

**The future of the welfare state: paths of social policy
innovation between constraints and opportunities**

Urbino, 17-19 September 2009

Long-term care policies in six European countries

The development of Cash for care schemes

(Draft)

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Paper presented at the 7th ESPAnet conference 2009
Session: nr. 2B - Paths of innovation of care policies in european welfare states

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All European countries share major challenges in addressing the social risk of dependency. In response to increasing needs and decreasing abilities to provide large amounts of family care, calls for the development of comprehensive long-term care systems have been intensified.

This presentation investigates the long-term care schemes implemented in six European countries (Austria, France, Germany, Italy, the Netherlands, Sweden) and questions the logic and evolution of the different LTC systems based on cash for care and/or support in kind. Three groups of countries can be distinguished: countries where LTC is based on support in kind (Sweden), countries where Cash for care prevails (France, Italy, Austria) and finally, countries with mixed system, combining cash benefit and support in kind (Germany and Netherlands). What type of regulation does it imply? What articulation between public and family support does it reveal? And what impact on care workers?

The analysis shows that the introduction of cash-for-care in LTC systems constitutes a common trend of the reform processes since the 1990s, with the development of a logic of “free choice” for the user. But the countries have different histories of LTC policies and of applying the cash approach. And the context, timing and regulation of the schemes are variegated. With the control of the use of the benefit, the regulation is stronger in France and the Netherlands, than in the other countries. The characteristics of the care allowances differ, as well as their link with employment policy and impact on care market. Yet, the involvement of the family – which appears as an important source of support everywhere – is a main element of convergence of the different Cash for care schemes.

1. Long-term care and cash-for care schemes

The introduction of cash for care schemes represents one of the main trends in social policies since the 1990s.

The fact that people in need of care may be granted allowances instead of in-kind services entails different objectives and visions of what long-term care protection schemes *should* be.

First, a key idea beyond the diffusion of cash-for-care interventions is that of “free choice”: older people and/or their families (depending on the context) should be granted the possibility to choose themselves which kind of care they need and they want. This free choice perspective is linked, on the one hand, to the promotion of autonomy and control for care users, as claimed by disabled peoples’ organization since the 1970s (Gledinning 2008), and, on the other hand, to the promotion of competition between care providers as an instrument to enhance quality and reduce prices (Kremer 2006). A second key element is that of the recognition of (formerly unpaid) informal care work insofar as many cash-for-care schemes allow the beneficiaries to compensate (or to employ) their own relatives (Ungerson...). Finally, cash-for-care schemes have been seen as an opportunity to develop long-term care schemes at contained prices compared to traditional services. The ageing of the population and the increasing care needs call, in fact, for cost-containment strategies, of which cash for care interventions represent one example.

This paper, instead of looking at the similarities between cash for care based interventions, looks at substantial differences between national experiences in cash-for-care. It has already been argued that the degree of regulation of cash for care schemes has major impacts on the *type of* commodification of care that these interventions entail (Ungerson and Yeandle 2007) on the development of specific forms of care works and of informal care (Da Roit et al 2007). There is however the tendency to look at the development of cash-for-care schemes as if they were separated from more general long-term care schemes. By contrast in this paper we claim that only when considering, on the one hand, the policy context in which these new schemes find themselves and, on the other hand, the specific regulations that they entail in each context, it is possible to grasp the sense of these reforms.

In order to analyze the diverse trajectories of cash-for-care policies we consider six European cases: Sweden, the Netherlands, Austria, Germany, France and Italy.

We first look at the policy and institutional context in which cash for care schemes have been introduced in these six societies (par.2). We then address the diversity in terms of regulation of the schemes and therefore the different visions that they entail (par.3).

In the concluding paragraph (4) we discuss three emerging long-term care configurations, based on our analysis.

2. Cash for care in long-term care schemes: trajectories and timing

In the five countries considered, cash-for-care schemes developed with different timing and within diverse policy settings. The degree of development of long-term-care policies at the time of the introduction of care allowances was quite varied and the logics of their introduction differ greatly.

For countries (the Netherlands and Sweden) with comprehensive long-term care policies built throughout the 1970s and 1980s, cash-for-care schemes represent an instrument to reform existing policies and adapt them to a new context. For countries with a traditionally scant and fragmented supply of social services for older dependent people, cash for care schemes represent the basis for the development of new social protection schemes (France, Germany, Austria). But there is also the case of countries that did not produce any considerable reform in the field of long-term care (Italy): here cash-for-care schemes become by *inertia* the keystone of social policies in this domain.

2.1. Flexibilising a formal long-term care system

In countries with well developed long-term care policies before the 1990s, cash for care schemes represent one (among other instruments) to reform policies and interventions that are deemed as too supply-oriented, costly, and unresponsive. The Dutch and Swedish cases illustrate well this type of development.

2.1.1. *The Dutch Persoonsgebonden budget (PGB)*

In the Netherlands an early and strong public long-term-care system developed. Since the late 1960s intensive residential long-term care was financed by a national compulsory insurance, the AWBZ (*Algemene Wet Bijzondere Ziektekosten*, Exceptional Medical Expenses Act), covering the care costs of dependent, mentally ill and handicapped people of all ages. The AWBZ, initially thought to cover the expenses related to nursing homes, was progressively extended to home care expenses and homes for older people.

On the premises of the national insurance, Dutch social policies promoted a strong de-familisation process of care for older people. Family members were not expected to contribute financially nor in terms of caregiving, even if this does not straightforwardly imply that informal care completely lost its importance. In the mid 1970s the proportion of older people living in institutional settings was the highest in Europe (Oecd 1996a, 1996b)¹. A process of containment/reduction of residential care was promoted since the mid '80s (Van den Heuvel 1997) was coupled by the development of home care services. More recently, changes in long term-care policies were deemed at targeting the beneficiaries, fostering the development of care markets and of informal care. The driving logics were on the one hand the changing position of care service users, who should be given say and choice about their own care and on the other hand cost containment and efficiency.

It is in this framework that the Dutch cash-for-care scheme has to be placed. Whereas until then care was only provided in kind, in 1995, the PGB (*Persoongebonden budget* - personal budget) was experimentally introduced: a limited number of persons eligible for home care were provided a cash allowance instead of in-kind services. The introduction of PGB raised a considerable debate. Old people unions and especially organisations of the disabled had been asking for the possibility to arrange their own care, to overcome dissatisfaction about lack of responsiveness of public services. However, cash allowances

¹ In 1965 the capacity of homes for the elderly was equivalent to 6.7% of the population aged 65 and above; it became 8.8% in 1970 and 9.7% in 1975. Moreover, if we add to the homes for the elderly the capacity of nursing homes the capacity goes beyond 12% in 1975 (de Boer 1999:30, table 2.2)

represented a major break with the traditional system of care in kind, for the beneficiaries, as well as for policy makers and providers. From 1995 onwards, a limited but increasing part from national AWBZ budget was allocated to applicants of PGB for home care. By 2001, all persons with an assessment for home care for at least three months were declared eligible for PGB, while no overall budget limit was set.

2.1.2. The destabilisation of the Swedish universalism

As the Netherlands, Sweden is characterized by a well established universal-oriented public long-term care system, which extends the very early provision of medical care by the state. Public responsibility developed in the 1950's, with the definition of social services for the elderly funded by taxes and based on a citizenship right (Morel, 2007). Elderly people have a right to care, institutional care or home care, regardless of their income and of the place where they live. In the 1990's, this ideal LTC system was confronted, as other European countries, to major financial difficulties and a first redefinition was imposed by the Ädel Reform in 1992. The reform, based on the redefinition of competences of the different territorial levels, shifted the responsibility for elderly care (home care services and nursing homes) from the county councils (regional level) over to municipalities. Three levels of government are concerned: at the national level, the parliament and the government set out policy aims and directives; at the regional level, the county councils are now responsible for health care and the municipalities are legally obliged to meet the care needs of the elderly. The Reform produced its effects and the necessary expansion of health services due to the socio-demographic trend was halted with a reduction of the number of beds in county council hospitals by over 45% between 1992 and 2002. LTC policy in Sweden was traditionally oriented towards institutional care. But for cost containments reasons, municipalities had to reduce it. This trend had a direct effect on home based care which has become a main component of the LTC system. New strategies have been developed with the restriction of social services to highly dependent elderly with limited family support. This is a significant turning point and marks the evolution of the ideas of universalism and individualism characteristic of the Swedish culture. Cash payments remains marginal but have developed in different ways to introduce some flexibility (Szebehely, 2005): the extension of the Attendance allowance established in the 1940s to long term care for frail elderly, the right to personal assistance with the Law of support service to disabled people (1994) which offers different types of support to people with severe functional impairment, including the right to employ a relative.

2.2. Introducing a new comprehensive scheme: France, Austria and Germany

In continental European countries, long-term care policies have been a more recent concern. While family responsibilities and scattered social provision traditionally characterized interventions for older dependent people, since the mid 1990s a new awareness of the dimension of the long-term care problem rises, with the introduction of national schemes of social protection. These schemes are mainly based on cash for care schemes, as the cases of Austria, Germany and France well illustrate.

2.2.1. The Austrian Pflegegeld

In Austria, until the early 1990s long-term care was largely viewed as being the responsibility of the family. This idea was rooted in the perception of the population, but it was also reflected in policy approaches. Policies were highly fragmented, with competences mostly devolved on the provincial administrations. Public support for the care of the frail elderly was threefold. First, there were cash benefits, mostly low, restricted to specific groups and disbursed in specific circumstances. Secondly, many municipalities had been providing residential care either in old people's homes and nursing homes or in facilities which mixed both types of residence. Funding of places was (and still is) based on social assistance principles. The third approach – social services in the community – was available at substantial levels only in a few regions before the 1990s, and even there it was often limited to nursing care (Hammer and Österle 2003).

The Austrian debate that led to the 1993 reform was greatly influenced by representatives of the handicapped. As a consequence, the future of long-term care policies was not focused on the elderly alone, but more generally on the social risk of dependency. And cash provision was strongly advocated as an approach enabling the empowerment and autonomy of the recipients. This idea of cash benefits was also favoured by other groups, for reasons of choice and ideas of market-driven developments in long-term care. This finally led to Austria-wide consensus on the need to reform long-term care (Pfeil 1994). The 1993 reform programme consisted of two main parts: an agreement between the federal and provincial authorities on responsibilities for long-term care provision, and cash benefit legislation. The agreement clarified the division of responsibilities between federal and provincial levels. Accordingly, the development of services in the residential, semi-residential and the community-care sector remained a provincial responsibility, while the federal level was responsible for developing arrangements that furnished social insurance coverage for carers. The cash benefit scheme followed one Federal and nine Provincial Long-Term Care Allowance Acts. The federal level was responsible for care recipients receiving pensions or similar benefits based on federal statutory provisions, while the provinces granted allowances according to the same principles to all those for whom the federal level was not competent, e.g. handicapped people or recipients of social assistance. While the cash allowance was established as a social right (with the possibility of appealing to the Labour and Social Tribunal), this was not the case of access to care services. After 1993, Austria did not see any fundamental change in the principles established. However, further developments impacted on the use of cash benefits, as well as on care arrangements (see the discussion below). Apart from some changes in benefit levels and in the assessment procedure, cash benefits have not been price-adjusted since 1996 (with the exception of 2005).

2.2.2. The German Long term care insurance (LTCI)

Germany has a strong tradition of voluntarism and family support. The organization of social care is therefore marked by continuity and attachment to the idea of subsidiarity and the shared care responsibility between family and society (Burau et al., 2007). Just as in other European countries, the costs of care policies became an important issue in the 1990s' and the decision was taken to implement a new LTC policy. With the introduction

of a LTCI in 1995, dependency became a specific social risk of the German social protection system. It is based on a universal principle, with an access to care provisions for individuals with substantial care needs, regardless of their level of income and according to their level of needs. But, in contrast with social health insurance, the LTCI is oriented towards basic needs only and must be complemented either by the resources of the family or by social solidarity. An important characteristic of the German LTCI is the choice given to beneficiaries between services in kind or cash benefits, to enable families to manage and organise themselves the care arrangement. It is allocated to all elderly people who are covered by health care insurance.

2.2.3. The French Allocation Personnalisée à l'Autonomie (APA)

Until the mid-1990s, the main social care policy for the frail elderly was the one which applied to the disabled: the *Allocation compensatrice pour tierce personne (ACTP)* (compensatory allowance for a third party), which was freely used by older people as well, with no controls. The political debate centred on certain key issues. The first was the choice between social insurance and social assistance (Frinault 2003). The second, and linked to the latter, was whether the scheme should be universal or concern only people unable to pay for any services. The third issue was how the policy should be funded and managed, and to what extent the state, local authorities and social security funds should be involved. One of the main obstacles was financial. In fact, in the context of budgetary constraints and a policy of curbing public expenditure, it was difficult to promote a policy whose cost had not been properly estimated until a national inquiry (HID inquiry of INSEE 1998-1999) identified the number of potential recipients (800,000 people). The decision was finally taken to define a new benefit, experimental in a first phase and generalised in 1997 with the creation of the *Prestation Spécifique Dépendance*, implemented at the level of the '*départements*'. The many criticisms of the scheme, and particularly the fact that only 15% of frail older people received the benefit (150 000 recipients only) made it necessary to reform the care system. The aim of the 2002 reform was clear: to move away from the PSD scheme, the objective of which was to reduce costs, and to increase the number of recipients. The *Allocation personnalisée à l'autonomie* was therefore created (APA), based on a universal principle, its amount is defined according to the level of dependency and the level of income.

The 2003 summer heat wave led to a new step adjusting the LTC policy. A "Plan for frail elderly people" was defined for the period 2004-2007 (a second Plan covers the period 2007-2012) and a new Fund for the frail elderly was created (*Caisse nationale de solidarité pour l'autonomie*). Financed by an employers' contribution (0.3% of total wages) in return for abolition of one day of public holidays, 0.1 of the CSG (tax principle), and the transfer of credits for frail elderly and disabled people from the social security fund, this Fund was a step towards the insurance principle (in 2006 the Fund amounted to 14 billion euros). This choice was confirmed in 2007, with the announcement of the creation of a "5th Risk" – dependency² – combined with the necessity to develop private insurance schemes. But the concrete implementation of such policy is still debated.

² The French social security system is based on four risks: illness, retirement, family and accident at work.

2.3. Leaning on the past

In Southern European countries the degree of development of long-term care services remains extremely limited. Italy represents an interesting case where cash-for-care schemes reflect the traditional approach to social protection (based on cash transfers) rather than a recent reform. In absence of any substantial reform, the pre-existing cash allowance became the pillar of the Italian long-term care system.

2.3.1. The Italian ‘*Indennità di Accompagnamento*’

In Italy the family has long been assumed to be the ‘caring’ agency, given the existence of only very weak governmental family policies (Saraceno 1998). The needs of dependent elderly people have traditionally had to be met mostly within the (extended) family. Unpaid informal care is traditionally the most important source of care. Accordingly, family members have been subject to extensive legal responsibilities in supporting their relatives (Millar and Warman 1996; Saraceno and Naldini 2006).

Notwithstanding the diversity of territorial trajectories and degrees of development, formal care – whether provided in institutions or at home –has remained marginal. In particular, the provision of home services has only been residual and administered at the local level, with a limited availability of resources. The most important and widespread governmental measure is a national cash allowance – the *indennità di accompagnamento*, literally ‘companionship indemnity’ – originally intended for adult disabled people, but extended to older people in the mid-1980s.

Only in the second half of the 1990s the issue of long-term care was entered the political agent. A commission set up in 1996 to evaluate the “macro-economic compatibility of social spending” recommended, among other lines of reform, a review of the system of disability support and the introduction of a scheme to protect the dependent elderly (Commissione Onofri 1997). However, the subsequent legislation did not substantially reform the system of social protection for the dependent elderly.

Recently, regions and local authorities have introduced supplementary care allowances for heavily dependent elderly people living at home in difficult economic circumstances. These cash benefits are territorially dispersed and subject to diverse eligibility criteria. Moreover, they are of minor importance with respect to the targeted population (Da Roit 2006), while the *Indennità di accompagnamento* became the most relevant intervention for dependent older people.

3. Different regulations

Cash-for-care schemes show great variations also in their specific regulation with respect to eligibility rules, the use that can be made of the cash transfers, the funding and co-payment system, the kind of working relations that these schemes promote. They appear as various combinations of three different logics: state logic, based on policies, family logic, based on kinship, moral and personal obligations, and market logic characterized by the principles of competition and choice (Bureau et al., 2007, p. 95)

3.1. Different logics and eligibility criteria

3.1.1. Access to the benefit, coverage and generosity (table 1)

The age, the level of dependency and the level of income are three main criteria used to define the eligibility rules in the six countries (Table 1). In Italy, because the measure was first introduced to provide adult disabled people, the evaluation criteria reflect those used to assess work incapacity: in order to be entitled to the benefit a person must be evaluated as 100% per cent unable to work and, additionally, in need of constant care in order to carry out everyday activities. Nevertheless, such broad criteria can give rise to different interpretations by the local commissions in charge of the assessment and endowed with considerable discretionary power. In 2006, the beneficiaries of the *Indennità di accompagnamento* amounted to 1.49 million people of all ages, though two-thirds of them were aged 65 and above, i.e. 1.06 million people or 9 per cent of the elderly population (INPS, online). As of 2005, total expenditure was 9.5 billion euro, i.e. 43 per cent of the total social assistance budget (INPS 2006: 111).

By contrast, in the other countries, the resources delivered vary according to the level of dependency. As the Dutch Personal Budget has been introduced as a new possibility within the existing long-term care system, eligibility rules are similar to those that refer to the long-term care services. An independent body (CIZ) is responsible for the assessment of the need for exceptional care, which is based upon the severity and permanence of the illness, and for the indication of the necessary care resources to be provided within the collective scheme. The French care system is based on a single assessment grid, the AGGIR grid, which distinguishes six levels of dependency: delivered at home and in institutions³, the APA is allocated up to the fourth level. Because the French scheme is a national scheme implemented at local level, and in order to guarantee access to the same services across the country, to each level of dependency (i.e. the level of GIR) corresponds a maximum amount of money (see table 1).

In Austria and Germany the benefit entitlement is based on a medical report on the need for long-term care, including the need for personal services and for assistance. Benefits are paid for all age-groups on the basis of the need level. The Austrian *Pflegegeld* distinguishes seven levels of needs and the German LTCI three different levels. In both systems, each level corresponds to a number of hours of care needs. In Austria, Level 1 represents care needs amounting to more than 50 hours per month, while qualification for level 7 requires care needs of at least 180 hours per month combined with a lack of coordinated arm and leg movement or comparable conditions requiring regular care-related measures during the day and at night. At the end of 2007, there were

³ In the case of institutions the benefit can either be allocated to individuals or globally to the institution itself, which uses it according to the dependency needs of the residents. The choice between the two options is made by the institution. In France, institutions for the elderly distinguish among three expenditure components: dependency costs (paid by the resident and the APA), accommodation costs (paid by the resident), and healthcare costs (paid by the health insurance).

more than 381,000 recipients (Statistik Austria 2009⁴), representing about 4.6% of the country's total population. About 80% of recipients were aged over 60.

In Germany, the recipient has to be limited in his/her daily activities for at least six months and to need care for at least 90 minutes per day. Half of this time must be needed for personal care. This situation corresponds to the "care level 1". The system distinguishes two other levels of care, for elderly people with more important care needs. Each level corresponds to a certain care package if the family chooses support in kind or a precise amount of money if the choice is support in cash.

The level of income is another eligibility criteria which differentiates the LTC systems in the six countries. Delivered regardless of the level of income of the recipients in Italy, Austria and even in Germany, where the LTC insurance concerns all people who contribute to the health insurance system, the support is means tested in the Netherlands, France and Sweden. In this perspective, the question is that of who pays for Long term care?

3.1.2. Who pays for Long term care?

The six LTC systems are characterized by different visions of the private-public division of responsibility for long-term-care. This is apparent if we look both at the level of funding and at the rules that govern private funding.

First, the amount of the allowance and the way in which it is calculated is either linked to the presumed costs of care for each individual case (in the Netherlands) or to the amount of money that the collectivity is able/willing to pay for supporting dependant people with a certain level or threshold of disability (in Austria, Germany and Italy). As we will see, France is a mix of the two systems.

Second, and consistently with the above mentioned principle, it is possible to identify two payment logics, which determine the respective contribution of the dependant person and/or the family and of the collectivity to the costs of care (Le Bihan, Martin, 2006). The co-payment logic implies a financial contribution of the family whatever the level of dependency, according to the level of income (means tested allowance), calculated as a reduction in the cash allowance. The Swedish universalism is a first example of this copayment logic: eldercare is almost totally financed by taxes. The user only pays a small part of the costs (5-6%). The largest share of the costs (82-85%) is covered by local taxes and the rest by National taxes (10%). With a larger contribution of the family, it also characterizes the Dutch and the French systems.

In the Netherlands, in case the user opts for a PGB, the amount of money paid under the scheme depends on the assessed need for different kinds of care (nursing, caring, household activities etc.) according to a national system of hourly tariffs. Budgets can range from 1.200 up to 43.700 Euro per year (CvZ 2007). The average yearly budget provided in 2006 amounted to 11,550 euro (which means ... /month). The cash transfer is deducted by a mean-tested co-payment. Means testing includes the income of the dependent person (and spouse) In 2006, 60% of the budgets were reduced after means

⁴ www.statistik.at

testing of an average amount of 950 euro per year. In France, the allowance is universal but its amount is proportional to the level of income of the recipients. Under 677,25 € of income per month, the care package is totally funded and above this threshold, the recipient has to pay a contribution. In 2008, the allowance, was delivered to 1 115 000 users, which represent 7,8% of the population over 60 years old. The average amount of the APA, which can reach 1 208,94 €, was of 460€/month. In sum, the Dutch and French systems define first the overall care need for receiving and set the proportion of private and public contribution.

By contrast, the lump sum logic – that characterizes Italy, Austria and Germany - implies an individual and family responsibility in covering any additional costs that is not covered by the allowance. The French scheme is partly built on this principle as to each level of dependency corresponds a maximum amount of money. The family has to pay for any cost of the care package above these amounts. If the amount of money received is higher than in Germany, it is still not sufficient to cover care needs of highly dependent elderly people.

3.2. Different regulations of the use of the benefit

One of the main arguments put forward by governments to justify the development of cash for care systems is “free choice”. This choice is implemented at different levels. In Germany and the Netherlands, the old person has the choice between support in kind or in cash. 70% of German recipients receiving home care receive cash benefits. In 2003, 4,6% of 65 years old and more received cash, only 1,1% a combination of in kind and cash and 2,3% social services (Federal Statistical Office, 2005, quoted in Bureau et al., p. 102). In relation to the generalisation of the scheme after the experimental period, the number of people personal budget holders in the Netherlands rose steeply in the second half of the 1990s. The number of beneficiaries was slightly above 5,000 and it reached 60,000 in 2003 (De Boer and De Klerk 2007: 151) and 80,000 in 2007 (VWS, 2008). Budget holders are around 10% of all people assessed to be in need of extramural care. Whereas the beneficiaries of the AWBZ as a whole are around 5% of the Dutch population, PGB holders are only 0.5%. The recourse to the budget seemed since the beginning to be more widespread among younger handicapped than older dependant people (Miltenburg and Ramakers 1998). In 2005, budget holders aged 65 and above were 43% of the total (De Boer and De Klerk 2007: 152).

Giving the family the choice to organize the more appropriate care arrangement (according to the specific situation of the person concerned) is presented as a way to satisfy the families wish for more flexibility. Explicitly set out in the French, German and Austrian policies, emerging in Sweden, choice was originally not an issue in Italy, where the logics of the measure was more that of supplementing the income of dependent people who could therefore afford additional expenses. Cash for care schemes differ greatly in the ways in which cash benefits can be used. In this respect two distinct trends can be identified among our five countries (Sweden is not directly concerned by the cash payments logic which remains marginal). In France and the Netherlands, the benefit is given to finance a specific care package according to the needs of the recipient, as defined and controlled by public services. This does not exclude private negotiations in

the two countries. First, in both countries, the benefit can be used to employ a relative (except the spouse in France). An hybridation between informal resources and professional care can therefore be chosen by the families. Besides, in the Netherlands, a small part of the budget – 1.5% - can be used freely.

But the control principle in France and in the Netherlands introduces tighter regulation of the cash for care scheme. In the two countries, the assessment of the level of needs of the frail elderly implies also the definition of a care package, indicating the number of hours of home help needed each week (which in the Dutch case is distinguished by type of care). In France, if the frail elderly can choose to employ a professional carer or an informal carer the social workers and doctors who assess the needs often discuss and negotiate this choice with the family. And when the level of dependency is high, the carer has to be a professional. Moreover, the “Conseil general” (local authority in charge of the cash for care scheme) has to organize the control of the use of the benefit and to follow through the situation. Finally, even though it is not officially defined in the Law, the role of the non profit organizations who provide for these professional carers is in practice very important (Campeon, Le Bihan, 2006): the manager of the structure organizes the interventions of the professional carers, according of course to the care package and he r becomes a regulator of the care arrangement and an interlocutor of the frail elderly and the family each time there is a problem.

In the Netherlands, once the dependant person has obtained an indication and is transferred a personal budget needs to arrange his or her own care package, within the limits set by the indication committee. A stronger responsibility is put on the budget holder compared to the French case.

In the three other countries, the recipients of the benefit are free to decide how to use it.. When social services are purchased (in Austria and in Germany), care allowances are the main source (and calculation base) of the co-payments to be made by users. However, care allowances can also be used to pay family or other informal carers, even if this usually consists of financial support rather than the payment of an actual wage. Finally, and this has been an increasingly important development in the past decade, care allowances are used to pay immigrant carers, in all three countries (Österle and Hammer 2007; Da Roit et al 2007; ...).

3.3. Who cares?

Even in service rich countries such as Sweden and the Netherlands the family network remains a significant provider of care. Different theoretical and empirical studies (Saraceno, 2008) have criticized the “crowding out” hypothesis, according to which “public solidarity crowds out private, altruistically motivated solidarity, since it does not make any difference who is providing the resources, but only that these are available” (Künemund, 2008, p. 106). On the contrary, most studies show that a strong welfare state does not reduce the willingness of families to provide financial and in kind support to their elderly parents. Our analysis questions another dimension of this issue; what is the impact of cash for care schemes on informal care? Our hypothesis is that cash for care policies more or less explicitly, encourages the development of informal care. In this

perspective, the “crowding in” hypothesis, when public resources – financial resources in the case of cash for care systems – stimulates familial support, appears more relevant.

If we consider the use of the benefits proposed in the six countries, everywhere cash for care may be used to provide care in the informal sector and even in family/household sphere. Nevertheless, the vision of family care, and the ways in which family care is fostered differs greatly.

3.3.1. Visions of family caregiving

Austria, Italy and Germany represent cases in which cash-for-care schemes are meant as a more or less explicit and not formalized support for informal care. The Austrian cash-for-care approach, *Pflegegeld*, is – among other objectives – explicitly intended as a means to support informal care arrangements. But it attempts to achieve this goal without explicitly linking the provision of family care to the receipt of cash for care. Earlier studies have shown that the *Pflegegeld* receipt is in general related to some kind of financial arrangement between the care recipient and the informal care giver (Badelt et al. 1997). It is only in individual cases that actual employment relationships are established. In the case of care between spouses, *Pflegegeld* usually becomes part of the common household budget. In other circumstances, the benefit is used to buy care services and/or is transferred to informal care givers as financial recognition or as a means to arrange for care. The Austrian *Pflegegeld* system has meant relief for many informal care arrangements and is evaluated quite positively by informal carers (Pochobradsky et al. 2005; Badelt et al. 1997). Similarly, the Italian cash benefit system was initially intended to help disabled people bear the extra costs due to their disability. Given the extremely low regulation of the use of the benefit, the *Indennità di accompagnamento* is used to supplement family income, to pay informal caregivers, or to buy goods and services related to the disability. Despite the LTCI, in Germany, elderly people do not use care services more often than in Italy (Keck, 2008). The system favours family care giving and provides financial incentives to employ a family carer instead of social services. These benefits were not intended to formalise informal care relations, and they were used to supplement the family income and to pay informal carers, until the explosion of the grey care market (see below).

In France and the Netherlands, the support of family care takes place through the ‘formalisation’ (and monetisation) of family care. We are in presence of fully commodified care. It is indeed possible to use the French APA to pay a relative (except for spouses), but, as for the APA in general, a care package is defined by social and health professionals. This payment is conceived as a wage, and the relation is an employer-employee relation. Similarly, in the Netherlands, only the care that has been recognised as deserving collective funding can be ‘bought’ from a family member (and more generally an informal caregiver), provided that a working contract is established. By contrast, the collective system is not supporting (in financial terms) the provision of informal care that would be guaranteed in any case by family members.

If the weight of family responsibility is evident in Germany, Austria and Italy, where cash for care schemes can be seen as a form of relief, it should not be underestimated also in France, the Netherlands and Sweden.

In Austria, Italy and France (despite the higher degree of regulation of cash-for-care schemes) the family has traditionally played a major role in the care arrangements of dependant people. In all three countries cash for care schemes attempt to provide some relief for family care, and cash for care is indeed a solution to defamilialise care work and it has provided family members with some financial assistance to buy care in the market. In the Netherlands and Sweden, by contrast, the high degree of defamilialisation has long been a feature of long-term care policies. In recent times the introduction of the PGB in the Netherlands can be seen as a way of re-familialising care (even if in relation to a payment).

At the same time, it is increasingly stressed how the collective provision should be considered as “additional” and complementary to informal care that is voluntarily provided by the informal network. Surprisingly, Sweden is also concerned by the shift of responsibility from public authorities to families. Social services are still conceived as individual right, but its definition is ambiguous and introduces flexibility: the only requirement is that the individual has a reasonable standard of living and the municipal obligation to meet the needs concerns elderly who do not have any other solutions. In practice public services are more and more targeted towards the most dependent elderly, with limited family support. Moreover different national or local measures have been introduced within the framework of a more flexible care service provision and the recognition of family care. With the Attendance Allowance and the Law of Support and service to Disabled people, it is possible to pay a family member, friend or neighbor. The objective is to encourage family care and also to formalize informal care with the opportunity to be employed by municipalities as social carers.

Next to this, except for Sweden where the care arrangement is managed by a professional care manager, in all countries, the priority given to home care leads the family to become “care managers”. Who else than the family can organize the care arrangement, follow the evolution of the situation of the frail elderly? Even in France where regulation is stronger and where the professionalisation of care work is developing, the family remains the pivot of the care arrangement (Attias Donfut, Lapierre and Segalen, 2002; Le Bihan, Martin, 2006). Moreover, the resort to external care is expansive and families can not always afford to pay for all the care needed. Therefore, family members still contribute substantially to the costs of long term care. For these different reasons, care arrangements are usually a mix of informal and formal care. Family members, and more specifically women, are responsible for taking decisions on care responses. It has even been pointed out that care arrangements are viable only if an informal family carer acts as a care manager, and even provide complementary care activities (Da Roit, 2007).

The development of care leaves is another solution adopted by countries to facilitate informal care. The objective is to enable working carers to invest in caring activities in a work life balance perspective. In countries such as France, Sweden or Germany, it concerns care at the end of the elderly parents’ life, but in Italy, employee have the right to three paid days per month for caring obligations.

Though the situation varies from one country to the other, the evolution towards an increase of family care is a common trend. This evolution does not have the same

importance in all the six countries, the pace of reform is not the same but in practice, every where care arrangements appear as a combination of formal and informal resources and family members' responsibilities increase, as carers or as care managers.

3.3.2. Visions on care work

The guiding principles of the cash for care schemes have major consequences on the organization of care work and on care workers themselves,

There are three connections between the schemes and the development of employment in long-term care: the extent to which working conditions of employees contracted under cash-for care schemes are regulated; the extent to which the development of care employment relies on resources distributed through cash-for care schemes and the extent to which policies make an explicit link between the development of long-term care policies and employment in the care sector.

The control principle implemented in France and in the Netherlands has major consequence on the organization of care work: even if the old person can still choose the carer, the latter must be declared. On the contrary, in Italy, Austria and Germany, cash for care schemes favoured the growth of the grey market. Whereas cash for care schemes are crucial instruments in three out of six countries (Austria, Italy, France), only in France the link between the development of long term care policies and employment is explicit.

It is widely recognised in Italy, Austria and Germany that long-term care needs have fostered the development of a private-care sector extraneous to social and labour regulations. According to recent estimates, there are currently between 650,000 and 800,000 (i.e. 5.5-7% of the population aged 65 and above) immigrant care workers in Italy (Da Roit and Castegnaro 2004; Mesini et al. 2006), between 10,000 and 40,000 care workers in grey markets in Austria (Streissler 2004), and ??? in Germany.

The development of these grey care markets is due to the externalisation of tasks from families to paid care workers. This trend is based on the availability of monetary resources and on the availability of relatively cheap and undocumented immigrant labour. In Southern European countries, Latin America or the Philippines have for long been major source countries for household help workers organised in grey markets. During the 1990s, care work became a more prominent part of work packages, and workers were increasingly 'employed' specifically for care tasks. In the same period, the Central and Eastern European countries became the main sources of this kind of care labour. This growth has been co-determined by substantial differences in wage levels, the lack of legal opportunities to work in Western European countries, and not least geographical proximity. This is particularly the case in Austria, where grey care market arrangements are usually based on fortnightly shifts, that is, with two care workers replacing each other every two weeks in a care arrangement (Österle and Hammer 2007). Whereas these 'care work commuters' are mostly from neighbouring Central European countries, care workers from Eastern European countries and South America with long-term permanence predominate in Italy.

This development of a grey market is driven by three interconnected factors. Firstly, for families with caring tasks, this solution is seen as a more cost-effective alternative to family care and or to social service provision. Indeed, immigrants can provide 24-hour care which would not be available from the social services or would be too expensive for

families. Secondly, the arrangements yield better incomes to those providing care compared to the income opportunities in their home countries (Österle and Hammer 2007), all the more so because the arrangements usually provide free board and lodging. Thirdly, the grey market system reduces the pressure of increasing demand for social services. This is particularly the case in Italy, where social acceptance of the phenomenon extends well beyond the care sector and has helped attenuate pressures for improved social services. Taking these interests together, cash benefits have not directly 'caused' the rise of the grey market in long-term care, but they have certainly helped its development, especially in relation to the fact that the public authorities do not require justifications for the use to which the cash-for-care benefits are put.

If immigrant care is an affordable alternative to traditional care arrangements, it is so outside labour and social security regulations. This incurs numerous risks for those providing care on this basis: for instance, a lack of social insurance coverage, a lack of job security, and a lack of health and safety protection (Österle and Hammer 2007). Moreover, this sector undermines the development of social services in terms of the quality of employment relationships and with regard to measures aimed at developing and supervising quality standards in the social services. An attempt to regularise grey market arrangements has been implemented in Italy by means of a mass regularisation of undocumented immigrant care workers in 2002-2003. In Austria, care work in grey markets became a huge political issue in the summer of 2006, when cases of 'illegal care' were denounced to the authorities.

The first reaction to this situation was a general amnesty, which currently expires at the end of 2007. At the same time, a broad public debate on grey care work and policy responses able to ensure 24-hour care has started. As a response, in June 2007 a new legal procedure was enacted, although it is still subject to fierce debate. According to the new provision, people in need of 24-hour care (or their family carers) can apply for a subsidy if they employ a carer, either working for an organisation or on a self-employed basis. The difference between the labour costs for regularly employing household help and what is currently paid for grey care work is used as a benchmark value. However, and this is of the key issue in the ongoing debate, means-testing regulations (referring to the applicant's income and assets) are quite strict.

Regularisation in Italy has helped establish some basic employment rights, even if it has been obvious that the effects of regularisation are not long-lasting in the Italian case. Austria has attempted to limit the extent of grey care markets by subsidising regular employment arrangements to ensure 24-hour care. However, with restrictive definitions of the target group, strict means-testing, and limited financial support, the effectiveness in broadly regularising 24-hour care is highly questionable.

The development of a private care market is a main issue of the elderly care policies and concerns all the countries studied. The last decade have opened the care sector – traditionally dominated by non profit providers in France and Germany or public services in Sweden – to private for profit providers. In Sweden, in 2003, some 11% of services for the elderly were contracted out to private for profit organisations (Morel, 2007).

Care work also raises the question of the professional carers. In the different countries, one important challenge is to ensure a sufficient and qualified workforce in the care sector. In fact, even if you are granted a permanent job, care work in general and care work with elderly in particular is not a very attractive sector of activity. In Sweden, statistics points to a shortage of some 200 000 care employees for elderly and disabled people by 2015. Even in rich services countries, the sector is threatened by an important turn over as care employee often choose to leave for other work opportunities. Qualification of employees and good working conditions are main issues and care markets are very precarious in all the countries.

In this perspective, the French scheme which creation was directly linked with employment policies and with the desire of French policy-makers to find a way to create new jobs in the services sector is very specific (Le Bihan, Martin, 2007). From the outset, improvement of care services for frail older people was also intended to promote a potential source of employment, be it relational (family, neighbours, friends) or home-help services, which in France are called 'services to individuals' (*services à la personne*). These concern child care, as well as house cleaning, care for the frail elderly, or any help that the family may receive in its everyday life. In 1997, the creation of a benefit for frail elderly people - the PSD - was therefore considered an opportunity to support the local non-profit service providers managing personal assistants for the frail elderly. Though the effects were at first hardly positive, statistics (Chol 2007) evidence that the situation has changed since that period with the introduction of the APA and the priority given to qualified care. First, they show a growth in the number of services covered by a 'quality agreement'. Indeed, in 2005 the number of organisations delivering services to individuals⁵ was estimated at 11,000 (there were 7,000 of them in 2002), so that there has been an 18% increase since 2004. Second, the number of employees working for individuals at home increased from 958,475 in 2003 to 1.1 million in 2005. Finally, the number of employees in *prestataires*⁶ services also increased from 166,733 in 2003 to 211,269 in 2005.

This link between care and employment issues is also important because of the development of measures in favour of employment. Thus, in the 1990s a tax deduction was introduced to encourage the employment of domestic workers. This measure concerned childcare as well as house cleaning and care for the frail elderly. French families can deduct half of the cost of employing a declared worker from their income taxes. This measure had a major impact and enabled upper- and middle-class families to resort to such facility. Also introduced was a voucher, the '*cheque emploi service*' ('service employment voucher'), which simplified the administrative payment procedure for families. More recently, in 2005, the "Borloo Plan", which concerns 'social cohesion', has organised the development of employment in this sector of services to

⁵ These statistics concern a larger sector than the 'personal assistants' who care for frail elderly. Services to individuals include care of the frail elderly, childcare, domestic tasks, and all support needed by individuals (such as gardening, computer help, odd jobs). Care of the frail elderly represents 60% of all services covered by 'quality agreements' and 33% of domestic tasks.

⁶ In France, families have three ways in which they can pay someone for the caring tasks: direct recruitment (the old person chooses the carer and is the employer), "mandataires" services (the carer is a professional of a non profit organization but the old person remains the employer), "prestataire" (the non profit organization is the service provider and the employer).

individuals. The aim is to extend access to such services, to professionalize the sector, and to simplify the administrative procedures. In February 2006 a specific plan for the development of such services announced the creation of between one to two millions jobs by 2010 and created a specific Agency to organise this sector (“*Agence des services à la personne*”). This strong link between employment and care policies and the priority given to qualified care do not mean that in France old people are cared for only by qualified care workers. First because just as in the other countries, there are not enough qualified care workers to meet the care needs, second because it remains more expensive than informal paid work and family can not afford it in situations of high levels of dependency. Therefore if there is no evidence of the development of a grey market, it does not mean that it does not exist⁷.

The Netherlands did not attach specific employment policy goals to the introduction of the PGB, On the other hand the growth of a large underground sector did not occur, probably due to the high degree of regulation of the measure. The long lasting development of long term care policies had an important effect on the growth of (mostly female) employment in the sector. On the other hand, the diffusion of the PGB still has a reduced impact given its limited development with respect to the provision of in-kind services. As a result, the consequences on care work of the introduction of the cash for care schemes can only be very limited for the time being. There is no evidence of a growth in the underground economy of care. The presence of migrant workers in care services, which has been investigated mainly qualitatively (The, 2008) appears limited to regular employment in nursing home.

4. Cash-for-care and long-term care configurations: discussion and conclusion

The paper highlights the extent to which cash-for-care schemes in Europe differ with respect to their relationship with broader long-term care policies, their regulation and the vision of (informal) care work they entail.

A first long-term-care configuration is that of a **(persistent) social service model** embodied by Sweden and the Netherlands. These social-service based LTC systems that have undergone several transformations in the past 15 years, the introduction of cash for care schemes being one of them.

In both countries the cash-for-care logic has been a breaking element with respect to the past. However, the weight of cash benefits remains very limited in both contexts (and even more so in Sweden) when compared to the overall coverage of the perspective long-term care schemes.

Moreover, also in the Netherlands, where the diffusion of cash for care is relatively greater, the scheme is characterized by a high level of regulation, generosity and inclusiveness.

Problems: costs; care shortages etc.

⁷ It exists as a complement of the APA, when families use their own financial resources to pay for care ; and it seems to exist also in some “departments” with the APA, when the control of the use of the benefit is too weak.

A second model is that of a **LTC strongly based on highly regulated cash for care scheme**. This model is embodied by France, where the development of a new social protection scheme was strongly based, on the one hand, on a policy based on cash-for-care and on the other hand, explicitly aimed at sustaining the development of care services (also for the purpose of boosting employment in the sector). Delivered to all frail elderly people over 60 years old proportionally to their level of income and defined to finance a specific care package, its use is controlled by local authorities. Considering the increase of the population concerned, the difficulty represented by the training of qualified workers, and the cost of such a scheme, a reform of the APA has been announced in 2008 (Vasselle, 2008). The public LTC allowance as it exists today will be targeted to the more needy. A basic amount of cash benefit will be attributed to all dependent people, and the complement will rely on individuals for those who can afford it, which implies the development of private insurance.

The third model is an **LTC system based on unregulated cash-for-care transfers**. This model is embodied by Austria, Germany and Italy, the difference being between the first two and the third country the historical trajectory that brought to the consolidation of the system: while in Austria and Germany the current LTC system is the result of an explicit new policy initiative that took place in the first part of the 1990s, in Italy it is inherited by the traditional system of social protection in favour of disabled people.

All three models display an apparent universalism (in the fact that they provide support to all dependent old people), which is in fact contradicted by the limited ability to cover care needs, the explicit reliance on family care and monetary contribution and the implicit reliance on a non-regulated and low-qualified a care market.

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Table 1 – Regulation of the cash for care schemes

	Benefit scheme	Benefit levels and benefit rates per month	Recipients	Entitlement criteria	Assessment tools	National – local	Use of benefits
Sweden?	Attendance Allowance	Symbolic payment	Informal carers				
Netherlands	<i>Persoonsgebonden budget (PGB)</i>	For a set of functions (household care (until 2007): personal care, etc.) need is evaluated in terms of number of hours of help needed (class). Each function-class is associated to an hourly rate Average budget, 2006: € 11,500/year	those in need of care	Needs tested Means tested (reduction of budget according to income); In 2006: 60% circa of budgets were reduced of € 950/year on average. No age limit	National standardised assessment tool; Implemented by local assessment boards	National legislation; national funding	Recipients must justify their expenses (only 1,5% can be use freely)

France	<i>Allocation personnalisée d'autonomie</i>	4 levels, 2007: up to 509.91€ for a Gir 4; up to 764,87€ for a Gir 3; up to 1 019, 83 for a Gir 2; up to 1.189.80€ for a Gir 1	those in need of care	needs tested over 60 years old; means tested	a unique grid: the AGGIR grid (6 levels of dependency)	national legislation; local implementation; mainly local funding	benefit must pay for a care package precisely defined by social and health professionals
Germany	<i>Long Term Care Insurance</i>	3 levels level 1: 205 € level 2: 410 € level 3: 665 €	Those in needs of care who contributed (social and health insurance recipients)	Needs tested	Unique medical grid	National legislation Local implementation	Free use
Austria	<i>Pflegegeld</i>	7 levels, 2007: € 148.30 - € 1,562.10	those in need of care	needs tested (> 50 hours of care needs; continuous care); not means-tested; no age limits	assessment by doctors covering nursing, personal, home and assistance needs	based on national and provincial legislation, administration and funding; but following the same principles	recipients are free in the way they use the benefit

Italy	<i>Indennità di accompagnamento</i>	Unique level, 2007: 457.66	those in need of care	needs tested (100% disability and need of continuous care); not means tested; no age limits	broad national criteria; implementation by local commissions	national legislation; national funding	recipients are free in the way they use the benefit
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Table 2 – Coverage rates and expenditure for LTC and cash for care schemes

	Benefit scheme	Population 65+ (% of total population) in million, year 2007	Coverage cash-for- care schemes on population 65+	Coverage residential care (estimates)	Coverage home care services (estimates)
Sweden (a)		1.6 (17.4%)			
Netherlands (b)	<i>Persoonsgebonden budget (PGB)</i>	2.4 (14.5%)	1.4%	6%	18%
France (c)	<i>Allocation personnalisée d'autonomie</i>	10.3 (16.2%)	Population 60+ 7,8%	6,2%	3,7%
Germany (d)	<i>Long Term Care Insurance</i>	16.4 (19.8%)	11%	4%	3%
Austria (e)	<i>Pflegegeld</i>	1.4 (16.9%)	20%		
Italy (f)	<i>Indennità di accompagnamento</i>	11.9 (19.9%)	10%	2%	3%

Sources: elaborations and estimates based on Eurostat data and:

(a)

(b) VWS 2007; De Boer and De Klerk 2007; Egging et al 2009

(c) * INSEE, 2008. ** DREES, 2003

(d) Federal statistical office, Germany (Genesis Database)

(e)

(f) Inps, online dataset of pensions' beneficiaries; Inps 2006;

Table 3 - Cash-for-care logics

	Benefit scheme	Timing and role in LTC policy	Weight of choice	Logics of private-public funding	Monetisation of informal care	Regulation of employment-employee relations	Link with employment policies	Grey care market
Sweden		Flexibilisation of long established LTC	Marginal	Public responsibility; private co-payment	Explicit	High	No	No
Netherlands	<i>Dutch personal Budget (PGB)</i>	Flexibilisation of long established LTC	Very important	Public responsibility; private co-payment	Explicit	High	No	No
France	<i>Allocation personnalisée d'autonomie</i>	Foundation of LTC policy	Important	Public responsibility; private co-payment	Explicit	High	Yes	No
Austria	<i>Pflegegeld</i>	Foundation of LTC policy	Important	Public limited responsibility; private complement up to the full costs of care	Implicit	None	No	Yes
Germany		Foundation of LTC policy	Important	Public limited responsibility; private complement up to the full costs of care	Implicit	None	No	Yes

Italy	<i>Indennità di accompagnamento</i>	Core position in fragmented and implicit LTC	Implicit	Limited public responsibility; private complement up to the full costs of care	Implicit	None	No	Yes
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