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THE CASE FOR LONG-TERM CARE POLICIES: THEORY AND AN OVERVIEW ACROSS THE OECD AND BRAZIL

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Abstract: In light of the demographic and socio-economic trends from the second half of the twentieth century, which have brought forth the necessity of elderly care, this paper aims to reflect on the case for long-term care (LTC) policies from a theoretical standpoint, considering the specificities of elderly care work and what those policies may achieve; also, it provides an overview of LTC policies across the OECD and Brazil in recent years. It finds large variation in the development of such policies across the OECD, which regardless, provide more coverage of care to the elderly than Brazil. Additionally, it suggests that the majority of countries do not sufficiently account for work-family balance conflicts of family carers.

Keywords: Elderly care; Work-family balance policies; Care crisis; Long-term care; Welfare states.

Resumo: À luz tendências demográficas e socioeconômicas da segunda metade do século XX, que trouxeram à tona a urgência do cuidado de idosos, esse artigo apresenta o argumento pelas políticas de cuidado de longo-prazo de um ponto de vista teórico, considerando as especificidades do trabalho de cuidado de idosos e quais são as potencialidades dessas políticas; ademais, apresenta panorama das políticas de cuidado de longo-prazo na OCDE e no Brasil em anos recentes. É encontrada ampla variação no desenvolvimento destas políticas na OCDE, mas que sempre provêm maior cobertura de cuidado de idosos do que no Brasil. Sugere-se que a maioria dos países ainda aborda de forma incipiente os conflitos entre trabalho e família para cuidadores familiares.

Palavras-chave: Cuidado de idosos; Políticas de conciliação trabalho-família; Crise do cuidado; Cuidado de longo-prazo; Estados de bem-estar social.

1. Introdução

Amongst the many areas of social policy, elderly care is attracting growing interest among policy-makers and welfare state scholars, despite traditionally not drawing a special interest. From the first experiences of a welfare state in Germany and subsequently the United Kingdom, to the post-war Keynesian expansion period, the welfare states across Europe have focused on insuring citizens against social risks stemming from a capitalist economy[1] (KERSTENETZKY, 2012). This means the *Treinte Glorieuses* welfare states were geared towards decommodification, achieved through a compulsory social insurance system. However, they were based on the male breadwinner model (the Nordic countries already incentivized a dual-earner model[2]), which relied upon the wife to do virtually all care and domestic work, which included caring for the elderly (ORLOFF, 1993; LEWIS, 1992; BORCHORST e SIIM, 2002).

Demographic and socio-economic trends, however, have increased the caring burden on women's shoulders and made for projections of a diminishing pool of family carers. The main demographic issue is population ageing: across the member-states of the Organisation for Economic Co-operation and Development (OECD), the share of the population aged 65 to 79 is expected to increase from around 10% to 15% in 2050, and the population over 80 – with a much higher probability of needing long-term care – is expected to grow from 4% to 9,4% over that same time frame (COLOMBO et al., 2011). In Brazil, between 2016 and 2036, the population aged 65 to 79 is projected to increase twofold and the those aged 80 or older to increase 2,6 times over the same time period (SOUZA, 2018). Even though the gains in male life expectancy are expected to increase the proportion of old people living in couples until 2050, where one may care for the other, therefore decreasing the proportion of frail elderly living alone (mostly women), the proportion of both-frail couples is projected to increase by 2050 (COLOMBO et al., 2011).

In broad strokes, the socio-economic trends are the acceleration of women's entry into the workforce on the second half of the 20th century; the changes in family structure, with an augmented proportion of divorce and single parenthood in lieu of the traditional married (heterosexual) couple; technological change, leading to less labor-intensive production techniques and the growth in the service sector versus manufacturing, which pays relatively smaller wages (IVERSEN, WREN, 1998; KERSTENETZKY, 2012). These processes also contributed to families needing a second provider, therefore making women's presence in the workforce definitive.

[1] In some countries, such as the United Kingdom in 1911, mandatory health insurance was also instituted (KERSTENETZKY, 2012).
[2] But even so, the family is the main agent of care provision (LEITNER, 2003).

In the wake of the care crisis created by those trends, organizing long-term care was acknowledged as policy priority for the future of the welfare states. In this article, the definition of long-term adopted is that of the specialized OECD report on this subject:

> Long-term care: is defined as a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL). This "personal care" component is frequently provided in combination with help with basic medical services such as "nursing care" (help with wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation or services of palliative care. (COLOMBO et al., 2011, p. 11)

In this text, elderly care is also used interchangeably. It is important to note that most caregivers are involved in low-intensity care, therefore, the need to receive care is more widespread than one might think at a first glance. Around half of all users in the OECD (varies between countries) are aged over 80, most of which being women (COLOMBO et al., 2011).

Besides catering to the needs of a bigger old-age population, long-term care policies have to be evaluated also through the lens of the carer and what incentives are being provided to them. The long-term care (henceforth LTC) policies can achieve de-familialization, therefore advancing on one of the objectives of the welfare state – identified by Esping-Andersen (1999) after the feminist critique[3] (Orloff, 1993; Lewis, 1992) of his seminal work *The Three Worlds of Welfare Capitalism* (1990) – or be familialistic, reinforcing the family's (mainly women's) caring duty (LEITNER, 2003). For having this de-familializing potential, that is, the potential to unburden families and diminish the extent to which an individual is dependent on kinship for care, the LTC policies may improve work-family balance, depending on their design (ESPING-ANDERSEN, 1999).

Work-family policies, in general, contribute to increasing employment levels, promoting economic growth, enlarging the tax base, therefore having the potential to more than cover the costs of the transfers women receive as social protection. They may also increase fertility rates, lower the risk of childhood poverty, and clearly empower women inside the family by diminishing their economic dependence upon their male partner (ESPING-ANDERSEN, 2009; LEWIS, 2009; DOMINGUES, 2018).

In this context, this paper aims to reflect on the case for LTC policies from a theoretical standpoint, considering the specificities of elderly care work and what those policies may achieve, and provide an overview of the LTC conditions across the OECD and in Brazil in recent years.

[3] The main point of their criticism was that Esping-Andersen's 1990 typology was centered around a male worker and based on the male breadwinner family model. Basically, it lacked a gender-sensitive approach, and Ann Orloff (1993) and Jane Lewis (1992) proposed alterations and new analytical categories. However, introducing the concept of de-familialization as a dimension of comparative welfare studies and recognizing the social and political function of the family, Esping-Andersen's 1999 work received criticism by Leitner (2003) for not defining familialism appropriately: it should be defined in terms of the family policy it is being used to classify.

Subsequently, the text is divided into two sections, followed by the concluding remarks. The first section addresses the theoretical standpoint and the second section shows data for long-term carers and care recipients across the OECD, serving as a lesson for policy improvement in Brazil, where the scarce policies are described.

2. Theory: the care work and the space for social policy

2.1. The specificity of care work

The caring work differentiates itself from other types of work traditionally embedded in the market context. There is no one definition of care work, but Karina Batthyány (2017) identifies three dimensions of care: (i) the material dimension, relating to the time spent performing care work; (ii) the economic one, relating to the costs involved and the (iii) psychological dimension, corresponding to the act be being responsible for someone else and its emotional consequences. The last dimension differentiates care work for other types of historically remunerated activities performed in the public sphere.

Despite being fundamental to social reproduction and economic production, the reproductive care work performed largely by women is undervalued. Even though part of the skills is acquired during the life cycle (no training necessary), traditional gender roles have assigned caring as a skill women naturally possess, that is one of the reasons why domestic workers earn less than workers with equivalent education and training in other sectors (ILO, 2013). Reproductive work (includes care and housework) suffers from an invisibility issue: as the industrial era increasingly associated work to paid work, and value to money, women's reproductive work was not perceived as work[4], and as social reproduction was separated from economic production, reproductive work has its social function obscured (BORIS; LEWIS, 2006, apud ILO, p. 68; FRASER, 2016). Since then, housework and care work have been undervalued, even when hired through the market.

Akin to the notion of "psychological dimension of care" feminist economists identify the reciprocity bond between the caregiver and the care recipient as a marked feature of this type of work (SOUZA, 2018). According to Araújo (2019), reciprocity can be defined as a feeling of worry towards another that translates into obligations; thus caring for the elderly can be seen as indirect reciprocity, because it involves the trade of material and symbolic goods between generations. Care as indirect reciprocity takes part in the ideological construction of sexual division of labor. The author also argues that the expectation of reciprocity transcends the family barrier and is also expected of paid carers, along with the notion of patience and sacrifice for love, recounted by interviewed carers as necessary

[4] Thankfully, since then, the field of feminist economics has successfully made the case for housework to be considered a type of work (BENERÍA, 2003).

skills to do the job. Such moral requirements of the carer are in opposition with the logic of the market[5], since remuneration is perceived as something that tarnishes the true meaning of care, constitute a barrier to better valuation for care work. This familial care model (based on sacrifice and reciprocity) is also a mechanism of subordination, as a level of emotional detachment is reported by the more skilled carers as necessary to gain bargaining power should any conflict between them and their employer arise (ARAÚJO, 2019).

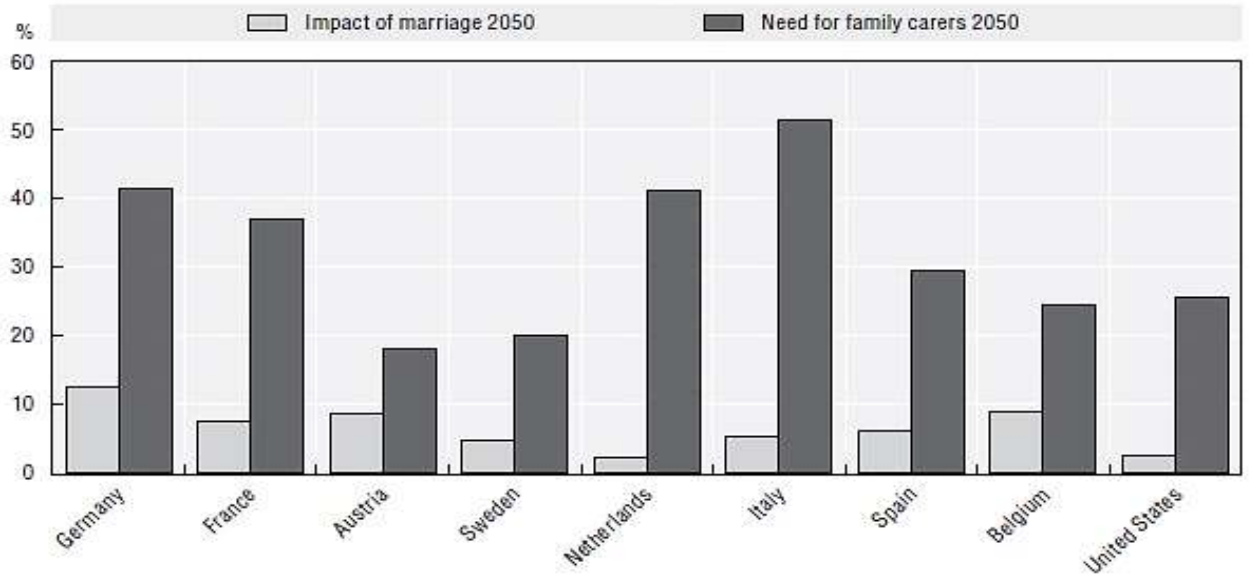
2.2. What is the space for public intervention?

Besides the issue of the value of care work and how it plays out once it is externalized, providing ways for families to share the care burden with the state or the market is in the interest of public policy, as stated in the Introduction. Since Esping-Andersen's (1990) seminal comparative welfare states work, the state, market and family were stablished as the three sources of care. As women entered the labor market, fertility rates dwindled, life expectancies grew, technology changed, unionization and party affiliation diminished and the service sector became prominent, new social risks arose, among which the care crisis (BONOLI, 2005; DOMINGUES 2018). In Brazil, the care crisis is predicted to worsen as, considering the most care-dependent age brackets of children under four years old and elderly over 80, the latter is projected to increase by 5,4 million as the former is projected to decrease by 2,8 million. There is, therefore, in Brazil, a positive net effect on care demand, as work-family balance policies have not improved enough recently, underperforming when compared to Uruguay in terms of childcare, as reflected in the stagnation in the female labor participation rate (SOUZA, 2018; DOMINGUES, 2018).

In the OECD, besides the change in the shares of those aged 65 to 79 and that of those 80 or older already mentioned, there is another important demographic implication of low fertility and mortality rates: a decreasing pool of working-age adults that may provide intensive care for their parents in advanced capitalist economies (COLOMBO et al., 2011). It is important to note that most family care is provided by elderly spouses, daughters, or in-laws in the 45 – 64 age group (LEITNER, 2003). Therefore, the ratio of carers to elderly people is decreasing. When considering only those aged 50 or more, the net effect of having more married old couples versus the growth in care demand, is negative, as shown in the Figure below (COLOMBO et al., 2011)[6].

[5] The less trained caregivers who were interviewed reported that, should they not need the money, they would not charge for their care work. Their main goal is not to maximize profits but their personal bond with the elder (ARAÚJO, 2019).
[6] The projections are made using "current proportions of the population being married by age group and gender and their corresponding forecasts in life expectancy" (COLOMBO et al., 2011, p. 66).

Figure 2.8. **The projected growth in frail elderly greatly outweighs that of potential caregivers**



Note: "Need for family carers" indicates the change in family carers necessary by 2050 in order to maintain the existing carer/care recipient ratio. This depends on demographic trends, the existing proportions of individuals with restrictions in daily living activities (ADL) and of those providing unpaid care. A relatively high need for family carers can reflect an existing low proportion of family carers among the oldest old *(e.g.,* Germany and Netherlands) or a high proportion of the oldest old having ADL restrictions *(e.g.,* Italy). *Impact of marriage* indicates expected change in the availability of potential carers (spouses), by 2050. The difference between the two indicates the size of the potential care gap.

Fonte: OECD. Help Wanted? Providing and Paying for Long-term Care. 2011. p. 66

This gap not as pronounced as in the figure above if we consider the existence of carers under 50 but it does signal to the necessity of developing social policies to face it. By allowing families to free up time that was previously allocated to care, work-family balance policies are economically oriented social policies that may achieve different goals, economically desirable outcomes (growth in employment, the tax base and fertility rates, inter alia) while incentivizing or not a more equitable sexual division of reproductive labor (KERSTENETZKY, 2012, 2017).

Work-family balance policies include a range of different measures, the dimensions in which policy makers in the European Union have focused on since the 1990s being Early Childhood Education and Care (ECEC), leaves to care for children and flexible working arrangements to care for them (LEWIS, 2009). ECEC services are consensually agreed to be efficient, with empirical studies finding positive effects on female employment, and negative impact on the gender wage gap and the wage gap between mothers and childless women (OLIVETTI e PETRONGOLO, 2017; CUKROWSKA-TORZEWSKA, 2017; KERSTENETZKY, 2012; ESPING-ANDERSEN, 2009). The leaves for care have more mixed gendered implications: on the one hand, they are intrinsically supportive of the family as the main source of care provision, therefore being classified by Leitner (2003) as a familialistic policy. On the other hand, the parental leave, differently from the classic

maternity leave and short paternity leave, can assist in shifting the sexual division of labor by introducing "daddy quotas", by allowing extra time (or total time) of parental leave to be taken only by the assigned second carer. The length of the maternity leave – or the portion of parental leave assigned to the mother – may also have mixed effects on female labor market attachment, with empirical research finding that up to one year the impact is positive (OLIVETTI e PETRONGOLO, 2017). Lastly, flexible working arrangements, which include flextime but also part-time work, have mixed gendered results. The literature suggests flextime is more beneficial to women, since it allows accommodating childcare schedules without harming their earnings, as part-time reduces their financial autonomy and, in the case of Brazil, is more frequent in the informal labor market (therefore risking social protection for those women who choose an informal job in other to reconcile work and care) (DOMINGUES, 2018).

In addition, as LTC policies gain impetus currently, it is important to note that they are also work-family balance policies. In fact, the regulation of home-based care work has such important implications for work-family balance that Blofield and Franzoni (2014) highlight this regulatory policy as one of the three categories of policies that reconcile work and family typology. LTC can be provided at home, informally by the family or by a formal hired carer, at an institution or at day-care centers (COLOMBO et al., 2011). The literature has pointed out to the benefits of home care for the well-being of the elder person, for the intra-familial relations and to it being less costly (GUEDES e KERSTENETZKY, 2013; COLOMBO et al., 2011). They may have different de-familialization outcomes, however. Before that issue is tackled, however, one theoretical issue remains: that of efficiency.

Although countries across the OECD have organized different LTC systems, on average, the share of public spending is much higher than private LTC spending. Except for Switzerland, where private spending accounts for 60% of total LTC spending, the average share of private spending is 15% of total spending across the OECD. Though there is underreporting of informal private spending and the cost of board and lodging in nursing homes, the public share of spending is undeniably important. Total spending on LTC accounted on average for 1,5% of member states' Gross Domestic Products in 2008 across the OECD (COLOMBO et al., 2011). Said Organisation proposes a typology of public LTC coverage, creating clusters centered around eligibility criteria: (i) universal coverage within a single program, either as part of a tax-funded social-care system such as in Scandinavia or through a social insurance scheme specialized in LTC such as in Germany, the Netherlands, Luxembourg, Japan and Korea or even by making it a part of the health system like in Belgium; (ii) universal personal-care benefits, whether in cash (Austria, France, Italy) or in-kind (Australia, New

Zealand), where benefits are commonly related to the ability to pay; (iii) safety-net, means-tested schemes, comprised of the UK and the USA (COLOMBO et al., 2011).

Therefore, it is interesting to reflect upon why the welfare states have reason to support LTC policies, besides the social justice motivations[7] and the negative utility one may accrue for living in a society where the elderly are not supported. A purely private insurance market would not be efficient in the case of LTC because of possible adverse selection (only those who thought they would need care in their old age would insure themselves), which would make compulsion necessary. A moral hazard problem might arise, theoretically, if insureds took less care of their own health in the years leading up to their *troisième age*, which is one of the reasons why all public LTC coverage systems across the OCDE have some form of private cost sharing[8](COLOMBO et al., 2011). The biggest issue, however, is information: such a long-term and complex contract as one covering long-term care involves uncertainty, not risk, whereby costs, and therefore, insurance premiums, are incalculable. Indeed, not even the direction of change in the probability of needing care is known, because of the sustained life expectancy growth in recent decades. This problem is present on both the supply and demand side of the market and, therefore, makes social insurance more adequate since the contract does not need to be fully specified as members subscribe, facilitating the necessary adjustments through time (BARR, 1998).

3. Recent policy experience in the OECD and the lessons for Brazil

To provide an overview of LTC in the OECD and what the policy foci are, it is interesting to start with the results of a survey with 28 OECD countries asked to identify policy priorities towards long-term care. 85% of countries ranked "Ensuring fiscal and financial sustainability" as the top priority, taking first place in the ranking, followed by "Encouraging home care arrangements" tied with "Enhancing standards of quality of LTC services" in second place, being given top priority for two thirds of the countries, followed by "Care co-ordination between health and LTC" in third place, perceived as a top priority for 52,4% of countries. One interesting result is that, on a scale of 1 to 5 in importance, the alternative "Encouraging informal care" was ranked as 5 for 27,8% countries and as 4 for 55,6% of countries. That further confirms the main concern is related to the cost of LTC overshadowing concerns with gender equality. This is relevant since the size of the informal LTC workforce is estimated to be at least twice as large as the formal LTC workforce, such as in Denmark, up to ten times as large in Canada, USA, the Netherlands and New Zealand. Most carers are women,

[7] According to Barr (1998, p. 200), "The various incapacity benefits are redistributive to the extent that claims are more common among the lower paid." That is, public LTC cover schemes promote vertical equity.
[8] According to traditional microeconomic models, coinsurance is an incentive mechanism by which the insurer shares part of the cost of a healthcare claim with the insured to avoid overconsumption (BARR, 1998).

with the likelihood of the carer being female rising with the intensity of care. Because of the demographic projections discussed above, public LTC expenditure of OECD-EU countries as a share of GDP is projected to at least double and possibly triple by 2050 (COLOMBO et al, 2011). Projections depend on hypothesis on future health improvements, possible efficiency gains and the availability of family carers.

The LTC workforce is mainly comprised of women working part-time in most countries and represented about 1,3% of the total OECD workforce in 2010, amounting to undersupply in Spain, Austria, Canada, Finland and Italy[9] (COLOMBO et al, 2011). According to a dynamic probit regression, the impact of care on labor force participation is only significant when individuals perform high-intensity care (at least 20 hours per week). In the Nordic countries, probably because of a more generous array of work-family balance policies, caregiving was not found to reduce working houses (according to a random effect tobit), while in countries of the liberal regime, medium ranges of care intensity (10 to 19 hours per week) were also found to decrease labor market attachment. However, a previous multinomial logit regression has found that the likelihood of non-employment compared to full-time employment is higher in Australia, the United Kingdom, United States for both genders. While in the overall European Union, only women were less likely to be in the labor market. Almost all countries have difficulty retaining LTC workers, which is expected to worsen as the demand for LTC increases unless wages grow in the sector[10]. For 23 countries with available data, about 70% of all users receive care at home. Despite this, most of the LTC spending originates in the institutions sector (COLOMBO et al, 2011).

LTC policies consist of either cash benefits or in-kind services, and most countries offer some sort of both. In Germany, in-cash benefits are set at a level equivalent to 50% of the cost of in-kind services, but most care recipients opt for the cash benefits (COLOMBO et al, 2011).

The array of different services for carers include: carers allowance; allowance for the person being cared for; tax credit; paid leave; unpaid leave; flexible work arrangements; training/education; respite care and counseling (COLOMBO et al., 2011). Training[11], respite care and counseling are not gendered measures and should be provided by all welfare states as it is important for both formal and informal carers to provide quality care, especially considering the higher rate of stress and mental illnesses reported by elderly carers. Tax credit is akin to a carer allowance, but it is not a common

[9] In Italy, families are opting to hire migrants, often working informally, to perform LTC work. There is little control over the use of the cash benefit the elderly in need of care receive (COLOMBO et al., 2011).

[10] The worry about providing negative incentives to work for informal carers is blatant in the OECD (COLOMBO et al., 2011) report, as it hopes to remunerate informal workers with cash benefits comparable with formal care workers average income, while hoping this income won't rise enough to provide negative incentives for family to continue formal work in other sectors.

[11] Quality oversight in the context of institutional care is the most common type of training policy (COLOMBO et al., 2011).

measure, only prominent in the welfare states of the liberal type (Canada and the United States, where it is means-tested). The main policies with gendered implications are, subsequently, allowance to the care giver versus the recipient, paid versus unpaid leave and flexible work arrangements, which are similar the work-family balance policies outlined before.

We argue the same findings the literature has for work-family balance policies for caring for children are valid for elderly care, since both populations share the trait of being dependent. Therefore, flextime is expected to enable carers to reconcile work and caring responsibilities without enhancing the caring gender role of women[12], enjoying the recommendation of the OECD (COLOMBO et al., 2011). Across the OECD, data from a 2004 survey shows part-time work is much more frequently used for maternal care than for other types of family care. Regardless, from a gender-sensitive standpoint, part-time work is not the preferred work-family balance measure as it hampers women's bargaining power vis-à-vis the husband (DOMINGUES, 2018). In terms of care leave, the literature points out that, when applied to children, paid leave with high replacement rates are critical to encouraging men to take it, because their wage is likely higher than the mother's wage and because of traditional gender norms (LEWIS, 2009). The same reasoning should apply in the elderly case scenario, whereby paid leaves not only are less famialistic, but also make for better work-family balance, as taking an unpaid leave from the labor market might not be possible for less well-off families.

The last type of policy for carers is the carer allowance versus the allowance to the care recipient – which is growing in popularity – who can then pay the caregiver a negotiated amount. The OECD (COLOMBO et al., 2011) supports the latter, on the grounds that it gives the person in need of care more freedom of choice[13] and also to avoid increase competition between family members by monetizing their relations. However, it is important to note that family members do not have the same preferences, so that giving a cash benefit to the care recipient will likely result in a less autonomous caregiver and that the view that money tarnishes the care relationship helps to maintain gender inequality.

We now turn our attention to LTC conditions in Brazil. With the demographic trends shown, the share of women taking care of both small children and elderly parents, estimated at 3,65% in 2008, is predicted to increase (COLOMBO et al., 2011). In Brazil, four relevant public policies involving elderly care exist: the Family Health Program (*Programa Saúde da Família)* and the Institutions for

[12] According to the OECD (COLOMBO et al., 2011) report, there are not enough empirical studies on the use flexible hours to care for the elderly to ascertain its implications.

[13] Indeed, a survey among users of cash benefits in the Netherlands, where there is little control over its use and the benefit varies based on an income assessment revealed great satisfaction (COLOMBO et al., 2011).

Long-Term Elderly Stay (*Instituições de Longa Permanência para Idosos*), day-care and community centers (SOUZA, 2018).

The first Program has home care as one of its objects, but it is focused on maternal care. Also, only 58% of households with at least one person aged 60 or over were visited. Almost half the households were visited once a month in 2013, the others were visited even less frequently, attesting to the fact that this Program does not provide sufficient elderly care, as their needs involve activities of daily living (ADL) (SOUZA, 2018). The Institutions are can be private or public, but the vast majority is philanthropic (65%), whereas only 5,2% were public in 2009. Those Institutions cover only around 1% of the elderly population and are concentrated in the richer regions of the country (Southeast and South), therefore, they have extremely limited and unequal coverage[14]. The day-care facilities are also very few, only 1345 in the country in 2016 (also concentrated in the Southeast). Lastly, the community centers enjoy greater coverage and public approval, with a total of 8454 around the country in 2016. However, they do not offer nursing care for those with ADL difficulties, they are focused on the well-being of healthy people in their *troisième age*, in tandem with a movement in Brazil to enjoy this phase of life (DEBERT, 2016).

Lastly, even though the country does not provide a carer or care recipient allowance, it is worthy of note that Brazil has a good social protection system for the elderly, comparatively with other countries in the region, there is little poverty among the elders. The *Benefício de Prestação Continuada*, by providing one minimal wage to the poor elderly, allows for the purchase of care through the market (SOUZA, 2018).

However, it is important to note how embedded in Brazil's legislation the principle of subsidiarity is regarding elderly care. According to Leitner (2003), the subsidiarity principle – according to which the state only intervenes with the family fails to provide care and the individual cannot for care for themselves – is generally present in elderly care even in Europe. However, there are constant reforms to the LTC care systems in OECD and a much larger array of services provided than in Brazil (COLOMBO et al., 2011). Also, in Brazil, the definition of subsidiarity is in the language of the laws guiding the care for the elderly (*Estatuto do Idoso, Política Nacional do Idoso*) and even in the Constitution (SOUZA, 2018; DEBERT, 2016). In this context, the Brazilian care system can only be classified as familialist, using Esping-Andersen's (1999) typology, or implicit familialist, using Leitner's (2003), which are the types with the least support for families and de-familialization (SOUZA, 2018).

[14] There is evidence of low demand for those Institutions, as they are perceived as low-quality and even a risk to the elder's health (SOUZA, 2018). Indeed, a survey in the state of Rio de Janeiro found that the vast majority (86%) believes the elder should be cared by their family (GAMA; ROCHA; ROMERO, 2017).

4. Conclusion

Even though elderly care is gaining momentum in the social policy agenda, the figures here presented have shown how much protection varies between countries. The care work has a historic undervaluation problem, but the policy-makers seem to focus on financial sustainability of LTC systems while not necessarily improving family carers' work-family balance conditions enough. To reap all the positive economic outcomes of work-family balance policies, while guaranteeing large (regardless of the issues surrounding means-tests) coverage, in-kind LTC services should be prioritized over cash benefits.

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