Coverage versus generosity: Comparing eligibility and need assessment in six cash-for-care programmes

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Abstract

This paper investigates the potential trade-offs between extension of coverage and adequate generosity in cash-for-care (CfC) programmes in six European countries (Austria, Ger-many, France, Great Britain, Italy, and Spain), which are characterised by different configurations of CfC programmes. Building on an empirical analysis of the eligibility rules, of the regulation applied to classify beneficiaries according to their level of dependency, and the ways CfC benefits are distributed among them, it becomes clear that these programmes differ substantially in terms of coverage and generosity. Such differ-ences reflect the variety of ways by which universalism, selec-tivity, and adequacy are built up together throughout Europe.

KEYWORDS

cash for care, coverage, eligibility, generosity, need assessment

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1 INTRODUCTION

In a time of permanent austerity, long-term care (LTC) policies in Western Europe have tried to cope with a growing demand for care throughout significant processes of institutional change and innovation. In this dynamic context, a significant trade-off has emerged between the extension of coverage and adequate generosity of benefits. National governments needed to find a balance between the increase in the number of beneficiaries and the amount of LTC benefits in order to save costs, on the one hand, and meet the increasing need for care on the other. Although path-breaking reforms have been quite rare over the last 10 years, a number of technical criteria and procedures relating to eligibility and generosity have been introduced and re-adapted to tackle this complex issue. Interestingly, although research on LTC policies has studied institutional changes and reforms introduced in Western European countries extensively in the last decades (e.g., Ranci & Pavolini, 2013; Greve, 2017), research has so far rarely considered how apparently only "technical"

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criteria and procedures—such as the definition of eligibility criteria, need assessment procedures, or benefit accounting methods—have been established and modified in different national contexts. However, it is mainly through these operational mechanisms that LTC benefits are provided to people with disabilities. Crucial facts such as the number of recipients or the amount of benefits depend indeed on "technical" criteria and procedures aimed at implementing the general principles stated in official policy programmes. Moreover, in an age of austerity and strong financial constraints, policy changes in LTC programmes may have been obtained especially through "soft" alterations of such technical mechanisms.

This paper will attempt to fill this research gap by first focusing on the criteria adopted in *assessing needs* in cash-for-care (CfC) programmes. Such criteria are used to define not only eligibility thresholds and different levels of needs but also the amount of benefits for each of these levels. This paper investigates how aspects such as the level of physical and/or mental dependency, income, and age can be considered and combined together differently in order to define the extension of CfC programmes and the allocation of benefits according to different degrees of need for care. Moreover, it considers how benefits have been distributed among beneficiaries with different levels of disability and need for care. This approach will show how LTC policies and, more specifically CfC programmes, although most of them recognise care benefits as a universal social right, are based on different compromises between selectivity and generosity.

The analysis will compare the CfC schemes of six European countries (Austria, Germany, France, Great Britain, Italy, and Spain), which are paradigmatic examples of different care regimes (Continental, Mediterranean, and Anglo-Saxon care regimes) in which CfCs have emerged and are characterised by different configurations. The analysis considers CfC programmes based on cash distribution and those to be used for in-kind services.

The structure of the paper is the following. First, we will briefly discuss how LTC programmes have generally dealt with a fundamental tension between extension of coverage and adequate amounts of benefits. Then the concepts of conditionality and generosity will be theoretically discussed to pave the way for our empirical study. The empirical analysis of CfC programmes for the six countries taken into consideration will focus firstly on conditionality and coverage, and secondly on generosity. Institutional information and technical details about eligibility rules and need assessment procedures will be described and discussed. The analysis will consider the following aspects: the different and multiple criteria used for need assessment (e.g., mobility, activities of daily living [ADL], cognitive aspects, and physical care), the levels of disability required in order to be entitled to benefits, the classification of different levels of disability, and the distribution of benefits according to such classification. From an empirical standpoint, the analysis is mainly based on written documents, both official papers and grey literature edited for administrative purposes, gathered in each country. Furthermore, available country-based macrodata has been combined together to compare levels of selectivity and generosity.[1]

Finally, a conclusion will discuss the main results by stressing how the various LTC programmes have, each in their own way, found a specific balance between extension of coverage and generosity of benefits.

2 THE TRADE-OFF BETWEEN COVERAGE AND GENEROSITY OF BENEFITS

In 2016, most LTC systems in Western Europe had some kind of CfC programme in place (Da Roit et al., 2016). In many countries, these programmes were introduced in the 1990s or early 2000s both to support the demand for care and to limit the financial impact of coverage widening through demand-side support measures, therefore reducing the potential trade-off between universalism and cost containment (Ranci & Pavolini, 2013; León, 2014). Starting from 2007, newly emerging financial and demographic pressures have increased tensions and trade-offs in the LTC policy field. On the one hand, the ageing process has greatly increased, especially in Mediterranean and Continental countries. It has destabilised the demographic intergenerational balance, contributing to the weakening of the care capacity of families. On the other hand, LTC policies, after a phase of stabilisation in the first decade of the

2000s, have entered a phase of stronger cost-containment orientation especially in the countries hit by the financial crisis where a new form of "restricted universalism" has emerged (Ranci & Pavolini, 2013). These trends show the difficulty of LTC policies, and CfCs in particular, to match the increased need for care emerging in the population without altering the existing coverage extension and generosity levels.

These structural tensions have led to searching for a new balance between cost-saving strategies and the necessity to meet an increasing need for care. In Nordic countries (particularly in Sweden) and in the United Kingdom, this tension has emerged very early and has been faced by targeting services and benefits, eventually driving the least severely and most affluent dependent individuals out of the public care system (Meagher & Szebehely, 2013; Glendinning, 2013). In Austria and France, implicit strategies have been adopted to drive down the cost of formal care services without reducing coverage levels (Österle, 2013). In Germany, a new reform in 2016 has increased the amount of benefits to better support people with cognitive disabilities. In Spain and Italy, cost containment has been dominant due to the high burden of the financial crisis (Ranci & Pavolini, 2013).

To understand these processes, we need to consider that the combination of financial constraints and an increasing need for care benefits has caused a stronger *trade-off between the extension of coverage and the generosity of benefits*. Spending cuts (or increase in funding) can affect both these aspects, either driving a reduction (or expansion) in the number of beneficiaries or a reduction (or increase) in the amount of benefits. A peculiar combination of extension and intensity of benefits is therefore found in each CfC programme. On the one hand, specific criteria define the entitlement of individuals to care programmes, which can be more or less selective. On the other hand, benefits are defined both in their type (e.g., cash or in-kind) and amount, very often in accordance with the level of care need. As a consequence, the combination of both these aspects (definition of entitlement to care and of the varied amount of benefits) has a relevant distributive impact whether it involves a small or a large part of those in need of care, or if it delivers big or small amounts of benefits. In a context of increasing numbers of people in need of care, both aspects are likely to become a very complex source of tension.

3 CONDITIONALITY AND GENEROSITY: A CONCEPTUAL DISCUSSION

Universalism in LTC policies has been mainly understood as the fact that across countries, LTC programmes are aimed at protecting the whole population against a specific social risk—disability—with no further constraints or limitations. Using the terminology of Clasen and Clegg (2007), these programmes are targeted to a specific "condition of category." In all the countries where LTC policy is universalistic, the need for care due to permanent disability is recognised as a mandatory, universal social right, which can be claimed by citizens on the basis of their specific care needs.

Universalism implies however some forms of conditionality. As Clasen and Clegg (2007) claim, "individual rights have always and everywhere been conditional in some ways" (p. 171). If the "condition of category" identifies a general risk against which people are protected, "though risk of membership categories are often taken as given in measures of social rights, it should be remembered that they are in fact socially constructed and politically managed, and thus subject to potential change, either in a more restrictive or more expansive or encompassing direction." (p. 172).

Among the CfC programmes considered here, means tests have almost *never* been included in the eligibility criteria. When copayment is envisaged, this does not prevent the universal right to access to these schemes. Even age limitations have rarely been considered, with the only exception of France (see below). It can be rightly claimed, therefore, that across Europe, only with a few exceptions CfC is recognised as a universal social right, giving all the people with LTC needs, without further requirements or constraints, eligibility for specific welfare benefits.

Of course, "need for care" is a specific requirement of eligibility for CfC programmes. This "condition of category" is subject to a specific "selective" assessment, differently shaped across countries, by which care needs are evaluated and eventually ranked according to specific criteria. Following Clasen and Clegg (2007), the "condition of category" must be further detailed by the "condition of circumstances" by which the general eligibility for a welfare benefit is more closely detailed in particular criteria entitling people to specific benefits. In CfC programmes, if disability represents the main "condition of category," the crucial (and basically, the only) "condition of circumstances" to be considered is the disability levels and related care needs. These aspects are usually evaluated through peculiar criteria and procedures of need assessment. This differentiation in the "condition of circumstances" has obvious impacts on the coverage extension of these programmes, which is, in some ways unexpectedly, highly differentiated across countries. More than through official, explicit statements, or general reforms, the way universalism has been combined with specific forms of selectivity is therefore based on criteria, classification, and ranking systems by which care needs have been assessed and categorised in each country.[2]

We can therefore conclude that criteria and procedures of care need assessment are the fundamental policy levers through which universal CfC programmes select their "appropriate" population target. Furthermore, such levers are functional to linking the "social right to care" to specific benefits and services. We will demonstrate that most of the differences in CfC policies across countries is due to different ways eligibility is defined and is linked to specific provisions.

The outcomes of CfC policies do not depend solely on levels of conditionality and related coverage rates but also on their level of generosity. Generosity of welfare programmes has been mainly measured by considering the amount of public expenditure or replacement rates (Green-Pedersen, 2007). These measurements are especially useful to capture the generosity of welfare programmes aimed at redistributing benefits to the poorest (as in the case of minimum income programmes) or to protect people against social risks implying a definite income loss (such as unemployment, for example). CfC programmes, even when consisting of cash benefits, do not properly follow either a "Robin Hood" logic (redistributing from the richest to the poorest) or a "quid pro quo" logic (protecting on the basis of previous contributions; see Kvist, Freundt, & Grundt Straubinger, 2013). They are mainly based on an *egalitarian logic*—similar to health care—by which people get welfare benefits according to their needs for care and independently from their contributions. The generosity of CfC programmes is therefore basically related to peculiar definitions of the need for care, which are defined on the basis of supposedly objective, "technical" criteria.

Diversified multidimensional scales and various complex assessment procedures have been introduced in CfC programmes to define nationwide, standardised classifications of disability levels (Carrino & Orso, 2014; Gori, Fernandez, & Wittenberg, 2016). Technical instruments such as ADL or instrumental ADL have been widely used to build up ranking lists. In the last decade, new instruments able to detect levels of mental disability (such as the Mime text, for example) have been developed and progressively used to take into account the huge growth of patients affected by Alzheimer's disease and other cognitive impairments. The introduction of disability tests has therefore allowed a standardisation of need assessment that is crucial, for nation-based cash benefits, to ensure that a universalistic social right to care is guaranteed to all the eligible persons without individual discriminations or territorial differentiation. A risk of overstandardisation is considered low as CfC programmes usually establish the rules of eligibility and the amount of benefits, whereas beneficiaries and/or care professionals are generally allowed to freely organise care arrangements or personalised care assistance plans.

In spite of the high level of standardisation of disability tests, generosity of CfC programmes is still very hard to be objectively (and therefore comparatively) assessed. As we will see below, the crucial point is that the amount of social benefits is differently associated to specific, technical classifications of disability levels. To follow an ideal, comprehensive, egalitarian approach, such amounts should cover the whole range of care needs of people with different classified levels of disability. In our cases, however, the amounts of benefits reflect not only such technical classifications but also budget restraints, targeting priorities and underlying ideas about preferences and expectations in terms of formal or informal care provision. As CfC are mainly cash-based benefits directly given to beneficiaries, their amount is not affected by labour cost but basically reflects their care needs. However, in the absence of a technical, objective definition of what a "care need" is or should be and how it is or how it should be covered, there is indeed ample room for discretionary decisions.

To conclude, the outcomes of LTC programmes are the result of a complex adjustment between conditionality and generosity. These two aspects are in a trade-off relationship. The more open and comprehensive levels of conditionality, the more pressure will be on generosity due to limitation in financial resources. On the other hand, conditionality could be highly selective but at the same time, it could bring generous benefits to the eligible population. Decisions on one side must be combined therefore with decisions on the other side. Finally, it is somewhat striking that this crucial adjustment is governed through technical, apparently neutral procedures aimed at assessing the need for care of the potential beneficiaries, with no room for public discussions.

4 CONDITIONALITY IN SIX CfC PROGRAMMES: DEFINING COVERAGE

This section explores conditionality in CfC programmes in the six countries covered by our analysis (see Table 1). First, we will consider the general approach of such programmes to conditionality and need assessment. Second, we will examine the different levels of coverage adopted by such programmes. To estimate coverage levels, we used 2015 data for Austria, Great Britain,[3] and Italy, 2016 data for France and Germany, and 2018 for Spain.

4.1 Conditionality

What all these programmes have in common is that they are understood as universal entitlements. Eligibility is therefore a right of citizenship. All these programmes are nationwide even though the provision of CfC may be delegated to regional (Spain and Germany) or local (France) governments. Finally, the programmes do not have age limitations even though they are mainly used by an older population. Only in France, the APA is targeted for the 60+ population, whereas in the Great Britain, cash benefits for the elderly and those for adults with disabilities are split into two separate programmes, but with almost equivalent amounts (around half of personal independence payment [PIP] beneficiaries are also entitled to Mobility Awards, resulting in receiving more money than those with attendance allowance [AA]). Unlike the general lack of means testing in CfC programmes, in France, the universal approach has been partially tempered by introducing a copayment system. Here, beneficiaries have to contribute to total costs of the APA if their personal income (also including the partner's income if living together) exceeds €800 per month. In this case, the copayment is proportionate to the income level: for example, for APA “à domicile” (home care), it is very low for incomes up to €1,000–1,250 (10–15% of the total cost), but it increases dramatically for higher income levels (up to 71% of the total costs for incomes above €2,500). The burden of copayment for residential care (APA en établissement) is less heavy given for incomes below €2,500 beneficiaries are exempted. In 2016, the copayment was significantly reduced for beneficiaries with high levels of disability and high incomes[4] to avoid that a large share of them exit the programme due to a very heavy copayment fee. Finally, in Spain, the amount of the CfC scheme also varies according to the economic condition of the beneficiary in some regions.

Given the strong universal approach of these programmes, the main conditionality comes from need assessment. However, the tools and procedures for assessing their needs are differently defined and implemented. The two oldest programmes (IdA in Italy and AA in the Great Britain) have an assessment system that allows higher subjective discretion. In Italy, law 18/1980 establishes that the right to IdA is available, without limits of age or income, to “disabled or challenged citizens totally disabled due to physical ailments or mental diseases, who are unable to move without the aid of a permanent companion or, not being able to carry out daily tasks of life, need continuous support.” Actual eligibility is established by medical commissions on the basis of two contradicting criteria: (a) total disability, calculated by considering the incidence of illness or deficits in relation to the *working capacity* of an individual, a criterion adopted in 1980 to provide a compensatory support to disabled people of working age and (b) persistent inability to carry out the own-age-related daily activities. Whereas the former criterion is inadequate to assess the need for care of frail older people, the latter allows a high level of discretion in the need assessment decision making of medical commissions. To sum up, the calculation of disability stands on a medical assessment of specific deficits or diseases and does not consider to what extent people actually need daily help or assistance. As a result, huge territorial inequality in the distribution of IdA was found (Gori, 2012).

TABLE 1 Cash-for-care programmes in six countries: A brief description

Country	Benefit	Levels	Minimum threshold to be eligible
Austria	Pflegegeld (PG)	7	65 hr of care every month
France	Allocation Personnalisée d'Auntonomie (APA)	6 (4 with entitlements)	GIR4 level
Germany	Pflegegeld	3 + 1 (from 2008) 5 (from 2016)	Until 2016: 90 min of help, *or* 45 min of basic care, every day Since 2017: 27 min of care every day *or* 15 points in the national scale, for the last 6 months
Italy	Indennità di Accompagnamento (IdA)	1	100% diagnosed disability
Spain	Prestación para cuidados en el entorno familiar (PCEF)[a]	3	25 points in the BVD scale[b]
Great Britain	Attendance allowance (AA) Personal independence payment (PIP)[c] Daily living allowance (DLA)	2 2 for daily living + 2 for mobility 3 for daily living + 2 for mobility	3 care activities in a day *or* continuous care to avoid danger, *or* nightly surveillance

Source. Own elaboration on national data.

Note. GIR4 (GIR1 = highest disability) includes cases with only physical impairments.

[a] The PCEF is one of the three cash-based measures introduced by LAPAD since 2007. In 2018, it covers 30% of total interventions implemented by LAPAD.

[b] The BVD scale ranges from 0 to 100 points and it asses the individual's ability in performing daily life or instrumental daily life activities. Twenty-five points means at least a support needed once a day in performing such activities or an intermittent/limited support needed for personal autonomy.

[c] PIP (DLA until 2013) includes two independent components: the daily living and the mobility awards.

In the Great Britain, need assessment is based on a self-compiled form by which potential beneficiaries can claim for obtaining the AA. The contents and internal coherence of the form is controlled by officials (who are not medically qualified) of the Department of Work and Pension. Their decision making is guided by a computerised assessment system based on an official handbook listing “care needs which are likely to arise from various disabilities and chronic illnesses” (Aylward, Dewis, & Henderson, 1998). However, it has been pointed out that, due to the fact that the impact of disability on the need for care is self-reported, the award decision depends on the ability of the potentially eligible person to accurately assess and report their needs (Pudney, 2010). This potential source of uncertainty in the decision-making process often requires additional evidence, which is often asked from medical professionals. A further aspect showing the high level of uncertainty in the assessment procedure is that the success ratio of mandatory reconsiderations asked by potential beneficiaries exceeds 50% of total cases: Eligibility is therefore a matter of frequent appeals. In the other British programme, the PIP, needs assessment is based on the consideration of daily living difficulties related to 10 main activities (such as preparing food, taking nutrition, washing, and bathing) in addition to mobility difficulties. At the beginning of the evaluation procedure, potential beneficiaries are asked to fill in a specific application form with which their condition of need is detailed. This form is then evaluated by health care professionals employed by two contracted providers who are external to the Department of Work and Pension: To a large extent, the evaluation takes place through face-to-face assessment.

In the other countries considered, the introduction of a CfC programme has come together with the insertion of an assessment tool providing a nationwide, direct, multidimensional evaluation of the need for care, with limited room for subjective interpretation. In Austria, the assessment of care needs is based on a medical doctor or nurse's examination following standardised procedures that cover medical, personal, and household requirements. A list defined by law ("Bundespflegegeldgesetz") provides guiding values related to the time required for specific services and assistance each day. For benefit levels 5 to 7, in addition to the time budgets, qualitative criteria are also taken into account. Whether informal care is available or whether respective resources are used in the care arrangement does not impact on the needs assessment. An equivalent system was also used in Germany until 2016. With the 2016–2017 reform, the need assessment procedure was drastically changed. In an attempt to better recognise cognitive impairments, the new assessment approach has shifted from a categorical definition (distinguishing between physical, mental, and psychological disabilities) to a holistic consideration of disability, and from a definition of "need for care" basically restricted to everyday life tasks to a more general notion where different areas of disability are considered together.

In France, a well-experimented specific diagnostic instrument (AGGIR—Gerontological Autonomy Iso-Resources Group) is used to assess the need for care. This tool provides a multidimensional assessment based on 10 "discriminant variables," which are combined together through a complex system of weights and rankings (managed by an algorithm), and results in a peculiar, individualised final assessment, which is expressed in a GIR (Iso-Resource Groups) scale. The GIR scale identifies six levels of disability. Adjustments in the assessment tool have been introduced over time to reduce the level of discretion still left to the professionals (doctors and social workers) in charge of its completion. In Spain, the reform of 2006 introduced a national, standardised assessment scale (Baremo de Valoración de la Dependencia, BVD), which must be adopted by all the regional governments to harmonise the access to the LTC system and classify its beneficiaries into different categories. It considers 10 areas of disability (plus an additional area in case of mental disability) and provides specific rules and weights to combine all these assessments into a simplified three-level classification.

To summarise, although these assessment instruments are built on different criteria, they share some relevant aspects. First, they have been introduced as policy tools necessary for the implementation of nationwide, standardised, and universal CfC programmes. They do not only guarantee standardisation of assessment and access criteria at national levels but also contribute to reduce territorial and individual discretion and provide a legal basis for establishing LTC as a recognised social right. Second, although CfC programmes imply that some form of caregiving is to be given to potential beneficiaries, the amount of caregiving and the possible involvement of either informal or formal caregivers is rarely considered as a relevant aspect of the evaluation. Caregiving is therefore considered to be part of the solution but is not considered as part of the problem to be tackled. Third, and consequently, the assessment is focused only on the individual disability conditions, though the adopted notions of disability are different from country to country. Fourth, all these instruments attempt to capture the need for care, and not the individual conditions of impairment or the presence of specific diseases. Finally, they are designed for multidimensional assessment not only of daily living conditions of the potential beneficiaries but also of aspects related to their mental and psychological conditions, whether or not these conditions have been medically diagnosed. The incorporation of cognitive disability has therefore brought about a clear distinction between medical diagnoses aimed at curing patients and need assessment procedures aimed at providing care support.

In spite of such common aspects, CfC programmes also show relevant differences. In particular, IdA and AA—both programmes originally targeted for the adult, working-age, population—are characterised by three particular aspects: (a) a focus on impairments and not on care needs; (b) a lack of a multidimensional assessment; and (c) a lack of transparent, standardised assessment scales. These different approaches have strong implications for the definition of the minimum thresholds to be reached to be eligible for such programmes.

4.2 Levels of coverage

In general, the assessment rules implemented in Italy and the Great Britain (AA+DLA/PIP) provide broader access to CfC programmes, reaching 22% of the 65+ population in Great Britain and 12% in Italy in 2015. In these two countries, minimum thresholds are fixed on the basis of scores (percentage of disability in Italy) or qualitative aspects (in Great Britain), which are considered by medical or professional commissions with poor transparency and low standardisation of the procedure. These programmes are characterised by uncertainty and opacity, but they show a very high level of coverage. This is only apparently a paradox: High levels of discretion and uncertainty due to the lack of strict eligibility criteria have long contributed to extend or limit the access depending on political or financial contingencies. In times of increasing need pressure and limited capacity of policy reform of the overall LTC systems, the British and Italian CfC programmes could be easily expanded, whereas in times of austerity, discretion has been used to limit access and decrease the coverage rate. In these countries, need assessment has been a weak policy instrument easily dependent on more general policy goals.

In the other countries, minimum thresholds have been fixed on the basis of a standardised scale establishing the amount of care needed by each applicant. Interestingly, in these countries, CfCs have come up with stricter need assessment procedures and much lower coverage rates. Only in Austria, the coverage rate is similar to programmes in Italy and the Great Britain, reaching around 18% of the 61+ population. This, however, is also determined by a programme that existed prior to the current PG programme, which in fact was similar to the IdA in Italy. In Austria, the minimum requirement is 65 hr of care need per month. In Germany, until 2016, the threshold was 45 hr of basic care per month, whereas the coverage was still lower than in Austria. This difference was due to distinct definitions of activities considered in the assessment and the calculation of time needed for these activities. In 2017, Germany changed the assessment procedure, which is now based on the overall level of independence of individuals (measured through a multidimensional scale by which only people with at least 15 points are eligible to benefits), rather than on time needed for care. In France, persons with a disability scoring lower than GIR4 are excluded from the APA. In Spain, they need to reach 25 points. Except for Austria, coverage rates (among the 65+ population) are always under 10% and have not changed drastically in the last 10 years. Only in Germany, the 2016–2017 reform has brought about an increase in coverage rates, which is intentionally driven by a change in the need assessment tool. In France, the same rules have been applied since the APA started (with only minor amendments), and the same has happened for Spain. In Austria, several adaptations and adjustments have taken place since 1993, including an increase in the minimum requirements in terms of care needs in level one and two, and including changes in the administration. But the overall need assessment logic did not change. Strict requirements, strong standardisation, and—compared to IdA in Italy and AA in Great Britain—higher public transparency have allowed a strong political and budgetary control of the CfC programme, fostering affordable expectations in the population, effectively keeping the need pressure under control through the adoption of restrictive eligibility criteria, and allowing technical changes only when budget and political conditions were favourable. Finally, and more importantly as we will see in the next part, in these countries, standardised need assessment has come together with more generous benefits for the people most on need.

5 GENEROSITY IN SIX CfC PROGRAMMES: CLASSIFYING DISABILITY AND NEEDS

Need assessment procedures are used not only to define eligibility but also to classify beneficiaries in different groups and entitle them to specific benefits. All CfC programmes considered, with the exception of IdA and partially of the AA, adopt a peculiar classification of different levels of disability, to which specific needs for care and related benefits are associated. Classifications are built on specific criteria that are supposed to allow a transparent, fair, and "undisputable" differentiation of disability levels. The criteria used to classify forms and levels of disability can be summarised into four general areas, even though there is no homogeneity in how these areas are combined and weighted in the final evaluation:

1. physical mobility within the house and outside;
2. activity in daily life (dressing, cleaning, feeding, meals preparation, housekeeping, etc.);
3. need for body care (medications, physical hygiene, health care, etc.); and

4. cognitive impairments (behaviour and/or communication issues, memory, language, etc.).

The most frequent and highly weighted element is limitations in ADL. ADL limitations are very important in Austria and Germany, whereas in France and Spain, they are considered important only for lower levels of disability. Another relevant area is the need for body care, often involving more specialised treatments and the integration of social and health care skills. Mobility is also often relevant though with different intensity according to the country. Finally, cognitive aspects are considered very important only in France for the highest levels of disability. In Austria, cognitive impairments do not count in the calculation of time needed for care, but they allow an extra time budget of 25 hr added to the calculation. In Germany, cognitive problems have gained more relevance in the new assessment procedure. In Great Britain, cognitive problems are not taken into consideration.

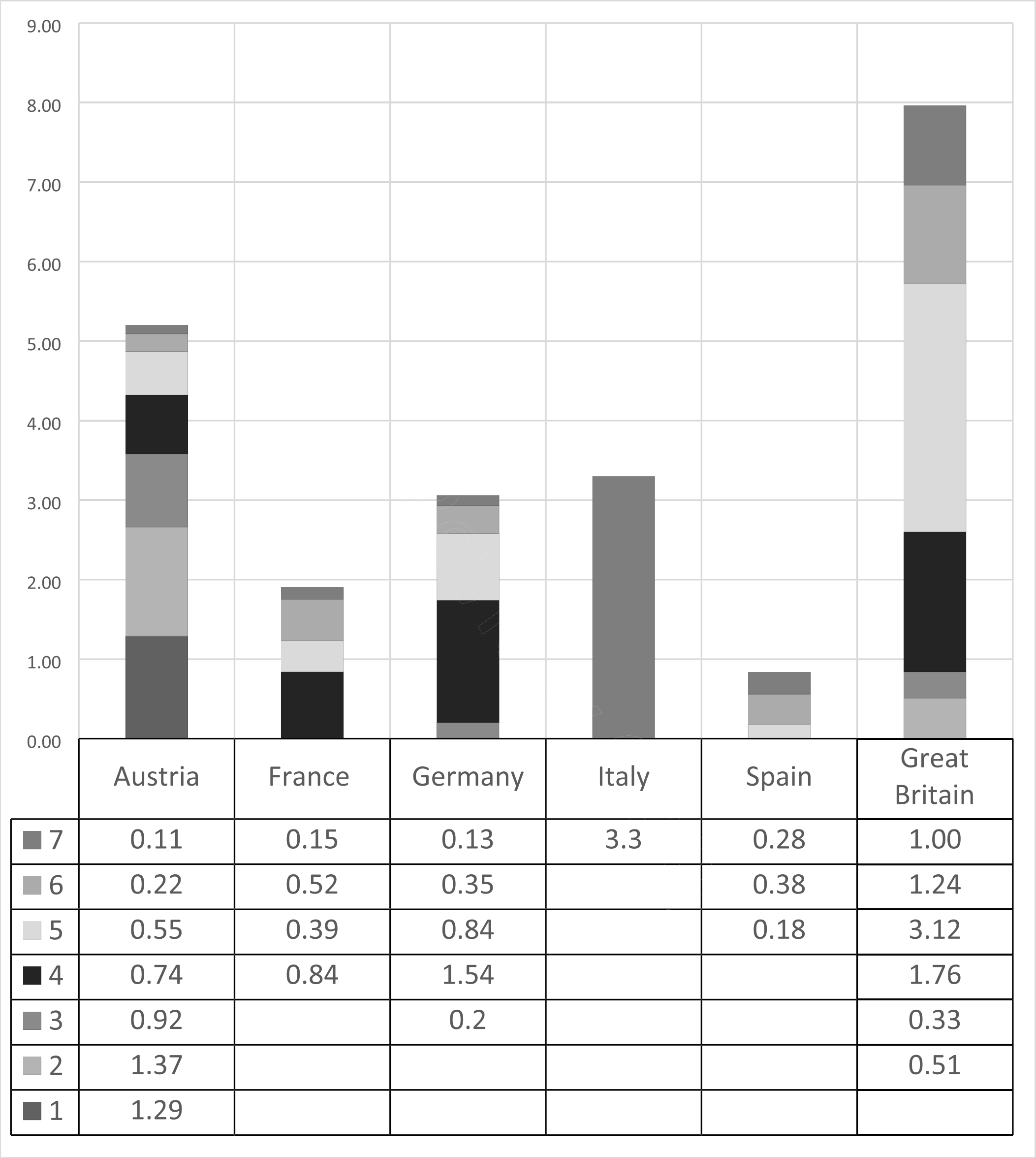
To sum up, although all CfC programmes (with the exception of the Italian IdA) adopt a multicriteria assessment approach, they differ in the weight and relevance given to different aspects. Differences across countries emerge in the consideration of cognitive impairments: Whereas in Germany, France, and Spain, they are highly relevant, in Great Britain, these problems have yet to obtain significant attention.

Need assessment is aimed not only at selecting eligible beneficiaries but also at classifying them according to different levels of disability. The number of levels considered varies considerably, ranging from just one for IdA in Italy to seven in Austria (see Figure 1). Apart from the traditional programmes (IdA and AA), beneficiaries of CfC schemes are ranked according to a strongly progressive classification. In Austria, Levels 5–7 include people whose need for care is at least three times higher than that of those at Level 1. In Germany, the class with the heaviest need for care scores at least four times higher than the lowest class. In France and Spain, progressivity is lower but still significant.

In general, the classifications follow a similar logic, though the extension of coverage is very different from programme to programme. The lowest levels include people with limitations mainly in mobility, ADL, or need for body care; they usually require support for specific daily activities. An intermediary group of beneficiaries is characterised by beneficiaries with multiple disabilities, which strongly limit their autonomy and mobility, requiring frequent assistance and care throughout the day even though there is usually no need for continuous surveillance. Finally, the highest levels include people whose physical and mental disability is highly compromised and in need of constant daily and nightly help; mobility is also severely impaired. Within this group, there is also a small set of beneficiaries with almost complete disability, many often suffering from mental and/or psychological problems, which require continuous body care and assistance for any daily activity and constant overnight surveillance.

Classifications are mainly used to distribute beneficiaries into a set of categories. This distribution varies from programme to programme as shown in Figure 1. With the exception of Italy, beneficiaries with the heaviest level of disability are included in one (for Great Britain), two (France, Germany, and Spain), or three (Austria) categories and cover less than 1% of the total population. Beyond these categories, beneficiaries with the lightest forms of dependency are distributed into a variable number of further categories. The different sizes of these lightest levels of dependency across countries depend on general policy choices regarding the extension of coverage and therefore the need-based conditionality recognised by the system.

These classifications are instrumental in differentiating the generosity of CfC programmes. With the exception of the Italian IdA, all CfC programmes considered link their classification in different levels of disability to a graduation of the benefit amounts. The amount and progressivity of benefits vary (see Figure 2), depending also on whether the benefits can be used without limitations or whether they are linked to the use of certain services. In the first case, the basic amount of benefits is usually very low (between €100–200 per month), whereas benefits for more severe dependency might be up to seven times higher (in Austria). With the exception of the two highest levels in Austria, cash benefits do not exceed €1,000 per month. In the second case, programmes providing cash for buying predefined services, progressivity is lower. Here, the lowest amount is around €400–500; however, the amount given to the most severe cases is much higher (up to €1,995 in Germany). Only two programmes—IdA and AA—do not follow this pattern. The former does not have a graduation, whereas the latter has two levels with only a small amount of differentiation. Due to the flat structure of such programmes,



	Austria	France	Germany	Italy	Spain	Great Britain
■ 7	0.11	0.15	0.13	3.3	0.28	1.00
■ 6	0.22	0.52	0.35		0.38	1.24
□ 5	0.55	0.39	0.84		0.18	3.12
■ 4	0.74	0.84	1.54			1.76
■ 3	0.92		0.2			0.33
■ 2	1.37					0.51
■ 1	1.29					

FIGURE 1 Coverage rates (on the overall population) by levels of disability as stated in the national regulations
Source. Own elaboration on national data.
Note. To allow for comparability, Level 7 includes beneficiaries in the highest disability level in all the countries (this does not necessarily correspond to the numbering of levels in the respective country). Data for Great Britain include AA, PIP (since 2013), and DLA (replaced by PIP in 2013 but still in force for children and those already in the programme). The number of levels were reduced to six combining together classes from different programmes with equal or similar amount of benefits. Year: Italy, Austria, and the Great Britain (2015), France and Germany (2016), Spain (2018) [Colour figure can be viewed at wileyonlinelibrary.com]

benefits do not reflect the individual needs. Individuals with very extensive care needs do not get adequate protection, whereas those with lower levels of disability often get more generous benefits than in any other European country.

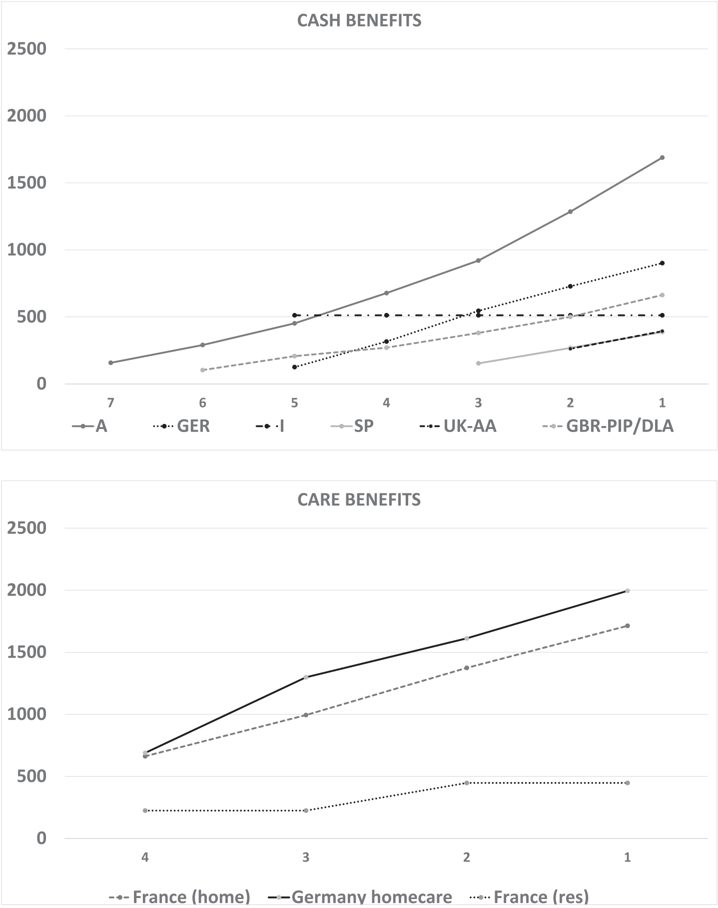


FIGURE 2 Monthly amount of cash benefits and care benefits for each level of disability
Source. Own elaboration on national data.
Note. For France, figures do not take copayment into account. APA en établissement amounts estimated using median value from "tarif medicale" (see Caisse nationale de solidarité pour l'autonomie, 2016). Data for Great Britain include AA, DLA (effective until 2013), and PIP (since 2003). Similar amounts of benefits from different programmes have been grouped together into a single category

6 CONDITIONALITY AND GENEROSITY

Need assessment is functional not only to test eligibility but also to classify beneficiaries into categories and to attribute specific amounts of benefits to each category. The policy design of CfC programmes is hence based on two potentially dilemmatic decisions: defining the need that makes individuals eligible and defining the benefits that are given for different levels of need. Potential dilemmas due to resource limitation exist between extension of the programme and care intensity on the one hand and between targeting and diluting benefits among the entitled beneficiaries on the other.

1. *Programme extension versus care intensity*: The more extensive the programme's coverage is, the less intensive care protection might be for each beneficiary (including the most in need) in case of resource limitations; or the higher protection is given to people (including those with severe limitations), the lower the number of people who are considered as eligible. Put in less dramatic terms, coverage extension must be combined with adequate intensity in care protection.

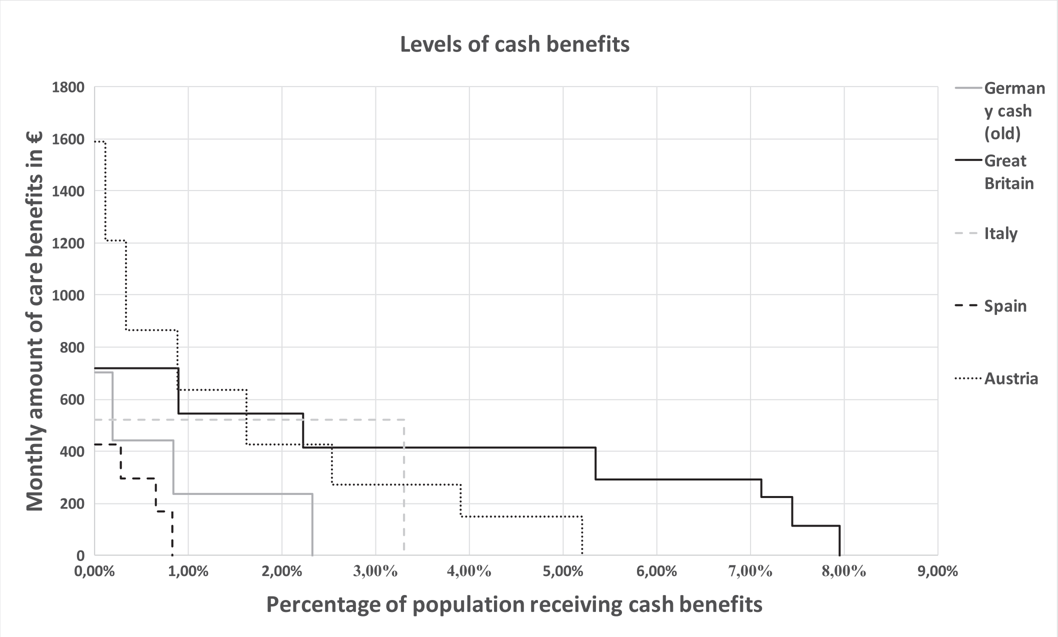


FIGURE 3 Coverage rates and amount of benefits of cash-based programmes by disability classes
Source. Own elaboration on national data.
Note. Amounts adjusted by PPPs (1 = EU28), 2015 values except for Spain (2018). Year: 2015, except for France (2016) and Spain (2018). Number of beneficiaries divided by total population (also for France, where the APA is restricted to population aged 60 or more)

2. *Targeting versus diluting benefits*: This dimension addresses the distribution of available resources among beneficiaries who have different levels of care needs. There are two extreme options: One is focusing on those most in need (giving smaller amounts of benefits to those with lighter forms of dependency), the other is diluting the benefits to all beneficiaries with no or little discrimination among them.

Figures 3 and 4 show how CfC programmes have combined conditionality with generosity. On the X axis, the coverage rate distinguishes between more or less extensive programmes, independently from the actual level of need for care in each country due to the ageing of population or other factors. The Y axis describes the generosity of the programmes by considering the amount of benefits given to each category of beneficiaries.[4] The slope shows how conditionality and generosity are combined giving way to a specific distribution of benefits. The analysis of cash benefits that can be used without restrictions is distinct from that of care benefits that can only be used to get predefined in-kind services.

For cash benefits, the results can be summarised as follows: Austria has the most inclusive and most generous cash-based programmes; not only is the coverage rate the second highest (covering more than 5% of the total population), but benefits are also more generous for the three categories with heaviest disabilities. The two most traditional programmes—IdA and AA—have a very large extension. Although inclusiveness is very high, benefits are not or only weakly distributed progressively according to the level of disability. In the case of IdA, all beneficiaries take the same amount of benefits whatever their need for care, whereas in the case of AA benefits, they are split into only two levels. As a consequence, the adequacy of such programmes for those most in need may be considered as very low if they are not complemented by further services. The programme established in Germany shows an opposite approach: It is more selective but at the same time more generous. Following the standardised need assessment procedure, the amount of benefits varies more significantly. This allows a higher concentration of benefits for a smaller portion of beneficiaries characterised by very severe limitations, whereas beneficiaries with less debilitating

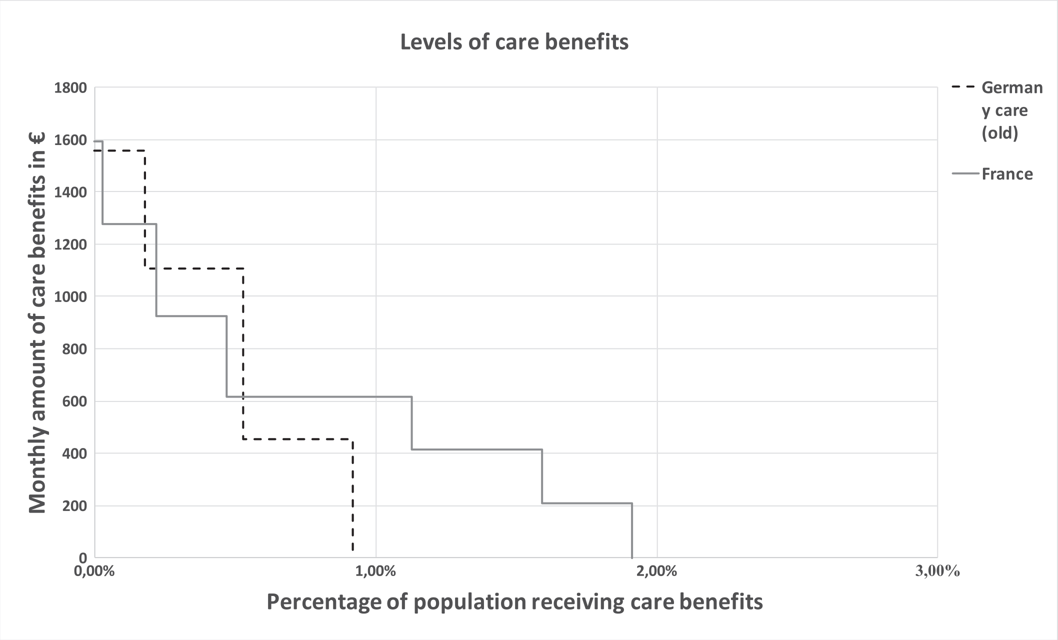


FIGURE 4 Coverage levels and amount of benefits of care programmes by disability classes
Source. Own elaboration on national data.
Note. Amounts adjusted by PPPs (1 = EU28), 2015 values except for Spain (2018). Year: Germany (2015), France (2016). Number of beneficiaries divided by total population (also for France, where the APA is restricted to population aged 60 or more)

forms of disability benefit from lighter support. In these cases, adequacy is guaranteed for those most in need at the cost of higher conditionality in accessing the CfC programme. In Spain, although the general logic follows the German pattern, the amount of benefits is much lower: This is the legacy of a historically residual LTC system, typical of Mediterranean countries.

Considering CfC benefits that are linked to a specific service use, only two countries are considered (see Figure 4): France and Germany. As shown, benefits are noticeably progressive according to the level of disability. Unlike the previous systems, the amount of benefits is generally higher, even for people with less severe forms of disability. This higher level of generosity is compensated in different ways: although the APA has introduced a copayment to concentrate generosity only on the poorest of the population, people in Germany can choose between cash benefits and a CfC option.

To sum up, dilemmas between conditionality and generosity have been tackled in our countries by adopting different strategies. Such strategies are the result of a compromise that is constrained by the total amount of available financial resources, that is, the overall generosity of care programmes. This aspect is shown in Table 2, in which we estimated the amount spent per 100 inhabitants (based on coverage rates and amount of benefits) by each scheme. Overall, in Great Britain and in Austria, CfC schemes result in largest spending; in Italy and Germany, they are in an intermediate position; and in France and, particularly, in Spain, the overall generosity is lower.

Considering also this aspect, three main strategies have been identified, adopted by specific countries with different levels of overall generosity.

In Austria, the programme is among the most generous in terms of total expenditures. It is also very inclusive while the amount of benefits is highly progressive in order to give more extensive support to those most in need. This is the result of a milestone reform in 1993 with a substantial financial investment in the CfC programme. The comparatively broad coverage in the Austrian system is largely determined by widely offered benefits that existed prior to

TABLE 2 Estimated yearly spending per 100 inhabitants (assuming the national distribution of beneficiaries per benefits levels) in the six cash-for-care programmes considered

	Average monthly benefit[a] (euros)	Average yearly benefit (euros)	Coverage rate (%)	Estimated spending per 100 inhabitants (euros)
Austria	449.5	5,394	5.20	28,051
France	618.0	7,416	1.91	14,164
Germany	497.7	1,618	3.20	19,412
Italy	520.8	6,250	3.30	20,626
Spain	311.2	3,734	0.83	30,99
Great Britain	417.9	5,015	7.96	39,919

Source. Own elaboration on national data.

Note. Benefits adjusted in PPS in PPPs (EU28 = 1), values for 2015 (2018 for Spain).

[a] Estimated by multiplying amount of benefits and number of claimants for each level. Copayment not included in French estimation. Data: 2015 except for France (2016) and Spain (2018).

the PG. It was paid as a flat-rate supplement to a public old age or invalidity pension. The benefits were absorbed by the new PG, but it was an explicit policy goal of the 1993 reform to not exclude those who received such benefits beforehand.

In two countries, Italy and Great Britain, CfC programmes are very extensive, providing all beneficiaries with a generous basic amount of support; the overall generosity of such programmes is quite high, especially in Great Britain. Unlike the Austrian programme, however, they lack progressivity, and therefore, they do not provide adequate support for the most in need. The social cost of a lower conditionality is therefore a lack of protection for the people with severe limitations: a situation that paves the way to a pronounced state of vertical inequality within the system. Both IdA in Italy and AA in Great Britain were introduced very early to provide adults with disabilities with a basic, extensive protection against LTC risks. The strong institutional inertia that has characterised LTC policies in these two countries has prevented any further change and adaptation of the programme to the needs of frail older people. Moreover, the extension of such programmes has made it possible for large social groups to capture this benefit, making any radical reform almost impossible.

Finally, a third strategy, adopted by Germany, France, and lately Spain, is more restrictive in access to the CfC programme but providing comparatively high, progressive support for those most in need. Whereas in Germany, the CfC scheme is highly generous, in the other two countries, restrictions in access come with lower overall generosity. In France, progressivity is only mitigated by a copayment system favouring a distribution of benefits in support of the poorest *and* the most in need for care. CfC support is intended to be used in predefined in-kind services in France, whereas in Germany, beneficiaries can opt between the two options. CfC programmes in these countries have been introduced only in the last two decades to explicitly protect the elderly from disability risks: They have been therefore tailored to their needs with peculiar attention paid to the people with most severe needs for care. Nevertheless, these programmes also have their share of shortcomings, mainly due to the lack of coverage for individuals with partial disabilities and the higher costs to be paid to provide adequate care for the most in need.

7 CONCLUSION

Where growing demand for social protection meets budgetary limitations, public governments face substantial trade-offs between coverage and generosity. This exploratory paper investigated how LTC policies deal with these dilemmas in CfC programmes that have become a major pillar in many countries across Europe. The analysis has compared the public regulation concerning access and generosity of CfCs in six European countries belonging to different care regimes. In doing so, it goes beyond existing comparative analyses that rarely dive into the details of technical criteria and procedures that determine coverage and generosity. Given that CfC policies recognise care as a universal social right, conditionality does in general not refer to issues such as income, age, or contributions made. Rather, it is the definition of need for care that not only determines the population who are given access to benefits but is also used for the definition of classes of beneficiaries, which in turn are assigned different amounts of benefits. This analysis has shown how the criteria and procedures applied vary significantly across the six countries studied. It shows moreover that, beyond the official recognition of the universal right to care benefits, policy choices dealing with strong financial and need pressures have found different compromises between universalism and selectivity and between coverage and generosity. More specifically, CfC programmes aimed at providing adequate protection to those most dependent had to strictly limit the eligibility, whereas programmes aimed at providing extensive coverage basically fail to protect people with highly debilitating forms of disability.

Further research should clarify whether this differentiation is due to historical legacies, the timing of reform processes, or to the different policy goals of such reforms and what the role of different stakeholders was. Moreover, it will be crucial to analyse more specifically how potential changes have affected needs assessment procedures over the years and how these "technical" changes can also be understood within more general policy "hidden" strategies of blame avoidance adopted in a context of permanent austerity (Bonoli & Natali, 2012). An additional point for further research regards the fact that we have analysed the complex relations between coverage and generosity in CfC programmes only looking at their policy design, in terms of criteria and procedures applied for the definition of beneficiaries and the relative benefits given to (different groups of) beneficiaries, whereas an alternative approach (e.g., Carrino & Orso, 2014) would be to start from comparable and similar levels of needs individuals might have and then to explore how these needs are covered by different CfC programmes. Finally, a comprehensive analysis of the dynamics taking place within the LTC systems and trade-offs between coverage and generosity should also consider in-kind services, identifying potential similarities or differences with CfC programmes within each country and across countries.

ENDNOTES

[1] Further information and details about the institutional data and the sources of quantitativa data used in this article can be obtained on request to the corresponding author.

[2] Clasen and Clegg (2007) also identified a third form of conditionality—conditions of conducts, mainly relating to behavioural requirements, which is not considered in this analysis.

[3] Data for Northern Ireland are not available.

[4] In 2011, median monthly revenues for those benefitting APA à domicile were 1,085 euros, and the third quartile was at 1,428 (Bérardier, 2014).

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