SPECIAL ISSUE ON CASH FOR CARE

Cash-for-care payments in Europe: Changes in resource allocation

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ABSTRACT

Resource allocation has been a main policy issue in cash-for-care schemes (CfCs) for older people in Europe since their inception. It regards how public support for older people with care needs is allocated between providing services in kind and cash-benefits. The raising pressures of an ageing population and the tensions on the financial sustainability of welfare regimes in place have further exacerbated the relevance of this topic over the recent years. Nevertheless, comparative research so far has overlooked changes in resources allocation in CfCs over time.

This article contributes to fill this gap, exploring changes in resources allocation of CfCs for older people in a sample of European countries - Austria, England, France, Germany, Italy, and The Netherlands - since the early '90s (or since the introduction of the scheme). It examines three analytical dimensions: *i)* the mix of public services and benefits provided to older people (CfCs, community services in kind, residential care); *ii)* the level of CfCs coverage;

and *iii)* its generosity. A combined view of these dimensions leads to the discussion of two dilemmas: how to allocate the resources devoted to CfCs in the light of the trade-off between its coverage and intensity? And, within the whole LTC system, how to allocate resources between CfCs and services in kind?

KEYWORDS

Cash-for-care, Europe, older people, coverage, generosity, policy mix

1. INTRODUCTION

Since the inception of cash-for-care schemes (CfCs) across Europe, mostly in the '90s, resources allocation has emerged as a key policy issue (Evers, Pijl & Ungerson, 1994; Ungerson & Yeandle, 2007). CfCs are cash benefits provided to disabled people in need of care to arrange their own care, either through the compensation of informal caregivers or the purchase of professional/market services (Da Roit & Gori, *infra*). This paper focuses on CfCs available for older people, conventionally defined as aged 65 and over. Therefore, resources allocation concerns here how publicly funded care services and benefits are distributed among older people under different circumstances.

Applying to CfCs the frame devised by Gori et al. (2016) for LTC policies, resources allocation mainly depends on three analytical dimensions: i) the policy mix: the mix of public services and benefits provided to older people (CfCs, community services in kind, residential care); ii) the level of coverage: the percentage of older people receiving CfCs; and iii) the level of generosity: the amount of cash provided to beneficiaries. A combined view of these dimensions – located within the design of the policies examined - leads to the two key dilemmas: how to allocate the resources devoted to CfCs in the light of the trade-off between its coverage and intensity? And,within the whole LTC system, how to allocate resources between CfCs and services in kind, in the light of their respective designs and functions?

Comparative research has so far overlooked changes in resources allocation in CfCs over time. This is consistent with the scarce interest of CfCs comparative analyses from a diachronic perspective, as Da Roit & Gori (*infra*) highlighted. But also with the tendencies – quite common in LTC comparative research - to "focus on cash-for-care schemes as specific policy instruments separate from more general LTC policies" (Da Roit & Le Bihan, 2010, p. 287) and to overlook the "trade-off between quantity and quality […] that is, the increase or maintenance of the present coverage in contrast with increase or maintenance of the present level of intensity or quality of care services" (Leon, Ranci & Rostgaard, 2014, p. 43). As such, we are not aware of any comparative research on the evolution over-time of resources allocation in CfCs for older people in European countries.

Using an original dataset, specifically designed for this exercise, this article contributes to fill this gap. It explores, for the first time to our knowledge, the transformations of resources allocation of CfCs for older people in a sample of European countries since the early '90s (or since the introduction of the benefit), identifying cross-country differences and highlighting common trends. After briefly introducing the country-specific CfCs design, the structure of the paper mirrors the frame presented above: different sections, therefore, examine the dimensions and the dilemmas posited.

The countries selected[1] are Austria, England, France, Germany, Italy, and The Netherlands and we look specifically at the following schemes[2]: *Pflegegeld*(Austria), Attendance Allowance (AA)/Disability Living Allowance (DLA) (England), *Allocation Personnalisée d'Autonomie* (APA) (France), the cash-option of *Pflegegeld*(Germany), *Indennità di Accompagnamento* (IdA) (Italy), *Persoonsgebonden Budget* (PGB) (The Netherlands)[3].

2. CFCs DESIGN

2.1 Administration

In Austria, England and Italy, CfCs are currently administered by the central government. In England, the CfCs administration has been centralized since its inception. In Austria, before 2011,

the benefit had been administered at local level for some particular groups of beneficiaries. In Italy, the needs assessment process became even more centralized in 2010, when responsibilities were further devolved to the medical professionals of INPS (the national institute administering national cash benefits) at the expenses of local medical commissions defined by the Local Health Authorities.

In France, the CfCs is defined by a national law and managed by local authorities (*Département*). In Germany, where the cash payment is an option of a comprehensive LTC programme in which users can choose between CfC, services in kind or –for those living in the community only- a mix of the two, the scheme is also defined nationally, but managed by over 110 LTC insurance funds. In the Netherlands, the LTC system was significantly reformed between 2007 and 2015, following a retrenchment rationale (see below). It is currently administered by three institutional actors: the national LTC insurance (high-need cases), health care insurances (home nursing) and municipalities (home care). PGB is available in each of these for those living in the community, but with different rules for eligibility and delivery.

2.2 Eligibility criteria

The benefits are devoted to people of any age in all countries except France, where APA is specifically targeted only to individuals aged 60 and over. In all countries surveyed, CfCs are disability-tested but not means-tested: eligibility depends entirely on the claimant's care needs irrespectively of his/her financial situation. Furthermore, everywhere the availability of informal care does not influence CfCs receipt (i.e. eligibility criteria are carer-blind). Another cross-country similarity lies in the status of entitlement: CfC benefits are delivered as individual rights to people assessed in care needs through standardized instruments and procedures which are set at national level.The entitlement does not depend on budget availability and/or on professionals' discretion.

Eligibility criteria have been extremely stable over-time, without significant changes since the scheme's inception. The main adjustments consisted in relaxing or tightening the needs-test. In England, in 1992, the needs-test was revised to extend coverage to people with medium level of dependency. More recently, Austria followed an opposite path, with the minimum monthly hours of

care needed for eligibility that increased from 50 (2011) to 65 (2015). In Germany, within the broad reform approved in 2017 (Nadash, Doty, & von Schwanenflugel 2018), the needs-test was modified to include previously overlooked situations, mostly related to cognitive impairments. In Italy, eligibility criteria remained unchanged. Between 2009 and 2015, however, a campaign aimed at verifying users' actual needs took place with the goal of identifying in order to identify people actually receiving IA without meeting those criteria.

The outlier is the Netherlands, where the access to PGB for people in need of home help and support was transformed in 2007 from an individual right, based on uniform national assessment procedures, to a decision decentralized at municipal level, which follows heterogeneous rules. The reform was part of a process aiming at reducing the scope of PGB as part of a wider restructuring of the overall Dutch LTC system, in a cost-containment direction. This process resulted in a complete redesignedLTC system in 2015, with its split into the three sub-sectors mentioned above (Marse & Jeurissen, 2016; Da Roit & Le Bihan, *infra*).

2.3 Nature of the benefit

While everywhere the benefit is paid to the person in need of care, not to a relative or to anyone else, countries differ with respect to other CfCs main traits. In Austria, England and Italy, the delivery of CfCs is detached from the system of in-kind services administered locally, with recipients free to use the cash benefit how they prefer, without any constraint (i.e. unconditional cash transfer). In Germany, users can choose between in-kind services and CfCs, the latter being an unconditional cash transfer amounting approximately half of the value of the former.

CfCs utilisation is more regulated in France and the Netherlands. In France, APA is paid to finance a specific care plan determined by a team of care professionals to deliver services at home or in a residential settings. Services can be delivered by formal and informal caregivers, with relatives (except spouses) who can be formally hired as care providers. In the Netherlands, users living in the community can choose between services in kind and CfCs, whose amount is on average 75% of the former. Cash benefits can be used either to compensate informal carers, including relatives, and/or to purchase care from formal providers; claimed expenditures must be documented.

The nature of CfCs has remained remarkably stable since the scheme's inception in all countries except the Netherlands. Here, since 2012 the controls on cash utilisation were progressively strengthened, with the stated aim to prevent PGB misuse.

2.4 Computation of the benefit

To define the benefit amount, users are classified according to the severity of their care needs. Established at national level, levels of care needs vary from just one (a flat rate) in Italy to seven in Austria. This procedure takes place in all countries except the Netherlands, where the possible CfC amount lies in a continuum related to the hours of care needed, assessed through a national instrumentation. In Austria, Italy, England and Germany, the cash benefit is determined exclusively on the basis of the care needs, while in France and the Netherlands the income of those assessed eligible is taken into account in determining the amount received, which decreases proportionally if the user's income is above a certain threshold. Conversely, in Austria, Italy, England and Germany receipt of CfC is taken into account (in different manners and at various scales) when defining eligibility and/or co-participation to the costs of publicly-funded care services.

In all countries examined, benefits levels are uprated over time, although by following heterogeneous paths with respect to both frequency and magnitude. CfCs benefits are generally uprated uniformly for all users/levels, mainly to keep pace with inflation. Specific increments occurred for people suffering from dementia only in Germany (various years) and in Austria (2009). A mechanism of automatic indexation is in place only in Germany, but only since 2015.

TABLE 1 AROUND HERE

3. METHODS AND DATA

3.1 Methods

We focus on three analytical dimensions: policy mix, coverage and generosity. The *policy mix* is defined as the share of LTC users by types of public support received[4]. We dichotomize between CfCs and in-kind-services users. These two groups are not necessarily mutually exclusive, given that eligibility criteria in some countries allow for possible overlapping in the receipt of CfCs and in-kind-services. The latter group is further decomposed according to whether beneficiaries receive support in the community or in a residential setting.

The reach of CfCs is assessed both at the extensive (coverage) and intensive (generosity) margins. We use annual data to define CfCs *coverage* as the ratio between number of old-age beneficiaries and the total old population living in private dwellings or in institutions. The coverage index constructed is insensitive on whether public support is adequate to cover the extra costs induced by the beneficiaries' disability. We then complement the coverage index by a measure of *generosity*: the average CfCs amount received by beneficiaries. This measure assesses CfCs intensity from the beneficiaries' viewpoint and corresponds to a weighted average of benefits awarded to beneficiaries.[5] Therefore, it takes into account the unequal dispersion of beneficiaries across different benefits' levels.

Cross-country differences in CfCs coverage and generosity are evaluated by means of coefficients of variations. The coefficient of variation measures the dispersion of data points (around their mean) by taking the ratio of the standard deviation to the mean. Given its standardised nature, it a useful statistics for comparing the degree of variation of data series that differ in their nature and mean values.

All monetary amounts are expressed at 2017 prices value through the Consumer Price Index (CPI).

3.2 Data and the collection process

A key challenge in assessing the cross-country dynamics of CfCs is the relative shortage of comparable and representative data. Official international surveys provide valuable quantitative information but are not particularly useful for our

purposes. OECD/Eurostat series are collected under the System of Health Accounts (SHA) without providing the fuller age groups breakdown required when focusing to old age. Additionally, CfCs sit in different places in different country's welfare systems. As such, country's SHA reporting practices differ, exposing our cross-country analysis to possible bias. As an example, in England, the Attendance Allowance is defined as welfare spending and not included in the LTC spending (Robertson et al., 2014). Microdata collected through surveys are often used in cross-country analysis (see e.g. empirical examples using the *Survey of Health, Ageing and Retirement in Europe* (SHARE), such as Brugiavini et al, 2018) but are not suitable for our analysis for two reasons. Firstly, there are no comparable survey data that could fully cover the long time horizon taken nor accounting for the specificity of the CfCs included in this analysis. Second, even if available, heterogeneous reporting behaviours across respondents in different countries would introduce bias in our empirical cross-country dynamic analysis.

In this paper, data were gathered by asking country academic experts to fill in a template (see Da Roit & Gori, *infra*) asking quantitative information gathered from administrative national data along with valuable information on the ongoing policy debate.

3.3 Limitations

Although the countries assessment is based on a common template, the way in which they are described and detailed varies. While for some countries, we were able to collate detailed administrative data for all the dimensions of interest, a longitudinal perspective was hampered for other countries by systematic differences in definitions and reporting across time or because enough level of details on the target population and/or dimensions of interest were not publicly available. This happens mainly in evaluating the policy mix among older people (e.g. for France and the Netherlands) and in assessing coverage for more distant time periods (e.g. for Austria).

The data on coverage we report for Austria refers to 61+ population and are therefore likely to underestimate coverage among 65+ population. Given that the bulk of recipients are very old (according to Colombo et al., 2011 p. 225, about 59% of those aged over 80 years and only 9% of the 60-80 year old population receive *Pflegegeld*) the age restriction we impose is likely to influence only marginally the denominator of our coverage index; in fact our data are very

comparable with those published by Da Roit & Le Bihan (Da Roit & Le Bihan 2010), where it has been estimated that about 18% of 65+ population received *Pflegegeld* in mid-2000s. Similarly, data for France refer to 60+ population. For the Netherlands, robust data are publicly available for six time points only: to fill the gaps, a linear interpolation approach was used.

Ideally, the coverage index should account for the differences in the probability of needing public support, known to rise with age and being conditional on eligibility criteria (e.g. disability status). Therefore, our coverage estimates are likely to identify a lower bound rather than the precise estimate, but we have reasons to believe that the cross-country variation observed is not driven by differences in the demographic nor the epidemiological pressures. The population in Italy, for example, is much older than the population in England, yet –as we will see in Section 5 - a percentage far lower of older people in Italy receive CfCs. Nor can be completely driven by differences in the epidemiological pressures given that estimates of the disability rates in older adults are thought to be comparable in the included countries (Chatterji et al. 2015). The approach followed in this paper makes use of official population data as denominator of the CfCs coverage index, with the great advantage of getting rid of potential cross-country variation induced by differences in the needs test criteria or in (unofficial) disability estimates.

The generosity of CfCs is evaluated through an "absolute" measure, expressed at 2017 prices. An analysis in relative terms would have the merit of taking into account cross-country differences and time trends in relation to differences in the living standards experienced by recipients. For example, by expressing the average amount of CfCs as a proportion of a measure of economic well-being experienced by the population of interest. While we agree that relative generosity matters, how that is put into practice in a convincing and non-contentious way in cross-country dynamic analyses is another matter.[6] In view of this and the lack of sufficient and reliable data to derive a relative measure for the entire period examined, CfCs generosity is evaluated only in absolute terms.

4. DIMENSION I - COVERAGE

The latest data available indicate that CfCs coverage varies considerably across countries. At the two extremes of the spectrum lie England (20.3%) and Austria (18.6%), and the Netherlands (0.8%). Italy (11.4%), France (7.6%) and Germany (7.3%) are in intermediate positions between the two ends (see Figure 1). Such a cross-country heterogeneity can be better appreciated when locating CfCs within the overall provision of LTC services. CfCs coverage, in fact, varies among countries to a bigger degree than it does with respect to community services in kind and in institutions (EU, 2016). This variability hints the different functions CfCs have in various LTC national systems, a point discussed in section 7.2.

The heterogeneity of CfCs coverage is not consistent with the similarities of the eligibility criteria highlighted in Section 2.2: the main reason lies in the broad differences affecting both the definition of care needs, the instrumentation in use to evaluate these needs and the cut-off level set to access the benefit (see Ranci et al., *infra*). In brief, while countries are highly similar in assigning to CfCs the status of an entitlement that depends exclusively on claimant's needs, they differ sharply in the setting of the actual level of needs.

Shifting to a diachronic perspective, an upwards trend has marked the period examined: coverage is today much higher than it was at the inception of the schemes in all country studied, with the usual exception of the Netherlands. With respect to the two most long-standing schemes, the English and the Italian ones, the comparison with the earliest evidence available shows a rise of about 128% in both countries. France is an intermediate position, with a growth of about 62%. Coverage has increased by about 26% in Germany, and by about 23% in Austria[7].

4.1 The three phases of coverage

Cross-country convergence is manifested also in the presence of three common phases:

- a phase of quick expansion after the inception of the scheme, when the share of older people in receipt of CfCs has soared at a very fast rate;
- followed by a phase of slow expansion, when the coverage was still increasing but at a lower rate;

- and a phase of containment, when CfCs coverage has shrunk, although at a magnitude far lower than the previous expansion that does not alter the long-term growing trend.

In England, the share of 65+ receiving CFC has risen in the nineties at an annual growth rate of about 8.6%, in the period 2000-2010 at a lower rate of about 4% per year and, since 2010 it has been observed a reduction in the CFC coverage (average annual growth rate: -3%). In Italy, the reach of *IdA* rose at an annual rate of 8% per year in the nineties, at 3% in the 2000-2010 and a reduction of 2% per year occurred later on. In Austria, the reach of *Pflegegeld* among older people rose steadily at about 1.6% per year in the nineties, then at about 1.2% per year up to 2012,nd fell by 1% per year thereafter. In France, a relatively fast increase in CfC coverage occurred in the first two years after inception (+19%), followed by a phase of stabilisation with a growth of about 2% and a period of containment after 2012 (-1%). In the Netherlands, we observe a stable increase after inception of +12% per year in the period 2001-2004, followed by a period of slower growth and of reduction from 2007 onwards.

In the first two phases, the CfCs eligibility at old-age were mostly unaltered. Increasing awareness of the population in navigating the system and/or the well-known appreciation of most older people and their families – although with various exceptions - for cash benefits (Da Roit, Le Bihan & Österle, 2016) might partially explain the rising trend in take-up rates observed after inception. For all countries, during the initial period that follows the CfCs inception, the stock of CfC recipients increased at a faster rate than the underlying population. The phase of slow expansion mainly occurs when CfCs reached a considerable coverage among the eligible population. In this period, the CfCs inflow (new claimants) is only slightly higher than the outflow (ceased payments), so that the stock of CfCs recipients still grows but at a pace that is more in line with the 65+ population growth.

The third phase – beginning around 2010 - occurred in a period marked by cost-containment policies affecting, to various degrees, the LTC sector in many countries. Two different approach to reduce coverage have been employed. In countries like Austria and the Netherlands, there was a stated choices to tighten eligibility criteria. England and Italy are –among the countries surveyed- countries where the eligibility procedures and the assessment instrumentation are characterised by

degrees of uncertainty and opacity. Under this setup, extending or limiting CfCs access might be achieved without formally modifying the eligibility criteria (see Ranci et al., *infra*). In these countries eligibility criteria remained unchanged while other factors intervened, such as the further centralisation of the assessment process and the campaign aimed at verifying users' actual needs (in Italy), and a changing climate due to a vigorous public debate (both in politics and in the media of both countries) emphasizing that the current configuration of CfCs entails a leakage of resources to the non-disabled population.

The apparent outlier is Germany. Here the reduction following its inception was mainly due to the raising percentage of users that – in the 2000s- chose the services in kind option in lieu of the cash-option of the *Pflegegeld* scheme. Conversely, the expansion occurred since 2012 is mainly attributable to its unique policy –among the surveyed countries- of strongly reinforcing its LTC system and widening its coverage.

FIGURE 1 AROUND HERE

5. DIMENSION II - POLICY MIX

Table 2 highlights three main messages. Firstly, in terms of users' partition, latest data available qualify CfCs as the backbone of the LTC system: the group of CfCs beneficiaries is, in fact, the largest. The outlier is again the Netherlands, where only about 4% of LTC users receive CfCs. Not surprisingly, the Netherlands is the only country where cash benefits have been a marginal element of the system since its inception with respect to both the share of LTC beneficiaries and its overall rationale (its design historically relies upon the provision of in-kind services). At the other extreme, there is France, where our policy mix indicator is un-informative (and therefore not reported in Table 2) given that APA corresponds *de facto* to almost the whole LTC French system[8]. The remaining countries lie between the two extremes, ranging from 49% of users in Germany to 86% in England. The emerging message consists in the lack of intermediate scenarios:

when the CfCs is an actual part of the design of a country's LTC system, it is the biggest one in terms of users. This imply that any major attempt to reform or revise the LTC system has (inevitably) to deal with it. Our findings are in line with studies that take into account the 15 old Europe countries (e.g. Riedel & Kraus, 2016). In fact, CfCs are and they have always been either an utterly marginal section (in the Dutch scale) of LTC systems based on services in kind (e.g. the Scandinavian countries), or the predominant source of public support, with the highest coverage in terms of users.

Second, shifting from users' percentage to the share of LTC public expenditure devoted to the different sources of care, the prominence of CfCs is considerably reduced. This is clearly attributable to the fact that, as noticed elsewhere (e.g. Campbell et al., 2016), CfCs benefits are far less generous than (the monetary value of) in kind benefits: as an example, in Austria, while the CfC users account for about 67% of the total LTC recipients, the CfC expenditure percentage is 56%; in Italy, we move from 63% to 50%, whereas in England from 86% to 43%.

Finally, following a temporal perspective, it is remarkable the stability of the share of CfCs users over-time within the publicly-funded LTC recipients in all countries examined. This is a result that will be resumed in section 7.2.

TABLE 2 AROUND HERE

6. DIMENSION III - GENEROSITY

Figure 2 displays the CfCs average monthly amount over-time. Latest data available identifies the Netherlands as the outlier, whose average value (€1,750) is more than three times higher than that of France, the second country in the ranking of generosity. The other countries lie in a more restricted range, from €534 in the latter to €389 in England, with Germany (€404), Austria (€460) and Italy (€512) in intermediate positions.

Shifting to the inter-temporal dimension, CfCs generosity - measured in real terms – has risen almost everywhere in the period examined but without clear cross-country trends as observed

for coverage. In fact, while the growth of coverage is remarkable in all countries, the scenario concerning generosity is mixed. Small increases have occurred in Germany, about 4%, and in France, about 6%. A biggest rise occurred in England and Italy: using the earliest evidence available, CfC generosity has augmented of about 59% in the former, and of about 65% in the latter. The exception to this common trend of increase is Austria, with a reduction of about 13% in CfCs real value[9].

As noticed in Section 2.4, benefit levels uprates followed heterogeneous paths across countries. Not surprisingly, therefore, changes in generosity mainly reflect this, without pinpointing common trajectories as it was the case for coverage. However, a clear message emerged: compared to the growth in CfCs coverage discussed in Section 4, CfCs generosity has grown far lower in all countries, a point that will be further discussed in Section 7.1.

7. CONCLUSIONS: DILEMMAS AND CHALLENGES

The paper has looked at some trends of resources allocation in Cash-for-Care payments devoted to older people in a sample of European countries. It is – to our knowledge – the first article published on this topic, an exploratory exercise with several limitations (some outlined in section 3). Despite these shortcomings, a number of points has come to light with respect to the three dimensions examined: *i)* the mix of public services and benefits provided to older people (CfCs, community services in kind, residential care); *ii)* the level of CfCs coverage; and *iii)* its generosity.

In this final section, results of the analytical dimensions previously examined and the country-specific CfCs design are combined to provide insights into the dilemmas presented in Section 1, regarding the trade-off between coverage and generosity of the CfCs (Section 7.1) and the place of CfCs within the whole LTC system (Section 7.2).

7.1 Dilemma I – The trade-off between coverage and generosity

A simultaneous look at the data on coverage (Section 4) and on generosity (Section 6) brings four key elements to light. Firstly, the latest data available clearly show that countries that achieved high CfCs coverage, do so at lower overall intensity (e.g. England) or by setting minimum awardable benefit levels that are comparatively the lowest (e.g. Austria). A trade-off between coverage and generosity – although with various modalities – seems to emerge.

Second, taking a long diachronic perspective, the observed increase in coverage is not strongly associated to a comparable increase in generosity. In each country examined, both have risen but with coverage at a (by far) higher percentage rate than generosity. In other words, within a common trend of growth, coverage prevailed upon generosity; the only exception is the *Pflegegeld* in Austria, with the rise of its coverage that is in sharp contrast with its reducing generosity, when expressed in real terms.

The prominence of coverage over generosity has been the outcome of both political action and political inaction. Major reforms of the LTC system took place in France, with the introduction of *APA* in 2002, in Germany, with the *Pflegegeld* introduced in 1995, and in Austria, with the *Pflegegeld* introduced in 1993. The political priority of these reforms was to expand public coverage to a larger number of users by assuring a pivotal role to CfCs. The effect of political inaction can be seen in England and in Italy, where the rise of CfCs coverage is to locate within the lack of long-awaited major national reforms of the LTC system, being widely discussed from the second half of the 1990s onwards, and the inadequate supply of in-kind services administered locally and provided discretionally and conditional upon public budget availability. As a result, the growing demand for public support to rising care needs in England and Italy has been covered by national cash benefit systems, the only entitlements to LTC. The opacity of the CfCs eligibility criteria in place has allowed an expansion of coverage without formally altering their setup (Chiatti et al., 2010).

Since the '90s (or since their inception) the development of CfCs in the countries surveyed has been, therefore, coverage-led. To understand the broad picture, the first step is to look at the policy arrangements inherited from the past. At the beginning of the period examined, LTC systems were scarcely funded and coverage was extremely low in all countries surveyed, with the exception of the Netherlands. The most important shortcoming of these systems – in the perceptions

of both the public opinion and the policy makers - consisted in leaving most dependent older people without any support (Glendinning, 1998). Hence, two different paths have been followed:where CfCs were introduced (Austria, France and Germany) the benefits have been the main element of major reforms pursuing the expansion of LTC coverage as the key policy priority. Where CfCs were already in place (England and Italy), it has been the programme that absorbed most of the increasing care needs. A common element further pushing the increase of coverage has been the high appreciation of most older people and their families for cash benefits, contributing to raise the take–up rates (Gori et al., 2016).

Third, this study highlights the novelties in the balance between coverage and intensity observed in the most recent years with respect to what discussed above by taking a longer perspective. It is striking to notice that the overall reduction in coverage observed in many countries sincehe beginning of the 2010s has not been accompanied by a similar reduction in overall generosity; the latter remained stable or slightly increased everywhere but Austria. The recent phase seems to indicate that the pendulum between the trends in coverage and intensity has started to swing to a direction opposite to the past. This evidence is to consider along with the increasing relevance in the political debate of several countries of the adequacy of CfCs benefits (Martinelli et al., 2017) and their (in)ability to meet the full costs of disability for recipients (Morciano et al, 2015).

Fourth, within a stable picture that shows growth rates in coverage being by far greater than the growth rates on generosity at any given period, the cross-country variation in coverage and generosity has reduced over time, showing a path of convergence. Excluding the peculiar Dutch case, a way to measure convergence, is to compare the coefficients of variation (CV, see Section 3.1 for details) in coverage and generosity at different time points. CV in coverage was about 0.58 in 2002, 0.56 in 2010 and about 0.47 in 2016. CV in generosity was of about 0.21 in 2002, 0.17 in 2010 and about 0.13 in 2016. Convergence in CfC coverage between countries occurred mainly in the latest decade, with the top three CfCs in terms of coverage (the English, the Austrian and the Italian) that fell considerably in their reach. In the same period, the two countries with relatively lower coverages maintained a stable reach (France) or increased it substantially

(Germany). Convergence in generosity, instead, occurred at a reduced pace and more smoothly over the entire period under consideration.

7.2 Dilemma II – The place of LTC within the whole LTC system

Our results highlight four main points. Firstly, the pivotal role of CfCs in the surveyed LTC systems clearly emerges from the combined analysis on the policy mix and on the overall LTC design. The share of CfCs users over the publicly-funded LTC recipients is higher than the shares of recipients of formal care in the community or in institutions (see Section 5). With respect to the overall LTC design, the governmental level ruling the benefits and the eligibility criteria have to be considered too. CfCs are ruled at national level – both when administered at central level (e.g. England, Italy), by the local authorities (France) or by insurance funds (Germany). They are delivered as individual rights exclusively according to care needs. Thus, CfCs differs from the system of services in kind, generally ruled at decentralized level and provided not as entitlements but – to various degrees - on a discretionary basis, conditional upon budget availability and upon claimants' economic circumstances[10] (Gori, 2018). The Netherlands confirms here its role as an "outlier" in our surveyed countries, with CfCs that play a "residual" role, both in quantitative (% of users) and historical terms.

Second, we observe a surprising robustness of CfCs in the long-run. Taking the policy design into account, Section 2 highlighted that no major structural changes has occurred in the period examined and that the CfCs overall design has remained mostly unaltered since their inception. Shifting to coverage, it has substantially increased everywhere, a long-term trend only marginally influenced by the most recent phase of reduction occurred in most of the examined countries. Stability of the overall CfCs design and coverage increase are therefore two common traits to most countries examined. On the other hand, the paths for services in kind have been heterogeneous: from a long-term trend of expansion (Germany) to the predominance of a cost-containment trend (England) to a mixed path, made by an initial expansion followed by a period of retrenchment (Italy). A comprehensive combined analysis of the two-part LTC system is beyond the scope of this paper (see e.g. Greve, 2017) but it is clear from our long-term perspective that CfCs emerged as the strongest element of LTC systems.

Besides the politicians' intention to avoid blame for spending cuts, there are various reasons that may explain such findings. With respect to the supply side, the status of legally defined entitlements make CfCs particularly complex to modify and, especially, to curtail. Furthermore, in most countries the same (or similar) CfCs is available for adults with disability too, who are politically particularly effective – through their organizations and advocacy groups - in protecting CfCs (Ranci & Pavolini, 2013). With respect to the demand side, there is the already mentioned well-known appreciation of many older people and their families for cash benefits, and, when available, the CfC option is often preferred over the services in kind option (Da Roit, Le Bihan & Österle, 2016).

Third, there is a well-established argument around the supposed costs-saving nature to expand CfCs in lieu of services in kind (e.g. Lundsgaard, 2005). Being the former usually provided at lower amounts than the latter – as confirmed by the evidence presented in Section 5 - CfC is regarded as a policy able to limit the financial impact associated with an increase in LTC coverage[11]. From the long-run perspective taken in this study, the high growth of CfCs in coverage might have resulted from the political choice to broaden the eligible population. But it could also be the individuals' (or their relatives) "reaction" to the new policy scenario: disabled people, and their families, who would not have applied for services in kind did so for cash benefits, incentivized by their preference for the latter. This increase in CfC take-up is similar to the "woodwork effect" noticed when community care were promoted as a cheaper alternative to institutions (see e.g. Weissert & Frederick, 2013). Therefore, the "net" costs-saving nature of expanding LTC coverage through CfCs might be lower than what observed, in particular in the long-run.

Finally, the high heterogeneity in CfCs coverage observed across country – higher than with services in kind (EU, 2016) – can hint their different functions within the LTC system. Countries with high coverage do so by covering lower levels of dependency. This would suggest a "preventive" function to escalating care needs that services in kind administered locally might not have. The CfCs in place in Austria and England, the countries with the highest coverage rate in the sample, might have a preventive nature that is more pronounced than for other countries. Indeed, in these countries there is a vivid debate between those who argues to concentrate resources towards

people with medium to high level of dependency and those supporting the preventive role of CfCs and their effectiveness in postponing the deterioration of older people care needs and the escalaton of care-related costs.

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Table 1. Cash for care schemes in selected European countries

	Scheme (Year of introduction)	Eligibility criteria	Nature of benefit	Computation of the benefit(Range max/min benefit, in €pm, 2016)	Administration
England[(a)]	Attendance Allowance (AA) (1970) Disability Living Allowance (DLA) (1992)	Entitlement basis No age limit Needs test	Detached from in-kind services delivery Free use	(AA) 2 levels of care needs (281-418) (DLA) 4 level of care needs (111-709)	Central government
Italy	Indennità di accompagnamento (IdA) (1980)	Entitlement basis No age limit Needs test	Detached from in-kind services delivery Free use	1 level of care needs (515)	Central government
Austria	Pflegegeld (1993)	Entitlement basis No age limit Needs test	Detached from in-kind services delivery Free use	7 levels of care needs (157-1689)	Central government
Germany	Pflegegeld (1995)	Entitlement basis No age limit Needs test	Choice between CFC , in-kind services or a mix Free use	5 levels of care needs (316-901)[(b)]	LTC insurance funds National legislation
France	Allocation Personnalisée d'Autonomie (APA) (2002)	Entitlement basis Age: 60+ Needs test	CfC allocated to finance a care plan defined by professionals	4 level of care needs Income-related reduction of benefit (662-1713)	Local government National legislation
The Netherlands[(c)]	Persoonsgebonden Budget (PGB) (2001)	Partial entitlement basis No age limit Needs test	Choice between CfC and in-kind services Users must justify expenses	PGB is allocated according to the required care Income-related reduction of benefit	National LTC insurance or Health care insurances or Municipalities

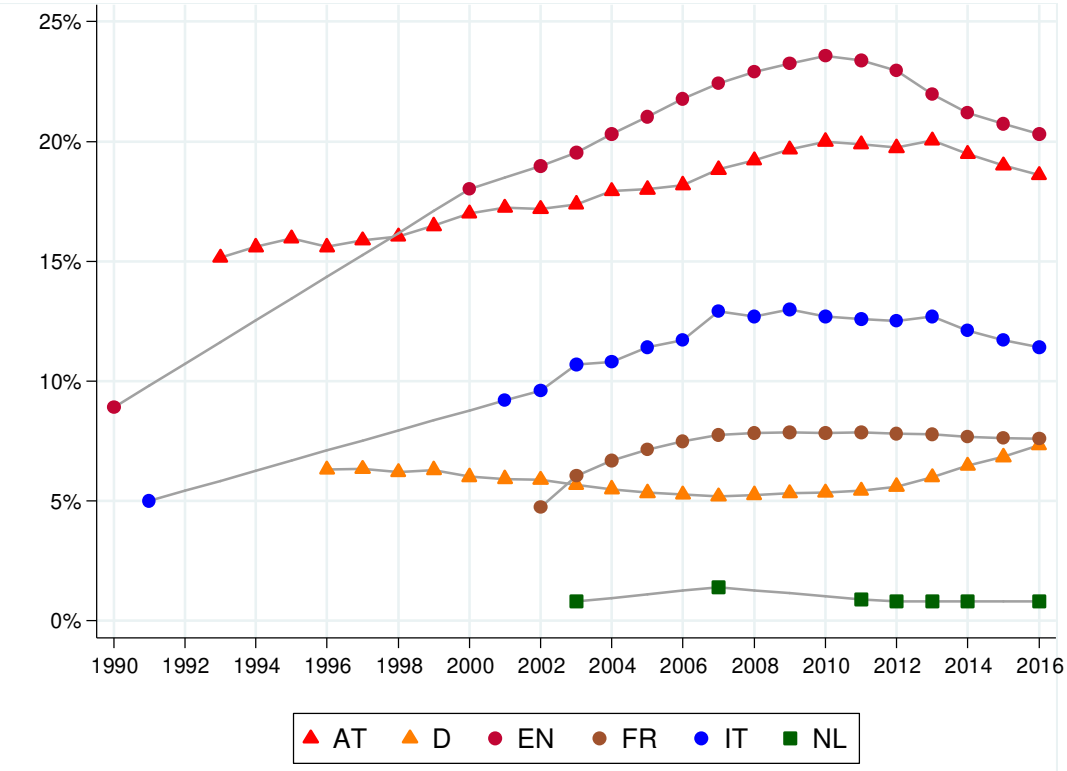
Notes: (a) The AA can be claimed from age 65 while the DLA must be claimed before reaching age 65 but continues in payment beyond 65. From 2013 DLA is gradually being replaced by the Personal Independence Payment (PIP), which differs from AA and DLA in certain details but like DLA is claimed before age 65 and then continues in payment beyond 65. PIP is available only for those that have initiated the claim from 2013: therefore very few over-65s are receiving it at the time of writing. (b) Users can choose between cash, service provision or a mix of the two (See Section 2.3 and Da Roit & Gori, *infra*). Only the cash option is considered as CfC. Levels of care needs refer to the CfC option only. (c) The table reports the common orientations among the three institutional actors administering PGB. The range max/min benefit is not computable for NL (See Section 2.4).

Table 2. LTC users by sources of public support received

Countries	Year	CfC	Community care	Residential care
Austria	*2000*	.	.	.
	2011	69%	20%	11%
	2015	67%	22%	11%
England	*2000*	62%	28%	10%
	2009	73%	20%	7%
	2015	86%	9%	5%
France	*2000*		N.A.	
	2010		N.A.	
	2015		N.A.	
Germany	*2000*	51%	30%	19%
	2009	46%	32%	22%
	2015	49%	29%	22%
Italy	*2000*	51%	35%	14%
	2010	62%	25%	13%
	2015	63%	28%	9%
The Netherlands	*2000*	.	.	.
	2011	4%	62%	34%
	2014	4%	71%	25%

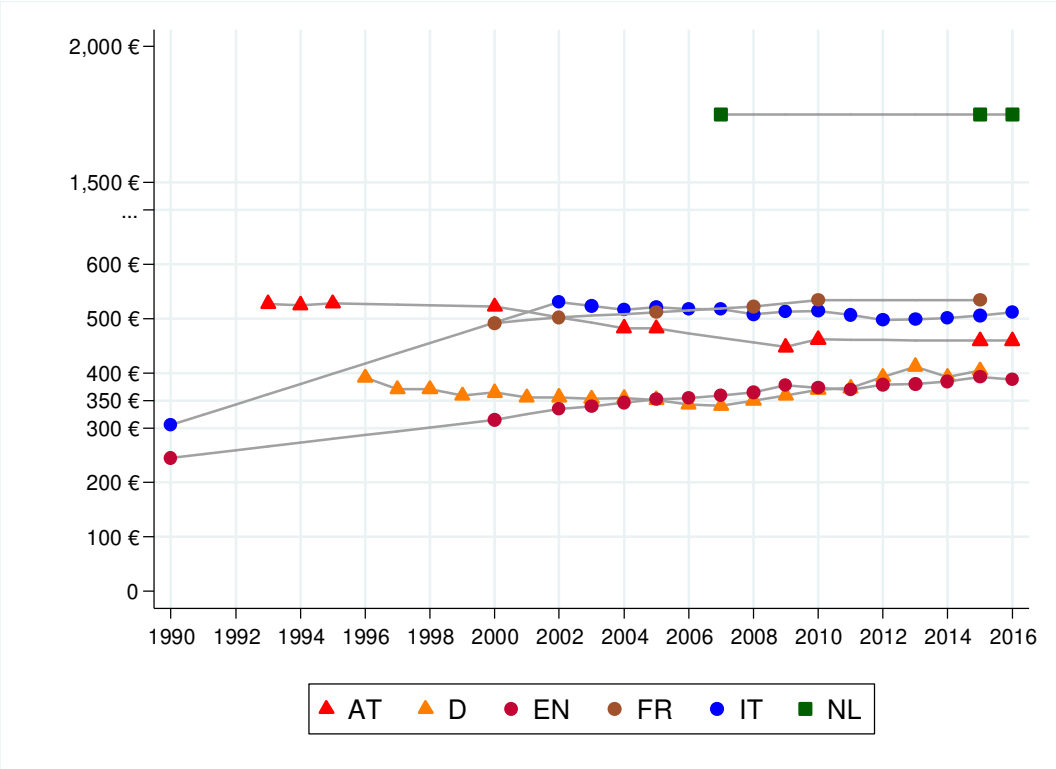
Notes: Authors' estimates from country academic experts data. (.) missing data. (N.A.) not applicable. Austria estimates include recipients for people of all ages, while the analysis in this paper focuses on older people (65+). The Netherlands estimates obtained by integrating national expert data with OECD health statistics data. See Section 3 for further details.

Figure 1. Trends in the share of 65+ population receiving CfC by Country



Notes: Authors' estimates from country academic experts data. See Section 3 for further details on methods and data.

Figure 2. Trends in the average monthly amount paid to CfC beneficiaries



Notes: Authors' estimates from country academic experts data. See Section 3 for details. Amount expressed in 2017 prices. Data for Austria (AT) and France (FR) are computed as weighted year-specific averages of the monthly benefit rates paid to the whole population (AT) and 61+ population (FR).

[1] The introduction to this Special Issue (Da Roit & Gori, *infra*) provides a detailed definition of CfCs and the rationale of both the countries selection and the time horizon.

[2] CfCs examined are not necessarily the only scheme in place but they are the highest – by far – in coverage. As such, we do not consider the "Personal Budget" (see Da Roit & Le Bihan, *infra*) and "Personal Independence Payment" (PIP) in England (see footnote in Table 1) and the *Assegni di cura* in Italy (see Gori, 2012).

[3] Consistently with the definition of CfCs employed, we consider the entire scheme as a CfCs in all countries but Germany, where the cash option only is taken into account (see Section 2.1).

[4] Our policy mix indicator differs from commonly employed coverage indicators that measure the shares of the total monetary value of LTC public programmes by care settings (e.g. Colombo *et al.*, 2011; EU 2016).

[5] Our measure differs from the measure used in Ranci et al., (*infra)* to describe the distribution of available resources among CfC beneficiaries with different level of care needs. The measure they employed, account for the level of intensity of CfC support from the perspective of the system, but does not tell us how different benefits are distributed across the population of CfC beneficiaries.

[6] Firstly, one must specify the concept of economic well-being to be used. Given our focus at old-age, the denominator of the relative generosity indicator should be specific to that age-group and based on household consumption expenditure or disposable income. Given differences in the social security systems of the surveyed countries, the income components to be taken into account would be debatable. Second, we must decide the "moment" (i.e. the mean, the median or other quantiles) of the distribution of the economic well-being indicator to serve as denominator for our relative generosity indicator. The choice would be relevant if countries differ in levels of economic inequality. Finally, given the draconian view taken in this paper, the economic well-being indicator would have to be year-specific. However, because of the long perspective taken in this paper, a measure for the entire time series is not (known to be) available.

[7] From 8.9% (1990) to 20.3% (2016) in England, from 5% (1990) to 11.4% (2016) in Italy, from 4.7% (2002) to 7.6% (2016) in France, from 5.7% (1995) to 7.3% (2016) in Germany and in from 15.5% (1993) to 18.6% (2016) in Austria.

[8] The APA is used to finance dependency at home and in institutions for older people of middle and high levels of dependency. Financial support can be allocated to older people assessed with lower levels of dependency who need help with domestic tasks by the pension funds. Older people in institutions can receive social assistance from the *Départements* to pay for their hotel costs.

[9] From €392 (1996) to €405 (2015) in Germany, from €502 (2002) to €534 (2016) in France, from €245 (1990) to €389 (2016) in Italy, from €306 (1990) to €512 (2016) in England, from about €528 (1993) to €460 (2016) in Austria. Data available for the Netherlands do not allow to trace the changes in generosity over-time.

[10] In Germany, the common dual-system observed - national CfCs and services administered locally – is complemented by a third possible source of formal care, the service in kind option of the *Pflegegeld (*Mätzke & Wib, 2017).

[11] A recent survey among high-level bureaucrats of the EU countries involved in LTC, asked about "what functions of LTC spending deserve policy attention in terms of cost-containment". 73% of respondents indicate residential care, 65% home care and 54% cash benefits (EU, 2016, p. 159).