

Bringing the family in through the back door: the stealthy expansion of family care in Asian and European long-term care policy

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Introduction: shared trends in long-term care in Europe and Asia

In the era of global ageing, amid political concerns about increasing care needs and long-term sustainability of current care regimes, most developed countries are seeking to minimize the use of institutional care and to expand formal home care for their older populations. In this context, formal home care means paid caregivers providing a range of help, care and support in the home of the older person. In long-term care reforms, concerns about public funding (is there enough money to pay for care?), formal providers (how can we ensure that they provide good quality care?) and the paid care workforce (are there enough of them; how can they be better trained?) are foremost (Timonen 2005; Rostgaard et al. 2012). An integral yet hidden part of all these reforms – and one that is often ‘buried’ beneath the above-mentioned concerns that are commonly aired – is the stealthily growing role of family carers.

Alongside the drive to reform and to expand formal home care, family care persists as the mainstay of elder care in almost all countries (Fujisawa and Colombo 2009). In welfare states that have an explicitly familialist orientation, family care is encouraged and incentivized (Leitner 2003). We define family carers as both those who are directly providing care, and those who play an indispensable role in coordinating and managing the care of their relative, even when part of this care is formal (Timonen 2009). The latter scenario can also be referred to as the broader ‘caringscape’ that consists of

responsibilities for and practices around organizing and managing care; functions that are mainly managed by women (Bowlby et al. 2010). For instance, arranging for and monitoring the delivery of formal care in an older relative's home is the kind of caring-about (as opposed to directly caring-for) activity that the caringscape comprises. In some countries, family care is being 'semi-formalized' through various supports and payments that the state channels to family carers, leading to a blurring of the boundaries between formal and informal care (Pfau-Effinger and Rostgaard 2011). However, this article does not focus on supports that are explicitly directed at family carers, such as carers' payments or care leave from work, but rather interrogates the more 'roundabout', stealthy ways in which family carers' involvement might be encouraged, or even necessitated, as a result of developments in *formal* home care policy.

Notwithstanding the development and expansion of formal home care policies, these are everywhere underpinned by family care. It is also important to ask whether elder care policies that are ostensibly focused on expanding formal care, might also be inculcating and spreading – more or less explicitly - a renewed or expanded culture of family care. In tandem with this, demographic change is driving family (spousal) care as the life expectancy gap between men and women is narrowing and marriage/partnership rates are higher among older cohorts than previously: the most important type of family care is shifting from care provided by adult children towards care provided by spouse/partner (Timonen 2009). These demographic patterns are contributing towards growing implicit familialism in care, which tends to be welcomed by policymakers and policy-formulating organizations as a contribution toward filling 'the care gap' (OECD 2011). This in turn reflects what Timonen (2016) terms the strong emergent trend of 'turning the problem into the solution' i.e. tapping into the 'free' resources of older adults and their families; such 'free' resources are inequitably drawn on as some groups end up having to respond by offering their care labor to a greater extent than others (women more than men; lower income families more than higher income families).

This article aims to identify and spell out how developments in *formal home care* bring about different modes of increasing, encouraging and necessitating family care inputs, across welfare states in Europe and Asia. In some cases, this is explicit, in other cases something that happens 'through the back door'. Nonetheless, in all cases there are implications for the family caregivers' time, health and employment options.

Previous studies have shown that long-term care policies are highly complex and vary greatly across industrially advanced economies, particularly when informal/home care is taken into account (OECD 2011; Jang et al. 2012; Courtin et al. 2014). Compared with the West, state-led long-term care policies for older people are recent developments in Asia, with the exception of Japan. Children and family members have always been at the centre of financing and providing care, and traditionally, filial duty (i.e. looking after one's parents) has been considered to be the cornerstone of society (Hashizume 2000; Koh and Koh 2008). Despite great variations in the region, social policy paradigms in Asia can be characterized as 'developmental' (Walker and Wong 2005; Lee and Ku 2007). In a developmental welfare state, social policy is regarded as secondary to the country's primary goal, namely, economic growth. Therefore, in order to meet various public and social demands, families have been the primary caregivers. However, in recent years (again outside of Japan), due to rapid economic growth, political democratization combined with dramatic demographic change (e.g. ultra-low fertility rate), social investment began to be seen as a key productive factor for economy, political stability and governmental legitimacy. Changes in family structure, living arrangements and increased levels of female labor market participation created the gaps in care provision. Against this background, the long-term care policies have been developed, proposed and implemented in many East Asian economies. Japan introduced publicly-funded long-term care insurance (LTCI) in 2000, followed by the Republic of Korea (2008). Taiwan also passed a long-term care bill in 2015. However, the 2016 general election brought a change of government in Taiwan, and it is expected that the current governing party (Democratic Progressive Party) will attempt to change the funding scheme to introduce a Nordic-style tax-funded care service model.

Although similar state-sponsored LTCI does not exist in Hong Kong, Singapore and Malaysia, the importance and urgency of policy measures in this area have been widely recognized by the respective governments. In Singapore, the Maintenance of Parents Act, passed in 1996, obliges adult children to support those aged 60 and above who are unable to subsist on their own. The Act has been criticized for damaging family ties because of the imposition of legal liability and financial obligations, and was amended in 2014. The proportion of the age group in Singapore has increased from 6.5 % in 1995 to 11.2 % in 2014. Recognizing the pressure, the means-tested cash benefit scheme called Silver Support scheme was proposed as a safety net, and approved in 2015 to support the older people facing financial difficulties (Lee 2015).

It appears on face value that the European-style welfare state has finally begun to be adopted in Asia, shifting the public-private boundaries and increasing the role of the state vis-à-vis the family. Ochiai (2004; 2009; 2010) has argued that the reconstruction of care networks in Asia have been necessitated by fertility decline and population ageing, although she recognizes different patterns in the way care work has been socialized and marketized across the region. The question still remains as to whether seemingly more pro-active governments have led to 'defamilization' (Kröger 2011; Yu et al. 2015) and more importantly, relieved the family of excessive burden as carers.

Expanding family care by stealth

Long-term care policy is a highly complex area, and constantly evolving. In Europe and Asia, there are three main methods of financing public long-term care: universal coverage with a single program, means-tested assistance schemes, and mixed systems. Within the first category, there exist statutory long-term care insurance models (e.g. Germany, Japan and South Korea), tax-based models (e.g. Nordic countries), and nursing and personal care through the health care system (e.g. Belgium). Under the first category (universal system), the degree of comprehensive coverage varies greatly (OECD 2011).

The countries using the means-tested assistance schemes include the United States, England and Singapore. The last category (mixed systems) can be found in Australia, France, Italy, Scotland and Spain. Under these systems, long-term care coverage is offered by a mix of different universal programs and benefits, or universal and means-tested long-term care entitlements can co-exist.

Among the above-mentioned schemes, we have identified three modes of increasing, encouraging and necessitating family care inputs through policy changes that are not explicitly or primarily about family care, but rather about expansion or changes in formal care. Although the three modes do not directly correspond to the financing schemes, some patterns and path-dependent nature of the reforms are emerging. The remainder of this paper is structured along those three lines, drawing on recent illustrative examples from both European and Asian countries; it is worth emphasizing that what we present here is a novel conceptualization, rather than a systematic comparison. The three modes of enhancing the importance of family care by stealth are:

- I. Integration of informal care into the broader care system, in ways that

sustain and enhance the supply of family care

- II. Reducing and modifying formal services so that the need for family inputs increases
- III. Enabling extremely flexible forms of care labor that necessitate the constant active involvement of family members in the broader 'caringscape'

We will now outline the logic of each mechanism in turn, drawing on illustrative examples of policy dynamics in both European and Asian countries.

[1] Integration of informal care into the broader formal care system

In several European and Asian countries, informal care has been integrated into the care system through insurance-financed payments. Given the relatively longer period since LTCI was introduced in Germany and Japan, we focus on these two countries to look at the key trends and outcomes (although there are some important differences between them, such as the greater focus on cost-containment from the inception of LTCI in Germany). Family care has been encouraged and rewarded in Germany through the long-term care insurance system that was established in 1995, arguably very successfully as the share of family care has not declined. However, there is evidence of significant differences in propensity to care for family members by social class and ethnicity, so that people from lower socioeconomic groups and ethnic minorities are most likely to opt for the family carer payment, as opposed to the cash payments to pay for formal care at home or in an institution which are more commonly used by higher socioeconomic groups (Theobald 2012). The German LTCI involves rigid administrative controls and fairly close monitoring through, for instance, regular visits to the home where the care is being delivered, and some compulsory training for family carers, but also expansion of carers' rights to, for instance, respite breaks; illustrations of the semi-formalization referred to above. Recent changes to the system have been designed to accommodate more categories of family carers, not just the full-time carers but increasingly also working carers who are facilitated by the labour market legislation that allows them to reduce their working hours for up to two years, to a minimum of 15 hours per week (Schmähl et al. 2012). This is a good example of how familialist welfare states are looking to both 'facilitate' the worker-carer model, and to maximize the availability of family care from all possible sources, with the help of policies where the ostensible focus is on expanding formal care.

Japan and the Republic of Korea have LTCI; both modelled their LTCI schemes on Germany's (Campbell et al. 2009). With a long history of caregiving practices by women (traditionally, a daughter or the eldest son's wife), Japan wanted to break the mold by emulating the German LTCI, and introduced a universal insurance scheme in 2000 (Campbell et al 2009; Ochiai et al. 2010; Rhee et al. 2015). Under the German scheme, a cash allowance is offered to 'compensate for' family care-giving, while Japan decided to restrict its LTCI only to formal services. In fact, cash allowances were proposed in Japan, but strong opposition was voiced from women's groups. They claimed that cash benefits would not relieve women of caregiving burdens (Campbell 2002; Campbell et al. 2009), an argument that seems to be borne out by the patterns of care provision in Germany where women are more likely than men to take up the family carer payment (Theobald 2012).

The original intention of introducing LTCI in Japan was to lessen pressure on families (i.e. primarily women) by increasing the volume of formal care services while trying to tackle the fiscal burden on health insurance for covering long stays in hospitals ('social admissions'). However, the tenacity of familism (in the minds of policymakers) soon became clear, as the process of changing labor market laws and practices required a long time. In addition, there remained gender disparities in wages and tax disincentives for housewives to take part in the labor market. In the meantime, the family unit has become smaller. For example, families living in three-generation households in Japan have decreased from 15% in 1986 to 6.9% in 2014 (Ministry of Health, Labour and Welfare 2014). Ochiai and colleagues (2010) examined the impact of the LTCI in Japan on families' caregiving practices. Although they report increased uptake of public care provision, which contributed to a slightly reduced amount of time spent by families giving care, they also note the persistence of familism. Therefore, the overall impact of the LTCI system remains inconclusive (Tamiya et al. 2011; Hayashi 2015).

As in Germany, cost containment was one of the main policy drivers for the Japanese government when the scheme was developed (Rhee et al. 2015). Since the introduction of the scheme, various strategies have been pursued to constrain spending. They include limiting the number of institutional beds, and tightening eligibility. The 2005 reform introduced care package restrictions only to those without family support. When beneficiaries live with family members, they are not allowed to receive much assistance with housework (Hayashi 2015; Campbell et al 2010). As mentioned above, the idea of cash benefits was rejected, and this also reflects the fact that in Japanese families, hiring

home assistants/carers has not been customary (Ochiai 2009). Migrant workers are not easily available either (due to restrictive immigration policy), which is in sharp contrast with the case of Taiwan and Singapore (Lan 2006).

In Japan, because of these supply and demand issues, families are still very much encouraged to remain the primary caregivers. From the supply side, there is still a relatively tighter control over migrant workers in general, and the low wages for care workers create the shortage of staff. From the demand side, tax disincentives are still there for women to enter and stay in the labor market. In addition, a strong sense of filial duty persists. Despite the decline in fertility and multi-generational households, sons and daughters provide care for their parents, or spouse's parents. From August 2015, co-payment rate by high-income earners has been increased from 10 to 20 percent, while some mitigation plans were introduced for low-income earners. Stricter eligibility requirements (based on need certification level) are also applied now to limit the use of special nursing care homes. Increased levels of cost-sharing and stricter access to formal care will bring more families back into caring roles.

[2] Reducing and modifying formal services so that the need for family inputs increases

Despite the adherence, in principle, to the idea of universalism in many European countries, financial constraints and budgetary ceilings are leading to limitations in entitlements to long-term care, especially in countries that developed long-term care policies at a relatively early stage and now perceive a need to control expenditure growth (Ranci and Pavolini 2015). When the eligibility criteria of access to care services evolves so that it comes to focus on those 'most in need' (whether defined mostly on the basis of income as in England, or on the basis of care needs as in the Nordic countries), increase in family care is an inevitable corollary. The most striking example of such 'rationing' in recent decades in Western Europe is England, where even older adults with modest incomes and assets have lost the right to public assistance with financing their long-term care (Glendinning 2012). In the traditionally more generous social care system of Sweden, 'rationalization' was achieved through gradual cutbacks in expenditure (that resulted in closer 'targeting' of services to those 'most in need'), and steps towards marketization in the name of a 'freedom of choice revolution' (Ranci and Pavolini 2015: 275-77).

'Rationing' of care in accordance with the older adult's ability to self-care is happening even in countries such as Denmark (long committed to de-familialism), as a result of

asking older adults to subscribe to restorative care approaches where the older adult is increasingly expected to regain independent living skills: families are responding by extending their role due to concern that the older person might not be able to live up to the high expectations of coping on their own (Rostgaard 2015). In the other Nordic countries, too, the increasingly strong focus of policy only on the most dependent implies that families must and should do more for everyone - the strong emergent discourse in these countries is that 'families are not doing enough for their older members' (Kröger and Leinonen 2012). A similar trend can also be observed in the Netherlands (Da Roit 2012) where specific guidelines govern which family care inputs are taken into account when designating the amount of formal care that an older person is due. Therefore, formal care is calibrated in accordance with whether and how much family care is available.

As mentioned earlier, Asian countries (bar Japan) have been late developers of formal care services such as LTCI, and generally minimalistic in their approach to welfare spending (Yu et al. 2015). However, the time lag also means that policy-makers in countries like the Republic of Korea or Taiwan had more models to learn from. As a result, various forms of cost-sharing measures in the Korean LTCI were considered and incorporated from the outset (Campbell et al. 2009; Rhee et al. 2015). It can also be argued that the formal care schemes in Asia have not been developed based on the idea of universalism in the first place. On the other hand, as the Japanese case highlighted, the volume of utilization of formal services can never be accurately predicted. The unexpected growth in the number of individuals eligible for formal services in Japan led to a range of cost-cutting measures such as room charges for residential care, capping of residential places at the rate of three per cent of the ageing population, and tighter needs assessment (Hayashi 2015).

[3] Enabling extremely flexible forms of care labor, which in turn necessitates co-ordination and oversight by family members

The most obvious example of this pattern in Europe is Italy, where a cash payment ('companion allowance') has gradually expanded in availability and come to be extensively used to hire migrant care workers and other caregivers outside the formal economy (Costa 2013). There is evidence that migrant care workers become part of the 'family system' and their role expands and evolves over time – responding to the needs and direction of family members who remain heavily involved (Gori 2012; van Hooren 2012). As pointed out above, such arrangements do not amount to the family abdicating

from all care but rather embed the family firmly in the 'caringscape' alongside the paid caregiver.

In similar vein, market mechanisms and freedom of choice can also drive family care. A good example of this is the increasingly diverse field of care providers in England, following greater emphasis on the care users' choices and designation as 'purchasers' of their own care. As a result of introducing this 'mixed economy of purchasing' and as a result of allowing Personal Budget (cash-for-care) recipients to select their own care providers, increased use of informal personal networks is anticipated (Glendinning 2012). Again, the family will be called upon to monitor the quality and functionality of these arrangements.

In some Asian countries such as Singapore and Taiwan, the commodification of care labour created a new market, making migrant workers widely available, while modifying the traditional social norm that children have to provide care themselves. Yet foreign domestic workers (primarily from the Philippines, Indonesia and Vietnam) tend to live with the family, are expected to be available 24 hours a day, and look after the older family members, which resulted in the need for co-ordination amongst the family, including the extended family (Asato 2009). In Singapore, the Foreign Maid Scheme was introduced in 1978, in order to encourage Singaporean women to participate in the labor market. As a result, the number of foreign maids increased from approximately 5,000 in 1978 to 160,000 in 2005 (i.e. one in six households) (Tamura 2009). In spite of stronger government commitments to social care in recent years, the emphasis on familialism and 'self-reliance' has never been swayed (Teo et al. 2006; Rozario and Rosetti 2012). For example, while cautioning against overreliance on foreign domestic workers, the government has consistently promoted the use of live-in domestic workers as its most effective policy instrument by relaxing certain employment restrictions, and reduced monthly levy on employers of such live-in care workers (Yeoh and Huang 2010). From May 2015, when a household unit has an eligible person for care (e.g. Singapore Citizen aged 65 years or above or child below 16), they are entitled to a concession of \$205 off the monthly levy for hiring a foreign domestic worker. The rate of the concession was increased from \$145. This incentivizes more people to employ a foreign live-in worker. Just as the Silver Support scheme, the Singaporean government's home care policy is underpinned by a means-tested safety net, as its guiding principle has been that the state should be 'the last resort' (Teo et al. 2006, 25). Its consistent emphasis on non-state actors ('Many Helping Hands'), filial duty and a relatively high proportion of co-residence

with an adult child reinforced the family's role in home care (Rozario and Rosetti 2012). Taiwan is another case in point.

As in Singapore, Taiwan introduced legislation to import foreign carers as caregivers in 1992. Since then, the Taiwanese government also made efforts to build social welfare and formal care systems in tandem with the informal care services provided by live-in carers. However, the budgetary resources available for long-term care schemes were limited and did not have much impact (Chou and Kröger 2004). As of 2007, over 40 per cent of frail older people are cared for by foreign carers, and there has been a steady increase in the number of live-in foreign workers (Chen 2014). Unlike Italy, the government in Taiwan made it compulsory for a host family to apply and pay for a qualification to hire a migrant worker, but the cost of hiring a live-in carer in home remained smaller than admitting an older person to formal care (Chen 2014). This was made possible by leaving care provision to a highly competitive market (and families), sustained by low wages of migrant workers. As public and private boundaries were increasingly blurred, the host family bears the additional responsibility of negotiating the 'caringscape' with their live-in carers, and also that of regulating the quality of care (Chen 2014; Asato 2014). Although it remains to be seen to what extent the currently-debated LTCI will affect the steadily expanding market of migrant carers, the caregiving role of family has not diminished through the government policies and interventions.

Discussion and conclusions

It is often stated that family care is a deep-seated 'cultural' phenomenon, difficult or even impossible to alter. We hope that the examples and discussion marshalled in this article serve to demonstrate the counter-argument, namely, that 'culture' in modern welfare states is malleable, and that it is always in many respects policy-driven. Instead of seeing cultures of care as reified entities, researchers and policy makers should be more attuned to how policies create incentives and gaps that families must respond to; and sometimes close those gaps so that families do not have to be as extensively involved in care. We concur with the view expressed by Ranci and Pavolini (2015) that the contemporary emphasis on care in the home is accompanied by implicit increases in the responsibility of the informal networks that are necessary to underpin home care. Policies that are ostensibly about formal care often serve to enhance the centrality of family care by stealth; a pattern that we identified in both 'the East' and 'the West'. Family care, while seemingly in the background of major long-term care policy reforms, is therefore often brought in 'through the back door'. As a result of these policy patterns,

demographic changes and of course also through explicit encouragement of family inputs in many countries, the role of family care is expanding in the midst of care regimes that on the face of it are not seeking to be more reliant on family inputs, but rather portray themselves as being in the process of enabling the ‘adult worker model’ (which is not easily reconciled with extensive family care) (Lewis 2001; Daly 2011).

As demonstrated by a comparative study of informal caregiving patterns in the Republic of Korea and European countries (Jang et al. 2012), the countries with lower GDP per capita and low rates of female labor participation show relatively high percentages of family (women) caregivers (i.e. Korea and Southern European countries). The snapshot analysis of data collected at around 2005 captures the difference between the more developed and generous welfare states in Northern European countries on one hand, and those with stronger familialism in Southern European and Asian countries on the other. However, the reform trends across the board point to more family involvement in caregiving in home settings. The major difference between Europe and Asia appears to be that in Asia, the expectations of the state’s role in providing care have been managed carefully over many years, through the emphasis on traditional family values and economic growth as the policy priority. The development of state-sponsored social welfare and services in Asia is a relatively new phenomenon (with the exception of Japan), and socialization of care has a much shorter history, compared with Europe. Therefore, on the surface, many recent policy initiatives in Asia were meant to shift the burden of caregiving from families to others. Yet these policy initiatives were driven primarily by economic considerations in response to dramatic demographic changes and new family/gender relations (e.g. ultra-low fertility rates and need for greater female labor market participation) in the region (Peng 2012). In the absence of universalism, the general acceptance that informal care is a family issue rather than a policy matter in Asia has contributed to seeking for solutions in the resources already available to families themselves or in the market, when policies create further gaps. In Europe, the shift in the discourse around family duties and responsibilities is more visible, and has been used to mobilize support for policy changes in formal care. Path dependency is also strongly evident in the greater propensity to increase the role of family care by stealth through cuts in existing services: where long-term care policies are more extensive and have a longer history (as in Europe vis-à-vis Asia), there is more scope to prune them back with the consequent increase in the role of the family.

Reinforcing the role of the family will drive inequalities in many different spheres of life. This is because some families (the better-off) will be able to purchase care instead of

directly providing it (if they so choose), whereas families with lower incomes/assets will have no choice but to engage in hands-on caregiving. This in turn impacts on educational and labor market opportunities, with long-term consequences over the life course for the carers who are still predominantly women. These include greater propensity to experience depression and loneliness, and greater likelihood of financial problems, particularly in their own retirement. In other words, when policymakers turn to the 'free' resource of family carers, some of those who shoulder a large part of the family care responsibility end up paying the price in a variety of indirect ways.

This paper has provided some recent examples of policy developments around formal home care in Europe and Asia, which have resulted in more involvement of families in the care of older people. We identified three different modes of increasing, encouraging and necessitating family care inputs that can be detected to varying degrees across European and Asian countries with relatively developed long-term care policies. Future studies are needed to examine longitudinal trends from a comparative perspective to confirm our findings and elucidate how government commitments to formal home care provision and financing interact with the changing nature and volume of family caregiving.

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