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Public policies and informal care for the elderly: to which extent are the different European countries ready to deal with a potential decrease of informal aid and how can we explain the existing differences between them?

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1. Introduction

In Europe, the general trend toward ageing societies is a common challenge all the governments have to deal with. Among other issues, this trend increases the number of persons likely to be one day in a situation of dependence: this "risk-dependency" increases indeed strongly after 80. From a theoretical point of view, we observe that industrialized countries have taken different paths towards meeting the needs of their dependent elderly: orientations chosen by the different countries are generally linked with the kind of their existing health systems and it exists so different kinds of care-regimes for elderly. Depending on these different institutional models, the level of development of long term care establishments and/or home help services by professionals may also differ.

Among common trends, one seems particularly worth noting: "Informal aid provided at home by family members, friends, or voluntary organisations is still the most important source of care in all countries" ('The OECD Health Project Long-term Care for Older People', 2005, p15), even in the countries where formal care is strongly developed and despite big disparities among countries. In the same OCDE report (p17), informal aid is defined as follows: "informal care is the care provided by informal care-givers (also called *informal carers*) such as spouses/partners, other members of the household and other relatives, friends, neighbours and others, usually but not necessarily with an already existing social relationship with the person to whom they provide care. Informal care is usually provided in the home and is typically unpaid". These informal carers are usually women, more often aged between 45 and 65 (OCDE, 2005, p108). The importance of informal aid in the current long-term care policies is underlined in this OCDE Study: "Even in countries with relatively extensive long-term care services, most long-term care is still provided by unpaid informal care-givers. In Sweden, for example, which has comparatively high expenditure on public services, an estimated two-thirds of the total volume of long-term care is provided informally by relatives, friends or others. The role of informal carers is therefore important in its own right and is increasingly recognised by policymakers in OCDE countries" (p50).

However, given socio-demographic evolutions expected in the coming decades (growing number of old people to take care, diminution of the ratio between the number of women aged between 45 and 69, who are the principal carers, and persons aged 80 and over, rise in the activity rate of women of working age…), it is unlikely that the family will continue to play spontaneously such an essential role. Thus, one of the

essential questions today regarding long-term care for the elderly is the existence or not of devices aimed at promoting informal aid and their extent and importance in the different countries. This is precisely what we will focus in this work. We can for instance read in the OCDE report of 2005 that "informal carers cannot be taken for granted as a resource, but require support in a number of ways (…)" (p46). All countries have thus an interest in promoting and supporting informal aid to try to anticipate its potential decrease in the coming years. This support can take different forms that will be presented more precisely latter, but the main devices implemented are diverse forms of financial support aimed at recognizing the work of informal carers, the possibility for informal carers to take "respite-time" notably thanks to the existence of institutions to which they can entrust their old relatives or counselling proposed to informal carers.

This paper is based on the assumption that the different countries are not in an equal situation and not prepared to the same degree to face this challenge. First of all, we assume that the different states, characterized by particular kind of welfare-states and of social care regimes for their old people, do not attach the same importance to this kind of devices and policies. The idea here is that these institutional differences between the three countries chosen (Germany, Italy and Sweden, each one pertaining, as we will see latter, to a particular kind of welfare-states and having thus developed a particular kind of care-regime for their elderly) influence first the pressure on the family carers (and thus their need of support) but above all the relative importance given to the goal of sustaining informal aid. The three case-studies of this work will be considered as illustration of the models they pertain, this to have an idea of the more general situation at a European level, even if this study is restricted to only three countries. Thus, we will privileged in this work an hypothesis that emphasizes the institutional factors rather than an hypothesis based on a more fonctionnalist approach, fonctionnalist approach where the countries that are under the strongest socio-demographic pressures (see above) are the ones (because of these pressures) that have indeed implemented the more devices to support informal care in order to try to counterbalance this negative expected trends.

To do so, a first theoretical part will present different typologies of (social) care-regimes, in order to identify clearly the three models each case-study pertains. This part will permit us to describe more precisely the institutional features characteristics of each country and model and, given theses characteristics, permit us also to formulate hypothesis about the relative importance and emphasis we can expect each country or model to attach to policies aimed at sustaining and supporting informal aid. This hypothesis will be tested in a second part devoted to the assessment and to the presentation of the different devices implemented in the different states to support

informal carers: we will thus be able to see if indeed the more or less emphasis put by each country on sustaining informal aid by public devices depends upon the kind of care-regimes they pertain. We strongly believe such an hypothesis will be validate and in order to give more strength to our argumentation, a third part will have a look on the socio-demographic pressures supported by each country, and so to try to prove that there is no causal link between the strength of these pressures and the importance attached to the support to informal care in each country. Finally, a more analytical part will try to make converge all these facts to have a more general look on the situation but also to try to answer as clearly as possible to our main interrogation (are or not the countries ready?) and to understand from where can come differences observed between the three case-studies.

2. *The theoretical framework: overview of different typologies*

The famous work of Gosta Esping-Andersen (1991) about the different worlds of welfare-states has inspired our main hypothesis, based on the assumption that different kinds of welfare-states are likely to have different attitudes towards the question of informal care, that is to say that we assume that Sweden, Germany and Italy do not support and encourage equally informal care given essentially by families, depending on which "worlds" of welfare-states each country pertains and thus depending on which institutions/entities are privileged and the most important in each ideal-type. However, focusing particularly on social transfers and the relationship between the state and the market (Bettio&Plantenga, 2004, p85), the work of Esping-Andersen is not particularly relevant for our study, where we want rather to have a look on the relationship between the state and the family, that is why we have to turn to more precise typologies about the subject we are interested in. Several typologies are here interesting. This part will try to present them as clearly as possible to have a clear idea of the kinds of (social) care regimes that have been developed in Europe, and particularly in the three countries we are interested in. This will permit us to formulate a hypothesis about the importance each model, given its particular characteristics, is likely to attach to informal care support.

Here the book of Burau, Theobald, and Blank (2007, chapter 3) has proved to be particularly useful, particularly two principal typologies. The first one concerning the ideas underpinning the governance of home care in different countries is based on the concept of gender cultures defines by Pfau-Effinger and give us a first idea of the respective roles devoted to the state and the family in each model. We can find here four main models, with at first the "housewife model of the male breadwinner family" where care is the responsibility of the family and where women are the primary carers. Then we have "the female part time carer model of the male breadwinner family" (women combine care responsibilities with part-time work, care is the responsibility of the family partly shared with state market and non profit sector), where we find Germany, and the last model identified namely the "dual breadwinner/institutional care model", characteristics of Sweden, where both genders are integrated into paid employment on a full time basis and where the responsibility of care lies with the state, market or non-profit sector. A fourth category has been added by the authors, "the dual breadwinner/female carer model": the care is still the responsibility of the families and women are expected to work in full time employment but also to be responsible for the care provision. In this classification, Italy is divided between the first (south of the country) and the last model (north) that are actually quite close.

The second typology is devoted to the institutions relating to the governance of formal care services but provides precious information about informal care, and so permits us to precise the models identified above. Four models are again presented, only three being interesting for us. Firstly the public service model where the state supports both types of services but the formal care services are available universally whereas only some support is attached to informal care (Sweden). We have then the family care model (Italy) where the state support is low for both types of services and the subsidiarity model (Germany): the state support for formal care services comes after other forms of support, notably informal care and consequently public services are limited and aimed to encourage family care. The table provided in the same book (page 97 "support strategy and care regimes") presents a good summary of the situation of the three countries: in Sweden, characterized by a public service model, the formal care provision is predominant whereas economic support for informal care giving is secondary, in Germany (subsidiarity model) the situation is reversed and in Italy both formal care services and economic support for informal care giving are secondary. Our work will be mainly based on these two important typologies. However a quick look on other classifications is interesting to strengthen the different models identified.

Indeed, these typologies coincide more or less with the one defined by Anttonen&Sipila (1996, pp96-97) about four different social care models. Informal caring is not formally included in their study but three of these models are however interesting for our study. They indeed give us information about the kind of social care model we can find in our three case-studies: the Scandinavian model of public services where services for elderly are widely available and based on a universal principle (characteristics of Sweden), the family care model of Southern Europe where there is a very limited supply of social care services and where most services are produced "on the informal or grey market" (Italy) and finally the central European subsidiarity model (Germany) where the primary responsibility for the care of elderly lies with the family and where religious and political organizations are major producers of services. In this model, "the volume of social care services for elderly people is at an intermediate level" (p97).

More recently, we can also use the work of Bettio & Plantenga (2004) that tries to identify different European care models too. In this typology, Italy pertains to the first cluster with other Southern countries where countries rely a lot on informal care given by the family and where formal care arrangements for elderly persons are underdeveloped. Germany is defined as a publicly facilitated, private care model: "whereas there is a systematic reliance on the family for the provision of care work and services, based on the principle of subsidiarity, the family is actively encouraged to perform this role

through receiving state support rather the direct interventions" (p101). This country is also medium provider as concerns institutional care for elderly. Finally, the two authors identify a Nordic countries model (Sweden) where there are moderate to high levels of all formal care resources and where we find a universalist approach. Thus, the family plays only a modest role in such a model.

Thanks to these typologies, three quite distinct models of social care regimes have emerged. We now have a better idea of the way of working of each model but also of the values governing each system. Grossly simplifying, we find in Sweden a high levels of services proposed to elderly under the responsibility of the state, in Germany this public support is less developed since the family is still defined as responsible of the care given to old people and thus sustains to perform this task and in Italy, public support is strongly underdeveloped: the family must assume almost alone most of the care-responsibilities. We assume that given these very different institutional arrangements characteristics of each country, the attitude of each state towards this challenge of informal aid may differ quite strongly depending on which institutional model a country pertains. For instance, the very first typology evoked above already gives us some information about the potential importance attached respectively to formal and informal care services (P50-51). In this way, Germany (as an example of "female par time carer model of the male breadwinner family) is likely to attach little support to formal care services (responsibility of care lies on the family) and medium support to informal care services, Italy (the north of the country as well as the south) attaches virtually no or little support to both kinds of services and Sweden to focus on the provision of formal care services (high support) and not or at least less on informal care services (little support). It is precisely this main hypothesis we will try to validate in the next section: we assume that countries where there is already a lot of institutional arrangements and services proposed to the elderly and their families, notably as concerns formal care, are also the ones that have the most anticipated this "informal aid" issue and thus have put in place devices and policies to support families. On the contrary, we believe that the countries already behind in elderly care are also the ones that are the less ready to deal with a potential decrease of informal aid in the coming years.

3. ***Range of devices and services proposed to informal carers: comparison***

In order to try to validate our hypothesis, this part will be devoted to the study of the devices and services existing respectively in Sweden, Germany and Italy to sustain informal carers in their work, with the aim of maintaining the high level of informal care that is currently, as we have seen before, a key dimension in the long-term care for the elderly. Help and support given to family carers can take different forms: carers can be given a statutory right to receive an assessment of their need for services, there can be also respite care services (possibility of entrusting old persons in day-care centres or for short-term stays) to permit carers to have a break in their responsibilities of caring old people, pension credits payments (for carers out of labour market because of their care responsibilities to maintain pension rights) to carers, direct cash payments, allowances for informal care, with the older person with the possibility of employing a personal attendant that can be a relative ('The OECD Health Project Long-term Care for Older People', 2005, p45 and p50).

My concern here was to find basis common (regarding information and statistics) for the three case-studies, so that the comparison between them could be as fair and equal as possible. That is why among a lot of different sources I decided to privilege the study of the project Eurofamcare (Mestheneos, E, and Triantafillou J, 2005) initiated in 2003, coordinated by the University of Hambourg and financed by the European Commission. This report presents the situation of family carers in 23 European countries, notably the three we are interested in in this study and is also according to my view the more precise and complete one currently about this very precise and restricted subject.

At the end of the study, we can find a very useful document for our work, namely a "matrix services for family carers for 23 countries" (annex 5) that compares the situation of the 23 countries for 12 different services proposed to family carers, regarding their level of availability (not/partially or totally), their statutory and their funding. We have sum up the more interesting results for our work in table 3.1.

Table 3.1:

	Germany	Italy	Sweden
Needs assessment (formal-standardised assessment of the caring situation)	PA (partially available)	NA (not available)	TA (totally available)
counselling and advice (e.g. in filling in forms for help)	PA	PA	TA
self-help support groups	PA	PA	TA
"granny-sitting"	PA	TA	PA
Practical training in caring, protecting their own physical and mental health, relaxation, etc	TA	PA	TA
weekend breaks	PA	PA	PA
respite care services	PA	PA	TA
monetary transfers	TA	TA	TA
management of crises		PA	PA
integrated planning of care for elderly and families (in hospital or at home)		PA	TA
special services for family carers of different ethnic groups	PA	NA	PA
other support centres for Family carers			

We can see thanks to this table a quite clear graduation: Sweden is obviously according to this classification the country that seems to attach the more importance to the support to informal carers, since almost all kinds of services are "totally available" in this country. Then comes Germany, where most of the services are only partially available and only two "totally available". Italy is almost in the same situation, but what is worth noting, and explains the classification of this country at the end of the graduation, is the fact that Italy is the only country among our three countries where two

services are not at all available. Actually, the only kind of service totally available in the three countries is the "monetary transfers" so it could be interesting to have a more precise look on these devices and notably on the financial recognition (in the same study, annex 6) granted to family carers. In Sweden, it exists the "Attendance Allowance", an untaxed cash payment to the dependent, used to pay the family members for their help. In Germany, an Attendance Allowance exists as well that the user can have in cash benefits (and then can use to reward informal carers) or can choose benefits in kind. In Italy, there is not a real financial recognition of the work of family carers at the national level (the State care allowance is granted only on the basis of necessity, being non-means-tested). At a local level, there are limited economic contributions for family carers as cash care allowances base on need and income. We can also add some tax concessions for families with special care burdens and other tax deductible costs. The rights of family carers are also important, notably regarding leave. In Sweden, the Care Leave Act of 1989 provides right to paid leave to take care of a family member in a terminal care situation and it is covered under the National Social Insurance. In Germany, there are also rights to leave for short period or for a maximum of one year that can be granted with or without wage adjustments. In Italy, you can benefit as a carer of the right of continuous or split unpaid leave for a maximum of two years if you are in the public sector (much less if you are in the private sector) and this period of leave is not calculated in the length of service or in the social-insurance scheme (annex 6 again).

It is important here to underline that these results confirm what we can read in most articles related to this subject. In this way, we can see in the OCDE report (2005, pp 52-53) that Sweden has developed "personal budgets and consumer-directed employment of care assistants" (through the "care's salary"), "payments to the person needing care needing care who can spend it as he/she likes" ("attendance allowance" that is a cash payment to the dependent who can then pay informal caregivers) and "payments to informal caregivers as income support" (with the care leave, see above). Comparatively, Germany has only implemented "payments to the person needing care who can spend it as he/she likes" (cash allowance for care, already evoked above). There is unfortunately no information about Italy in this document but other articles confirm the results already obtained. The *La lettre de la Proximologie* (Droits et statut des aidants : mythe ou réalité ? Analyse comparée des dispositifs européens' , 2006) underlines that in Italy, there is no official status for familial carers but only some kinds of financial rights (p10). In Germany, dependent elderly receive an allocation but not family or principal carers (p9) even if these familial carers can benefit some kind of technical support or support to give cares by health professionals. According to this article, it exists a real

"Swedish model" in this area that should be an example for other countries. The study concludes that "contrary to Northern countries, […] some southern countries like for instance Italy, do not recognize the role of care-givers for old or dependent people. Germany and France have lost time as well" (p9) and states that the principal conclusion of the Eurofamcare study (evoked above) is that "it is easier to be a familial carer in Northern Europe than in Southern Europe" (p20). Finally, the article of Assous&Ralle also devote a special part to this question of informal aid (pp 29-30): devices implemented in Germany and in Sweden (as well as in Austria, Finland, Ireland or United Kingdom) are presented but nothing is said about Italy, what can confirm the idea that the level of development of devices in this country is far lower than in the two other countries.

We can thus see that it seems indeed that "institutions matter". The different institutions/entities privileged in each country, characteristics of a particular model of social care regime seem to influence the importance attached by each model to this issue of informal aid. Indeed, results are somewhat striking, in the sense that the graduation found in table 3.1 corresponds quite strongly with the different care regime models presented in part 1 and thus tends to confirm our main hypothesis: countries or models where public support for elderly is already strong (particularly Sweden) are the ones that have also implemented the more diverse range of services to sustain informal aid. The contrary is also true: where public services to frail elderly are usually weak (and thus where the pressure on the family is the strongest), less has been done for helping informal carers. To try to confirm this hypothesis and results obtained here, we will know have a more precise look of the socio-demographic pressures supported by our three case-studies. We assume indeed that there is no link between the strength of these pressures and the importance attached to the support to informal aid, that is to say that in our belief, it is not the countries that needed the most to implement devices and policies to sustain informal caring that have indeed done it in the reality.

4. ***The level of development of devices is disconnected from the strength of socio-demographic pressures supported by each country***

These socio-demographic pressures are important to take into account in the sense that it is logically less necessary for a country with a high level of development of formal care services and so relying less on informal aid to "invest" in such devices aiming at sustaining informal care. On the contrary, the country with the oldest population or where we expect the ageing trend to be the strongest may need to pay more attention to the ways of supporting informal care.

Three factors are here worth considering. The first one is the ageing cycles. Currently, the proportion of persons aged 65 and over in Italy and Germany is between 15% and 17% and the proportion of persons aged 80 and over (among the elderly) between 23% and 26%. In Sweden, the "oldest" country in the world, the corresponding figures are of 17,4% and 28% for the same categories (Assous&Ralle,2000, p8). However, if we consider the previsions for 2020, Italy becomes one of the oldest countries with 6,8% of its population as a whole aged 80 and over. Germany will be above the European average (5,6%) as well and Sweden slightly below with 5% of its population aged 80 and over (p9 of the same report).

The second factor to take into consideration is the availability and the level of development of formal care services in each country, since the more is developed this supply of services, the less pressure on families is strong. This second aspect is strongly related to the kind of care-regimes characteristic of each country, already presented above that is why we will just quickly evoke this aspect, using mainly models distinguished by Assous and Ralle (2000): one presents the proportion of elderly living with their children (weak, strong or intermediate proportion, p27) and the other one is about the level of formal care services in each country. The three countries are here in a quite different situation:

- Sweden is classified in the "weak model" for the first typology and pertains for the second one to the "northern Europe" model characterized by a high proportion of elderly living in long-term care establishments and more than 10% of them receiving home help.

- Italy is respectively in the "strong model" and in the "southern Europe" type where the proportion of elderly living in long-term care establishments is low and where less than 5% of these old persons benefiting from homecare services.
- Germany is in an intermediate situation for both typologies

Finally, it is important to consider the activity rate of women of working age (informal care is usually given by women) and the ratio between the number of women between 45 and 69 (the principal carers) and persons aged 80 and over. The last thirty years, this ratio has diminished by a third in the OCDE countries (Assous&Ralle,2000, p27). This ratio is currently about 3,8% on average and is likely to decrease in the coming years to reach 3,1% in 2020. In Sweden, this ratio will remain stable but in the two other countries, it will decrease, particularly and more strongly in Southern Europe. Moreover, the activity rate of women aged between 45 and 59 is currently lower in southern Europe than in northern Europe and is consequently likely to increase strongly in the coming years. We thus see clearly that Italy is likely to meet much more difficulties than Sweden and even Germany in the coming years.

To sum up briefly, it is obvious that Germany, but above all Italy, rely more on informal care than does Sweden, where the level of development of formal care services is much more important. It is also worth noting that both countries, but again especially Italy, will in the coming years meet more socio-demographic difficulties and challenges than Sweden, where the population is already quite old and the activity rate of women high. Combined with the facts presented about the devices implemented in each country to support informal aid, this tends to confirm our main hypothesis. Indeed, we have seen that Sweden was the country that has put the more emphasis on the devices aimed to support informal carers and we just saw in this part that it is precisely the country that "needed" the less to do so. On the contrary, the country meeting (or that will meet in the future) the strongest socio-demographic pressures (Italy) is precisely the one that has implemented the less policies to facilitate and maintain the high level of care given by family. In the same way, this country is the one having at its disposal the less number of formal care services, what is obviously again linked with the kind of care-regimes existing in this country and thus on the institutional background. Germany is in an intermediate situation regarding all the factors relevant here that is to say the level of formal care services, the socio-demographic pressures and the degree of development of devices to sustain informal aid. This country is thus expected to meet less difficulties than Italy in the future but obviously more than Sweden.

5. ***Analysis: which countries are the more ready and how to explain differences?***

It is now time to have a more analytical look on all these facts and figures and to come back to our initial interrogations, trying to know which countries will be the more able deal with this potential decrease of informal aid but also what can explain the big differences observed between the three countries all along our study.

It follows from the above that obviously, Sweden is the country more ready to face this challenge: informal aid is not in this country as important as in other models and its decrease is not expected to be really important in the coming years. If decrease there is however, it will be limited thanks to the range of services and devices sustaining families in their task. Sweden is an interesting case: care of the elderly is traditionally in this country the responsibility of the state and the family has not any kind of obligation towards old people. However, despite these characteristics, public authorities seem to have understand and recognized the importance (that can be decisive in the future) of informal care as concerns this very particular area of long-term care for the elderly. Formal care services are still the primary kind of care for elderly people in this country but it does not mean that Sweden has "let down" informal care: responsibility of care lies in this country with the state, market or non-profit sector and that is why the state supports both types of services. This can be explained by the fact that the national policy in this country is based on the idea that the care given to old persons are a public responsibility. Thus, if families choose to do it themselves, they must benefit from a form of support and recognition (p5 of the *Lettre de la Proximologie*, 2006). For formal care services but also for devices devoted to informal aid, Sweden is somewhat "in advance" compared to the two other ones, and this is obviously linked to the care-regime characteristic of this country.

As concerns Germany, the level of formal care and home-base services (medium level for both) is not as developed as it is the case in Sweden but this country proposes from now on different kinds of devices to the family, in order both to maintain the level of informal care and to preserve the family like institutions proposing short-term stay for elderly in order to relieve families, replacement of informal carers by professionals or the possibility for the carers to benefit from diverse insurances and pensions (Assous&Ralle, 2005, p29). The cash allowance in Germany was clearly created to favour informal care givers. In this country, it seems that the level of formal care services is not really

important and that the support to informal carers, even if it does not reach the level of Sweden, is relatively developed, perhaps because this kind of support fits better with the values and ideas governing care in this country where family is still the primary institution in charge of the care.

Italy is finally the country among our three case-studies that appears to be the less ready: not only is this country the one having the less formal care services available, the ageing cycle and the ratio between the number of women between 45 and 69 and persons aged 80 and over the more unfavourable, it is also the one that seems to put the less emphasis on services to informal carers. A big effort will be necessary in the coming years in this country, as concerns formal care as well as informal care services, if it wants to face the challenge of an ageing population. We can actually note in this country more and more monetary transfers aiming at supporting informal care provision, but it is not enough yet to balance the limited provision of formal care services in this country. This situation can be explained because care of elderly in Italy is not defined as a state responsibility: family (and especially women) is still the primary responsible for this kind of care, and these ideas are strongly present in the Italian society: we can for instance read in the *Lettre de la Proximologie* (2006, p10) that in 2004, more than 80% of the Italian population answer "yes" to the question "do you think that working age adults must help their parents?", whereas only one Swedish out of three answer yes to the same answer (according to the Eurobarometer Alber&Köhler of 2004).

Here appears strongly the importance of ideas, values and culture in this particular area of informal care, at the border between the state and the family. Bettio and Plantenga (p109) underline (using Alber) that "care strategies are very closely related to the national identity of a given country" and that "care strategies thus transmit important signals about what is considered the most desirable organization of society". For them, this goes against the idea of any potential convergence in national care strategies; concerning our work, it seems that it is one very important factor explaining the big differences observed between our three case-studies.

6. Conclusion

If we operate a quick return to our starting interrogation, it is worth noting that different kinds of welfare-states or kinds of care regimes do indeed seem to attach different importance to the support of informal aid. This work has confirmed our initial hypothesis according to which it is not the countries that needed the most to implement devices aimed at sustaining informal care (the ones relying the more on the family because of the insufficiency of formal care services and being or expected to be under the strongest socio-demographic pressures) that have done so in the reality, but rather the countries that already attached a great importance to the care of frail elderly trough formal care and home-base services that propose currently the more services and devices to informal carers. As concerns this very particular area of informal care at the border between the state and the family, it appears thus that institutions (not only formal institutions but also values, identities, ideas, rules and the social system as a whole) strongly matter. We now know not only which countries and so which models are the more or the less ready to face up this potential decrease of informal aid but we also have a beginning of answer for explaining why we can observe such huge differences.

It is important to keep in mind that the three case studies chosen in this work are only illustration of the welfare-state or care regimes models they pertain. However, we believe these illustrations to give a quite good idea of the situation that could exist in the different European countries pertaining to the different models evoked.

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