


Article

Sustainable Care in a Familialist Regime: Coping with Elderly Care in Slovenia

Maša Filipovič Hrast ^{1,*} , Valentina Hlebec ^{1,2} and Tatjana Rakar ¹

¹ Faculty of Social Sciences, University of Ljubljana, 1000 Ljubljana, Slovenia; valentina.hlebec@fdv.uni-lj.si (V.H.); tatjana.rakar@fdv.uni-lj.si (T.R.)

² Faculty of Health Sciences, University of Ljubljana, 1000 Ljubljana, Slovenia

* Correspondence: masa.filipovic@fdv.uni-lj.si

Received: 15 September 2020; Accepted: 12 October 2020; Published: 15 October 2020



Abstract: In countries with prevalent family care and less developed care services, it is important to understand the ways families cope with the care needs of their frail family members as part of policy learning to make care systems more sustainable. Filial care is a vital element of family care, yet is significantly restrained by the involvement of carers in the labour market; unequal gender distribution of the care burden; and insufficient recognition of, and policy support, for family care. This article considered the issue of the sustainability of elderly care in a familialist country, Slovenia, by identifying the coping strategies families adopt for the provision of care. To this end, in-depth qualitative data based on a purposeful sample of 55 community-resident users of social home care services and their 55 family carers were used. We identified five external coping strategies: use of formal care services, use of extended family network, use of wider community network, cohabitation, and home adjustments. Among internal strategies, we detected work-related adjustments; abandoning leisure activities; abandoning vacations; establishing new routines; accepting and finding satisfaction in care; increased psychological distress, such as worries and overburdening; and some unmet care recipient needs. Very few strategies may be described as supported by policy actions, despite such support being essential for increasing the sustainability of the family-based care model.

Keywords: care system; familialism; Slovenia; coping strategies; carers; care users

1. Introduction

Caregiving by spouses to partners or adult children to older parents is a crucial important care issue since the family remains the key provider of care for the elderly across Europe [1–3]. Significant differences are visible among countries in the roles held by formal services and the family in providing care for the elderly. Similar variability is also observed regarding the extent of public financing of long-term care services/systems among European countries. The costs of long-term care are highest in northern and western European countries and significantly lower elsewhere in Europe (ranging from 2.7% of GDP in Sweden to 0.2% in Hungary [4]). These differences are discussed in the literature according to different care regime typologies [1,5–8]. We can broadly distinguish two broad categories, i.e., defamilialism, where the family's care obligations are reduced/replaced by either the market or the state, and familialism, where the family is the main provider of care and receives some or little support for that. The most defamilialised countries are in northern Europe, while Mediterranean and central-eastern European countries are the most familialised.

Therefore, how families cope with care needs and are supported in this by policies is vital for the sustainability of care policies generally, but in familialist regimes in particular, which are the focus of this article. While in one variety of familialism, the role of the family in providing care is unsupported

(mainly Central and Eastern European (CEE) countries), in another it is supported by policy measures (e.g., Austria), as described in different typologies of familism by Saraceno, Keck [1,5] and Leitner [8]

Slovenia is a country that offers little formal support for older people ageing in the community. The country's elderly care model may be characterised as implicit familism [9–11]. The Slovenian care model is, on one hand, based on a long tradition of institutional care intended to support people with severe disabilities and care needs. Such institutional care provides facilities for up to 4%–5% of the population aged 65 and above. On the other hand, family care is assumed and prescribed by a legal obligation to financially support the costs of care. This deeply woven expectation that families take care of their members originates from the socialist era, and before 1992 was accompanied by the grey and unregulated provision of services to fill the institutional care–family care gap. Formal services for dependent people residing in the community began to develop after 1992, mostly in the form of social home care. However, the provision is limited to 4 h a day and its financing is divided between the resident municipality (up to 50%) and the private out-of-pocket contribution of users or their family members [12] (p. 32). Social home care, which is only provided to about 1.7% people aged 65 plus [12] (p. 80), has slowly and hesitantly developed, and is hardly cost-effective for end users. The only other measure for supporting a family carer providing care to an adult family member is up to 14 days' sick leave if the family member resides in the same household as the dependent person.

Like elsewhere, in Slovenia the familist care model faces several sustainability challenges. The work–life balance perspective of meeting working carers' needs is becoming a critical issue in European welfare states. Still, most attention is given to working parents, while public policies have rarely considered working and holding responsibilities for caring for older relatives as a conciliation issue [13]. Given rapid population ageing, the concurrent growth of care needs, increase in women's labour market participation, and rises in the retirement age, the numbers of workers with caregiving responsibilities will rise considerably in the near future, becoming a critical issue of the sustainability of all care regime types, especially familist ones. The burden put on family carers is ever more recognised, as seen in the emphasis on “replacement care” to support work and care in some countries, e.g., in England [14].

Moreover, gender issues related to care for older people have received significant attention in the literature and gender differences are particularly pronounced in filial care [15–17]. Gender inequalities are a salient issue in familist regimes, as both legal obligations and public support for the caring role of the family encourage support in a gender-specific way (see [18]).

Further pressure on care systems' sustainability arises from economic circumstances and consequent austerity measures in many countries. The trend of defamilialisation has been halted, with some countries seeing a trend towards refamilialisation, e.g., via subsidies of domestic care or enabling individual choice [19,20]. The increasing care needs and tighter budgetary constraints are being managed in numerous ways, ranging from a bigger involvement of migrant workers [20–23] to withdrawal of the state and strengthening the role of the market. Such changes are encouraged, for instance, by cash-for-care schemes, the emergence of semi-formal forms of care work enabled by the possibility of paying a relative for care, privatisation, as well as deinstitutionalisation trends [10,20,21,24–26].

Hence, the sustainability of care in familist care models encounters several challenges that must be addressed by policymakers. As Verbakel [27] discussed regarding the policy implications for reducing the expected growing pressure on family carers, the rising cost of formal long-term care brought by demographic pressures is neither sustainable nor affordable for future welfare states. This study's results also showed that services for informal caregivers did not ease the negative well-being consequences they experienced. Therefore, our study aimed to add to what is known about the needs of older people and their carers to determine which types of services and policies help caregivers to cope and perform care in order to achieve and maintain a sustainable care system. We analysed how carers cope with care in the familist care regime of Slovenia. Identifying the coping

strategies used assists in properly understanding the care system's needs and informs policymaking to achieve a sustainable care system from the user's perspective.

2. Coping Strategies: Related Literature

Coping strategies are approaches people often rely on in the face of adversities to help manage challenging life events while maintaining their emotional and psychological well-being. They refer to the notion of coping developed by psychologists in the 1970s, specifically introduced and developed by Lazarus [28], to explain how individuals confront stressful events in various ways. Coping was defined as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” [29] (p. 141). The notion of coping soon spilled over to other disciplines and acquired a broader meaning to denote different actions and ways of behaviour that help people improve the way they function in a particular situation (see [30]). It is therefore a useful tool in the analysis of care and identification of the strategies policies should support or address so as to increase the sustainability of care and support family carers in familialist care regimes.

Caregivers' coping resources comprise a dynamic and complex set of cognitive, emotional, and behavioural responses aimed at regulating their emotions, solving their problems and maintaining their psychological resistance and strength to stay engaged in caregiving [31]. For example, Monroe et al. [32] distinguished internal, external, and government-supported coping strategies. Internally directed strategies are things people do themselves, within their own lives or households without relying on other people, to cope with the challenge. Externally directed strategies are strategies people adopt, outside of their own internal, psychological, or physical resources, to cope with the challenge. In contrast, government-supported strategies refer to public programmes that people turn to cope with the challenge, emphasising the need for government policies to ensure caregiving is sustainable.

Pratt et al. [33] distinguished internal coping strategies (confidence in problem-solving, reframing the problem and passivity) from external coping strategies (spiritual support and extended family). On the individual level, Sun et al. [34] identified two coping styles: deliberate coping and avoidance coping. Deliberate coping relates to higher life satisfaction scores, while avoidance coping relates to lower life satisfaction scores and higher caregiver-burden scores. Positive coping mechanisms (e.g., information-seeking, taking action) may have positive and even protective effects on health, whereas negative coping mechanisms (e.g., distraction, venting) have adverse effects [35]. Similarly, studies show that active coping leads to caregivers having fewer depression symptoms by solving caregiving problems and reducing caregiving stress (e.g., [36]). On the contrary, avoidant coping styles lead to worse outcomes since they are composed of maladaptive thoughts and actions, like denial or disengagement used to decrease the emotional consequences of stress [37].

The above-mentioned coping strategies concerning care indicate that, while most caregivers undertake caring tasks, capacity to effectively cope with the care varies. Research has revealed important differences among carers in the degree of negative outcomes experienced [38]. Lloyd et al. [39] stated that emotion-focused strategies appear to buffer caregivers from the negative impact of stress, while dysfunctional strategies leave caregivers more vulnerable to it. Kim et al. [40] reported that familism was associated with avoidant coping, resulting in poorer outcomes for the mental and subjective physical health of carers. In addition, several studies have shown that the family's ability to cope with conflicts arising from caregiving responsibilities affect both the quality of care provided and the quality of the caregiver–care receiver relationship [41].

Policy goals should therefore include recognising coping strategies and strengthening positive coping strategies. Policies must be assessed not only by the resources they use or how many services they provide, but also by whether they achieve their objectives (see [42]). Research on family relations and well-being in the caregiving context within multigenerational households showed that care issues are an important issue in family conflicts [43] and that this is insufficiently addressed by public policies.

The deficient attention of policies to issues of care for older people within families is also evident in the current COVID-19 pandemic, where welfare states of Europe have addressed work–life balance issues by introducing measures to assist working parents while schools and preschool facilities are closed. Still, only a few states introduced similar measures and benefits for those caring for older people [44]. This makes it necessary to investigate coping strategies in order to develop sustainable interventions and policies able to promote the well-being of both carers and care receivers.

3. Materials and Methods

3.1. Design, Setting, and Sample

The empirical study was undertaken as part of a larger, international project: J5-8235 Exploring and understanding welfare state determinants of care provision for older people in the community in Slovenia and Austria (1.6.2017–31.5.2020). Face-to-face, semi-structured interviews were conducted in Slovenia with 55 older people receiving care in the community and residing with a spouse and/or their children, or who had children but were living alone in spring and summer 2019. At the same time, interviews were conducted with self-identified primary family carers (spouses, children, children-in-law, or grandchildren). The focus of this study was family caregivers as well as older people receiving care. The interviewees were purposely sampled to ensure a wide representation of characteristics, like different living arrangements, socioeconomic status, and gender of care recipients/caregivers who all received informal and formal care. For illustration of the study flow see the study flowchart (Figure 1).

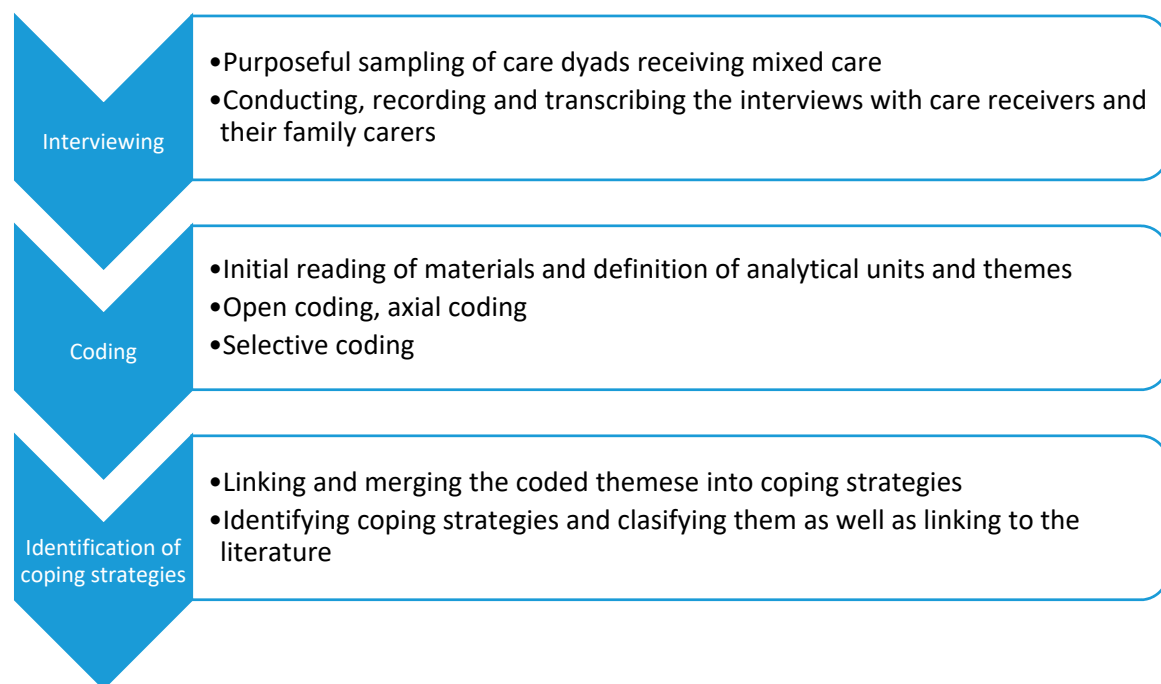


Figure 1. Study flowchart.

3.2. Procedures

The interviewees all received an information sheet about the study; their participation was voluntary and their identification details were deleted to prevent the identification of personal information. They were interviewed separately, at their home, but if requested carers and users were present in the same room during the interview. Approval for the qualitative field work was obtained from the ethical committee at the Faculty of Social Sciences, University of Ljubljana prior to project

starting in 2016 (2016-01/KERFDV). In this study, analysis was undertaken of the Slovenian sample only. All interviews were recorded and transcribed verbatim. We used Nvivo software for the data analysis.

3.3. Data Analysis

The data analysis was carried out using open, axial, and selective coding [45], analysing different themes in the initial stage, and then merging them into separate coping strategies. The themes and codes used to identify the coping strategies in the analysis were: adjustments (life adjustments, leisure, work, home, and routines), family relationships (intergenerational and intragenerational support), life circumstances (place of residence, social network), general needs, unmet needs, experiencing the need for help, caregiving burden, and welfare state (accessibility and availability, policy recommendations). These themes were then merged into separate coping strategies. Based on the theoretical distinction, the identified coping strategies were further classified into external and internal coping strategies.

4. Results

4.1. Coping Strategies of Family Carers in Slovenia

We distinguished in our analysis between coping strategies linked solely to the individual family carer/dyad and coping strategies that were embedded in the wider family and community, roughly following the internal–external strategies distinction already found in the literature (see [32,33]). Building on this distinction, we identified five external strategies and seven internal strategies in qualitative data provided by adult children providing care to dependent parents (see Table 1). The large majority of these strategies were neither government supported nor addressed. Only formal care services are provided by the public sector, and thus represent a government-supported strategy. The issue of the strategy of accepting care may be labelled partly supported due to government-supported programmes that, while enabling the education and training of family carers and also aimed at improving the quality of life of family carers, are severely underdeveloped.

Table 1. Individual and external coping strategies.

	Government-Supported/-Addressed Strategy	Active/Passive Strategy
External coping strategies		
using formal care services	yes	active
use of the extended family network	no	active
use of a wider social network	no	active
cohabitation strategy	no	active
home adjustments	no	active
Internal coping strategies		
work-related adjustments	partly	active
abandoning leisure activities, routines	no	passive
abandoning vacations	no	passive
keeping and establishing new routines	no	active
accepting and finding satisfaction in care	partly	active
worries and overburdening linked to care	no	active
some needs remain unmet	no	passive

We also differentiated passive from active strategies, labelling passive strategies as those linked with the abandoning of tasks and routines, and active strategies as all those that mean new behaviour, new routines, finding new resources (for a passive–active distinction, also see [46]). The next section presents all of the identified strategies and briefly discusses their shortcomings described by the interviewees.

4.1.1. External Coping Strategies

Within external coping strategies, we detected five distinct strategies, namely: use of formal care services, use of extended family network, use of wider social network, home adjustments, and cohabitation. All of these strategies were active and directed at finding additional (social, psychological, or other) resources to better enable the care.

The first coping strategy was meeting the need by using formal care services, most commonly the introduction of social home care, although other formal services available in the market were also used, albeit not extensively (e.g., I16, a female CG, stated: “Well, when she was in hospital, and later in xx in rehabilitation, I called everywhere, searched the Internet for all options. And started making preparations.”) Formal services can be used either at the beginning of care needs or at some later stage as care needs grow. In addition, this strategy was actively used as if a dyad since, even though it was mainly organised by the carer, it was something the care receiver needed to agree to, and in some cases, and they initiated it themselves. Applying the classification of Monroe et al. [32], this was the only strategy that is clearly government supported, as the public network provides social home care services in Slovenia.

This situation has lasted already a couple of years. And I started feeling tired. This is why I found help. A doctor gave me advice on using social home help, as I did not know this existed. And I called them up, where they organise this and they helped me. But there is not enough help, as much as one would need (I55, CG, female)

However, the interviewees noted that this strategy also has some shortcomings embedded in the nature and organisation of the service in Slovenia. The interviewees described the issue of the availability of such services, especially when not received at the time needs arise and also not enough hours of care being received.

I called the Centre for Social Home Help and they said ‘No way’ that they could come and help for an hour (. . .). And then we waited. This was at the end of summer and we waited until March of the next year. (I14, female)

They also reported several limitations of social home help in Slovenia, whereby certain tasks cannot be delivered by formal carers, like tasks labelled as being of a more medical nature and should thus be provided by another service, such as a community nurse. An example of a situation was given where social home help was available for dressing the person, yet the family carer needed to be there at the same time because some of the medical tasks (bandaging legs) may not be performed by social home care workers.

Another thing that is very inconvenient is that they do not do the bandaging of the legs. At the start, they did that. But then it was said that it is too medical and they do not do that. This is most unpractical since you have to be present at the exact time they dress her, to bandage the legs. There is no solution here. You have to be at home. (I16, CG, female)

Another complaint of the interviewees was the time certain tasks were carried out, which sometimes was not the most convenient time for the users, e.g., putting the user to bed at an early hour when formal carers were available even though the user would prefer to go later.

Only that the hours would change. Not at 7 am, but at 8 in the morning. Only this, nothing else. (I18, CR, female)

Other issues mentioned were the problem of the constant changing of a larger number of formal carers, and the issue of new carers who perform the tasks less well and rush more.

The difference is that on the weekends those carers come, who do not know exactly . . . This transition is not ok. Sometimes the new people come and grandma is very angry since they do not know how to handle her. And they come earlier and are in a hurry, as they have more users. (I5, CG, male)

The second coping strategy very commonly found among the interviewees was use of the extended family network. Here, the most important factor is support of the main family carer by their partner, and then also by their children (i.e., grandchildren of the older person). The latter provided mainly secondary support in case of the absence of the (primary) caregiver, but also occasionally appeared as very active and continuous caregivers and therefore made up an important part of an extended family network of care.

Well, I have a large family and we have divided this a little. So, it isn't just me. Not only one person. We are 5, 6 carers in the game, so it is all divided. (I59, CG, female)

The support of the extended family network is often somewhat limited due to other obligations, other caring obligations, work, or distance.

Yes, the daughter lives in (city in another country). (. . .). And the son lives in (city in the country). But he is so busy, so that under no circumstances could he . . . well, if I need something yes. But to be a large help, then no. (LP1, CG)

Use of the extended family network sometimes enables respite and vacation time for the primary carer, but also has negative consequences such as that shared caring responsibilities in some cases means also not sharing holidays, going places together, and similar, to ensure care is continuous, as the quote below illustrates.

We have to go separately, I went on a trip that I would have preferred to take together, if it were possible. (LP31, female)

The third coping strategy, which, was only rarely mentioned and saw relatively limited use, was the use of a wider social network, i.e., mainly neighbours or friends. Neighbours of the care receiver mainly functioned as support for the carer, providing some sort of respite (in the hours they visited) or small aid, or providing control in times of absence.

It is like that, I have a good neighbour. She has sometimes looked over my father, when we had to go to the doctor. And another neighbour is here across, who I can call upon. (Lp4, CG)

Cohabitation strategy is positioned among the external strategies since it entails the move of the entire family due to the care receiver's needs or the absence of the move of a family already cohabiting (due to anticipation of the care needs). Cohabitation in Slovenia is quite a common living arrangement and CEE countries characteristically have more multigenerational households than in western or northern Europe [47]. It is often something that precedes care needs and therefore relates more to opportunities for care arising from proximity (see [48,49]), but as a coping strategy we refer only to decisions made due to (anticipated) care needs.

When I lived in (a bigger city), I came every week. I had an apartment in a house. When my mother become immobile, I said they should come to leave on the ground floor and I would move in on the upper floor. But they didn't want to hear about that. So I moved with my son here, to be available to them. (I28, CG)

The move can be the result of the burden of care on two separate households, as shown below:

In 2014, I moved here because I was too tired with that every day. You cannot have one woman and a house and an apartment . . . managing two households was too much. We decided that I should come here. I slept over a few nights. And we decided this would not be so bad. And so it came that I stayed here. (Intervju14, CG, female)

The last external coping strategy is home adjustments. Older people and their carers often adjust the older person's home in order to better enable care. These adjustments are usually small scale involving little cost, and include changes in bathrooms (such as chairs and handles for holding), a change of bed, and similar.

You see, we built this ramp so that we can go out with a wheelchair. We made a bathroom without a tub, only tiles on the floor. And we bought a wheel chair, for showering. (I 14, CG, female)

4.1.2. Internal Coping Strategies

We identified as individual, internal coping strategies as those that only relate to the caring dyad and encompass strategies that people use—their activities, behaviour, and mental attitudes that relate to how their life has changed and been adapted to the provision of care.

The first individual strategy related to their inclusion in the labour market and how to balance work and care. Our sample namely targeted sons and daughters providing care, presuming that they were more often (still) included in the labour market than, for example, the spouses of the care receivers. This strategy refers to work-related adjustments that usually encompass adapting one's working schedule to the care (e.g., one interviewee worked nights to be able to care during the day) or relying on their employer's understanding to make their work more flexible and compensating for missed work hours at other times. The only part which is government-supported is currently sick leave for a sick family member, but this only applies to those living in the same household and not to all family members.

Recently, I changed my schedule so that I work from 9 am to 1 pm and come home (. . .) I did this also before, but I worked more hours. Now I have cut my working hours and work from 9 to 1 pm. (I28, CG, female)

Many interviewed caregivers acknowledged the understanding and flexibility of their employers in this respect. However, given that this is not a particular government-supported strategy, it depends purely on the goodwill of employers: "When a situation arises, I ask for those additional hours, if needed. Luckily, I have an understanding boss regarding this, so . . . " (LP16, CG, female).

It seems that people who are unable to make their work more flexible often adjust the care to their work ("I couldn't adjust my job. So, the care is adjusted to the work. It is in the morning at 6 am, and in the evening, when I can", I40, CG, female) or are unable to become primary carers or rely more on formal care provision: "Constant care, which I cannot provide. I cannot leave my job, can I?" (LP2, CG).

Due to being in work, the interviewees also had a problem responding to urgent care needs and, here, either the flexibility of work to respond is important or relying on a wider family network and hence having someone else to respond. Help must be given to carers to address these urgent care needs.

The second individual strategy linked the abandoning of leisure activities, hobbies, or certain routines, reducing and even abandoning socialising with one's friends and family. This is particularly problematic as research has shown that participating in leisure activities importantly reduces the caregiving burden [50].

Well, I simply forgot a bit about my own life. Now, after 2 years, I wonder if that is really expected and demanded from me, that I neglect my personal life, my personal pleasures. Or that I put my children second. Because I first make sure that they (mother and father in law) are taken care of . . . (Intervju11, female)

The problem of this strategy is that it can lead to feelings of being trapped or being all-consumed by the care, as the quote below shows.

What can I say? I am trapped. This is how it is, I cannot go anywhere . . . mostly at home. (LP18, CG, female)

In relation to this need, the carers mentioned that to enable them some leisure time they need additional services such as respite services and supervision, something smaller in scale and flexible, also just half an hour a day, or simply having someone in a short time of absence to be available for sporadic monitoring.

The third individual strategy was abandoning vacations. Due to healthcare needs, the carers often were unable to go on vacations. They were also using vacation time at work to provide various care needs of the care receiver.

To tell you honestly, we haven't been on vacation for 5 years. And if we go somewhere, we need to find a replacement. For example, the mother of my daughter in law died in February and we had to find someone. (LP29, CG, male)

Despite some respite services being available in such cases in Slovenia in the form of temporary living in a nursing home, the interviewees did not often use them, as the following quote illustrates: "I was thinking and discussing . . . with my husband we had already asked around if she could go to a home at vacation time. But it is hard in the homes and I think she wouldn't go" (LP10, female).

In contrast to the above, we also identified the more active coping strategy of establishing new routines or keeping and adapting (not abandoning) existing routines.

Instead of going for a walk in the evening, I came over to them. I have this in me, I know that dad would take care of . . . , but I still come and check the medicines, sometimes they are already in bed, I just say hi, sometimes we put pyjamas on and take care of things. (LP11, CG, female)

Internal individual strategies are those that indicate the individual's attitude to the provision of care. An important strategy here is accepting and finding satisfaction in care. It relates to the caregiver finding satisfaction in providing care, seeing it as something they are good at, yet it also relates to accepting the care need as something normal in life—this is especially important, not only for the caregiver but also from the aspect of the care receiver.

Everything is upside down. Not bad, you know. If you have people around you and you get what you need, it is fine. Best to say thank you and thank god it is like this. (I12, CR, female)

Well, you need to just accept this change . . . I cannot say it was easy. But it is like this, life goes as it goes. And you handle every day as it comes. This is not some high philosophy. (LP22, CG)

A potentially more destructive coping strategy relates to overburdening and worries linked to care, such as dissatisfaction with care due to high expectations and constant concerns about the care receiver and organising life entirely around care. This relates to the important issue of the overburdening of family carers, which has already received significant attention in the literature [50–53] and needs to be better addressed by policymakers because the overburdening of family carers is a threat to the care system's sustainability.

You have to adjust your way of life. Basically, you have to give up everything. (LP31, CG, female)

Sometimes, I cannot find the strength for everything. What bothers me is guilt that I do not do enough. For mum, for my husband, or for the kids. I am always haunted by guilt. (I55, CG, female)

For leisure activities, carers noted that having some additional flexible short-term service, e.g., someone available to perform some kind of supervision, and occasional control that everything is all right, would already decrease these worries. It is interesting to note that the carers did not mention information technology as an option that might be useful in such cases. It is unclear whether this is because they were unfamiliar with or disliked it. In addition, family carers missed additional information, training on what to do in cases of emergency, e.g., an older person throwing up, falling, and similar, as this knowledge would reduce their level of worry.

I sometimes feel I would need professional help, to be educated on how to deal with older people, if they fall, if they vomit . . . in that sense. How to react . . . (I30, CG, female)

The last strategy identified was that some needs remain unmet. Despite the interviewed sample comprising people in receipt of family care as well as formal care, in the interviews we could identify that either carers or care receivers (more often the former) felt that some needs remained unmet. This points to the need to understand the concept of unmet needs in a more complex way, not only through the presence or absence of a formal/informal carer, as is often operationalised in quantitative studies of unmet needs [54,55]. Among mentioned unmet needs, the most pronounced was the need for more socialising of the care receiver.

24 h a day. 24 h a day for me. It is boring, to be like this 24 h a day. I do nothing. (I3, CR, male)

Maybe if someone would come and maybe talk, maybe 1 h maximum. Or play a game xxx, so that she gets distracted. (Lp2, CG)

Further, the additional interviews showed that more innovative care approaches were lacking, e.g., for people with dementia:

If it were possible ... I recently saw on television something on dementia, on how we should work on with people more. Not only this basic, but for example, with music. So that one would work with the person, as if they are living in the time when they remember everything. And play that music. (I56, CG, female)

5. Discussion

Our main results show that in the familialist care regime under study family carers receive little or no support from the government, and thus only one coping strategy was clearly identified as being supported by the government: the provision of social home care services. This is a vital service that enables care at home, yet has several shortcomings as already identified in other research in Slovenia [56,57], such as its relatively high costs despite being subsidised, unequal accessibility among the regions concerning the costs/availability of care (e.g., weekend availability). This was also evident in the interviews, especially the insufficient hours of care and the timing of the care. However, what also surfaced was the inflexibility and limitations of the services provided, where some quite routine tasks were not performed by social home carers, adding significantly to the burden of coordinating care tasks. Therefore, along with the general strengthening of the availability and flexibility of social home care, what is needed is a redefinition of tasks (including necessary tasks that currently only family carers are permitted to do, while social home carers may not).

The next very important coping strategy was use of the extended family network, of course unsurprising in a familialist care system where three generations cohabitating is also more common since both CEE countries and southern European countries have more multigenerational households than in northern or western Europe [47,58]. However, government policies do not recognise this as an important strategy, while cohabitation could provide an important way of easing the burden, while also allowing a high quality of life on the condition that dwellings are appropriately adapted for this purpose. Therefore, home adaptations were another important strategy that enabled better care and a higher quality of life of both the user and caregiver. This holds important implications for housing and care policies that promote ageing in place, yet no measures exist to promote and support housing adaptations for older people in general, and specifically housing adaptations for multigenerational households. Housing design, accessibility, and maintenance are an important part of sustainable housing in old age and are required to support ageing in place [59]. Accordingly, this represents an important venue for improving the sustainability and adaptation of the housing system, as well as the sustainability of the care system.

Use of community networks was a present strategy, but not often mentioned. It seems the role of neighbours in supporting older people with more complex needs is small. Research has also put forward the decreasing role of neighbours in Slovenia as a result of the transition, while older people remain more connected within the community and depend more on neighbourly support than other

age groups [60]. When available, neighbours seem to provide small aid and respite, but they also function as control and aid in the case of emergencies. The relevance of a community network for older people is underscored in the literature [61–65] and its importance was also acknowledged by policymakers on the European level more than a decade ago [66]. The new experience of COVID-19 also indicates the potential of these networks in specific circumstances when services and also more distant family help might become unavailable. Strengthening and promoting such informal networks therefore remains an important challenge for policymakers.

Among the internal strategies, work-related adjustments were vital, and flexibility at work enabled carers to perform their role. Work-related adjustments are common and, despite some reports of employers' understanding, this might also be something that is linked to the particular sample, because such flexibility enabled them to become carers while those without an understanding employer were unable to take on a caring role. Also related to this is the identified extensive use of vacation time for carers, which implies the need for a higher number of vacation days due to being in a caring situation, so as to improve the quality of life of family carers. Work-related strategies must be developed to enable greater leave and also more flexible work, as well as to make employers more sensitive to the caring roles of their employees. Here, a model is present in the existing approaches to the recognition of caring for children, where part-time work and other flexibilities are commonly recognised in Europe, but are still relatively lacking in relation to care for the elderly, particularly in CEE countries. For example, different leave policies or subsidised part-time working arrangements should be applicable to all dependent family members. Alternatively, on the company level, a family-friendly company certificate that considers work and care reconciliation issues, including elderly care, needs a better definition in the legislation to avoid the issue being simply a matter of employers' goodwill.

The fact that several of the internal strategies were linked to abandonment—of either vacation, leisure activities, or hobbies, as well as socialising—reveals the need to develop various flexible respite services. Not only for longer periods, like vacations, which are available in Slovenia albeit to a limited degree as short-term placements in a nursing home, but also flexible short-term respites, either through 24-h care for a short period or also flexible short-term services that offer support as needed. Such services are almost entirely missing in Slovenia.

An important identified strategy was accepting care and finding satisfaction in care, which we may link with what the literature describes as a positive coping style that reduces stress and negative consequences for the caregiver (see [36,37]). Policymakers should work to further strengthen this as it would also reduce the negative coping that was detected, namely, increased worries and being overburdened by care, which was also noted by the interviewees. Support for family carers is vital from the perspective of the system's sustainability, and also warranted from the perspective of economic contribution in the form of the time and work these carers contribute to the welfare system. Since worries were often linked with two aspects, lacking information/knowledge and lacking control in times of absence, specific strategies should address these issues. One important avenue is to use ICT, which seemed to have not been used among the interviewed sample despite some options existing in Slovenia (e.g., an emergency button or other technologies like home telehealth, telecare), yet these options remain barely used [67,68]. Supporting the use of ICT should therefore become an important government strategy.

6. Conclusions

The sustainability of care in a familialist care regime is a relevant issue for family carers and policymakers. The former, for sustaining the quality of life of family carers and dependent family members, and the latter, for better understanding the weak points in care provision and supporting the main way of providing care in society. We explored the care system's sustainability by identifying families' coping strategies on the provision of care. To this end, we used in-depth qualitative data based on a purposeful sample of 55 community-resident users of social home care services and their 55 family carers to identify various internal coping strategies and external coping strategies, i.e., how they

were supported by various resources outside the caring dyad. Our results distinguished internal and external strategies, and also active and passive strategies. We found a large mix of these strategies and the interviewees employed several strategies for coping with care. However, among the strategies identified only a few can be said to receive some government support. This is largely support in terms of the provision of social home care, while support for other strategies is quite modest, such as the provision of respite care, counselling, and training for family carers, or does not exist.

The analysis of coping strategies in Slovenia revealed several points policymakers should address in order to ensure the sustainability of its care system. Still, our research has several limitations. An important one is that the interviewed sample comprised family carers and older people who used the social home care service. This, therefore, preselected family carers already using one important active and government-supported strategy in care. To paint a broader picture of coping strategies in need of policy support to ensure the system's sustainability, we also need to research the coping strategies of family carers who do not rely on the formal care system. However, research in Slovenia indicates the social home care system is used when care needs grow significantly and our sample therefore indicates the coping strategies of carers with a greater care burden. Yet, since we identified many active strategies but little was identified by way of avoidance coping [34], this might also be linked to the selection bias of having more active carers, i.e., carers more likely to adopt various active strategies. Moreover, the general description of the coping strategies also does not account for possible differences in groups of carers who are able and willing to use various strategies. Here, distinctions in income and gender, as well as in age and family situation, are relevant for further study and might indicate inequalities in certain groups' ability to employ different strategies.

Our analysis indicates how coping strategy research is a useful tool for understanding the care system's sustainability from the perspective of users (i.e., carers and older people) and can inform policymaking. The findings are also relevant for other familialist care regimes, however given that coping strategies are defined by culture, norms, family and cohabitation patterns, and policy circumstances, they are also country-specific. For instance, in Slovenia we have found no strategy that would include, for example, migrant carers within households, which is a strategy increasingly seen in certain countries as either part of the formal care sector or informal care strategies (see [23,69]). Moreover, strategies were not identified that rely more on market solutions and various forms of market services since these are not strongly developed, but are presumably found elsewhere. Comparative research is therefore called for to stress these country-specific differences.

Author Contributions: Conceptualization, M.F.H.; methodology, formal analysis, M.F.H.; writing—original draft preparation, M.F.H., T.R., V.H.; writing—review and editing, M.F.H., T.R., V.H.; funding acquisition, V.H. All authors have read and agreed to the published version of the manuscript.

Funding: The research was financially supported by ARRS (Javna Agencija za Raziskovalno Dejavnost RS), grant numbers J5-8235 Exploring and understanding welfare state determinants of care provision for older people in the community in Slovenia and Austria (1.6.2017–31.5.2020) and P5-0200 Quality of Life of Social Groups (1.1.2004–31.12.2021).

Acknowledgments: The authors are grateful to M. Mrzel for her technical assistance and to M. Bales for providing language editing.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. Saraceno, C. Varieties of familism: Comparing four southern European and East Asian welfare regimes. *J. Eur. Soc. Policy* **2016**, *26*, 314–326. [\[CrossRef\]](#)
2. Osterle, A. Long-term Care in Central and South-Eastern Europe: Challenges and Perspectives in Addressing a New Social Risk. *Soc. Policy Adm.* **2010**, *44*, 461–480. [\[CrossRef\]](#)
3. Lowenstein, A. Caregiving and Elder Abuse and Neglect—Developing a New Conceptual Perspective. *Ageing Int.* **2010**, *35*, 215–227. [\[CrossRef\]](#)

4. OECD. *Health at a Glance 2017: OECD Indicators*; OECD Publishing: Paris, France, 2017; Available online: https://doi.org/10.1787/health_glance-2017-en (accessed on 15 July 2020).
5. Saraceno, C.; Keck, W. Can we identify intergenerational policy regimes in Europe? *Eur. Soc.* **2010**, *12*, 675–696. [\[CrossRef\]](#)
6. Esping-Andersen, G. *Social Foundations of Postindustrial Economies*; Oxford University Press: Oxford, UK, 1999.
7. Bettio, F.; Platenga, J. Comparing Care Regimes in Europe. *Fem. Econ.* **2004**, *10*, 85–113. [\[CrossRef\]](#)
8. Leitner, S. Varieties of familialism. *Eur. Soc.* **2003**, *5*, 353–375. [\[CrossRef\]](#)
9. Hlebec, V.; Srakar, A.; Majcen, B. Care for the elderly in Slovenia: A combination of informal and formal care. *Rev. Za Soc. Polit.* **2016**, *23*, 159–179. [\[CrossRef\]](#)
10. Hlebec, V.; Rakar, T. Ageing policies in Slovenia: Before and after austerity. In *Selected Contemporary Challenges of Ageing Policy*; Tomczyk, Ł., Ed.; Uniwersytet Pedagogiczny w Krakowie: Krakow, Poland, 2017; pp. 27–51.
11. Filipovič Hrast, M.; Schoyen, M.; Rakar, T. A comparative analysis of people's views on future policies for older people. *Rev. Za Soc. Polit.* **2019**, *26*, 153–169. [\[CrossRef\]](#)
12. Kovač, N.; Orehek, Š.; Černič, M.; Nagode, M.; Kobal Tomc, B. *Analiza Izvajanja Pomoči Na Domu V Letu 2018, Končno Poročilo*; IRSSV: Ljubljana, Slovenia, 2019.
13. De Roit, B.; Naldini, M. Should I Stay or Should I Go? Combining Work and Care for an Older Parent in Italy. *South. Eur. Soc. Politics* **2010**, *15*, 531–551. [\[CrossRef\]](#)
14. Pickard, L.; King, D.; Brimblecombe, N.; Knapp, M. The effectiveness of paid services in supporting unpaid carers' employment in England: Analysis using large-scale survey data and implications for policy. *J. Soc. Policy* **2015**, *44*, 567–590. [\[CrossRef\]](#) [\[PubMed\]](#)
15. Da Roit, B.; Hoogenboom, M.; Weicht, B. The Gender Informal Care Gap. *Eur. Soc.* **2015**, *17*, 199–218. [\[CrossRef\]](#)
16. Bonsang, E. Does informal care from children to their elderly parents substitute for formal care in Europe? *J. Health Econ.* **2009**, *28*, 143–154. [\[CrossRef\]](#) [\[PubMed\]](#)
17. Haberkern, K.; Schmid, T.; Szydlik, M. Gender differences in intergenerational care in European welfare states. *Ageing Soc.* **2015**, *35*, 298–320. [\[CrossRef\]](#)
18. Schmid, T.; Brandt, M.; Haberkern, K. Gendered support to older parents: Do welfare states matter? *Eur. J. Ageing* **2012**, *9*, 39–50. [\[CrossRef\]](#)
19. Eichler, M.; Pfau-Effinger, B. The 'Consumer Principle' in the Care of Elderly People: Free Choice and Actual Choice in the German Welfare State. *Soc. Policy Adm.* **2009**, *43*, 617–633. [\[CrossRef\]](#)
20. Pavolini, E.; Ranci, C. Restructuring the welfare state: Reforms in long-term care in Western European countries. *J. Eur. Soc. Policy* **2008**, *18*, 246–259. [\[CrossRef\]](#)
21. Deusdad, B.A.; Pace, C.; Anttonen, A. Facing the Challenges in the Development of Long-Term Care for Older People in Europe in the Context of an Economic Crisis. *J. Soc. Serv. Res.* **2016**, *42*, 144–150. [\[CrossRef\]](#)
22. Rummery, K.; Fine, M. Care: A Critical Review of Theory, Policy and Practice. *Soc. Policy Adm.* **2012**, *46*, 321–343. [\[CrossRef\]](#)
23. Shutes, I.; Chiatti, C. Migrant labour and the marketisation of care for older people: The employment of migrant care workers by families and service providers. *J. Eur. Soc. Policy* **2012**, *22*, 392–405. [\[CrossRef\]](#)
24. Le Bihan, B. The redefinition of the familialist home care model in France: The complex formalization of care through cash payment. *Health Soc. Care Community* **2012**, *20*, 238–246. [\[CrossRef\]](#)
25. Yeandle, S.; Kröger, T.; Cass, B. Voice and choice for users and carers? Developments in patterns of care for older people in Australia, England and Finland. *J. Eur. Soc. Policy* **2012**, *22*, 432–445. [\[CrossRef\]](#)
26. Da Roit, B.; Le Bihan, B.; Österle, A. Longterm care policies in Italy, Austria and France: Variations in cash-for-care schemes. *Soc. Policy Adm.* **2007**, *41*, 653–671. [\[CrossRef\]](#)
27. Verbakel, E. Informal caregiving and well-being in Europe: What can ease the negative consequences for caregivers? *J. Eur. Soc. Policy* **2014**, *24*, 424–441. [\[CrossRef\]](#)
28. Lazarus, R.S. *Psychological Stress and the Coping Process*; McGraw-Hill: New York, NY, USA, 1966.
29. Lazarus, R.S.; Folkman, S. *Stress, Appraisal, and Coping*; Springer Publishing Company: New York, NY, USA, 1984.
30. Schroder-Butterfill, E.; Marianti, R. A framework for understanding old-age vulnerabilities. *Ageing Soc.* **2006**, *26*, 9–35. [\[CrossRef\]](#)
31. Gottlieb, B.H.; Wolfe, J. Coping with family caregiving to persons with dementia: A critical review. *Aging Ment. Health* **2002**, *6*, 325–342. [\[CrossRef\]](#)

32. Monroe, P.; Tiller, V.R.; O'Neil, C.E.; Blalock, L.L. We make our ends meet good: Coping strategies of former welfare reliant women. *J. Loss Trauma* **2007**, *12*, 199–221. [\[CrossRef\]](#)
33. Pratt, C.C.; Schmall, V.L.; Wright, S.; Cleland, M. Burden and coping strategies of caregivers to Alzheimer's patients. *Fam. Relat. Interdiscip. J. Appl. Fam. Stud.* **1985**, *34*, 27–33. [\[CrossRef\]](#)
34. Sun, F.; Kosberg, J.I.; Kaufman, A.V.; Leeper, J.D. Coping Strategies and Caregiving Outcomes among Rural Dementia Caregivers. *J. Gerontol. Soc. Work* **2010**, *53*, 547–567. [\[CrossRef\]](#)
35. Carandang, R.R.; Asis, E.; Shibamura, A.; Kiriya, J.; Murayama, H.; Jimba, M. Unmet Needs and Coping Mechanisms Among Community-Dwelling Senior Citizens in the Philippines: A Qualitative Study. *Int. J. Environ. Res. Public Health* **2019**, *16*, 3745. [\[CrossRef\]](#)
36. Haley, W.E.; Levine, E.G.; Brown, S.L.; Bartolucci, A.A. Stress, appraisal, coping, and social support as predictors of adaptational outcome among dementia caregivers. *Psychol. Aging* **1987**, *2*, 323–330. [\[CrossRef\]](#)
37. Sayegh, P.; Knight, B.G. The Effects of Familism and Cultural Justification on the Mental and Physical Health of Family Caregivers. *J. Gerontol. Psychol. Sci.* **2010**, *66B*, 3–14. [\[CrossRef\]](#) [\[PubMed\]](#)
38. Kneebone, I.; Martin, P. Coping and caregivers of people with dementia. *Br. J. Health Psychol.* **2003**, *8*, 1–17. [\[CrossRef\]](#) [\[PubMed\]](#)
39. Lloyd, J.; Muers, J.; Patterson, T.G.; Marczak, M. Self-Compassion, Coping Strategies, and Caregiver Burden in Caregivers of People with Dementia. *Clin. Gerontol.* **2019**, *42*, 47–59. [\[CrossRef\]](#) [\[PubMed\]](#)
40. Kim, J.; Knight, B.G.; Flynn Longmire, C.V. The role of familism values in stress and coping processes among African American and White dementia caregivers: Effects on mental and physical health. *Health Psychol.* **2007**, *26*, 564–576. [\[CrossRef\]](#)
41. Lieberman, M.A.; Fisher, L. The effects of family conflict resolution and decision making on the provision of help for an elder with Alzheimer's disease. *Gerontologist* **1999**, *39*, 159–166. [\[CrossRef\]](#)
42. Kroger, T.; Puthenparambil, J.M.; Van Aerschot, L. Care poverty: unmet care needs in a Nordic Welfare State. *Int. J. Care Caring* **2019**, *3*, 485–500. [\[CrossRef\]](#)
43. Lowenstein, A.; Katz, R. Living arrangements, family solidarity and life satisfaction of two generations of immigrants. *Ageing Soc.* **2005**, *25*, 1–19. [\[CrossRef\]](#)
44. Eurofound. *COVID-19: Policy Responses Across Europe*; Publications Office of the European Union: Luxembourg, 2020.
45. Boeije, H. *Analysis in Qualitative Research*; Sage: Los Angeles, CA, USA, 2010.
46. Kavčič, M.; Filipovič Hrast, M.; Hlebec, V. Starejši ljudje in njihove strategije shajanja s tveganji za zdravje = Older people and their strategies for coping with health risks. *Zdr. Varst. Slov. J. Public Health* **2012**, *51*, 163–172.
47. Iacovou, M.; Skew, A. *Population and Social Conditions*; Eurostat Statistics in Focus: Luxembourg, 2011.
48. Hank, K. Proximity and Contacts between Older Parents and Their Children: A European Comparison. *J. Marriage Fam.* **2007**, *69*, 157–173. [\[CrossRef\]](#)
49. Jacobs, T.M.; van Broese Groenou, M.I.; de Boer, A.H.; Deeg, D.J.H. Individual determinants of task division in older adults' mixed care networks. *Health Soc. Care Community* **2014**, *22*, 57–66. [\[CrossRef\]](#)
50. Thompson, E.H.; Futterman, A.M.; Gallagher-Thompson, D.; Rose, M.J.; Lovett, S.B. Social Support and Caregiving Burden in Family Caregivers of Frail Elders. *J. Gerontol.* **1993**, *48*, 245–254. [\[CrossRef\]](#) [\[PubMed\]](#)
51. Taylor, M.; Quesnel-Vallée, A. The Structural Burden of Caregiving: Shared Challenges in the United States and Canada. *Gerontologist* **2017**, *57*, 19–25. [\[CrossRef\]](#) [\[PubMed\]](#)
52. Braithwaite, V. Understanding stress in informal caregiving: Is burden a problem of the individual or of society? *Res. Aging* **1996**, *18*, 139–174. [\[CrossRef\]](#)
53. Pinquart, M.; Sörensen, S. Associations of stressors and uplifts of caregiving with caregiver burden and depressive mood: A meta-analysis. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2003**, *58*, 112–128. [\[CrossRef\]](#) [\[PubMed\]](#)
54. Vlachantoni, A. Unmet need for social care among older people. *Ageing Soc.* **2019**, *39*, 657–684. [\[CrossRef\]](#)
55. Srakar, A.; Filipovič Hrast, M.; Hlebec, V.; Majcen, B. Social exclusion, welfare regime and unmet long-term care need: Evidence from SHARE. In *Ageing in Europe: Supporting Policies for an Inclusive Society*; Börsch-Supan, A., Ed.; W. de Gruyter: Berlin, Germany; Boston, MA, USA, 2015. [\[CrossRef\]](#)
56. Hlebec, V.; Filipovič Hrast, M. Ovrednotenje dostopa do socialne oskrbe na domu z vidika uporabnikov. *Teor. Praksa Rev. Za Družbena Vprašanja* **2015**, *52*, 48–66.

57. Hlebec, V. Evaluation of access to long-term care services for old people ageing in place in Slovenia = Ovrednotenje dostopa do storitev dolgotrajne oskrbe ljudi, ki se starajo v domačem okolju v Sloveniji. *Zdr. Varst. Slov. J. Public Health* **2018**, *57*, 116–123. [[CrossRef](#)] [[PubMed](#)]
58. Glaser, K.; Stuchbury, R.; Price, D.; Di Gessa, G.; Ribe, E.; Tinker, A. Trends in the prevalence of grandparents living with grandchild (ren) in selected European countries and the United States. *Eur. J. Ageing* **2018**, *15*, 237–250. [[CrossRef](#)]
59. Luciano, A.; Pascale, F.; Polverino, F.; Pooley, A. Measuring Age-Friendly Housing: A Framework. *Sustainability* **2020**, *12*, 848. [[CrossRef](#)]
60. Filipovič Hrast, M. Prostorska determiniranost omrežij starejših in vloga sosedov v časovni perspektivi. *Teor. Praksa Rev. Za Družbena Vprašanja* **2007**, *44*, 298–316.
61. Henning, C.; Lieberg, M. Strong or weak ties? Neighborhood networks in a new perspective. *Scand. Hous. Plan. Res.* **1996**, *13*, 3–26. [[CrossRef](#)]
62. Guest, A.M.; Wierzbicki, S.K. Social ties at the neighborhood level, Two decades of GSS evidence. *Urban. Aff. Rev.* **1999**, *35*, 92–111. [[CrossRef](#)]
63. Barker, J.C. Neighbors, Friends and other non-kin caregivers of community-living dependent elders. *J. Gerontol.* **2002**, *57b*, 158–167. [[CrossRef](#)] [[PubMed](#)]
64. Kohli, M.; Karsten, H.; Kunemund, H. The social connectedness of older Europeans: Patterns, dynamics and contexts. *J. Eur. Soc. Policy* **2009**, *19*, 327–340. [[CrossRef](#)]
65. Litwin, H. Social networks and well-being: A comparison of older people in Mediterranean and non-Mediterranean countries. *J. Gerontol.* **2009**, *Series B* *65*, 599–608. [[CrossRef](#)]
66. European Commission. *Confronting Demographic Change: A New Solidarity between the Generations, Green Paper*; European Commission: Brussels, Belgium, 2005.
67. Nagode, M.; Dolničar, V. Assistive technology for older people and its potential for intergenerational cooperation: Critical review of the present situation and identification of key constraints for wider uptake. *Teor. Praksa: Rev. Za Družbena Vprašanja* **2010**, *47*, 1278–1294.
68. Kerbler, B. Older people and the innovative forms of living and care. *Antropol. Časopis Cent. Za Etnološka I Antropološka Istraživanja Filoz. Fak. Univ. U Beogr.* **2013**, *13*, 73–87.
69. Tingvold, L.; Fagertun, A. Between Privileged and Oppressed? Immigrant Labor Trajectories in Norwegian Long-Term Care. *Sustainability* **2020**, *12*, 4777. [[CrossRef](#)]

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.



© 2020 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<http://creativecommons.org/licenses/by/4.0/>).