Uncovering Familialism: Cash-for-Care Schemes in England and Finland

Abstract

This article compares cash-for-care schemes supporting older people with health-related social care needs in England and Finland, and their informal carers. The meso-level policy analysis drills down into the governance arrangements underpinning cash-for-care schemes including their eligibility criteria, generosity and territorial variations. It explores their implicit and explicit intentions, function and effects in defamilialising, familialising or refamilialising families' caring responsibilities. This reveals inconsistencies in the familialising and defamilialising effects of schemes according to individuals' characteristics, choices and policy restrictions. It also exposes an overarching tendency to familialise or refamilialise the activity of caring for older people, exacerbated by austerity-related politics.

Introduction

This article compares the care policy options provided to older adults and their informal carers in two post-industrial European states, Finland and England (on account of social care being a devolved policy area in the UK). The two countries share similarities, with long-term care being set in a context of population ageing, austerity politics and the diversification of care options incorporating both services and cash-for-care to promote user choice. A closer examination of how individual states are responding to the needs of their citizens aged 65 and over who experience social care needs relating to long-term health conditions is required. Since care continues to be predominantly provided by informal carers (Zigante, 2018), the long-term care policy tools that address informal care, must be in the focus of analysis too. A better understanding of the implications of these policies for older adults in need of care and their informal carers is essential given these societal trends are affecting growing numbers of citizens, in particular women.

This study analyses similar policy tools in different welfare state contexts. England typifies a liberal welfare state where the state plays a significant albeit residual role in targeting public support for long-term care at citizens on low incomes through operating a "safety-net" system (Comas-Herrera et al., 2010), while advancing the marketisation of care via municipalities commissioning care services from the care market, and wealthier citizens purchasing care directly from for-profit and not-for-profit service providers. Meanwhile, in the 1980s and early 1990s Finland was considered part of the Nordic welfare states with one of the most advanced systems for safeguarding citizens'

rights to social care based on national legislation, and providing tax-funded, needs based and locally implemented public service provision via municipalities (Kröger, 2019). However, since the 1990's the marketisation of care has shifted the Finnish care model further away from the Nordic one (Anttonen and Karsio, 2017). The increasing burden of care costs on families and difficulties in accessing care services have accelerated this transition (Kröger, 2019). Still, at the ideational level there is a consensus on the benefits of maintaining a Nordic model (Kuisma, 2017). Both countries share demographic similarities with 17.8% of the Finnish population and 16.5% of the UK population being aged over 65, and age dependency ratios are 26.9% and 24.9% respectively (Countrymeters, 2021a, 2021b). Moreover, both countries' long-term care policies emphasize ageing in place which promotes growing older at home (Care Act 2014; Act on Supporting the Functional Capacity of the Older Population ... 2012/980), but also arguably places more responsibilities on families to provide care. In this article those aspects of care policy aimed at ageing in place by supporting informal care with cash will be investigated and compared to assess the extent to which such policy tools affect the caring responsibilities of families by defamilialisation, familialisation or even refamilialisation. These concepts facilitate a more nuanced analysis of the states' treatment of the family in the provision of informal care (Leitner, 2003, 2014).

Defamilialisation describes the extent to which states enable individuals to reduce their dependency on family care by providing alternative sources of support. This can be achieved by replacing informal care with the provision of formal care services from either the public, not-for-profit or for-profit sectors (Le Bihan et al., 2019). Familialism considers whether families are expected to provide care as part of their familial obligations, either formally through state legal intervention or implicitly through policy absences (Le Bihan et al., 2019), or if states recognise the need to provide informal carers with financial support or services to sustain their caring role (Saraceno and Keck, 2010). Refamilialisation refers to the new public discovery of informal care to reduce public spending on care (Pavolini and Ranci 2008). This policy analysis aims to look beyond the surface of the care policy tools and uncover the implicit nuances of cash-for-care schemes in practice.

Conceptual framework for comparing cash-for-care schemes in England and Finland

Researching types of familialism

Care policy analysis must consider the treatment of both members of the care relationship by state policies (Saraceno, 2010). States may provide support directly to the adult with care needs or their carers, or they may indirectly support the carer by providing direct support to the adult. This makes

comparing different states' care policy tools a complex task because the treatment of the members of the caring dyad may be contradictory. Moreover, the boundary between informal and formal care is increasingly blurred (Pfau-Effinger and Geissler, 2005).

Three key types of policy tools are used by states to address citizens' financial and support needs which arise from requiring or providing care. Firstly, social security benefits, allowances and insurances, offer varying degrees of financial compensation to people either for the costs associated with having an illness or impairment, or for the costs incurred in providing care (Glendinning et al., 2009). Secondly, social care services and funding provided by municipalities which provide physical assistance to older people and their carers, including replacement care to substitute informal carers thereby enabling them to have a break or participate in the labour market. These services may be provided by the state directly; the state may commission for-profit or not-for-profit services; or the state may provide cash or vouchers to the older person or carer to commission their own services (Häikiö and Anttonen, 2011). Thirdly, employment-related measures, care leaves or flexible working arrangements, either permit carers to continue to participate in the labour market or temporarily decommodify them, allowing them time to provide care (Glendinning et al., 2009).

This article applies an analytical framework based around the concept of familialism (see Table 1) to those policy tools used in the form of cash-for-care in England and Finland via the social security system or municipalities. Cash-for-care refers to state payments or subsidies for people to provide, purchase or otherwise fund their care (Kemp and Glendinning, 2006).

Table 1: Defining familialism, defamilialism and refamilialism according to existing literature.

[Table 1 here]

Familialism exists where the state relies heavily on families as providers of care (Naldini, 2003). This concept can be de-constructed into underlying sub-categories. Le Bihan et al.'s (2019) examination of what constitutes *unsupported familialism* accommodates Saraceno and Keck's (2010; also Saraceno, 2010) concept of *familialism by default,* where there are no publicly supported alternatives to informal care, and Leitner's (2003) *implicit familialism* whereby policies neither actively support the caring function of the family nor offer defamilialization. Meanwhile Saraceno's (2016) *prescribed familialism* sees families given explicit responsibility through laws to care for their family members without specific support from the state. Arguably, in these cases the state either does not recognise, or does not seek to address, family care and the needs of caregivers. Le Bihan et al. (2019) acknowledge that Saraceno (2016) also categorised families paying privately for care from

the care market due to a lack of state support as illustrative of unsupported familialism. However, they simultaneously equated this strategy with *defamilialization through the market*, demonstrating an interplay between the blurred boundaries of familialism and defamilialization.

Where states recognise and attempt to address some of the needs of family carers through the provision of policies to help maintain their care responsibilities, the term *supported familialism* is used (Saraceno and Keck, 2010; Saraceno, 2016). Le Bihan et al. (2019) include Leitner's (2003) *explicit familialism* in this overarching category*,* whereby a lack of alternative service provision co-exists alongside policies aimed at strengthening family caring activities. If states provide a selection of familialising and defamilialising policy options Leitner's (2003) additional category, *optional familialism,* applies*,* whereby families can potentially choose whether or not to provide the care themselves or rely on formal care services instead.

Meanwhile *defamilialization* frees families from a share of the required caring work through the provision of care services. However, while Leitner (2014) considers this to occur in the absence of familializing policies, Saraceno (2016) notes that it may include policies that help families to provide care, defamilialising just part of the care demands. Variation exists in how defamilialization is achieved. *Defamilialization through the market* occurs when cash transfers, vouchers or tax benefits are offered by the state to individuals to buy services in the wider care market or when the state funds market-based service provision (Saraceno, 2010, 2016; Le Bihan et al., 2019). *Defamilialization through public provision* occurs when public services are provided by the state (Saraceno, 2016).

Leitner (2003) notes how the different policy combinations states select emphasize different opportunities or constraints when arranging care for older adults, with gendered consequences. Limited support for family care tends to reproduce the gendered division of labour in the family thus accumulating women's care responsibilities, whereas the provision of care services gives women the opportunity to access paid employment, although often in the care services sector. Moreover, policies which promote *defamilialization through the market* may turn into *familialism by default* when lower income families lack the means to access market-based care services (Saraceno 2010).

Analytical framework for comparing cash for care schemes

Table 2 describes the cash-for-care schemes selected for this comparative analysis and specifies which policy tool categories they occupy: social security cash benefits and tax allowances; cash and equivalent support provided by municipalities. Although macro-level cross-national comparisons of cash-for-care schemes are more commonly undertaken, a more nuanced meso-level analysis is used

here. The lens of familialism and defamilialization is applied to better understand how the specific cash-for-care schemes implemented in Finland and England treat long-term care and informal care. This comparison supports the evaluation of the similarities and differences between the observed characteristics of these countries' policy tools in relation to their familialising or defamilialising intentions and effects. Consideration is given to whether the cash-for-care schemes look the same and are the same, look the same but are different, look different but are the same, or look different and are different. The following aspects of each scheme were incorporated into this analysis to understand their familialising and defamilialising outcomes:

- *Eligibility for accessing the scheme (means-tested, need-tested, relational and locational criteria).* The eligibility criteria determine the types of characteristics the state considers individuals must have to be considered eligible to access public support thus targeting or excluding particular types of informal carers and care-receivers from either the policy tool's familialising or defamilialising effects. The characteristics may include the caring dyad's income or capital; employment status; number of hours of care they provide or level of need; their relationship to each other and living arrangements.
- *The generosity levels of the financial support provided.* The more generous the scheme: either the more defamilialising its effects if the recipient is permitted to use the cash to pay for formal care services; or the more it may promote supported familialism by recognising the financial costs of providing care for informal carers. The less generous the amount the more it is associated with prescribed or unsupported familialism
- *State regulation of the scheme including contractual arrangements and use of resources*. The level of regulation applied to the scheme may determine the extent to which it offers various types of familialism (prescribed, default, optional, supported) or defamilialism.

In combination these three elements expose the ways in which the selected policy tools steer how individuals within care relationships organise and pay for the care they need or provide and expose whether, therefore, the cost of care is familialised, defamilialised or even refamilialised by the state.

Table 2: Overview of cash-for-care schemes in England and Finland under analysis

[Table 2 here]

A further contribution of our study is that we distinguish between explicit and implicit cash-for-care schemes. Explicit schemes offer cash payments to cover the cost of care-related provision and are

generally regulated. Meanwhile, implicit cash-for-care schemes offer cash or tax benefits that can cover associated care costs, such as assistive devices or home renovations, or are unregulated allowing for unprescribed use. The analysis starts by focusing on explicit cash-for-care schemes provided either via municipalities or the social security system and considers the extent to which they can offer families defamilialisation, or supported, or other less protective forms of, familialism. It then moves on to undertake a similar comparison in relation to the implicit cash-for-care schemes found across the two countries.

Explicit cash-for-care schemes

First, the personal budgets and direct payments provided by English municipalities, and the social security benefit Carer's Allowance are discussed, followed by an examination of the Informal Care Allowance provided by Finnish municipalities.

England

A number of explicit cash-for-care schemes are provided by different areas of state administration in England to older adults requiring care and their carers with varying defamilialising or familialising effects. Personal budgets are the main form of support available from municipalities which adults and carers can use to pay for support to meet their assessed needs. The Care Act 2014 and associated regulations and statutory guidance provide national needs-based eligibility criteria to determine if an adult or informal carer is legally entitled to a personal budget, and set out how municipalities should determine their means-tested user fees (DHSC, 2019), which minimizes territorial variations. The personal budget amount provided is determined by the individual's needs assessment, and is subject to an annual review to ensure the funding is being used appropriately to meet those needs (Care Act 2014). Personal budgets are a form of *optional familialism* because they can be used in multiple ways, with the potential for both defamilialising and familialising effects. The extent to which either objective is achieved depends on the individual's wishes given the personalisation principles underpinning the English adult social care system aim to provide individuals with choice and control over how their needs are met (DHSC, 2018).

All eligible adults must be offered two options (or a combination of the two) for how their personal budget is delivered, which will be considered first in relation to the potential defamilialising effects. A non-cash personal budget can be managed on the recipient's behalf by the municipality and used to commission formal care services to meet their eligible needs. This is an example of

defamilialization through the market, since most care services in England are located in the for-profit sector and to a lesser extent the not-for-profit sector (Allen et al., 2011 in Marczak and Wistow, 2016). Where individuals opt for a cash personal budget, provided as a direct payment – a form of semi-regulated "routed wages scheme" (Ungerson, 1997) – the state pays the monies into the recipient's designated bank account. They can then either commission their own regulated care services from the market or employ their own unregulated, but formally employed care staff acquiring formal responsibilities for managing their employee's employment contract, wages, statutory employment rights, health and safety and absences (Carers UK, 2017). Direct payments therefore also represent a form of *defamilialization through the market* and have been explicitly used to develop the marketisation of social care provision in England (Ungerson and Yeandle, 2007), with the current regulations prohibiting them being used to purchase any remaining public services (Age UK, 2018).

The potential for direct payments to offer familialising effects is constrained by relational and locational regulatory restrictions (Care and Support (Direct Payments) Regulations 2014), because the cash can only be used by an adult to formally employ their informal carer to provide their care if they live separately to one another. Where this is possible direct payments take the form of *supported familialism* in financially supporting informal carers to continue to provide care as an employee of their family member. However, where close family members live in the care recipient's household, arguably a form of *prescribed familialism* prevails when the adult is unwilling to use their Direct Payment to access alternative defamilialising service provision from the market and wishes to rely on their co-habiting carer to meet all or some of their needs but is legally restricted from formally employing them using their direct payment. These restrictive regulations can only be disregarded if the municipality considers this option to be the only way to meet the individual's care needs because there are no alternatives. This scenario represents a form of reluctant *supported familialism* given that the intention is to avoid state resources being provided to employ family members who otherwise provide the support for free. A further explicit form of *supported familialism* occurs where informal carers receive a personal budget in the form of a direct payment, assessed via a carer's assessment under the Care Act 2014*,* to meet their own specific eligible needs. However, informal carers are not permitted to defamilialise themselves using these monies. If a carer wants a break from their caring role, any replacement care costs must be covered by the adult's personal budget. This type of risk shifting can cause disputes between caring dyad members because of the legal powers municipalities have to charge adults and carers in receipt of personal budgets user fees (Morgan, 2018).

The means-tested nature of adult social care in England arguably undermines the notion of *supported familialism* to some extent, as these user fees can be perceived as excluding and punitive given the low financial threshold for them being activated. In 2021/22 individuals with savings in excess of £23,250 are charged the full cost for any municipality support provided to meet their needs; those with savings below this threshold but above £14,250 must pay an assessed contribution towards their care costs; leaving only those with less than £14,250 and a low income exempt from financial charges (DHSC, 2021). Although Government guidance cautions municipalities against charging carers user fees, some still do (Carers Trust, 2015). Moreover, these financial rules mean that more affluent families often experience *unsupported familialism.* Consequently, they defamilialise themselves through the market directly by self-funding their own services, which accounts for 25% of all domiciliary care hours (Knapp, 2018). The only state support available to these individuals is discussed in the implicit cash-for-care schemes section. The impact of central government austerity-related budget cuts on municipalities and care relationships must also be considered. The estimated £7 billion reduction in adult social care funding since 2010 (ADASS, 2018) has caused municipalities to cut existing service provision and reduce personal budget amounts (ADASS, 2016, in HCCLGC, 2017), leading to 400,000 fewer people receiving publicly funded social care (Bottery et al., 2019). Arguably this has had *refamilisalising* impacts on care provision in England, with adults relying more on informal care provision than previously (Glendinning, 2016).

The other explicit cash-for-care scheme in England, Carer's Allowance, is accessed via the social security system. Care-giver allowances have previously been categorised as a form of wage replacement intended to compensate carers financially for the income from paid employment that is lost due to care-giving (Riedel and Kraus, 2011), and as such could be considered a form of *supported familialism*. However, it is demonstrated here that this is neither the intention nor outcome of the English scheme. Carer's Allowance can be paid to informal carers no matter what their relationship or living arrangements with the person they care for are, as long as they provide a minimum of 35 hours of care every week to someone who is eligible to receive a disability allowance such as Attendance Allowance (Gov.UK, 2021b; 2021c). Carer's Allowance claimants are subjected to an income test, which excludes any individual earning more than £128 per week (£512/month) (Gov.UK, 2021c). Moreover, the level of Carer's Allowance is exceptionally low, with a taxable flat rate of £67.60 per week (£270.40/month; £3,515/year), with national insurance credits also provided towards carers' future state pension entitlements (Gov.UK, 2021b). The at-risk-of-poverty threshold in 2017/18 calculated for one-person households was £152 per week (£7,904/year)[1] (Joseph Rowntree Foundation, 2020). Successive Governments have recognised this allowance does not prevent informal carers from living in poverty (Department for Work and Pensions, 2010),

indeed more than a million carers do so (Joseph Rowntree Foundation, 2020). Consequently, this financial support can only be described as symbolically recognizing informal care but offers no wage replacement or meaningful payment to compensate the caring role and actively restricts carers' earning capacity. Carer's Allowance therefore represents a form of *implicit familialism*. Informal carers are either forced to forgo this state support, continue to work, and rely on defamilialization via the state or market to meet the adult's care needs or the carer accepts this support but is forced to restrict their labour market participation and income to provide care. Neither option represents a choice in the way of *supported or optional familialism* due to the punitive financial implications for the carer and the aforementioned restrictions on accessing alternative financial support from municipalities via personal budgets where care relationship members live together.

Finland

The only explicit cash-for-care scheme in Finland is Informal Care Allowance (ICA). ICA provides a combination of cash and time off for carers, and replacement care services to the person being cared for during the carer's time off. The scheme seemingly represents a form of *supported familialism* with carers being paid directly by the municipality to provide care, with the benefit payment being classed as taxable income. Since the use of this money is not regulated, ICA can also be seen as *optional familialism*, if used to buy services. It is the adult in need of care who applies for the allowance, and anyone with an existing relationship to them can be considered their informal carer if mutually agreed.

All municipalities provide ICA but each can decide the more specific needs testing criteria for granting the allowance as detailed national guidelines do not exist. The needs assessment conducted by municipality staff includes an evaluation of whether the carer is capable of doing care work, which considers their health status and can include a home visit to check the suitability of the home environment for informal care provision (Linnosmaa et al., 2014). A medical certificate confirming the adult's care needs is also required. To be considered eligible for ICA, generally the need for care must be substantial so that the older adult either cannot live alone, or without the informal care would require institutional care. However, Finnish municipalities may decide how many care bandings to offer; how the bandings are defined including how substantial the care needs are and the frequency and intensity of care undertaken by the carer; and the level of benefit provided for each banding. The only requirement is that municipalities adhere to national regulations setting out

the minimum benefit level (Act on Support for Informal Care 2005/937), which in 2021 was €413 per month (€103/week).

Territorial variations are revealed when examining ICA care bandings across two selected municipalities: Espoo the second largest city in Finland (280,000 inhabitants) and the rural county of Kainuu (consisting of seven municipalities which jointly organize health and social care for 74,000 inhabitants). Both Espoo and Kainuu have three care bandings that have differing requirements related to care work and offer different ICA benefit levels. The least demanding care banding is worth € 454,70/month (€113,70/week) in Espoo and € 416/month (€104/week) in Kainuu. In Espoo the care bandings permit care to be needed seldom or never at night, while in Kainuu the care must be required 24 hours a day or daily with minor interruptions. Moreover, comparing the most demanding care banding (where informal care is equivalent to long-term institutional care), exposes even greater territorial differences, being worth €1791,05 /month (€447,80/week) in Espoo and €826,70 month (€206,90/week) in Kainuu (Espoo, 2021; Kainuun sote, 2021). It is obvious therefore, that supported familialism in Finland has a regional dimension. ICA is more commonly used in Kainuu than in Espoo, but in Kainuu informal carers do more intense and binding care work for lower benefit levels than in Espoo. The *supported familialism* in Espoo is, in comparison with Kainuu, a type of *optional familialism through the market*, since higher benefit levels allow individuals to buy services.

There is an additional income-related dimension to familialism in Finland because the benefit levels are generally not enough to live on. The benefit payment component of ICA is neither means- nor income-tested, however, lower income groups receive ICA less frequently than higher income groups (Hannikainen, 2018), possibly since living alone is more common among lower income groups (Vaalavuo, 2018) making informal care less available. Although ICA is used to support caring for individuals of all ages, in 2018 nearly 60% of those being cared for with the support of ICA were aged 65 or over (Sotkanet, 2020). Since the majority of those caring for somebody aged 65 or over are also retired, ICA may represent a form of *supported familialism* for these retired recipients because they are also in receipt of state income support via a pension.

The nature of this cash-for-care scheme also needs consideration. The Finnish ICA scheme cannot be categorised as a routed wages scheme as found in England or a proper wages scheme, where informal carers are formally employed by the municipality with adequate salary levels (Ungerson, 1997), which arguably offers the most optimal form of *supported familialism*. No employment contract exists between the carer and the state, instead a written agreement is drawn up between the two parties and municipalities are considered to have certain obligations towards these carers.

Firstly, they are obliged to insure the carers in case of occupational hazards and occupational illnesses (Act on Support for Informal Care 2005/937). Secondly since 2016-18, municipalities must provide carers with coaching, training and health and wellbeing check-ups (Act on Support for Informal Care 2005/937). These provisions indicate a degree of accountability by the state towards the carer's welfare and indirectly the person they care for, not dissimilar to an employer's health and safety responsibilities. We therefore categorise the Finnish ICA as a pseudo-wages scheme (see Table 2).

Meanwhile the service element of ICA provided to the adult in need of care represents a form of *defamilialization through public provision*. The municipality may provide home care services which can include domestic support, personal care, and home nursing. However, the amount of home care provided varies greatly, and in 2016 only about 16% of care relationships in receipt of ICA nationally received additional home care services (Kehusmaa and Erhola, 2018). Municipalities have the right to charge income-tested user fees for these services and they can make the fees reasonable, with ICA sometimes being paid at a lower level if services are also provided (Mattila and Kakriainen, 2014). A further defamilialising opportunity municipalities provide to ICA recipients is the right to a two day break a month, with three days provided if the person requires care 24-hours a day. The municipality must organise the replacement care for the adult during the carer's time off with a reduced user fee (Act on Support for Informal Care 2005/937). Although 80% of carers have the right to three days off, just over 50% activate this entitlement (Leppäaho et al., 2019).

At face value ICA represents a form of *supported familialism,* but when it is placed in the context of other aspects of Finnish long-term care policies, the outcome differs. Both institutional and home care provision is more strictly targeted than previously, resulting in the supply of informal care and the usage of ICA increasing (Kröger, 2019). Therefore, Finnish reforms and austerity measures are arguably forcing individuals to undertake informal care by making the defamilialising options of care services less accessible, leading to a process of *refamilialisation*. Added to which an estimated 20,000 informal carers provide intensive informal care without ICA (Kehusmaa, 2014) and municipality budget restrictions mean that some applicants who meet the needs-test for ICA are not receiving it (Mattila and Kakriainen, 2014). The decreasing availability of public services and insufficient budgeting of ICA points towards *implicit familialism* that is disguised behind ICA (supported familialism) and public services (defamilialism).

Implicit cash-for-care schemes

In this section we analyse implicit cash-for-care schemes: the English unregulated cash benefit Attendance Allowance, followed by Finnish disability and tax allowances.

England

Attendance Allowance is a non-contributory disability allowance for adults aged 65 and over administered centrally by the national Benefits Agency. In contrast to the means-tested logic of municipality support, this cash benefit is available to anyone requiring assistance due to having a physical or mental disability for at least six months, regardless of their financial circumstances (Gov.UK, 2021a). However, the level of financial support provided to recipients can only be described as a residual form of welfare. Recipients needing frequent help or constant supervision during the day, *or* supervision at night, receive £60 per week (£240/month), while those requiring help day *and* night receive £89.60 per week (£358.40/month) (Gov.UK, 2021a). Attendance Allowance is a well-used form of support with around 1.57 million older people receiving Attendance Allowance in 2019 (Gov.UK, 2020) compared to only 550,000 who received support from municipalities in 18/19 (Bottery and Babalola, 2020). The unregulated nature of this allowance provides some defamilialising and familialising opportunities, however these are severely restricted by the low payment level. For example, it can be used to partially supplement private care costs as a form of *defamilialisation through the market*, with an estimated 29% of older people putting it towards the cost of self-funding care in their own home (Institute of Public Care, 2015). It can also act as a restricted form of *supported familialism*, by permitting older people to provide financial or other kinds of gifts to lubricate reciprocal systems of care within their informal care networks (Glendinning, 2006). However, where Attendance Allowance recipients receive a personal budget from the municipality, they are expected to use the allowance to pay their user fees (DHSC, 2019), thereby curtailing any potential familialising effects.

Finland

The Care Allowance for Pensioners (CAP), administered by Kela, the Social Insurance Institution, provides financial support for pensioners with a disability or chronic illness to cover care costs such as special foods or rehabilitation. In 2019 there were 214,000 beneficiaries, 76% aged 65 or over (Kelasto, 2020). Access to the allowance is needs-tested and it is paid monthly at either a basic (€71), middle (€156), or higher rate (€329) (approximately €18; €39 and €82 per week) and is not classed as taxable income (Kela, 2021). No national assessment criteria are in use, with each case being assessed individually. Eligibility requires a doctor to confirm the medical diagnosis and its

impact on reducing the individual's functional ability to manage everyday activities during the past year and continuing for a year into the future. The use of CAP is not regulated, so similarly to England it may offer familialisation or defamilialisation through the market or public provision. However, the low generosity level is more likely to promote *familialisation*, since even the highest monthly benefit level would only buy approximately two hours of home care from the market.

Of the two countries only Finland provides a care-related tax allowance in the form of a tax credit for domestic help which permits certain tax deductions on care services bought directly from the market. As such it is a textbook example of *defamilialisation through the market*. The tax credit can be used to deduct 20% of the salary and social security contributions if the care work is done by an employed worker. If the work is done by a prepayment-tax-registered independent contractor or company, the deduction can be as high as 50% of these costs. The tax credit was originally designed for domestic repairs and building work, however, since 2001 its use has been extended to care work too. Deductions can only be made from labour costs. The tax credit has a yearly ceiling of €2,250 per person in 2021 and children may use it for their parents or parents-in-law, thus buying services for the older generation and deducting the labour costs in their own tax record (Vero, 2021). Consequently, this type of defamilialisation has an income and relational bias whereby wealthier individuals with higher income levels and families benefit the most. It represents an income transfer of public monies to more affluent families since individuals need to have enough taxable income to benefit from this scheme. It has been estimated that €5 million worth of domestic tax credit is not claimed by pensioners since their taxable income is not high enough (Grönberg and Rauhanen, 2015). Additionally, less than a third of pensioners in Finland who use the tax credit have a spouse, and not all older adults have children, or some have children whose income levels are low so they cannot benefit from this support.

Discussion

By adopting an in-depth meso-level analytical framework to compare the cash-for-care policy tools across two countries a more detailed and nuanced understanding of the complexity and the interconnectedness of those implicit and explicit schemes and their various effects in terms of familialisation, defamilialisation and refamilialisation, could be exposed. The components of the conceptual framework and application to compare and contrast the schemes helped to uncover the 'hidden agendas' by making both implicit and explicit intentions of the schemes more easily detectable. Adopting a cross-national comparative approach, rather than single case study, also helped highlight features that may otherwise go unnoticed including the refamilialisation trend, as

austerity and ageing in place politics have led to an increasing reliance on informal care to reduce public spending in both countries (Kröger, 2019; Glendinning, 2016).

First the policy effects were considered across the members of the caring dyad, but were also revealed to be impacted by individuals' specific characteristics and the intersection of those characteristics. The relevant characteristics included; carers' employment status due to employment restrictions being applied; individuals' income and savings level; and the relationship between the caring dyad and their living arrangements. Consequently, it is possible to conclude that across both countries the cash-for-care scheme eligibility criteria create inequalities across different income groups with low income individuals/families being disadvantaged. This is either because the rules are more likely to exclude them from using the scheme as in the case of Finland's tax credit scheme where the income transfer of public monies to support families' defamilialisation through the market is geared towards those with higher income levels since individuals with lower income levels do not earn enough taxable income to utilise it. Similarly, in England where low income family members live together they are prevented from being employed to provide care using the adult's direct payment. Furthermore, individuals with low incomes are more likely to be forced to accept the punitive rules applied by some schemes even though they may maintain or worsen their poverty. This is illustrated by England's Carer's Allowance and Finland's ICA schemes both of which require intensive care work to qualify and either leave little time for employment or prohibit employment beyond a very minimal level even though the benefit levels are not high enough to support subsistence.

Second, by drilling down into the governance arrangements underpinning specific cash-for-care schemes it was possible to realise that the intentions, function and effects of those schemes should not be taken at face value. A more thorough analysis is needed to dispel any assumptions and replace them with a more nuanced account of how the scheme's implementation in reality could alter their assumed familialising or defamilialising effects. Moreover, this helped to reinforce that schemes do not necessarily have a one-size-fits-all outcome for recipients and highlighted certain similar effects across the English and Finnish cash-for-care schemes. For example, it was possible to expose the territorial variations in the extent of familialisation in Finland's ICA scheme. By including both generosity and regulation in the analysis it permitted Le Bihan et al.'s (2019) categorisation of Attendance Allowance and Carer's Allowance in England as offering a form of *optional familialism through the market* to be challenged. The low generosity levels of these cash benefits and Care Allowance for Pensioners in Finland neither supports families to care nor allows them to truly defamilialise their care provision by replacing it with substantive service provision from the care

market. It is therefore more accurate to describe these schemes as representing a form of *implicit familialism*.

In the case of personal budgets in England, a single scheme was revealed to have differing familialising and defamilialising effects depending on an individual's circumstances and choices and their interaction with the scheme's eligibility criteria. A superficial perspective can assume personal budgets represent a form of *optional familialism* for all recipients by offering defamilisation via the market and supported familialism where direct payments are used to formally employ an adult's informal carer – however these options only apply where the caring dyad live separately to one another. It is *prescribed familialism* which prevails when the adult is legally unable to formally employ their co-habiting carer. Where informal carers receive a personal budget in their own right the *supported familialism* here is also distinct because it cannot be used to pay themselves to provide care or defamilialise themselves. The interaction of regulations both within and across different national schemes could also alter their familialising and defamilialising effects. For example, in Finland, the amount of ICA benefit paid to a carer may be affected by the level of services provided to the adult. Moreover, the user fees charged by municipalities for receiving a personal budget in England can impact on whether an individual can use their Attendance Allowance to self-fund any other formal or informal care provision.

Finally, across both countries it is possible to see how the wider policy context could also change the outcomes of implicit and explicit cash-for-care schemes. Similarities in the resource restrictions emerging from austerity-related budget cuts manifest in a variety of ways across the two countries including: increasingly strict needs-testing for care services in Finland; and reductions in the amount of cash or services provided by municipalities to adults and carers in both countries. This resembles a form of *implicit familialism* where individuals are either forced to increasingly rely on informal care or pay for their own care privately. Consequently, the formal intentions of policy tools such as Finland's ICA and England's personal budgets which seemingly promote supported familialism and defamilialism can end up disguising the reality where funding deficits ensure that refamilialisation is in fact the key trend. In these ways the objectives of the English liberal welfare state have extended privatising care-related costs to families and individuals to manage, meanwhile Finland's explicit and implicit re-familialization moves them ever further away from the Nordic welfare state where public services are central in care provision for older adults. Given the policy tools under investigation have been implemented over a period of 50 years by Governments of varying political affiliations, these findings subscribe to the feminist argument that what lies at the heart of this treatment of care is the lack of value placed upon it by capitalist societies which intentionally fail to recognise informal and formal care work as worthy of adequate financial compensation and support by the state (see

OECD 2020). Although undertaking this meso-level analysis was challenging due to the complexity of care policy systems at that level, it has proved worthwhile and could be extended in future research to incorporate work-related care leave and services, paying more attention to gender.

Conflict of interest statement

The Authors declare that there is no conflict of interest.

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Note

1. Based on a net disposable income after housing costs.

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Table 1: Defining familialism, defamilialism and refamilialism based on the existing literature

	Types	Definition
Familialism	Prescribed familialism (Saraceno, 2016) Explicit familialism (Leitner, 2003)	National law states family must provide care
	Familialism by default (Saraceno, 2016, 2010) Unsupported familialism (Saraceno, 2016; Le Bihan et al., 2019) Implicit familialism (Leitner, 2003)	No support for family care and no public support for other alternatives
	Supported familialism (Saraceno, 2016; Le Bihan et al., 2019) Optional familialism (Leitner, 2003)	Public support for informal care
Defamilialism	Defamilialization via state provision (Saraceno, 2016)	Public support via state provision to free families from care responsibilities
	Defamilialization through market provision (Saraceno, 2010, 2016) Optional familialism through the market (Le Bihan et al., 2019)	Public support via state cash benefits to buy services from the market to free families from care responsibilities
Refamiliali[illegible]	Increased reliance on informal care as public spending on, and access to, social care is reduced (Pavolini and Ranci, 2008; Vabø and Szebehely, 2012)	Rationing of defamilialising public services and support replaced by informal care

Table 2: Overview of Cash-for-care schemes in England and Finland under analysis

Recipient	**Adult with care needs**			**Informal carer**		
Policy Tools	**Disability benefits**	**Tax allowances**	**Routed wages schemes**	**Carer allowances**	**Pseudo-wages scheme**	**Carer direct payment**
Explicit Objective	Social security system payment to cover disability/ care costs	State support to buy services from the care market	State funding provided to adult to employ carer (formal/ informal	Social security system payment as wage replacement to carer	State funding pays informal carer directly to provide care	State funding provided to carer to meet their needs
England	**Attendance Allowance**: Benefits Agency	Not used	**Personal budget via Direct Payment**: municipality	**Carer's Allowance**: Benefits Agency	Not used	**Personal budget via Direct Payment**: municipality
Finland	**Care Allowance for Pensioners**: Social Insurance Agency	**Tax credit for domestic help**: Taxation Agency	Not used	Not used	**Informal Care Allowance**: municipality	Not used