The face of Europe is changing – not only as a result of enlargement – but its age profile is rising, both in the general population and in its workforce size. This ageing population will place strong upward pressure on financial and human resources for long-term care in the years ahead. Family members, friends, neighbours and other informal carers provide the bulk of care provision to ill, frail and disabled individuals of all ages. These carers are not paid for the work they do, but they enable those with care needs to remain at home and in their local community, at a considerable saving to the state. There is a real danger that informal care is being forced to compensate for the inadequacies in state support. In addition, the needs of carers tend to take second place, with many experiencing serious – financial, health and social consequences. One thing is certain – urgent reform is required, based upon greater recognition of the role and contribution of carers. This factsheet aims to provide general information on the current situation of carers in the European Union.
It must be noted that due to issues such as language and accessibility, the author has not been able to comment on developments in certain European countries. There may therefore be some unintentional bias towards Western European countries in this factsheet.

**Background**

In 2007, researchers from Vilans, MOVISIE and Mezzo in the Netherlands produced a first factsheet for Eurocarers entitled *The Contribution of Carers to Long-term Care, especially for Older People* (Tjadens et al, 2007). Since its publication, important new research has been published, for instance, a range of reports have been produced from the EUROFAMCARE\(^1\) and SHARE\(^2\) (Survey on Health, Ageing and Retirement in Europe) studies. In addition, there has been an extensive review of relevance on Care Provision within Families and its Socio-Economic Impact on Care Providers (Glendinning et al, 2009a). Findings from the Second European Survey on Quality of Life have also been produced (Anderson et al, 2009).

**About this Factsheet**

This factsheet aims to provide an up to date account of the current situation of carers in Europe, including:

- Demographic information on Europe and carers
- Who are carers and what do they do
- The contribution of carers to society
- The impacts of caring
- Support measures available to carers
- European policy areas relevant to carers

This factsheet, along with the 2007 publication, is intended to assist policy makers, carers’ organisations and health and social care providers to understand the role of carers and the needs for support in social and economic policy.

**How will Europe’s population develop?**

Three factors underlie Europe’s ageing society: high life expectancy, persistently low fertility rates and baby-boom cohorts are reaching higher ages (Eurostat, 2009). Latest population projections\(^3\) estimate that the EU-27’s population will rise to a high of 521 million persons in 2035, thereafter falling to about 506 million inhabitants by 2060 (Eurostat, 2008). However, these changes will not be distributed equally across the Member States. The populations of Cyprus, Ireland and Luxembourg are projected to grow by over 50% from 2008 to 2060, while the populations of Belgium, Spain, France, Sweden and the United Kingdom are projected to grow by between 15% and 25% by 2060. In contrast, the populations of Poland, Estonia, Hungary, Slovakia and Germany are projected to have shrunk by between 10% and 20% by 2060, with even stronger declines of between 20% and 30% in Bulgaria, Latvia, Lithuania and Romania (Eurostat, 2009).

One thing is constant across Europe: in general Europeans are living longer, expected to gain five years in life expectancy by the year 2050 (European Commission, 2006a). It is estimated that the number of people aged 65+ will increase by three-quarters between now and 2050; with the old age dependency ratio expected to double during the same period (European Commission, 2008). The proportion of the population over the age of 65 will almost double over the next 40 years, from 17% in 2005 to nearly 30% by 2050. The ‘very old’, i.e. people over 80 years of age in the EU will rise from 4.1% of the population in 2005 to 6.3% in 2025 and 11.4% in 2050 (Eurostat, 2008). More than two thirds (67.2%) of the EU population were of working age (15 to 64 years old) in 2007- EU projections suggest that this relatively large proportion of the population may shrink gradually to about 57% of the total. At the same time, families are having fewer children – an average of only 1.5 children

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1 EUROFAMCARE is an international research project funded within the 5th Framework Programme of the European Community, Key Action 6: The Ageing Population and Disabilities, 6.5: Health and Social Care Services to older People. A range of research papers have been produced since the projects’ completion. Further information is available from [http://www.ukc.de/extern/famcare](http://www.ukc.de/extern/famcare)

2 The Survey of Health, Ageing and Retirement in Europe (SHARE) was a multidisciplinary and cross-national database of micro data on health, socio-economic status as well as social and family networks of more than 30,000 individuals aged 50 or over in which 11 European countries participated. A range of research papers have been produced since the projects’ completion. Further information is available from [www.share-project.org](http://www.share-project.org)

3 Population projections provided through EUROPOP2008 convergence scenario, see Eurostat (2008)
per woman, well below the figure of 2.1 required to maintain population levels. As a consequence, the age profile of EU Member States’ population is rising (Eurostat, 2009).

The shrinking EU population of working age will affect the tax base for funding public services and the available pool of formal and informal carers (Eurostat, 2008). While there are currently four people of working age (between 15 and 64 years) for every one person aged over 65, by 2060 this ratio will have declined to only two to one, putting greater pressure on public finances (European Commission, 2009). Although advanced age does not necessarily lead to a need for care, demographic ageing nevertheless serves as a useful indicator of the future demand for long term care (European Commission, 2008).

An ageing population will place a strong upward pressure on public spending for long-term care. For example, as a proportion of GDP, projected long-term care expenditure will increase by 168% in Germany, 149% in Spain and 138% in Italy between 2000 and 2050. At the same time, projections suggest that a decline in the supply of informal care provided to older people will result in increased admissions to residential care, and this could have considerable financial consequence (Comas-Herrera et al, 2003). To cope with this issue, it is necessary to find a way to limit the cost imposed by this process (Bonsang, 2009). According to the EU Commission Ageing Report (2009): ‘There is a window of opportunity – a period of about ten years during which labour forces will continue to increase – for implementing the structural reforms needed by ageing societies.

**Figures 1 and 2: Projections for the proportion of the population in various age groups in the European Union (27 countries), 2005 -2050 (as of 1st January 2008)**

![Figure 1: Population projections, EU-27 (% of total population)](image1)

![Figure 2: Population projections, persons aged 80 years and more, EU-27 (% of population)](image2)

*Source: Eurostat (2008)*

**What is a carer?**

Historically, care by family and friends has provided the bulk of home care and still remains so. The central place of the family and extended kinship networks in delivering support to older and disabled people is a consistent theme across all European welfare regimes. Only during the late 19th century did state involvement in health and social welfare begin to augment, but not displace, this form of provision (Tarricone and Tsouros, 2008). ‘Family carers in particular, precisely because of being family members, for a long time have been denied any formal acknowledgement. Only in recent years, because of the dual phenomenon of population (therefore also kinship), aging and increasing women’s labour market participation, frail elderly…care has emerged as an issue and entered the policy agenda’ (Keck and Saraceno, 2009:4).

There is no consistent definition of ‘informal and family carers’ used by governments and researchers in different countries. Informal care-giving activities are embedded in, and arise from long-standing kin and other
relationships (Glendinning et al., 2009a). However, carers can be described in many different ways – according to their own characteristics (their age, gender, ethnicity); according to the characteristics of the person receiving care (carers of individuals with a mental health problem, carers of individuals with dementia); or according to the relationship between the carer and care receiver (as spouse carers, parent carers) (Glendinning et al., 2009b) (or as children carers). Social care is embedded within, and is a product of, close interpersonal relationships (Glendinning and Bell, 2008). As well as physical and mental labour, care may involve emotional labour – working on and through the feelings of others with the aim of affecting their emotional state (Hochschild, 1983). Providing care and support is also generally a private activity, usually occurring within the home and often involving intimate bodily contact (Twigg, 2000).

An informal carer has been defined by Eurocarers (2007) as ‘a carer that looks after family, partners, friends or neighbours in need of help because they are ill, frail or have a disability; the care they provide is unpaid.’ A definition of family care was proposed as part of the Eurofamcare study, relating to care for older people: ‘family care’ is care and/or financial support provided by a family member for a person 65-years of age or over needing at least four hours of personal care or support a week, at home or in a residential care institution (Mestheneos and Triantafillou, 2005). The following definition of a carer was employed by (Glendinning et al., 2009a) in a study of care-provision across Europe: (someone) who provides help to someone with a chronic illness, disability or other long-term health or support need, outside a professional or formal framework’ (p.14).

How many carers are there?

Estimates of the numbers of carers in the EU have been found to vary due to a number of factors such as the definitions of the carer and the methods used to identify carers. In addition, the significant differences in patterns of family obligation and formal welfare services between the older and newer member states mean that figures from the EU15 cannot simply be scaled up to reflect current EU membership (Glendinning et al., 2009a).

The most recent source of EU-wide data concerning carers is the second European Quality of Life Survey (EQLS) (Anderson et al., 2009). It has been noted that while the EQLS does not provide data on the actual number of carers in Europe, it does outline some relevant proportions of people aged 18-plus (Glendinning et al., 2009a). In the EU27, 3% of people state that they care for an elderly or disabled relative several times a week, 4% do it once or twice a week and 8% do so less than once a week. Altogether, a quarter of people report involvement in care for an elderly or disabled relative. Higher rates were reported in the 3 Candidate Countries (CC3) of 7%, 6% and 6% respectively (Anderson et al., 2009).

It was estimated that in 2005 there were around 19 million carers over the age of 25 in the EU (Grammenos, 2005). Of these, 9.6 million were caring for at least 35 hours per week. It was also estimated that the numbers of carers aged 25-plus would increase by 13% by 2030, to 21.5 million (providing at least 20 hours a week care) and 10.9 million (providing at least 35 hours a week care) (Grammenos, 2005). It has been highlighted that when this is recalculated to include only those who report they are involved in caring on a daily basis, this leads to the estimate that some 32 million people care on a daily basis – this is however an over-estimate, given the basis of the EQLS (Glendinning et al., 2009a).

Another estimate on the number of carers in Europe is based on data from the First European Quality of Life Study, which found that about a quarter of the population (aged-18 plus) was involved in caring (Alber and Köhler, 2005). This leads to an estimate of 100 million carers in (the then) EU. If this figure was to be recalculated taking into consideration the enlarged EU and using data provided by the Second European Quality of Life Study, it is estimated that this would amount to some 125 million carers in Europe (Glendinning et al., 2009a).

It is important to note that the current fragmentation of the traditional large family group into small family units in an urbanised context may be reducing the number of people who can provide care to dependent family members. However, it is also important to acknowledge that even when families were larger it was usual for only one or two members to be the main carers. In addition, female labour market participation has risen steadily, and greater emphasis is placed on facilitating paid work and enhancing career opportunities for women. Increased female labour market participation and tighter regulation of labour markets are likely to result in the availability of a smaller pool of family care (Tarricone and Tsouros, 2008). Nevertheless, many carers somehow reconcile care with employment. It has been pointed out that in OECD countries; the availability of spousal caregivers reduces national expenditure on long-term care (Yoo et al, 2004).
Table 1: Daily care and housework, by gender and country group (%) Adapted from Anderson et al 2009

<table>
<thead>
<tr>
<th></th>
<th>EU27</th>
<th>EU15</th>
<th>NMS12</th>
<th>CC3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Caring for and educating children</td>
<td>25</td>
<td>35</td>
<td>24</td>
<td>34</td>
</tr>
<tr>
<td>Cooking and housework</td>
<td>29</td>
<td>79</td>
<td>31</td>
<td>81</td>
</tr>
<tr>
<td>Caring for elderly/disabled relatives</td>
<td>4</td>
<td>9</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

Question 36: How often are you involved in any of the following activities outside of paid work? a) Caring for and educating children; b) Cooking and housework; c) Caring for elderly/disabled relatives. The data show the proportion of respondents who answered ‘every day’.


Who are carers?

The gendered nature of informal care is clearly evident in available data, with more women providing care than men. In all countries, women are more likely to be carers and are also more likely to provide more physically intimate, emotionally demanding and longer-term care (Glendinning and Bell, 2008). The Second EQLS found that 9% of women in the EU 27 reported to be providing care to an elderly/disabled relative, compared with 4% of men (Anderson et al, 2009) (See Table 1 above). Not only do men provide less care on a daily basis than women, the care they do provide is also generally less intensive and involves different activities from women carers. Men were found to spend on average 11 hours and women 15 hours each week caring for elderly or disabled relatives.

Reporting daily involvement in elder care is highest in the 50-64 age group (9%), followed by the 35-49 age group (7%). Overall women in the middle years of life have been found to be faced with care responsibilities for both elderly dependents and children, and potentially with a third role in paid employment as well (Anderson et al, 2009). It has been noted that the concentration of carers in the 50-64 age group reflects the prevalence of older people as the recipients of care and the roles of adult children in providing that care (Glendinning et al, 2009a).

Figure 3: Ensuring access to homecare

Percentage of those aged 65+ receiving long-term care services at home (most recent date)

Sources: Huber et al. (2009) based on national sources, OECD Health Data 2008, EUROFAMCARE national reports and Eurostat demographic data.

Notes: See table 1.

EU average refers to the unweighted average of available observations of EU countries from different years.

Source: Huber, 2009
According Eurofamcare, 76% of those caring for an older person were found to be women. Women were also predominately found to be the main older person cared for (68%). Carers of older people were found to have an average age of 55, while nearly half were children of the older person, the mean number of hours per week spent caring was 45.6, and the average care episode lasted for five years (Triantafillou and Mestheneos, 2006).

Older individuals and those with low education levels, compared with younger people and people with higher education levels, have been found to be more likely to provide informal care according to SHARE data (Glendinning et al., 2009a). A relationship between the provision of care and income has also been found, such that people in the lowest income quartile are more likely to be involved in providing care than those in the highest quartile, with the proportion decreasing from 8% to 3% for elder care (Anderson et al., 2009).

Using data from England and Australia, it is estimated that between 2% and 4% of all children and young people have additional care responsibilities, usually as a result of the chronic illness or disability of a parent (Becker, 2007).

It is important to note that as the population of Europe ages, so too will the population of carers – this poses a special challenge in that many carers may themselves have their own set of health and social care needs. Over the next 30 years, care by spouses in England is likely to increase substantially. However, if current patterns of care remain the same, care by adult children will also need to increase by nearly 60% by 2031. It is not clear that the supply of care by children will rise to meet this demand. There may be a significant 'care gap' in the years ahead, with demand for the provision of informal care outweighing supply (Pickard et al., 2007).

There is a growing concern that the reliance on family care across Europe is too high and will not be sustainable in the years ahead, without measures to improve support to carers.

**Why do people care?**

Informal care at home has been identified as the preferred option of care by most EU citizens. Disabled and older people tend not to want institutional care, and families and other informal carers prefer strongly to continue to care for their dependent family members in their own homes and local communities (European Commission, 2006b). However, Marin et al. (2009) note that there is a danger that policy makers will view informal care as a free resource that will ultimately make up for deficiencies in provision of publicly provided care.

The quality of alternative to informal care is an important issue for carers. Concern for the cared-for person’s well-being is the motivation for providing care in most instances. Carers will not willingly substitute paid care of an inferior quality (Himmelweft, 2008). Family carers in the Netherlands were asked about their motivations to care: more than 60% of carers considered the family care giving as a matter of course, 25% were giving care because the person cared for preferred to stay at home, 8% saw no alternative and 5% cared in order to keep the relationship good (Dutch Social and Cultural Planning Office, 2004). A key motive for providing the Eurofamcare study was love, reciprocity and/or wanting to do something in return for the care recipient (TEUSURE, 2006). Analysis from SHARE data indicates that informal care provided by children or grandchildren to their elderly parents across Europe are substitutes to formal home care, while informal care is a complement to doctor and hospital visits. However, these relationships were also found to differ according to a European North-South gradient (Bolin et al., 2007).

Across Europe, family members are consistently identified as the main source of support and help for many needs- practical, emotional and financial (Anderson et al., 2009). Analysis of the dependence of older people on their relatives in some parts of Europe has recently been undertaken by Huber (2009), using information from the Eurobarometer Special 283 (2007). In general, the findings represented the availability of wider support networks to carers and recognition of carers in their role. As part of the Eurofamcare study, family carers of older people were asked about their willingness to continue to provide care (TEUSURE, 2006). Over half were unwilling to consider placing the older person in a care home. However, this figure varied between countries, with Swedish carers more willing than others to consider care home placement. Under current circumstances, carers in Poland and Greece were barely willing to consider placement at all (See Figures 4 and 5). These figures may be a reflection of the system of the residential care available across countries. In addition, almost 61% of carers were willing to continue caring unconditionally even if this meant having to provide more care (TEUSURE, 2006).
What to carers do?

Carer activities can be measured in a number of ways such as hours per week, types of activities, or duration of the care period. The average caring period across Europe has been found to last 60 months, with over 27% of family carers reported to having stopped caring after one year (Triantafillou and Mestheneos, 2006).

The Eurostat study on health care and long-term care from 2007 provides information on care-giving activities for a parent or parent-in-law. An average of 3.5 caring activities was identified among the sample, with visiting regularly to keep company the most common activity reported by 49% of those with experience of long-term care (Eurostat, 2007). The frequency of caring activities identified are outlined in the figure below (Figure 6).

The Eurofamcare study reported older peoples’ needs for care and help reported by family carers across Europe:

- Domestic needs e.g. housework – 92%
- Emotional/psychological/social needs e.g. companionship, reassurance – 89%
- Mobility needs e.g. inside or outside the house, transport – 82%
• Financial management e.g. paying bills for the cared for from the older person’s own money – 80%
• Organising and managing care support e.g. contacting services – 79%
• Health care needs e.g. assistance with medication, medical treatment, rehabilitation, therapy etc – 79%
• Physical/personal care needs e.g. washing, dressing, eating or going to the toilet – 66%
• Financial support e.g. supporting older person by providing them with money – 36%

(Triantafillou and Mesthenecos, 2006)

The type of care provided by carers of people of all ages in different care-giving situations in the Netherlands was recently analysed (de Boer et al, 2009). The kind of care provided was found to vary, depending on the social relationship between the carer and care recipient. Distant family and friends were found to provide much less emotional support/ supervision and accompaniment with visits than carers living closer. The intensity of the care provided generally decreased as the social distance between care-giver and care recipient grew for other types of support (Glendinning et al, 2009a).

Table 2: Types of care, according to social relationship with the person requiring care, 2007 (in %)

<table>
<thead>
<tr>
<th></th>
<th>Emotional support and supervision</th>
<th>Accompaniment with visits</th>
<th>Household care</th>
<th>Accompaniment with arranging affairs and administration</th>
<th>Personal care</th>
<th>Nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>79</td>
<td>90</td>
<td>93</td>
<td>61</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Parent(-in-law)</td>
<td>87</td>
<td>86</td>
<td>82</td>
<td>77</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Child</td>
<td>86</td>
<td>83</td>
<td>68</td>
<td>61</td>
<td>46</td>
<td>40</td>
</tr>
<tr>
<td>Rest</td>
<td>78</td>
<td>56</td>
<td>61</td>
<td>41</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>78</td>
<td>77</td>
<td>62</td>
<td>29</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: de Boer et al. (2009)

Adapted from Glendinning et al (2009a)

The role which carers play depends on the condition of the cared for person and as his/her situation changes, so too will the level and nature of care provided. For instance, carers of individuals with a terminal illness face particular issues approaching end of life such as managing complex and unpredictable conditions that may change daily; recognising the impending onset of the terminal phase; planning for the future in the face of uncertainties; emotional demands of preparing themselves (and the ill person) for the coming death; and, sometimes, dealing with complex family relationships (Arksey and Corden, 2009).

Recent European data emerging from the SHARE study has found that informal care provided by adult children was an effective substitute for long term formal care as long as the needs of the elderly are relatively low and require everyday skills such as shopping for groceries or cleaning the house. However, as the complexity or disability level increases, the burden imposed by care may become so heavy that it tends to require both formal and informal care (Bonsang, 2009).

In addition to the role of carer, there may be a significant number of ‘sandwich’ carers – those with a responsibility for both childcare and care for a disabled or older person (Glendinning et al, 2009a).

Contribution of carers to society

‘Care provided by family members, friends or other informal carers still represents the bulk of care provision to the elderly in Europe, even if the profile of supplied informal care differs according to cultural preferences, living arrangements of older people and availability of formal care services and design of benefits’ (Marin et al, 2009: 13-14).
Economic data illustrates the contribution of carers across Europe:

- The estimated value of care-giving in six EU member states exceeds public expenditure on formal care and care allowances (Rothgang et al, 2006)
- In England, the value of the care provided by family carers is estimated to exceed the budget of the National Health Services for the whole UK (Yeandle and Buckner, 2007)
- There are estimated to be over one million professional nurses across the EU, compared with the 9.6 million family carers providing 35 plus hours a week care (EFN, 2003 in Glendinning et al, 2009b)

While the contributions of carers are rarely included in calculations of the costs of long term care systems, this does not mean that these contributions are budget neutral (Glendinning et al, 2009a). Indeed, carers face a number of significant opportunity costs including foregone earnings and leisure, displaced household expenditure, poor health and relationship breakdown and a redistribution of employment, health and future opportunities for wellbeing between women and men (Jenson and Jacobzone (2000) in Glendinning et al, 2009a). These ‘opportunity costs’ will be outlined in the following sections.

**Impacts of caring**

A range of factors will shape the carers’ experience and the impact of providing care on their wellbeing and socio-economic circumstance. These include the following: the age and gender of the carer and care recipient, the kin and generational relationship between carer and care recipient, the health and prognosis of the care recipient, the socio-economic and labour market status of the carer and the availability and access to formal health and long-term care services (Glendinning et al, 2009a).

While providing care is often an enriching and rewarding experience when the expectations placed on carers are reasonable and adequate supports are provided. Caring may also be a source of burden and stress on a number of levels, with costs to many aspects of the carers’ life – emotionally, physically, socially and financially. The hidden costs of informal care can be substantial and have indirect implications for wider economic competitiveness (e.g. if carers cannot undertake paid employment) and public spending on services such as healthcare (if carers develop health problems as a result of unsupported caring) (Glendinning, 2008).

The concept of burden is quite complex. Burden includes both objective and subjective elements that may interact or may vary completely independently from each other. Thus someone with an apparently heavy objective burden (in terms of the number of hours per week spent caring, the tasks involved or the duration of the care-giving episode) may not necessarily feel burdened. In contrast, others with relatively light responsibilities may feel extremely (over-) burdened. Reasons for these apparent inconsistencies may include the quality of the relationship with the person receiving care; felt motivations and rewards experienced from caring; and the presence of other competing commitments such as paid work (Glendinning et al, 2009:16).

The risks of carer burden have been found to increase in a number of instances: where carers reported poor health status; where high levels of care were provided; when the care recipient had behavioral problems; and when the carer did not feel supported by social services (Lamura et al, 2007) (See Figure 7). A reduction in paid working hours was also found to be a high risk factor predicting carers’ feelings of burden; affecting women more than men.

**Figure 7: Risk Factors for carer’s burden**

![Risk factors for carer's burden](source: Lamura et al 2007)
Health impact

The physical and emotional health of the carer is of vital importance for the continuation of provision of care in the home. There is evidence to suggest that carers are at risk of becoming ‘patients’ themselves (Reinhard et al, 2008). In general, the more intensive and demanding the caring role, the higher the likelihood of adverse physical and psychological effects on carers (Glendinning and Bell, 2008). Carers have been found to be three times more likely to report ill-health than the non-carer population (Singleton et al, 2002). Negative health effects on the carers are more common where there is greater intensity in the type or quantity of assistance provided (Schulz and Sherwood, 2008). Irish research by Care Alliance Ireland (2008) found that carers presented a considerably less positive picture of their quality of life in comparison to the general population. Carers reported high levels of depression, back pain and anxiety. Negative aspects associated with family caring included restricted leisure hours and a high risk of being exposed to stress, emotional strain and social isolation. The extent of limitation posed by caring on leisure/recreation appeared to be a key factor both in reporting both adverse health effects and low quality of life for carers. More recent Irish work has found that carers face a series of challenges in their role and these may have an effect on their mental and physical health (The Carers Association and the Irish College of Psychiatrists, 2009).

In the Eurofamcare study, the highest quality of life was reported by carers in the UK and Sweden (65% and 67% respectively). In contrast, the lowest quality of life was reported by carers in the Mediterranean regions (Greece 50%, Italy 51%). It was concluded that higher quality of life may reflect the availability of support services and policies targeted to carers (Lamura et al, 2007). In addition, carers in the Eurofamcare study frequently reported physical health problems as a result of the demanding care activities. Other complaints frequently reported included loss of energy, sleep deprivation, stress or panic attacks, pain, depression, headaches or weight changes. Psychological problems were also reported among carers such as poor concentration; feelings of anxiety, guilt, insecurity and depression (Lamura et al, 2007).

Carers’ health has been shown to worsen the longer they are providing care, with physical health found to decline after the first year of caring (Hirst, 2004). Low incomes and lack of breaks from caring are other factors which contribute to poor health among carers (Carers UK, 2009). Religion has also been found to alleviate feelings of depression for carers in some European countries (TEUSURE, 2006).

Social impact

Carers may experience barriers to participation in wider society, isolation and poverty in their role. The definition of poverty currently used by the European Union is as follows: People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation. They are often excluded and marginalised from participating in activities (economic, social and cultural) that are the norm for other people and their access to fundamental rights may be restricted (European Commission, 2004). This definition currently underpins the EU’s strategic response to tackling poverty and social exclusion, with 2010 being designated European Year against Poverty and Social Exclusion.

Caring responsibilities often limit the time available to carers to have a life of their own. In Ireland, it was found that many carers do not have access to supports to allow them significant time off from their caring duties to have a social life or to more generally participate in the community and wider society (Carers Association in partnership with Caring for Carers Ireland and Care Alliance Ireland, 2008). Indeed, half of carers of older people across Europe who took part in the Eurofamcare study reported feeling ‘trapped’ in the care situation (Lamura et al, 2007).

Financial impact

Research undertaken by Carers UK (2007) found that 72% of carers were financially worse off as a consequence of becoming a carer. The reasons given included the additional costs of disability, giving up paid employment to provide care, the inadequacy of current benefits and charges for services. Family carers may face higher bills than the non carer population (such as extra heating, laundry and transport costs) (Carers UK, 2009). Carers have reported various financial problems caused by caring for an elderly person: the cost of medicines, extra
travel, telephone, heating, (out of pocket) payments for health care, and loss of (delayed) income if carers could not combine work and care (Rothgang et al, 2006).

Combining work and care

Interest in supporting carers in combining care with paid employment while forming part of the wider work/family reconciliation policy framework, has also arisen partly in pursuit of higher employment levels, to which all EU governments have committed themselves. Carers, along with mothers of young children, constitute one of the few remaining groups still incompletely integrated into the labour market. Concern to enable carers to enter employment also arises from growing recognition of the massive contribution made by unpaid carers in meeting the care needs of disabled or elderly which would otherwise fall on the taxpayer (Himmelweit, 2008). It is important to note that most carers in employment have more than just the two roles of carers and worker. They often have also a family of their own, a partner and children, sometimes also grandchildren (Keck and Saraceno, 2009). Although people who are retired or unemployed, housewives or part-time workers are most likely to have heavy care responsibilities, 41% of carers of older people across Europe were found to be in paid work. Sweden had the lowest percentage at 33%. In contrast, the highest percentage was in Greece with 47% of carers in employment. 15% of working carers had reduced their working hours as a result of caring for elder relatives, and most had experienced a decline in their income as a result (Triantafillou and Mestheneos, 2006).

Employed men in the EU 27 who also care for an elderly or disabled relative have been found to spend on average eight hours per week caring (Anderson et al, 2009). Employed care-giving women spent 11 hours per week caring. In the NMS12 these data are the same. In the CC3 working caring women spent fewer hours per week (nine) caring. However, the efforts of working carers are not evenly distributed across Europe as illustrated in the graph below (Figure 8).

In a survey of carers of working age in the UK undertaken by Yeandle et al (2007), many working carers were found to be in poor health and struggling to make ends meet. Almost half of those carers working part-time said they were only in work of this type due to their caring responsibilities. In Germany, Keck and Saraceno (2009) found all carers in paid employment in their study were experiencing pressure on their time and on their loyalty. However, the points of pressure varied. For some, the main point of concern was the job and how to deal with job demands given the caring demands. For other carers, the main point of concern was inadequacy of the caring arrangement and the concern that something would happen to the care-recipient while at work. For still others, the main tensions concerned neither caring nor work arrangements, rather the constraints which both obligations put on the carers' private life: on the relationship with and the welfare of children, partners, and friends (Keck and Saraceno, 2009). An Irish survey of working carers found that 56% of respondents were unaware of the services and supports available to assist them in their caring role and 20% of people were providing care to two people (Carers Association, 2009).

As part of the Eurofamcare study, it was found that overall there were far fewer opportunities for reducing working hours for carers in Eastern Europe and some Southern European countries compared to Nordic and Western-European countries (Triantafillou and Mestheneos, 2006).

Arskey et al (2005) reported that working carers find planning for retirement difficult, partly because it is influenced by many unknown factors related to the caring situation. However, they point out that there is evidence that some carers do not plan ahead because of reasons specific to care-giving. These include a lack of time because of caring responsibilities, not knowing whether adult disabled children would be living independently or still at home with parents and the possibility of having to pay for residential or nursing home care. Arsey et al (2005) also note that for many carers, it is more important to attend to current financial affairs and commitments rather than make financial provisions for a future retirement that for many people could be a considerable number of years away.
Figure 8: Number of hours spent caring per week, working carers by gender and country

Source: Anderson et al., 2009

Carers need support in combining paid employment with providing care in terms of *time, cash and services* (Himmelweit, 2008). Both respite care and systems of longer-term leave enable carers to undertake paid employment (Eurofound, 2009). It has been highlighted by Arskey and Corden (2009) that flexibility in the workplace (as well as flexible services) as a key requirement. In addition, carers who are unable to combine paid work and informal care have a reduced probability of re-entering the labour market once care-giving ceases. Moreover, any period of reduced labour market participation affects carers’ pensions, savings and financial independence when they reach old age (Glendinning and Bell, 2008). Vittanen (2007) notes that the short-run costs of reduced or interrupted labour supply are compounded by lower collected pension entitlements in the longer-run.

One thing is certain: in order to maintain the high employment rates which are needed across Europe, and to sustain their own household income and build to their pensions, carers must be supported in combining work and care (Yeandle, 2008). An increase in government formal care expenditure has been shown to have a positive effect on the employment levels of 45-59 year old women across Europe by Vittanen (2007), thus having relevance in the attainment of EU employment targets. Current policies relating to carers, including employment policies across Europe, are outlined in a later section.

**Care Cultures across Europe**

*There is arguably no major area of social policy in the European Union (EU) in which Member States differ more than in the way long-term care for people who depend on ongoing social and medical help is organised and funded. Very large differences exist between and within countries in the division of labour: between informal care (provided by family members, friends and volunteers) versus professional services funded from public and private sources; or in the mix between home care and residential care provision. Also, public and private funding for long-term care varies across Europe to a degree that is not seen for any other social programme, including health care* (Marin et al., 2009:5).

The balance between informal and formal care differs substantially from country to country and changes over time within countries as it is connected to particular political, economic, demographic and cultural factors (Tarricone and Tsouros, 2008). Glendinning et al (2009a) note that there are a number of relevant factors used by authors in contrasting care culture typologies such as housing and living conditions; culture and expectations about the role of (extended) families in relation to care; expenditure on health and long-term care; religious and/or social background, average healthy number of life years; labour market and gender variations.
Some point to a North-South divide such as Pommer et al. (2007a) in European ‘care cultures’. In southern European countries, informal care was found to remain as the dominant source of home care. Without the contribution of unpaid carers, Pommer et al. (2007a) note that home care would be unsustainable and many acute needs would remain unattended. In Northern European countries the situation was found to be different where informal care is less common, as municipalities provide extensive personal care and domestic services, and informal care tends to focus on providing companionship and social support. In a later publication, Pommer et al. (2007b) distinguish between three main care clusters across 10 European Countries – the Scandinavian (Sweden, Denmark, Netherlands), the Continental (Belgium, France, Austria, Germany) and the Mediterranean (Italy, Spain, Greece) types. In the Scandinavian group, individuals generally carry primary responsibility for their own care provision, with government stepping in when the individual experiences health problems. The nuclear family is primarily responsible in the event of health problems in the Continental Model. This role is fulfilled by the extended family (including relatives outside of the nuclear family) in the Mediterranean model. However, it also noted by Pommer et al. (2007b) that this is no more than a broad categorisation, with the Netherlands moving towards the Continental model as a result the introduction of the ‘usual care’ concept.

Five categories of eldercare countries were developed by Lamura et al. (2007), following analysis of a combination of quantitative European data sources as part of the Eurofamcare study (see Figure 9 below). Elderly people are at high risk of poverty in familialist countries, with limited options to ‘buy’ care and heavy reliance on informal carers when the need arises. Also, when the average income level in a given country is low, the probability is that public long-term care provision may be lacking in both quantity and quality, while out-of-pocket payments may be relatively high (Glendinning et al., 2009a).

**Figure 9: Clustering of elder care countries across Europe**

Support to Carers across EU

As seen in the table below (Table 3), there exists a range of care clusters across Europe and this is reflected in the level of support provided to carers in any given country. Local factors including levels of and eligibility criteria for, welfare service provision and cultural expectations about kinship obligations – are also likely to affect carers’ experiences of burden. Thus, where there is little formal service provision and care is assumed to be predominantly a private family responsibility, heavier care obligations and more severe socio-economic consequences may be expected than in countries where extensive formal services for older and disabled people are available (Glendinning et al., 2009a).
Table 3: Supportive Measures for carers in different EU countries

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Recognition of caring role in legislation (Arskey and Corden, 2009)</td>
<td>Three pieces of legislation supported by national Carers strategy (UK); Carers covered under specific legislation (FI)</td>
</tr>
</tbody>
</table>
| Assessment of carers needs (Arskey and Corden, 2009)  | • Legal right to assessment (UK, FI)  
• Carers needs taken into account through assessment of patients’ needs (NL)                                                        |
| Financial support for carers (Glendinning et al, 2009a) | • Personal Budgets (UK, NL, Flanders region of BE)  
• Care Allowance paid to older or disabled person (DE, A, FR)  
• Care Allowance paid directly to carer (UK, IE)  
• Respite Care Grant (IE)  
• Paying carers instead of formal social service provision (FI, SE)  
• Paying carers in recognition of care giving responsibilities (NL) |
| Employment support for carers                        | • Entitlement to paid leave (NL)  
• Social security benefit (UK)  
• Right to unpaid leave (UK) (NL)  
• Right to leave at discretion of employer (FI)  
• Right to request change to working arrangements (UK)  
• Carers Benefit and right to unpaid leave (IE) |
| Information, advice and emotional support            | Locally functioning support centres for family carers (NL, UK, IE)  
Advocacy                                              | • National carers’ organizations providing support and advocacy (IE, UK, NL, FI, FR)                                                |
| Respite care                                          | • Weekly leave of care (FI)  
• Voluntary palliative home care (NL) (IE)  
• Short-term care in institutions, day care or replacement of informal caregiver (SE)(IE)  
• Services by volunteers (AT, FR, BE,IE, BU, HU, IE, FI, DE, EL, IT, NL, PL, SI, UK, SE, NO) |
| Training/ Education for carers                       | Quality guarantee for those training carers (AT)  
Primary care services offering carer training and ‘caring for the care’ programmes (ES)  
Government funded training (IE)                        |
| Recreation and other support (Triantafillou and Mestheneos, 2006) | Health check-ups for informal carers (SE)  
Financial support for purchase of an alarm (SE)  
Information about complaint procedures, etc. (SE) |
| Peer Support                                          | Alzheimer’s café (NL), Social Club Model (IE) (Keogh and McGettrick, 2008)                                                                   |
| Technology/ ICT                                       | Solutions for adjusted housing, adjusted living, and adjusted care (NL, IT, FI, DE, UK, FR )                                                  |

A variety of supportive measures for carers exist across Europe. In general, different measures adopted reflect ‘fundamental differences in societal attitudes to uncertainty, inequality, transparency, citizenship and the role of unpaid care’ in addition to country specific constitutional and fiscal arrangements that influence the development of social policy (Glendinning and Bell, 2008:11). In some countries supporting family care-giving is one piece of wider social care policy and provision – whereby measures aim to balance the rights and needs of both disabled and older people and family carers (Glendinning and Bell, 2008). Table 3 gives an outline of the supportive measures available to carers across Europe.

Key issues have been identified in the use of support measures across Europe by Triantafillou and Mestheneos, 2006). Lack of information and the older persons’ attitude towards the use of services were identified in public-Nordic countries (Sweden, Denmark and the Netherlands). In countries of the so-called standard care mix (UK, France, Germany, Austria and the Czech Republic) costs, waiting lists and bureaucracy were viewed as just as relevant as lack of information about services. The most bottlenecks in use of services by carers were reported in countries with family-based policies (Portugal, Spain, Greece and Ireland). Finally, lack of information, high costs, long waiting lists and lack of transport were key issues in the transition countries (Poland, Slovakia, Slovenia, and Hungary – countries with very limited long-term care provisions).

Assessment of the needs and situation of individual carers has emerged as an important measure among member states in ensuring they receive flexible and quality support services (the table above outlines countries where

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* Source: unless otherwise stated adapted from Glendinning et al (2009a) and Tjadens et al (2007)
such assessment is currently present). However, existing assessment practice is still inadequate in many countries. The Carers Outcome Agreement Tool (COAT) developed by Hanson et al (2006), working collaboratively in Sweden and the UK, could be used as model for working with family carers in order to adequately address their own needs. COAT views the carer as a ‘co-expert’. Carers and practitioners therefore work together to agree the type of goals and outcomes that carers see as important, and the support needed to achieve this, thus becoming part of a comprehensive long-term carer strategy.

The importance of continued education and training of carers has become part of the wider EU Lifelong Learning Programme. As a consequence, an innovative research project – CARERS (Content Materials to Raise Employability and Reinforce Skills of Carers) is currently taking place across six EU countries. Its overall objective is to design a programme of education and training specifically aimed at informal carers, providing answers to meet their real needs in their support work as well as for their own emotional wellbeing. It is also working in sync with the ‘ECL European Care License’, which is designing a basic entry certificate in the care sector that could become a recognised and accepted certificate across Europe.

Another growing trend among several member states has been the introduction of personal budgets in order to support carers and promote choice and flexibility in long-term care, whereby the older or disabled person purchases care themselves, either from a nursing or care agency or by directly employing a carer themselves. The table above outlines where such schemes are currently present. It is important to note that under this scheme, the relationship between care recipients and carer becomes one of employer-employee (Glendinning et al, 2009a). Compared to agency care, Arntz and Thomson (2008) found that personal budgets yield better care outcomes with regard to the overall support of formal and informal caregivers. However, personal budgets were not found to improve care outcomes when compared with the much less generous cash payments, due to a strong crowding out of informal by formal care.

**When Caring Ends**

There is strong evidence to show that the psychological, social and physical health consequences of caring may leave some family carers poorly equipped for life after care (McLaughlin and Ritchie, 1994). Many former carers’ lives have been found to involve three distinct phases: the post caring void, closing down ‘the caring time’ and constructing life post caring (Larkin, 2009). Indeed, many carers find themselves totally unprepared for life after caring e.g. to return to paid work.

Looking after a loved one may have taken up a massive part of many carers’ lives, with the needs of the cared for individual taking priority. When this caring ends (i.e. due to the death of the individual, moving of individual into alternative accommodation or may no longer need to provide care), many carers find it difficult to deal with this significant change to their own life circumstances. It is of vital importance that former carers are adequately supported in the period immediately following the cessation of providing care through bereavement and counseling services, returning to work, training and education programmes, and social inclusion programmes.

**European policy and Carers**

According to Arskey and Moree: ‘Governments of advanced European welfare states with ageing populations are struggling to reconcile what seems to be conflicting policies. On one hand, they are trying to increase labour markets participation of women and older workers. On the other hand, they are making more demands on people to care for disabled, chronically ill and frail older relatives and friends’ (2008:649). Part of this problem is that carers are indeed undertaking ‘work’ in their role as carer, although this is not classified as work in the general sense. Attention has been given at varying levels across countries to the roles of family carers in developing policies and practice to support older and disabled people (Glendinning and Moran, 2009). One thing is certain: the European Commission (2009) believes that the importance of carers’ contributions will increase in the future, as the numbers of older and very old people increase, as the figure below illustrates. Hence, Arskey and Moree (2008) note that the dual demands of sustaining informal care and maximising labour market participation will continue to be an ever present challenge in reforming long-term care.

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5 See [www.carers-project.eu](http://www.carers-project.eu) for full details.
The integration of the issue of family carers for the elderly into the EU political agenda is extremely recent. The reason for this lateness lies in the evolution of the political agenda in itself as mandated by the Member States to the EU and the introduction of the social dimension after the Lisbon Summit in 2000 (European Older People’s Platform, 2004). The EU currently has no formal policy instruments specifically relating to carers. However, several key European policy documents have relevance to long-term care and carers and each will now be outlined in turn:

The EU Charter of Fundamental Rights (2000)\(^6\) – this document is referred to by the European Treaty of 2007 and is a potentially legally binding document. It sets out the main shared values of EU members’ states concerning the rights of their inhabitants in terms of dignity, freedom, equality, solidarity, citizens’ rights and justice. Some of the articles are of relevance to carers (i.e. Article 15, Article 21, Article 33), although carers are not specifically mentioned (Glendinning et al, 2009a).

The Lisbon Strategy and the Open Method of Co-ordination – the EU’s ambition of becoming the world’s leading knowledge economy – requires co-ordination between EU-wide economic policies and those of member states. This extends to policy areas such as public expenditure on health and long-term care where the EU has no legal remit. As a result the Open Method of Coordination was developed in 2004 thus enabling member states to share examples of good practice (for example in supporting carers) (Glendinning et al, 2009a).

2007 EPSCO Council Statement – leaders of member states were requested by the EPSCO Council in 2007 to put support for carers at the top of their respective policy agendas. As a consequence, carer support was stated to be a political issue in at least half the member states (Glendinning et al, 2009a).

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The previous Eurocarers’ factsheet summarised the multiple policy domains that can affect carers across Europe (Tjadens et al, 2007). The table below outlines these policy debates in 2009 terms:

<table>
<thead>
<tr>
<th>EU-policy debate</th>
<th>Impact on carers</th>
</tr>
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| The European employment strategy, including the employability debate, working time, prolonging working life, social inclusion, equal opportunity and gender-equality issues | • Reconciling work with caring responsibilities for people other than children  
• Working for longer hours and/or extending duration of working lives lead to increased pressures to reconcile work with care |
| Pension debate                                                                   | • As care responsibilities are currently greatest among 45-65 year olds, the pension age and pension levels impact on carers  
• Also ensuring that pension contributions’ entitlements are maintained during periods of caring reduces risks of poverty for carers in their own old age |
| The debate about social (and health) services of general interest                 | • Liberalisation of social and health services may lead to the marketisation of care. Not all carers will be able to afford market rates |
| Prevention, active ageing policies                                               | • Preventative health strategies may reduce demands for care                                                                                   |
| Corporate social responsibilities                                               | • Whether employers are ‘carer-friendly’ will affect carers’ ability to combine paid work and care                                              |
| European Alliance for Families                                                    | • Carers find themselves primarily within family networks                                                                                     |
| Health Strategy                                                                  | • Poorly supported care can impair carers’ physical and/or mental health. Disease prevention and healthy living policies may reduce demand for family care |
| Life-Long Learning                                                               | • Higher education is believed to lead to healthier lifestyles, thus potentially reducing needs for care                                         |
| (Economic) migration                                                             | • Many legal (and illegal) immigrants into and within the EU work as semi-professional carers, thus potentially filling gaps between formal services and family carers |
| Demographic debates                                                              | • These include solidarity between younger and older people as seen COM (2007) 244  
• Most care is provided by women working in low paid jobs or unpaid in family settings. Economic liberalisation and the creations of new care markets, including the provision of cash payments to support family care, risks institutionalizing women in unpaid or very low paid caregiving roles |
| New technologies, e-inclusion, e-care, c-health                                   | • New technologies may alleviate burdens on carers by providing new solutions to existing problems. They may also reduce care responsibilities by increasing (and introducing new definitions) of healthy life-years.  
• On the other hand, new technologies may increase carers’ responsibilities, through the transfer of medical care to the home |

There are a number of necessary policy priorities at EU and national levels that require focus in order to meet the needs of carers over the coming years, they include:

- The requirement of member states to make the role played by carers visible – through their current contributions to the sustainability of long-term care arrangements, and the actual and hidden costs of these contributions.
- The encouragement of member states to develop longer-term strategies and consider the contribution that carers could make in meeting the growing demands for a long-term care workforce.
- Facilitation of developments through the OMC Social Protection process focusing on the dissemination and evaluation of current measures in terms of target groups, coverage, effectiveness, sustainability and cost-effectiveness (Glendinning et al, 2009a).
Carers and the current financial crisis

With the current economic crisis facing Europe, there is a risk that existing cost-containment pressure on long-term care services may increase. Public policy may be tempted to shift at least some of the responsibility of long-term care back on private households and family carers. This could have serious consequences particularly for countries that are still in the early stages of upgrading their long-term care services (Marin et al, 2009). The 2008 Joint Report on Social Protection and Social Inclusion states that ‘postponements of plans to modernise and develop long-term care infrastructure can be expected’ (Marin et al, 2009: 17). Recent research by Carers UK (2008) outlines that two thirds of family carers are spending their own income or savings to pay for care themselves. In addition, many carers were found to be suffering from financial hardship such as the following: experiencing debt, struggling to pay essential bills, unable to afford house repairs, cut backs on food to make ends meet, and difficulties paying rent/mortgage.

Who speaks for carers?

European Level- Two groups specifically speak for carers at the European level, both of which were launched in June 2007:

- The European Parliament Interest Group on Carers
- Eurocarers, the European association working for carers

The European Parliament Interest Group on Carers was launched in June 2007 with the aim of ensuring that policy development takes the issues of carers into account and to check policies for their impact on the situation of carers. It is made up of MEP’s from across various parties and is closely linked to the work of Eurocarers.

Eurocarers is a non-government organisation (NGO), is not for profit and is democratically organised. It seeks to represent and act on behalf of all informal carers, irrespective of their age or the particular health need of the person they are caring for. Eurocarers brings together organisations representing carers and those involved in research and development. Among its principal aims are:

- Contributing to policy development at national as well as European level supported by evidence-based research:
  - acting as a voice for informal carers and issues relevant to carers
  - translating relevant EU policy developments to members operating at national and regional level.
- Exchanging, gathering and dissemination of experience, expertise and good practice, as well as innovations

Eurocarers also aims to collaborate with other interest and advocacy groups at national and EU level – including organisations representing disabled people, women’s organisations, organisations campaigning against social exclusion and poverty – in order to promote recognition of carers and carers’ interests and shape a policy environment that is more favourable to carers.

Other organisations such as AGE, Coface and Alzheimer Europe also have a keen interest in carers’ issues, often acting as advocates for carers at a European level.

National level - There is a major variation in the existence of carers’ organisations across Europe as illustrated in the figure below (Figure 11). Many carers’ organisations rely on charity and/or national government funding. Some organisations are still very small, while others can be viewed as professional organisations with large numbers of staff.
**Needs of carers**

Across the European Union, carers can be seen to have multiple needs. Eurocarers has published guiding principles to clarify the needs of carers⁷. According to the ten guiding principles, carers require:

1. Recognition – Carers should be recognised for the central role they play in community care, and this recognition should be reflected in all policies having effect on carers.
2. Social Inclusion – Carers have a right to a social life.
3. Equal Opportunity – Carers should have equal opportunities in all spheres of life.
4. Choice – People should have the right to choose freely whether they want to be a carer, and to what extent they want to be involved in caring; people needing care should have the right to choose who they wish to be their carers.
5. Information – Carers should have easy access to the information, guidance, advocacy, advice and training they desire – fitting to the stage of their carer’s career.
6. Support – Carers need financial, practical and emotional support in their role as carers as well as access to needed formal care that is available and affordable.
7. Time off – Carers should have the opportunity of taking time off. Therefore, adequate relief i.e. respite care arrangements, acceptable both to the carer and the cared for person, must be readily available and tailored to carers’ needs.
8. Compatibility of care and employment – Carers should have the possibility to combine caring with paid employment. This presupposes labour market policies that allow for caring activities as well as formal care available during working hours.
9. Health promotion and protection – Carers’ own health care needs should be recognised.
10. Financial security – Carers should be covered by social security schemes such as income replacement benefits, accident insurance and old age pensions, in order to avoid impoverishment as a consequence of caring.

⁷ For further details on Eurocarers Guiding Principles for Carers go to [http://www.eurocarers.org/page3.htm](http://www.eurocarers.org/page3.htm)
## Contact details for national carers’ organisations

<table>
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<tr>
<th>Country</th>
<th>Official Name</th>
<th>Website</th>
</tr>
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<tbody>
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<td></td>
<td>Princess Royal Trust for Carers</td>
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### Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>EU15</td>
<td>European Union of 15 member states (pre-2004)</td>
</tr>
<tr>
<td>EU25</td>
<td>European Union between 2004 – 2007 (EU15, plus NMS10, see below)</td>
</tr>
<tr>
<td>EU27</td>
<td>European Union as of 2007: including Romania and Bulgaria</td>
</tr>
<tr>
<td>NMS10</td>
<td>The group of 10 countries that became EU members in 2004: Lithuania, Estonia, Latvia, Poland, Hungary, Czech Republic, Slovakia, Slovenia, Malta, Cyprus.</td>
</tr>
<tr>
<td>CC3</td>
<td>3 candidate countries – Croatia, Former Yugoslav Republic of Macedonia (FYROM) and Turkey</td>
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<tr>
<td>Country Codes</td>
<td>AT=Austria; BE=Belgium; BU=Bulgaria; CZ=Czech Republic; EL=Greece; ES=Spain; FI=Finland; FR=France; DE=Germany; HU=Hungary; IE=Ireland; IT=Italy; MT=Malta; NL=Netherlands; NO=Norway; PL=Poland; PT=Portugal; SE=Sweden; SI=Slovenia; UK=United Kingdom</td>
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References:


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