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Paying for Long-Term Domiciliary Care: A Comparative Perspective

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ABSTRACT

Concerns over growing numbers and proportions of older people in industrialised societies have prompted interest in the development of cheaper ways of providing long-term care for older people. While debate in the UK is currently focused on the costs of residential and nursing care, other European and Nordic countries have introduced schemes designed to encourage or sustain the provision of 'social' care by family members, friends and 'volunteers', on the assumption that this can be provided at lower net public expense than either residential care or formally-organised domiciliary services.

Drawing on material from a detailed comparative study, this paper describes four different models on which such payments are currently based. These models are discussed and evaluated, taking into account factors which include the eligibility criteria for payments; maximising the autonomy of older people and family care-givers; and the relationships between financial payments and access to services.

These models locate systems of payment within the broader context of financial and service support designed to help frail older people and those who support them. They therefore highlight the importance of considering both financial support and services in comparative studies of social welfare provision. However, further evaluation and policy development is hindered by the lack of evaluation of different models of paying for care and a lack of evidence about the experiences of older people and care-givers.

KEY WORDS – long-term care; domiciliary care; payment for care; comparative.

Introduction: the demographic and policy context

The changing demographic profiles of industrialised societies, especially their declining fertility rates and the growing longevity of their older

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citizens, are well known. All member states of the EU can expect a significant increase in their older populations in the next 30 years, led by Germany which is predicted to have three out of ten of its population over age 60 by 2020 (McGlone and Cronin 1994: 10). Moreover, *very* old people constitute the fastest growing section of the older population; between 1961 and 2026 the population aged 85-plus will increase more than five-fold (Grundy 1995). Increasing longevity and differential mortality rates among women and men have also contributed to an increase in the numbers of older and very elderly people living alone (Grundy 1995). To the extent that living alone is a major risk factor for admission to long-term institutional care, this may further increase future demands for services.

At the other end of the life course, all EU countries are also experiencing declining fertility rates. The total EU fertility rate is now below the level (2.1 children per woman) needed to replace the population (McGlone and Cronin 1994).

Taken together, these trends are raising questions about how shrinking working age populations can both generate the tax revenues and provide the labour necessary to support increasing numbers of older people needing help and support with everyday tasks, with personal care and with nursing and medical care (Laing 1993; Clarke 1995; Help the Aged 1995; Richards and Coote 1996). For example it has been estimated that in the UK in 1991/93, 35.3 m people of working age funded £45.5 bn of services to older people; in 2021, 36.6 m people will need to fund services costing £59.7 bn (Help the Aged 1995). National governments, policy commentators and academics are therefore increasingly questioning how the costs implied by these projections of population ageing might be controlled or contained; and about the respective contributions which should be expected from the state, families and older people themselves towards the costs of care in old age. Although these debates frequently focus on the funding of care within long-term institutional settings, the issues they raise are equally relevant to the funding of community and domiciliary-based services.

Within the UK, policies have focused on containing public expenditure on long-term institutional care by means-testing access to 'publicly-funded' residential and nursing home care under the guise of the 'community care' reforms (DoH 1989; Walker 1995). Recent guidance on NHS responsibilities for long-term care (DoH 1995) reinforces this shift to the means-testing of access to all but strictly medical and nursing care. This policy focus has been reinforced by the emergent and increasingly influential normative assumption that for

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both fiscal and ideological reasons primary (but not necessarily sole) responsibility for the funding of long-term care should rest with the individual and the family rather than the state (for example, Commission on Social Justice 1994).

There has been rather less concern in the UK about how the formal and informal domiciliary and community-based care needed by future generations of older people is to be paid for. This may hitherto have been a less urgent issue than in some other European countries. First, expenditure on domiciliary services is very tightly constrained by the current financing of local government 'community care' services. Secondly, even some of these costs are offset by the increasingly heavy charges made to service users (National Consumer Council 1995). Thirdly, access to social security benefits by both disabled older people and informal carers are very tightly drawn (McLaughlin 1991; Glendinning and McLaughlin 1993*a*). Together, these various mechanisms may have helped to contain costs and therefore reduced the urgency of the issue in the UK, compared with other countries.

However, we would argue that greater attention to the means of providing appropriate funding for domiciliary-based help and support for older people is urgently required. First, the volume of care provided on an informal basis by friends, neighbours and 'volunteers' already far outstrips that provided either within institutional settings or by formally organised statutory and voluntary services. Throughout the EU, the family is overwhelmingly the main source of care for older people; two-thirds of their care comes from family members, compared with only 13 per cent from public social services, 11 per cent from privately paid services and 3 per cent from volunteers (Walker 1995). Secondly, the value of the informal care provided to people aged 65 and over is estimated to be more than five times that of combined NHS and local authority expenditure on long-term residential and domiciliary care services. If each hour of care is assigned a notional value of £7 (similar to public sector gross pay rates), public sector spending amounts to £6,336 million, compared with the equivalent of £32,500 million by the informal care sector (Laing 1993). Moreover, despite major changes in both the labour market and family structures, there is no evidence to suggest that the volume of informal family care is likely to diminish in the future (Finch 1995).

Thirdly, long-term care provided on an informal basis has important linkages with other major policy areas, including labour supply and access to occupational welfare and pension benefits (Evandrou and Winter 1992; Glendinning 1992*b*; Phillips 1994; Carmichael and Charles 1995); changes in the public/private 'mix' of welfare services

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(Evers and Leichsenring 1994; Pijl 1994; Evers 1994); and social integration, gender inequality and citizenship (McLaughlin and Glendinning 1994; Ungerson 1994, 1995). Failure to give careful consideration to the supply and funding of domiciliary and community-based care therefore carries the serious risk of unintended, but nevertheless adverse, consequences in these related policy areas.

It could therefore be argued that the single most important cost containment measure currently in operation within the UK is the (largely unacknowledged) reliance on heavy inputs of time, effort and often substantial material resources by relatives in providing help and support for frail older people. However effective this policy may be in the short term, simply allowing the costs (broadly defined) of informal care-giving to lie where they currently fall is to risk storing up considerable inequalities and impoverishment for the future. Informal care-givers, whether family members, friends or 'volunteers', currently receive little financial recompense or protection from the state (McLaughlin 1991); they and the older people they give help to are also less likely than older people living alone to receive local authority and other services (Qureshi and Walker 1989; Evandrou 1991; Allen *et al*. 1992; Twigg and Atkin 1994). The economic and material consequences of being heavily involved in care-giving are therefore likely to have continuing – even lifelong – consequences, especially if earnings and pension entitlements are adversely affected (McLaughlin and Ritchie 1994; Hancock and Jarvis 1994; Carmichael and Charles 1995). As Laing (1993: 115) argues:

> Of all the gaps in the welfare state's arrangements for covering long-term care risks, this [support for informal care-giving] appears to merit the most urgent review on grounds of equity.

This paper is based upon the assumption that the state has a continuing role to play in supporting the long-term care of older people who (as is currently mainly the case) receive most of their care from close family members. However, what that role should be, over and above the current relatively small expenditure on social security for non-employed carers and the rather patchy and ambiguous service support for older people and carers, is still far from clear. The purpose of this paper is to make a contribution to debates around this issue.

Because a number of other European countries have already addressed this issue in the context of wider debates about the provision of long-term care and have developed a range of policy responses to them, it is instructive to see what can be learnt from their experiences. In the following section of this paper we will draw on an earlier detailed

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comparative study (Glendinning and McLaughlin 1993*a*) to illustrate four different models of financing long-term domiciliary care. Thus, a *social security model* (as in the UK and Republic of Ireland) pays an allowance directly to an informal carer to replace income foregone through lost employment opportunities. A *social insurance approach* (as in Germany) makes provision for an older person's care needs as part of her/his contribution to a state-regulated insurance scheme. An *attendance allowance model* (as in France and Italy) combines elements of the first two, awarding a social security payment to the older person with which s/he may then reimburse informal and family care-givers. Finally, in some Scandinavian countries (especially Finland), financial payments in respect of informal care-giving are embedded within (and often substitute for) social welfare services; this model might therefore be called *a social services approach*.

These four models will be evaluated in terms of the extent to which they offer equitable treatment between those needing and those providing care; the equitable treatment of different groups of carers; and issues of citizenship and social inclusion for both older people and carers. Central to this evaluative discussion will be a concern with the enforced 'care dependency' which can be at the heart of poorly resourced informal and family care-giving relationships. To what extent do the various models of supporting long-term domiciliary care help to reduce the enforced dependency of a frail older person with insufficient financial resources on an informal care-giver and/or the enforced financial dependency of an adult care-giver on an older person? Glendinning (1992*a*), Baldwin (1995) and McLaughlin and Glendinning (1994, 1995) offer a fuller discussion of these issues.

As the intention is to describe and evaluate different conceptual *models* of paying for long-term domiciliary care, the following section will not provide comprehensive accounts of all the help available to support long-term family-based domiciliary care-giving in the various countries. However, it will indicate the relationships between different models of financial support and the availability of services in kind. The availability of, and the relationships between, financial and service forms of welfare provision are particularly important concerns for women, who constitute a majority of both care-givers and older care-recipients. Moreover, how long-term domiciliary care is supported financially will be intrinsically linked to other, more general, features of welfare regimes (Lewis 1992; Anttonen and Sipilä 1995).

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Models of paying for long-term domiciliary care

A social security approach

In both the UK and the Republic of Ireland, financial allowances are paid direct to informal carers through national social security systems – the Invalid Care Allowance (ICA) in the UK and the Carer's Allowance (CA) in the Republic of Ireland. Financial support for informal care in the Republic of Ireland was first introduced in 1968 with the Prescribed Relative's Allowance (PRA); this was paid as an increase to the pensions of disabled older people in respect of a relative living with them and providing full care and support. However, by the late 1980s there was wider awareness of the needs of carers themselves for an income in their own right and a number of cases where the PRA had not been passed on to the carer were widely publicised. The Carer's Allowance, part of the Irish means-tested social assistance scheme, therefore replaced the PRA from November 1990.

In the UK, ICA was introduced in 1976 for men and single women carers of working-age and extended to married women in 1986. ICA is intended to 'protect' incomes by partially replacing earnings which have been lost or foregone as a consequence of providing at least 35 hours of care a week. The level of ICA is so low that carers with no additional income or substantial savings are eligible for additional means-tested assistance benefits.[1]

The most important feature of this approach is the explicit acknowledgement by the state of the *independent* rights of older people and informal or family care-givers to their own incomes. In principle, income entitlements – whether in respect of the work of caring or to replace income foregone by retirement from remunerative work – do not involve the financial dependency of the care-giver on the receiver of care.[2] Indeed, the switch from the PRA to the Carer's Allowance in the Republic of Ireland was explicitly intended to give family care-givers a greater degree of financial independence from the relatives who they were looking after (see McLaughlin 1994).[3]

In addition, because these payments are located within national social security systems, they are also governed by universally applicable principles of rights and entitlements, rather than discretionary and variable decision-making on the part of local welfare professionals. These rights and entitlements are largely categorical albeit, in the case of Ireland, means-tested; they do not depend directly upon extensive medical assessments of the abilities, disabilities and care needs of the older person. Moreover, because of the separation of national social security systems from local social welfare systems, receipt of these

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payments does not preclude either care-givers or older people from simultaneously receiving statutory health and social care services; they are not intended to be *substitutes* for these services (though they may enable some older people or carers to purchase more of them from private or informal sources).

On the other hand, within the UK, the principle of social security payments to informal care-givers has been contested on the grounds that payments to carers detract from the 'purchasing power' of those who need help and support. This argument has been articulated most cogently by younger disabled people (see Morris 1993), but has also been promoted in relation to the care needs of older people by economists wishing to stimulate the private care market by increasing the purchasing power of older people (see Laing 1991).

A further disadvantage is that social security-based payments for supporting long-term domiciliary care appear to be very low, both when compared with earnings or other social security payments within their respective countries and in relation to other types of payment for care (Glendinning and McLaughlin 1993*a*). The UK's ICA is the lowest rate available in the whole social security system, while the Irish Carer's Allowance is the same as basic social assistance. Carers in the UK regard the low level of payment as very inadequate recompense for the extensive hours of work which they often undertake (McLaughlin 1991). Moreover, as part of increasingly residual social security systems, such payments offer little protection against the risk of longer-term poverty on the part of informal care-givers, who may be prevented from taking remunerated employment for many years. Thus for the past ten years in the UK, the national insurance contributions which are credited when carers receive ICA have only protected their basic state retirement pension rights and, until 1996, will not count towards entitlement to unemployment or sickness benefits when care-giving ends. There are no measures to protect carers within the increasingly important occupational and private pensions schemes. Moreover, as social security-based payments for care are intended to replace earnings lost from paid employment, they are only available to care givers of working age and exclude substantial numbers of older carers (22 per cent of carers in the UK, for example, are providing substantial amounts of personal care – Parker and Lawton 1994).

Finally, from the point of view of both givers and receivers of care, social security payments confirm and formalise without question what are essentially private, informal arrangements. There is no regulation of either the amount or the quality of the care which is expected from the care-giver or which can be guaranteed to the older person:

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> … these benefits are not conditional on particular aspects of care being carried out … Once … minimal conditions are fulfilled, an allowance or benefit payable to the carer is put in place and no further questions asked (Ungerson 1995: 37–38)

A social insurance approach

Payment for long-term care needs has been explicitly incorporated into – and recently expanded within – the German social insurance scheme. Since January 1995, under the newly introduced care insurance scheme, older people have been able to qualify for benefits in respect of their needs for long-term, non-medical care. Does this social insurance approach address some of the shortcomings of the social security approach, or simply contain additional shortcomings of its own?

Prior to 1991, entitlements to financial help with domiciliary nursing and personal care were only available for up to four weeks after discharge from hospital. Older people were therefore often unnecessarily readmitted to hospital in order to requalify for nursing and personal care benefits on discharge (Dieck 1994). In January 1991, as the first stage of a programme of measures to improve financial security for those in need of extra help and care, a care allowance for severely disabled people was introduced under the sickness insurance scheme (Dieck and Garms-Homolova 1991). For the first time, health insurance schemes made a distinction between 'illness' which is amenable to treatment and covered by sickness insurance; and the long-term state of 'care dependency', part of the costs of which are covered by care insurance. Benefits can be available in the form of a monthly cash payment or a set number of service 'assignments' in kind (or any combination of the two). In the first half of 1991 only 12 per cent of successful applicants for this new care allowance chose the service option; a small scale study of the reasons for this choice indicated that older people and/or carers considered the service option to be both too low and insufficiently responsive to individual needs (Engels 1992).

Despite this reform, the coverage of benefits for older people with long-term needs for domiciliary personal and/or domestic help remained inadequate. An entirely new care insurance scheme was therefore created, one which reinforced the distinction between treatable 'illness' and long-term 'care dependency'. The new care insurance is financed by contributions from current employees and employers (the latters' contributions compensated by the cancellation of a public holiday), which together pay for the care needs of current generations of older people.

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Entitlement to care insurance benefits rests on a medical assessment of the amount of care required, at one of three levels; this determines the level of care benefit to be paid. Again, benefits can be in the form of a monthly cash payment, a set number of service 'assignments' in kind or any combination of the two; allowances or subsidies for equipment and home adaptations; and allowances to cover the cost of using day care or respite overnight care facilities. The value of 'cash' payments is only about half the value of services in 'kind'. At the lowest assessed level of 'care dependency', the choice is between a payment of DM400[4] or services worth DM750 a month; at the highest level of 'care dependency' the cash allowance is DM1300 compared with services in kind of up to DM2800 a month. In three per cent of 'high care dependency' cases, this may be increased still further, up to DM3750 a month (BAS 1994). Experience of the earlier sickness insurance scheme reforms suggests that there is likely to be a marked preference for cash payments over the (higher value) service allocation, which will be used to either (i) augment the household incomes of older people; (ii) recompense family care-givers at the discretion of the older person; or (iii) purchase cheap home help services in the 'grey' labour market (see Ungerson 1994). This anticipated preference for cash payments is again likely to reflect the perceived unresponsiveness of formal services to individual needs (Evers and Olk 1991).

Entitlement to any benefit under the care insurance scheme rests entirely upon the circumstances of the person who needs help and support; the needs and circumstances of any informal care-givers (with two important exceptions – see below) receive no consideration. Informal care-givers, whether family members or 'grey' or 'black' labour market employees, therefore have no rights to an income of their own and are dependent on the discretion of the older person to pay them as s/he considers appropriate.

On the other hand, the new care insurance scheme also includes two features which are of considerable potential benefit to informal and family care-givers. First, because it forms part of a comprehensive national social insurance scheme, it also includes some protection against the risk of care-related long-term poverty. Thus informal carers providing at least 14 hours a week care and receiving no more than the dependency-graded care insurance cash benefit for looking after someone who qualifies for care insurance, will also have their retirement pension and accident insurance contributions paid for them. Secondly, the care insurance scheme includes provision for a break from care-giving, which was introduced earlier as part of the 1991 sickness insurance reforms. This 'holiday care allowance' allows respite care at

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home or in a respite care centre to be purchased (maximum value DM2800 a year) for up to four weeks, to provide a break for someone who has been the main carer for at least 12 months.

Although the German care insurance scheme is the most comprehensive attempt yet to address the question of provision for long-term care needs, there remain a number of anxieties. One concerns the appropriateness of the assessment process, which is largely medical and which may underestimate the social care needs of mentally ill or confused older people. Secondly, even if an older person chooses the more generous 'service option', this is unlikely to cover all their needs for help. Although the service option is in real terms more than twice as generous as the cash payment, it only provides for a very limited number of service inputs. At each of the three levels of 'care dependency', only about half the help actually needed will be covered by the insurance benefit 'in kind'. At the lowest level of 'care dependency', additional service inputs of at least 20 hours per month would be needed; for the most severely dependent older people additional services of more than 80 hours a month would be necessary (Allemeyer 1994). Older people who need, or who choose, to receive all their help in the form of service inputs therefore still have to purchase additional service inputs from their own personal income or, if not affluent enough, to apply for social assistance help towards their outstanding service needs (in which case, under the principle of subsidiarity, some financial contribution from relatives may be required).

The care insurance scheme therefore recognises the separate needs of care-givers in two important respects: the long-term economic insecurity which can result from reduced opportunities for paid work (and hence contribution to a social insurance scheme); and the need for a guaranteed break from care-giving. Unlike the UK's allocation of ICA, the insurance scheme also offers some minimal regulation of private care arrangements. Thus even if the cash allowance, with no formal service inputs at all, is chosen, a member of a social services provider organisation will still undertake a domiciliary visit every three or six months (depending on the level of 'care dependency') to check on the adequacy of these arrangements.

However, there is no acknowledgement of the on-going income needs of care-givers, who remain entirely dependent on the discretion of the older person to pass on money received in respect of their care needs. The fact that the payment is derived from the insurance contribution record of the older person may further undermine any sense of the carer's entitlement to an independent income. At the same time,

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because both the cash payment and the service allocation are below the value of the care actually needed by an older person, older people are still likely to have to depend on unpaid family members for at least some of their care.

Finally, projected demographic changes in Germany may undermine its long-term fiscal robustness. Because of its 'pay as you go' nature, the care insurance scheme involves an explicit transfer of resources from the current working age population to older people. By 2025 it is estimated that Germany will have a projected dependency ratio of 1:1, and that the proportion of people aged 80 and over will have increased by 40 per cent (Datenreport 1992). It is therefore far from clear whether the current value of care insurance benefits can be sustained.

An 'attendance allowance' model

A third model, which applies in both Italy and France, involves the payment of a benefit to older persons in respect of their care needs, with which they then recompense informal and family carers. Entitlement to the payment depends entirely on the medical and/or financial circumstances of the older person; the needs or circumstances of informal or family carers are accorded even less consideration than in the social insurance model described above.

For example, Italians who find themselves 'unable to walk without the permanent help of a companion or not being able to carry on the actions of everyday life' (Ministero dell'Interno 1989), who need continuous assistance and who are not in residential care, are entitled to an *indennita di accompagnamento*, or 'companion payment'. Entitlement depends solely on the older person's level of disability, regardless of their financial circumstances. The '*companion payment*' contribution is intended to enable older people to remain in their home settings, assisted if necessary by family members; the economic contribution is made because it is believed that costs of assistance are high, irrespective of an individual's financial situation (Mengani and Gagliardi 1991: 23).

The *indennita* is paid to persons needing care, not to those who provide it. If passed on in its entirety to an informal carer, it could purchase between 40 and 60 hours of commercial home care per month (at 1992 Italian rates). However there is no recognition of informal care-givers' rights to an income of their own or a break from caring, nor of the need to protect their long-term pension entitlements.

In France, the *allocation compensatrice pour tierce personne* is paid to those with an incapacity of at least 80 per cent, who need help from another

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person to accomplish ordinary daily living activities and whose incapacity has begun after pension age. Unlike the Italian *indennita*, entitlement to the *allocation compensatrice* is means-tested, depending on the income level of the older person needing care. Here the income needs of the care-giver are even less likely to be acknowledged (see Glendinning and McLaughlin 1993*a* and BASYS 1992, for further details of both countries).

Although this 'attendance allowance' approach does not formally recognise the needs and circumstances of family and informal carers, it nevertheless assumes that the money involved will actually be transferred in full to carers. It also assumes that the payments represent a major contribution towards *all* the care needs of the older person. Indeed, in Italy the 'companion payment' is conceptualised as an alternative to the total care which would be provided in an institutional setting. There is therefore an assumption that all care needs will be met by the persons to whom the payment is transferred, with little additional support from statutory services. In contrast, under the German care insurance scheme a choice between formal and informal services, or flexible combinations of the two, is possible.

However, the main problem with this 'attendance allowance' model is that it conceptualises family carers as 'shadows' of the person who needs the help and support. There is little consideration of issues of social justice or equity for carers; no acknowledgement of their longer-term economic insecurities and risks; and no acknowledgement of the power inequalities and potential conflicts between those with care needs and those who provide care on an informal basis. Entitlements are assessed primarily on the medical and social care needs of the older person; even though the older person's financial means may be assessed, the income needs of informal or family care-givers are given no consideration. This is particularly so where financial support for care needs is embedded within a social assistance scheme, whose overall objective is simply to ensure the physical 'survival' of older and infirm citizens.

A 'social services' approach

In the fourth model described here, financial support for long-term domiciliary care is located within, and acts as a substitute for, social services and social welfare systems. Finland, for example, has a long history of providing Home Care Allowances in cash, in order to reduce demands on directly provided services. In 1990, two per cent of those aged 65 or over received home care allowances (Sipilä and Anttonen 1994). A similar, but much less extensive, system operates in Sweden.

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Home Care Allowances are awarded on the basis of the level of care needed by the older person but, with the agreement of the older person, are paid by the local municipality directly to an informal care-giver. Carers therefore have some independent income of their own and their living standards are not entirely dependent on the willingness of the older person to pass on the allowance or contribute it to a shared housekeeping 'pool'. Moreover, qualitative studies of Home Care Allowance recipient households indicate that the Allowance also enhances the status and esteem of care-dependent older people *vis-a-vis* their care-givers (Glendinning and McLaughlin 1993*b*).

However, the local administration of social services and social welfare allows for considerable variations. There are considerable differences between Finnish municipalities in their total budgets for Home Care Allowances; municipalities also have some autonomy in deciding the level of payments and the criteria on which eligibility is assessed. Some municipalities, for example, do not pay allowances to spouse care-givers or to care-givers who are themselves over retirement age. This can lead to major differences in levels of Home Care Allowances and in the circumstances in which they are paid. These variations are exacerbated by the assessments of Home Care Allowance applicants, which can be carried out according to different procedures by different types of social welfare professionals.

The consequence of this combination of local autonomy and professional discretion is that carers in similar circumstances, with similar income needs and providing help to older people with similar levels of need, may find themselves receiving very different levels of Allowance – or, indeed, no payment at all. This territorial inequity is of increasing political concern in Finland. However, proposals to introduce some degree of standardisation by linking levels of Allowances to municipal home help wages have been rejected as too costly.

Because Home Care Allowances are viewed as a (cheaper) substitute for formal service provision, older people and care-givers are unlikely to receive much, if any, additional service support. One small study of Home Care Allowance recipients found substantial unmet needs for home help services, bathing and respite care, especially where the care-giver was not living with the older person (Glendinning and McLaughlin 1993*b*). However, since 1993, care-givers being paid a Home Care Allowance have been entitled to an annual break from care-giving and the crediting of their retirement pension contributions; this may help to alleviate some of the strain on otherwise unsupported care-givers.

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Conclusions

The different models of supporting long-term domiciliary care described above reflect a number of key differences between different countries, including the historical configurations of welfare services, attitudes towards women within the family and the labour market, and the relative strength or weakness of ideologies of family responsibility for the care of frail older people. For example, the ideology of family responsibilities which is particularly strong in Germany and Catholic South European countries may have inhibited debates about carers' entitlements to independent incomes and the protection of their labour market rights; both the 'social insurance' and the 'attendance allowance' models show a marked lack of concern for these issues. However, whether or not these models bear any correspondence to other models of social welfare regimes (Esping-Anderson 1990; Anttonen and Sipilä 1995) will not be discussed here.

Nor is it easy to compare the four different models of supporting long-term domiciliary care in terms of the levels of benefits, their adequacy relative to average living standards, or their coverage of potentially eligible populations. Although earlier work on this subject (Glendinning and McLaughlin 1993*a*) did calculate the comparative levels of the principal payments for care standardised for purchasing power, such comparisons are not very helpful without a great deal of contextual information. First, comparisons of payment levels need to take into account both benefits paid to carers and those paid to frail older people; yet there is no way of knowing what proportion of the latter are actually shared with or paid over to informal or family carers. Secondly, such comparisons also need to take account of a range of other variables, such as the availability of free health care and social services, which might substitute for some of the work of informal and family carers. Overall, there appears to be little research which has evaluated or compared the *outcomes* of different models of supporting long-term domiciliary care. It is therefore difficult to know how well the different systems of care allowances actually perform, within the context of other variations in national and local welfare and social security programmes.

The overall context within which these developments are taking place, both in the UK and elsewhere in Europe, is one of cost-containment. This context creates strong incentives to draw boundaries increasingly tightly around the responsibilities and remits of particular services or agencies and, wherever possible, to offload the costs of services elsewhere – in this instance, mainly onto the families of older people. The various models described in this paper reflect the (implicit

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or explicit) recognition that informal, family-based care-giving is cheaper than any formally organised or purchased alternative. It is likely that this assumption will continue to drive the development of policy in this area. It is therefore also unlikely that any system of state-regulated or funded financial support will ever cover the full market costs of long-term domiciliary care.

From the models described above, no single, ideal system of supporting informal domiciliary care-giving emerges. All appear to contain some disadvantages as well as advantages, for the givers and/or the receivers of care. For example, the social security approach of the UK and Republic of Ireland appears to provide the most explicit recognition of the rights of care-givers to an income which is independent of their family obligations and responsibilities. Both this social security approach and the German social insurance model are also based on clear, nationally-applicable rules of entitlement. These leave little scope for the kinds of discretionary decision-making and 'street level bureaucracy' which can arise when local resources are constrained (Cornwell 1993). However, the levels of payments in both the UK and the Republic of Ireland are very low and this is not likely to change, given continuing constraints on national social security expenditure and pressures to expand means-testing and other mechanisms for 'targeting' payments.

Might systems of payment which are embedded in local social welfare services reflect more accurately the actual amount of care-giving work which is undertaken? Certainly so far as evidence from Finland suggests, this can result in considerable territorial injustice, with different amounts of money being paid to carers across the country for similar amounts of work. In addition, payments for informal domiciliary care which are conceptualised entirely as *substitutes* for formal service inputs risk leaving older people with no monitoring or regulation of the quality and quantity of care they receive and carers with no support or help to carry out the task.

In the long run, debates and policy developments in this area are bedeviled by a simple lack of knowledge. Despite the wealth of descriptive material now available, there is little information on the attitudes and experiences of older people and family care-givers in relation to different models of supporting informal domiciliary care; there is even less information about which models might produce the best outcomes. Of course the evaluation of outcomes in this area is notoriously difficult. These are likely to include concepts such as autonomy and choice, economic security and quality of life, which are highly contested at the best of times, but even more so when the potentially different interests and needs of older people and care-givers

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are involved. However, until these difficult issues are grasped, it will be difficult to make any progress on developing policies which address the different (and sometimes competing) interests of the state, older people and family care-givers.

NOTES

1 In addition to ICA, the UK has two care benefits targeted at older people with substantial care needs. The attendance allowance is awarded on the basis of an older person's need for help with personal care and/or supervision. When introduced in 1971 it was intended to help meet general extra costs associated with severe disability (with 'attendance' needs as a proxy indicator of severe disability). However, there is evidence that both formal service providers and recipients of the allowance themselves increasingly expect it to be used to pay for formal and/or informal care services (Horton and Berthoud 1991; Baldock and Ungerson 1994). Secondly, within the social assistance (Income Support) scheme, a 'Severe Disability Premium' can be claimed by disabled adults who are living alone and who have no-one claiming Invalid Care Allowance for looking after them. This payment *is* clearly intended to allow the older person to purchase help and support which other claimants might obtain from a co-resident informal carer.

2 In *practice*, levels of both carers' and older people's minimum income entitlements are so low that some financial dependency is very likely (Glendinning 1992*a*).

3 In the UK, acknowledgement of the separate entitlements of care-givers and older people is somewhat modified, because a carer's entitlement to ICA depends on whether the older person receives certain benefits in respect of her/his needs for care.

4 At the time of writing, DM100 was equivalent to £40, so these payments ranged from £160 (DM400) to £1500 (DM3750).

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