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Multiplier effects of informal social services

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Disclaimer

This deliverable is part of Task 3.3 "Examine interactions between formal social protection and informal social services". This task assesses how formal social protection policies (income & in-kind services) can favour the multiplier effect of the informal social services provided by beneficiaries in different institutional contexts, to better understand present and potential complementarities that go beyond the crowding in/out arguments. The analysis of different outcomes in terms of sustainable wellbeing in different institutional settings for equivalent social spending levels, will shed light on how the informal social services role in care, education and employment guidance, contribute to individual and social sustainability.

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Introduction

This working paper examines how formal social protection and care policies interact with informal care and support activities, and how these interactions can generate multiplier effects that enhance individual wellbeing and the sustainability of welfare systems. Rather than treating informal care as residual or falling outside the public realm, the report conceptualises it as a constitutive component of welfare production, whose effectiveness and sustainability depend crucially on its articulation with formal systems of income support, public services and labour regulation.

The central objective is therefore not to assess whether formal social protection crowds out or crowds in informal care, but to move beyond such binary framings and analyse the conditions under which complementarities and synergies emerge. These complementarities - referred to here as multiplier effects - occur when formal policies enable, protect, and enhance informal care and mutual support, while informal practices in turn reinforce social cohesion, wellbeing, and the legitimacy and effectiveness of welfare institutions.

The report is conceptual and policy-oriented. It aims to provide a theoretical and analytical framework that can guide future empirical research and policy evaluation on the interactions between formal and informal care systems. It is organised as follows. Following this introduction, Section 1 clarifies the key concepts underpinning the analysis - informal care, formal social protection and multiplier effects - and situates their interrelationship within contemporary welfare-state debates. Section 2 sets out the theoretical foundations by examining how feminist ethics of care, social investment, capability and eco-social approaches understand the relationship between formal and informal care. Despite their differences, these perspectives converge in moving beyond binary understandings of formal and informal provision. Section 3 further develops the conceptual framework. Section 4 then applies the concept of policy complementarity to long-term care (LTC) and to care systems more broadly. Sections 5 and 6 turn to the European Care Strategy and assess its relevance for the recognition and support of informal carers. Sections 7 and 8 examine recent developments in LTC policy in Spain and Italy. Section 9 compares the main post-COVID reforms in both countries, with particular attention to their materialization of the National Recovery and Resilience Plans and the European Care Strategy, and to the extent to which they advance the formal recognition and support of informal carers. Finally, section 10 summarizes the main conclusions.

1. Clarifying core concepts: informal care, formal social protection, and multiplier effects: moving beyond binary frameworks

The first contribution of this report is conceptual clarification. The term “informal social services” is often used imprecisely and risks conflating very different phenomena. This working paper narrows and specifies its focus. We define informal care and support primarily as the unpaid provision of practical, emotional, and relational support to individuals typically delivered by family members, friends, neighbours, or members of close social networks. This may include a large variety of tasks from helping with domestic or administrative chores, to spending some time together, to carry out medical procedures (Triantafillou et al., 2010; Wieczorek et al., 2022; European Commission, 2021; OECD, 2022; Costa-Font and Vilaplana-Prieto, 2025). Drawing from this definition, informal care is a) typically provided outside the realm of formal public or market provision and b) it is usually non-monetized and non-instrumental, yet structured by reciprocity, moral obligation, affective ties, and social norms. Informal care is provided and received throughout the life-cycle although it might be concentrated in particular life-course stages or transitions. Informal care is the time, space and work not encapsulated by formal care, that is, informal care is all care that cannot be identified as publicly regulated and collectively organised provision, delivered through state, market, or third-sector arrangements, and governed by legal, professional, and institutional frameworks (Daly and León, 2022). While informal care has blurred and unstable boundaries, formal care includes in-kind services (such as long-term care, childcare, home care, residential care, and community services), income supports linked to care needs, labour market regulations, and social security mechanisms that structure how care is provided, accessed, and combined with paid work (European Commission, 2021; OECD, 2023).

As to formal social protection, the European Pillar of Social Rights (EPSR) defines it as a comprehensive set of public systems, services, and rights that protect individuals against social and economic risks while promoting social inclusion and access to essential services. The EPSR situates social protection alongside employment and fair working conditions as one of the three core dimensions of social rights in the European Union, affirming that “everyone lacking sufficient resources has the right to adequate minimum income benefits” and that access to healthcare, long-term care, and essential services is fundamental to social participation and dignity (European Commission, 2017). Under this framework, social protection extends beyond traditional income replacement schemes to include minimum income support, pensions, unemployment benefits, healthcare, long-term care, childcare, housing, and disability services, reflecting a life-course approach to social risks (European Commission, 2021). By framing social protection not only as a safety net but also as an enabling system the EPSR links income security with access to quality services and social rights.

The concept of multiplier effects is introduced to capture positive interactions and feedback loops between different policy domains. A multiplier effect exists when formal welfare and care policies enable and support informal care, but the concept goes beyond the simple effectiveness of individual supportive policies. It refers to reinforcing interactions whereby the effect of one policy is strengthened, enabled or altered by the presence of another, generating cumulative gains across

different outcomes or over time. Typical examples in the welfare literature include complementarities between cash benefits and services in fields such as care or activation. Empirically, such effects can be examined by assessing whether outcomes vary according to particular combinations of policies and, in quantitative analyses, through interaction effects that test whether the impact of one policy depends on the presence or characteristics of another. More specifically, adequate in-kind services, work–life balance measures and income security may reduce care burdens and time poverty, allowing informal carers to provide high-quality relational care, maintain labour-market attachment and engage in community life. These outcomes may, in turn, contribute to sustainable wellbeing and reinforce the effectiveness and legitimacy of formal welfare systems. In other words, coherent combinations of in-kind services, income protection and the "right to care" can generate cumulative benefits by stabilising employment and work–life balance and reducing downstream risks (Gough, 2022; Laruffa, 2022; Hemerijck et al., 2023; Laruffa and Hearne, 2024; León, 2024). Multiplier effects therefore refer to processes of cumulative gain generated by reinforcing interactions between policy instruments and their effects. The opposite would be the process of cumulative losses or erosion that occur when the personal and social resources required to sustain care are not supported through policies or institutions. This would be what Rai and others refer to as depletion which focuses on the unequal distribution of social reproductive work - ranging from global care chains to micro-level household dynamics - which harms the lives of those who provide care, whether paid or unpaid, to an extent that often exceeds the conditions necessary for sustaining a decent life (Rai et al., 2014). In a way, depletion can be understood as an 'inverse' multiplier, that is, when welfare states and labour markets implicitly rely on unpaid care without adequate support leading to systemic social and gender inequalities.

These definitions imply that the appropriate unit of analysis is not formal or informal care in isolation, but the institutional configuration through which different forms of care and social protection are combined. The following sections examine how different strands of welfare scholarship conceptualise these configurations and their consequences.

2.'Informal care' in different theoretical foundations

The idea of multiplier effects is grounded in different but intersecting theoretical paradigms: Social Investment (SI); the Capabilities Approach (CA); Feminist ethics of care (FC) and eco-social frameworks (ES) (see table 1). The differences between these perspectives lie primarily in their central analytical focus, which in turn shapes their methodological orientations, the types of evidence they prioritise, and the policy implications they derive. And yet, the boundaries between these traditions are becoming increasingly permeable.

Table 1. Formal and informal care in different theoretical framings

PERSPECTIVE	CORE ISSUE	FORMAL SOCIAL PROTECTION AND FORMAL CARE	INFORMAL CARE	SUPPORTS FOR INFORMAL CARERS	MULTIPLIER EFFECTS
Feminist ethics of care	Power, gender inequality, social reproduction; relational/normative dimensions of care	Formal care is a political and gendered institution: design and quality determine redistribution/recognition; risks reproducing feminised precarity	Informal care is not "natural"; often unpaid, gendered, and structured by institutions → cumulative penalties (income, health, voice)	Redistribute responsibilities; recognise and value care; provide income security, time rights, respite, quality services; avoid offloading costs to women	Care is redistributed and socially valued; warns of inverse multipliers when policy relies on unpaid care → intensified inequality
Social investment	Life-course risk prevention; employment and welfare sustainability	LTC services + income protection + work–life balance + carers' rights as productive social infrastructure that favours employment trajectories	Informal care is integral but risky if unsupported as It can weaken labour outcomes)	Enable reconciliation (leave/flexibility), protect income (allowances/credits), ensure service availability to prevent "care shocks"	Coherent mixes reduce downstream poverty/exit/care breakdown
Capabilities	Substantive freedoms and agency; "conversion factors"	Evaluates policies by whether they expand real freedoms (autonomy, health, participation)	Informal care outcomes hinge on resources + institutional/social conversion factors (norms, labour markets, services) and carers' voice	Reduce time poverty/insecurity/burden; expand effective choice via services/respite + income + time rights + protections	Supports expand freedoms over time; rejects formal/informal binaries because they miss conversion factors shaping real outcomes
Eco-social sustainable welfare	Wellbeing within ecological/fiscal/social limits; depletion and sustainability	Care is part of wellbeing infrastructure; must avoid growth-dependent expansion and prevent hidden depletion; prioritise care quality and workforce sustainability	Informal care is crucial but finite; cannot be implicitly expanded without time poverty, depletion, gender inequality	Support carers as a sustainability measure: income security, time rights, access to quality services/respite; decent paid-care jobs; coordinated mixes	Preventive policies to reduce long-run system pressures; warns that neither unpaid care nor commodified services can expand indefinitely -

Source: Own elaboration

The core concerns that initially distinguished each perspective are now more frequently shared across them, and many apparent differences stem less from opposing conclusions than from the analytical angle from which each theoretical strand approaches complex social realities. For example, feminist scholars' longstanding focus on unpaid care and the persistent gender inequalities affecting women's wellbeing - both in the short and long run - is now more visible in social investment, capabilities, and eco-social research. Likewise, issues that were once more strongly associated with the capabilities thinking, such as individual agency and subjective wellbeing are increasingly integrated into each of them.

Across these literatures, informal care is not treated as exogenous to welfare institutions. What differs is primarily the dimension of its consequences that each perspective foregrounds: redistribution and recognition, employment and life-course risks, substantive freedoms, or social and ecological sustainability.

Feminist and ethics-of-care scholarship provided the original break with residual conceptions of informal care. Care theorists (Tronto, 2010) understand care as a moral and political practice grounded in interdependence. Unpaid care is also work that sustains labour markets and welfare systems while remaining undervalued and disproportionately allocated to women (Bhattacharya, 2017; Fraser, 2016). When informal care is treated as "private" or "natural," the costs of dependency are shifted onto households, and this produces cumulative inequalities in present and future earnings (Dowling, 2022). From this perspective, informal care is not residual but systematically structured through welfare institutions, labour market organisation and gendered norms. The formal–informal boundary itself becomes a political construct that obscures redistribution and power. Thus, the ethics of care literature puts the emphasis on shifts in normative understandings of care, responsibility, and justice. To the extent that care is a relational practice essential to social reproduction, it is a legitimate object of public responsibility. This logic argues for broader recognition-oriented policies irrespective of employment status and beyond instrumental understandings of work-care reconciliation.

The social investment perspective reaches a somewhat similar conclusion from a different analytical starting point. Rather than foregrounding recognition and gendered power, it highlights life-course risk and employment sustainability. When care responsibilities are met primarily through unsupported family provision, it has the potential to weaken labour market attachment, reduce skill accumulation and generate long-term poverty risks, particularly for women (Hemerijck, 2017; Hemerijck and Matsaganis, 2024; Morel et al., 2011). From the policy orientation of SI, the impact of informal care on those who do the work is dependent on the availability of income protection, work-family balance policies and in-kind services such as childcare. In this view, informal care interacts with employment and the welfare state in a way that shape present and future social risks of some groups. As we will see, the idea of policy complementarities or multiplier effects from a social investment perspective is anchored in the idea of 'preventive infrastructures' to mitigate inequalities across the life-cycle and ensure labour market opportunities. Applied to informal care, the SI framework leads to employment-centred forms of support that offer limited protection to non-employed carers.

The Capabilities framework places the focus elsewhere. Drawing on Sen (1999), this approach asks whether carers and care recipients possess substantive opportunities to achieve valued functionings such as autonomy, health, dignity and social participation (Hobson, 2013; Robeyns, 2017; Yerkes et al., 2020). Informal care may enhance wellbeing when it is supported and compatible with other life domains, but it may constrain agency when it generates time poverty, insecurity or lack of choice. Institutional "conversion factors" - in-kind services, income security, and social norms - mediate how care responsibilities translate into capabilities. Thus, although starting from a different premise, CA also see policy design (and complementarities) as shaping not just how informal care is situated but the impact that it has on people's chances in life. Central to the development of this framework is the

understanding that risks and opportunities are not evenly distributed across society but differ by gender, migration status, ethnicity and socio-economic background. Thus, here too, the multiplier effect that can be reached by establishing policy complementarity is seen as having an important equalising potential.

Finally, the Eco-social literature emphasises the need to value and support informal care as part of a broader plea for reorganising economies and provisioning systems –including time, services, and community supports, so that wellbeing can be secured within social and ecological boundaries (Büchs et al., 2026; Gough, 2022; Koch, 2025). Reliance on an implicit expansion of unpaid care is not only inequitable but also unsustainable in ageing societies facing fiscal and ecological constraints. When systems depend on ever-increasing volumes of unsupported informal labour, they generate forms of social depletion such as the exhaustion of carers' time and health and the declining of care quality. Applied to informal care, eco-social approaches explain carer support policies as necessary investments in the resilience of welfare systems, putting greater emphasis on collective responsibility, service provision, and respite rather than labour market attachment alone.

Taken together, these four theoretical perspectives provide the evaluative criteria used in the empirical analysis. Feminist care theory directs attention to the distribution and recognition of care; social investment to employment continuity and life-course security; the capabilities approach to substantive choice, autonomy, time use and wellbeing; and eco-social perspectives to depletion and the long-term sustainability of both unpaid and paid care. Table 2 translates these theoretical concerns into analytical concepts and illustrative indicators.

Table 2 Analytical concepts and indicators.

Theoretical perspective	Main analytical concept	What this means empirically	Illustrative indicators
Feminist care theory	Redistribution, recognition, gendered responsibility	Whether policy redistributes care costs and responsibilities rather than taking unpaid care for granted	Independent carers' rights; benefit generosity; gender composition of carers; respite provision; reliance on unpaid or low-paid migrant care; working conditions in paid care
Social investment	Employment continuity and life-course protection	Whether caring can be combined with employment without generating long-term income penalties	Paid/unpaid carers' leave; flexible working rights; pension credits; Social Security protection; access to services that reduce care intensity
Capabilities approach	Choice, autonomy and substantive freedoms	Whether carers and recipients have genuine alternatives rather than merely formal entitlements	Service availability; personalized assessment and care planning; possibility of combining cash and services; unmet need; time autonomy; accessibility and take-up
Eco-social approach	Depletion and sustainability	Whether the care arrangement can be sustained without exhausting carers, workers or public capacity	Intensity of unpaid care; respite; workforce shortages; service capacity; recurrent financing; reliance on precarious labour; territorial inequalities

3.Moving beyond binaries in Long-term Care

The theoretical perspectives discussed above have a common empirical implication for LTC: the effects of any individual policy instrument depend on the wider policy configuration in which it operates. Cash-for-care provides a particularly useful illustration. Similar cash benefits may produce very different outcomes depending on their design, the availability of services, labour-market regulation and the socioeconomic context in which they are implemented (Pavolini, 2021; Ranci et al., 2025). Some provide resources that directly or indirectly compensate family carers, while others give care recipients financial resources with which to organise or purchase care. Their implications for informal caregiving, labour-market participation and service use therefore depend heavily on benefit generosity, eligibility conditions, permitted uses and their relationship with formal service provision. Cash benefits and formal care services are therefore not necessarily competing alternatives. Under appropriate institutional conditions, they may operate as complementary components of a wider care package.

When cash-for-care benefits are embedded within well-developed LTC systems, they can increase flexibility, strengthen informal carers' capacity to provide care and enhance the autonomy and choice of care recipients. They may also facilitate female employment, both by enabling carers to combine work and care and by supporting employment within the formal care sector. In such circumstances, cash operates as one component of a balanced care mix that combines services, income support, labour regulation and social protection. The same instrument may have very different effects, however, where public service provision is weak and regulation limited. In these contexts, households may use cash to organise care privately because adequate formal services are unavailable or inaccessible. If benefit levels are insufficient to purchase regulated professional care, this may encourage greater reliance either on unpaid family members or on inexpensive and weakly regulated private care workers. Cash transfers may thereby reinforce familial responsibility, reproduce gendered divisions of care and contribute to segmented care markets characterised by low wages, limited professionalisation and weak quality control (Ranci et al., 2025).

Which of these dynamics prevails depends both on the wider care regime and on the design of the cash benefit itself. Relevant conditions include the availability and affordability of formal services, overall public expenditure on LTC, benefit generosity, eligibility rules, the degree to which payments are conditional on specified uses, their connection to needs assessment and individual care planning, labour-market regulation and mechanisms for monitoring care quality. The relationship between cash benefits and services is particularly important. Cash-for-care may operate as a supportive complement to formal provision when recipients can combine it with adequate services and professional support. Where services remain scarce, however, the same benefit can function predominantly as a substitute for public provision and shift responsibility back onto households. Calls for greater policy integration therefore require careful attention to these institutional conditions rather than an assumption that particular instruments are intrinsically complementary.

Yet moving beyond the formal–informal binary also requires recognising that not all valuable dimensions of care can or should be replaced by professional provision. Care contains emotional and relational components that depend on time, continuity and meaningful social interaction. The prevention of involuntary loneliness and the promotion of social connection provide a clear example. Research increasingly demonstrates the relationship between loneliness and social isolation and adverse physical and mental health outcomes (Hawkley, 2022), while the World Health Organization (2025) has

emphasised their wider consequences for health, mortality and social participation. Contemporary research therefore points towards interventions that combine individual support with opportunities for social participation, accessible community spaces and supportive institutional environments (Dahlberg et al., 2024; Hawkley, 2022, 2023; Wigfield et al., 2022).

Many of these forms of support involve sharing time, space and everyday activities rather than providing specialised medical or professional interventions. In situations of long-term dependency, the hours devoted to companionship, supervision, practical assistance and relational support may greatly exceed the amount of strictly medical or professional care required. This creates a broad range of possible combinations between formal and informal provision. The policy objective need not therefore be to minimise informal care as such, but to create the material, temporal and institutional conditions under which it can be provided without generating excessive burdens, inequalities or loss of autonomy.

This also broadens the range of policies relevant to the organisation of care. Alongside work–life balance measures, income security and formal care services, housing arrangements shape whether proximity or shared living is feasible; working-time regimes influence the time available for care; and social infrastructure such as libraries, community centres and cultural spaces can facilitate social interaction and meaningful shared time. Social norms and gendered expectations also influence how care responsibilities are distributed and how individuals prioritise different uses of their time. The quantity and quality of informal care are therefore shaped not only by LTC policy narrowly conceived, but by a wider institutional environment that affects the resources and choices available to households.

Conversely, the expansion of formal provision does not necessarily imply that a care system adequately supports informal carers. Service coverage may increase while carers continue to lack income security, social protection, time rights or recognition of their own needs. Formalisation is therefore not synonymous with the redistribution of care responsibility, just as high levels of informal care do not necessarily indicate policy failure. The relevant question is whether informal caregiving reflects genuine choice and takes place under conditions that protect carers' wellbeing, capabilities and longer-term social rights.

There is, in this sense, nothing intrinsically problematic about informal, unpaid reproductive work. The problem arises when welfare systems take such care for granted or depend on it without providing adequate support. Informal care should therefore be materially supported through services, income protection, respite and time rights, while also being socially recognised as a valuable contribution to individual wellbeing and social reproduction. This perspective reinforces the broader argument of this report: the effectiveness and sustainability of care systems depend less on choosing between formal and informal provision than on constructing policy configurations in which different forms of care and social protection reinforce one another rather than shifting risks and costs onto families.

4. Studying Policy Complementarity and Multiplier Effects in Care Systems

The empirical implication of the preceding argument is that care policies should be analysed as configurations of interacting instruments rather than as independent programmes. The key question is whether services, income supports and time rights reinforce one another and generate cumulative improvements in wellbeing, equality and sustainability, or whether gaps in one domain undermine gains in another.

Empirically, care systems already operate through policy mixes. Long-term care regimes combine home care services, cash-for-care schemes, carers' allowances, leave rights and labour market regulations. Yet evaluation often isolates single instruments - for example, the employment impact of carers' leave- without examining how these measures function together. A complementarity perspective would instead be interested in understanding the extent to which services reduce care intensity while leave schemes protect short-term employment and pension credits to secure long-term income, or the extent to which gaps in one area undermine gains in another. Multiplier effects arise when institutional arrangements align so that improvements in one domain reinforce outcomes in others - for instance, when accessible services and flexible work enable sustained employment, which in turn supports income security and reduces future poverty risks.

Studying complementarity therefore requires a shift in the methodological approach. First, analysis must move from single-policy evaluation to institutional configurations. This can be done comparatively, by examining clusters of policies across countries or over time and identifying recurring combinations associated with better outcomes. Second, outcomes must be assessed dynamically. Rather than focusing only on immediate service uptake or short-term labour supply, research should trace life-course trajectories to understand dynamics of employment continuity, earnings progression, pension accumulation, health status and reported wellbeing among carers and care recipients. Third, attention should be paid to distributional effects. Complementarity must be evaluated not only in aggregate terms but in relation to gender, class, ethnicity, household composition, among others. Finally, complementarity analysis must remain attentive to the possibility of inverse multipliers. When policy mixes rely heavily on unpaid care without adequate services or income protection, they may generate cumulative strains - labour market exit, capability erosion, gender inequality and depletion. The study of complementarity is therefore not a presumption of harmony, but an empirical investigation into whether institutional design produces reinforcing gains or reinforcing losses. In sum, analysing policy complementarity allows us to move beyond binary debates and to assess care systems as hybrid institutional arrangements whose effects are interactive, cumulative and contingent.

In this report, this methodological approach is applied through a qualitative comparative case study of Spain and Italy. These two countries provide a useful comparative design because they share a Southern European, strongly familialist care tradition while differing significantly in their institutional starting points. Spain entered the post-COVID period with an established national LTC entitlement

system, whereas Italy continued to rely on a fragmented combination of cash benefits, regional health provision and municipal social care, allowing us to examine different pathways towards policy complementarity under broadly comparable structural constraints. The analysis examines changes in the institutional configuration of long-term care, income support, work–life balance measures and support for informal carers, and how these different policy components are combined in practice, drawing on legislation, policy documents, administrative evidence and relevant secondary literature. The purpose at this stage is not to estimate the causal magnitude of multiplier effects, but to identify the institutional conditions under which complementarities or inverse multipliers are more likely to emerge. A subsequent stage of the research could complement this qualitative analysis with quantitative evidence on outcomes such as employment continuity, income security, service uptake and care intensity, as well as with analyses of the positive or negative effects generated by interactions between different policy instruments. Such analysis could assess how these interaction effects vary according to policy design, implementation, take-up and the wider institutional and socioeconomic context.

5. Studying Policy Complementarity and the Implementation of the European Care Strategy

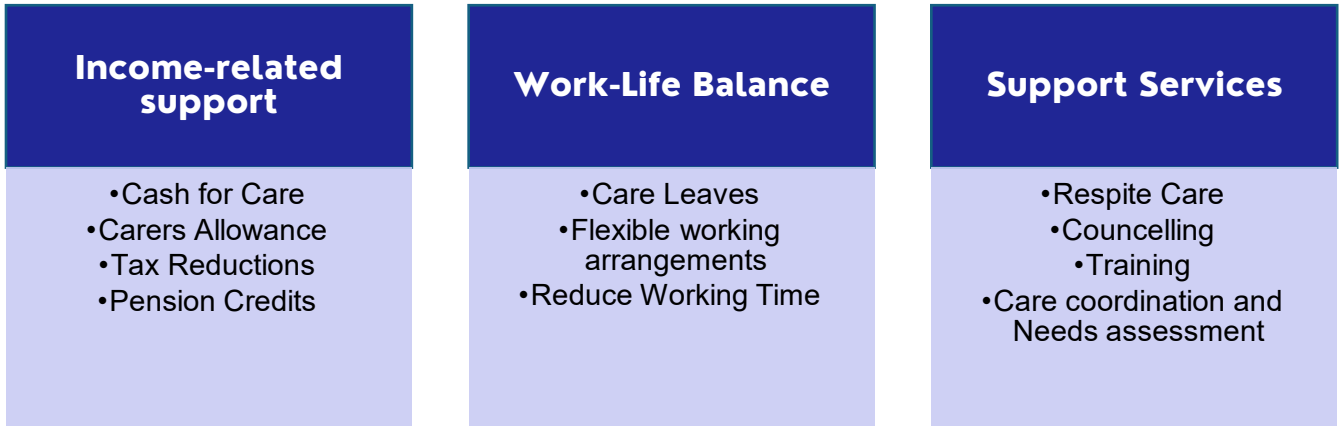
The European Care Strategy (ECS) provides a useful setting in which to apply this framework. Because its implementation takes place primarily through national and subnational welfare systems, it allows us to examine whether European initiatives alter the combination of services, income support, work–life balance measures and direct support for informal carers in practice.

The ECS represents the most comprehensive recent attempt at the European level to reshape care systems and strengthen support for both care recipients and informal carers. Through the Council Recommendation on access to high-quality long-term care and related policy initiatives, the strategy encourages Member States to expand care services, improve working conditions in the care sector, and introduce measures that recognise and support informal carers. However, as with many European social policy initiatives, implementation occurs primarily at the national level and in many countries at either regional or local levels.

To explore these dynamics, this study proposes focusing on the reforms and investments included in National Recovery and Resilience Plans (NRRPs). The NRRPs constitute a particularly relevant empirical entry point because they represent one of the largest recent sources of investment in social and care infrastructure across Europe. In several Member States - including Spain and Italy - NRRP reforms explicitly address long-term care systems, home- and community-based services, and the recognition and support of informal carers. These plans therefore provide an opportunity to observe whether European policy initiatives are contributing to new forms of policy complementarity between formal care provision and informal caregiving.

For empirical purposes, the evaluative dimensions derived from the four theoretical perspectives are examined through three clusters of policy support: income-related measures, work–life balance provisions and direct support services. The analysis considers both the design of measures within each cluster and the extent to which they interact in ways that redistribute care responsibilities, protect employment and income, expand substantive choice and prevent depletion. These clusters have been widely identified in the literature as key mechanisms supporting informal caregivers (Wieczorek et al., 2022; Cahill et al., 2023; Kim et al., 2024).

Figure 1. Components of Analytical Framework



The first cluster, income-related supports, aims to protect the economic security of individuals providing care. These include cash-for-care benefits, carers' allowances, tax reductions, and pension credits for periods spent providing care. In evaluating these measures, attention should be paid to their institutional design, including eligibility rules, benefit generosity, coverage, and the conditions attached to their use. The analysis should assess how these income supports interact with other elements of the care system. For instance, cash benefits may complement formal services when they enhance flexibility and autonomy for care recipients and carers, but they may also reinforce familial responsibility and gender inequality if implemented in contexts where services remain limited.

The second cluster, work–life balance, aims to enable individuals to reconcile paid employment with care responsibilities. These measures include paid or unpaid carers' leave, flexible working arrangements, reduced working hours, and employment protection mechanisms. Evaluating these policies involves examining their duration, compensation levels, eligibility conditions, and uptake. From the perspective of policy complementarity, the key issue is whether these instruments effectively prevent labour market exit and support stable employment trajectories for carers.

The third cluster, support services, addresses the practical and emotional challenges associated with caregiving. These services may include respite care, counselling, training, care coordination, and needs assessments for carers. Their availability and accessibility are crucial for reducing care burden and time poverty, thereby enabling informal care to be provided in ways that sustain both carers' wellbeing and the quality of care.

The core analytical objective is to examine their interaction within broader care systems. Policy complementarity exists when different instruments reinforce each other and contribute to cumulative improvements in wellbeing and social sustainability. For example, accessible home-care services may

reduce the intensity of caregiving, work–life balance policies may enable carers to remain in employment, and income supports may protect long-term economic security. Together, these measures can stabilize care arrangements and generate multiplier effects that benefit both carers and care recipients.

At the same time, the analysis remains attentive to the possibility of inverse multiplier effects, or depletion dynamics. When care systems rely heavily on unpaid care without adequate services or income protection, policies may generate cumulative strains, including labour market exit, time poverty, and persistent gender inequalities. In such cases, policy mixes may shift responsibility to families rather than supporting sustainable care arrangements.

To capture these dynamics, the analysis will examine four main dimensions: first, the care regime context, including cultural norms and institutional expectations regarding the role of informal carers; second, the direct policy instruments supporting carers within the three clusters described above; third, the degree of coordination and complementarity between policy areas, such as the relationship between cash benefits and service provision; and fourth, recent policy changes, identifying expansions, retrenchments, or stagnation in relevant policy domains.

6. The European Care Strategy

The relevance of the European perspective on care governance for the support policies identified in Figure 1 above depends on how formal and informal care are framed at the European level and on the extent to which these framings influence national policy developments. This section briefly reviews the European Union's growing involvement in care policy, with particular attention to initiatives addressing informal carers. The following section takes the recent adaptation of Spanish legislation to the European Care Strategy as a case in point to understand support to informal carers through specific financial instruments such as the Recovery and Resilience Facility.

To analyse the evolution of EU care policy perspectives on informal care, this study draws on recent academic literature as well as key European Commission documents associated with the Council Recommendation of 8 December 2022 on access to affordable high-quality long-term care (2022/C 476/01). The analysis focuses on how policy supports for informal care identified in Figure 1 are framed in relation to the different theoretical perspectives outlined in Table 1.

After the 2008 crisis, the European Union adopted an increasing role in shaping members states care provision (Elomäki and Copeland, 2026). Since competence in this field largely remains with Member States, the EU had only limited direct involvement in care policy, and most European initiatives addressing care emerged indirectly through labour market regulation and gender equality policies. The following Directives fall within this rubric: Directive on Pregnant Workers (92/85/ECC), Parental Leave Directive (96/34/EC), Part-Time Work Directive (97/81/EC), Directive on Fixed-term work (99/70/EC),

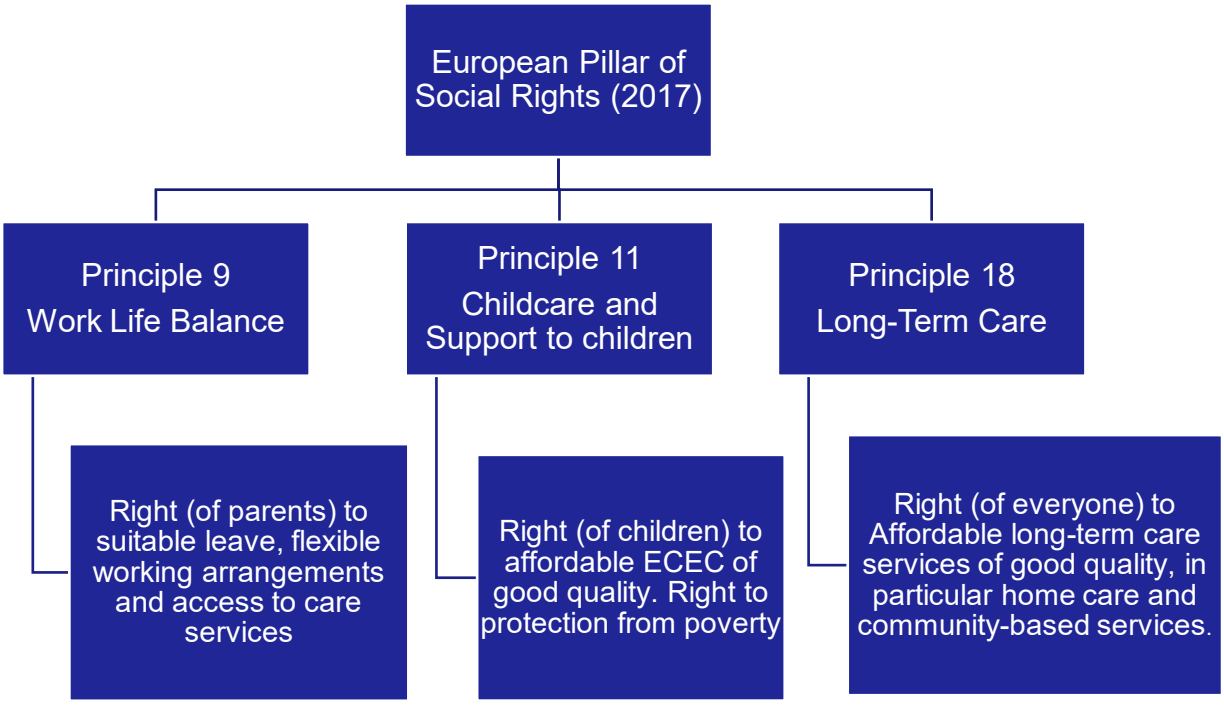
These measures sought to facilitate women's participation in paid employment by mitigating some of the care-related constraints they face. However, they were mainly concerned with the reconciliation of employment and family responsibilities, especially for working mothers, rather than with the broader and more complex question of care needs and care work in contemporary societies (Caracciolo di Torella, 2023). More specifically, the Pregnant Workers Directive (92/85/EEC) was primarily framed as a health and safety measure, aimed at protecting pregnant workers, workers who had recently given birth, and breastfeeding workers in the workplace, including through maternity leave and protection against dismissal, rather than as a broader intervention into the social organisation of care. The Parental Leave Directive (96/34/EC) represented an important step forward in recognising that care responsibilities should not fall exclusively on mothers. It thus introduced minimum requirements on parental leave and time off for urgent family reasons and sought to promote equal opportunities for men and women by encouraging fathers' greater involvement in childcare. Yet its main focus remained the reconciliation of work and family life for parents of young children, rather than the wider field of informal care across the life course. The Part-Time Work Directive (97/81/EC) and the Fixed-Term Work Directive (99/70/EC) were even more indirect in their relationship to care. Their primary objectives were to improve the quality of non-standard work, prevent discrimination, and provide greater flexibility in working-time arrangements, making it easier for workers to adapt employment to family responsibilities.

The impact of all these EU regulations on improving the repertoire of national work/life balance policies cannot be underestimated. However, from the perspective of what we are discussing here, none of the mentioned directives treat care itself as a distinct field of social policy, nor did they substantially address the specific needs of informal carers of older persons, people with disabilities, or those requiring long-term and intensive support. Within this framework, informal care work remained largely implicit. That is, acknowledged insofar as it affected labour market participation, but rarely recognised as socially necessary work requiring direct support, rights, and institutional coordination. The more complex issue

of care needs and care work in contemporary societies remained largely unaddressed (Caracciolo di Torella, 2023).

A gradual shift began with the proclamation of the European Pillar of Social Rights (EPSR) in 2017, which elevated care as a key dimension of the European social policy agenda (see Figure 2). Care is explicitly referenced in several of its principles, notably Principle 9 (Work–Life Balance), Principle 11 (Childcare and Support to Children), and Principle 18 (Long-Term Care).

Figure 2. Care within the European Pillar of Social Rights



Although the EPSR is not legally binding, it played a crucial agenda-setting role by articulating a normative framework that strengthened the legitimacy of EU-level action in the field of care. One important outcome of this process was the adoption in 2019 of the Directive on Work–Life Balance for Parents and Carers, which constitutes the first EU legislative instrument to include carers - beyond parents - as a central category within work–life balance regulation (Caracciolo di Torella, 2023).

The COVID-19 pandemic further accelerated the recognition of care as a structural policy issue across Europe. The crisis exposed the fragility of many long-term care systems (Daly et al., 2022), the heavy reliance on unpaid family carers, and the deeply gendered distribution of unpaid care work. Shortly after, the European Commission launched the European Care Strategy (ECS) on 7 September 2022 as part of the implementation of the European Pillar of Social Rights Action Plan. In several respects, the ECS represents a conceptual shift by embracing a broader and more integrated understanding of care. It moves beyond earlier narrow social investment policy frames that primarily treated care as an obstacle to female employment and instead recognises care as a fundamental component of welfare systems, social cohesion, and economic sustainability.

While the strategy lacks binding force - reflecting the mentioned fact that care policy remains largely within national competence - it illustrates the growing role of soft governance mechanisms in EU social policy. Through recommendations, coordination mechanisms, monitoring, and funding instruments, the European Union seeks to influence national policy trajectories and encourage convergence in care provision across Member States. In this sense, the ECS can be understood as part of a broader process of Europeanisation of care policy, in which EU institutions shape policy debates, normative frameworks, and reform agendas even in areas where formal legislative competence remains limited (Plavgo and Hemerijck, 2024).

The ECS pursues several interconnected objectives. It aims to improve the availability, accessibility and quality of care services; address labour shortages and working conditions in the care sector; strengthen work–life balance arrangements; and recognise the role of informal carers. Importantly, the strategy adopts a life-course perspective, encompassing both early childhood education and care (ECEC) and long-term care. It explicitly acknowledges the needs of both care receivers and caregivers and emphasises the interdependence between formal and informal care provision. By linking the protection of informal carers with the expansion and professionalisation of formal care services, the ECS highlights the complementarity between these two dimensions of care policy. This framing reflects an increasingly widespread understanding that sustainable care systems require both robust formal services and effective support for informal carers, and assumes the essential complementarity and synergy of main care policies (Caracciolo di Torella, 2023). Thus, the concept of care was broadened to incorporate references to gender, socio-economic inequalities, rights, demographic change, and wider notions of sustainability. This expansion enhances the analytical relevance of a European-level conception of care, facilitating its alignment with the different theoretical paradigms outlined in Table 1. Furthermore, the strategy situates care within broader structural transformations affecting European welfare states. It explicitly recognises the role of demographic ageing, labour market changes, and gender inequalities in shaping care needs and care provision. At the same time, the ECS emerged in the context of the EU's post-pandemic recovery agenda, linking care policies to the objectives of the Recovery and Resilience Facility, the green transition and the digital transition. In this perspective, care is increasingly framed as part of the EU's social investment agenda, contributing both to economic resilience and to gender equality (Caracciolo di Torella, 2023; Thissen and Mach, 2023).

Of particular relevance for long-term care systems across Europe is the Council Recommendation on access to affordable high-quality long-term care, adopted on December 8, 2022 (Council of the European Union, 2022/C 476/01), which forms a core component of the European Care Strategy. This recommendation represents the first coordinated EU-level framework specifically addressing the

development of LTC systems. It invites Member States to develop national action plans aimed at strengthening their long-term care systems by expanding services and improving the situation of both paid and unpaid carers. With regard to care services, the recommendation calls for improvements in adequacy, availability, quality, affordability and accessibility, encouraging countries to develop a balanced mix of services including home care, community-based care and residential care (Caracciolo di Torella, 2023; Thissen and Mach, 2023; Daly, 2025). The recommendation also addresses working conditions in the care sector, calling for better wages, improved career opportunities, enhanced training and stronger social dialogue and collective bargaining.

In relation to informal carers, the recommendation (2022/C 476/01) includes the following article 9:

> It is recommended that Member States establish clear procedures to identify informal carers and support them in their caregiving activities by:
>
> (a) facilitating their cooperation with long-term care workers.
>
> (b) supporting their access to the necessary training, including occupational health and safety, counselling, healthcare, psychological support and respite care, as well as supporting them in balancing work and care responsibilities.
>
> (c) providing them with access to social protection and/or to adequate financial support, while making sure that such support measures do not deter labour market participation..

However, despite growing awareness that informal care represents a larger share of GDP than formal care, and that sustaining and revaluing informal care constitutes one of the major demographic challenges for the future, provisions supporting informal carers remain comparatively underdeveloped.

While the recommendation emphasises the importance of supporting informal carers and highlights the role of the 2019 Work–Life Balance Directive, it provides limited guidance on key policy areas such as income support, pension entitlements, or broader forms of social protection for carers who are not in paid employment. In particular, the situation of non-employed informal carers receives little explicit attention. This reflects a persistent tension within European care policy: although informal care is widely recognised as essential to the functioning and sustainability of care systems, and implicitly counted on as a cost control mechanism, policy frameworks often struggle to translate this recognition into comprehensive and enforceable support mechanisms (Daly, 2025).

Moreover, broader contradictions within European care governance further complicate the policy landscape. As Elomäki and Copeland (2026) note, EU care policies are shaped by competing policy orientations, including tensions between fiscal austerity and public investment, commodification and decommodification of care, and familiarization and defamiliarization strategies. These tensions operate both within EU-level policy frameworks and across the diverse welfare regimes in Europe. As a result, the future trajectory of European and member states care policies remains uncertain, with no clear consensus on how care challenges should be addressed either at the national level or through European coordination.

Overall, the European Care Strategy represents an important step in placing care more firmly on the European policy agenda. Its underlying logic is largely rooted in social investment, as reflected in its emphasis on expanding public care services and improving the working conditions of care workers. At the same time, the strategy incorporates elements that go beyond an employment-centred rationale, including a stronger focus on rights and wellbeing, thereby pointing towards broader conceptions of welfare - or, at least, a more expansive understanding of social investment.

However, this openness to multiple interpretations - and, in some cases, contradictions (Daly, 2025; Elomäki and Copeland, 2026) - combined with the absence of clear targets comparable to those established for early childhood education and care, as well as the limited hints for investment frameworks, makes it difficult to anticipate how the European Care Strategy will translate into coherent policy trajectories. As a result, its effectiveness will depend to a large extent on how individual countries interpret and implement its recommendations within their own institutional and care regime contexts, which continue to shape the balance between formal services, market provision, and family-based care.

7. Testing policy complementarity in a familialist welfare regime: Spain's post-COVID LTC reform

7.1. Introduction and pre-COVID legacy

Spain entered the post-COVID reform cycle with a long-term care (LTC) system that still was strongly dependent on family care, but Law 39/2006 on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency had created the Sistema para la Autonomía y Atención a la Dependencia (SAAD) and recognised access to care as a subjective right. It established a national framework combining cash benefits and in-kind services, based on an assessment of dependency and an individual care programme. It also formally recognised non-professional carers, usually relatives, and provided for training and other support measures, although implementation was devolved to the autonomous communities. (Rodríguez-Cabrero et al., 2018; Costa-Font et al., 2022; Pavolini, 2021).

This 2006 reform represented a decisive departure from the previous model, in which families - and particularly women - supplied most care with limited public support. Nevertheless, the system that emerged remained more familialist and cash-oriented than originally envisaged. The Prestación Económica para Cuidados en el Entorno Familiar (PECEF) became the largest single benefit, despite the law's stated preference for professional services. Cash support was tied to an assessed care plan, but benefit levels remained modest and formal services were often insufficient to offer households a genuine alternative to intensive family care. (Costa-Font et al., 2023; Pavolini, 2021).

The pre-COVID trajectory combined initial expansion, austerity and gradual recovery. Between 2007 and 2010, public LTC expenditure increased as SAAD was implemented. From 2012, however, retrenchment reduced state funding, constrained benefits and services, lengthened waiting times and suspended state-funded Social Security contributions for recognised non-professional carers. The agreed level of state financing was abolished in 2012. From 2015, funding and coverage recovered incrementally, and state payment of carers' Social Security contributions was restored in 2019. Yet, on the comparable measure used in the European Commission's 2024 Ageing Report, public LTC expenditure remained approximately 0.8% of GDP in the 2022 base year, placing Spain below more service-intensive European systems. (Rodríguez-Cabrero et al., 2018; Asociación Estatal de Directoras y Gerentes de Servicios Sociales [AEDGSS], 2025; European Commission, 2024).

By 2020, SAAD had created a national entitlement structure and a substantial formal-care sector, but it had not displaced the central role of families. The system combined public benefits, relatively low-intensity services, unpaid care and low-paid formal work, including domestic and migrant care. Almost 70% of people in situations of dependency were estimated to receive care exclusively from family members, most commonly spouses or daughters (Ministerio de Derechos Sociales, Consumo y Agenda

2030 [MDSCA], 2024b). The inherited challenge was therefore not the absence of an LTC system, but the limited capacity of an existing universal framework to provide sufficiently intensive, coordinated and equitable alternatives to family care. (MDSCA, 2024a; European Commission and Social Protection Committee, 2021; AEDGSS, 2025).

7.2. The post-COVID reform cycle

COVID-19 exposed the weaknesses of this settlement. The pandemic strengthened the political case for expanding public provision, improving residential quality and moving towards more personalised home- and community-based care. (AEDGSS, 2025; MDSCA, 2024b).

The first major response was the Dependency Shock Plan (Plan de Choque en Dependencia) for 2021-2023, which meant a significant funding push between 2021 and 2023 (with the help of 3817 million € from the Recovery and Resilience European funds). The Plan restored and expanded the agreed level of state financing, sought to reduce waiting lists and supported improvements in coverage, service quality and employment conditions. Next Generation EU resources financed complementary investment and system transformation, but the expansion of SAAD's recurrent financing was a national fiscal decision. (Consejo Territorial de Servicios Sociales y del SAAD, 2021; Instituto de Mayores y Servicios Sociales [IMSERSO], 2023).

European funds nevertheless played a major role in the broader reform programme. Through Component 22 of the Recovery, Transformation and Resilience Plan, the state transferred more than EUR 2.73 billion to the autonomous communities between 2021 and 2024 for social-service modernisation, infrastructure and the transformation of LTC. Royal Decree 675/2023 increased maximum cash-benefit amounts and the intensity of home-help provision, relaxed some access and compatibility rules and broadened the circumstances in which people outside the immediate family could be recognised as carers. These changes strengthened the possibility of combining PECEF with professional services, although implementation continued to vary territorially. (Royal Decree 675/2023; MDSCA, 2024b).

The State Strategy for a New Model of Care in the Community: A Deinstitutionalisation Process, 2024-2030, gave the reforms a broader normative and institutional direction. It seeks to enable people with support needs to live in ordinary community settings, strengthen person-centred planning, expand home and proximity services and transform residential provision. Its initial allocation is EUR 1.323 billion, comprising approximately EUR 1.09 billion from the Recovery and Resilience Facility and EUR 233.2 million from the European Social Fund Plus. These resources support several policy fields - including older people, disability, child protection and homelessness - and should not be interpreted as recurrent SAAD financing. The Strategy itself recognises that its longer-term implementation depends on future national, regional and local budgetary commitments. (MDSCA, 2024b).

The Strategy overlaps closely with the European Care Strategy and Spain's response to the Council Recommendation on affordable, high-quality LTC. Both agendas emphasise person-centred and community-based provision, better coordination, improved care employment and greater recognition of informal carers. The Spanish strategy goes further in presenting deinstitutionalisation as a rights-based transition towards community living and in stressing non-market and social-economy provision. Its transformative potential, however, depends on expanding services rather than merely transferring care from institutions back to families. (European Commission, 2022; Council of the European Union, 2022; MDSCA, 2024a).

By 2026, post-COVID reforms had produced measurable changes in coverage and policy combinations. Government data for March 2026 recorded 1.655 million people receiving an effective SAAD benefit or service. Community-based benefits represented 57.2% of all recognised provisions, while the average number of benefits per recipient increased from 1.27 in 2020 to 1.44 in March 2026. PECEF remained the largest single provision, accounting for 31% of benefits, followed by teleassistance at 27% and home help at 17%. The waiting list had fallen by approximately 51% since 2020, although average processing times and territorial inequalities remained substantial. (IMSERSO, 2026).

The legal reform of the Dependency and Disability Acts represents the next stage. The government submitted the bill to Parliament in 2025; the Congress of Deputies approved it on 14 July 2026 and sent it to the Senate. The reform is intended to remove incompatibilities between benefits, update the service catalogue, strengthen personal assistance and proximity services, broaden home support and recognise teleassistance as a right. At the same time, Royal Decree-Law 17/2026 increased the state-guaranteed minimum level of SAAD financing. The decree projected a central-government contribution of EUR 5.513 billion in 2026, combining the minimum and agreed protection levels. These developments indicate a significant effort to consolidate the post-2021 expansion, although the statutory reform had not yet completed its parliamentary passage in July 2026. (Congress of Deputies, 2026; Royal Decree-Law 17/2026).

So far, in quantitative terms, since the beginning of SAAD in 2007, the most important development in LTC during the last decades, and also for the period 2019-2025, is the large growth of low-paid workers in the domestic and care sector, who with over 600,000 people, mostly women and of migrant origin, constitute one of the largest occupational groups in the country. The average annual wage in Spanish LTC (16,400€ in 2023) is just 60% of the national average annual wage (26,600€ in 2023) (Asensio et al., 2025). This is so close to the minimum wage that recent increases of the minimum wage may be the most important measure for improving the working conditions of paid carers. Still, a situation where paid carers get almost just half the average salary, may be the largest obstacle to a more equal rebalance of formal-informal care, since for many externalizing largest amounts of care remains the easiest option.

7.3. Informal carers after the reforms

Regarding policies to support informal carers, as it happens with the ECS, neither Spain’s response to the European recommendation nor the Spanish new State Strategy sets out objectives or reforms commensurate with the attention given to other areas. Consequently, the immediate future of informal carers remains dependent on incremental improvements to existing support measures, which nonetheless have been important since 2021 (AEDGSS, 2025; Asensio et al., 2025; Jiménez-Martín and Viola, 2024, 2026).

The post-COVID period has improved the formal recognition and material support of informal care, but it has not created a comprehensive national carers' policy. PECEF continues to provide the main direct financial resource associated with family care. The benefit is assessed within SAAD and linked to the care recipient's dependency level and economic circumstances, but its average value remains low relative to the time and opportunity costs of intensive caregiving. In 2024, the average monthly PECEF payment was approximately EUR 264 (AEDGSS, 2025). It therefore functions mainly as partial compensation rather than as an income capable of replacing paid employment. (AEDGSS, 2025; OECD, 2022; Eurocarers, 2025).

Recognised non-professional carers may enter a special Social Security agreement whose contributions are paid by the state, protecting some future pension entitlements. But coverage remains limited relative to the total population providing informal care. Eligibility depends on recognition within the individual care programme, and many carers are retired, outside employment or unaware of the mechanism. The measure mitigates some long-term costs of caregiving but does not compensate adequately for lost earnings, restricted careers or intensive daily care (Costa-Font et al., 2023; Eurocarers, 2025).

Work-life balance rights have also expanded, partly through the implementation of Directive (EU) 2019/1158. Employees now have five days of paid leave for serious illness, hospitalisation or major medical intervention involving specified relatives or co-residents, alongside rights to request working-time adaptation and longer unpaid leave. These provisions strengthen the position of working carers but remain much more effective for short-term or intermittent needs than for continuous LTC. They also offer less protection to self-employed, precariously employed, retired or economically inactive carers (European Parliament and Council of the European Union, 2019).

Direct carer services remain uneven. Training, information, counselling, respite and temporary replacement provision differ substantially across autonomous communities and municipalities. The growth of teleassistance and home help may indirectly reduce family burden, but day services, respite care and temporary residential provision remain comparatively underdeveloped. Spain also lacks a standalone national carers' act defining carers as rights holders independently of the care recipient (OECD, 2022; Eurocarers, 2025; AEDGSS, 2025).

The sustainability of informal care is inseparable from the formal workforce. The expansion of SAAD has generated a large feminised sector, yet pay and working conditions remain weak. In 2026, SAAD-related services employed more than 500,000 people, approximately 80% of them women, while official estimates indicated the need for a further 261,000-639,000 workers by 2030, depending on future coverage and service priorities. Without a better-paid and more stable workforce, the expansion of community care risks continuing to rely on the combination of underpaid formal labour and unpaid family care (Asensio et al., 2025; Jiménez-Martín and Viola, 2026).

7.4. Assessment: from expansion to policy complementarity?

From the multiplier perspective developed in this report, Spain's post-COVID trajectory shows a gradual strengthening of complementarities between formal benefits, services and informal care. The Shock Plan expanded recurrent funding and coverage; European funds supported infrastructure and organisational change; Royal Decree 675/2023 facilitated more flexible combinations; and the 2024 Strategy and pending statutory reform seek to consolidate personalised community-based packages. The increase in the number of provisions received per person suggests that SAAD is moving, at least incrementally, away from single-benefit responses (MDSCA, 2024b; Jiménez-Martín and Viola, 2026; IMSERSO, 2026).

Nevertheless, complementarity should not be equated with the simple accumulation of low-intensity provisions. Cash, teleassistance and limited home-help hours may coexist without substantially reducing family burden. Positive multiplier effects require sufficiently generous benefits and reliable services, meaningful choice, respite, care coordination and employment protection for carers. They also require high-quality residential provision for periods or situations in which home care is neither preferred nor feasible (Pavolini, 2021; OECD, 2022; Cabello Neila, 2025; AEDGSS, 2025).

All things considered, Spain has moved further in expanding coverage and combining services within an established universal framework, but its care model remains constrained by low expenditure, territorial inequality and gendered low-cost provision. The post-COVID reforms have created momentum towards a more person-centred and community-oriented system and have increased the visibility of informal carers. Yet unsupported or weakly supported family care remains a central pillar. The decisive question is whether the recent financial expansion and legal redesign can be sustained beyond European investment cycles and translated into more intensive services, better care jobs and enforceable rights for carers. Without those conditions, deinstitutionalisation may shift responsibility-from residential institutions to community and private homes - without achieving a structural redistribution of care (European Commission, 2024; AEDGSS, 2025; MDSCA, 2024b).

Table 3. Post-COVID evolution of the Spanish LTC system

	SPAIN
Care regime and inherited structure	Spain has had a national LTC entitlement system since Law 39/2006 created SAAD. The system combines assessed cash benefits and services, but remains familialist, territorially unequal and comparatively low-spending. PECEF became the largest single benefit, while families - particularly women - continued to provide most daily care. Austerity after 2012 reduced state financing and suspended Social Security contributions for recognised carers; gradual recovery began after 2015 and contributions were restored in 2019. (Law 39/2006; Rodríguez-Cabrero et al., 2018; Costa-Font et al., 2022; Pavolini, 2021).
Post-COVID reforms	The 2021-2023 Dependency Shock Plan increased recurrent state financing by around EUR 600 million annually and restored the agreed funding level. Component 22 of the Recovery Plan separately financed investment in social-service modernisation and community care. Royal Decree 675/2023 increased benefit amounts and home-help intensity and relaxed some compatibility rules. The 2024-2030 Community Care Strategy promotes deinstitutionalisation and person-centred provision. In July 2026, Congress approved the reform of the Dependency and Disability Acts and sent it to the Senate. Royal Decree-Law 17/2026 further increased central-government financing. (Consejo Territorial de Servicios Sociales y del SAAD, 2021; Royal Decree 675/2023; MDSCA, 2024b; Congress of Deputies, 2026; Royal Decree-Law 17/2026).
Support for informal carers	PECEF provides partial cash compensation but remains low relative to intensive care demands. Recognised non-professional carers may receive state-funded Social Security contributions, although coverage is limited. EU-driven work-life balance reforms expanded paid leave and working-time adaptation. Respite, counselling and training remain uneven, and Spain has no comprehensive national carers' act. The expansion of formal services indirectly supports carers, but weak pay and shortages in the predominantly female care workforce constrain its impact. (Royal Decree 615/2007; Royal Decree-Law 6/2019; OECD, 2022; Eurocarers, 2025; Asensio et al., 2025).

Emerging complementarities and limits	SAAD is increasingly combining benefits: provisions per recipient rose from 1.27 in 2020 to 1.44 in March 2026, and community-based support accounted for 57.2% of recognised provisions. The pending reform would remove incompatibilities and expand home, personal-assistance and teleassistance rights. However, combinations may still consist of low-intensity services, expenditure remains around 0.8-1% of GDP, territorial inequalities persist and unsupported family care remains central. The key challenge is to convert wider coverage into sufficiently intensive, sustainable and genuinely chosen care packages. (IMSERSO, 2026; European Commission, 2024; AEDGSS, 2025; MDSCA, 2024b).

Source note: own elaboration.

8. Evolution of LTC and support for informal carers in Italy: The post-COVID reform cycle

8.1. Introduction and pre-2019 legacy

Italy entered the post-COVID reform cycle with a long-term care (LTC) system that was extensive in reach but weakly integrated. Before 2019, care was organised through a set of institutions that had developed separately: the national Indennità di Accompagnamento (Attendance Allowance), regional health services, municipal social services, family care and a large market of privately employed migrant care workers (badanti). This configuration reflected the broader characteristics of the Southern European welfare model: public intervention concentrated on cash transfers, while families - especially women - remained responsible for organising and delivering most everyday care (Ferrera, 1996; Naldini, 2003; Pavolini and Ranci, 2008).

The Attendance Allowance became the central national LTC instrument. It is universal, non-means-tested and largely unconditional: eligibility depends on severe disability and the need for continuous assistance, but recipients are generally free to decide how the benefit is used. This flexibility has offered households important income protection, yet the allowance has remained weakly connected to professional services, individual care plans or quality control. Home care has likewise been divided between Assistenza Domiciliare Integrata (ADI), delivered by regional health systems, and municipal Servizio di Assistenza Domiciliare (SAD). Their separation, together with wide regional variation, has frequently left families acting as de facto case managers (Repubblica Italiana, 1980; Pavolini and Ranci, 2008; Arlotti and Aguilar-Hendrickson, 2018).

Three design features explain why this instrument has been so consequential. The allowance was introduced by Law 18/1980 for civilian disabled adults and consolidated by Law 508/1988; its extension to dependent older people was a de facto development rather than a legislative decision, and it was therefore never retrofitted to perform coordination functions. It is flat-rate rather than graduated by dependency level, non-means-tested, tax-exempt and disconnected from any care plan or monitoring of use. Its scale is nonetheless considerable. At the end of 2024 there were 2,361,982 recipients, approximately 25 per cent more than the 1,892,245 recorded in 2011, at a monthly amount of EUR 531.76 and a total annual cost of EUR 14.6 billion (Istituto Nazionale della Previdenza Sociale [INPS], 2025a, Table D1). In 2016 the allowance covered around 10.8 per cent of the population aged 65 and over, while 13.7 per cent of that age group report at least one limitation in activities of daily living, rising to 41 per cent among those aged 85 and over (European Commission and Social Protection Committee, 2021, pp. 186-188; OECD, 2025). The allowance is therefore neither generous relative to need nor targeted on its intensity: it is a broad, flat and unconditional transfer operating in the absence of the service infrastructure that would make it complementary.

Between the financial crisis and 2019, fiscal restraint and institutional inertia limited service expansion. Successive National Plans for Non-Self-Sufficiency brought incremental resources, but they did not create a unified national system. Families therefore continued to combine a cash benefit, low-intensity public provision and privately purchased care. The ‘badante model’ allowed many older people to remain at home, but also reproduced inequalities: access depended on household resources, while much of the work was performed by low-paid migrant women. Thus, on the eve of the pandemic, formal social protection supported familial care financially without substantially reducing its organisational, employment or gender costs (Arlotti and Aguilar-Hendrickson, 2018).

The reasons for this outcome are institutional as much as fiscal. Since the creation of the Servizio Sanitario Nazionale in 1978, health-related care, including the nursing components of home care, has been the responsibility of regional health authorities, while social care has been left to municipalities and the state has been confined to framework legislation and financing. Arlotti and Aguilar-Hendrickson (2018) describe the result as a vicious layering of multilevel governance: each reform added a further layer of competences without removing the previous ones, so that the state regulates the Attendance Allowance through INPS, the regions regulate ADI and municipalities deliver SAD, with no operational connection between the three levels. Italy is therefore not a case of long-term care reform that was attempted and then cut back, as in Spain after 2012, but a case of structural non-reform that persisted across political cycles and austerity alike. As the 2021 European long-term care report put it, no major LTC reforms had been introduced, planned or even discussed in detail in recent years in Italy (European Commission and Social Protection Committee, 2021, p. 196).

Austerity then removed what limited service capacity had been built. Central state financing for social care and social assistance fell by 91 per cent between 2008 and 2012, from EUR 2.5 billion to EUR 0.2 billion, and by 2011 Italian per capita expenditure on family and children policies stood at approximately 56 per cent of the Western European average, and social exclusion expenditure at 15 per cent (Pavolini et al., 2015). Successive National Plans for Non-Self-Sufficiency did not close this gap: the 2019-2021 cycle was funded at EUR 573 million, against annual expenditure of more than EUR 13 billion on the Attendance Allowance alone. This sequence is also relevant to the assessment of the European contribution developed in section 9.3, since the same European architecture that now finances care investment exercised its strongest pressure, between 2008 and 2012, on fiscal consolidation and labour market deregulation rather than on social investment.

8.2. The post-COVID reform cycle

COVID-19 changed the political salience of LTC. It exposed weaknesses in regulation, staffing and coordination. The pandemic therefore acted as both a diagnostic shock and a political catalyst. It strengthened demands for care closer to home and made the fragmentation between hospitals, primary care, municipal services and family support more visible. This diagnosis is consistent with León et al. (2023), who show that the weak institutional embedding, regulation and coordination of nursing homes left them in a policy blind spot during the first wave of the pandemic.

The National Recovery and Resilience Plan (Piano Nazionale di Ripresa e Resilienza, PNRR) provided the principal financial and institutional opportunity for reform. Mission 6 on health promotes territorial care, home assistance and digital coordination, including Community Houses (Case della Comunità), Territorial Operational Centres (Centrali Operative Territoriali) and multidisciplinary teams. Ministerial Decree 77/2022 translated this agenda into organisational standards for primary and community health care. Mission 5 also supports social inclusion, independent living and community-based provision. Together, these measures aim to shift care away from hospital-centred and institution-centred responses and to improve continuity across settings. (Presidenza del Consiglio dei Ministri, 2021; Ministero della Salute, 2022).

The reform direction also converges with the European Care Strategy adopted in 2022. Both agendas stress accessible, high-quality and community-based care, stronger links between health and social services, and better working conditions in the care economy. Comparative research on the lessons of COVID-19 similarly points towards more open, integrated and comprehensive LTC systems rather than isolated sectoral interventions (Casanova et al., 2025). In Italy, however, the European agenda has operated through a domestic reform process centred on territorial health care and the reorganisation of fragmented national, regional and municipal responsibilities. The EU contribution has therefore been strongest as a source of investment, policy direction and reform conditionality rather than as a direct creator of carers' entitlements.

The most important legislative change was Law 33/2023, the first comprehensive national framework specifically addressing policies for older people and non-self-sufficiency. The law created the basis for the Sistema Nazionale per la Popolazione Anziana Non Autosufficiente (SNAA), intended to coordinate health, social care and income-support measures. It placed greater emphasis on Single Access Points (Punti Unici di Accesso), multidimensional assessment and personalised care planning. Conceptually, this represents a major change: the state is no longer presented merely as a payer of cash benefits but as responsible for organising coherent care pathways around the needs of older people and their families. (Repubblica Italiana, 2023).

Legislative Decree 29/2024 implemented significant parts of this framework, and Legislative Decree 93/2025 subsequently amended and corrected several provisions. One of the most visible innovations is the experimental Prestazione Universale, operating from January 2025 to December 2026. It combines the Attendance Allowance with an additional assistance component of up to €850 per month, but only for people aged at least 80 with very high care needs, an income-tested socio-health ISEE not exceeding €6,000 and entitlement to the Attendance Allowance. The additional component must be used to employ a qualified domestic care worker under a regular contract or purchase eligible non-residential services. Unlike the traditional allowance, it therefore seeks to connect cash support to formalised care and domiciliary provision. (Repubblica Italiana, 2024, 2025; INPS, 2025b).

The Prestazione Universale is analytically important but limited in scope. Its narrow eligibility conditions mean that it cannot by itself transform the broader cash-centred model. Nevertheless, it introduces a different policy logic: public cash is tied to specified care inputs, regular employment and home-based

support. It can therefore be interpreted as an experiment in producing stronger complementarities between income protection, service provision and labour-market regulation. (INPS, 2025b).

Both the scale of the experiment and its first results deserve attention. The eligibility conditions imply a target population of approximately 25,000 people, against 2.36 million recipients of the Attendance Allowance: even full take-up would have covered around one per cent of the cash-benefit caseload. Take-up, however, has been far below target. According to the monitoring data reported by the Ministry of Labour and Social Policy in the documentation accompanying the 2026 Budget Law, fewer than 5,000 applications had been submitted by September 2025, with an acceptance rate of 41 per cent and approximately 2,000 effective beneficiaries. The first Italian instrument designed to tie cash support to a care plan and to formalised employment has therefore reached fewer than one in ten of the households it was intended for.

This outcome is analytically more interesting than the design itself, and it bears directly on the argument of this report. A complementarity is not created by attaching conditions to a transfer; it is created when the services, the assessment capacity and the information channels to which the transfer refers are actually available. Where they are not, conditionality does not redirect care towards formal provision but simply excludes households from the benefit. The Prestazione Universale is, in this sense, the clearest available demonstration that policy complementarity is an institutional achievement rather than a drafting decision.

The 2025 corrective decree is itself evidence that the reform remains institutionally unsettled. It adjusted elements of the 2024 implementing framework while preserving the overall direction towards integrated access and domiciliary care. By 2026, therefore, the reform cycle had moved beyond legislative announcement and into operational implementation, but it had not yet generated a uniform national care model. The practical content of the new architecture continues to be determined through regional programming, local service organisation and the progressive implementation of essential social-service standards. (Repubblica Italiana, 2025).

Implementation is the central uncertainty. The new system depends on cooperation between the state, regions, local health authorities and municipalities, all of which enter the reform with unequal administrative and service capacity. Assessment and care planning cannot reduce family burden unless sufficient home-care hours, respite care, day services and professional workers are available. Recent evidence from the local level confirms that the scarcity of public provision, private-care costs, limited information and complex access procedures remain significant barriers, while migrant care workers continue to bridge gaps between public resources and household needs (Santini et al., 2025). The PNRR has financed infrastructure and organisational change, but it does not automatically guarantee the recurrent expenditure required to staff services after the investment period. Regional inequalities and shortages of nurses, social-care workers and qualified home-care personnel may therefore turn formal integration into an administrative procedure rather than a substantive improvement in care. These workforce constraints are not specific to Italy, but recent comparative work identifies recruitment, retention, skills and working conditions as central obstacles to the implementation of more adequate European LTC systems (Pavolini and Marlier, 2025).

Three of these constraints can be quantified. First, ADI is in many local contexts designed as a response to acute or post-acute needs and is subject to an episodic limit of around three months, which makes it structurally inadequate for the stable and intensive needs that demographic ageing is expanding most rapidly (Santini et al., 2025). Second, residential capacity is unevenly distributed: the national average of 70 beds per 10,000 inhabitants in 2021 conceals a gap between the North-East, at 100, and the South, at 33.4 (Santini et al., 2025). Third, unmet need is already documented on both dimensions that the reform is meant to address: 36.9 per cent of older people in Italy report being unable to access professional home care for financial reasons and 30.3 per cent because the service is unavailable, the

highest figure in the EU-27 against a European average of 9.7 per cent (European Commission and Social Protection Committee, 2021, p. 186). Assessment procedures and single access points cannot by themselves alter these figures.

The expenditure comparison also requires caution. On the comparable public-expenditure measure used in the European Commission's 2024 Ageing Report, Italian LTC expenditure was approximately 1.6% of GDP in the 2022 base year - higher than Spain's 0.8%, but below the most service-intensive European systems. Broader estimates may be higher when additional social-care spending is included. More important than the headline figure is the composition of spending: Italy continues to devote a large share to cash benefits, while the availability and intensity of services remain uneven. (European Commission, 2024; OECD, 2023).

The composition can be measured. In 2019 the Attendance Allowance absorbed 52 per cent of Italian public LTC resources, against a European average of approximately 26 per cent, while integrated home care accounted for 19.5 per cent, against a European average of 25.5 per cent (Santini et al., 2025; European Commission and Social Protection Committee, 2021). Italy therefore devotes twice the European share to an unconditional cash transfer and a below-average share to services. Service capacity is correspondingly thin: public home care, ADI and SAD combined, reaches at most 4.7 per cent of the population aged 65 and over, and residential care 3.2 per cent (OECD, 2025), while the formal LTC workforce stood at approximately 260,000 in 2016, equivalent to 1.9 workers per 100 people aged 65 and over against an EU-27 average of 3.8 (European Commission and Social Protection Committee, 2021, p. 188).

8.3. Informal carers after the reforms

The post-COVID reforms have increased the visibility of informal carers, but direct support remains less developed than reforms to governance and care-recipient benefits. The Attendance Allowance continues to be the main indirect resource available to families. It can compensate relatives or finance a badante, yet it does not provide carers with independent rights to income replacement, pension protection, respite or needs assessment. Italy still lacks an enacted comprehensive national carers' law. This pattern reflects a broader European tendency to extend public support for family caregiving without necessarily displacing family responsibility, with continuing risks of gender and social inequality (Arlotti et al., 2023).

The scale and the intensity of Italian informal care can be documented. Approximately 5.8 per cent of the population provides informal care, a comparatively low share by European standards, but 41 per cent of those carers provide more than 20 hours of care per week (European Commission and Social Protection Committee, 2021, p. 189). Italy therefore combines a narrow base of carers with an unusually high intensity of commitment for those involved. Regional evidence points in the same direction: in a study conducted in the Marche region, 71.4 per cent of family carers were women, the average care load was 62 hours per week, and 28.3 per cent of carers were also in paid employment (Santini et al., 2025). Against this, national support remains close to absent. The 2021 European report records that no real support measures for informal carers, such as training, skills validation or respite, are available at national level, and that local and regional initiatives are limited (European Commission and Social Protection Committee, 2021, p. 189). Until Law 33/2023, Italian legislation did not contain a national definition of the family carer at all.

The distinctive feature of the Italian configuration is that this gap has been filled by a privately organised market for migrant care labour. In 2024 there were 817,403 registered domestic workers and 902,083

employing households; for the first time personal carers overtook domestic cleaners as the largest category, at 50.5 per cent of the total, and 68.6 per cent of them were foreign nationals, principally from Romania, Ukraine and the Philippines. In 37.9 per cent of employing households the head of household is aged over 80 (Osservatorio Domina, 2025). These figures refer to registered contracts alone; the 2021 European report estimates approximately 800,000 migrant care workers, many in irregular or partly irregular contractual situations, and notes that labour conditions in the sector are often not particularly good (European Commission and Social Protection Committee, 2021, p. 188). Bettio, Simonazzi and Villa (2006) codified this arrangement as the migrant-in-the-family model, which rests on three simultaneous conditions: a supply of women workers sustained by wage differentials with their countries of origin, a demand for care that public services do not meet, and a public cash transfer generous enough to help finance a private solution but not to finance a regular one. The relationship between the allowance and this market is explicit in the European assessment: the monthly amount is only sufficient to employ a migrant care worker where household income is adequate, and is not sufficient for low-income households (European Commission and Social Protection Committee, 2021, p. 188). The transfer therefore stratifies rather than equalises, since middle-income households convert it into purchased care while low-income households absorb the whole care load within the family.

Working carers receive some protection through Law 104/1992, which provides paid leave and employment safeguards for eligible employees caring for relatives with severe disabilities. The implementation of the EU Work–Life Balance Directive has also strengthened carers' leave and flexible-working provisions. These rights are valuable but selective. They primarily benefit people in stable formal employment and offer much less protection to precarious workers, the self-employed, retired carers or those who have already left employment because of intensive care responsibilities. (Repubblica Italiana, 1992; European Parliament and Council of the European Union, 2019).

Law 33/2023 and the associated assessment architecture potentially improve carers' position by requiring family circumstances to be considered in personalised planning. Single Access Points may also simplify navigation across health and social services. Yet recognition has advanced faster than enforceable entitlements. Respite, counselling, training and psychological support remain territorially uneven and often depend on local initiatives or third-sector provision. (Repubblica Italiana, 2023, 2024).

A further post-COVID development is the government bill on the recognition and protection of family caregivers, approved by the Council of Ministers in January 2026 and under parliamentary examination in July 2026. The bill indicates that carers have become a more explicit national policy constituency. However, because it had not yet become law, and because the proposed economic support is tightly targeted, it should be treated as an emerging reform rather than an established national entitlement. (Presidenza del Consiglio dei Ministri, 2026).

8.4. Assessment: from parallel provision to complementarity?

From the multiplier perspective adopted in this report, Italy's post-COVID trajectory is best understood as an attempt to convert parallel policy instruments into an integrated care system. Before the pandemic, the Attendance Allowance, ADI, SAD, family care and privately employed migrant care interacted mainly through household improvisation. The reforms establish mechanisms through which assessment, health care, social services and cash support could reinforce one another. This is particularly important in light of comparative research showing that the consequences of cash-for-care depend on how payments are regulated and connected to services, employment formalisation and support for recipients and carers (Ranci et al., 2025).

This potential should not be overstated. Cash transfers strengthen informal care when they are combined with adequate services, respite, professional guidance and protection for carers' employment and income. In the absence of these conditions, the same transfers have consolidated a low-cost equilibrium based on unpaid female labour and poorly paid migrant care, and the Italian case documents that outcome rather than merely warning against it. Similarly, personalised plans only expand capabilities if meaningful choices are available in practice.

The Italian case is in fact the clearest empirical instance of the inverse multiplier set out in section 1, and it can be stated in the terms of this report's own framework. A positive multiplier requires that a formal instrument be tied to an assessment of need, so that resources follow intensity; to a care plan, so that cash is articulated with services; and to some form of accountability over use, so that the transfer finances care rather than substituting for it. The Attendance Allowance meets none of these three conditions, and it has not met them for forty-five years. What follows is not a distortion of the instrument but its normal operation: the transfer finances the cheapest available private solution, households that purchase it withdraw from public provision, and demand for services remains low enough to justify not expanding them. Santini et al. (2025) find, in this respect, that employing a migrant care worker is associated with a lower probability of using public services. Depletion, in the sense used by Rai et al. (2014), is here not a risk attached to the policy mix but its steady state.

This is also why the reforms examined above matter more than their present scale suggests. Law 33/2023, the 2024 and 2025 decrees and the Prestazione Universale are the first Italian instruments to introduce the three missing conditions, even if for a narrowly defined group and, so far, with very limited take-up. The question raised by the Italian case is therefore not whether integration is the right direction, but whether an architecture designed for approximately 25,000 people can be scaled to a caseload of 2.36 million without resolving the relationship between the new conditional benefit and the old unconditional one, which the reform has so far left untouched.

All things considered, the post-COVID period marks a significant change in the governance and political recognition of Italian LTC. The PNRR, Ministerial Decree 77/2022, Law 33/2023, the 2024 and 2025 implementing decrees and the Prestazione Universale have created a more coherent reform architecture and a clearer orientation towards home- and community-based care. Yet service capacity, recurrent funding and carers' enforceable rights remain weaker than the new institutional framework. Italy has therefore moved beyond institutional inertia, but not yet beyond a familialism that is supported by cash and left unsupported by services. Whether the reform produces a structural transition will depend on its capacity to expand high-quality services, improve care employment and treat informal carers not only as resources for the system, but as citizens with their own social rights and wellbeing needs (Arlotti et al., 2023; Pavolini and Marlier, 2025; Santini et al., 2025).

Table 4. Post-COVID evolution of the Italian LTC system

	ITALY
Care regime and inherited structure	Familialistic and institutionally fragmented. The universal, non-means-tested Indennità di Accompagnamento remains the principal national cash benefit. Regional ADI provides health-related home care, while municipal SAD provides social assistance. Before COVID-19, limited coordination and low service intensity meant that families organised most care themselves, frequently employing migrant badanti. (Ferrera, 1996; Naldini, 2003; Pavolini and Ranci, 2008; Arlotti and Aguilar-Hendrickson, 2018). In 2019 the allowance absorbed 52% of public LTC expenditure against a European average of approximately 26%, while integrated home care accounted for 19.5% against 25.5% (Santini et al., 2025; Social Protection Committee and European Commission, 2021).
Post-COVID reforms	The PNRR and Ministerial Decree 77/2022 strengthen territorial health care, Community Houses, operational coordination and home assistance. Law 33/2023 creates the framework for the SNAA, Single Access Points, multidimensional assessment and personalised care planning. Legislative Decree 29/2024, corrected by Legislative Decree 93/2025, provides the main implementing architecture. (Presidenza del Consiglio dei Ministri, 2021; Ministero della Salute, 2022; Repubblica Italiana, 2023, 2024, 2025). (León et al., 2023; Casanova et al., 2025; Santini et al., 2025).
Support for informal carers	Support remains predominantly indirect through the Attendance Allowance. Law 104/1992 and EU-driven work–life balance reforms protect some employed carers, but pension protection, respite, counselling and training are not nationally guaranteed. A government caregivers bill entered parliamentary consideration in 2026 but had not become law by July. (Repubblica Italiana, 1992; European Parliament and Council of the European Union, 2019; Presidenza del Consiglio dei Ministri, 2026). (Arlotti et al., 2023; Pavolini and Marlier, 2025).
Emerging complementarities and limits	The experimental Prestazione Universale links an additional cash component to regular domestic employment or eligible non-residential services for a narrowly targeted group. It signals movement towards stronger cash-service complementarities. However, regional inequality, workforce shortages, low service intensity and uncertain recurrent funding may prevent governance reform from producing substantial change in everyday care. (Repubblica Italiana, 2024; INPS, 2025; European Commission, 2024; OECD, 2023). (Ranci et al., 2025; Santini et al., 2025; Pavolini and Marlier, 2025). Take-up in the first period has been very low: fewer than 5,000 applications by September 2025, an acceptance rate of 41% and approximately 2,000 beneficiaries, against a target population of some 25,000 and 2.36 million recipients of the Attendance Allowance (Ministry of Labour and Social Policy, monitoring data accompanying the 2026 Budget Law; INPS, 2025).

Source: own elaboration.

9. Spain and Italy after COVID-19: Divergent pathways towards more integrated long-term care

9.1. Common inheritance, different institutional starting points

Spain and Italy entered the post-COVID period with care systems rooted in a common Southern European inheritance: strong family responsibility, highly gendered informal care, limited service intensity and extensive reliance on low-paid, often migrant, care labour. In both countries, public intervention had historically supported rather than displaced familial provision. Yet this shared familialism concealed an important institutional divergence. Spain had already created a national long-term care (LTC) entitlement through Law 39/2006 and the Sistema para la Autonomía y Atención a la Dependencia (SAAD). Italy, by contrast, still lacked an integrated national LTC system: the Indennità di Accompagnamento, regional health services, municipal social care and privately organised family provision operated according to separate logics (Arlotti and Aguilar-Hendrickson, 2018; Pavolini and Ranci, 2008).

This difference shaped the reform context faced after COVID-19. Spain's task was primarily to expand, finance and rebalance an existing universal system whose coverage had grown but whose benefits and services remained too weak to offer a genuine alternative to intensive family care. Italy's task was more foundational: to create a governance architecture capable of coordinating policy instruments that had historically developed in parallel. The contrast between the two countries is between a partially institutionalised familialism in Spain and, in Italy, a configuration closer to what Saraceno and Keck (2010) call familialism by default: public money sustains family care without any institutional mechanism connecting it to services, so that households absorb care needs with their own resources rather than with publicly organised alternatives.

9.2. Post-COVID reform trajectories: expansion versus institutional construction

The pandemic generated different reform trajectories because the institutional starting points differed. Spain concentrated on refinancing, expanding and rebalancing an existing entitlement system, while Italy sought to construct mechanisms capable of integrating previously separate cash, health and social-care provisions. Spain can therefore show more immediate changes in coverage and combinations of benefits, whereas Italy's main post-COVID achievements lie in governance, assessment and coordination. The comparison is consequently one between the deepening of an existing system and the institutional construction of integration.

Territorial inequality remains a common constraint, but it takes different institutional forms. In Spain, autonomous communities implement a common national entitlement and service catalogue, producing variation in waiting times, benefit mixes and service intensity. In Italy, regional differences are compounded by the structural separation of health and municipal social care and by the absence, until recently, of a common national LTC framework. Decentralisation therefore modifies a shared reform agenda differently: in Spain it generates uneven implementation of the same system; in Italy it also affects whether an integrated system exists in practice.

9.3. Expenditure, services and the role of European resources

Comparable expenditure data reinforce the contrast but require careful interpretation. The European Comparable expenditure data reinforce the contrast but require careful interpretation. The European Commission's 2024 Ageing Report estimates public LTC expenditure in the 2022 base year at approximately 1.6 per cent of GDP in Italy and 0.8 per cent in Spain (European Commission, 2024). Italy therefore spends considerably more on this measure. This does not mean that Italian households necessarily receive more comprehensive services. A large part of Italian expenditure is absorbed by the universal and largely unconditional Attendance Allowance, while service availability remains territorially uneven. Spain spends less overall, but its cash benefits are embedded in SAAD assessments and individual care programmes and are increasingly combined with teleassistance, home help and other services.

The difference of composition can be quantified. In 2019 the Attendance Allowance alone absorbed 52 per cent of Italian public LTC expenditure, against a European average of approximately 26 per cent, while integrated home care accounted for 19.5 per cent against a European average of 25.5 per cent (Santini et al., 2025). Public home care in Italy reaches at most 4.7 per cent of the population aged 65 and over (OECD, 2025). The higher Italian ratio therefore measures the size of an unconditional cash transfer rather than the reach of a care system, and the two countries are distinguished less by how much they spend than by whether spending passes through an assessment and an individual care plan.

European resources have been decisive in both countries, although in different ways. In Spain, the post-2021 expansion of recurrent SAAD financing was principally a domestic fiscal decision, while Next Generation EU resources financed capital investment and the transformation of social services. In Italy, the PNRR was more central to the creation of the new territorial and governance architecture. In both cases, however, European funds are temporary and investment-oriented. They cannot substitute for the

recurrent national and regional expenditure needed to staff home care, provide respite, improve wages and maintain community infrastructures. The long-term test is therefore whether EU-supported reforms become embedded in ordinary public budgets.

This assessment should be set in a longer time frame. European involvement in Southern European welfare has not been consistently expansionary. Between 2008 and 2012 European fiscal surveillance exercised its strongest pressure on consolidation and labour market deregulation, and Italian central financing for social care fell by 91 per cent over those four years (Pavolini et al., 2015). The European contribution to care policy has therefore alternated between retrenchment pressure and investment support within little more than a decade, which is itself a reason to treat the durability of the current cycle as an open question rather than as a trend.

9.4. Informal carers and the formal care workforce

Spain provides somewhat stronger formal recognition of informal carers, but PECEF remains low - around EUR 264 per month on average in 2024 - and access to respite, counselling and training is uneven (AEDGSS, 2025; OECD, 2022). As regards Italy, support remains more indirect and the institutionalisation of carers' social rights is less advanced.

The Italian figures make the asymmetry concrete. Approximately 5.8 per cent of the population provides informal care, but 41 per cent of those carers do so for more than 20 hours a week (European Commission and Social Protection Committee, 2021, p. 189), and no national training, respite or skills-validation measures are available to them. At the same time, Italian households employed 817,403 registered domestic workers in 2024, 50.5 per cent of them as personal carers and 68.6 per cent of these foreign nationals (Osservatorio Domina, 2025). The principal Italian response to care need is therefore neither a public service nor an unpaid relative alone, but a privately employed worker financed in part by the care recipient's allowance.

Both models depend on a feminised and undervalued formal workforce. Spain's SAAD expansion has created a large care sector, but wages remain low and staff shortages threaten future service growth. Italy relies heavily on migrant badanti employed directly by households, frequently outside a fully professionalised service system. These are not peripheral labour-market issues: they determine whether home- and community-based care expands carers' choices or merely relocates responsibility to private households. Deinstitutionalisation without adequate staffing, regulation and pay risks reproducing the same low-cost model in a different setting (Asensio et al., 2025; Pavolini and Marlier, 2025; Santini et al., 2025).

9.5. Policy complementarity and multiplier effects

The comparison reveals two distinct routes towards policy complementarity. Spain is moving from single provisions towards more flexible packages within SAAD. The relaxation of incompatibilities and the growth in provisions per recipient suggest stronger interaction between cash benefits, teleassistance and home help. Yet complementarity remains shallow when each component is low in intensity. Several small provisions do not necessarily reduce carer burden, enable employment or generate meaningful choice.

Italy is attempting a more fundamental shift from parallel provision to coordinated pathways. Single Access Points, multidimensional assessment and personalised plans could bring together health, social care and cash support. The Prestazione Universale also experiments with linking cash to regular employment and specified services. However, these mechanisms will have little multiplier effect if the services to which they refer are unavailable or inaccessible. Italy's risk is therefore integration without capacity; Spain's is coverage without sufficient intensity.

Overall, Spain currently stands further along in the practical expansion and combination of LTC support, while Italy has undertaken the more foundational reconstruction of governance. Spain's principal challenge is to deepen an existing universal system through higher and more stable financing, greater service intensity and better employment conditions. Italy's is to translate a new national framework into consistent territorial provision and enforceable support for carers. Despite their different trajectories, both systems continue to rely heavily on women's unpaid care and low-paid migrant labour. Their post-COVID reforms will generate durable multiplier effects only if cash, services, labour regulation and carers' rights reinforce one another rather than continuing to compensate for gaps elsewhere in the system.

Table 5. Comparative summary of post-COVID LTC reform in Spain and Italy

	SPAIN	ITALY
Institutional baseline	National entitlement since Law 39/2006. SAAD combines assessed cash benefits and services through an individual care programme, but remains family-dependent and regionally uneven.	Before Law 33/2023, no integrated national LTC system. Attendance Allowance, regional health care, municipal social services and family provision operated largely in parallel.
Comparable public LTC expenditure	Approximately 0.8% of GDP in the 2022 base year of the 2024 Ageing Report. Lower overall spending constrains coverage intensity and quality.	Approximately 1.6% of GDP on the same measure. Higher spending is partly explained by the large universal Attendance Allowance and does not necessarily imply stronger services. More than half of it is absorbed by the allowance itself: 52% in 2019, against a European average of approximately 26%.
Main post-COVID reform logic	Expansion, refinancing and rebalancing of an existing entitlement system.	Construction of a national governance and coordination architecture.
Principal measures	2021-2023 Dependency Shock Plan; Component 22 investments; Royal Decree 675/2023; 2024-2030 Community Care Strategy; 2026 financing and statutory reforms.	PNRR Missions 5 and 6; Ministerial Decree 77/2022; Law 33/2023; Legislative Decrees 29/2024 and 93/2025; experimental Prestazione Universale.
Cash-service relationship	PECEF is assessed and tied to the individual care programme. Recent reforms relax incompatibilities and increase combinations with teleassistance, home help and other services.	Attendance Allowance is universal, non-means-tested and largely unconditional. Prestazione Universale introduces a narrowly targeted attempt to connect additional cash to regular employment or eligible services.
Support for informal carers	Formal recognition: state-funded Social Security contributions for recognised non-professional carers and expanded work-life balance rights. But benefits remain low and indirect through care recipient's allowance; respite and training are uneven; no comprehensive carers' act.	Support remains indirect through the care recipient's allowance. Employment-based leave protects some workers, but pension protection and nationally guaranteed respite are absent. A carers bill was still pending in 2026.
Care workforce	Large, feminized and migrant based formal sector, but low wages and shortages limit service expansion. Minimum-wage increases behind significant improvements for paid carers.	Heavy reliance on migrant badanti directly employed by households, alongside shortages in professional community services and marked regional variation.
EU role and sustainability	EU funds support infrastructure, digitalisation and community-care transformation; but recurrent SAAD expansion will depend primarily on domestic public financing.	PNRR funding is central to territorial health and governance reform. Long-term success depends on recurrent resources for staff and service delivery after the investment period.
Comparative multiplier assessment	More developed practical combinations, but risk of coverage without sufficient intensity.	More ambitious integration architecture, but risk of integration without service capacity.

Source: own elaboration based on the Spanish and Italian country sections and the references cited therein.

10. Conclusions

The relationship between formal social protection and informal care cannot be understood through a simple opposition between public provision and family responsibility. Informal care is neither an external resource that welfare states can draw upon without consequence nor a residual activity that will necessarily disappear as formal services expand. It is institutionally produced and shaped by the availability of services, income protection and labour-market conditions. The relevant question is therefore not whether formal provision crowds informal care in or out, but whether different policy instruments are effectively implemented, accessible and taken up in ways that allow them to combine to sustain care, protect carers and recipients, and expand their capabilities over time. Policy complementarities may therefore exist in formal design without necessarily materialising in practice.

The concept of multiplier effects captures the cumulative gains that may arise from such combinations. The different social policy measures are not independently additive. Their effects depend on how they interact. Conversely, gaps in one area may undermine advances in another and generate inverse multipliers: labour-market exit, time poverty, declining health, inadequate care and the reproduction of gender and socioeconomic inequalities.

The Spanish and Italian cases demonstrate the value of a configurational approach to the relationship between formal social protection and informal care. Both countries entered the post-COVID period with strongly familialist long-term care systems, in which women continued to provide most unpaid care and low-paid migrant workers filled gaps in formal provision. Yet they did so from different institutional starting points. Spain had already established a national entitlement through the Sistema para la Autonomía y Atención a la Dependencia (SAAD), whereas Italy continued to rely on a fragmented combination of the Indennità di Accompagnamento, regional health services, municipal social care and privately organised household provision. The reform challenge in Spain has therefore been to expand and strengthen an existing system; in Italy, it has been to construct the institutional architecture of an integrated LTC system.

The comparison identifies two distinct but incomplete routes towards policy complementarity. Spain has pursued the expansion and rebalancing of an established entitlement system, whereas Italy has undertaken the more foundational task of constructing an integrated governance architecture. Spain has therefore progressed further in practical combinations of benefits and services within an established entitlement system, but risks coverage without sufficient intensity or quality; Italy has moved further in institutional redesign but risks integration without service capacity. In both cases, weak support for informal carers and reliance on a low-paid, feminised and frequently migrant workforce continue to limit the redistributive potential of reform.

In neither country, however, can service expansion or formal recognition be treated as evidence of multiplier effects in themselves. In Spain, PECEF remains central, benefit levels are low, respite and other direct supports are limited, and work–life balance provisions primarily protect carers who remain attached to formal employment. In Italy, support is even more indirect: families generally rely on the care recipient's Attendance Allowance, while nationally guaranteed pension protection, respite and independent carers' rights remain underdeveloped. In both countries, formal service expansion depends on a predominantly female and frequently migrant workforce characterised by low pay, insecure employment and staff shortages. Greater public recognition of care has therefore not yet produced a commensurate redistribution of time, income and responsibility.

In both cases, territorial inequalities and multilevel fragmentation complicate implementation. European funding has accelerated reform, but much of it is temporary and investment-oriented; it cannot replace the recurrent expenditure needed to finance staff, home-care hours, respite, care coordination and improved employment conditions.

Deinstitutionalisation illustrates particularly clearly why outcomes depend on the wider policy configuration. When accompanied by adequate services, professional support and meaningful

choice, it can enhance autonomy, sustain care at home and reduce pressure on families. When introduced without sufficient capacity, it may simply relocate care from residential institutions to private households, intensifying unpaid work and caregiver depletion. Community care is therefore not inherently empowering: its effects depend on whether responsibility is genuinely shared between the state, services, workers, carers and care recipients.

The Spanish and Italian experiences also clarify both the contribution and the limitations of the European Care Strategy. The Strategy has widened the European understanding of care beyond a narrowly employment-centred rationale and has encouraged recognition of the interdependence between formal services, paid care work and informal caregiving. Yet soft coordination and temporary European investment cannot by themselves produce coherent national systems. Multiplier effects ultimately depend on sustained public financing, enforceable carers' rights, adequate service provision and coordination across policy fields and levels of government.

The broader conclusion is that care-policy performance should be assessed through institutional configurations rather than isolated measures. Success cannot be measured only by expenditure, beneficiary numbers, service coverage or the volume of informal care. It must also be evaluated in terms of meaningful choice, income security, time autonomy, health, service quality and the distribution of care responsibilities. Spain and Italy both show an important change of direction, but they also reinforce the report's central argument: multiplier effects do not arise automatically from recognising informal care or expanding individual programmes. They are an institutional achievement, produced when services, income protection, carers' rights and the regulation of paid care work are deliberately aligned around equitable and sustainable wellbeing.

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