The role of social networks in using home care by older people across Continental Europe

**ABSTRACT**

The diversification of caregiving arrangements in European societies has drawn attention to the factors that condition the use of care by older people. Social and family relations appear as a key factor, mainly to be related to the availability and accessibility to potential informal caregivers. Recent studies evidenced that geographical proximity and a larger social network increase the probability of receiving informal support in old age. However, the ways in which interpersonal relationships are associated with the use of formal care, as well as the cross-country variability of this association, have been barely explored.

Using a sample of 37,708 individuals aged 65 and over from Wave 6 of the *Survey of Health, Ageing and Retirement in Europe* (SHARE), this study examines to what extent the characteristics of older people’s social networks predict the use of three types of home care; formal, informal, or combined, exploring the cross-European convergences and divergences. Binomial logistic regressions are conducted to compare four macro-regions in continental Europe (*northern countries*: Denmark and Sweden; *western countries:* Austria, Belgium, France, Germany, Switzerland, and Luxembourg; *southern countries:* Italy, Spain, Greece, and Portugal; and *eastern countries:* Poland, Czech Republic, Slovenia, Estonia, and Croatia). The structure, availability and accessibility to the members of the social network are the major predictors of the receipt of informal care everywhere. Regional divergences are observed regarding to formal care, alone or combined with informal caregivers.

**Keywords**: Caregiving, family ties, formal care, social support, disabilities, survey analysis

**What is already known about this topic**

* The closer geographical proximity and a larger size of social networks increase the probability of receiving informal care.
* There is a lack of cross-European comparative studies exploring the effect of social networks on using home care by older people.
* Few studies explore the effect of social networks on using other types of care, such as formal or combined formal and informal care.

**What this paper adds**

* Social networks also predict the use of formal care at home, alone or combined with informal care.
* Having a partner is positively associated with using informal care and negatively associated with using formal and combined care in all European regions.
* Social network’s characteristics associated with using formal and combined care diverge more among regions compared to those correlated with the use of informal care.

**INTRODUCTION**

The increase in life expectancy in Europe has implied that non-lethal but disabling pathologies predominate in the epidemiologic profile of older adults (Christensen, Doblhammer, Rau, & Vaupel, 2009). The changes in elderly morbidity patterns have made care a key mechanism for achieving later-life wellbeing and compensating for the deterioration of physical and cognitive functions (Ross, Lloyd, Weinhardt, & Cheshire, 2008). Currently, partners and adult children continue to be the primary caregivers of older people, coexisting with a variety of formal care options, including professional nurses and domestic helpers (Geerts & Van den Bosch, 2011). The partaking of European welfare states in the social care supply have led to diversifying those actors involved in caring, resulting in older Europeans gradually moving from receiving no care or only informal care, towards an increasing use of private and public services (Bolin, Lindgran, & Lundborg, 2007; Bonsang, 2009; Gooberman-Hill & Ebrahim, 2006; Litwin & Attias-Donfut, 2009).

In the context of the growing pluralism of potential caregivers, a more accurate understanding of the factors determining the use of home care for older people is of critical policy importance, not only due to the intimate link between old age wellbeing and care, but also in the light of the implications that social care provision is expected to have for public expenditure in a near future (Lipszyc, Etienne, & Xavier, 2012; Trigg, 2011).

The utilisation of home care is conceptualised as an individual behaviour determined by the interrelation between multiple individual and societal factors (Andersen, 1995; Andersen & Newman, 2005). An extensive body of literature evidenced that *family* is a key social determinant of care use in old age to be related to the availability and accessibility of potential informal caregivers, which used to be the first resource in the case of need (Kadushin, 2004). Having a partner (Geerlings, Pot, Twisk, & Deeg, 2005) and/or adult children (Van Houtven & Norton, 2004) reduces the probability of receiving professional nursing assistance. In this line, older adults without relatives tend to make use of care services more often (Kalwij, Pasini, & Wu, 2014; Rogero-García, Prieto-Flores, & Rosenberg, 2008), to co-reside with others negatively affects receiving formal care (Rodríguez, 2014) and the adult children living near older parents are more willing to assume caregiving tasks (Charles & Sevak, 2005).

Most research so far have explored the influence of the family context in care utilisation inferring social relations from the existence of significant others, such as partners, adult children, friends, etc. (Litwin, Stoeckel, Roll, Shiovitz-Ezra, & Kotte, 2013). Nonetheless, some findings pointed out that having relatives or co-residing with them does not guarantee *per se* the provision of care, but the type and quality of family ties are the factors which mostly condition such supply (Hjälm, 2012; Melchiorre et al., 2013; Mentzakis, McNamee, & Ryan, 2009). Research considering the characteristics of the interpersonal relations of older people confirmed that the size of the social network and the residential proximity of its members are associated with an increased use of informal care (Rodríguez, Recover, & Ballesta, 2017).

Against this background, this study sets a two-fold objective. Firstly, to explore the association between the characteristics of older people’s social networks and the use of three types of home care; informal, formal and combined. Meanwhile most researches are focussed on informal care, the association between social networks and the use of formal care remains practically unexplored, even more referred to both types combined (Rodríguez et al., 2017). Secondly, the study aims to examine the extent such associations diverge or converge among regions of continental Europe, given the cultural differences affecting family and social relations across the continent. The result of this study contributes to expand our understanding of how the characteristics of the social network benefits or restricts home care use by older people.

**The role of social networks in home care**

Social networks are a system of human interrelations based on affective bonds through which goods and services are altruistically exchanged (Antonucci & Akiyama, 1987). Supportive behaviours perfectly exemplify the exchange of ‘goods and services’ established among confidants, which could materialise in diverse ways: *emotional* (empathy, love, trust, etc.), *instrumental* (tangible aid and services, including financial help), *informational (*advice, information, and suggestions to solve problems), and *appraisal* (constructive feedback and decision-making assistance; Barrera, 1986; House, 1981). Despite the variety of classifications, the frontiers between different types of supportive behaviours are diffuse and difficult to operationalise for empirical purposes (Heaney & Israel, 2008).

Generally, studies approaching the influence of social relations in caring conceptualise *care* as a functional behaviour. The provision of care refers to individual and social practices aimed at restoring, maintaining, or improving individuals’ wellbeing and quality of life; often by helping with daily tasks, such as bathing, dressing, eating, shopping, etc. In fewer cases, care is also considered an informational activity, for instance helping with paperwork (Berkman & Glass, 2000).

There are solid evidences that the characteristics of the social networks; composition, size, geographical proximity, frequency of contacts, density, and quality, are particularly related with the use of informal care in old age (Jacobs, Broese van Groenou, Aartsen, & Deeg, 2018). On the one hand, larger social networks benefit the receipt of informal support by increasing the availability of potential informal caregivers (Rodríguez et al., 2017). On the other hand, having confidants living in the immediate vicinity is a strong determinant of receiving informal care when they are the partner and/or adult children, but not in the case of other relatives, neighbours, or friends (Jacobs et al., 2018). Also, regular contact with close network members is advantageous for receiving informal care, especially for single parents receiving support from their adult children (Nepomnyaschy, 2007).

## European care models

Macro-level conditions are sometimes even more determining than the existence of relatives regarding to the availability and accessibility of home care (Albertini, Kohli, & Vogel, 2007; Brandt, Haberkern, & Szydlik, 2009; Motel-Klingebiel, Tesch-Roemer, & von Kondratowitz, 2005; Solé-Auró & Crimmins, 2006). In Europe, there is a broad cross-national variability in the features defining long-term care (LTC) systems: type of LTC policies, eligibility criteria, variety of care providers (public, non-profit, private for-profit, mixed, etc.), range of services, etc. (Genet et al., 2011). This, together with the diversity of norms and values guiding social relations, results in a heterogeneous map of structural factors influencing the care opportunities for older people.

Attempts to categorise the European care models have resulted in manifold cross-country typologies. Some are exclusively based on the divergences and convergences among national LTC systems: type of financing, organisation of services, (de)centralisation level of legislation, implementation level, etc. (Da Roit & Le Bihan, 2010; Da Roit, Le Bihan, & Österle, 2007; Kraus, Czypionka, Riedel, Mot, & Willemé, 2011).

Other classifications based on the cultural norms and values guiding the exchange of support sort the European care models according to a northwest-southeast gradient of normative solidarity. Filial obligations are more embedded in family expectations in southern and eastern European countries, while more developed welfare states in northern and western Europe moderate the demanding character of family obligations, especially regarding support of older people, enhancing individualistic social norms (Daatland, Herlofson, & Lima, 2011). Bettio and Plantenga (2004), and later Pommer, Woittiez, and Stevens (2007), proposed a classification that identifies three macro-regions of European care models: 1) the *Scandinavian model*, characterised by public LTC systems that are often universal and more comprehensive aid services, despite the paid-for services play also an important role, 2) the *Continental model*, in which the nuclear family is the main resource for older persons in need and 3) the *Mediterranean model*, in which the extended family (including relatives outside the nuclear family) fulfil the role of main caregiver. Until very recently, eastern European countries remained systematically excluded from these typologies due to the lack of available data (Genet et al., 2011).

**Hypotheses**

Based on the existing literature, our first hypothesis is that the availability and accessibility of members of a social network whom older people regard as confidants are associated with the use of informal care, but also with the use of formal care, or the combination of informal and formal care. Our second hypothesis is that the different care models in Europe make that the influence that the characteristics of the social network have on the use of home care varies depending on the region.

**METHODS**

data. Our study communities were purposively sampled by staff of

Medicare Locals who acted as the overall sponsors of the project.

Each of the six communities (three in each state), in remote or rural

areas, had morbidity data showing high incidence of poor dental/oral

health, varying accessibility to dental/oral health services, varying

population size and population diversity. They were all communities

of place (Wilkinson, 1991) and all had local and/or visiting oral health

services.

We deployed a case study design using qualitative and quantitative

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population size and population diversity. They were all communities

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services.

**Survey**

The database for this analysis is the *Survey of Health, Ageing and Retirement in Europe* (SHARE), which is a cross-national panel survey started in 2002 (a new wave is published approximately every two years) that collects individual and household information about health, socioeconomic status, and the social and family context of older people in continental Europe (Malter & Börsch-Supan, 2017). The Munich Center for the Economics of Aging (MEA) of the Max Planck Institute for Social Law and Social Policy coordinates and manages the study, while the statistical services and research institutes of each country administer the survey questionnaire. Data collection is conducted using face-to-face structured interviews at the respondents’ home with the Computer-Assisted Personal Interviewing (CAPI) instrument.

From Wave 4 onwards, ethical approval for SHARE was reviewed and approved by the Ethics Council of the Max Planck Society and the respective country ethics committees or institutional review boards whenever required (see [overview and summary of the ethics approvals](http://www.share-project.org/fileadmin/pdf_documentation/SHARE_ethics_approvals.pdf)for more information).

The present study uses the cross-sectional data from Wave 6 (fieldwork finished in November 2015), which contains a special module about the social networks of older people.

**Sample**

The target population of SHARE is people aged 50 years and over during sampling, who have their regular domicile in the respective SHARE country. People who were imprisoned, hospitalised, or out of the country during the survey period are excluded. Each country team selects a representative probability-based sample according to sampling design guidelines approved by MEA. The recruitment of participants is based on national registers and population censuses, by country. All participating countries, except Luxemburg, reached the 30% minimum individual-level response rate demanded for the baseline and refreshment samples in Wave 6 (for details of Wave 6, see Malter & Börsch-Supan, 2017).

In Wave 6, eligible persons were born in 1964 or earlier, living in Austria, Belgium, Croatia, Czech Republic, Denmark, Estonia, France, Germany, Greece, Italy, Israel, Luxembourg, Poland, Portugal, Spain, Sweden, Switzerland, and Slovenia. To conduct the analysis, from a sample of 68,231 respondents, a subsample of individuals aged 65 and over with at least one person in their social network (*N* = 37,708 individuals) was selected. The age criterion utilised to establish our target population is based on the threshold over which individuals start to receive home care more regularly, around age 65 (Vlachantoni, Shaw, Evandrou, & Falkingham, 2015).

***The use of home care***

*Home care* is operationalised using three items included in the SHARE questionnaire in Wave 6, which ask whether the respondent has received formal and/or informal care (from outside/inside the household) in the previous 12 months (Table 1). *Formal care* refers to professional or paid services for personal care (e.g. getting in and out of bed, dressing, and bathing/showering), help with domestic tasks (e.g. cleaning, ironing, and cooking), meals-on-wheels (i.e. ready-made meals provided by a municipality or private provider), or help with other activities (e.g. filling a drug dispenser). *Informal care* from outside the household refers to personal help (dressing, bathing/showering, eating, getting in or out of bed, and using the toilet), practical help (home repairs, gardening, transportation, shopping, and household chores), or help with paperwork (filling out forms and settling financial or legal matters). Informal care from inside the household only refers to help with activities of daily living (ADLs). In this case, other types of tasks (domestic chores or paperwork) are considered part of the shared daily life among co-residents. The information registered by SHARE related to the formal and informal support received by older adults primarily refers to instrumental care and informational support for informal care. This should be considered in the interpretation of the results.

<< INSERT TABLE 1 HERE >>

***Characteristics of the social network***

The SHARE questionnaire collects information about social networks following a direct approach, which states that social ties, as a subjective phenomenon, function primarily when they are considered significant by the individual (Litwin et al., 2013). The social networks are not inferred from the existence of significant ones in the network (e.g. partner, children, friends, etc); they are identified by the respondent as the most relevant persons. The reliability and validity of this measurement was previously confirmed by other surveys, such as the US National Social life, Health and Ageing Project (Cornwell, Schumm, Laumann, & Graber, 2009).

SHARE implements an ‘ego-centred’ model to capture the elderly individuals’ social network. Responding to the question “*Looking back over the last 12 months, who are the people with whom you most often discussed important things?”,* the respondent is invited to identify people with whom they interact the most and in whom they have a degree of confidence (up to seven persons). Possible answers include spouse/partner, mother, father, mother-in-law, father-in-law, stepmother, stepfather, brother, sister, child (1 to 9), other child, son-in-law, daughter-in-law, grandchild, grandparent, aunt, uncle, niece, nephew, other relative, friend, ex-colleague, neighbour, other acquaintance, therapist or other professional helper, and housekeeper/home healthcare provider. In addition, SHARE registers information about the characteristics of these persons: gender, age, residential proximity, contact frequency, social network size, and overall satisfaction with the social network.

**Analytic strategy**

Binomial logistic regression models are used to explore the potential of social networks as a predictor of home care use by older people. This technique allows modelling the association between an observed dependent variable and a set of variables by a function based on a nonlinear probability distribution (Menard, 2002). It is expected that the small size of the sample in some reference categories of the dependent variable could affect the statistical significance of the results (King & Zeng, 2001; Nemes, Jonasson, Genell, & Steineck, 2009). This applies for using formal care in northern (4%), southern (5%), and eastern countries (1%). To minimise the small-size effects, the association of social networks with using formal care in these regions has been explored using a Firth logistic regression (1993), which reduces bias in maximum likelihood estimates of coefficients.

The models were conducted separately for each type of care and region in continental Europe, adopting the cross-regional typology elaborated by previous studies analysing European care regimes using SHARE data (Brenna & Di Novi, 2016; Crespo & Mira, 2014). This establishes three ‘macro-regions’: northern Europe (Sweden and Denmark, *N* = 4,595 respondents), western Europe (France, Germany, Austria, Belgium, Switzerland, and Luxembourg; *N* = 12,018 respondents), and southern Europe (Italy, Spain, Portugal, and Greece; *N*= 10,268 respondents). The present study adds a fourth cluster grouping the eastern European countries (Poland, Czech Republic, Slovenia, Estonia, and Croatia; *N* = 10,817 respondents). The addition of this group (eastern Europe) adds to the unique contribution of the paper; however, 30% of the respondents in this group came from Estonia, and another 30% from the Czech Republic.

To allow the comparability of results, the models were estimated with sampling weights that corrected for nonresponse and sample design. Standard errors were adjusted for clustering at the household and individual level using Stata’s (version 15.0) SVY command. The evaluation of the goodness-of-fit for the logistic regression models was conducted by interpreting the value of the statistic pseudo *R*².

Unobserved heterogeneity, which refers to the variation in the dependent variable caused by other unobserved variables, is especially problematic when comparing distinct logistic regression models due to possible variation across groups and samples. As a strategy dealing with this challenge, we use average marginal effects to calculate the coefficients in the models (Mood, 2010). These summarise how the change in the dependent variable relates to the change in a covariate and could be read in terms of the probability of change.

**Dependent variable**

From the information related to care use registered in SHARE, three binary dependent variables are constructed (response categories yes/no); *informal* care (individuals exclusively use personal/practical care from their social networks), *formal care* (individuals exclusively use personal/practical care from professional or paid services), and *combined care* (individuals receive support from both previous sources).

### Predictors

The covariates are sorted into three clusters of micro-level determinants according to the A-N behavioural model (Andersen, 1995; Andersen & Newman, 1973)

* *Predisposing characteristics,* which influence the willingness to use home care: age group, gender, and members of the social network (partner, adult child(ren), other relatives, and friends)
* *Enabling resources,* which facilitate or impede access to care (family and community resources): network size (up to two members: below-average social network size of older Europeans / more than two members: above-average size), geographical proximity (nearest social network member lives in the same household/ within 1-5 km radius), contact frequency (daily contact in person, phone, mail, email, or other electronic means with at least one social network member), and overall satisfaction with the social network (continuous variable ranging from 0 (not satisfied) to 10 (very satisfied)). The models also controlled for household income calculated in quartiles.
* *Need factors* associated with the objective and subjective evaluation of health-related conditions: self-perceived health status (very good or good health/less than good health), ADL limitations; bathing/showering, dressing, self-feeding, functional mobility, personal hygiene/grooming, and toilet hygiene) (low level 1–3 limitations / high level 4-6 limitations), IADL limitations; housework, taking medications as prescribed, managing money, grocery or clothing shopping, using the telephone or other communication, using technology, and transportation within the community) (low level 1–3 limitations / high level 4-6 limitations). Hospitalisation in the previous 12 months.

<<< INSERT TABLE 2 ABOUT HERE >>

(The supporting material contains the detailed sample distribution by region: Tables 7, 8, 9, & 10)

**RESULTS**

The statistical associations of the predictors were examined using chi-square tests, primarily showing significant correlation for each regional model (Table 2).

## Social networks and the use of informal care

The results showed a cross-national pattern of having one’s partner as the first call for informal care (Table 3). This is especially visible in northern European countries, where having a partner in the social network increases the probability of using informal care by 17%. Having adult children in the network of confidants slightly increases the probability of using informal home care in southern countries. In eastern countries, having other relatives and friends in the social network increases using informal care by 6%.

The size of the network of confidants also showed a significant association. Having a larger social network (> two members) is positively associated with using informal care in all regions, increasing the probability of receiving such care by 8% in northern and eastern countries, by 12% in southern countries, and by 13% in western countries. The geographical proximity is also associated with using informal care. In the case of northern countries, having confidants living within 5 km decreased the probability of receiving exclusively informal care, while in the rest of the regions, co-residing with a member of the social network increased the probability of receiving informal care.

Looking at the other predictors, females are less prone to exclusively receive informal care in northern, western, and southern countries. A negative association between poor health status and receiving informal care is observed. As age increases, the probability of receiving exclusively informal care decreases. Furthermore, the report of difficulties with daily tasks is also negatively associated with receiving informal home care. As IADL limitations become more severe, the probability of receiving informal care in all regions decreases.

**Social networks and the use of formal care**

Alternatively, having a partner as a confidant is negatively associated with using formal care in all regions (Table 4). A larger social network of confidants is positively correlated with using such care in western and eastern continental Europe, increasing the probability of using exclusively formal care by 3% and 8%, respectively. Geographical proximity, with members of the confidants’ network living within 1-5 km, showed a positive association in northern countries and the same was true for daily contact in eastern countries. The probability of receiving formal care at home increases with age in southern and eastern countries. As expected, experiencing IADL limitations increases the probability of using formal home care everywhere, especially in northern European countries.

**Social networks and the use of combined care**

The social networks of confidants also showed some predictive potential when the support received combined informal and formal home care (Table 5). The predisposing characteristics related to social networks (i.e. social network composition) present a significant association in western, southern, and eastern European countries, where having a partner decreases the probability of receiving both types of care. However, this was not the case in northern countries.

Enabling factors related to social networks present associations with using combined care in northern, western, and southern countries. In western European countries, the size of the confidant network is the most important predictor. Having more than two confidants increases the probability of receiving combined home support, while co-residing decreases the probability by 5%. Geographical proximity is the most relevant predictor in southern European countries; co-residing with confidants decreases the probability of receiving this type of care by 5%, while living within 1‑5 km decreases the probability by 3%. In northern Europe, maintaining daily contact and a high level of satisfaction with the confidant network has the same effect by decreasing the likelihood of using a combination of support types.

Observing the other predictors, age is a key factor for receiving a combined form of home care in all regions. As individuals age, the probability of receiving combined home care increases. The predictors regarding need factors present similar associations in all regions. Having IADL or ADL limitations is associated with using a combination of formal and informal care. In northern, western, and southern countries, experiencing a higher level of IADL limitations increases the probability of receiving combined care.

<< TABLE 3, 4 & 5 ABOUT HERE >>>

## Discussion

The aim of this research was to examine the role of social networks as a predictor of home care utilisation by older people, considering three types of support: informal, formal, and combined, while examining the degree of convergence and divergence among regions in continental Europe.

The results related to the use of informal home care are consistent with previous literature (Rodríguez et al., 2017), showing that the characteristics of social networks are strongly associated to the use of informal home care by older Europeans. In turn, and confirming our first hypothesis, the results of this study also evidenced that social networks are correlated with the use of formal care, although showing less potential in predicting such use. In this sense, having a partner, which is negatively associated with using formal/combined care in all regions, emerged as the most relevant factor. In line with other studies (Larsson, Thorslund, & Kåreholt, 2006; Rogero-García et al., 2008), the existence of close confidants, especially a partner, reduce the probability of receiving professional assistance, which could indicate a level of substitutability in the relationship between informal and formal caregivers.

Our second hypothesis stated that the different care models in continental Europe make expectable that the association between the characteristics of the social network and the use of each type of care varies among regions. This was only partially confirmed, mostly for formal and combined care. Our findings revealed relative similarity in the factors related to the use of informal care across continental Europe. In particular, characteristics pertaining to three dimensions: the structure of social ties (i.e. kin relationships), the availability of confidants (i.e. larger social network), and accessibility to confidants (i.e. geographical proximity), come out as the major predictors of informal home care everywhere. Nonetheless, how these dimensions play out in each region diverges according to the northwest-southeast gradient of familism (Daatland et al., 2011), which determines the cultural construction of social relations; i.e. who is considered as family member, living arrangements, patterns of contact, etc. As result, in northern and western countries, only having a partner increases the probability of receiving informal care, while the same is true in the southern region with other members of the nuclear family besides the partner (i.e., adult children), and in eastern countries with the members of the extended family. The same occurs with geographical proximity, which is positively associated with using informal care in all regions, but conditioned by the household patterns in each cluster of countries. In western, southern, and eastern countries, especially the latter two where the proportion of multigenerational households is higher (Hank, 2007), co-residing in the same dwelling or building with a member of the social network predicts the use of informal care. In the case of northern European countries, this association is found when there is at least one member of the social network living within 1‑5 km. Moreover, these findings substantiate the relevance of the availability of social networks for providing informal home care. As the number of confidants of the older adult increases, the probability of receiving help from this network is augmented in all regions, especially in western and southern European countries.

Regarding to the use of formal care, having only one’s partner in the social network appears to prevent using this type of care in all regions. The rest of factors significantly diverge. Two reasons could explain this variety of associations. First, the interrelation between social networks and using formal care could be largely determined by structural conditions (i.e. LTC policies, eligibility criteria, variety of care providers, etc.) compared to informal care. Second, the data source has a limited sample of older adults exclusively using formal care, which affects the robustness of the results.

The results should be interpreted considering the following limitations. First, as it was mentioned in the introduction, the existence of confidants does not guarantee that they provide informal care to older people. To some extent, this caveat can be mediated for spousal relationships and by the strong results indicating the receipt of informal support when a spouse is co-residing with the older respondent. Second, it would be useful to analyse a larger sample of older people using formal care to perform a more detailed analysis. Finally, the associations shown do not imply causality, given the cross-sectional nature of the data. In some cases, such as for daily contact, the association could be interpreted as a “reverse effect” (i.e. more frequent contact is not the cause but a consequence of care use).

The findings have important implications for policy design in home care use by older people. First, the association between having members of the family as confidants and informal care use in European regions indicates the need to maintain and strengthen support for informal carers throughout the continent. Such support can include cash benefits, respite care for informal carers, a combination, or carers’ credits, which many European pension systems have already introduced (Möhring, 2017). In northern and western Europe, increased daily contact with confidants and higher satisfaction with the social network are associated with a lower likelihood of using formal or combined care, which is evidence of the substitutability of formal and informal care with the aim of addressing the in-home needs of older people (Mentzakis et al., 2009). This finding has implications for future practice in home care use to promote greater interaction and collaboration between older people’s informal social networks and formal care providers involved in supporting older people. For future research, against the context of the expected increase in care demand (Pickard et al., 2007), a more detailed understanding of the balance between informal and formal care within the combined category (e.g. predominantly informal or formal) would help further examine how configurations of care use are associated with older people’s networks of confidants.

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Supporting Material:

Table 7. Descriptives of Northern European countries sample

Table 8. Descriptives of Western European countries sample

Table 9. Descriptives of Southern European countries sample

Table 10. Descriptives of Eastern European countries sample