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Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies

BARBARA DA ROIT and BLANCHE LE BIHAN

Utrecht University; École de Hautes Études en Santé Publique

Context: In response to increasing care needs, the reform or development of long-term care (LTC) systems has become a prominent policy issue in all European countries. Cash-for-care schemes—allowances instead of services provided to dependents—represent a key policy aimed at ensuring choice, fostering family care, developing care markets, and containing costs.

Methods: A detailed analysis of policy documents and regulations, together with a systematic review of existing studies, was used to investigate the differences among six European countries (Austria, France, Germany, Italy, the Netherlands, and Sweden). The rationale and evolution of their various cash-for-care schemes within the framework of their LTC systems also were explored.

Findings: While most of the literature present cash-for-care schemes as a common trend in the reforms that began in the 1990s and often treat them separately from the overarching LTC policies, this article argues that the policy context, timing, and specific regulation of the new schemes have created different visions of care and care work that in turn have given rise to distinct LTC configurations.

Conclusions: A new typology of long-term care configurations is proposed based on the inclusiveness of the system, the role of cash-for-care schemes and their specific regulations, as well as the views of informal care and the care work that they require.

Keywords: Long-term care, cash-for-care, care work, informal care.

Address correspondence to: Blanche Le Bihan, EHESP-SOLO, Avenue du Professeur-Léon-Bernard - CS 74312, 35043 Rennes Cedex (FR) (email: Blanche.LeBihan@ehesp.fr).

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Since the 1990s, cash-for-care schemes have been a common trend in social policies, particularly in the field of long-term care (LTC). Instead of services, these schemes give people monetary benefits, which they can use to purchase care services.

Most of the literature on this topic concerns the common objectives and possible implications of cash-for-care schemes. One of the main ideas behind cash-for-care is "free choice"; that is, disabled (older) people and/or their families may choose among different kinds of care and care providers, thereby giving them both autonomy and control, which disabled people's organizations have sought since the 1970s (Glendinning 2008). The resulting competition among care providers also has enhanced the quality and efficiency of care (Kremer 2006) in accordance with a "new public management" perspective (Ferlie, Lynn, and Pollitt 2007). Another objective is the recognition of (formerly unpaid) informal care, since many cash-for-care schemes allow beneficiaries to compensate or employ their relatives (Ungerson 1997). Finally, cash-for-care schemes can be seen as opportunities to offer LTC policies that are less expensive than traditional services.

A closer inspection of cash-for-care schemes in various European countries also reveals some striking differences among them. First, the strict regulation of cash-for-care schemes has strongly influenced the "commodification of care" (Ungerson and Yeandle 2007), as well as the development of specific forms of care work and informal care (Da Roit, Le Bihan, and Österle 2008). Moreover, besides some exceptions (Lundsgaard 2005), researchers have tended to focus on cash-for-care schemes as specific policy instruments separate from more general LTC policies.

The aim of this article is, on the one hand, to extend the discussion about the diversification of cash-for-care schemes and, on the other, to place them in broader institutional frameworks, namely, as part of general LTC policies. We claim that only when looking at the diverse institutional contexts in which these new schemes developed and the specific regulations that they entail can we understand them.

We first consider the policy and institutional context in which cash-for-care schemes have been introduced in Sweden, the Netherlands, Austria, Germany, France, and Italy, particularly the degree and forms of development of previous LTC policies and the specific policy debates concerning each. We then address the specific regulations of the schemes

and their different visions of informal care and care work. Finally, we discuss three LTC patterns that emerged from our analysis.

Cash-for-Care in LTC Schemes: Trajectories and Timing

Cash-for-care schemes were developed at different times and in different policy settings. When we looked at the development of LTC policies at the time that care allowances and reforms were introduced, we found three distinct groups of countries.

When they drew up comprehensive LTC policies during the 1970s and 1980s, the Netherlands and Sweden used cash-for-care schemes as instruments to adapt existing policies to changing circumstances. France, Germany, and Austria, which had few and inconsistent social services for (older) dependent people, used cash-for-care schemes as the basis of new social protection schemes. Finally, Italy, which undertook no major reform in its LTC policies, by default used cash-for-care schemes as their basis.

Making Existing LTC Systems Flexible

For countries that had well-developed LTC policies before the 1990s, cash-for-care schemes represented only one instrument (among others) to reform policies that were seen as too supply oriented, costly, and unresponsive. The Dutch and Swedish cases illustrate this type of development, and with similar tensions. Although new public management ideas and instruments are important to both, the issues of choice and the empowerment of users are far more prominent in the Netherlands than in Sweden. The result was that cash-for-care schemes were more central to making the LTC system more flexible in the Dutch case than in the Swedish case.

The Dutch Persoonsgebonden Budget (PGB). The Netherlands had a strong, collective LTC system quite early. Since the late 1960s, LTC has been financed by a national compulsory insurance, the Algemene Wet Bijzondere Ziektekosten (AWBZ), which covers the care costs of dependent people of all ages. Although it was initially intended mainly

for residential care, the AWBZ was gradually extended to domiciliary services and comprehensive home care assistance.

As a result, the Dutch policies first promoted taking the care of older people away from the family, by means of social policies similar to those of the Scandinavian countries. But the Dutch system became increasingly expensive and also was criticized for its paternalism and the excessive power of professionals. Beginning in the 1990s, several reforms sought by the beneficiaries led to the development of care markets and of informal care. The Dutch cash-for-care scheme—the Persoongebonden budget (PGB, or Personal Budget)—is one of these reforms, and it marks the success of organizations of older and disabled people, which sought more freedom and autonomy, more individual responsibility, and fewer state costs (Kremer 2006). Introduced as an experiment in 1995, the PGB was generally adopted in 2001, when anyone needing home care could choose a PGB, traditional services, or a combination of the two. PGB users are allowed to spend their allotment on professional care (from either a market or a nonprofit organization) or to employ a professional or an informal caregiver.

Challenging Swedish Universalism. Sweden has a well-established, universal, public LTC system. In the 1950s, social services for the elderly were introduced, funded by taxes and provided on the basis of citizenship rights (Morel 2007). But by the 1990s, this ideal LTC system was beset by financial difficulties. It was first revised by the Ädel Reform of 1992, when the overall responsibility for social care and health care for the elderly devolved to the municipal level. As a result, the number of elderly "bed-blockers" in county council institutions was reduced; the cities' housing capacity for frail elderly was expanded; and round-the-clock home care was offered (OECD 2005).

In order to contain costs, other strategies were adopted as well, including enhancing the role of family caregivers. Care services were thus increasingly restricted to highly dependent elderly with limited family support (Sundström, Johansson, and Hassing 2002), thereby greatly lowering the coverage of home care (OECD 2005). All these changes challenged the system's universalism (Burau, Theobald, and Blank 2007) and increased the family's responsibilities.

In accordance with this framework, cash payments have been used to introduce some flexibility into the system (Szebehely 2005). The Attendance Allowance, which was established in the 1940s for the care

of disabled family members, was extended to the frail elderly. Some municipalities also introduced an allowance for caregivers, which the frail elderly could use to employ a relative. Finally, 63 percent of Sweden's municipalities extended to disabled people the right to personal assistance and offered them different types of support, including the right to employ a relative (Burau, Theobald, and Blank 2007). In fact, unlike in the other countries we studied, care allowances are still being debated in Sweden as part of the controversial issue of economic support for informal care, which could reduce the availability of formal services and thereby threaten the participation of women in the labor market. In other areas of welfare, particularly child care, the issue of choice has never been a crucial one in Sweden, where the main concern has been to prevent new policy measures from hindering women's independence (Hiilamo and Kangas 2009).

Establishing New LTC Policies

LTC policies have been a more recent concern in the continental European countries. Although family responsibilities and some social provisions have traditionally characterized care for the (elderly) disabled, since the mid-1990s a new awareness of the enormous LTC problem has emerged. The result, as the cases of Austria, Germany and France illustrate, has been the introduction of national social protection schemes based in particular on cash-for-care interventions.

The Austrian Pflegegeld. In the past, Austrians viewed LTC as the family's responsibility, and its policy provisions were highly fragmented. Modest cash benefits were restricted to specific groups and disbursed only in specific circumstances. Residential care was provided by many municipalities on the basis of social assistance (means-tested) principles. Before the 1990s, home care services were available only in a few regions, and even these were often limited to nursing care (Hammer and Österle 2003).

The debate that led to the 1993 reform was greatly influenced by organizations of disabled people. Consequently, the LTC policies were not focused exclusively on the elderly, but more generally on all dependent persons. Both disabled people's organizations and other groups supporting choice and market-driven reforms of LTCs strongly advocated cash benefits as an approach enabling the recipients' empowerment. This 1993 reform was therefore enacted on the basis of a broad consensus

(Pfeil 1994). The Austrian federal government set up a social insurance scheme for dependents that gave a care allowance to all people meeting established criteria based on needs (regardless of income). The provinces were responsible for residential and semiresidential services and home care, and the allowance's beneficiaries could choose how to spend their benefit. There have been no fundamental changes in these principles since 1993.

German Social Insurance. Like Austria, Germany has a strong tradition of voluntarism and family support marked by the idea of subsidization and the sharing of care responsibility between family and society (Burau, Theobald, and Blank 2007). Until the early 1990s, LTC was based on a means-tested system managed by the Länder (federal states) and the cities. But increasing needs and the growing financial pressure on local authorities led to a reform in 1994 recognizing that dependency was a social risk and creating LTC insurance (LTCI). The new policy is funded by the state's social services and provides benefits on the basis of need, regardless of income. But unlike social health insurance, the LTCI covers only basic needs and must be supplemented by either the family's resources or social assistance. Beneficiaries may choose between receiving services or a cash benefit. This mixed system was justified as the best way to acknowledge the investment of family caregivers through cash payments and to guarantee high-quality care through professional services.

The French Allocation Personnalisée à l'Autonomie. Until the mid-1990s, the main measure for frail older people in France was the Allocation compensatrice pour tierce personne (ACTP, or compensatory allowance for a third party), a care allowance devised for disabled people and available to older people as well. In the mid-1980s, dependency was added to the political agenda. Even though several experts' reports agreed on the importance of tackling the problem, there was no consensus on a solution, especially on the choice between social insurance and social assistance (Frinault 2003), on whether the scheme should be universal or reserved for the "poorest," or on the division of responsibilities between the state and local authorities. Despite some experts' recommendation of care services, a cash-for-care scheme was adopted (Martin 2003). Following the tradition of social assistance (Lafore 2003), in 1994 the government experimentally introduced a new means-tested benefit for the poorest dependent old people, which was implemented at the local level (by the *départements*). The generalization of the benefit in 1997 was

widely opposed, given its very low coverage. So in 2002, the Allocation personnalisée à l'autonomie (APA) was introduced, a cash scheme based on universalistic principles and with the objective of increasing the number of recipients. Recipients can use the allowance to employ a care worker of their choice, including a relative (except their spouse).

Since the introduction of the APA, the debate in France has centered on the coverage of dependency as a fifth risk, after the other four in France's social security system (health, pensions, family, and work accidents). In 2004, the creation of the Fund for Autonomy (Caisse nationale de solidarité pour l'autonomie)—financed by employers' contributions, national taxation, and the transfer of credits from the social security fund—was a first step toward LTC's traditional social insurance principles. More recently, however, the French government announced that it would in fact introduce a mixed system based on public support and private insurance (Le Bihan and Martin 2010).

Relying on the Past: Missed Reforms

LTC policies still are extremely rare in southern Europe. Italy represents an interesting case whose cash-for-care schemes reflect the traditional approach to social protection (based on cash transfers) and have not been substantially reformed.

The Italian Indennità di accompagnamento. In Italy, the family has long been assumed to be the "caring" agency, given the country's weak and fragmented policies (Saraceno 2003). Unpaid informal care traditionally has been the most important source of care, and family members have extensive legal responsibilities for supporting their relatives (Millar and Warman 1996; Saraceno and Naldini 2007). Formal care, provided in institutions or at home, is marginal; instead, services are administered mainly at the local level, with few resources available. A national cash allowance, the Indennità di accompagnamento (IdA, or companionship indemnity), which was introduced in 1980 for adult disabled people, was extended in the mid-1980s to older people, long before the issue of LTC entered the political debate. The recommendations of a commission formed in 1996 to evaluate the "macroeconomic compatibility of social spending," to review the system of disability support, and to introduce a LTC scheme (Commissione Onofri 1997) were substantially ignored. Recently, however, several regions and local authorities have introduced

supplementary means-tested allowances for heavily dependent elderly people living at home. These allowances are dispersed locally, are subject to varying eligibility criteria, and have had little systemic impact (Da Roit 2007b). Rather, the IdA has become the main intervention for dependent older people (Ranci 2008).

Different Regulations

Cash-for-care schemes also differ markedly in their specific regulations with regard to eligibility rules, the use of cash transfers, the funding and copayment system, the kind of working relations promoted by these schemes, and their mix of formal and informal care.

Payment Rationales

Access and Coverage. Age, need, and income are the three main criteria used to define entitlement to cash-for-care schemes in the six countries considered here (see table 1).

Five of the six countries do not impose an age limit on access to the cash benefit. Because the PGB was introduced in the Netherlands as a variant of the main LTC policy—which covers the entire population—age is not a criterion for eligibility. In Italy, the IdA, initially intended for disabled adults only, was later extended to all older people, so the same regulations apply regardless of age. Likewise in Sweden, the existing regulations for the disabled were extended to the elderly. In the three countries that introduced cash payments as the basis for the new LTC schemes in the 1990s, the specific way in which they constructed the policy problem has affected the age for eligibility. When they introduced their new schemes, Austria and Germany explicitly decided to adopt a general policy rather than an old people's policy. In France, by contrast, because it has a separate policy for disabled people, the APA is intended for people aged sixty and older.

The benefits in most of these countries vary according to need. Because the Dutch Personal Budget was introduced as a new measure within the existing LTC system, the eligibility rules are similar to those for the LTC services. An independent body (CIZ) is responsible for the assessment, which is based on a national assessment tool. Based on the number

TABLE 1
Regulation of Cash-for-Care Schemes

Country	Benefit Scheme	Recipients	Entitlement Criteria	Benefit Levels and Benefit Rates per Month	Assessment Tools	National and Local	Use of Benefits
Sweden	Attendance allowance	Dependents, who can pay an informal caregiver	Min. care need of 17 hrs/week	€487 max	Depends on care manager	Defined by municipalities	Symbolic payment for informal caregivers
Netherlands	Persoonsgebonden budget (PGB)	Dependents	No age limit Needs test Income-related reduction of benefit	Hourly rates per function Average budget, 2006: €11,500/year In 2006, 60% of budgets were reduced by €950/year on average	National assessment tool implemented by local assessment boards	National legislation and funding Since 2007, responsibility for home help decentralized to municipalities	Recipients must justify expenses (1.5% can be used freely) Professionals and informal caregivers (including relatives) can be employed
France	Allocation personnalisée d'autonomie	Those in need of care	Age: 60+ Needs test Income-related reduction of benefit	4 levels, 2007: up to €524,84 for a Gir 4; up to €787,26 for a Gir 3; up to €1,049, 68 for a Gir 2; up to €1,224,63 for a Gir 1 Average amount: €494	A single grid: the AGGIR grid (6 levels of dependency)	National legislation; local implementation; mainly local funding	Benefits pay for a care package defined by professionals. Relatives can be hired (except spouses)

Germany	Long-term care insurance	Insured dependents	No age limit Needs test Income not considered	3 levels level 1: €215 level 2: €420 level 3: €675	Unique medical grid	National legislation, local implementation	Free use
Austria	Pflegegeld	Dependents	No age limit Needs test Income not considered	7 levels, 2007: €148.30 to €1,562.10	Assessment by doctors	National and provincial legislation, administration, and funding; but following the same principles	Free use
Italy	Indennità di accompagnamento	Dependents	No age limit Needs test (100% disability and need for continuous care) Income not considered	Flat-rate payment, 2009: €472 €457.66	Loose national criteria, locally implemented	National legislation and funding; regional administration	Free use

of hours of the specific care needed, recipients may choose either a corresponding number of hours of services or, if the user opts for a PGB, a monetary sum. The French system also is based on a national assessment grid, which distinguishes six levels of dependency. The APA is determined up to the fourth level, and each level is given a maximum amount of money to be allocated according to the recipient's needs and income.

Austria and Germany base their assessment on a medical grid. The Austrian Pflegegeld has seven levels of needs, and the German LTCI has three levels. In both systems, each level corresponds to a range of monthly hours of required care. Whereas the Austrian benefit is entirely monetary, German users may choose between care services and a cash allowance, the level of which is lower compared to the value of the services allocated if the recipients choose the services option. Only in Italy is need used as the sole criterion for benefits. Because the IdA was introduced first for disabled adults in addition to other cash provisions, the level of need required to receive the benefit is very high and is a flat rate. Moreover, the criteria are similar to those used to assess work incapacity and are so broadly defined—one must be completely unable to work *and* in need of constant care—that much of the evaluation decision is left to the local assessment bodies.

Sweden has no single assessment grid, and the Attendance Allowance, whose amount varies among municipalities, is delivered to elderly people according to their level of dependence and the amount of care needed, calculated in hours of help given per week.

In Italy, Austria, Sweden, and Germany, the beneficiary's income has no impact on eligibility and on the amount of cash transfers, whereas in the Netherlands and France, the benefit is reduced—in the form of a copayment—as the beneficiary's economic resources increase.

This diversity in eligibility criteria, together with the availability of alternatives to the cash-for-care benefits, has important consequences on the six countries' coverage of cash-for-care schemes (see table 2). In both Sweden and the Netherlands, the coverage of services, both residential and domiciliary, are comparatively very high, but the beneficiaries of care allowances are only a tiny minority of the older population (as low as 1.4% in the Netherlands and 0.1% in Sweden), and cash payments still represent only a small part of the LTC provision. In the Netherlands, the overwhelming majority of beneficiaries has continued to opt for traditional services. In Sweden since the 1980s, the number of recipients

TABLE 2
Coverage Rates for LTC and Cash-for-Care Schemes, Mid-2000s

Country	Benefit Scheme	Population 65+ (% of total population) in millions, 2007	Coverage of Cash-for-Care Schemes for Population 65+ (%)	Coverage of Residential Care (estimates, %)	Coverage of Home Care Services (estimates, %)
Sweden	Attendance allowance	1.6 (17.4%)	0.1	7	10
Netherlands (a)	Persoonsgebonden budget (PGB)	2.4 (14.5%)	1.4	6	18
France (b)	Allocation personnalisée d'autonomie	10.3 (16.2%)	7.8 (on population 60+)	6	n.a.
Germany (c)	Long-term care insurance	16.4 (19.8%)	11	4	3
Austria (d)	Pflegegeld	1.4 (16.9%)	18	4	n.a.
Italy (e)	Indennità di accompagnamento	11.9 (19.9%)	10	2	3

Sources: Calculations and estimates based on Eurostat data; Lundsgaard 2005; OECD 2005; and (a) De Boer and De Klerk 2007; Egging, Pommer, and Woittiez 2008; and VWS 2007; (b) DREES 2003; and Pla 2009; (c) Federal statistical office, Germany (Genesis Database); (d) Statistik Austria; and (e) INPS, online dataset of pensions' beneficiaries.

of these cash payments has even fallen because cash-for-care is not the principal strategy to contain LTC expenditures (Lundsgaard 2005). By contrast, cash payments are at the core of the LTC systems in the other four countries, where the recipients of allowances greatly outnumber the recipients of services or where the latter also use the care allowance to pay for these services.

Who Pays for Long-Term Care? The specific ways in which the interventions are designed also reflect different visions of the private/public division of responsibility for LTC.

The generosity of the (care or cash) provision and the way in which it is calculated are linked to either each beneficiary's estimated care needs—possibly reduced by an amount paid by the users on the basis of their economic circumstances—or the amount of money that the public authorities are able or willing to pay for the support of dependent people with a certain level of disability. Two different rationales determine the extent to which the costs of care are sustained by the dependents and/or their families and by the state policy (public policy) (Le Bihan and Martin 2006): the "copayment" rationale and the "lump-sum" rationale.

The copayment rationale implies the assumption of responsibility for care needs by the state and a financial contribution by the individual and/or family, whatever the level of dependence. This rationale is well represented by the Swedish global elderly care system and the Dutch cash *and* care system. In Sweden, access to services is generous and subject to a copayment that is marginal with respect to the overall costs of those services. In the Netherlands, when a user opts for the PGB, the same rationale applies: the amount of the benefit is based on the value of the overall care needed, minus a private contribution, which remains small.

By contrast, the lump-sum rationale, used in Italy, Austria, and Germany, is based on the idea that the state (public authorities) contributes a certain amount of resources to the costs of care, and it implies an individual and family responsibility for covering any other costs. In comparison, the benefits for highly dependent people are particularly low in Italy (€472) and in Germany (€665) but is the *average* budget in the Netherlands. In Austria, despite a similar payment rationale (Da Roit, Le Bihan, and Österle 2008), the benefits are higher. Likewise, according to the lump-sum rationale, Sweden's Attendance Allowance is considered as a "symbolic payment" to support family caregivers but in fact is as large as the Italian IdA (around €487).

The French scheme is mixed. On the one hand, it has a copayment rationale similar to that of the Dutch PGB. When a beneficiary's income rises above a given threshold, an income-related contribution is requested. On the other hand, the French scheme is also partly built on the lump-sum rationale, because it offers a *maximum* benefit for each level of dependency, and the family must pay the cost of any care above this amount. Although the amount of the benefit is higher than in Germany, Italy, or Austria, it is less than in the Netherlands and, in any case, is insufficient to cover the greatest care needs.

These regulations entail different assumptions of LTC policies and views of who should care and how. We address this issue next by looking at the LTC policies' different cash-for-care schemes, especially the meaning of choice, family care, and care work (table 3).

The "Free Choice" Rationale. One of the main arguments that governments use to justify cash-for-care systems is "free choice." An explicit goal of the Dutch, French, German, and Austrian policies and, to a limited extent, of the Swedish policy is enabling dependent people and their families to choose the most appropriate care arrangement. In Italy, choice—which originally was not an issue—has recently gained ground.

Choice is implemented at different levels. First, in Sweden and the Netherlands, elderly people can choose whether they want their home care to be provided by a public, nonprofit, or for-profit entity.

Second, in Germany and the Netherlands, it is possible to choose between care services or cash benefits or a combination of the two. In Italy, Austria, and France, however, beneficiaries must rely solely on their allowances.

Third, all cash-for-care systems give some freedom to users to determine the type and amount of care they receive. But the regulations differ greatly in how the cash benefits may be used. There are two different models. France, the Netherlands, and Sweden have tighter regulations. The benefit is meant to finance a specific care package—defined as the number of hours per type of care—according to the recipient's needs as defined and controlled by the social service system. This includes the right to choose one's personal assistant, who may be a professional or a relative (except, in France, one's spouse). But the use of the benefits is strictly controlled, and the users must justify their expenses. By contrast, in Germany, Italy, and Austria, recipients are free to spend their benefits as they wish. In Germany, however, an agency periodically reviews the

TABLE 3
Cash-for-Care Rationales

Country	Benefit Scheme	Timing and Role in LTC Policy	Weight of Choice in Debate	Rationales of Private vs. Public Funding*	Monetization of Informal Care	Regulation of Employment/ Employee Relations	Link with Employment Policies	Importance of Gray Care Market
Sweden	Attendance allowance	Flexibility of established LTC policy	Marginal	Copayment	Explicit	High	No	Limited
Netherlands	Dutch personal Budget (PGB)	Flexibility of established LTC policy	Very important	Copayment	Explicit	High	No	Limited
France	Allocation personnalisée d'autonomie	Foundation of LTC policy	Important	Copayment	Explicit	High	Yes	Limited
Austria	Pflegegeld	Foundation of LTC policy	Important	Lump-sum	Implicit	None	No	Large
Germany	Long-term care insurance	Foundation of LTC policy	Important	Lump-sum	Implicit	None	No	Large
Italy	Indennità di accompagnamento	Core position within fragmented and implicit LTC policy	Implicit	Lump-sum	Implicit	None	No	Large

Note: *Copayment rationale = public/collective responsibility, with private copayment; lump-sum rationale = limited public responsibility integrating mainly private responsibility.

recipients' circumstances, which means that the families must decide a care arrangement.

Visions of Family Care. Among the explicit or implicit aims of cash-for-care policies is the encouragement of informal care (Glendinning and Kemp 2006), which the state uses its financial resources to stimulate or support. In all the countries considered, the benefits may be used to pay informal caregivers, generally including close relatives. Yet the ways in which family care is fostered and the underlying vision of family care differ greatly.

The cash-for-care schemes in Austria, Italy, and Germany are intended to provide implicit and non-formalized support for informal care without directly linking the benefit to compensation for the caregivers. The benefit thus often represents additional income for the user, and the financial arrangements between the beneficiaries and their caregivers are left to the family (Badelt et al. 1997; Da Roit 2007a). Other mechanisms are even more implicit. For instance, in Germany, where, in theory, it is possible to choose between cash and care services, there are, in practice, financial incentives to employ a family caregiver (Keck 2008). The reason is that the system covers basic needs only, so the social services delivered are insufficient to cover all the old person's needs and the family must contribute. Families therefore opt for cash and decide on their own care package.

By contrast, in France, which shares with Germany, Austria, and Italy a traditional preference for family care, family care is supported by a "formalization" (and monetization) process, which has given rise to openly commodified family care, similar to that in the Netherlands. It is indeed possible to use the French APA to pay a relative (except for the spouse), but this payment is regarded as a wage from an employer to an employee, for which the relative is expected to perform the caring tasks defined in the care package. Similarly, in the Netherlands, the care funded by the PGB can be purchased from an informal caregiver, but a work contract must be drawn up. In Sweden, the Attendance Allowance is seen as a symbolic payment to informal caregivers, although measures have been introduced to link the payments to informal caregivers to labor-market wages and enable informal caregivers to be employed by municipalities as professional caregivers.

Visions of Care Work. The availability, qualifications, and working conditions of care workers are problematic issues in all six countries. In the past two decades the care sector—traditionally dominated

by nonprofit providers in France, Germany, and the Netherlands and by public services in Sweden—has been opened to private, for-profit providers. Moreover, cash-for-care schemes have created new forms of employment. The guiding principles of these schemes have affected not only informal care but also the organization of care work and the caregivers themselves.

In addition, France's and the Netherlands' control over the use of benefits has affected the organization of care work: even if the users can choose their caregiver, the latter must be officially hired. By contrast, in Italy, Austria and Germany, cash-for-care schemes—whose use is free—tend to favor the growth of a gray market in the care sector.

A private care sector not controlled by social and labor regulations has clearly emerged in Italy, Austria, and Germany. According to recent estimates, there are currently between 650,000 and 800,000 (i.e., 5.5% to 7% of the population aged sixty-five and older) immigrant care workers in Italy (Da Roit and Castegnaro 2004; Mesini, Pasquinelli, and Rusmini 2006), between 10,000 and 40,000 in Austria (Streissler 2004), and 100,000 in Germany (Theobald 2009). In these countries, the tasks that families hand over to paid care workers are based on the availability of both funds and relatively cheap and undocumented immigrant labor. For southern Europe, Latin America and the Philippines have long been a major source of household help workers organized in gray markets. During the 1990s, care work became a more prominent part of the demand for domestic labor, also due to the availability of cash-for-care benefits. In the same period, Central and Eastern Europe became the main sources of this kind of labor. Its growth has been determined by substantial differences in wage levels, the lack of legal opportunities to work in Western Europe, and, not least, geographical proximity. This is particularly the case in Austria and Germany, where gray care market arrangements are usually based on fortnightly or monthly shifts, that is, with two care workers replacing each other in a care arrangement (Österle and Hammer 2007; Theobald 2009). In Austria and Germany, most of these "care work commuters" are from neighboring Central European countries (Poland, Czech Republic, and Hungary), whereas in Italy, care workers have long come from Eastern Europe and Latin America.

If cash benefits have not been the direct "cause" of the rise of the gray market in LTC, they have certainly supported its development, because of three interconnected factors. First, for families, this solution

is a more cost-effective alternative to family care and the provision of social services. Immigrants can provide twenty-four-hour care, which would not be available from social services or would be too expensive (Da Roit 2007a). Second, the arrangements offer better incomes to these caregivers than they could earn in their home countries (Österle and Hammer 2007), especially because the arrangements usually provide free room and board. Third, the gray market reduces the pressure of the increasing demand for social services. Moreover, the (by now well-established and -recognized) existence of a private care market has moved the focus of LTC policies to the regulation and qualification of private care, which tends to take the migrant-caregiver model for granted as the predominant solution to the increasing demands of LTC. This can be seen in the three countries' various attempts to regulate the migrant care market. Italy has tried to standardize the gray market arrangements by regulating the undocumented immigrant care workers in 2002/2003 and more recently in 2009, but this has had only short-term effects. In 2006, Austria tried to rein in the gray care market by voting a time-limited amnesty for all families who had resorted to illegal migrant caregivers (Egger de Campo 2008). In 2007, a law regulating the employment of migrant care workers defined the conditions of such employment. But because of its narrow definition of the target group (highly dependent old people), strict means-testing, and limited financial support, this law has not been successful in broadly regulating twenty-four-hour care. Moreover, the system has been criticized as jeopardizing the development of a formal care sector, but the argument of cost still prevailed (Theobald 2009). Just as in Italy and Austria, Germany's resort to migrant care workers is seen as a means to reduce public expenditure for LTC. Nonetheless, regulating such a system is also a matter of debate and has set the defenders of an affordable legal care professional sector against the advocates of standardizing care practices (Theobald 2009).

By contrast, the introduction of the French scheme was directly linked to employment policies and the concern of the policymakers for creating more jobs in the service sector (Le Bihan and Martin 2007). From the outset, the development of care services for older people was also intended as a source of employment (*services à la personne*). Although the effects were at first hardly positive in the aftermath of the 1997 reform, because families preferred to employ a relative through direct payment rather than resort to professional services, the situation has changed since the 2002 reform and the introduction of the APA (Le Bihan

and Martin 2007). In 2005, the number of organizations delivering services to individuals was estimated at 11,000, an increase of 57 percent since 2002 and 18 percent since 2004 (Chol 2008). The number of professional workers employed by families also rose, from 958,475 in 2003 to 1.1 million in 2005.

Additional measures were used to strengthen the link between personal services and employment. In the 1990s a tax deduction was introduced to encourage the employment of domestic workers and made domestic services affordable for middle-class families. A voucher, the *cheque emploi service*, was created to simplify the administrative procedures. In 2006, the policy, aimed at expanding access to such services and professionalizing the sector, predicted the creation of one million to two million jobs by 2010, and it established a specific agency to organize the sector (Agence des services à la personne). But this close 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. The reasons are, first, because of shortages in the sector, similar to those in other countries, and, second, because such labor is more expensive than informal paid labor and families cannot afford it in cases needing a great deal of care. Therefore, although there is no evidence of the development of a gray market, this does not mean that one does not exist, especially when families use their own financial resources to purchase care in addition to the APA or in the presence of weak controls on the use of the APA.

Cash-for-Care and LTC Configurations: Discussion and Conclusions

The introduction of cash-for-care schemes is an important common trend among LTC policies in Europe. In countries where public investment in care policies is traditionally strong, and in countries where LTC as a policy issue has arisen more recently, care allowances have been used to maintain or increase the informal care available, to contain costs, and to support care markets. Although this development shares many features, we discussed only the extent to which cash-for-care schemes in Europe differ in their relationship with broader LTC policies, their regulation, and the vision of (informal/formal) their care work.

The different LTC patterns are based on the inclusiveness of the system, the role of cash-for-care schemes and their specific regulations, as well as the views of informal care and the care work that they entail.

The first long-term care configuration is Sweden's and the Netherlands' (persistent) *social service model*. These social service–based LTC systems have undergone several transformations in the past fifteen years under the pressure of new public management ideas and users' movements, with the introduction of cash-for-care schemes being one of them. In both countries, the cash-for-care rationale has led to a break with the past, aiming at making the plan more flexible with the increasing differentiation of demand, and also more cost-effective. Particularly in the Netherlands and, to a much lesser extent, in Sweden, care allowances are instruments through which free choice and the development of markets in the care sector are encouraged. Given the greater importance of formal services in the system and the voluntary nature of informal family caregiving, cash-for-care schemes also are an attempt to bring care back to the family through its cash payments. Even so, cash benefits remain very limited in both countries (and even more so in Sweden, where other solutions have been adopted to return care to the family), compared with the overall coverage of the respective LTC schemes. Moreover, in the Netherlands, where cash for care is relatively more widespread, the scheme is nonetheless known for its regulation, generosity, and inclusiveness.

A second configuration is that of a *LTC system based on a highly regulated cash-for-care scheme*. This model is exemplified by France, where the development of a social protection scheme in the field is relatively recent and is a substitute for its earlier, fragmentary approach mostly based on family responsibilities. The new policy is strictly linked to the development of a cash-for-care intervention that uses most of the public resources allocated to the policy towards elderly people (distinct from health system). Access, care management, and use of the benefit, along with an explicit attempt to boost employment in the care sector, are strictly regulated by social services. In this framework, what in other contexts may seem a return to family care is also an attempt to formalize and recognize informal care and to remove care from the family by providing additional formal resources in the form of regulated domestic care work. The future of this system is in doubt, however, because in 2008 France announced measures to reduce

LTC expenditures and involve private insurance (Le Bihan and Martin 2010).

The third configuration is a *LTC system based on little-regulated cash-for-care transfers*. This model is exemplified by Austria, Germany, and Italy, the difference being the trajectory that led to the system's consolidation. In Austria and Germany, the current LTC system is the result of an explicit new policy initiative undertaken in the first part of the 1990s, whereas in Italy it was inherited from the traditional system of social protection for the disabled and extended to elderly care. In all three cases, however, the cash-for-care system is the most important form of intervention in LTC. If the distinctive feature of the German system with respect to the other two countries is the choice between cash and care, the financial incentives embedded in the system (Keck 2008) make this choice more apparent than real. Conversely, what distinguishes these systems from France's is the limited regulatory capacity of their systems. All three models in theory are universal (i.e., they provide support to all dependents, regardless of income). But in practice, this is contradicted by their limited ability to cover (high) care needs, their explicit reliance on the care, organizational capacity, and monetary contributions provided by families, and their implicit reliance on an unregulated and low-quality care market. As in the French case, these cash-for-care schemes could not be described as instruments to return care to the family, because most care already is provided by the family. Instead, cash-for-care interventions allow and sustain the partial removal of care from the family through the reliance on an unregulated care market explicitly recognized by public policies. Families still, however, are the only responsible actors of "care management." They determine the care packages, allocate additional resources, and negotiate employment relations, with little interference from the public authorities.

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