isolated domestic situation, through the identification with the well-being of the care-dependent person connected to the readiness to help and moral or legal constraints that make it difficult to express annoyance and frustration (Fine/Glendinning 2005). From the perspective of the informal carers caring activities are related to emotional costs, e.g. witnessing the physical decline of a loved one, physical costs due to the care burden, but also a loss of income or increasing financial costs and a compulsory retreat from further social relations due to the lack of time (Jani-Le Bris 1993; Tjadens/Pill 2000). In a German inquiry women aged 65 years and older cited care for a relative as a significant risk to their own social integration (Böhnke 2006).

Access to resources, the power of decision-making and a broad definition of the ageing process, including genetic, economic, social and cultural dimensions, prove to be significant variables that must be taken into account in any analysis of the interaction between processes of social exclusion, care-dependency in old age and care. The risk of social exclusion in old age is strongly connected to a poor health status and difficulties to perform daily functions, which impede participation in social activities and the maintenance of social relations. Cultural expectations concerning the place of frail elderly people in a society erect a further barrier to participation in social activities. A vicious circle may occur where a lack of social relations and social support leads to a further deterioration of the health status. The exposure to the risk of social exclusion differs between the elderly according to their socio-economic position, gender or living-situation. In contrast, accessibility of adequate care resources as well as a self-concept of the elderly based on belonging and trust may provide a basis to counteract exclusionary processes.

The outlined approach reveals the complex interplay of a wide range of variables necessary for an analysis of social exclusion in old age, care dependency and care. In the following two major issues are addressed on the basis of empirical findings:

1) Care resources: access and combination

The accessibility of care resources will be demonstrated by analysing the combination of different care resources for different groups among the elderly and in different care situations. An investigation into care burdens for informal carers and financial burdens due

to the purchase of different types of paid services reveals the consequences of different care arrangements for users and informal carers.

2) Social integration

The issue of social integration is illuminated in two respects. The living situation and the frequency of contacts with relatives, friends and neighbours are used as indicator for the level of social integration. Feelings of loneliness and sadness are analysed as indicators for the psychological situation of the elderly.

3. Empirical research: Care resources and social integration in five European countries

The research is based on the assumption that the patterns of care arrangements differ between European countries. Findings from a questionnaire survey and an in-depth interview study on care arrangement patterns and the situation of the informal carers in five European countries are used as an empirical basis to discuss the issues. The investigation was carried out in Austria, Belgium, Germany, Italy and Northern Ireland (as a part of the United Kingdom), i.e., five countries with distinctive approaches to elderly care.

Austria, Belgium and Germany represent the continental European approach, where care benefits were introduced since the 1990s and the establishment and expansion of care services were promoted. In all three countries the care benefits aim at facilitating the purchase of paid services and at supporting family care. Significant differences exist between these countries with regard to the level of available professional care services and the emphasis on care services with Belgium at the top and Austria and Germany at lower levels (Pacolet et al 2000; Bettio/Plantenga 2004). The services are also financed in different ways. In Germany comparatively high care insurance benefits (up to 1918 € per month in home-based care) paid to the care receivers form the only financial basis for the services, which are delivered to the care receivers at cost-effective, non-subsidized prices. Elderly people on low incomes can receive additional means-tested care benefits from the state. In Austria and Belgium in addition to the care benefits paid to the care receivers, the delivery of services is directly subsidized, which enables an adaptation of the prices to the economic situation of the individual user. Despite this subsidization, in Austria the care benefits are comparatively high (up to 1531.50 € per month). Care benefits in Belgium are

comparatively low (125 € per month) but care services may be subsidized by up to 80% (Cuyvers/Pintelon 2003; Egger de Campo/Just 2003, Theobald 2004).

The approach in Italy towards care for the elderly is characterized by a strict family orientation; the family is seen as the main provider of long-term care, while professional care services are widely underdeveloped (Pacolet et al 2000; Bettio/Plantenga 2000). Professional care services in Italy are delivered according to the principles of income and very often even according to the family-situation, i.e. they are oriented towards the lower socio-economic classes in society and the elderly without adequate family support.[2] In contrast, provision of long-term care in cases of care dependency is seen as a societal task in Northern Ireland, where professional care services are universally provided at low costs or even free of charge to elderly people 75 years or older on the basis of need (McCormick/Harpur 2003). Elderly care policies in Northern-Ireland differ significantly from the policy approaches in other regions of the United Kingdom, especially in England, where services are mainly supplied to those on lower socio-economic levels.

At least 90 care-dependent elderly people living in urban areas in each country – or, if they themselves were unable to so, their informal carers - participated in the questionaire survey.[3] In a next step 40 participants of the survey study were selected from each country for in-depth interviews. The samples are not representative according to the selection criteria, i.e. care dependency and urban living. Due to the access to the respondents mainly via different types of services in Germany, Italy and Austria the users of professional services are overrepresented in these samples. Especially in the Italian case, where professional care services are selectively provided according to the criteria "income" and "family-situation", the sample represents an often-disadvantaged group among the care dependent elderly. The findings of the investigation cannot, therefore, provide exact numbers about the situation of care dependent elderly in urban areas of the countries in question. They can, however, be used for a detailed, qualitatively analysis of the combination of different types of care resources and their relationship to different social groups and care situations.

[2] The regulations differ between the provinces and municipalities.
[3] With 115 respondents the Belgian sample is the only exception.

3.1 Care arrangements: Allocations of care resources

A detailed discussion of the allocation of care resources and their combination in different social and care situation provides the starting-point for the analysis of the development of care arrangements in the countries compared.

With the exception of the Italian sample, the family and the professional services are the main care providers in all samples (see table 1). In the Austrian sample a high level of professional care services is combined with a high level of care by relatives or partners sharing accommodation or by relatives living in easy reach. In the Belgian, German and Northern Irish

Table 1: Basic pattern care resources

Supported by	Austria	Belgium	Germany	Italy	Northern-Ireland
Professional services	70.8%	78.3%	78.9%	44.9%	83.0%
Relatives in same flat/house	60.7%	44.3%	38.9%	17.8%	31.8%
Relatives within easy reach	58.4%	82.6%	57.8%	23.3%	60.2%
Privately hired helpers	44.9%	17.4%	55.6%	8.9%	30.7%
Neighbours	24.7%	44.3%	33.3%	68.9%	28.4%
Friends	15.7%	46.1%	20.0%	10.0%	37.5%
Volunteers	3.4%	7.8%	8.9%	0.0 %	3.4%
Total: Care resources	2.8	3.2	2.9	1.8	2.8

samples a high level of service use is combined with a high level of support from relatives within easy reach but with a lower level of assistance – compared to Austria – of relatives or partners sharing living accommodation. In contrast to the other two countries, in the Austrian sample professional services are provided with a lower frequency. One reason for the pattern characteristic in the Austrian sample is the high proportion of the elderly who live with relatives, especially with their children. Here, the service provision supports this type of living-situation.

In addition, in the Austrian and German samples about half of the elderly hire private helpers, while the support of wider networks, i.e. help from friends or neighbours is quantitatively low.[4] In Belgium, by contrast, privately hired helpers are far more rare and almost 50% of the elderly receive support from friends and neighbours. The Northern Irish

[4] Within the questionaire survey a distinction was made between professional services and privately hired helpers. Professional services are defined as services delivered by public or private service providers. Privately hired helpers are directly hired by the care dependent elderly or the informal carers. The latter includes also assistance and help offered at the black market.

sample takes a position in the middle, with about 30% receiving help from privately hired helpers and friends and neighbours.

In the Italian sample a low level of family support from relatives sharing accommodation or relatives living nearby is combined with a low level and less frequent assistance by professional services and an even more rare assistance from privately hired helpers. With 68% among the respondents the neighbours are most often reported as care providers. The neighbours assist the elderly on a weekly basis; i.e. 95% of the respondents supported by their neighbours report assistance once or several times a week. Despite the support, only in the Italian sample do the elderly complain about unmet needs in a wide range of daily caring activities. The number of help resources also indicates a lack of assistance. According to the samples in our study, in Italy the elderly can draw on an average 1.8 help resources, compared to 2.8 in Austria and Northern-Ireland, 2.9 in Germany and 3.2 in Belgium. These differences cannot be explained by the level of care dependency of the elderly.

On the basis of the variables "living-situation, level of care dependency, socio-economic class and gender" the patterns of care arrangement and the allocations of different care resources can be revealed in a greater detail. In all country samples, care arrangement patterns are most influenced by different living situations, i.e. living alone or sharing accommodation, but decisive country differences can be observed when it comes to the kind of help afforded.[5] In all countries in our study the elderly who live alone receive significantly more assistance from professional services or privately hired helpers with housekeeping chores. Only with housecleaning and laundry did we find a significant

[5] Elderly living on their own receive almost/ significant more care from (Chi-Square): **Austria:** Relatives within easy reach: .030; Neighbours: .009; Privately hired helpers: .042; Prof. services /privately hired helpers related to the following activities: Cold meals: .000; Cooking: .000; Food shopping: 000; Laundry: 011; House cleaning .003, Repair work: .002;
Belgium: Relatives within easy reach: .010; Prof. services/privately hired helpers related to the following activities: Personal hygiene: .032; Dressing/Undressing: .032; Going to bed: .047; Check/control: .006; Eating: .013; Cold meals: .043; Cooking: .002; Laundry: .031; Housecleaning: .000; Repair work: .024
Germany: Professional service in general: .001; Prof. services/privately hired helpers related to the following activities: Personal hygiene: .000; Shower/Bath: .004; Pedicure: .003; Toileting: .035; Dressing/Undressing: .000; Going to bed: .033; Check/control: .016; Eating: .000; Cold meals: .000; Cooking: .000; Food shopping: .000; Laundry: .000; Housecleaning: .004; Repair work: .041; Errands: .000;
Italy: Relatives within easy reach: .038; Neighbours: .015; Professional services in general: .000; Prof. Services /privately hired helpers related to the following activities: Cold meals: .000; Cooking: .000; Food shopping: .000; Laundry: .000; Housecleaning: .000; Social activities: .011
Northern-Ireland: Prof. services/privately hired helpers related to the following activities: Pedicure: .000; Dressing/Undressing: .035; Eating: .046; Cold meals: .002; Cooking: .000; Food shopping: .005; Laundry: .001; Housecleaning: .001

proportion of assistance carried out by privately hired helpers.[6] Differences between the country samples are related to basic nursing care. In the German sample, all activities within this area are provided far more frequently to the elderly living alone. In the Belgian and Northern Irish samples the differences in the area of basic nursing care concern only some activities and are less pronounced, while in the Austrian and Italian samples the provision of professional care services or assistance by privately hired helpers comprises housekeeping chores only.[7] With the exception of Northern Ireland and Germany additional care resources are used more often, mainly the help of relatives within easy reach, but also neighbour's support and the assistance of privately hired helpers in the Austrian sample.

In all samples higher levels of care dependency are related to different patterns of care arrangements.[8] One difference concerns the help provided by family members. In the German, Austrian and Northern Irish samples, elderly people with a higher level of care dependency get more help from relatives with whom they share accommodation, i.e., they are more likely to be living with a partner or relatives. Only in the German sample does one find a significant increase in the level of assistance from relatives living nearby. The second difference is related to the use of professional services. A significant increase in the take-up rates of professional services exists in the samples of Italy, Belgium and Austria and there are indications in Northern Ireland of an increase in the frequency of delivered services.[9] In the German sample more care-dependent elderly use the assistance of

[6] In the Northern Irish and Belgian samples it applies to housecleaning only. In addition, in the Belgian sample even housekeeping is mainly carried out by professional services.

[7] In the Belgian, German and Northern Irish samples basic nursing tasks are conducted by professional services.

[8] Elderly with an increasing level of care dependency receive almost/significant more care from (Mann-Whitney U):

Austria: Relatives within the same flat: .000; Professional services in general: .029; Volunteers: .050; Prof. services /privatly hired helpers related to the following activities: Food shopping: .044; Transport: .035

Belgium: Professional services in general: **.**000; Prof. services /privately hired helpers related to the following activities: Shower/bath: .020; Laundry: .050; Transport: .034.

Germany: Relatives within the same flat: .002; Relatives within easy reach: .020; Friends: .036; Privately hired helpers: .025; Prof. services/privately hired helpers related to the following activities: Pedicure: .013; Dressing/Undressing: .045; Cooking: .046; Housecleaning: .048; Errands: .044

Italy: Neighbours: .047; Friends: .042; Professional services in general: .000; Prof. services/privately hired helpers related to the following activities: Cold meals: .000; Cooking: .000; Food shopping: .007; Laundry: .018; Housecleaning: .000

Northern-Ireland: Relatives within the same flat: .000; Prof. services/privately hired helpers related to the following activities: Pedicure: .029; Toileting: .037; Cold meals: .018; Cooking: .014; Food shopping: .002; Laundry: .004; Housecleaning: .009; Repair work: .001

[9] The frequency of professional care services is related to the availability of a main informal carer in the Northern Irish sample (Chi-Square .005). The availability of a main informal carer is closely related to the living situation (80% of the main informal carer are sharing accommodations), which in turn is related to the increase of the level of care-dependency.

privately hired helpers significantly more often than professional services. A third difference exists with regard to assistance provided by wider networks – friends and neighbours – in the German and Italian samples.

As a third variable the position in the socio-economic class structure (indicators: income, education, occupational status) is analysed.[10] With the exception of the Northern Irish and Austrian samples, there is a tendency in all samples for those of the lower socio-economic levels to draw more frequently on support from relatives or partners.[11] Only in the Austrian sample do care receivers in this situation tend to use professional services more often. Interestingly, there is an almost significant inverse correlation concerning the use of the assistance of privately hired helpers, i.e. the elderly receiving fewer professional services are more often supported by privately hired helpers.[12]

In the Belgian, Northern Irish and the German samples the elderly on higher levels of the socio-economic scale get more professional services. In the German and even more significantly in the Northern Irish samples, this is related to the use of professional services in general. In the Belgian sample it applies to different activities within the area of housekeeping and basic nursing care.[13] In addition, in the German and Northern Irish samples those higher up on the scale are more frequently supported by privately hired

[10] **Austria:**
Elderly with a higher socio-economic status receive almost/significant more care from (Chi-Square):
Prof. services/privately hired helpers related to the following activities: Transport. 034 (Education)
Elderly with a lower socio-economic status receive almost/significant more care from (Chi-Square):
Professional services in general: Income: .048; Education: .010
Prof. services/privately hired helpers related to the following activities: Cold meals: .031 (Education); Laundry .013 (Education).
Belgium:
Elderly with a higher socio-economic status receive almost/significant more care from (Chi-Square):
Prof. services/privately hired helpers related to the following activities: Going to bed:. .042; Eating:.006; Cold meals: .030; Cooking: .009;Laundry:.000; Housecleaning: .065; Repair work: .000; Social activities: .026
(All Education)
Germany:
Elderly with a higher socio-economic status receive almost/significant more care from (Chi-Square):
Professional services in general :.032 (Occupational status); Privately hired helpers: .003 (Income);
Prof. services/privately hired helpers related to the following activities: Pedicure:.046 (Income); .035 (Occupational status); Dressing/Undressing; .012 (Occupational status); Housecleaning: .047 (Income) .033 (Occupational status); Social activities: .054 (Occupational status)
Northern Ireland:
Elderly with a higher socio-economic status receive almost/significant more care from (Chi-Square):
Professional services in general: .000 (Income); Privately hired helpers: .036 (Education);
Prof. services/privately hired helpers related to the following activities: Shower/bath: .007; Dressing/Undressing: .035; Going to bed: .029; (All income); Laundry: .036; Housecleaning: .035 (All Education)

[11] Chi-Square: Belgium: Relatives within the same flat: .038 (Income); .044 (Education); Germany: Relatives within easy reach:. .033 (Occupational status); Italy: Relatives within the same flat: .034 (Income)

[12] Chi-Square: .064

[13] In the Belgian sample privately hired helpers are only active in the area of housecleaning.

helpers. We even find a significant positive correlation between both types of help resources in these two countries. In the Italian sample no significant correlation can be found with regard to professional services, privately hired helpers and support of friends and neighbours and socio-economic class.

With the exception of Austria a gender influence in the care patterns can be found in all country samples. In general, there is a tendency for men to receive more informal family help in general or with regard to different activities, while women tend to receive more professional care services. In the Northern Irish sample the differences are not very pronounced, and apply to only one daily help activity for men – going to bed - and one for women – assistance with pedicure. [14] The differences in the Italian and German samples are more pronounced. Care-dependent women in the Italian sample receive professional services far more frequently, while the care-dependent men more often draw on informal help.[15] In the German sample care-dependent women get more professional services for a wide range of daily activities, while the care-dependent men are more often supported by relatives within the same flat and by privately hired helpers.[16] Italy and Germany are the two countries with the highest proportion of elderly women living on their own and the greatest difference between men and women with regard to the living-situation.[17] In addition, compared to the other country samples the criterion "living alone" determines the care pattern to a large extent (see above). In the Belgian sample a different trend can be found, i.e. female respondents are more often supported by relatives within easy reach.[18] One reason for this pattern may be the high proportion of women living on their own in this sample and the active involvement of the relatives within easy reach who provide daily care. A last interesting point is the support of social activities by professional services. Only in the Northern Irish and Belgian samples we find a gender bias in favour of men. [19]

[14] Northern-Ireland: Chi-Square Eating men: .013; Pedicure women: .033

[15] Chi-Square: Italy: Women - Professional services in general .002; Men - informal help with regard to Eating: .028; Food shopping .035; Laundry. .003

[16] Germany: Chi-Square: Women. Dressing/Undressing .053; Going to bed . 004; Cold Meals .007; Cooking .001; Food shopping .001; Laundry .026; Men: Relatives within the same flat .000; Privately hired helpers .049

[17] Proportion of the respondents of the samples who are "live alone": Germany: Men: 31.0%, Women 72.1%; Italy Men 48.6%; Women 80.0%

[18] Belgium: Chi-Square: Relatives within easy reach .091

[19] Chi-Square Belgium: .010; Northern-Ireland. .013

3.2 Care arrangements: Informal care-giving and care burdens

The characteristics of informal care giving, the situation of the main informal carers, their care burdens and the financial burden arising from delivered paid services are discussed in order to reveal the wider consequences of the care arrangement patterns for the elderly themselves and their main informal carers.

The availability of a main informal carer is taken as a starting point for the analysis of their situation (see table 2). In the Austrian, Belgian and Northern Irish samples between 66% and 77% of the elderly are supported by a main informal carer.[20] The corresponding figures for Germany and Italy are 54% and 22% respectively. The proportion in the Italian sample may be an underestimation as only 31.9% of the elderly consider their partner or relative with whom they live as an informal carer compared to 92.6% in the Austrian, 91.9% in the German, 79.3% in the Northern Irish and 38.7% in the Belgian sample.[21] In the Belgian sample, however, the low proportion is compensated by a high level of main informal carers who live nearby–in contrast to the Italian sample. Nevertheless, even if the figure is underestimated in the latter due to the low proportion of the elderly who share accommodation with someone, it does not change the picture as a whole.

Table 2: The main informal carer

	Austria		Belgium		Germany		N-Ireland		Italy	
Main informal carer available	69	76.7%	85	73.9%	49	54.4%	59	65.6%	20	22.2%
Who from :										
Daughter(in-law)	34	49.3%	51	60.0%	20	40.8%	12	40.0%	1	5.3%
Partner female	10	14,5%	9	10.6%	20	40.8%	5	16.7%	9	47.4%
Son (in-law)	9	13.0%	16	18.8%	2	4.1%	7	23.3%	1	5.3%
Partner male	8	11.6%	5	5.9%	6	12.2%	1	3.3%	0	0.0 %
Other relatives	6	8.7%	3	3.5%	1	2.0%	4	13.3%	5	26.3%
Friends/neighbours	2	2.9%	1	1.2%	0	0.0%	1	3.3%	3	15.7%
Total	69	100%	85	100%	49	100%	30	100%	19	100%

Missing: In the Northern Irish and the Italian samples not all elderly who report having an informal carer gave detailed information.

[20] A main informal carer is defined as: "A person who organises and/or carries out the caring activities"
[21] The interviewer in Italy reports that care receivers often consider the care of their partners as natural and as a part of their role within marriage.

Differences between the country samples can be found with regard to the familial relationship and gender of the main informal carers. Within the Austrian, Belgian and Northern Irish samples the children - in particular the daughters and even some sons (between 13 to 23%) - are reported to be the main group among the informal carers. Different patterns of care provision and living situations of the elderly form the background of this finding. While the elderly in the Austrian sample are more likely to live together with their children, in the Belgian sample the children living within easy reach take over this responsibility even where the elderly live together with a partner. In the Northern Irish sample this can be explained by the high proportion of elderly people (67.8%) - living on their own.

In the German and Italian samples partners are most often named as main informal carers. In the Italian sample not a single male partner is reported as a main informal carer, while 12.2% of male partners are reported as the main informal carers in the German sample. A further quantitatively important group among the main informal carers within the German sample are daughters and within the Italian sample "other relatives", i.e. nieces or nephews as well as neighbours and friends.

The reasons for the involvement of the informal carers differ from country to country. In the in-depth interviews, the Austrian, Belgian and German respondents partly describe their caring activities as self-evident, meaningful or as based on a positive close relationship. Roughly half of the interview partners in Austria, around one third in Germany and even two respondents in Belgium, however, complain of a lack of alternatives, e.g. non-availability of adequate professional services. In the Italian sample informal care giving is based on the norms of familial responsibility, even from nieces and nephews, or carried out by neighbourly solidarity. Informal carers in the Northern Irish sample describe their engagement as voluntarily and the actual care provision as negotiated in a round table conversation between the professional carers and the family members.

Feelings of exhaustion reflect the care burdens of the main informal carers related to the care arrangements. In the German sample about half of main informal carers, about one third in the Austrian and more rare in the Northern Irish and Belgian samples are reported to be exhausted (see table 3). Of the Italian respondents almost half state that they

"don`t know" which indicates that the dimension "exhaustion" is not noticed by a considerable proportion of the care receivers.[22]

Table 3: Main informal carer is exhausted in %

	Yes	Somewhat	No, don`t think so	Don`t know
Austria	36.2	37.7	23.2	2.9
Belgium	8.2	15.3	65.9	10,6
Germany	46.9	16.3	34.7	2.0
N-Ireland	11.8	27.9	42.6	17.6
Italy	0.0	12.5	43.8	43.8

In the German sample the elderly with a main informal carer use professional services significantly less often; we find the same trend in the Italian sample, although the correlation is not significant.[23] For the Northern Irish respondents the availability of a main informal carer is significantly related to an increase of the frequency of professional services.[24] The low level of support with professional services in the German sample and the contrastingly intense support in the Northern Irish sample may explain the different levels of reported exhaustion.

Professional services within the Northern Irish sample are initiated by professionals within hospitals or by a general practitioner, who refers the elderly or the family members to the care manager or social services. The German interview partners cite hospital discharge as the decisive access point to professional services. The care needs of the elderly are brought forward as the reason for using services, while no interview partner stated that it was to lighten the load of the informal carer. Within the Italian sample professional services are used when no family carer is available or they can no longer carry out caring tasks. The care needs of the elderly are cited as the basis for the arrangement of professional services by the interviewpartners of the Belgian sample. The main informal carers` low level of feelings of exhaution indicates adequate support from professional services and further informal carers.

[22] The question is answered by informal carers and care-dependent elderly respectively. The care receivers may underestimate the level of exhaustion, but it does not change the picture in general. With the exception of the Italian sample between 15-23% of the care receivers do not know whether the main informal carer is exhausted.
[23] Chi-Square: Germany: .000; Italy: .159
[24] Chi-Square. Northern Ireland: .005

Only those interviewed in Austria stated that the reasons for arranging professional services were the care needs of the elderly and, to an equal extent, the desire to unburden the informal carers or to enable labour market participation. Professional services are mainly initiated and arranged by the family members or social networks, which may arise from the interest of the informal carers to be unburdened. However, the high level of exhaustion shows that there is insufficient relief for the main informal carers, but that feelings of exhaustion decrease when additional helpers are hired privately.[25]

Economic costs that arise due to the purchase of care services may lead to a further burden related to the care situation (see tables 4 and 5). With only 21.6% of the respondents paying for services received and just 10% of them assessing the costs as a burden, the respondents in the Northern Irish sample experience the most favourable situation. In the Austrian, German and Italian samples about half of the elderly have to pay for some of the services, and more than 90% of them judge the payments to be a burden. Half of the respondents in the German and Italian samples even describe them as a severe burden. In the Belgian sample the largest proportion of the elderly have to pay for the services and very often for almost all care services. However, only 55.8% of these respondents consider this to be a burden and only 21.1% as a severe burden.

Table 4: Costs for services paid by the care receivers[26]

	Yes, (almost) all		Yes, some		No	
	Count	**%**	**Count**	**%**	**Count**	**%**
Austria	14	15.9	32	36.4	42	47.7
Belgium	73	66.4	20	18.2	17	15.5
Germany	5	5.7	44	50.0	39	44.3
N-Ireland	4	4.5	15	17.0	69	78.4
Italy	11	13.4	45	54.9	26	31.7

[25] Chi-Square: Austria: .067
[26] The costs include payments for all types of services respectively privately hired helpers.

Table 5: Costs for care services are a burden

	Yes, a severe burden		Yes, a minor burden		No	
	Count	%	Count	%	Count	%
Austria	18	35.3	28	54.9	5	9.8
Belgium	20	21.1	33	34.7	42	44.2
Germany	26	53.1	15	30.6	8	16.3
N-Ireland	0	0.0	2	10.5	17	89.5
Italy	24	43.6	31	56.4	0	0.0

Whether the respondents experience a financial burden or not is related to an increasing level of care dependency and their income situation. In the Belgian sample a higher level of care dependency is related in a highly significant measure to the experience of a financial burden.[27] This may explain the ambivalent relationship between privately paid services and financial burdens. Elderly people who have to pay all services themselves complain of a financial burden far less frequently than those who only pay for some services. It can be assumed that the first group only needs assistance in some areas due to a lower level of care dependency. In Belgium professional services are highly subsidized and affordable, especially, if one only needs a small number of the services. The rising costs due to the increasing level of care-dependency do not take the modest flat-rate care benefit (independent of the level of care needs) into account.

In the German sample the reported financial burden also increases significantly with the level of care dependency and manifests the same trend as the Italian sample, which reveals an insufficient covering of costs in cases of more severe care dependency.[28] The income situation is related to the financial burden in the German sample and is visible as a trend in the Austrian sample, which indicates difficulties with the purchase of care services, especially for the elderly on lower incomes.[29] In the Belgian sample, the relationship between socio-economic class and an experienced economic burden is more contradictory. Elderly people with a higher occupational status report significantly more often that they experience the costs as a burden, however, this also applies – quite significantly - to the elderly with lower incomes.[30]

[27] Mann-Whitney U: Belgium: .004
[28] Mann-Whitney U: Germany: .035; Italy: .078
[29] Chi-Square: Germany: .081; Austria: .164
[30] Chi-Square: Belgium: Occupational status: .031 and Income .075

3.3 The social integration of the elderly

The frequency of contacts to relatives not living under the same roof and friends and neighbours are taken as indicators for the social integration of the elderly. The term "contacts" has been very widely defined, i.e. including even phone-calls, and thus includes all types of contacts to people outside the own home.

Table 6: Frequency of contact to relatives not living with the respondents

	Austria	Belgium	Germany	Northern Ireland	Italy
Daily, several times per week	38 42.2%	85 73.9%	40 44.4%	49 55.1%	37 41.1%
Once per week, several times per month	22 24.4%	22 19.1%	24 26.7%	23 25.8%	19 21.1%
About once per month	4 4.4%	2 1.7%	4 4.4%	2 2.2%	10 11.1%
Several times per year	9 10.0%	1 0.9%	2 2,2%	5 5.6%	1 1.1%
More rarely	7 7.8%	4 3.5%	3 3.3%	7 7.9%	10 11.1%
N/a	10 11.1%	1 0.9%	17 18.9%	3 3.4%	13 14.4%
Total	90 100 %	115 100 %	90 100%	89 100%	90 100%

The figures show a picture of close contacts between the care-dependent elderly and relatives who do not live under the same roof (see table 6). In Austria, Germany, Northern Ireland and Italy about half of the respondents have daily or weekly contact with such relatives, whereas almost all of the Belgian respondents do. However, in Austria, Germany and Italy large percentages (19%, 22 %, and 26%, respectively) only rarely have contact with such relatives or have no relatives whatsoever. In all countries, children and grandchildren make up the main part of social contact.

Table 7: Frequency of contact to friends/neighbours

	Austria	Belgium	Germany	Northern Ireland	Italy
Daily, several times per week	12 13.3%	50 43.5%	40 44.4%	48 53.9%	48 53.3%
Once per week, several times per month	26 28.9%	44 38.3%	17 18.9%	19 21.3%	20 22.2%
About once per month	15 16.7%	7 6.1%	7 7.8%	3 3.4%	11 12.2%
Several times per year	4 4.4%	1 0.9%	0 0%	3 3.4%	0 0%
More rarely	21 23.3%	13 11.3%	13 14.4%	5 5.6%	2 2.2%
N/a	12 13.3%	0 0%	13 14.4%	11 12.4%	9 10.0%
Total	90 100 %	115 100 %	90 100 %	89 100 %	90 100 %

In Belgium, Germany, Northern Ireland and Italy approximately half of the respondents reports frequent contact to friends or neighbours, whereas this is only the case for 13 % of the Austrian respondents (see table 7). In addition, many respondents report no or only rare contact with friends and neighbours (e.g. 37 % of the Austrian sample and 29 % of the respondents in Germany). In Belgium, Northern Ireland, and Italy these figures are lower with 11 %, 18 %, and 12 % of the care-dependent elderly, respectively.

Care arrangements and the use of professional care services are differently related to the level of contacts. In the Northern Irish sample and partly in the Austrian sample, the elderly who report more contacts are supported more often by professional services and in the Austrian case even by privately hired helpers.[31] In these samples social contacts and informal and formal types of help support each other. In the Belgian sample a high level of contacts to relatives is related to a lower use of professional services in some areas.[32] This confirms, once again, the importance of close relatives for care and assistance in the Belgian case. In the German sample the elderly with only rarely contacts to close relatives, friends and neighbours are provided with more professional services for certain activities related to basic care provision.[33] However, in the interviews transport- and mobility services are put forward as an opportunity to maintain social relations despite functional impairments. Only in the Italian sample do the elderly with rare contacts to relatives receive significantly more professional services as a whole, which indicates an orientation of service provision to the elderly without adequate family support.[34]

3.4 Psychological wellbeing

For psychological well-being, feelings of belonging in particular are seen in the discussion on social exclusionary processes as a significant resource to prevent social exclusion (see Wessels/Mediema 2002 above). In the ADL scale of the investigation three items are used

[31] Chi-Square Northern Ireland: Contacts to relatives: Dressing/undressing: .067; Eating: .046; Shopping .004; Contacts to friends: Pedicure 067; Laundry: 001; Housecleaning .096; Austria: Relatives: Preparing cold meals: .081; Cooking: .013; Housecleaning: .011; Privately hired helpers in general: .004; Friends: Cooking: .081; Housecleaning: .017; Privately hired helpers in general: .099. In both countries privately hired helpers are only involved in housecleaning.
[32] Chi-Square: Belgium: Repairs: -.058; Leisure: -.044, Errands. .013;
[33] Chi-Square: Germany Relatives: Eating: .098; Housecleaning: .077; Friends: Toileting: .070; Going to bed: .096; Leisure activities: .035. Only within the area of housecleaning privately hired helpers are active.
[34] Chi-Square: Italy: .043

to measure the psychological situation of the elderly: feeling lonely and downhearted, as well as the use of mental health treatment.[35]

Table 8: Feelings of loneliness

	Austria		**Belgium**		**Germany**		**Northern Ireland**		*Italy*	
Sometimes	25	27.8%	43	37.4%	24	27.9%	36	40.4%	35	38.9%
Often	11	12.2%	15	13.0%	6	7.0%	8	9.0%	28	31.1%
Total	36	40.0%	58	50.4%	30	34.9%	44	50.3%	63	70.0%

Table 9: Felt downhearted and sad the last month

	Austria		**Belgium**		**Germany**		**Northern Ireland**		**Italy**	
A little of the time	9	10.0%	30	26.1%	8	9.3%	30	33.7%	41	46.6%
Some of the time	24	26.7%	30	26.1%	41	47.7%	18	30.2%	18	20.5%
A good bit of the time	14	15.6%	20	17.4%	10	11.6%	5	5.6%	11	12.5%
Most of the time	10	11.1%	3	2.6%	5	5.8%	5	5.6%	7	8.0%
All of the time	6	6.7%	2	1.7%	3	3.5%	2	2.2%	0	0 %
Total	63	70.1%	85	73.9%	67	77.9%	50	77.3%	77	87.6%

Table 10: Mental health treatment

	Austria		**Belgium**		**Germany**		**Northern Ireland**		**Italy**	
Yes	18	20.0%	22	19.1 %	29 %	34.5	15	16.7%	3	3.3 %
Do not know	4	4.4 %	4	3.5 %	0 %	0.0	0 %	0.0	0 %	0.0

In all five countries a majority of the respondents reported that they had felt downhearted during the previous month and a considerable number also said that they sometimes or often feel lonely as well (see tables 8 and 9). The finding represents a serious obstacle to good mental health in old age. Despite this, only minorities have ever been treated for

[35] ADL-scale: (Activities of daily living): The "Easycare scale" is employed, which was developed in a EU-project and is used in different European countries.

mental health problems (see table 10). Given that mental health problems are widely stigmatized and generally hidden, the number may well be higher.

Feelings of sadness and loneliness, as well as the combination of the three "depression items" are correlated to the level of care-dependency, the living situation and the provision of care. In the Austrian sample, a higher level of physical disabilities is significantly related to feelings of sadness.[36] In the Belgian and German samples, elderly people who report difficulties with vision score higher on the combination of the depression-items.[37] One overridingly important factor for the psychological situation of the elderly is their living situation. In the Austrian, Italian and Belgian samples respondents living alone score significantly higher on the combination (sum score) of the depression-items.[38] In the German sample this correlation concerns only the elderly who live alone on a low income; i.e. 25% below the median income.[39] Feelings of loneliness prove to be most decisive and highly significant with regard to the correlation between the living-situation "live alone" and the psychological well-being.[40] In the following, the significance of the living-situation will be demonstrated and compared with the influence of the frequency of contacts.

Table 11: Elderly respondents living under one roof: Feelings of loneliness

Living together with	**Austria**	**Belgium**	**Germany**	**Northern Ireland**	**Italy**
- Partner:					
Never lonely	19 82.6%	28 71.8%	19 82.6%	13 72.2%	20 83.3%
- Children:					
Never lonely	7 67.7%	3 54.4%	4 72.7%	3 60.0%	1 100 %

Note: In the Italian sample, only two elderly respondents live together with their children and only one respondent answered the question.

[36] Spearmans Rho: Austria: .05
[37] Spearmans Rho Belgium: .02; Germany: Kendall`s Tau-b: .008
[38] Mann-Whitney U: Italy: .000; Belgium: .001; Austria: .005
[39] Kendall`s Tau-b: .078
[40] Chi-Square: .000

Table 12: Elderly respondents living on their own:
Frequency of contacts and feelings of loneliness

	Austria	Belgium	Germany	Northern Ireland	Italy
Feelings of loneliness:					
- Never lonely	14 38.9%	15 28.8%	29 55.8%	24 40.0%	6 9.8%
- Sometimes	15 41.7%	24 46.2%	17 32.7%	29 48.3%	29 47.5%
- Often	7 19.4%	13 25.0%	6 11.5%	7 11.7%	26 42.6%
Frequent contacts to:					
- Relatives	21 60.0%	41 78.8%	24 58.5%	35 59.3%	20 41.7%
- Friends/Neighbours	5 14.3%	28 52.8%	24 50.0%	37 71.2%	30 57.7%

Note: "Frequent contacts" is defined as daily contacts, or several times per week

In all country samples, the elderly who share their home with someone else, in particular with their partner, reported lower feelings of loneliness than those who live alone (see tables 11 and 12). For the latter, significant differences can be found between the country samples, that are in addition not directly related to the frequency of contacts in the overall samples. On the basis of the in-depth interviews, the findings for the Italian and Belgian samples, where feelings of loneliness are widespread despite frequent contacts, will be analysed in a greater detail.

The high proportion in the Italian sample of the elderly feeling lonely can be explained as a consequence of the prevalent family values and restrictions of care delivery. The interview participants complain about the lack of care by family members, which is against the norms of the family-oriented model of care in Italy. Contacts, conversation and social support by friends and neighbours are reported as the most effective coping-strategy, but this does not prevent the development of feelings of loneliness. These respondents said that in a case of emergency during the night no support or assistance would be available and they felt helpless and abandoned.

Despite frequent contacts to relatives, friends and neighbours feelings of loneliness are widespread for the elderly living in our Belgian sample. Cultural differences may be one explanation for the finding, as the respondents in general report more often higher

feelings of loneliness. The interview partners reported almost daily visits from their children living nearby or they meet their neighbours for a chat or to play cards. Such contacts can only partly improve the situation, which is explained by the elderly themselves with the death or loss of the partner.

3.5 Risk-groups

In the following, two risk groups are defined in order to determine in greater detail those among the elderly who are at risk of social disintegration or of being in a burdened care situation. One risk group is defined by the living situation – elderly people living alone – and in addition a low frequency of contacts to relatives, friends and neighbours. The focus is on the issue of low social integration, the characteristics of this group and the psychological consequences. In the second risk group we analyse the issue of depressed economic circumstances due to the care situation. Owing to the small numbers of respondents in these groups, the findings can only be taken as indications for characteristics, difficulties and relationships.

Table 13: Risk group 1

- Care dependent elderly living alone
- Rarely contacts to relatives/ friends/neighbours (once a week or less)

Country	Respondents		Risk group	
	Sample	- Living alone	Count	%
Austria	90	36	12	30.0
Belgium	115	53	6	11.3
Germany	90	53	8	15.1
N-Ireland	90	61	7	11.5
Italy	90	61	8	13.1

In the Austrian sample one third of all elderly people who live alone belong to this risk group, which is a very high proportion among compared to their counterparts in the other country samples. This proportion indicates considerable obstacles with regard to social integration. In the other country samples between 11-15% of the elderly living on their

own can draw only rarely on social contacts. In Austria, Germany and Italy, it is mainly women who belong to this risk group, i.e. in the Austrian sample only women are included and in the German and Italian samples only one and two men, respectively. This finding corresponds with a high proportion of women among the elderly living alone in these three countries.[41] A further trend can be seen with regard to occupational status. Respondents in Germany and Northern Ireland who had had white-collar occupations are overrepresented in this group, in the case of the latter, to a considerable extent.[42]

As one would expect, because of their living situation the respondents in the risk group in all countries are supported more often by professional services or privately hired helpers, which is significant for most activities.[43] Exclusive use of professional services is not significant, but in the Belgian, German and Northern Irish samples only one of the elderly of the risk group report receiving no professional care services. There are some activities where the members of the risk group receive informal help, even if it is on a lower level than for the other respondents.[44]

Compared to the other respondents, the elderly in this risk group score significantly higher on the depression items with feelings of loneliness as decisive and highly significant factor.[45] In the Austrian, Belgian and Northern Irish samples a low level of frequency of contacts reinforces the feelings of loneliness, which are already experienced by the elderly living on their own. However, in the Italian sample, the frequency of contacts does not influence the correlation (see above). Feelings of sadness proved to be most significant for the German respondents.[46] In contrast to the negative psychological situation, the respondents score significantly better in the performance of instrumental and basal daily activities.[47] A better performance of daily activities forms the precondition to living alone even in this situation, while the more negative score concerning the depression-items seems to be a result of the social situation and not solely of the level of the care dependency. Both findings show the precondition of the living situation and the considerable psychological impairments.

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[41] Female proportion of elderly living alone in the sample as a whole: Austria 91.7%, Germany 83.0%, Italy 72.1%; Northern Ireland: 78.7%, Belgium 60.4%

[42] Mann-Whitney U.: Northern Ireland: 038

[43] Chi-Square: Personal hygiene: .049; Dressing: .055; Eating: -033; Cold meals: .000; Cooking; .003; Laundry: .001; Housecleaning: .001; Repairs: .001; Leisure activities: 001; Errands: .001; Transport: .001, Check/Look after: 080

[44] Bathing, Pedicure, Eating, Cooking, Shopping, Laundry, Housecleaning, Repairs, Leisure activities, Errands, Transport, Check/look after

[45] Depression sum score: Mann-Whitney U.: .055; Feelings of loneliness: Chi-Square:.005

[46] Chi-Square: .020

[47] Mann-Whitney U.: .010

Table 14: Risk group 2

- Income 25% below median-income
- Costs of care are regarded as a burden

Country	Respondents		Risk group	
	Sample – Income 25% b.m.		Count	%
Austria	90	51	26	51.0
Belgium	115	29	21	72.4
Germany	90	25	7	28.0
N- Ireland	90	14	0	0.0
Italy	90	52	33	63.5

This risk group is quantitatively more important than the first and, what is more, significant differences exist between the country samples. The proportion of respondents is very high in the Austrian, Belgian and Italian samples, while it is comparably low in the German and non-existent in the Northern Irish samples. By distinguishing between a minor or a severe burden we find 38.1% of respondents in the Belgian, 48.5% in the Italian and 53.8% in the Austrian samples experience a severe level of burden. Interestingly, in the German sample the overall proportion of respondents who experience a burden is quite low, but where it was experienced, it was a severe burden for 88.9% of respondents. The findings can partly be explained by different ways of adapting user costs to the income situation. In the Italian, Austrian and Belgian samples, general adaptations to the income of the elderly are inadequate. The findings from the German sample reflect the way in which care services are paid for: Below an income threshold the costs for the professional care service provision are fully covered by the welfare state. In addition, services are often used within the range of benefits granted by the long-term care insurance or the welfare state.

In the Austrian, Belgian and Italian samples, the samples with the highest proportion in this group, more respondents tend to have a lower level of education.[48] In contrast to risk group one, no gender influence can be observed. Even though more elderly people who live alone are to be found in this group, this is only significant in the Austrian sample with a high proportion of widows or widowers.[49] In the Italian sample, we find the

[48] Chi-Square: Austria.088; Belgium: .130: Italy. .218
[49] Chi-Square: Austria: 000

same trend with 26 of 33 respondents in this group living alone, while the Belgian and German samples do not show this trend.

The respondents also tend to use more informal help instead of professional or privately hired assistance, but it is only significant for three variables.[50] This indicates that the elderly try to lower the economic burden by reducing their recourse to paid services. The exception is the Italian sample, where the respondents in our study receive significantly more professional care services and are more likely to get more help from relatives with whom they share accommodation.[51]

Although the characteristics of the two risk groups differ considerably, the psychological situation is quite similar. Elderly within this risk group score significantly higher on the depression-score, and shows better scores – although not significantly – in the area of instrumental and basal activities.[52] The findings reveal that an economic burden arising from the costs of care services in a low-income situation leads to a negative psychological situation and a reduced use of services. The comparatively higher ability in the performance of basal daily activities indicates that in such a risk situation a certain level of performance may be required in order to avoid an institutionalized solution.

4. Conclusion: Social exclusion, social integration and care

The concept of social exclusion aims to provide a theoretical tool for the analysis of „new social cleavages“ in society, i.e. the analysis of the situation of its members at the fringes. In old age risks of social exclusion are related to health problems and difficulties to perform basic functions. The provision of access to adequate care resources, the promotion of social contacts to the family and wider social networks and feelings of belonging can all serve to counteract social exclusionary processes (see Wessels/Mediema 2002 above).

On the basis of an investigation in five Western European countries care arrangements and patterns of social integration and psychological well-being have been analysed. The comparison of different care arrangements, care burdens for the main informal carer and the economic burden due to the purchase of services reveals the accessibility of an adequate care provision. Social contacts to relatives, friends and

[50] Chi-Square: Transport .031; Repairs .030; Check/look after .001
[51] Chi Square: Italy Professional services .010; Relatives within the same flat: .022
[52] Mann-Whitney-U: Depression-score: .053; Basal and instrumental activities: .252

neighbours, the living-situation and the psychological well-being are illuminated to reveal patterns of social integration. The findings show that country-specific care approaches lead to care arrangements and risks of an inadequate care provision depending on the social and care situation of the elderly. Values, regulations and modes of funding of professional care services are decisive for the development of the arrangements. Patterns of social integration and psychological well-being are influenced by care provision but also the living and social situation.

In Austria, Belgium and Germany, family members and professional services are assigned a basic role in care delivery. In the implementation of the policies the countries differ with regard to the emphasis and mode of funding of professional services, which results in the development of different care arrangements and risks for certain groups among the elderly. In the German sample, a major risk factor arises from the low level of service use of the elderly with family support with a low or medium income. The main informal carers in Germany complain most frequently on feelings of exhaustion. The high costs, which are not adapted to the individual income, constitute an obstacle for service use and when the costs for service use exceed care or welfare benefits it is perceived as an economic burden. For the respondents in the Austrian sample the adaption of prices to the individual incomes facilitates access to care services independent of the socio-economic status, but the restricted frequency of care services reduces the unburdening effect and is compensated with the purchase of private assistance by those at higher socio-economic levels. Due to an adequate sharing of caring-activities between the family members (mainly the children) and professional services in the Belgian sample the care burden for the main informal carers is comparatively low. The highly subisdised care services are available at moderate costs, but may become an economic burden with increasing care-dependency.

The elderly care approaches in Northern Ireland and Italy build a stark contrast. While in the Italian approach the family is seen as the main provider, in Northern Ireland, society is assigned the major responsibility. The findings of the Italian sample illustrate the difficulties of care provision in a family-oriented approach, when the close family is not available to take over the care provision. Despite the support of the neighbours and the members of the wider family, e.g. nieces and nephews, a lack of assistance with regard to daily activities was only observed for the Italian respondents. Furthermore, a high economic burden due to the purchase of services is reported in particular for the members of the lower socio-economic classes. In Northern Ireland, by contrast, the involvement of

the informal carers is seen as voluntarily and the sharing of tasks between the family and professional carers is a matter of negotiation. There, only a small proportion of main informal carers reports being exhausted, which indicates an adequate level of support in daily care provision and the use of services is not perceived as an economic burden. Despite a generous care delivery in general, however, those on higher socio-economic levels receive even more professional services and additional assistance from privately hired helpers.

In the investigation a pattern of close social contacts to family members, neighbours and friends becomes apparent, which can be promoted by professional and informal care provision depending on the country. Despite the positive trend for a small group among the respondents indications of a more socially isolated situation are detectable; between 11-15% of the elderly who live alone can rely on only rare social contacts. Austria is the exception here where fully 30% of respondents who live alone have only sparse social contacts. Compared to the other countries, the elderly in our Austrian sample have only little social contacts with their neighbours. Due to their living-situation, women are particularly at risk of becoming socially isolated. A close social network and intense family relations even before the advent of care-dependency and services, which support social participation can prevent or counteract social isolation.

In all country samples the respondents reported psychological problems, such as feelings of loneliness and sadness but only rarely reported professional treatment. Feelings of loneliness and sadness develop in a complex interplay of the level of care-dependency, the living situation, available social contacts and expectations. Especially the elderly respondents who live alone cite feelings of loneliness, and the negative psychological situation may be reinforced when they cannot fall back on wider social contacts. An inadequate provision of care and the additional economic burden arising from the costs of care services, in particular for those on lower incomes, are also related to a negative psychological situation. The Italian example conveys how a lack of care and unmet expectations towards the family give rise to feelings of loneliness despite close contacts to neigbhours and friends.

The research confirms the strength of the concept “social exclusion”. The broad analysis of the interplay of care resources, patterns of social integration and psychological well-being related to variables such as socio-economic class, gender, level of care-dependency and living-situation enables a sophisticated analysis of the social situation of the care-dependent elderly and their informal carers. A cross-country comparison of the

influence of elderly care approaches calls for a detailed consideration of elements involved, whereby distinction must be made between the norms, the implementation and the perception of the elderly respondents. The very different social situations of the care-dependent elderly even within one country reflect that the elderly care approaches causes different realisations, which are not only due to individual preferences but also to available opportunities.

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