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# Resistance to change. The problem of high non-take up in implementing policy innovations in the Italian long-term care system

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## ABSTRACT

This article illustrates how the implementation of ‘interstitial’ innovation in welfare policy can be hampered by resistance to change on the part of its intended beneficiaries by means of a case study of a policy innovation in long-term care in Italy: the Home Care Premium (HCP) programme. In a policy area characterised by long-standing institutional inertia, HCP represents an innovative programme which provides a generous, conditional cash-for-care benefit to encourage the regular employment of in-house care assistants. However, the implementation of the scheme was hampered by high non-take up (NTU) rates, i.e. the percentage of beneficiaries who did not claim the cash-for-care benefit for which they were eligible.

The article uses a ‘mixed method’ approach to show how high NTU rates can be explained by individually ‘situated’ decisions taken by the intended beneficiaries based on cost-benefit evaluations that are deeply rooted in social attitudes and adaptive practices shaped by the existing institutional context. The study also shows how the policy design of the programme partially failed to manage the institutional complementarity of different welfare programs effectively, thus weakening the capacity of this ‘interstitial’ policy to bring about policy innovation. The results of the case study may therefore be of interest to scholars interested in policy change and the role played by beneficiaries in policy implementation.

**Abbreviations:** non-take up (NTU); long-term care (LTC)

## KEYWORDS

implementation; resistance to change; non-take up; long-term care policy; Italy

## 1. Introduction

This paper is about resistance to change in policy implementation. Such resistance is rooted in the practical arrangements of welfare beneficiaries, which in turn are strongly embedded within the existing institutional framework. While literature on policy inertia has traditionally stressed the importance of either institutional or political drivers such as lock-in effects, the reproduction of specific administrative logics, or veto points (Pierson, 2001), in this paper we argue that welfare reforms can also be hampered by resistance to change on the part of beneficiaries, thus preventing new programmes from

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being fully implemented. Even if political and administrative obstacles are removed, reforms may be still prevented by the lack of compliance of welfare clients who are the intended beneficiaries of such changes. Hence, the mere existence of social needs that are not satisfied by existing welfare programmes and become the target of new programmes does not imply that welfare changes, once implemented, are directly welcomed by beneficiaries.

Resistance to change on the part of the intended beneficiaries of reforms can be very difficult to explain and counter-intuitive. First, there is a problem of measurement. How can non or low take-up of innovative welfare benefits be measured? (Bargain, Immervoll, & Viitamäki, 2012). Second, identifying the main causes of resistance to change is also highly problematic. What empirical data can be used to show why reforms are not welcomed by beneficiaries, in the absence of specific information regarding their preferences? To what extent is this resistance explained by aspects of policy implementation such as administrative inability to provide information, or excessively restrictive rules to access or bureaucratic procedures? How can we measure the role played by the attitudes or social practices of beneficiaries? Finally, what alternatives are there for potential beneficiaries who do not access a specific innovative programme?

In this paper, we describe a case of a partial failure to implement an innovative long-term care (hereafter LTC) programme in Italy. The Home Care Premium (hereafter HCP) programme was launched in 2012 by the National Institute for Social Security (hereafter INPS) in an attempt to overcome the main limitations of the existing LTC system in Italy, characterised by low generosity, institutional inertia since at least the 1980s, and heavy reliance on family-based 'do-it-yourself' care arrangements (Naldini & Saraceno, 2008; Ranci & Pavolini, 2013). With high care demand largely unmet by the existing Italian LTC system, the HCP programme was expected to be popular among potential beneficiaries. However, despite being implemented under an adequate policy and financial framework, the 2014 version of the scheme on which this article focuses was a partial failure given the unexpectedly high non-take up (hereafter NTU) rate for an innovative, specific conditional cash-for-care scheme designed to cover the cost of regularly employing an in-house care assistant.

In this article we argue that this was due to lower than expected levels of interest in the scheme among eligible HCP beneficiaries who already received other LTC benefits and lack of adequate incentives to access the new programme in the policy design. The traditional informal care arrangements already adopted by potential beneficiaries (based on family solidarity and/or irregular employment of migrant care workers), which are encouraged by the present Italian LTC system, were indeed strongly challenged by the new scheme, which promoted a shift towards more professional, formalised care arrangements. However, large numbers of beneficiaries of the traditional system did not see this change as advantageous and so did not claim the HCP cash-for-care benefit. Our general hypothesis, therefore, is that these high NTU rates were the result of the individually 'situated' decisions of HCP clients, strongly affected by the existing institutional framework of LTC policies.

In this sense, an analysis of the HCP case is interesting for two main reasons. First, it can contribute to the theoretical debate on public policy implementation. It shows how dominant, economically advantageous care arrangements, largely sustained by

established welfare schemes, have a significant impact on policy implementation by potentially restricting and hindering institutional innovation (Béland, 2016; Béland & Ridde, 2016). Second, it shows that against a policy landscape characterised by a long-standing lack of innovation (such as the Italian LTC system), policy change requires a long-term perspective and major public investment to counter adaptive behaviour that is deeply rooted in the existing institutional framework.

The paper is organised as follows: [Section 2](#) describes the theoretical framework and discusses how the literature on institutional change and policy implementation considers the role played by beneficiaries' preferences and practices in hindering or facilitating reform dynamics, with a special focus on the issue of NTU rates. [Sections 3 and 4](#) describe the main features of the Italian LTC policy field and of the HCP program. [Section 5](#) briefly describes the data and methods used. [Section 6](#) analyses the issue of NTU in HCP by comparing different target groups of potential beneficiaries and illustrating and explaining the main critical issues to emerge from the study. Finally, [Section 7](#) summarises and discusses our main findings.

## **2. Implementing institutional innovation and resistance to change: the theoretical framework**

In recent decades, several hypotheses about the dynamics of institutional innovation have been advanced in the literature regarding the transformation of welfare policies. In the 1990s the prevailing neo-institutionalist perspective emphasised continuity and a certain resistance of welfare policies to change due to path dependency dynamics (Pierson, 2001). In this sense, the welfare state was mainly framed as a sort of 'immovable object' or 'frozen landscape', one in which established social programmes created lock-in effects and the continuous reproduction of a specific institutional logic (Béland & Powell, 2016). Conversely, the power resources approach stressed a more general trend of welfare retrenchment in the context of the neo-liberal paradigm (Korpi & Palme, 2003).

More recently, however, several studies have shown that, despite institutional and budget constraints, welfare states have changed (Morel, Palier, & Palme, 2012). In effect, several reforms based on recalibration and social investment strategies have been implemented in response to emerging new social risks, albeit to different extents in the various European welfare states (Hemerijck, 2017). Moreover, the institutionalist literature has shown that institutional change can be brought about not only by abrupt reforms or as a result of specific exogenous pressures, but also through gradual, incremental (yet transformative) dynamics of change, in which small changes can lead to significant institutional transformations (Streeck & Thelen, 2005).

These types of institutional change tend to be embedded within specific political and institutional frameworks (Mahoney & Thelen, 2010). While in the political sphere 'veto options' can be put in place by policy actors to obstruct change, institutions can give more or less free rein to specific interpretations and/or enforcement conditions which either encourage or prevent innovation. Indeed, not only are institutional rules often characterised by a certain degree of ambiguity and subject to interpretation and debate, they are also frequently enforced and implemented by different institutional actors (for

instance bureaucrats and courts of justice), each with a distinctive role in shaping the dynamics of institutional change (Mahoney & Thelen, 2010).

From this perspective, the process of implementation is a crucial step in the concrete dynamic of institutional innovation. For instance, in their analysis of the structure of the policy cycle, Howlett, Ramesh, and Perl (2009) have pointed out that, once institutional reforms are put in place, additional critical issues are likely to emerge in relation to the dynamic of implementation. Accordingly, Béland (2016) argues that the implementation phase is a crucial step in policy development and to a large extent determines whether the process of change itself is a success or a failure. Several potentially significant factors in this phase have been identified by scholars. While many authors have stressed the role of professional organisations and ‘street-level’ bureaucracy, others have noted that target groups themselves may significantly shape the dynamic of implementation (Béland, 2016; Vancoppenolle, Sætren, & Hupe, 2015; Zhu, 2010).

Resistance to welfare programmes among target groups is illustrated by NTU rates. NTU essentially refers to the non-receipt of a social benefit by citizens who are entitled to them (Eurofound, 2015). Scholars have identified two main factors that can increase NTU rates: (a) how the programme is structured (including how it is administered and implemented); (b) the choice of beneficiaries (Currie, 2004; Daigneault, Jacob, & Tereraho, 2012; Hernanz, Malherbet, & Pellizzari, 2004; Matsaganis, Levy, & Flevotomou, 2010). The former have to do with bureaucratic barriers preventing potential beneficiaries from obtaining the information and/or knowledge they require about the programme or its eligibility rules. This may be due to a lack of publicly available information, complex eligibility rules, and delays or uncertainty in administrative procedures, which are all aspects that may increase the transaction costs (mainly related to accessing and processing information) of claiming, and therefore reduce claims among beneficiaries with reduced capacity to access information and overcome administrative complexity. In contrast, the latter factor – the choice of beneficiaries – relates to the potential risks of social stigma that can discourage potential claimants, particularly when the process is based on means testing or face-to-face assessment. Moreover, assuming a rational choice decision model, some groups of potential beneficiaries may not be interested in claiming when the costs clearly outweigh the benefits, i.e. in the absence of a ‘positive net value’ (Daigneault et al., 2012).

However, such assumptions have been criticised by several scholars. For instance, Van Oorschot (1995); Van Oorschot (1998) has pointed out that NTU rates cannot be accounted for by a simplistic cost-benefit approach at any given point in time, but rather by dynamic processes which occur in separate stages. During the *threshold* stage, potential users are not aware of the programme or its eligibility rules. During the *trade-off* stage, they weigh up the costs of claiming a benefit to which they are entitled. Finally, during the *application* stage, their claim may be hampered by mistakes, delays, rejections or the cancellation of the programme. At the same time, potential beneficiaries are, crucially, not fully autonomous, self-interested agents but ‘situated agents’, acting in contexts shaped also by cultural assumptions and ideas (Riphahn, 2001; Prior & Barnes, 2011).

In this sense, although the literature on policy implementation has traditionally neglected this issue, the direct, often significant impact of cultural attitudes and ideas on agenda setting and policy-making has been increasingly recognised insofar as it may

either restrict or support new policies, or exacerbate incongruities between the formulation and actual implementation of policies (Béland, 2016; Béland & Ridde, 2016). This aspect becomes even more crucial when policy implementation implies redefining established, socio-culturally embedded norms, beliefs and practices (Mergaert & Lombardo, 2014).

However, if values and cultural attitudes play an important role in policy formulation as well as in its implementation, they are ‘not a set of shared meanings that propels human actions in a coherent and homogeneous way, but a “repertoire” or “tool-kit” from which individual actors construct their strategies of action’ (Saraceno, 2016, p. 317). In this sense, cultural values must be considered in terms of their complex, mutual relations with social action and institutional settings (Van Oorshot, Opielka, & Pfau-Effinger, 2008). It is within this complex structure of opportunity and constraints that individual cost-benefit decisions and choices about claiming are to be taken.

Building on this perspective, we argue here that the implementation of institutional change in welfare policies requires the compliance not only of collective actors involved in change, but also of potential beneficiaries, who cannot be considered mere ‘passive’ recipients of policy benefits, but ‘situated’ agents with specific attitudes and adaptive practices. As the NTU issue clearly shows, welfare beneficiaries may be highly resistant to change, thus hindering ‘from the bottom’ the dynamic of institutional innovation.

### 3. Context: Italy’s long-term care system

The LTC policy field in Italy is characterised by entrenched, long-standing inertia. To understand the innovation potential of the HCP programme and the difficulties it faced, an overview of the Italy’s existing care system is in order.

Compared with other European countries, Italy has traditionally been characterised by a scarcity of measures to support the needs of frail elderly people. In such a context, care needs have traditionally been covered by informal means, or what has been defined ‘familism by default’ or ‘supported familism’ (Saraceno, 2016; Saraceno & Keck, 2010), the latter mainly as a result of the ‘unintended’ logic underlying the growing expansion over the years of cash-for-care schemes (see below). The care burden mainly falls upon family caregivers, who are mostly women because of the large gender inequalities in the allocation of unpaid domestic and care work which still persist in Italian society. At the end of the 1980s, it was estimated that Italian women performed around 85% of all unpaid household work. More recent data show only a slight decrease in this unequal division of unpaid care tasks (Albertini & Pavolini, 2015).

Public LTC benefits have been traditionally of two types, with no coordination between them. The first is a national cash-for-care benefit called *Indennità di accompagnamento* (hereafter IdA). The second consists of local or regional welfare programmes providing residential and home care services. This second strand is characterised by marked geographical inequality (Ascoli & Pavolini, 2015) due to the lack of central regulation and inadequate financial support for the local development of extensive in-kind services. Given these conditions, IdA constitutes the mainstay of the Italian LTC system. In 2016, over half of the total public LTC expenditure went through IdA (Network Non-Autosufficienza, 2017).

IdA is a national, universal, non-means-tested cash allowance (517,84 euros per month in 2019). All citizens certified as totally dependent are entitled to it. It is an unconditional cash-for-care scheme; cash benefits can be freely spent by beneficiaries as they wish (Da Roit, Le Bihan, & Österle, 2016). Introduced in 1980 to provide support for adults with disability, IdA was extended to the elderly only in 1988. Over the last 25 years, its use for dependent elderly people has grown exponentially: it covered less than 3% of the population aged over 65 in 1989, rising to 11.6% by 2015 (Pavolini, Ranci, & Lamura, 2017). The elderly accounted for 20% of all beneficiaries in 1989; this figure had risen to 76% by 2015. Population ageing has thus led to a large concomitant increase in public spending on IdA (Costa, 2013). The level of coverage afforded by IdA in Italy is one of the highest in Continental Europe (Da Roit et al., 2016).

In neo-institutional terms (see Section 2 above), the recent evolution of IdA is similar to what Streeck and Thelen (2005) have called a 'gradual but transformative' institutional change, i.e. a policy drift (Ranci & Pavolini, 2013). Indeed, over the years IdA has shifted from being a programme targeting adults with disabilities to a measure addressing the care needs of dependent older people, and from a measure targeting a relatively limited number of potential beneficiaries to one that is expected to cover a rapidly growing target group. The ultimate outcome is that the cash-based nature of Italy's publicly funded LTC system has become entrenched.

Nevertheless, the two main problematic aspects of IdA remain. The first is that it is a flat-rate benefit and as such is not adjusted to the level of disability or related care needs of beneficiaries. The second is that it is an unconditional benefit. The negative impact of these two aspects has been extensively described in the literature. IdA does not provide adequate support for those most in need while potentially allowing the cash benefit to be used in an inappropriate way. Once eligibility to IdA is granted, an unconditional cash benefit is provided (that is, there are no conditions attached to how the money may be spent). As a consequence, IdA benefits are widely used, especially among poorer households, to supplement income. Furthermore, cash is used to cover the financial costs of withdrawal from the labour market on the part of the (mostly female) family members who care for dependent individuals on a full-time basis (Saraceno, 2010). Finally, cash is also used to purchase services on the private market without the cost of offering a regular contract, thus indirectly fostering the growth of a grey care market (more on which below).

Despite growing care demands due to population ageing and family changes, structural reform of IdA has not been undertaken in Italy in the past few decades (Pavolini et al., 2017). This inertial reproduction of the consolidated structure of LTC policy is in marked contrast to the dominant trend towards innovation and reforms that has characterised LTC policy in most Continental and Southern European countries (Ranci & Pavolini, 2013).

Such institutional inertia has led to a bottom-up reshaping of the Italian LTC system at the societal level (Da Roit, 2010; Da Roit & Sabatinelli, 2013). More specifically, families have increasingly come to rely on individual, private care provided by migrant care workers, mostly women (commonly called *badanti*), to a large extent directly employed by families, often without a regular employment contract, and suffering harsh working conditions (Costa, 2013). In 2013, there were an estimated 800,000

care workers, 90% of them migrants, generally employed by families without a regular employment contract (Pavolini et al., 2017).

Several factors operate at various levels to support this peculiar form of care arrangement and to exacerbate institutional inertia in this policy field (Burau, Zechner, Dahl, & Ranci, 2017; Costa, 2013; Da Roit & Sabatinelli, 2013). First, the existence of a large, unregulated care market, which is broadly tolerated at the social and political level, has lowered the costs of private care arrangements while guaranteeing a high degree of flexibility in terms of working hours and care tasks. Italian families appreciate the economic benefits and round-the-clock coverage of such arrangements (24/7 care in the case of live-in migrant care workers), which are also in keeping with dominant cultural attitudes which attach high value to ‘ageing-in-place’ strategies (as opposed to the institutionalisation of the elderly). Secondly, given its unconditional nature and the absence of any specific checks, IdA has been a key factor in encouraging the use of undocumented migrant care workers.

The shift to a ‘migrant-in-the-family’ care regime (Bettio, Simonazzi, & Villa, 2006) has partially redressed the persistent gender imbalance in the area of care responsibilities and unpaid work in Italy. Families have been able to externalise tensions due to the care deficit thanks to the growth of a marginal labour market for female immigrants characterised by informal employment, lack of protection, low wages, lack of qualifications and high risk of entrapment (Cordini & Ranci, 2017; Da Roit, 2007). This shift has also had significant implications for equality, as this ‘new’ care market has mainly developed among the middle classes (Albertini & Pavolini, 2015; Da Roit, 2007), while the care burden in poorer households has largely remained with daughters and daughters-in-law (Saraceno, 2010). In the latter category, care arrangements are shaped not only by traditional intergenerational solidarity based on filial obligations, but also by the economic advantage of sharing housing with older dependent family members who receive both a pension and an unconditional care allowance such as IdA (Da Roit, 2007).

#### **4. Innovation against a background of policy inertia: the case of HCP**

Given the institutional inertia that characterises the LTC field, innovation at the national level has only been possible in ‘interstitial’ policy spaces, where political resistance to change is limited, and where additional (though residual) financial resources could be invested in complementary care schemes designed to overcome the main gaps and limitations of the existing LTC system.

The most important of these ‘interstitial’ innovations has been HCP, which provides support for individuals who have to cope with disability. It is an occupational, contributory scheme targeted exclusively to current and retired public employees and members of their family (i.e. parents, partners and children).

Under the 2014 version of the scheme analysed here, HCP consisted of two measures: *i*) a national cash-for-care benefit to cover the costs of employing an in-house care assistant with a regular employment contract; *ii*) the provision of in-kind care services by local municipalities. These two measures were provided independently of each other and could be freely combined by beneficiaries.

Eligibility for both benefits was based on occupational criteria (to qualify, the beneficiary had to be or have been a public sector employee or to be a member of



**Table 1.** HCP 2014. Individual monthly benefit (€) for the HCP cash-for-care benefit, according to ISEE and ADL scores.

	ISEE	0–8,000	8,000–16,000	16,000–24,000	24,000–32,000	32,000–40,000	40,000–48,000	48,000+
ADL	103–120	1,200	1,000	800	600	400	200	0
	84–102	900	700	500	350	200	0	0
	65–83	600	500	400	200	0	0	0
	48–64	300	250	200	0	0	0	0

Source: HCP 2014 rules (INPS, 2015)

the employee's immediate family) as well as an assessment of care needs. A means test was introduced to target the individuals most in need. [Table 1](#) shows the monthly amounts of the cash-for-care benefit granted to beneficiaries according to their disability and income levels. Higher HCP amounts were granted to the poorest and most dependent beneficiaries.

A specific assessment tool, based on a standardised Activities of Daily Living (ADL) test, was developed to differentiate degrees of independence in 12 areas (indoor and outdoor mobility, personal hygiene, dressing, eating, housekeeping, etc.) and availability of care support provided by family caregivers, professional in-kind services, or in-house care assistants. Beneficiaries were ranked into four classes according to their degree of independence in terms of ADL and care support. Each class was eligible for a different amount of the benefit.

The means test was based on the ISEE (*Indicatore della Situazione Economica Equivalente*), a national indicator introduced at the end of the 1990s (and subsequently reformed in 2013) by the Italian government to assess the economic condition of households claiming benefits. ISEE considers claimants' household income, the value of households' assets (such as property, movable assets, etc.) and rent costs. Seven categories were drawn up based on the ISEE indicator in order to rank HCP clients according to their economic condition, and progressive amounts of the benefit were granted to the poorest.

HCP was conceived as a complementary benefit to provide those most in need with additional support. As a consequence, the amount of other cash-based disability benefits already granted to HCP beneficiaries was fully deducted from their HCP cash-for-care entitlement. For example, for IdA beneficiaries with the highest ADL score and the poorest economic condition, the monthly HCP benefit (1,200 euros) was reduced by the amount of their IdA benefit (500 euros in 2014) (see [Table 1](#)).

The most innovative aspect of HCP was conditionality with regard to the use of the cash-for-care benefit. Unlike IdA, the cash-for-care benefit could only be used to cover the costs of employing an in-house care assistant. Beneficiaries were required to draw up an employment contract with a care assistant for a minimum number of weekly hours (for instance, beneficiaries with an ADL score of between 97 and 120 were required to provide a contract of at least 20 hours per week). INPS directly verified the hours of work paid each month, including the payment of social security and pension contributions. If the beneficiary did not fulfil all the requirements, the benefit was immediately suspended.

For in-kind services, beneficiaries required a minimum ADL score of 33, representing partial disability (lower than the minimum level of 48 required to be eligible for the

HCP cash-for-care measure), in order to be eligible. The amount of services provided depended exclusively on their ISEE score. Unlike other LTC schemes introduced in Europe, however, the monthly amount of the benefit was set at a significantly lower level than cash-for-care benefit (ranging from 200 euros per month for the poorest households to 40 euros for the most well-off households). Deductions for IdA beneficiaries were not introduced in this case.

To sum up, HCP was a significant innovation given the inertia of LTC policy in Italy (Naldini & Saraceno, 2008). Two aspects were especially innovative. First, the amounts of HCP benefits were differentiated according to the level of disability and income of eligible individuals in order to improve coverage for those most in need. Beneficiaries with the most severe level of disability or in the worst economic conditions received over double the cash-for-care benefit received by better-off clients. In this sense, HCP overcame the vertical inequality of IdA due to the flat character of the measure (see Section 3). Second, the conditional nature of the HCP cash-for-care benefit was a major advance on the unconditional character of IdA, which encouraged (and still encourages) the growth of an unofficial care market based on migrant workers (Van Hooren, 2014). In this sense, HCP was an important response to some of the most significant weaknesses of the Italian LTC system.

## 5. Data and method

In this section, we analyse the implementation of the HCP cash-for-care scheme in 2014, with a special focus on the issue of NTU rates. In contrast to the standard definition of NTU, here it is taken to be the percentage of eligible HCP beneficiaries who actually did not claim the cash-for-care benefit for which they were eligible.

The 2014 HCP programme began with a public invitation for applications in January 2015. The number of beneficiaries was capped at 30,000. Local authorities were asked to apply to provide the in-kind services included in the programme: the final programme included 57.4% of local authorities in Italy. Applications by current and retired public-sector employees and their relatives were collected for two months, with a total of 54,000 applications being received during the period. HCP beneficiaries were selected on a 'first come, first served' criteria, only in areas where local authorities agreed to provide the in-kind services included in the programme. Once deemed eligible, beneficiaries were allocated a specific amount according to their ADL and ISEE scores and allowed to claim/not to claim one or both the HCP benefits.

Take up rates and other aspects of the programme became object of specific examination requested by INPS to assess the implementation of the programme. This analysis was performed using a 'mixed method' approach, based on INPS figures for the total number of HCP applicants and recipients. A database of information about ADL scores, ISEE levels and the amounts of benefits claimed and obtained for all the HCP beneficiaries was created by INPS and represented the main source of our data analysis. Further qualitative information about administrative procedures and the implementation of the HCP programme was gathered through 60 interviewees with key informants (INPS officers, municipal social workers) and beneficiaries.

## 6. Analysis. the issue of NTU: empirical evidence

Despite expectations of a very high uptake of HCP cash-for-care benefits among eligible recipients, in practice, the NTU rate for the programme was high, with 23% of HCP users not claiming the benefit. In contrast, only 7% of beneficiaries did not claim in-kind services, for which the maximum monthly amount was only 200 euros (less than half the maximum current monthly amount for IdA). Hence, even though the two measures were not alternatives to each other, HCP beneficiaries showed less interest in a new, conditional cash-for-care benefit providing much greater levels of support than HCP in-kind services or other kinds of LTC benefit available in Italy. An NTU rate of 23% is not necessarily high for welfare benefits. However, such a result may be considered a significant failure in the case of HCP. First, NTU rates are generally higher in means-tested minimum income benefits, due to the strong stigma associated with such programmes (Matsaganis, Paulus, & Sutherland, 2008), than they are in care programmes (Berthoud, 2010). Second, in our case, the relatively high NTU rate was the result of individual choices made by eligible beneficiaries who had already accessed HCP benefits: 23% of HCP beneficiaries did not actually claim the most important benefit for which they applied.

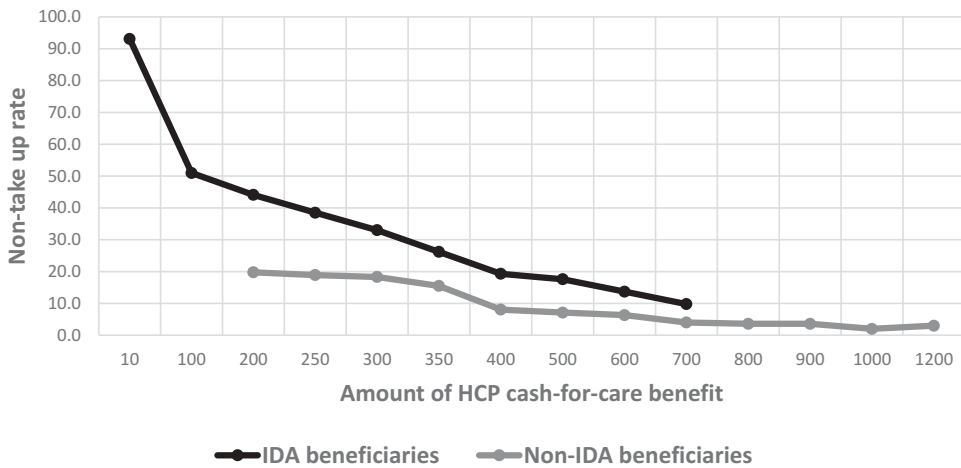
Thirdly, INPS expected the take-up rate for HCP to be close to 100%, as it was introduced against a background of increasing care demand, limited public support and an expanding private care market (see Section 3).

How can we account for such a result? Considering the main potential factors proposed in the literature to account for NTU (see Section 2), lack of information/knowledge about the programme does not explain why 23% of HCP users did not claim the cash-for-care benefit. Once users were entitled to HCP, they had access to all the information and were free to claim any benefit included in the HCP portfolio, including both cash-for-care and in-kind services. The administrative procedures of INPS were equivalent in both cases, and cash-for-care benefits were delivered promptly and through very simple procedures. A stronger administrative barrier for beneficiaries was the obligation to draw up a new employment contract with their domestic assistant and pay their social security and pension contributions each month. This barrier may well have raised the (initial) transaction costs for users with limited capacity.

Most NTU, therefore, seems to be related to the trade-off stage, in which potential recipients weigh up costs and benefits. Indeed, there is evidence that NTU is clearly related to the amount of the entitlement: while the NTU rate by caseload (defined as the number of entitled non-recipients divided by the total number of HCP clients) was 23%, the same rate calculated by expenditure (defined as the amount of benefit not claimed by non-recipients, divided by the total amount of benefits available to HCP recipients) was 13.9%. Moreover, the correlation between take-up rates and benefit amounts was positive, both in absolute terms (.73), considering the nominal value of the benefit, and relative terms (.49), considering the benefit in proportion to the ISEE indicator.

The main conclusion to be drawn from this analysis is that the cash-for-care benefit provided by INPS, designed to provide financial support for the regular employment of an in-house care assistant, was not adequately designed to meet the care needs of a significant proportion of eligible potential beneficiaries. This was particularly true for

users who were entitled to low amounts because of their (relatively) high income or (relatively) low level of disability. In such circumstances, the amount of the HCP benefit did not outweigh the expected costs. As information and transaction costs in the threshold stage were very low (as explained above), we may assume that additional costs were linked instead to the use of the HCP benefit, such as the impact of this measure on care arrangements and/or the interaction with other LTC benefits. The evidence supports this hypothesis, as the NTU rate was significantly higher among HCP clients who were also beneficiaries of IdA than it was among non-IdA beneficiaries. The caseload NTU rate for the former was 30.3% while for the latter it was only 10.1% (i.e. three times lower). NTU rates by expenditure were 18.8% and 7.3%, respectively.



**Figure 1.** HCP cash for care benefit: NTU for IdA and non-IdA beneficiaries.

Source: authors' graph based on INPS data

**Table 2.** NTU rate among HCP beneficiaries receiving IdA who claimed the cash-for-care benefit by ADL and ISEE (monthly HCP amount in euros is shown in brackets).

		ISEE					
		0–8,000	8,000–16,000	16,000–24,000	24,000–32,000	32,000–40,000	40,000–48,000
ADL	48–64						
	65–83	62.2 (100)	92.0 (20)				
	84–102	19.3 (400)	44.1 (200)	95.8 (20)		0	
	103–120	9.8 (700)	17.6 (500)	33.0 (300)	46.0 (100)	0	0

Source: authors' table based on INPS data

**Table 3.** NTU rate among HCP beneficiaries *not* receiving IdA who claimed the cash-for-care benefit by ADL and ISEE (monthly HCP amount in euros is shown in brackets).

		ISEE					
		0–8,000	8,000–16,000	16,000–24,000	24,000–32,000	32,000–40,000	40,000–48,000
ADL	48–64	18.3 (300)	18.9 (250)	20.7 (200)			
	65–83	5.9 (600)	6.3 (500)	7.1 (400)	14.6 (200)		
	84–102	3.6 (900)	4.0 (700)	9.5 (500)	15.5 (350)	38.3 (200)	
	103–120	3.0 (1,200)	2.0 (1,000)	3.6 (800)	9.1 (600)	16.7 (400)	25.9 (200)

Source: authors' table based on INPS data

Figure 1 illustrates this result by breaking NTU rates (and related benefit amounts) down into those for beneficiaries and non-beneficiaries of IdA (see also Tables 2 and 3).

The left tail of the distribution curve for IdA beneficiaries shows very high NTU rates for very modest HCP benefit amounts. The NTU rate for IdA beneficiaries fell below 20% only for monthly amounts above 400 euros. Below this threshold, the NTU rate was extremely high (between 44% and 96%). This result is mainly due to the policy design of the measure: as explained previously, in the case of IdA beneficiaries, an amount equivalent to the IdA benefit (around 500 euros per month) would be deducted from the HCP benefit. For instance, HCP beneficiaries in the most severe conditions of need (ADL disability 103–120 and ISEE below 8,000 euros) would receive 700 euros as against 1,200 euros for non-beneficiaries of IdA. Most of the gap in the NTU between IdA and non-IdA beneficiaries is therefore explained by the lower amount of HCP benefit to which those already receiving the IdA benefit were entitled.

However, there was still a difference between the two groups that is not explained by different entitlements. Graph 1 shows that, for equivalent amounts of HCP benefits, the NTU rate among IdA beneficiaries was always higher than the NTU rate among non-IdA beneficiaries. The relative gap (the difference between the two amounts divided by the lower amount) is indeed essentially constant throughout the distribution of the amounts of the benefit. In general, therefore, IdA beneficiaries were more reluctant to claim than non-IdA beneficiaries, and this resistance was due to the significant impact of the HCP cash-for-care benefit on their IdA-based care arrangements. The NTU of IdA beneficiaries fell below 20% only for high HCP amounts (over 400–500 euros per month).

## 7. Discussion

In the previous section, we considered alternative explanations of significant NTU rates for the HCP cash-for-care benefit on the basis of available evidence.

Lack of information/knowledge about the programme was not a significant factor as beneficiaries had already accessed the general HCP programme. NTU rates emerged as an issue only at the trade-off stage, during which, according to Van Oorschot (1998); Van Oorschot (2002), beneficiaries weigh costs and benefits. Indeed, we observed a significant increase in NTU rates among HCP clients entitled to claim small amounts. Our initial conclusion, therefore, is that NTU rates were largely determined by individual decisions on the part of eligible clients who judged costs to exceed expected benefits.

Who were the potential recipients that did not claim the cash-for-care benefit? As shown in the previous section, NTU rates were particularly high among IdA beneficiaries: three times higher than among non-IdA beneficiaries (30% as against 10%). The rate changed according to the amount of the HCP benefit, falling to below 20% for high amounts of HCP benefit and rising to 49% and above for low-to-medium amounts. A closer examination of the criteria used by HCP clients receiving or not receiving IdA to claim/not to claim the cash-for-care benefit was therefore necessary.

Of the competing explanations for NTU rates discussed in Section 2, information costs are deemed to have no significant effect, as they also applied to non-IdA

beneficiaries with no great impact on their take-up. Stigma, too, was not considered to be an issue for recipients of cash-for-care benefits, and certainly not for individuals who already claimed a cash benefit such as IdA. Finally, while administrative costs relating to the regularisation of in-house care assistants may have had an effect (especially for potential claimants whose care assistants did not have a regular contract), it is also true that non-IdA beneficiaries had to bear similar costs with no great impact on their take-up rate.

What peculiar factors are therefore crucial in explaining the case of IdA beneficiaries? Our analysis provides two answers. First, IdA beneficiaries were faced with a significant pecuniary trade-off due to the policy design of the measure, which meant that an amount equivalent to their IdA benefit would be deducted from their HCP benefit, significantly reducing the associated cost-benefit ratio and increasing the NTU rate. Secondly, NTU rates among IdA beneficiaries were highest also when their entitlements were equivalent, or even more generous, than those claimed by non-IdA beneficiaries: IdA beneficiaries, therefore, proved particularly resistant to claiming the HCP cash-for-care benefit.

To explain this resistance, we need to consider the main difference between IdA and HCP cash-for-care. While claiming IdA benefit is not conditional on how the money claimed is used, thus allowing an in-house care assistant to be employed illegally or the money to be spent as part of the general household budget, HCP beneficiaries, in contrast, were required to provide a regular employment contract in order to claim their benefit. In other words, IdA beneficiaries had to bear additional *opportunity costs* arising from greater limitations in the discretionary use of their unconditional cash-based benefit.

Two main opportunity costs can be identified. First, IdA beneficiaries, particularly among the poorer strata of the population, become accustomed to spending cash benefits freely as part of the household budget to cover unpaid care activities of family members (a large extent economically inactive or unemployed women). Access to the HCP cash-for-care benefit did not allow this, as in the new system cash benefits had to be used to regularly employ a care assistant. In other words, IdA beneficiaries claiming HCP were forced to shift from an informal, family-based care arrangement to a formal, market-based care arrangement: a radical change which was economically advantageous only when public cash benefits totally covered the costs of formally externalising care.

Second, IdA beneficiaries can freely use IdA to pay an undocumented migrant care worker (for a very low wage), guaranteeing high flexibility in terms of working hours and care tasks. The formalisation of care work entailed by HCP benefits carries a number of costs: less flexibility in care arrangements (in terms of working hours and care tasks) and more costs related to the payment of social contributions as well as holiday pay, 13<sup>th</sup> month salary, severance pay (such costs, including social security contributions, are around one third of the gross monthly wage when care work is formalised). Again, IdA beneficiaries tended to claim the HCP benefit only if it was generous enough to cover these costs.

In conclusion, high NTU rates among IdA beneficiaries were the result of the individual 'situated' decisions of HCP clients based on a cost-benefit evaluation deeply rooted in attitudes and adaptive practices shaped by the existing institutional context.

In more general terms, the partial failure to implement HCP was due to the fact that, though HCP was designed as a complementary cash-for-care support for people with high care needs, it practically implied a radical overhaul of existing care arrangements and the regularisation, formalisation and progressive professionalisation of care. In practice, the effect of this measure was severely limited by the persistence of a national, cash-based measure (IdA) which significantly shapes the care arrangements and social practices of many individuals who were eligible for HCP, for whom informal care arrangements and irregular employment of a care assistant were highly advantageous. The implicit assumption of HCP was that professionalization of care work by providing strong public financial incentives would lead to higher quality in the sector by reducing the advantages associated with previous informal care arrangements. However, our results show that resistance to change was not only stronger than expected but also mainly based on individual-situated decisions shaped by the existing institutional framework and not sufficiently altered by the policy design of the new programme.

## 8. Conclusions

In public policy studies, the role played by potential users in policy implementation has been essentially neglected. Recently, a number of studies have sought to fill the gap by showing how eligible beneficiaries of new measures can have a direct, significant impact on implementation, potentially restricting and preventing institutional and policy change (Béland, 2016; Béland & Ridde, 2016).

Building on this idea, in this article we have analysed the implementation of an innovative experimental national programme in Italy, HCP, characterised by the introduction of a generous conditional cash-for-care programme aimed at promoting the regularisation of in-house care assistants (to a large extent migrant care workers). This programme was devised to fill the main gaps in the existing LTC system, characterised by prolonged institutional inertia at the national level and the recent growth of a 'migrant-in-the-family' care regime (Bettio et al., 2006).

However, in spite of its particularly innovative policy design, the implementation of the HCP program partially failed because of modest take-up rates and entrenched resistance to change among beneficiaries already entitled to other national cash-for-care benefits such as IdA. Indeed, especially for low-to-medium HCP cash-for-care benefit amounts, a large number of IdA beneficiaries chose to maintain a lower (but unconditional) amount of IdA benefit and not take advantage of the more generous (yet conditional) HCP benefit. We have shown that social resistance to policy change is the result of complex, mutually reinforcing institutional and practical factors. In short, the overall institutional framework of LTC renders traditional, unconditional cash-based benefits more advantageous, to the extent that a large number of beneficiaries of traditional measures do not claim any additional benefit as they do not want to change their existing care arrangements.

'Interstitial' innovation has been seen as an 'easier' way to break down institutional inertia and stickiness as it may reduce political opposition and incrementally modify attitudes and interests. However, our study shows that there may be considerably less room for such interstitial change if policy implementation does not alter adaptive

practices which are deeply rooted in the existing institutional framework. In such a context, innovation is likely to fail to foster compliance among potential beneficiaries, especially when the degree of generosity and the policy design of the new programme do not boost a radical change in such adaptive practices.

One implication of this result for the analysis of policy implementation is that interstitial innovation is rarely accepted by the beneficiaries of established welfare programmes in the absence of rules (mainly concerning access to the programme and its generosity) that can influence their economic benefit or adaptive practices. In this respect, policy design is crucial to create institutional complementarities between alternative or parallel programmes, thus preventing unexpected negative effects such as high NTU rates.

It is difficult to transform long-standing, adaptive care practices by means of limited, short-term, concentrated programmes. Overcoming resistance to change requires strong, permanent, far-reaching investment in political and financial resources. Our study shows that beneficiaries have the last word and may say no even to well-funded yet imperfectly designed innovative welfare measures.

### Disclosure statement

No potential conflict of interest was reported by the authors.

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### References

- Albertini, M., & Pavolini, E. (2015). Care policies in Italy between a national frozen landscape and local dynamism. In U. Ascoli & E. Pavolini (Eds.), *The Italian welfare state in a European perspective. A comparative analysis* (pp. 133–156). Bristol: Policy Press.
- Ascoli, U., & Pavolini, E. (eds). (2015). *The Italian welfare state in a European perspective. A comparative analysis*. Bristol: Policy Press.
- Bargain, O., Immervoll, H., & Viitamäki, H. (2012). No claim, no pain. Measuring the non-take-up of social assistance using register data. *The Journal of Economic Inequality*, 10(3), 375–395.
- Béland, D. (2016). Ideas and institutions in social policy research. *Social Policy & Administration*, 50(6), 734–750.
- Béland, D., & Ridde, V. (2016). Ideas and policy implementation: Understanding the resistance against free health care in Africa. *Global Health Governance*, 10(3). Retrieved from: <http://www.ghgi.org>



- Béland, D. E., & Powell, M. (2016). Continuity and change in social policy. *Social Policy & Administration*, 50(2), 129–147.
- Berthoud, R. (2010). The take-up of Carer's Allowance: A feasibility study. ISER Working Paper Series 2010-38. Institute for Social and Economic Research.
- Bettio, F., Simonazzi, A., & Villa, P. (2006). Change in care regimes and female migration: The 'care drain' in the Mediterranean. *Journal of European Social Policy*.
- Burau, V., Zechner, M., Dahl, H. M., & Ranci, C. (2017). The political construction of elder care markets: comparing denmark, Finland and Italy. *Social Policy & Administration*, 51(7), 1023–1041.
- Cordini, M., & Ranci, C. (2017). Legitimising the care market: The social recognition of migrant care workers in Italy. *Journal of Social Policy*, 46, 91–108.
- Costa, G. (2013). Long-term care Italian policies: A case of inertial institutional change. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe. Investigating institutional change and social impacts* (pp. 221–241). New York: Springer.
- Currie, J. (2004). *The take up of social benefits, WP n.10488*. Cambridge, MA: National Bureau of Economic Research.
- Da Roit, B. (2007). *Changing intergenerational solidarities within families in a Mediterranean welfare state. Elderly care in Italy*. *Current Sociology*, 55, 251–269.
- Da Roit, B. (2010). *Strategies of care: Changing elderly care in Italy and The Netherlands*. Amsterdam: Amsterdam University Press.
- Da Roit, B., Le Bihan, B., & Österle, A. (2016). Cash-for-care benefits. In C. Gori, J. Fernández & R. Wittenberg (Eds.), *Long term care reforms in OECD countries. Successes and failures*. Bristol: Policy Press.
- Da Roit, B., & Sabatinelli, S. (2013). Nothing on the move or just going private? Understanding the freeze on child and elder care policies and the development of care markets in Italy. *Social Politics*, 20(3), 430–453.
- Daigneault, P. M., Jacob, S., & Tereraho, M. (2012). Understanding and improving the take-up of public programs: lessons learned from the Canadian and international experience in human services. *International Journal of Business and Social Science*, 3(1), 39–50.
- Eurofound. (2015). *Access to social benefits: Reducing non-take-up*. Luxembourg: Publications Office of the European Union.
- Hemerijck, A. (ed.). (2017). *The Uses of Social Investment*. Oxford: Oxford University Press.
- Hernanz, V., Malherbet, F., & Pellizzari, M. (2004). Take-up of welfare benefits in OECD Countries: A review of the evidence. OECD Social, Employment and Migration Working Papers, No. 17. Paris: OECD Publishing.
- Howlett, M., Ramesh, M., & Perl, A. (2009). *Studying public policy: Policy cycles and policy subsystems* (3rd ed.). Toronto: Oxford University Press.
- INPS. (2015). Avviso pubblico progetto home care premium assistenza domiciliare. Rome. Retrieved from: <https://www.inps.it/docallegati//Mig/Welfare/HCP%202014%20Avviso%20Home%20Care%20Premium.pdf>.
- Korpi, W. E., & Palme, J. (2003). New politics and class politics in the context of austerity and globalization: Welfare state regress in 18 countries, 1975-95. *The American Political Science Review*, 97(3), 425–446.
- Mahoney, J., & Thelen, K. (2010). *Explaining institutional change*. Cambridge: Cambridge University Press.
- Matsaganis, M., Levy, H., & Flevotomou, M. (2010). Non-take up of social benefits in Greece and Spain. *Social Policy & Administration*. 44(7), 827–844.
- Matsaganis, M., Paulus, A., & Sutherland, H. (2008). *The take up of social benefits, Research note*. Brussels: European Commission.
- Mergaert, L., & Lombardo, E. (2014). Resistance to implementing gender mainstreaming in EU research policy. In E. Weiner & H. MacRae (Eds.), *The persistent invisibility of gender in EU policy* (pp. 1–21). European Integration online Papers (EIoP), Special issue 1, Vol. 18, Article 5. Retrieved from: <http://eiop.or.at/eiop/texte/2014-005a.htm>

- Morel, N., Palier, B., & Palme, J. (2012). *Towards a social investment welfare state?* Bristol: Policy Press.
- Naldini, M., & Saraceno, C. (2008). Social and family policies in Italy: Not totally frozen but far from structural reforms. *Social Policy & Administration*, 42(7), 733–748.
- Network Non-Autosufficienza, N. A. A. (2017). *L'assistenza agli anziani non autosufficienti*, 6 Rapporto, Santarcangelo di Romagna, Maggioli.
- Pavolini, E., Ranci, C., & Lamura, G. (2017). Long-term care in Italy. In B. Greve (Ed.), *Long-term care for the elderly in Europe development and prospects* (pp. 75–92). London: Routledge
- Pierson, P. (2001). *The new politics of the welfare state*. Oxford: Oxford University Press.
- Prior, D., & Barnes, M. (2011). Subverting social policy on the front line: Agencies of resistance in the delivery of service. *Social Policy & Administration*, 45(3), 264–279.
- Ranci, C., & Pavolini, E. (eds). (2013). *Reforms in long-term care policies in Europe. Investigating institutional change and social impacts*. New York: Springer.
- Riphahn, R.T. (2001). Rational poverty or poor rationality? The take-up of social assistance benefits. *Review of Income and Wealth*, 47(3), 379–398.
- Saraceno, C. (2010). Social inequalities in facing old age dependency: A bi-generational perspective. *Journal of European Social Policy*, 20(1), 32–44.
- Saraceno, C. (2016). Varieties of familialism: Comparing four southern European and East Asian welfare regimes. *Journal of European Social Policy*, 26(4), 314–326.
- Saraceno, C., & Keck, W. (2010). Can we identify intergenerational policy regimes in Europe? *European Societies*, 12(5), 675–696.
- Streeck, W., & Thelen, K. (eds). (2005). *Beyond continuity. Institutional change in advanced political economies*. Oxford: Oxford University Press.
- Van Hooren, F. (2014). Migrant care work in Europe: Variety and institutional determinants. In M. Leon (Ed.), *The transformation of care in European societies* (pp. 62–82). Basingstoke: Palgrave MacMillan.
- Van Oorschot, W. (1995). *Realizing rights: Multilevel approach to non-take-up of means-tested benefits*. London: Avebury.
- Van Oorschot, W. (1998). Failing selectivity: On the extent and causes of non-take-up of social security benefits. In H.-J. Andress (Ed.), *Empirical poverty research in a comparative perspective* (pp. 101–130). Aldershot: Ashgate.
- Van Oorschot, W. (2002). Targeting welfare: On the functions and dysfunctions of means-testing in social policy. In P. Townsend & D. Gordon (Eds.), *World poverty: New policies to defeat an old enemy* (pp. 171–193). Bristol: Policy Press.
- Van Oorshot, W., Opielka, M., & Pfau-Effinger, B. (2008). *Culture and Welfare State Values and Social Policy in Comparative Perspective*. Cheltenham: Edward Elgar.
- Vancoppenolle, D., Sætren, H., & Hupe, P. (2015). The politics of policy design and implementation: A comparative study of two belgian service voucher programs. *Journal of Comparative Policy Analysis: Research and Practice*, 17(2), 157–173.
- Zhu, Y. (2010). Target groups' views and policy implementation: Lessons from Guiyang's housing monetarization reform. *Politics & Policy*, 38(4), 817–841.