Thematic Panel 19 - The Mediterranean Big Chill? Factors, trends and impacts of care policies inertia in Southern European countries

Traps and unexpected effects of innovation in a context of institutional inertia: the case of Italian "Home care premium" program

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Abstract

Home Care Premium (HCP) is an innovative LTC program introduced by INPS (Italian National Social Security Institute) in 2012 and renewed in 2014 and 2017. This program is aimed at covering the care needs of minors, adults and older people with disability. Currently restricted only to public employees and their relatives, it offers two main provisions: a) cash transfer aimed to support families in paying a personal care assistant b) in-kind services provided in accordance to an individual care plan.

Given the well known inertial dynamics of the Italian LTC policy field, HCP could be considered as a crucial innovation. Indeed, compared with the main cash-for-care scheme payed in Italy to people with disability (Indennità di Accompagnamento), HCP strongly links cash transfer to a required registration of a formal employment contract for the care assistant. Furthermore, the amount of the cash transfer is defined considering both the household income and the level of need measured through an ADL assessment scale. In this sense, HCP strongly innovates the existing Italian cash-for-care system in two aspects: i) it introduces conditionality in the use of the cash transfer; b) it graduates the amount of benefits according to the household economic situationand the level of disability of recipients.However, the implementation of HCP has shown problematic aspects, related both to specific structural features of the HCP scheme and to the difficulty to change the existing LTC institutional multi-level governance system.

First, out of 54,000 applications and a potential take-up of 44,000 beneficiaries, only 26,000 individuals were covered by HCP. As shown in the paper, this surprisingly low take-up rate is mainly due to the low compliance of both beneficiaries and local authorities involved in the program (often reluctant to formalize agreements with INPS, or simply unable to organize the supplementary care services required by the HCP program). Secondly, a huge local discretion in the use of HCP care benefits has emerged, contributing to exasperate territorial disparities among citizens and strongly limiting the central control of INPS.

Focusing on the HCP 2014 edition, this paper aims to describe these problematic aspects, highlighting the institutional traps and perverse effects of institutional innovation in an inertial context like the Italian LTC policy field.

1. Introduction

This paper is focuses on a specific long term care (LTC) program introduced by INPS, the Italian National Social Security Institute, in 2012 and then renewed in 2014 and 2017: HCP - Home Care Premium. HCP is aimed at covering the care needs of minors, adults and older people with disability and it is restricted only to public employees and their relatives. It offers two main provisions: a) a cash-for care benefit aimed to support families in paying a personal care assistant; b) in-kind services provided in accordance to an individual care plan.

Given the well known inertial dynamics of the Italian LTC policy (Da Roit and Sabatinelli 2013; Ranci and Pavolini 2013; Pavolini et al 2017), HCP represents a paradigmatic example of institutional interstitial innovation, through which it's possible to identify some of the main institutional, organisational obstacles that affect policy reform in this policy field. Starting from these premises, section 1 describes the institutional context in which HCP is embedded, i.e. the Italian LTC system and its evolution during the past decades. Section 2 focuses on the main national LTC cash-based measure in the Italian context: the "Indennità di Accompagnamento" (IdA): we will describe the main critical features of such measure to highlight what is the potential contribution of HCP in terms of innovation. Section 4 analyses the implementation of HCP (focusing on the 2014 edition), while Section 5 identifies the most problematic aspects, traps and unexpected effects emerging in the implementation process. Finally, the concluding section sums up the main findings, focusing on the paradoxical implications of interstitial innovation occurring in a policy framework dominated by long-standing institutional inertia.

2. The context: the Italian LTC system and its evolution during the past decades

As well known, Italy is a paradigmatic example of the so-called Southern European welfare model (Ferrera, 1996; Ascoli and Pavolini 2015). In this model, LTC services for dependent older people are mainly provided by family caregivers (mainly women)through intergenerational solidarity, in an institutional context dominated by public policies mainly consisting in cash benefits and lack of in-kind care services (see tab. 1). This situation implies a sort of unsupported familism (Keck and Saraceno, 2010) or passive subsidiarity (Kazepov 2015).

Table 1: The Italian LTC for dependent elderly people in a comparative perspective, 2012*(% of beneficiaries on population aged 65 and over*

	D	FR	UK	S	IT	*North*	*Centre*	*South*
Social home care**	8,1	6,5	4,4	11,7	1,3	*2,3*	*0,7*	*1,5*
Nursing home care***					4,2	*4,4*	*4,3*	*3,8*
Residential care****	4,0	4,4	2,8	4,9	2,3	*3,6*	*1,6*	*1,2*

Source: for D, FR, S (Oecd online data - Long-Term Care Resources and Utilisation http://stats.oecd.org/Index.aspx?QueryId=30140). For UK (England) (Campbell et al 2016, 49). For Italy our elaborations on data retrieved from NAA (2015):

As far as the institutional setting, the supply of LTC in Italy has been traditionally characterised by the presence of two main parallel tracks, based on different criteria for eligibility.
The first and most important track consists of a cash-for-care programme: the "Indennità di accompagnamento" (attendance allowance, hereafter IdA). The second track, is based on local welfare programmes, which include the provision of residential and domiciliary services, offered either by the regions on behalf of the National Health System (NHS) or by the local authorities in charge to provide social care support. This second track is strongly affected by geographical inequality(see table 1) (Pavolini et al 2017), given the lack of central regulation as well as of adequate financial support for the development of extensive LTC in-kind services at the territorial level. Therefore, in this context, IdA represents the bulk of the Italian LTC system. In 2014, around 35 billion euros (equal to 2.2% of the GDP) were spent by the Italian State for LTC provision, specifically addressing the needs of frail older people (INPS 2016). One third of total expenditure went through the IdA, which covered more than half of the overall population receiving benefits.
The IdA is a nationwide universalistic no means-tested allowance (515 euros per month in 2017), accessible to all citizens certified as totally dependent. The right to this benefit is officially ensured to those who are totally disabled. It must be considered as an unconditional cash for care scheme as cash benefits can be freely spent by beneficiaries without any constraint in their use (Da Roit et al. 2016).
Although the IdA was introduced in the 1980s primarily to provide a support to adults with disability, it was extended to the older population only in 1988. Over the last 25 years there has been an exponential growth of its use by dependent older people: while the coverage level among the 65+ was inferior to 3% in 1989, it reached 11,6% in 2015 (Ranci 2008; Pavolini et al. 2017). If older people represented around 20% of all beneficiaries in 1989, they became 76% in 2015 (Ranci 2008; Pavolini et al. 2017). Due to growing population ageing, public expenditure related to IdA has therefore hugely increased at the same time (Costa 2013). As a result of this trend, nowadays IdA has a coverage level that is one of the highest in a comparative perspective (Campbell et al 2016).

Tab. 1 - Cash for care allowances: coverage rate (%) on population aged 65 or over, various years.

	IT	FR	D	UK
Cash for care scheme	Indennità di Accompagnamento	Allocation personnalisée	Pflegestufe	Attendance Allowance
Year	2015	2014	2012	2012
Coverate rate %	*11,6*	*7,7*	*6,4*	*15,2*

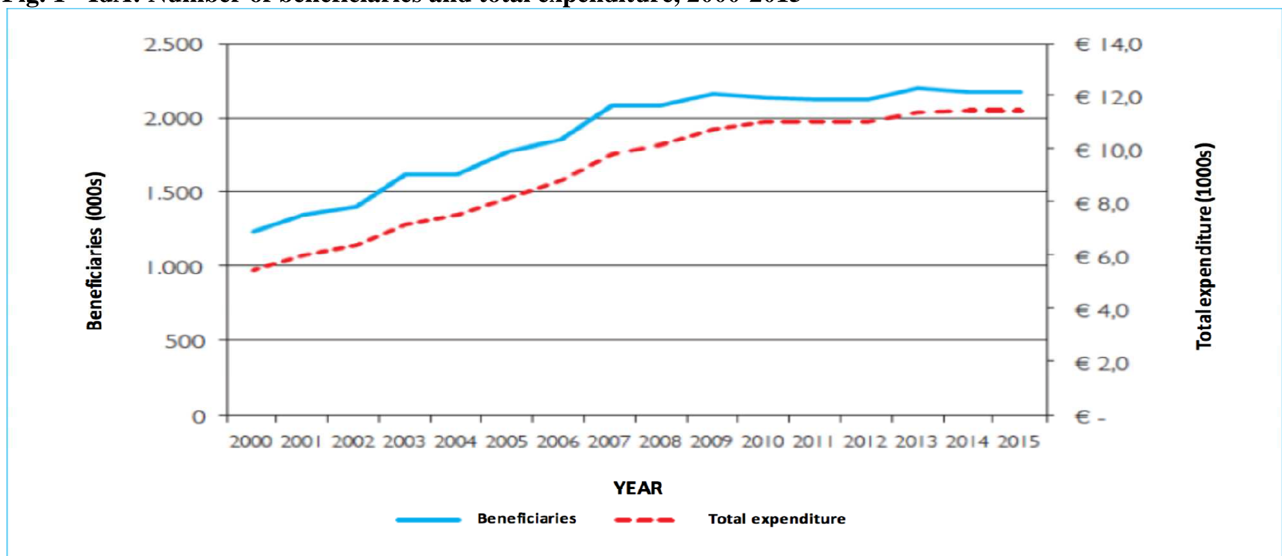
Note: for France % calculated on population aged 60 and over.
Source: for IT (our calculations on INPS's data for number of beneficiaries (INPS 2016, 83); Eurostat online for population aged 65 and over); for FR (our calculations: number of beneficiaries (http://www.data.drees.sante.gouv.fr/ReportFolders/reportFolders.aspx?IF_ActivePath=P,545,546); Eurostat online for population aged 60 and over); For D and UK: Campbell et al (2016, 56).

From an institutional point of view, IdA is managed by the National Institute for Social Security (INPS), a huge public body that is charge of all public cash-based benefits and public pensions distributed to the Italian population. There is no coordination between INPS and the regions or local authorities providing home and residential care services. Indeed, although access to IdA is managed by specific medical commissions under the responsibility of the regional administrations (see also next section 3), this aspect has not implied an institutional coordination of IdA with in-kind care services provided by the regions themselves.

In a social context mainly characterized by growing care needs associated with population ageing and changes in the family structure (Pavolini et al. 2017), a structural reform has not been undertaken in Italy over the past decade. This inertial reproduction of the consolidated structure of the LTC policy (Costa 2013; Ranci and Pavolini 2015) is in strong contrast with the dominant trend towards innovation and reforms that has characterized LTC policy in most of the European Continental countries (Pavolini and Ranci 2013).
A minor exception has been a certain dynamism of local and regional governments (Leon and Pavolini 2014; Pavolini et al. 2017), in introducing new programs (e.g. cash for care measures) aimed to the cover the growing needs of dependent older people. However, this dynamism has not stimulated a pressure for a wider reform of the LTC policy field due to the financial weakness of these local programs and the lack of central regulation in supporting them (Leon and Pavolini 2014; Pavolini et al. 2017).
In the wake of this substantial institutional inertia, a bottom-up redefinition of the Italian care regime has taken place over the years at the societal level (Da Roit, 2010; Da Roit and Sabatinelli, 2013). More specifically, families have increasingly relied on individual, private care provided by migrant care workers (commonly called 'badanti'). In 2013, a presence of approximately 800,000 care workers was estimated, 90% of them migrants, to a large extent directly employed by families without a specific contract and training (Pavolini et al. 2017).
As pointed out by Bettio et al. (2006) this phenomenon has implied a sort of transition from a 'family' to a 'migrant in the family' model of care. Several factors operating at different levels have supported this peculiar form of marketization of care (Da Roit and Sabatinelli 2013; Costa 2013; Pavolini et al. 2017, Burau et al., 2016): first, the presence of a vast, widely socially and politically accepted, grey market, haslowered the costs of private care (at the same time guaranteeing high flexibility in terms of working hours and care tasks)forlower and middle class families; second, families could easily use IdA benefits to partially cover care costs; and finally, financial constraints, austerity policies of national governments, and veto points expressed by organizations of adults with disabilities and pensioners' trade unions (worried about potential risks of retrenchment also in the IdA), have hindered a general LTC reform aimed at expanding public financing and needs' coverage.

3. The hidden evolution of IdA and its main critical features
In this context of absence of structural reforms and growth of a private social care market, IdA has become almost the only public benefit given to the increasing number of frail older people in need for care. Figures showing this increase are impressive (see figure 1 below).

Fig. 1 - IdA: Number of beneficiaries and total expenditure, 2000-2015



Source: INPS (2016, 82).

In neo-institutional terms, the evolution of IdA in the last two decades is similar to what Streeck and Thelen (2005) defined as a "gradual but transformative" institutional change (a policy drift) (Ranci and Pavolini 2013). Over the years IdA has shifted from a program targeted to adults with disability to a measure addressing the care needs of dependent older people; and from a measure designed for a relatively contained

number of potential beneficiaries to a measure expected to cover a rapidly growing target group. The final outcome has been a strong radicalization of the cash-based character of the Italian public LTC system.
Three main factors explain this dynamic. First, IdA has been functionally used to pay the expansion of the private care market. Favored by the absence of specific controls on the use of these resources, IdA has been a key factor in sustaining the recourse to migrant care workers directly hired by families without formal contracts and in precarious working conditions.
Second, the access to IdA has been regulated through a very complex system, by which specific medical commissions nominated by the regional administrations took a key role in assessing the care needs of potential beneficiaries. The institutional separation between the responsibility of access (given to medical commissions) and that of funding (given to INPS), exasperated by the lack of established standard criteria for needs assessment and related tools (see below), has perversely conveyed medical commissions to expand the access to IdA, stimulated sometimes by locally-based clientelistic practices, especially concentrated in poor local contexts (Ascoli and Pavolini 2012; Gori 2012).
Finally, the managerial "automatism" and the easy-to-use characteristics that are inherent to IdA have favored the expansion: once entitlements have been recognized by medical commissions, payments become automatic and actually not subjected to any further control or need assessment (only in the last years, INPS has promoted extraordinary campaigns in order to reduce the numbers of the so called "fake disables", i.e persons who falsely claimed to be disabled).
More generally, the resilience of IdA and its high popularity have favored the institutional freezing of the Italian LTC system. The easiest solution to the increased care deficit has been the simple extension of IdA to an increasing number of frail older people. The "success" and popularity of the measure have therefore reduced the pressure for a more profound change in the structure of the public LTC system. The more the public funding of IdA has grown and the more has been the amount of money invested in this measure, the lesslikely has been the chance for a structural change. Its functionality has become a harsh institutional trap preventing any further LTC reform.
Nevertheless, despite its success, the practical implementation and use of IdA has left many problems unsolved, as many scholars have pointed out (Ranci 2008;Beltrametti 2009). We identify four main critical aspects.
First, access to IdA is not conditioned to a standard detailed definition of the need for care, nor a specific assessment tool has been introduced to evaluate the care needs of beneficiaries. In other European countries (such as Germany or France), access to cash for care schemes is instead strictly based on a highly standardized need assessment procedure. Specific assessment tools have been introduced to consider a widespread range of aspects of disability: mobility, activity of daily life (e.g. dressing, cleaning, feeding, meals preparation, housekeeping, etc..), cognitive disturbs (e.g. behavior and/or communication disturbs, memory, language, etc.), need for physical/body care (e.g. medications, physical hygiene, health care, etc.). This assessment is then carefully considered in defining the amount of care to be given to each beneficiary. However, in the case of IdA assessment criteria are very vague, stating only that eligibility to the measures is based on two general requirements: 100% inability to walk and perform everyday tasks, and need for continuous care (Pavolini et al 2017). The lack of standardization in need assessment paves the way for high discretionary left in the hand of the medical commissions (Gori 2012), thus favoring locally, temporally variable operational definitions of the eligibility criteria.
A second critical aspect regards the amount of the IdA benefit. This is not related to the degree of dependency but is a flat rate. In all the other European countries cash benefits are diversified according to the level of disability. For instance, in Germany three levels of dependency (plus an extra-level for significant limitations in daily living activity) are considered; in France the levels of dependency considered in the calculation of the APA benefit are four, while in Austra seven levels are considered (Da Roit et al. 2016). On the contrary, the flat amount of IdA makes this measure very poor for the most severely dependent, and more generally contributes to increase the "vertical" (i.e. related to different levels of disability) inequality of the Italian LTC system.
Thirdly, IdA consists of a unconditional monetary transfer, while LTC schemes usually include a mix of cash and care measures. For instance, the LTC insurance scheme adopted in Germany allows a choice between money transfers and services or a combination of cash and care. The French APA is a voucher which beneficiaries can only spend either by purchasing in-kind services or by paying the support provided by an individualcaregiver (including relatives with the exception of spouses) through a formal contract (Da Roit et al. 2016). Furthermore, IdA does not involve any form of control about how resources are actually spent. Once the eligibility is recognized, the monetary transfer is given without any restriction placed on its use. As

a consequence IdA benefits are widely used to purchase services on the private market without restrictions, and indirectly encourage the growth of the grey market of care.
Finally, in the calculation of the IdA benefit a selectivity based on the income conditions is not foreseen. In France, for example, the APA includes a co-payment system by which higher income people have to pay more for the same care benefits. In Italy, though most of the beneficiaries are in poor conditions due to disability and older age, the same amount of benefits is given to people with different income situations, so preventing any targeting or focusing of benefits on the most in need.

4. Any way for change? The role of interstitial innovation and the HCP scheme

Analysis of the trajectories of departure from the Bismarckian welfare model has stressed the relevance of interstitial institutional innovation (Palier 2010). Within an institutional context affected by inertia and static structure, interstitial experimentations can show what are the main institutional, organisational obstacles to policy reform, and may pave the way for less marginal changes. On the other hand, reforms or institutional innovation imply not only top-down political decisions played at central levels, but also a process of implementation where institutional actors, contextual conditions, inter-institutional relationships play a key role in either facilitating or preventing change. As the recent history of LTC reforms has shown, "not all that glitters is gold" (Pavolini and Ranci 2015), i.e. political reforms in LTC are subjected to alteration and even retreat due to exogenous (new financial constraints) and/or endogenous dynamics (related to difficult implementation).
Given the main critical aspects which affect IdA, in this and the next sections we will focus on a specific process of interstitial institutional innovation which has taken place in Italy over the last years: the implementation of Home Care Premium (HCP), considering in particular the 2014 edition (ended in December 2016). As shortly described in the introduction, HCP is an innovative and experimental LTC program implemented by INPS since 2012 and then renewed in 2014 and 2017. It is an occupational welfare scheme restricted to public employees as well as public retired employees and their relatives, and it is aimed at supporting the ageing in place of dependent people, thus avoiding their institutionalisation in residential homes. Two measures are included in HCP: a) the "prestazione prevalente", a voucher aimed to support families in covering the costs of a personal care assistant; b) the "prestazione integrativa", i.e. provision of in-kind care services by specific aggregations of local municipalities ("Ambiti SocialiTerritoriali", hereafter ATS). The activation of these two measures (which can be also combined together by beneficiaries) is conditioned to a needs assessment and to the drafting of an individual care plan jointly defined by a social workers and the family.
The monthly amount of the "prestazione prevalente" for each beneficiary was defined considering both the level of disability/need and the income level (measured through the ISEE, the national Indicator of Equivalent Economic Conditions, which takes into account both work income and movable/immovable assets) (see table 2). The level of disability was assesses through the adoption of a stardardized ADL test, while the means test was used not to select the access but only to define the amount of the benefit. This amount was moreover reduced in case the beneficiary was already entitled to other disability monetary benefits (such as IdA, for example) in order to favour the complementary between HPC and other LTC schemes. ADL and means tests were also used, in different ways, to regulate the access to in-kind services ("prestazioni integrative")(see table 3).

Tab. 2 - HCP 2014 – Individual monthly (€) amount for the "HCP - prestazione prevalente"

	ISEE							
		0–8.000,00	*8.000,01 – 16.000,00*	*16.000,01 – 24.000,00*	*24.000,01 – 32.000,00*	*32.000,01 – 40.000,00*	*40.000,01 – 48.000,00*	*48.000,01 -*
ADL	*103 - 120*	1.200,00	1.000,00	800	600	400	200	0
	84 – 102	900	700	500	350	200	0	0
	65 – 83	600	500	400	200	0	0	0
	48 – 64	300	250	200	0	0	0	0

Source: HCP 2014 regulation.

Tab. 3 - HCP 2014 – Individual budget (€) for in-kind services "prestazioni integrative"

ISEE	*Budget*
0 – 4.000,00	2.400,00
4.000,01– 8.000,00	2.325,00
8.000,01 – 12.000,00	2.250,00
12.000,01 – 16.000,00	2.100,00
16.000,01 – 20.000,00	1.950,00
20.000,01 – 24.000,00	1.800,00
24.000,01 – 28.000,00	1.650,00
28.000,01 – 32.000,00	1.500,00
32.000,01 – 36.000,00	1.350,00
36.000,01 – 44.000,00	1.050,00
44.000,01 – 56.000,00	750,00
56.000,01 – 72.000,00	450,00

Source: HCP 2014 regulation.

In the 2014 edition, though access to HCP was formally nationwide, it was actually limited only to specific areas where local service organisations (ATS) have agreed to contribute to the HCP experimentation. According to the experimental plan, the access to HCP was limited to a maximum take-up of 120 beneficiaries for each area and the selection of beneficiaries was based on a time criteria (the application date), not on the basis of the level of disability or ameans-test.

In general terms, HCP must be considered as a relevant innovation in LTC policies according to the following reasons: a) it is led by the same national institution (INPS) which is responsible for funding and managing IdA: this fact enhances the chance for institutional learning and makes HCP a special case of top-down, centralistic experimentation; b) it is a measure which is only complementary to IdA: in this sense HCP has not been the object of protest and claims by IdA stakeholders; c) as a complementary program, it is aimed at filling the gap between the care needs and IdA benefits, so experimenting measures that are more appropriate to care needs. There are also limits: a) the number of recipients is rather limited even though nation-wide diffused; b) due to its complementary function, it does not inform about the possible impact of a new measure totally replacing IdA.

Building on the structural weaknesses affecting the IdA (see previous section), HCP constitutes a relevant institutional innovation within the Italian LTC policy field. The main innovative contributions are the following:

a) firstly, it introduces a standardised tool for need assessment (i.e. the ADL test), which is uniform and conditional for the access to this scheme. Furthermore, the same tool is used to graduate the amount of the benefits (in particular in the case of the "prestazione prevalente") according to the level of disability. In respect of the traditional procedure of needs assessment, the main innovations are: a) it includes a standardised system of disability assessment; b) it does not consider only the health conditions of the recipients, but it is focused on ADL functions; c) it is managed by local services and social workers, thus overcoming the traditional dualistic structure of the LTC system (see section2 above);

b) secondly, HCP differentiates the amount of benefits according to the level of disability and income, as it happens in similar measures adopted in many European countries. In the case of the "prestazione

prevalente", beneficiaries in heaviest conditions take more than double of the benefits guaranteed to people with the least level of disability (see table 2). In this sense HCP overcomes the flat character of IdA and the vertical inequality which is peculiar of this measure (see section 3 above).
c) thirdly, HCP can be used *only* for specific purposes. Recipients can use the "prestazione prevalente"only to cover the costs of a domestic assistant providing in-house care through a regular work contract. The amount of the benefit strictly depends on the actual number of working hours fixed in the work contract. Beneficiaries of the "prestazione integrative" receive, instead, in-kind services provided by ATS on the basis of a personal assistance plan jointly defined by social workers and families. As we have mentioned before, INPS delegates local authorities to provide these services and cover the costs of such activity, providing additional funds to ATS for their managing activity. In this sense, HCP introduces a voucher system, fully overcoming the mere distribution of monetary benefits that still characterises IdA (see section 3 above);
d) finally, HCP is distributed according to a "selective universalism" principle, by which poorest beneficiaries get more benefits than the others. The amount of both the "prestazione prevalente" and the "prestazioni integrative" is defined by combining income and disability criteria together. In this way HCP allows a better targeting of care services and a special focus on the poorest population, without introducing any means-test selection in the access to this scheme.
To sum up, the institutional design of HCP seems to overcome all the main critical weaknesses of IdA. In same way, it represents exactly what many scholars and some politician have considered and proposed as the most suitable innovation for the Italian LTC system: a nation-wide program based on a standardised need assessment procedure, characterized by a differentiation of the benefits in order to guarantee an higher support for the most in need, which provides an effective cash-for care measure that allows people to receive qualified, regular care services. Is this really the case?

5. Implementing HCP: innovation in an institutional context characterised by inertia
The implementation of HCP started in 2014 and was object of an evaluation in 2016[i]. Together with the innovative aspects already mentioned, three main problems have been observed: a) the low compliance of ATS; b) the low take-up of (supposed) beneficiaries; c) a high local discretion.

Low compliance of ATS
Overall, the ATS adhered to HCP only in 57% of cases (see table 4). In particular, many local authorities were reluctant to adhere to HCP as they did not comply with the HCP regulation, or simply they were not able to organise the required activities and services. The 2014 HCP showed also strong regional variance in the participation of ATS, which was generally higher in centre-south regions (coverage rate: 68%) than in northern regions (where only 40% of ATS adhered to HCP). This huge territorial gap in the compliance of local administrations mainly reflects the differentiated level of development of LTC services across the country: while in Southern and Central regions, local LTC services are very residual, in Northern regions there is a more articulated and extensive territorial system of LTC protection (see section 2). In this context, experimentation funded by central State authorities, such as HCP, is more likely to be met with favour in areas where services are underdeveloped, while in areas with higher service provision innovation is accepted in the measure that it complements existing lines of action.

Tab. 4 - HCP 2014 ATS's coverage rate (%). Data for macro areas

Macro areas	*Total n. ATS (a)*	*n. ATS HCP (b)*	*HCP coverage rate (%)*
North	250	99	39,6
Center	120	82	68,3
South	276	190	68,8
Total	**646**	**371**	**57,4**

Source: Ranci *et al.* (2016).

Low take-up
A second critical point was a low take-up. Table 5 shows the average maximum cap of beneficiaries agreed between INPS and the ATS, the average number of demands received and the average number of individual care plans activated. The last column in table 5 contains the take up rate, calculated as the ratio between the

average number of individual care plans and the average maximum cap of beneficiaries: in each of the macro areas a full coverage has not taken place. Moreover, at a disaggregate level, no regions reached a full coverage. This problematic result is due to many factors, among which the most important is a scarce capacity of local authorities to disseminate the information about HCP (see in table 5 the low average number of demands collected in each macro areas compared with the maximum cap of supposed beneficiaries)[ii].

Tab. 5- HCP 2014 - ATS's take-up. Data for regions and macro areas

Macro areas	*average nr. of max. beneficiaries*	*average nr. of demands received*	*average nr. care plans activated*	*Take-up*
North	83	125	63	0,77
Center	92	148	76	0,83
South	99	154	70	0,70
Total	93	145	69	0,75

Source: Ranci *et al.* (2016).

The take-up was especially low for the access to the "prestazione prevalente" (which consists in a voucher to be used to pay personal care assistance): only 46% of applicants accepted this voucher while 93% of beneficiaries took a "prestazione integrativa", which is based on in-kind service provision. The take up resulted even lower for HCP beneficiaries already entitled to IdA. According to the HCP regulation, IdA and HCP could be cumulated only through a reduction of the amount given in the HCP program, thus lowering its convenience, or totally nullifying it (see the monthly amounts in both cases in tables 6 and 7).

Tab. 6 - % of HCP beneficiaries with IdA who took up the "prestazione prevalente" by ADL and ISEE (within round brackets HCP €monthly amount considering IdA deduction)

		ISEE					
		0-8000	8000-16000	16000-24000	24000-32000	32000-40000	40000-480000
ADL	0						
	33-47						
	48-64	5,12 (€ 0)	3,52 (€ 0)	1,53 (€ 0)			
	65-83	37,82 (€ 100)	8,02 (€ 0)	4,24 (€ 0)	2,55 (€ 0)		
	84-102	80,75 (€ 400)	55,88 (€ 200)	6,19 (€ 0)	3,25 (€ 0)	0	
	103-120	90,18 (€ 700)	82,41 (€ 500)	66,96 (€ 300)	53,97 (€ 100)	0	0

Source: Ranci *et al.* (2016).

Tab. 7 - % of HCP beneficiaries without IdA who took up the "prestazione prevalente" by ADL and ISEE

		ISEE					
		0-8000	8000-16000	16000-24000	24000-32000	32000-40000	40000-48000
ADL	0						
	33-47						
	48-64	81,73 (€ 300)	81,10 (€ 250)	79,31 (€ 200)			
	65-83	94,14 (€ 600)	93,75 (€ 500)	92,88 (€ 400)	85,42 (€ 200)		
	84-102	96,43 (€ 900)	96,02 (€ 700)	90,53 (€ 500)	84,52 (€ 350)	61,73 (€ 200)	
	103-120	96,99 (€ 1200)	98,02 (€ 1000)	96,43 (€ 800)	90,91 (€ 600)	83,33 (€ 400)	74,07 (€ 200)

Source: Ranci *et al.* (2016).

High local discretion

The introduction of a specific standardised ADL scale for need assessment was a crucial innovation of HCP compared with the regulation of IdA (see above section 3). Local authorities were in charge of such assessment procedure and this fact - from an institutional point of view - represented a sort of innovative

inter-governmental integration in the Italian context, given the traditional dualistic structure which characterizes the Italian LTC system. However, the experience of HCP shows how this type of innovation can be affected by pitfalls and traps. In particular, a high level of local discretion in the use of the ADL scale emerged in the needs assessment provided by local social workers. As shown in table 8, in some regions, especially located in the Southern part of the country (such as Calabria and Campania), the average ADL scores assigned by local social workers were generally very high (over 80 points out of 100), more than 10 points above the national average for the individuals enrolled in HCP. On the other hand, in other northern regions (such as Lombardy or Emilia-Romagna) the average scores were below 70.

Tab. 8 - Average ADL scores and % of HCP beneficiaries with other disability benefits by region

Regions	*Average ADL scores*
Calabria	94
Campania	88
Sardinia	84
Umbria	82
Tuscany	81
Lazio	79
Sicilia	78
Friuli V. G.	77
Apulia	74
Abruzzo	72
Liguria	71
Veneto	69
Molise	69
Basilicata	68
Marche	68
Lombardy	66
Emilia Romagna	65
Piedmont	64
Trentino-South Tirol	59
Aosta Valley	55
Italy	**77**

Source: Ranci *et al.* (2016).

In general, these problems reduced the innovation carried out by HCP. Below we summarize the main critical aspects emerging in the implementation that partially hindered the capacity of HCP to overcome the main limitations of the traditional LTC system, and particularly of IdA. We consider how the most innovative aspects of HCP were partially hindered in the practical implementation of the program.

1. *Introducing a standardised assessment tool*: while a standardised ADL scale for need assessment was actually experimented in all the local authorities involved in the program, a high level of local arbitrary discretion resulted in its use. Such discretion did not depend so much on territorial variations in the disability rates as on other dynamics: the attempt by local authorities to attract more resources and services; the hidden consideration by social workers of relevant aspects related to the economic conditions of beneficiaries not normally accounted for in the ADL scale, particularly diffused in the poorest areas of the country; the difficulty for local services located in poorest areas to provide services that could complement HCP. More generally, local discretion was higher in the southern areas in the country where social services are poorly developed and therefore HCP was likely to be considered as the only way to provide people in need with services. The territorial inequality of the country therefore made the introduction of standardised procedures very difficult as local discretion was still very high and the level of dependency on national programs was highly differentiated across the country. On the other hand, the institutional design of HCP reproduced a strong split between assessment (attributed to local authorities) and funding (totally depending on INPS) responsibilities, and therefore contributed to a strong bias in the distribution mechanisms of the HCP benefits.
2. *Graduating the benefits*: the graduation of HCP benefits was implemented all over the country by following the same criteria fixed by INPS (shown in tables 6 and 7). However, many aspects have

conjured to reduce the impact of such important innovation: a) people with lower level of disability did not apply for HCP as the amount of the benefits would have not great enough to motivate the effort incentive; b) the compliance of ATS was very different across the country and this fact contributed to individual inequality in the access to the program: people with high disability who were resident in areas where a high number of potential beneficiaries applied for HCP had less chance to get benefits than people with lower disability who were resident in remote areas with few demands.

3. *Shifting from monetary benefits to cash-for-care*. HCP delivered a voucher to be used to employ family care assistants on a regular basis ("prestazione prevalente") or in-kind services provided by local authorities ("prestazione integrativa"). In this sense HCP greatly innovated as it experimented a revolutionary shift from distribution of monetary benefits to conditional cash-for-care. However, this important innovation was considerably limited by a very low take up. The main problems were: a) the complementary of HCP in respect of IdA caused many problems as many people did not want to get HCP as they preferred to keep using IdA with no restrictions in the use of monetary benefits; b) people already entitled to IdA found low convenience to meet the criteria established by HCP as the HCP benefit was very low given the deduction of the IdA (as well of other disability benefits already received) (see tables 6 and 7).

To sum up, the innovative character of HCP was partly reduced because of two main problems. First, innovation required setting up a multilevel system of provision of home care services, but this task resulted to be very difficult to be performed. While the program was regulated and financed at the national level by INPS, the implementation required the involvement of local institutions, who took responsibility in the selection of beneficiaries and in the delivery of care services. In a country with huge territorial inequality, not only the goals and interests of local authorities are very different, but also their service capacity. In the areas where the service capacity is lower, there is higher compliance but larger room for goal distortion at the same time. As a consequence, both standardised tools and distribution of benefits were affected by local discretion not explicitly considered in the national regulation of HCP. On the other hand, even richer areas had a selective approach to HCP as most of them simply did not have much interest in participating in the program. Second, in the transition from an old system to a new one, most the users have preference that are still best satisfied by the old system; indeed, shifting to conditional cash-for-care required introducing restrictions in the use of cash-for-care benefits which many people simply did not accept. The low take-up of HCP shows how deeply and strongly is rooted in specific behaviours and expectations the present institutional settings.

6. Conclusion: learning from innovation?

Given the structural critical features which affect the Italian LTC policy field (see section 3), HCP represents a crucial interstitial innovation through which institutions can learn and test how dynamics of change can take in place on the one hand, and how, on the other, institutional traps and unexpected effects can hinder innovation due to endogenous dynamics emerging in a context characterised by a long-standing institutional inertia.

As we have shown, HCP addresses all the main critical features of IdA offering an alternative LTC measure through a complex multilevel system of provision, in which regulation and funding responsibilities are under the national level by INPS, while implementation implies the involvement of local authorities (i.e. the ATS), which take responsibility in need assessment, selection of beneficiaries and production of in-kind services.

Our analysis (see section 5) has shown that most of the innovation of HCP has been partly reduced because of the low compliance of the actors involved in the implementation process. We identified two main problems which have undermined the real impact of HCP.

The first problem is caused by the low take up of HCP, due to the basic fact that the new measure, though the amount of the HCP benefits is very high, is not generous enough to allow a radical change in the preferences of potential beneficiaries. Most of the present beneficiaries of IdA still prefer a lower amount of benefits without restrictions than a higher benefit introducing restrictions in the use of money transfers. Current care arrangements of the Italian families greatly rely on the chance to use the public IdA money to pay badly-paid migrant care workers providing domestic care without a regular work contract. A voucher system necessarily implies a rise in the price of care which many Italian families are not simply available to pay.

The second problem is related to the high territorial inequality existing in the country. We have shown that the low take-up rate of HCP has been also due to the low compliance of local authorities (the ATS) both in the activation and in implementation of this program. Northren regions have adopted a very selective approach towards HCP and have expressed a limited interest in participating to the program given the higher

level of development of LTC services in these regions. This selection has contributed to the rise of territorial equality, as citizens with high levels of care needs, but residents in local contexts without a specific agreement between INPS and ATS were excluded from HCP.
In the case of the Southern regions, the participation has been higher, but at the same time the implementation has been affected by a high local level of discretion in the use of the ADL scale. In these contexts HCP was often considered as the only way to provide people in need with services, thus contributing to a goal distorsion dynamic.
To conclude, HCP shows two aspects that conjure against innovation in LTC policy in the Italian context, and eventually in other national contexts. First, policy innovation requires a multilevel institutional setting in which responsibilities for funding, regulating and implementing are strongly and coherently coordinated. Institutional fragmentation exacerbated by territorial inequality, increases the risk of goal distortion and instrumental discretionary in the local use of benefits. Second, the policy legacy is made not only of political opposition to change from the stakeholders of old programs, but also of expectations and actual care arrangements that are both strongly resilient and highly adapted to the existing LTC system. Any change in the overall system requires therefore a financial investment that is able to alter the adaptive convenience of the present system. The path towards innovation is paved therefore with sharp institutional traps that may hinder also a perfectly designed reform.

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[i]The Polytechnic of Milan was asked by INPS to carry out an assessment of HCP after some years of implementation (Ranci *et al.* 2016). The evaluation was based on a mixed method approach, considering both quantitative data (regarding the number and type of services provided) and qualitative information (gathered through interviewees with key informants in 10 ATS involved in the implementation of HCP).

[ii]A second factor is related to the specific way through which the access to HCP was regulated. The call for HCP was open only for one month and there was no chance for later applicants to be accepted into the program.