

I. GUEST EDITORIAL**Cash for Care: Implications for Carers***

By Caroline Glendinning

Providing substantial amounts (particularly over 20 hours a week) of care to a disabled or elderly relative or friend is associated with reduced labour market participation, poverty and adverse psychological and physical health. Many countries have introduced "cash for care" measures. Sometimes their primary objective is to provide financial support for the older or disabled person to help meet the additional costs of needing care. In other instances "cash for care" aims at offering consumer-style choice to older and disabled people. In such instances, benefitting carers, if at all, is a secondary aim. Moreover, these measures differ widely in terms of target group, eligibility criteria, interactions with formal care services, payment levels and whether they are means-tested. Their impact on carers also varies, depending on local labour markets, the availability of formal long-term care services, and, critically important, social attitudes towards the roles of families (and women within families) in caring for older and disabled people. This article provides a critical overview of the main models.

Personal budgets or consumer-directed employment of carers

Instead of receiving services, an older or disabled person can choose to receive a personal budget of an equivalent value to purchase care themselves, either from an agency or by directly employing a carer. There is increasing interest in consumer-directed cash-for-care schemes as a means of increasing choice and flexibility in long-term care; such schemes exist in the U.K., the Netherlands, some U.S. States and the Flanders region of Belgium. In the Netherlands and the Flanders (and to some extent in the U.K.) the personal budget recipient can employ a close relative. The relationship between care receiver and carer thus becomes one of employer-employee. In the Netherlands, employment above a minimum number of hours per week is regulated by a formal contract setting out the carer's terms and conditions of employment. Personal budget schemes in England and many U.S. States involve intermediary agencies to manage payroll, taxes, recruitment and training.¹ Older people are more likely than younger disabled people to employ relatives as their service providers.²

The level of a personal budget is usually calculated by multiplying the number of hours of care needed against an hourly rate (at least the legal minimum wage), thus in principle offering appropriate economic rewards for care. However, carers employed in this way report increased feelings of obligation and difficulties in negotiating time off.³ Consequently the total value of the care provided usually far exceeds the payment received.

The reliability of the carer's income depends on continuing good relationships between employer and employee. Carers are also financially vulnerable if the older or disabled person dies or enters hospital or long-term care. Personal budgets may attract new family members, such as newly retired relatives, into care work. However, carers employed by personal budget-holders occupy a marginal position between the formal and informal care workforces; formal training or career advancement schemes are very rare. Carers who have spent periods employed by a personal budget holder may find themselves disadvantaged when they try to re-enter the formal labour market. Carers employed by personal budget holders may also find they are unable to access any formal care services to support or relieve them in their role.

Employing family carers through a personal budget is not universally popular. In the Netherlands, only about ten per cent of all those receiving social insurance-funded long-term care choose to receive this in the form of a personal budget. In 2007 one-third of budget holders relied only on care provided by

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¹ OECD (2005).

² Wiener *et al.* (2003).

³ Breda *et al.* (2006).

relatives, one-third only on care provided by care organisations and one-third on a combination of the two.⁴

Care or attendance allowances paid to the older or disabled person

Here the cash payment is made to the disabled or older person, sometimes with no formal requirement as to how it should be used. However, in many instances it is expected that the allowance will be given to or used by a family carer.

Care or attendance allowances are paid in Germany, Austria and France. In Germany, someone eligible for long-term care insurance can choose between service "assignments" up to a specified value or a lower, non-taxable cash benefit (or a combination of the two). The cash benefit option has always been more popular because beneficiaries prefer family care to formal services from strangers. However there is no obligation on the recipient to give the cash benefit to the carer; there is evidence that it is not always transferred in full;⁵ and in other households it may simply be added to the joint household income rather than constituting an independent income for the carer.

In Austria, lower income care allowance recipients are likely to use the benefit to support family carers; professional families are more likely to use it to employ live-in carers through the "grey" labour market. In both instances, the low level of the allowance institutionalises care-giving as women's work.⁶

Care allowances have many of the drawbacks of personal budgets. Carers are likely to find themselves financially dependent on the person they are caring for. Lundsgaard⁷ also argues that such payments can create an incentive "trap", attracting informal carers away from the formal labour market if interactions between care allowances, taxes, unemployment benefits and other income transfers are not well controlled.

On the other hand, it is possible to add measures specifically intended to benefit informal carers to a care allowance (although again these can only be accessed if the care recipient qualifies for the care allowance). In Germany, informal carers of care allowance recipients are entitled to four weeks' break each year (with care insurance paying the costs of respite care). Their pension and accident insurance contributions are also paid if they are not in full-time paid work and providing 14-plus hours care per week. Recent German reforms have increased funding for voluntary sector respite care centres, reduced the threshold so that respite care can be received after six months instead of a year, and introduced training courses for carers and retraining courses for carers wishing to return to paid work.

It is in principle possible in both Austria and Germany for care allowance recipients to also use some formal services, which helps to relieve the burdens on carers. However, in Austria continuing shortages and high costs of formal services make extensive reliance on informal care inevitable.⁸

Care allowances paid directly to carers to replace lost earnings

The U.K., Ireland and Australia all offer benefits as part of their national social security systems to replace the earnings lost by working age carers who have no, or only minimal earnings, because of their care responsibilities. Here, care-giving is treated as a labour market-related risk similar to unemployment or sickness; carers are assumed to be members of the labour market and have entitlement to an income in their own right. However, the level of the payment is usually very low and eligibility often depends on a strict test of carers' means and assets; it therefore offers only minimal social protection. Where such allowances also attract payment of carers' State pension contributions, some longer-term protection may be provided as well.

This income maintenance model is not compatible with carers' continuing labour market participation; eligibility criteria assume the carer has no paid work and probably no other source of income either. On the other hand, it does not preclude either carers or the people they support from also receiving services.

⁴ Da Roit and Le Bihan (2008).

⁵ Wiener *et al.* (2003).

⁶ Kreimer (2006).

⁷ Lundsgaard (2005).

⁸ Kreimer (2006).

A variation of this approach, in Sweden and Canada, is to provide carers with income during temporary absence from work, along with rights to return to the same job. This measure is targeted at carers of terminally ill people, but is not effective for longer-term care commitments.

Paying carers instead of formal social service provision

Here, care-giving is formalised within a quasi-employment relationship, but with the local authority as the employer rather than the care recipient (as in the personal budget model). This model operates in a number of Scandinavian countries.⁹ It reflects the high levels of female labour market participation in these countries, their continuing relatively high levels of publicly-funded services, and the challenges of delivering formal social services in sparsely populated rural areas.

In Finland, for example, the Informal Carer's Allowance is awarded on the basis of an older person's care needs but is paid directly to the carer, who contracts with the municipality to provide an agreed level of care according to a care plan. The majority of carers employed in this way are spouses or other close relatives and a third are aged 65 and over.¹⁰ Levels of Informal Carer's Allowances are lower than the value of formal home care services; they offer no incentive to continue caring, but are believed to encourage carers to continue their existing care-giving responsibilities.

Carers employed by Finnish municipalities are entitled to three free days a month during a period when the nature of the care they have provided has been demanding. The municipality is responsible for providing substitute care, usually in a nursing home, but there is a serious lack of personalised and suitable substitute care options. Some municipalities have developed alternative schemes whereby another relative or friend is paid by the municipality to provide "substitute" care in the older person's home to give the main Carer Allowance recipient a break.

Paying carers in recognition of their care-giving responsibilities

There are a few examples of payments to carers simply in recognition of their care-giving work.

In the Netherlands an annual "Carer Compliment" payment was introduced in 2007. All carers supporting people eligible for long-term care insurance benefits can receive the Carer Compliment, which is worth €250 (tax-free). However, in its first year only ten per cent of those expected to be eligible applied; this was believed to be partly due to the lengthy and bureaucratic application process. Eligibility criteria have therefore been relaxed somewhat; it is now estimated that 266,332 carers might receive the Compliment, although its value may be reduced slightly.¹¹

The Australian Carer Allowance is an income supplement paid simply in recognition of the carer's role and to help with the extra costs associated with care-giving. It is paid directly to carers who provide full-time daily care for a disabled adult, older person or child and can be claimed for each person who is cared for. It is a universal, non-taxable benefit, and is not dependent on the carer's income or assets, or whether or not they have paid work. There is therefore no loss of benefit and potential disincentive for carers who remain in, or move into, paid work.

Conclusions

The various cash-for-care models have different implications for carers' ability to undertake other, remunerative, work, and for their ability to access formal services that substitute for family care and therefore provide a break from care-giving. Most restrictive in both respects are cash-for-care models that assume informal care-giving to be a full-time role that is therefore incompatible with mainstream labour market participation and is also assumed to substitute for formal care services.

All the cash-for-care models offer low levels of financial reward in comparison to the actual level of care provided. Even where hourly payment rates are at or above the legal minimum wage, the total volume of care provided usually far exceeds the hours that are actually paid for. Income replacement benefits for carers wholly unable to work are typically means-tested as well as paid at very low levels. Low levels of payments for informal care reinforce existing gender inequalities and have little potential to

⁹ Jenson and Jacobzone (2000); OECD (2005).

¹⁰ Martimo (1998).

¹¹ Vijfinkel *et al.* (2008).

alter the gender distribution of care work. "An unequal distribution of caring work contributes to income inequality, inequalities in retirement incomes and in participation in social life."¹²

Cash-for-care models also do little to bridge the boundaries between informal care and formal labour market participation, for example by explicitly encouraging carers to retain contact with the labour market while caring. There is also little evidence of measures to formalise the skills acquired in informal care-giving as potential assets for future employment,¹³ even where carers have previously been employed by care recipients holding a personal budget, although a scheme along these lines has recently been introduced in Spain. Some workplace-based measures do offer carers leave for an extended period with their jobs protected, but long-term paid leave is unusual.

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II. INVITED ARTICLE I

Rational Behaviour of Insurance Intermediaries and Private Health Insurance Coverage in India

By Sukumar Vellakkal *

Introduction

In India, out-of-pocket spending by households on health care occupies about 72 per cent of the total health expenditure¹⁴ and it pushes 2.2 per cent of the population below the poverty line each year.¹⁵ Health insurance can be a viable and feasible financial solution; however, only less than 3 per cent of Indians have health insurance coverage,¹⁶ and the underlying reasons for such low coverage are mostly unexplained. With special reference to the private health insurance, this paper examines the role

¹² Jenson and Jacobzone (2000): 34.

¹³ Fujisawa and Colombo (2009).

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¹⁴ WHR (2006).

¹⁵ Peters *et al.* (2002).

¹⁶ World Health Survey (2003).