
CARE REGIMES ON THE MOVE
Comparing home care for dependent older people
in Belgium, England, Germany and Italy

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- Table of contents -

- Table of contents -	3
- Table of illustrations -	8
- Abstract -	11
- Introduction and executive summary - Contemporary public schemes in the field of home care in Belgium, England, Germany and Italy	13
1. <i>Objectives of the research</i>	13
2. <i>What is home care for dependent older people?</i>	14
3. <i>“Care regimes” – a useful category of analysis</i>	16
4. <i>Home care reforms in Europe</i>	17
4.1. Reforming “what” services are provided	17
4.2. Reforming “how” services are organised	18
4.3. Belgium, England, Germany and Italy under tight scrutiny	19
5. <i>Methodological aspects of the research process</i>	20
6. <i>How is this report organised?</i>	20
6.1. Rationales of care reforms	21
6.2. Plural economy and welfare mix	21
6.3. Performance	22
6.4. Gender contract	22
6.5. Transnational path departure and reciprocal influence of national care reforms	22
7. <i>Key results of the research</i>	22
7.1. Rationales of home care	22
7.2. Variations in the targeting of home-based support for dependent older people across Europe	23
7.3. Multilevel governance of home-based support: does it induce regional disparities and hinder innovation?	24
7.4. The process of marketisation in home care	25
7.5. The use of formal and informal care by dependant older people based on information from the Share database on individual’s care arrangements	26
7.6. Variations in measuring and improving performance in home care services: the degree of marketisation matters	27
7.7. Analysis of the gender aspects of care reforms: moving towards different worlds of defamilialisation	28
7.8. Are we witnessing path departure in national care regimes?	29
8. <i>General conclusions</i>	30
8.1. Do the different care regimes foster a universal provision of home care services?	31
8.2. Do the different care regimes foster “best value” for money in care delivery?	32
8.3. Do the different care regimes improve the quality of care and employment?	32

- Note on publicly funded home care schemes: key features -	34
1. <i>England</i>	34
1.1. A highly standardised, “in kind” provision of social care, operating as a quasi-market	34
1.2. The rise of Personal Budgets.....	35
1.3. Social security cash allowances	35
2. <i>Italy</i>	35
2.1. The central role of cash for care allowances	36
2.2. Incentives to regularise home care workers	36
2.3. Fragmentation of the home care market.....	36
3. <i>Germany</i>	38
3.1. Long term care insurance: tied cash fostering a regulated para-medical care	38
3.2. Heavy reliance on informal care networks.....	38
3.3. A complement to long term insurance: means-tested local “in kind” provision	39
3.4. Conditional cash benefits as incentives to regularise home care workers	39
4. <i>Belgium</i>	39
4.1. A tutelary regulation of home care services	39
4.2. Cash for care allowances.....	40
4.3. The service voucher: a quasi-marketisation of housework	40
- Chapter 1 - Reflecting on discourses at times of reforms: The main rationales mobilized in debates around home care (1990-2010).....	42
1. <i>Introduction</i>	42
2. <i>Methodology</i>	43
3. <i>Why reform?</i>	44
3.1. The centrality of the “ageing” argument	44
3.2. Seeking “best value” as a driver of reforms	45
3.3. The opportunity to enhance user’s empowerment.....	46
3.4. Discourses supporting “diversification” of providers and funding	48
4. <i>What is “best care”?</i>	52
4.1. Issues of solidarity and equal access	52
4.2. Achieving “best care” through reforms: family in relation with other types of providers	53
5. <i>Conclusions: tensions in the care regimes revealed by their rationales</i>	57
- Chapter 2 - Variations in the targeting of home-based support for dependent older people across Europe	
1. <i>Introduction</i>	61
2. <i>Methodology</i>	62
3. <i>Key components of National systems</i>	63
3.1. Belgium.....	63
3.2. Italy	65
3.3. Germany.....	67
3.4. England	71
4. <i>Inter country differences in home care support</i>	73
5. <i>Policy implications</i>	76

- Chapter 3 - Multilevel governance of long term care: does it induce lower coverage rates and so hinder innovation?	84
1. Introduction.....	84
2. Long term care systems	86
3. European Care states and regional variation	87
4. National coverage rates in the different countries	87
5. A comparative analysis of the coverage rates	88
6. The relationship between regional resources and performance	90
7. Growth and innovation at regional level and national levels	92
8. The coherence of the policy and the supply for the elderly	95
9. Conclusion.....	96
Appendix 1: technical appendix to Table 1	97
Appendix 2: technical appendix to the regression analysis.....	99
- Chapter 4 - The process of marketisation in home care	103
1. Introduction.....	103
2. Methodology.....	104
3. The mixed economy of supply.....	106
4. The impact of competition: price versus quality.....	109
4.1. Entry barriers.....	110
4.2. Different channels for competition	111
4.3. The governance of the trade-off between price and quality	114
5. Who pays for care?.....	115
6. Concluding remarks	119
- Chapter 5 - The use of formal and informal care by dependent older people: Empirical evidence from the Share database on individual care arrangements.....	121
1. Introduction.....	121
2. Individual care arrangements: a welfare mix approach	122
3. Methodological aspects and sample description.....	125
3.1. The Survey on Health, Ageing and Retirement in Europe (Share)	125
3.2. The target population	126
3.3. Variables of interest	126
3.4. Methods.....	129
3.5. Sample description	131
4. Care arrangements in Belgium, Germany and Italy	135
4.1. No care	137
4.2. Informal care only	137
4.3. At least formal care	137
4.4. Use of care and gender	139
5. Determinants of care arrangements.....	139
6. Conclusions: some methodological issues raised by the analysis.....	142

- Chapter 6 - Measuring and improving performance in home care services: A four country comparison	
1. Introduction.....	145
2. What is performance?	145
3. Case Studies	149
3.1. Belgium.....	149
3.2. England	151
3.3. Germany.....	154
3.4. Italy	156
3.5. Summary	157
4. Discussion	159
5. Conclusion.....	163
- Chapter 7 - A cross-national analysis of the gendered aspects of care reforms. Towards different worlds of defamilialization	
1. Introduction.....	164
1.1. What is defamilialization?.....	164
2. The gendered background of the reforms.....	167
2.1. Main features of the “gender contract”	167
2.2. Gender equality in LTC: a rationale for reform?.....	174
3. Sustaining the unpaid informal caregiver	175
3.1. Combining elderly care and work	175
3.2. Incentivizing informal care through routed wages and carer’s allowance	177
4. The professional paid carer’s autonomy.....	180
4.1. Care markets	180
4.2. Migrant carers in paid care.....	186
4.3. Defamilialization alongside deprofessionalization?	188
5. Issues regarding defamilialization of the cared-for	190
6. Conclusions: Towards composite worlds of defamilialization	190
- Chapter 8 - Transnational path departure An “open method” of comparing change in European home care regimes.....	194
1. Introduction.....	194
2. Comparing evolving welfare systems with an open method.....	196
3. Home care regimes on the move: National case studies and their comparative message(s).....	198
3.1. Germany.....	199
3.2. England	201
3.3. Belgium.....	202
3.4. Italy	204
3.5. Evolutionary dynamics from a cross-country perspective	206
4. Conclusion.....	208
- Annex 1 - Methodological guidelines of the research	210
1. Introduction.....	210
2. The establishment of tenders for service providers	211
2.1. A highly standardised home care quasi-market in the UK	211

2.2. The marketization of home care based on informal care and on heterogeneous local quasi-markets in Italy	211
3. <i>The establishment of competition between providers through the funding of the demand</i>	212
3.1. The service vouchers (“titres-services”) in Belgium: a quasi-marketization of house work embedded in a tutelary regulation of home care services	212
3.2. Dependency insurance in Germany, establishing a regulated market of care – primarily para-medical – services	213
4. <i>Analytical framework and research questions</i>	214
Axis 1: Plural economy and welfare mix	217
1. <i>Definition</i>	217
2. <i>Operationalization</i>	220
3. <i>Conclusions and important issues</i>	226
4. <i>Further readings</i>	228
Axis 2: Gender contract	230
1. <i>Definition</i>	230
2. <i>Operationalisation</i>	233
3. <i>Conclusions and important issues (1 page)</i>	240
4. <i>Further readings</i>	241
Axis 3: The rationales of care reforms	243
1. <i>Definition</i>	243
2. <i>Operationalisation</i>	244
3. <i>Conclusion (+/- 2 pages)</i>	250
4. <i>Further readings</i>	250
Axis 4: Performance	251
1. <i>Definition</i>	251
2. <i>Operationalization</i>	253
3. <i>Conclusion</i>	256
4. <i>Further reading</i>	256
- Bibliography -	257

- Table of illustrations -

Table 0.1: Key targeting-related characteristics of community support schemes.....	41
Table 1.1: Lead role and central character in “best care”	57
Table 1.2: Rationales related to care reforms as expressed in national contexts	59
Table 2.1: Definitions of care levels for long term care insurance	68
Table 2.2: SLTCI benefits in services and cash (monthly, euros)	69
Table 2.3: Data sources: Belgium	81
Table 2.4: Data sources: Italy	82
Table 2.5: Data sources: England.....	82
Table 2.6: Data sources: Germany	83
Table 3.1: National Long Term Care System: mean and regional variation in uptake by 65+ of Care In Kind and Cash benefits in the four countries.....	89
Table 3.2: Regression analysis on Uptake Home Care 65+: England	99
Table 3.3: Regression analysis on Uptake Personal Budget 65+: England	99
Table 3.4: Regression analysis on Uptake Social Security Benefits 65+: England	99
Table 3.5: Regression analysis on Uptake Home Care 65+: Germany	100
Table 3.6: Regression analysis 1 on Uptake Residential Care 65+: Germany.....	100
Table 3.7: Regression analysis 2 on Uptake Residential Care 65+: Germany.....	100
Table 3.8: Regression analysis 1 on Uptake Long Term Insurance 65+: Germany.....	100
Table 3.9: Regression analysis 2 on Uptake Long Term Insurance 65+: Germany.....	101
Table 3.10: Regression analysis on Uptake Regional Cash for Care 65+ corresponding figure 1: Italy	101
Table 3.11: Regression analysis on Uptake Home Care 65+ corresponding figure 1: Italy ..	101
Table 3.12: Regression analysis on Uptake Residential Care 65+ corresponding figure 1: Italy	101
Table 3.13: Regression analysis 1 on Uptake Social Security Benefits corresponding figure 1: Italy	102
Table 3.14: Regression analysis 2 on Uptake Social Security Benefits corresponding figure 1: Italy	102
Table 4.1: The supply of home care services	106

Table 4.2a: Who pays for home care? Home care expenditure in England for individuals aged 65+ years (absolute and %) (£m).....	116
Table 4.2b: Who pays for home care? Home care expenditure in England for individuals aged 65+ years (Per cent of total expenditure).....	116
Table 4.3a: Who pays for home care? Long term home care expenditure in Germany and Belgium (absolute) (€m).....	116
Table 4.3b: Who pays for home care? Long term home care expenditure in Germany and Belgium (%)	117
Table 4.4: Long term home care expenditure in Italy > 65 years (absolute and %) (€m)	117
Table 5.1: The proxy variable for formal and informal care.....	127
Table 5.2: Sample description.....	131
Table 5.3: Number of difficulties by country and gender (weighted).....	132
Table 5.4: Difficulties encountered by adults 65+ by sex and country (in %).....	133
Table 5.5: Mean proportions (%) of living conditions by country and gender (weighted)....	135
Table 5.6: Multinomial logistic regression model for care arrangement	140
Table 5.7: Probability of receiving any care (Logit Model)	141
Table 6.1: A summary of performance assessment across the four countries	158
Table 7.1: Female earning and employment model	172
Table 7.2: Elderly care obligation is placed on women	173
Table 7.3: Tools to support informal carers : summary	179
Table 7.4: Working in care: summary.....	187
Table 7.5: Principal characteristics of the defamilialization process	191
Table 8.1: Key characteristics and developments in European home care regimes	205
Table 8.2: Dynamics of change in a cross-country perspective.....	207
Figure I.1: Mapping care practices from personal care to social care.....	15
Figure 2.1: Monthly state expenditure on “social care” support for older people, per older person	74
Figure 2.2: State support (average net expenditure and percentage of the older population covered) for dependent older people in Flanders	78
Figure 2.3: State support (average net expenditure and percentage of the older population covered) for dependent older people in Wallonia	78

Figure 2.4: State support (average net expenditure and percentage of the older population covered) for dependent older people in Italy	79
Figure 2.5: State support (average net expenditure and percentage of the older population covered) for dependent older people in Germany	79
Figure 2.6: State support (average net expenditure and percentage of the older population covered) for dependent older people in England	80
Figure 3.1: Correlations Italy	92
Figure 4.1: The process of marketisation	105
Figure 5.1: Care arrangements: a welfare mix approach	124
Figure 5.2: Number of difficulties by gender in Belgium, Germany and Italy	134
Figure 5.3: Care arrangements (% , total and by sex)	136
Figure 5.4: Detailed care arrangements.....	138
Figure 6.1: POW diagram	147
Figure A1.1: Care as a social construct.....	219
Figure A2.1: Operationalisation of the concept of gender contract through three dimensions and two levels.....	233
Figure A4.1: The set of factors relevant to the analysis of performance in social care services	253

- Abstract -

Taking the reforms of the 1990s as its starting point, this report examines the dynamics of change experienced by Belgium, England, Germany and Italy in their home care sectors. Central to our analysis is the process of “marketisation”. This constitutes one of the major trends in all these four countries, yet its nature and impact show important national variations.

The data referred to in this report relate to developments in and around various home care sectors, and cover both societal and organisational dynamics. Country-based research teams gathered the information, each team following identical methodological guidelines.

After a brief description of the main public home care schemes in the four countries (set out in a preliminary chapter), this report uses official documents and grey literature from the care sector to analyse the discourses underpinning reforms in the field (Chapter 1). Chapter 2 compares national processes for setting and implementing service eligibility policies (covering eligibility by need and through financial means-testing), and their implications as demonstrated by quantitative indicators of population coverage and intensity of provision. In addition, the analysis contrasts key features of the support provided, such as: whether the resources are provided in cash or through services “in-kind”; the extent of user choice over the type of service and of provider commissioned; and the existence of systematic processes for assisting individuals in the design of their support plans. Chapter 3 addresses the question of whether the increasing multi-level governance of home-based support has induced regional disparities and/or hindered innovation. Chapter 4 looks at the channels of marketisation, one of the key trends that has affected the “personality” of European care regimes. We first examine the impact of marketisation through the lenses of the evolution of the welfare mix. Then, in order to assess its effects on the final user, we investigate how the “market” works. Finally, given these features, we analyse how the process of marketisation affects the cost paid by users. Chapter 5 looks at the welfare mix as applied to care arrangements at the individual’s level in Belgium, Germany and Italy. It examines the way dependant older people and their families cope with the need for care and how they combine formal and informal care¹. The Share database, that gives information on older people’s living circumstances, will be used to identify the determinants of care use. Performance assessment is playing an increasing role in the governance of home care services in Europe. Chapter 6 discusses the consequences of performance assessment on the governance of the home care sector. The aim of this chapter is to explore how widely performance measurement and assessment techniques are being used within home care and to analyse their role in the context of differing system objectives and structures. Chapter 7 discusses the gender related aspects of these reforms and, in particular, looks into their impact in terms of defamilialisation on family care givers,

¹ Care is *formal* if there is an explicit and recognized contract in the public sphere between the cared-for and the care-giver (direct employment) or between the cared-for and the home-care service. Care is *informal* if it is the object neither of an explicit contract nor of any recognition in the public sphere (help given by a member of the household or a close relative outside the household for example). Care is *semi-formal* when it is provided by so-called “informal carers” who receive compensation as care providers either through cash for care schemes or tax benefits.

professional care givers and cared-for. The final chapter (chapter 8) deals with the issue of converging (or diverging) care regimes in Europe by applying the “open method” of comparing institutional change to the four countries under study. The question of whether care regimes are or not embracing a *transnational path departure* is explored.

The conclusions of this research will be of relevance for any country or region struggling to design a home care system for an ageing population. The coordinators of this research project have submitted a proposal for a special issue of *Ageing and Society* based on the main chapters of this report. Authors of the chapters will also submit articles to a range of journals.

Key words

Dependant older people, Care regime, Home care, Quasi-markets, Cash for care

- Introduction and executive summary² -

Contemporary public schemes in the field of home care in Belgium, England, Germany and Italy

1. Objectives of the research

In response to population ageing in many European countries, long term care (LTC) for dependant older people has evolved considerably over the past two decades. However, costs containment objectives and the influence of New Public Management³ discourses about the “inefficiency” of public spending have been important sources of tensions during this reform process (Ferlie, Linn & Politt, 2007).

In this context, different market-oriented reforms have characterised the recent restructuring of publicly funded home care: (1) the increasing contracting out of home care services and the consequent shift in the balance of provision from in-house provision to outsourced provision (by private “for profit” or “not for profit” providers) (Daly & Lewis, 2000; Pavolini & Ranci, 2008); (2) a shift towards the direct purchasing of care by individuals and their families through the public transfer of cash payments (Ungerson, 2005; Ungerson & Yeandle 2007; Da Roit, 2010; Rostgaard, 2011) or vouchers (Bode, Nyssens & Gardin, 2010); and (3) a greater reliance on the private funding of care by individuals and their families (Shutes et al., 2011). These trends mean that not only the organisation, but also the overall philosophy of LTC, is progressively changing. A shift towards more competition among providers and an individualisation of service supply can be observed almost everywhere in Europe, alongside an emphasis on the empowerment of the user, who is increasingly considered as a client or “customer” (Pavolini & Ranci, 2009).

The objective of this research is to study the responses of European states to the need for home care, starting from the reforms they have undertaken in this field over the past two decades. It also aims to identify the patterns of evolution of contemporary *regimes of care* in the light of these recent changes and, more specifically, in the context of growing marketisation. Our general hypothesis is that the trend of marketisation has had a differentiated impact on national care regimes.

² This Introduction also serves as an Executive Summary. It includes a short introduction, an outline of the theoretical framework and methodology, and presents the main results of the research. All references are included in the general bibliography at the end of the report.

³ New Public Management (NPM) is a policy-orientation originating in the 1980s which aims at reforming the public sector. The basic tenet of NPM is that market-like management of the public sector will lead to increased cost-efficiency, without jeopardizing its missions.

2. What is home care for dependent older people?

Our research focuses on public schemes that provide home care *services* or *cash* to support dependent older people aged 65 and over living in their own homes (known in French as “personnes âgées dépendantes à domicile”).

“Care” refers to the activities and relationships involved in meeting the physical and emotional requirements of dependent adults and children. These requirements can be temporary or permanent, as in the case of adults whose conditions require constant supervision and LTC. LTC is defined as “*a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL) (...)*” (OECD, 2009).

In our research, we have focused on LTC, whether it is delivered “in kind” or through “cash for care” schemes. We are conscious that there are also aspects of care that include various other dimensions – which bring in emotional and ethical issues (Paperman, 2005; Martin, 2008) – but these are beyond the scope of our research. Our work spans the issues that are central to the current debate in ageing societies: demand for LTC is increasing; it can be provided both by families and professionals; it is less standardised than medical services; and services are usually provided by low qualified, mostly female, workers.

There have been long-running semantic debates about the use of terms like “home care”, “community care”, “personal care” and “social care”. “Home care” and “community care” are often considered synonymous in the anglo-saxon literature, and it can also be difficult to define the demarcation lines between “social care” and “personal care”. One of the key issues is therefore to consider whether the use of these distinct terms brings any added value to the analysis, or whether it simply sows confusion, and whether for the purposes of comparative analysis the reality covered by these terms is sufficiently explicit that comparisons can be undertaken with non Anglo-Saxon contexts. This report uses different terms because we believe it helps render the diversity of material realities and practices of care.

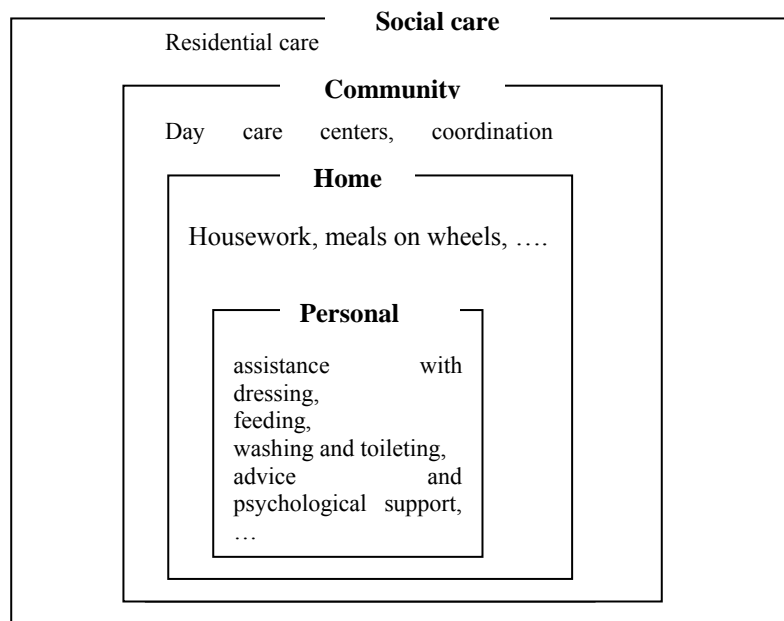
“Home care” (sometimes also called “domiciliary care”) covers all activities that are undertaken in the home where the dependent older person usually lives, with the objective of enabling “*people to stay in their own homes as long as possible*” (Jamieson, 1991: 7). We take the term to cover both “personal care”, which includes services such as assistance with dressing, feeding, washing and toileting, as well as advice, encouragement and emotional and psychological support and help with instrumental activities of daily living such as “housework” (or home help) and the preparation of meals. Housework (or home help) refers to chores relating exclusively to objects, such as cleaning, doing the laundry, etc ...

We also examine services provided outside the user’s home, such as day care, and their coordination as they both help to maintain disabled old adults in the community. In some countries, the range of services aimed at supporting individuals, at home or in institutions, with personal and instrumental activities of daily living is referred to by the term “social care

services”. The term “community care” is used to refer to those social care services provided outside of institutions.⁴

In our research, “home care” excludes medical and paramedical home care (such as nursing). The dividing lines between these categories are however sometimes blurred since these categories are “socio-political” constructions. For example, in some countries, toileting may only be provided by nurse, while in others it is part of home care. We are also aware that the demarcation between personal care and housework is also often difficult.

Figure I.1: Mapping care practices from personal care to social care



Our research includes “cash for care” schemes. These are defined as all financial transfers, at the regional or national level, designed for older dependent adults. This covers social security transfers, and schemes where users can choose between “cash for care” or “in kind” services, or a combination of both. In some countries, a care manager establishes a care plan with the user, in others, users are entirely free to spend the money as they choose. Therefore, cash can be deployed to meet a wide variety of needs. When the cash transfer is a pure monetary transfer without any restrictions over its use, purchases do not have to be limited to home care, but can be spent on a range of home care, home nursing, residential care or other types of services.

⁴ *Community care* was at the centre of various critiques in the 80s. Some of these came from feminist research arguing that community was a euphemism for “women” as “*in practice community care equals care by the family and in practice care by the family equals care by women*” (Ungerson, 1987). Jamieson (1991) along with Higgins (1989) argue that community care is understandable in an English context but too complicated to operationalise as a comparative category. Instead, here it is used to refer to social care services provided outside residential settings, including services provided outside the user’s home such as day care services, as they help to maintain disabled older adults in the community.

3. “Care regimes” – a useful category of analysis

Based on different theories and empirical studies on care, many uses and implicit definitions of the “care regime” concept can be identified (Letablier, 2001; Duffy, 2005, Himmelweit, 2007; Martin, 2008). A closer observation, however, distinguishes two levels of analysis: “micro” and “macro” (Martin, 2008). On the former, an obvious interest in care relations emerges from the literature. Micro-level studies of care help to rehabilitate the reality of human (inter)dependence (Paperman, 2005) and the virtues of solicitude (Sevenhuyzen, 1997; Brugère, 2008). The “micro” level tends to generate research on care relations on different forms and practices of care and on their discourses. This level touches on the issue of the norms and values underlying public as well as individual actions in terms of care.

Since the State is assumed to ensure a certain level of well-being to men and women at the individual level, care is one of a state’s many prerogatives. One can thus identify a second perspective, oriented towards the “macro” level, where research tries to understand how care is produced and distributed and to what extent it is a category of analysis of the welfare state (Daly & Lewis, 2000; Daly & Rake, 2003). In this case, political, economical and social structures are at the forefront of investigation.

In the literature, the social politics of care are increasingly being studied using the concept of “care regime” which is part of the “macro” perspective. It helps to demonstrate how regulations at the national level are affecting the share of care between formal and informal providers (Bettio & Plantenga, 2004), between family, market and state (Evers & Svetlik, 1993; Lewis, 2002; Degavre & Nyssens, 2008). Care regimes put “*care (caregiving and care receiving) at the center of any analysis of [the] welfare state*” (Knijn & Kremer, 1997: 328) and can be considered as the “*caring dimension of the welfare state*” (Knijn & Kremer, 1997: 329). This dimension includes the right to receive care (through measures in favour of home based care) and the right to time for care (through exemptions from the obligation to work, direct payments, care leave, and part-time work). For Kofman and Raghurma, “*care regimes can be conceptualised as the institutional and spatial arrangements (locations) for the provision and allocation of care*” (2009: 4).

A quick look at the historical background is necessary to understand the full meaning of “care regime” and to appreciate its heuristic value. In an early article by Lewis and Hobson (1997), “care regimes” refer to the situations of single mothers in different welfare states in Europe in terms of socio-economic resources. Bettio and Plantenga (2004) extend the concept to cover all actors and devices that contribute to provide assistance to people. They distinguish between care regimes privileging formal or informal care. Although the border between the two is porous, informal care regimes support generally unpaid care provision by relatives without a legal contract, and paid undeclared care work. The other type of care regimes support formal care provision governed by a legal contract and generally part of a wider social policy programme in the field of care. As an analytical tool care regimes have a strong institutional dimension, to the extent that they incorporate the set of measures developed by public authorities to “produce” care and show thus the care strategies implemented in various countries.

The analytical power of the care regime concept comes precisely from putting side by side all public policy measures that are directly or indirectly oriented towards care. It is also particularly effective for making comparisons between states and facilitating their classification within a typology. The types and amounts of resources mobilised for the purpose of home care, as well as the discourses around the state's prerogatives or around which actors should provide care and how, help to constitute care regimes. The concept of care regimes is the starting point of the methodology that has been applied in our research.

4. Home care reforms in Europe

Comparative literature on LTC has been flourishing since 2000 and has produced evidence of a European convergence in terms of care regimes. Even if European countries vary overwhelmingly in terms of their traditions, they have reformed their systems along more or less similar lines: through introducing a mix of “in kind” and “in cash” (either tied or not) provision, the quasi-marketisation of care services, promoting a client-oriented approach, through the use of less standardised care packages, and focusing on informal caregivers (Lewis, 1997; Pavolini & Ranci, 2008; Rostgaard, 2011). The need throughout Europe to constrain the costs of public policies, combined with the acceptance of the New Public Management discourse, is usually considered an explanation for these similarities.

At the centre of our research are public policies that relate to home care, and how they aim to maintain dependent adults at home. Here we present a brief summary of the key components of public interventions in this area.⁵ Although each country has taken a slightly different reform path, a number of common trends can be identified. Across European countries the reform process tended to lead to changes in “what” services are provided and in “how” they are organised.

4.1. Reforming “what” services are provided

In recent years, avoiding unnecessary entry into residential care has become a central objective of many care systems across Europe. As a consequence, many Western European countries have increasingly sought to provide, as far as feasible, care services in the homes of older people. This focus on community-based care has been argued for on the grounds that most individuals prefer to stay in their own homes and wish to delay entry into residential care for as long as possible. Importantly, however, the rationale for supporting people in their own homes is also linked to the lower costs of community-based care. In other words, home care and other community-based services have been seen as a way of improving user satisfaction while also helping to contain public social care expenditure.

⁵ The details of the schemes are presented in the next chapter.

The last 10 years have also seen a marked increase in the use of cash-based schemes to allocate support to disabled people (Ungerson, Yeandle et al., 2007). As with the focus on community-based services, the emphasis on cash meets a double objective. On the one hand, cash is often seen as a mechanism for promoting bottom-up, user-led services. This type of programme consists of cash transfers to the beneficiaries and their families which they can spend in different ways depending on the specific programme, but which are mainly used either to purchase professional services or to pay informal caregivers. While these schemes vary widely in their specific forms across Europe (Da Roit & B. Le Bihan, 2010; Da Roit, B. L. Bihan & Osterle, 2007), the provision of cash is seen as a way to foster greater consumer choice and to improve the general responsiveness of the system to the needs and preferences of dependent people. The key goal is to maximise independence and choice for service users and their carers. This covers the choice between formal and informal care provision, the choice of type of providers, and offers opportunities to reduce the care burden of family carers through hiring additional help.

Advocates of direct payments argue that by transferring control for the commissioning process to service users themselves, services become increasingly “personalised” and therefore better tailored to the wishes and preferences of individual care users, which in turn leads to improved outcomes. In addition, it is argued that users are often best placed to commission from a wider pool of supply of support services and can be more creative in terms of “tapping into” local resources such as their network of family and friends in order to get support at a more cost-effective price than through traditional formal services. Cash systems have therefore been presented as a possible way to help contain the growth in social care expenditure while also improving the empowerment of service users and their families.

4.2. Reforming “how” services are organised

Traditionally, the state has been the main provider (through direct provision) or has delegated – sometimes partially – the provision of care services to non-profit organisations (“associations”) entrusted with a public service mission under direct oversight from the state. In these configurations, the state is seen as a “tutor” and “agent” of the service user, in charge of protecting his/her interests, for instance by developing regulatory mechanisms (such as compulsory minimum standards) to guarantee the quality of the services provided.

Public regulation in the field of social services has been criticised for generating productive inefficiencies (too many resources used for the system’s administration), allocative inefficiencies (inadequate consideration of the users’ interests) and unfairness (Bode, Gardin & Nyssens, 2011).

With the aim of tackling these inefficiencies, many European countries have reformed the governance arrangements of their social care system in line with the recommendations of the New Public Management doctrine (Pollitt, 1986). As a result, since the 1980s, a series of reforms introduced various market principles and incentives within the public sector, such as the client-based approach or the management of services and organisations via the evaluation

of results (outputs). In the health and social care sectors, quasi-markets have been introduced as an instrument for achieving greater efficiency in the delivery of care services (Knapp & Wistow 1999; Knapp, Hardy & Forder, 2001). Although far from monolithic in the literature (Bode et al., 2011), the quasi-market concept is at its core characterised by a separation between the roles of funder and of provider of services (Le Grand, 1991): in practice, the state often continues to assume the financing of services, but is no longer the only provider. Other providers, belonging to the public or the private sector, whether “for profit” or non-profit, can compete to provide the service. In the countries where state (“in house”) providers played a dominant role, governments have sought to disconnect them institutionally from their funding departments or to outsource their activities. Elsewhere, the “terms of trade” between funders and providers have been transformed by rewriting the contracts to be agreed between funding agencies and independent providers. Beyond this, care recipients (or their families) have been encouraged, in some cases, to behave like consumers by using state allowances or vouchers to purchase services according to their own preferences. Whatever the regulatory approach, however, competition among providers became a crucial element for generating incentives to improve efficiency in the use of resources.

The precise form of the recent reforms about “what” and “how” services are delivered has varied across European countries, in line with factors such as cultural identity (e.g. social expectations about informal care), socio-economic, demographic and budgetary circumstances, historical models of welfare state organisation (e.g. Bismarckian models vs. the Anglo-Saxon tradition) and local attitudes towards the use of *market* mechanisms to deliver public services.

4.3. Belgium, England, Germany and Italy under tight scrutiny

Four European states and their regions are the focus of this research: Belgium, England, Germany and Italy. This set contains: one “liberal” welfare state (England); two continental-corporatist welfare regimes, albeit with very different orientations in the provision of welfare – Belgium being much more service-led than Germany; finally, Italy, characterised as a “familiastic” welfare state relying mostly on financial transfers.⁶ None of these countries is really a “newcomer” (Burau, Theobald & Blank, 2006: 2) in the field of long term care and they have all experienced major reforms in the field of home care in the last 20 years in order to respond to growing and changing needs.

⁶ In order to be complete, one of the Nordic and East-European countries should have been included in the study. For practical reasons, it was not possible in the framework of this research. Please refer instead to ROSTGAARD, T.(2011), *LIVINDHOME: Living independently at home*, SFI – The Danish National Centre for Social Research, 252p.

5. Methodological aspects of the research process

As mentioned earlier, the research theoretically relies on the concept of “care regimes” and intends to demonstrate how these regimes transformed as a result of reforms. While the term is increasingly present in the literature, it remains to a large extent unstabilised regarding its definition and dimensions or parameters. We implement the care regime concept through four “axes” which served as a framework for the data collection⁷:

1. Rationales of care reforms: the discourses underpinning reforms as present in official documents or care actors’ grey literature
2. Plural economy and welfare mix: the changing roles of the state, the market, the third sector and families following the reforms
3. Performance of care: assessment systems in each country
4. Gender contract: women as carers, professional, familial or informal, and the possible consequences of the reforms for gender inequalities

The data referred to in this research report cover developments in and around various home care sectors, looking at both societal and organisational dynamics.

The project included teams from various parts of Western Europe (Belgium, England, Germany and Italy), who compiled qualitative and quantitative data on national home care regimes which were then discussed during joint seminars. National experts mapped each given care regime in a (context-sensitive) “case story”, in line with a number of mutually agreed research questions (the “methodological guidelines”). While the data used for composing these stories were often quantitative in kind, the research process included qualitative assessments of the meaning behind these (often highly culturally specific) data. The group then turned to comparative analysis by cross-checking the characteristics “synthesised” from the information provided in these case stories. This was accomplished by researchers from other teams discussing the national “case stories” during joint seminars. Moreover, each research team was multi-disciplinary, and this ensured an inter-linkage of approaches from economics and sociology. Hence, the overall international team embarked on a variety of participant observations conducted according to Barbier’s methodology (2002: 195) in order to map cross national differences within a common analytical framework.

6. How is this report organised?

The report starts with a preliminary chapter summarising the main public policy measures implemented in home care since 1990 in Belgium, England, Germany and Italy. The core of the report is then organised along the four axes mentioned earlier: rationales of home care, plural economy and welfare mix, gender contract, performance and, as a concluding chapter, the transnational path departure of regimes of care.

⁷ These axes are further detailed in the “Methodological guidelines” (see annex).

6.1. Rationales of care reforms

Chapter 1 focuses on the rationales of care reforms. After describing the main public schemes in home care in the four countries, we analyse the discourses underpinning the reforms that occurred in the field as evidenced by official documents and care actors' grey literature.

6.2. Plural economy and welfare mix

Place of the State

Chapter 2 compares the national processes for setting and implementing (through needs assessment and means-testing) eligibility criteria and their implications in terms of what quantitative indicators reveal about population coverage and intensity of service provision. In addition, the analysis contrasts key features of the support provided, such as whether the benefits are offered in cash or “in kind”, the extent of user choice over the type of service and over the provider, and the existence of systematic processes for assisting individuals to design their own support plans.

Chapter 3 seeks to answer the question of whether the increasing multilevel governance of home-based support has induced regional disparities and/or hindered innovation as has been argued by Kazepov (2010). It considers how issues of quality are currently at the forefront of national public debates, some countries having made substantial steps towards assessment of home care services.

The place of the market

Marketisation is, according to the literature, a key trend that has affected the “personality” of Europe's care regimes. Chapter 4 looks into the channels of marketisation. The analysis shows this shift to be nuanced, however, by considering its very nature and the impacts in each of the countries under study. First, we examine the impact of marketisation through the lens of the evolution of the welfare mix. Then, in order to assess its effects on the final user, we investigate how the “market” works. Finally, given these findings, we analyse how the process of marketisation affects the cost paid by the users.

The welfare mix as applied to care arrangements

Chapter 5 looks into the way dependant older people and their families cope with the need for care and how they combine formal and informal care. The aim here is precisely to examine how care arrangements vary according to individual determinants and national contexts by using the Share database.⁸

⁸ The SHARE database (“Survey on Health, Ageing and Retirement in Europe”) contains information on individual life circumstances of adults aged 50 and over in 11 European countries. The survey deals with different aspects of adults' living conditions and well-being before and after retirement.

6.3. Performance

Performance assessment is playing an increasing role in the governance of home care services in Europe. Chapter 6 discusses the consequences of the adoption of performance assessment procedures on the governance of the home care sector. The aim of this chapter is to explore how widely performance measurement and assessment techniques are being used within home care and to analyse their use in the context of differing system objectives and structures.

6.4. Gender contract

According to the literature, families have remained the backbone of care arrangements in most European countries. Family carers – among whom a large majority are women of working age – exemplify the high individual costs of the burden of care. The question arises whether recent reforms have sought to compensate for this high cost or not. Chapter 7 discusses the gender aspects of the reforms and, in particular, looks at the impact they have had in terms of defamilialisation.

6.5. Transnational path departure and reciprocal influence of national care reforms

A concluding chapter (Chapter 8) asks whether Europe's care regimes are converging or diverging. It applies the "open method" of institutional change comparison to the four countries under study. The question whether care regimes are, or are not, embracing a *transnational path departure* is explored.

7. Key results of the research

7.1. Rationales of home care

Chapter 1 aims to reconstruct "rationales" that emerge as "*programmatic conceptions and idioms used in political debates*" about elderly care and to reflect the way in which care-related "*social relations (...) in society are perceived*" (Bussemaker, 1998: 72). Rationales of reforms, either criticising or justifying the transformations that have occurred, are interesting for contextualising the basis on which decisions are made and political orientations are chosen in the home care domain. They highlight the choices that were made at a particular moment and give indications of what various actors consider as "best care".

In this chapter, we present the main rationales that are active in Belgium, England, Germany and Italy through the study of a series of official documents as well as grey literature. Rationales either preceded or accompanied reforms but they can be considered to some extent as still "active" and as preparing further transformations in the care sector. We focus particularly on: the arguments in favour of reforms ("why to reform?"); on how these reforms were operationalised ("how to reform?"); on how the normative issues characterising

traditional welfare states (norms and values) were dealt with; and, eventually, on what “care arrangement” was promoted as the most valued.

On the reasons for reforms, we will show that ageing populations are a central concern in all countries. Unsurprisingly, the much illustrated evidence of increasing numbers of older people has been, and still is, an important argument in favour of taking action in the home care field. The chapter then articulates the other rationales explaining the paths that reforms should be following, that is: *empowering* the user (a top priority in England, but elsewhere understood mainly as “*more access to information*”); *diversifying sources of care* (understood as more care from different actors and in particular a greater role for the “market” in Germany and England, and more “family care” in Italy and Belgium) and getting “*best value for money*” (a dominant argument in England).

These arguments are obviously connected with the dominant influence of the New Public Management doctrine which has definitely marked public policies by introducing efficiency and performance assessment as the main drivers of social action. However, we show in this chapter that these elements are interpreted differently from country to country and from care culture to care culture, and that the values underpinning the welfare state – like justice or equal access – remain of some importance. Finally, we review the empirical material in order to highlight what are the roles foreseen for family care, informal care and professional care in the existing definition of *best care*.

7.2. Variations in the targeting of home-based support for dependent older people across Europe

Chapter 2 examines the recent evolution of the state offer of home care support, as well as the role of home care in relation to other forms of “social care” support (including disability-related cash benefits) in order to provide a comprehensive picture of the offer of state support available in each national setting. The chapter compares national processes for setting and implementing (through needs assessment and means-testing) eligibility criteria and their implications in terms of population coverage and intensity of service provision. In addition, the analysis contrasts key features of the support provided, such as whether the resources are given in cash or “in kind”, the extent of user choice over the type of service and over the provider, and the existence of systematic processes for assisting individuals in the design of their support plans.

The chapter demonstrates very significant variations in the average state expenditure per older person across the four systems studied. These differences are present both in terms of overall levels of expenditure and between types of support (“in kind” or cash, and in the community or in residential care). Overall, per capita expenditure in the two Belgian regions exceeds by far the levels of expenditure in the other three countries considered. To a considerable extent, these differences are driven by very high levels of per capita residential care expenditure in Belgium.

Leaving residential care out of the picture, we then focus on public support for both “in kind” home care service and “cash for care”. This shows that Flanders and England spend as much (though the former slightly more) to support older people, with the same split between “in kind” services and “cash for care”. This split is similar in Wallonia, but with lower overall expenditure. In Italy public money is mainly devoted to “cash for care”. Of the four countries examined, Italy exhibits the lowest levels of expenditure on “in kind” support. In contrast with the situation in Germany, in the Italian case, the limited level of expenditure on community services is not explained by a “substitution” effect linked to high levels of residential care provision. In fact, overall levels of community and residential expenditure are the lowest in Italy. Finally, Germany appears as the least generous country. This is particularly remarkable given that the analysis for that country includes home nursing, a service that is not included in the assessment of the other countries.

Comparative analysis provides useful evidence about the selectivity and coverage of existing schemes. In Germany, coverage is limited to a relatively small proportion of the older population, as it is the case in England with social care brokered by local authorities. Social security benefits in England cover however a much greater proportion of the population as it is the case in Italy, although with significantly lower average intensity.

In England, Italy and Germany, locally organised and means-tested support systems tend to target a relatively small proportion of the population, but provide more intensive levels of care than more universal benefit schemes. Home care expenditure is constrained by limited financial resources, and the available support is therefore targeted on those with the highest needs and the lowest financial means. However, this not the case in Belgium, which has the highest coverage rate for “in kind” services. Compared to England, more people receive “in kind” services but at a lower intensity of provision.

Overall, the analysis identifies important variations in the offer of support across countries in terms of the range and intensity of resources provided. These differences appear to be linked to cultural factors, such as variations in the expected role of the family and the state, and to differences in the public objectives of the social care system.

7.3. Multilevel governance of home-based support: does it induce regional disparities and hinder innovation?

In all the countries we analysed, the care policy for dependent older people at home is a mixture of financial benefits and services. These instruments tend to be implemented at different levels: financial instruments at the national level and services at the regional level. While this can create coordination problems, some authors see the decentralisation of some competencies as part of a conscious strategy to limit the development of the care infrastructure. Only regions with high income may be in a position to guarantee a high supply of services. Kazepov’s (2010: 282-283) main thesis is that regional variations in service levels and an unequal and unbalanced supply coincide with the growing importance and autonomy of regional authorities, particularly when the central state no longer has a broad mandate or

the power to legislate in the care field. He argues that this is particularly relevant in a context of fiscal retrenchment, when the process of decentralisation could lead towards intensified targeting and a more restrictive policy in the regions concerned.

Our empirical assessment confirms that huge regional differences exist in the take up not only of services but also of the (uniform and national) financial benefits. However, none of these differences is related to region's differential income levels of the regions, but to other phenomena. The exception is Italy, where the huge income differentials of the autonomous regions *are* positively related to the uptake of all kinds of services and indirectly of the national cash benefits. Kazepov's thesis therefore seems to be questionable and one-sided. Our analyses show that the territorial division of social care authorities is generally not the cause of low coverage or, indeed, of lack of innovation.

The degree of innovation in LTC policy is not so much determined by the distribution of the levels of authority but by the type of LTC chosen by policymakers. Service-oriented countries (England and Belgium) have exhibited considerable policy innovations in the last decade (at the national level in both countries and at the regional level in Belgium, where real authority and resources have been devolved). Cash-oriented countries (Germany and Italy) exhibit very few policy innovations at the national level, but some experimental innovations at regional level. In these two countries, the medical system seems to be more innovative with regard to its approach of chronic illness. Policy innovation is thus a characteristic of the type of LTC; the distribution of policy authority between national and regional levels has no enduring effect on innovation in the countries studied.

Overall, multi-level governance of home care sometimes creates complex policy structures and implementation processes, but seems to have no decisive influence on the level of innovation or on the level of supply of benefits and services (except in Italy). The type of the LTC system chosen and the type of welfare state seem to have more impact than variations in the level at which governance is situated.

7.4. The process of marketisation in home care

Different market-oriented reforms have characterised the recent restructuring of publicly funded home care. Our work starts from the premise that the interaction between these market-oriented reforms and "path dependency" will affect differently the process of marketisation. Marketisation can be activated through two different routes: (1) a direct link from public provision to the market, via contracting out and relaxing the regulations, rules and conditions limiting the scope of "for profit" institutions and (2) a direct link from what is paid by the user and/or family (either through co-payment or direct purchase), to the regular or more often irregular market, a link which can be supported by public "cash for care" payments or tax credits.

First, we examine the impact of marketisation through the lens of the evolution of the mixed economy of supply, emphasising the diversity of actors in the provision of welfare – the state,

“for profit” organisations, the third sector, carers directly employed by households, and families. In summary, in both Germany and England, as a result of the reshuffling of the welfare mix, the “for profit” sector now has a larger size than 10 years ago. In Belgium, however, the growth of the “for profit” sector has been limited to the voucher market (housework), as the law prevents it from entering the home care sector. In Italy, attempts at promoting the regularisation of care workers have favoured “not for profit” organisations (such as social cooperatives) that have tried to take advantage of the system of accreditation. Care workers directly employed by families have an increasing role in Italy and Germany, in the former mostly in the irregular market.

In order to assess its effects on the final user, we then investigate how the “market” works, that is, how it is regulated and the role that price and quality competition play both in the care service market and in the care labour market (including the grey market). For those home care services which are regulated by the state, the scope of price competition still appears limited. Constrained by price regulation, providers seem to have taken the competition to other fields, either by diversifying into new, unregulated service segments or by focusing on cost containment, which essentially means containing labour costs.

Finally, given these features, we analyse how the process of marketisation affects the cost paid by the users. When looking at out of pocket home care expenditure, we conclude that co-payments have not increased in recent years. However, public financial resources have not kept up with the rising need for home care, which has led to an increasing number of families having to rely on privately-arranged home care provision, which is not regulated by the state. With the increased use of “cash for care”, this has meant that users have been encouraged to behave as consumers exercising choice in a care market. In this segment of the market, providers’ freedom to set prices has come up against families’ income constraints. In some cases, the labour cost has been reduced through voucher schemes (Belgium) or reduction of social contributions paid by the user (Germany, Italy). Faced with higher prices, families increasingly turn to the irregular market to buy cheaper services (mostly basic home care) not covered by the “public” umbrella (Italy).

7.5. The use of formal and informal care by dependant older people based on information from the Share database on individual’s care arrangements

Comparative literature on care regimes has demonstrated that European countries vary considerably in their social care organization. Each national care system has its own organization in terms of financing (who pays?) and provision (who cares?) (Szebehely, 2005). The previous chapters of this report have highlighted the level of public expenditures for home care, targeting principles and coverage rates in Belgium, England, Italy and Germany, and then given an overview of the shares of market-oriented (or “for-profit”), public and non-profit care providers. In this chapter, a micro-level “welfare mix” approach is presented, which improves the characterization as well as the understanding of care regimes after the reforms that took place in the 1990s. This chapter aims at examining care arrangements that

dependent older people patch together in order to fill their needs. We will turn from a macro-level to a micro-level analysis of the welfare mix and explore care arrangements at the level of the individual by using a synthetic indicator of the use of care and looking into the main determinants of such arrangements. The main question driving the analysis is to see whether there are significant differences between countries regarding individual care arrangements, as observed at the macro-level.

The first section aims at giving a theoretical base to different kinds of care as observed in individuals' arrangements. Based on Karl Polanyi's (1944) approach to socio-economic principles as applied to our field of interest, individual care arrangements will be presented in terms of the welfare mix they represent, i.e. through the lens of the different monetary and non-monetary resources they mobilize. Care providers will be identified as responding to certain socio-economic logics (redistribution, reciprocity, domestic administration and, finally, the market principle). We will then discuss methodological issues in order to transfer these different categories into proxy variables, and finally explain how we constructed these variables as well as the sample based on the Survey on Health, Ageing and Retirement in Europe (Share) database. Our methodological design is very much inspired by Geerts' paper (2009) on the use of formal and informal care by elderly people. Her objective was to give evidence for country differences in the use of care as well as to find out what were the main determinants of the use, which is also the objective of this chapter. Despite some methodological limitations, we found out that inter-country differences at the level of policy are reflected at the level of the individual use of care. Individual determinants (age, living arrangements and level of difficulties experienced in every day life) have proved to be significant as well. Gender, on the contrary, does not seem to play a role. The results obtained by the multinomial regression show coherence with the main characteristics of the care regimes that were studied. Most of the hypotheses that arose from the macro-level information at our disposal were validated. Public policies defining the outlines of care arrangements in each country will be mentioned throughout these sections.

7.6. Variations in measuring and improving performance in home care services: the degree of marketisation matters

Performance assessment is playing an increasing role in the governance of home care services in Europe. Ideally, the assessment of service quality should capture outcomes for everyone involved either directly or indirectly in the care intervention (e.g. the user, care workers, care managers etc.). Outcome indicators are direct indicators of the final impact of the service, such as the well-being of users and care workers. It is the conversion of inputs to outcomes, and not outputs (such as volume of home personal care hours, number of users, etc), that is central to performance assessment. But the most significant problem associated with the outcome-based approach to performance measurement is the notorious difficulty in measuring outcomes, because so many other factors may intervene.

Moving beyond these difficult technical questions, we demonstrate how cross-national variations in performance assessment can be understood as responses to the political contexts and features of individual every system.

Where provision is organised within a tutelary model (as in Belgium's home care sector), there are close and longstanding relationships between public administration and providers. There is no system of benchmarking, and performance assessment focuses on intermediate outputs. Providers have "an obligation to means" rather than "an obligation to results" i.e. to be accredited they must comply with input-related standards.

Marketisation creates a clear rationale for particular forms of performance assessment. Where there are quasi-markets, relationships are likely to be of a shorter duration, more business-like and based less on trust. In this situation, purchasers lack mechanisms of direct control. Thus some form of oversight is necessary to gather data about providers' operations for the purposes of quality assurance and accountability for public expenditure. In the countries where the logic of markets exists, and in the context of the growing role of independent home care providers, the collection and use of service performance related evidence could be critical in order to guarantee the efficient functioning of the care market by helping to address problems of incomplete and asymmetric information. Important questions remain, however. First, to what extent performance assessment frameworks, in particular those based on highly standardised measurement processes, can fully capture the complex array of factors contributing to good quality and good service performance in the home care sector. Second, how the different approaches to performance assessment support informed choice and improve the efficiency of the market. Due to these difficulties and to the different degrees of marketisation of the care system between countries, we see that performance is not always measured by looking at outcomes. Process and structural quality indicators are still commonly used in the studied countries, even if they provide a limited picture of the performance of the whole system.

7.7. Analysis of the gender aspects of care reforms: moving towards different worlds of defamilialisation

Family caregivers are historically major providers of home care and have thus been affected, either directly or indirectly, by home care reforms. In terms of individual effects, research on female carers shows that payments for care can either be experienced as reinforcing the obligation to care or, on the contrary, as a 'reward and reciprocation'. Yet, one key issue that is still understudied is precisely what consequences these reforms have had on the economic autonomy that women can have as care-givers and as care users.

The objective of Chapter 7 is to study some of the gendered consequences of recent home care reforms in Belgium, England, Germany and Italy. The literature questioning the gender aspects of the welfare state and the gendered consequences of its action often uses the concept of 'defamilialisation' which studies social policies' potential to emancipate women and men from family obligations, particularly in terms of financial autonomy through employment or

welfare payments. The way care regimes defamilialise (or fail to do so) can also be examined from the perspective of care receivers and professional care givers. While the defamilialising potential of public policies has been extensively examined from the perspective of family caregivers, it is less documented for care receivers and professional carers. For care receivers, issues of autonomy vis-à-vis the family are also at stake: money transfers give the opportunity to choose (to opt for another form of care than that delivered by close relatives for instance) and to rely less on the willingness of a relative, to receive a (more or less) professionalized care or, if this is not available, to be able to give (money) in exchange for the care received and, in a sense, to reciprocate for family care. From the perspective of professional carers, issues of defamilialisation are mainly related to the fact that paid work in the formal care sector enables workers to uphold a “socially acceptable standard of living” themselves.

In this chapter, we will discuss the three-fold defamilialization effect of care reforms. This effect is only interpretable taking into account nationally specific contextual elements. After a brief presentation of this background, we will argue that the defamilialization effect of the care policies cannot be described as uniform between and within countries. We will distinguish between weak (or strong) defamilialising effects for professional care-givers with precarious (or regular) working conditions, weak (or strong) defamilialising effects from the perspective of the cared-for who need affordable services, but strong (or weak) from the perspective of the families, that are offered more (or less) possibilities for externalising their care “duties”. Some individual characteristics (like social status or income) can also be of importance in estimating the defamilialising effects of care policies. All these elements contribute to shape what we call “composite worlds of defamilialisation”.

We will first give some information on the background of the reforms in order to understand the context of defamilialization. It is not possible to understand the extent of the transformations that have occurred in care systems without establishing some of the main features of the “gender contract” and the reforms. In a second stage, we will examine the measures supporting the informal unpaid caregiver and the possibility he/she gets to be either replaced by formal care or remunerated. Then, we will discuss the professional paid carer and the conditions in which he/she performs care work, to see if a “socially acceptable standard of living” is achieved. Finally, we will also briefly discuss the care receiver perspective and offer country-specific conclusions by presenting the worlds of defamilialisation identified.

7.8. Are we witnessing path departure in national care regimes?

During the period 1980 to 2010, there was an international diffusion of the “market” rationale in the institutional organisation of home care throughout large sections of the Western world, including countries considered by comparative welfare state theory as “Mediterranean” or “conservative”. Chapter 8 shows that the marketisation process *as such* is rooted in developments occurring first in liberal welfare states (e.g. England) but is progressively diffusing into other national contexts. However, the very process and approach through which marketisation takes place seems to be specific to each country and sometimes even to a particular region. Moreover, other factors come into play regarding the development of care

regimes and have an impact on how, and how far, marketisation is spreading. Among these, we could identify the influence of professions, the role and structure of the voluntary sector, and social norms regarding family duties. The interplay of these factors on the one hand, and the “market idea” on the other, brings about different configurations regarding the role of formal and informal care or of the various types of providers that are involved in home care (for instance, in Germany, professionalised service supply increasingly becomes the norm, while families and third sector provision are still the cornerstones of the care regime). Equally, embedded marketisation can sit alongside either greater standardisation or enhanced fragmentation (with “tayloristic” care becoming a “standard” in the German care market, and with high staff and provider turnover being typical of fragmented care in the UK, for instance).

The analysis undertaken in this last chapter looks at these dynamics through the lens of comparative methodology. The key argument is that to comparatively assess welfare state change such as the one reflected by “marketisation”, a fine-grained approach is needed which goes beyond mere macro-institutional, or mere quantitative or cluster analysis. Rather, if the question is whether there is convergence or path dependency regarding different care regimes, a methodology sensitive to the institutional, organisational, professional and cultural contexts is needed. From observations made during the research project and with regard to the work approach of our international research team, we infer that comparative assessments work best when national experts exchange not only formal data but also contextualised information about cultural and institutional frameworks, in a process we label the “open method of comparison”. This open method (a term inspired by the name of a EU method of governance in the social domain) is viewed as providing a “full picture” of evolving care regimes around the world.

8. General conclusions

Even if public expenditure on LTC is relatively low in all the countries under study compared to health care expenditure or pensions (Rodrigues and Schmitt, 2010: 4), the extent of the reforms as well as the public budgets involved since two decades do not indicate a quantitative retrenchment of the state in the home care sector. On the contrary, *“provisions around social care, especially cash transfers, represent a notable, and sometimes the only, case of programme expansion within contemporary welfare states”* (Daly and Lewis, 2000: 295). In this context, this report illustrates extensively that there exist a number of options to policymakers to support dependent older people in the community. How these support systems are implemented depends on the nature and range of the policy objectives, which can range from merely providing a safety net, to maintaining older dependent people in their own homes for as long as possible, or even to the creation of employment in the care economy. Furthermore, the translation of these objectives into policy measures and ultimately into organisational structures is mediated by important cultural values, and in particular by the nature of social expectations about the role of families in the care of their dependent relatives. From the point of view of change to the welfare state (Andersen, 2007), care regimes in

Belgium, England, Italy and Germany have moved with a more or less accelerated *rhythm* towards a reorganisation of their home care sector in terms of *direction* (more marketisation for some countries), *degree* (some countries are more deeply affected than others) and *level* (new rationales indicate possible changes in the care culture). Yet from a social policy point of view, it is also important to question the outcomes of these transformations and how, at a more normative level, care regimes contribute to maintain older dependent people at home. We can identify three issues to use when evaluating this contribution.

8.1. Do the different care regimes foster a universal provision of home care services?

Levels of public expenditure vary from one country to the other. Of the national systems explored, Belgium is the country which has favoured the most “in kind” provision for supporting dependent people (both personal care and housework), with services available to a large spectrum of the population. Cash distributed through the national security system is seen as a supplementary allowance targeted on the most needy (in terms of dependency and in financial terms).

England is characterised by a locally run, means-tested “in kind” system reflecting “Poor Law principles”, combined with a central, state run universal social security system based on cash transfers. “In kind” provision is limited to older people with very severe needs and with limited financial resources. However, for this segment of population, the volume of support is relatively generous and focuses on the provision of support for personal care (not housework). Over time, fewer users are more heavily supported and more people are outside the publicly funded system. Looking ahead, the rise of personal budgets may imply a shift from “in kind” provision to “cash for care” at the local level, too. This, in turn, could lead to an increasing role for families or for personal assistants directly contracted by families.

With almost no “in kind” home care provision, Italy distributes as much cash as England through its national security system, but allocates the smallest proportion of any of the four countries at the local level, thereby fostering a shift from a model based on unpaid family care to one based on informal, paid care provided by often irregular immigrant minders. Like Italy, provision of formal home care is almost non-existent in Germany.

The German system appears to rely very heavily on the contribution of informal carers, and the relatively low level of public expenditure also seems to reflect the cultural expectations about the role of family members in the care of dependent older people. In recent years, the number of beneficiaries of LTC Insurance has slightly increased but benefits have been allowed to erode significantly in real terms.

While co-payments have not increased in the period under study, it appears that public financial resources have not kept up with the rising demand for home care. This creates two options: either dependent old people have to rely more on informal care provided by families, or they must use the private, most often irregular, care market. Poorer users favour the former option, richer ones the latter.

8.2. Do the different care regimes foster “best value” for money in care delivery?

Performance assessment is playing an increasing role in the governance of home care services in Europe. The performance of a home care service cannot be assessed without considering the quality of the care it delivers. But for a service to perform well it must deliver care efficiently and, arguably, where the service is public there should also be equity of access to, and delivery of, care. This introduction of explicit standards and measures of performance exemplified a new form of public administration known as New Public Management.

Both England and Germany, which have relatively developed quasi-markets where users exercise choice and providers compete, exhibit the greatest use of inspection and the biggest focus on outcomes. In addition, in both these countries regulatory information on quality is publicly available, with an emphasis on its role in supporting user choice. In contrast, Italy does not fit this pattern: although it has a quasi-market for home care, there is limited use of inspection and the focus during the accreditation process is on inputs. The most likely explanation for this difference is the limited use of formal provision in Italy.

Important questions remain, however. First, to what extent can performance assessment frameworks, in particular those based on highly standardised measurement processes, fully capture the complex array of factors contributing to a definition of good quality and good service performance in the home care sector? Second, how do the different approaches to performance assessment support informed choice and improve the efficiency of the market? Due to these complexities and the different degrees of marketisation of the system, we see that performance is not always measured by looking at outcomes. Process and structural quality indicators are still commonly used in the different countries (especially in Belgium), even if they provide a limited picture of the performance of the whole system.

8.3. Do the different care regimes improve the quality of care and employment?

Politics plays an important role in the way the debate regarding quality is framed in each country. Both Belgium and Italy focus on workers, which in Italy is likely to be due to the large, irregular, and mostly migrant, workforce. In Belgium the large number of people supported and the concomitant size of the workforce is often a factor, since the welfare and well-being of a large, organised workforce is politically important. In contrast, in England and Germany the focus on service users is less political and more a response to the organisation of a home care market which serves users not workers.

The introduction of market principles into the home care sector has not lead to price competition in the parts of the care market subject to regulation, either because of legal barriers to entry or price controls. Where fees (subsidies and co-payments covering the cost of the services) have been set at levels deemed too low, the pressure on margins has been passed on to wages and labour conditions (resulting in lower wages and poor working conditions) and sometimes on to the quality of care.

In most countries, policies that aim to ensure the quality of care and care work conditions have focused on private providers. However the results have been quite different. In Italy, homogeneity in service provision and minimum levels of service are still far from being achieved. The actual implementation of home care policy is left to each individual region, with wide geographical disparities persisting both in terms of individual rights and the services provided. Conversely, in Germany the LTC insurance law defined the orientation of quality standards, developed within nursing science, as a precondition for care provision. As a result, providers are required to establish a quality management system and to comply with standards fixed at the national level. However, financial considerations may yet erode some of these controls. It has been argued that, in their endeavour to reduce costs, private providers employ under-qualified or untrained staff in excess of the maximum legal rate permitted of 50% of fully-trained personnel per establishment.

The trade-off between cost containment and quality of care and care work seems to loom larger in England. Quality control is entrusted to regulation, while competition is deemed important in order to take care of price/cost effectiveness but in practice results in a high turnover of providers and staff. Evidence suggests that working conditions are indeed poor in the sector, with difficulty filling staff vacancies.

In Belgium, price/cost efficiency does not seem to be a priority, while quality seems to be ensured by strict monitoring of very detailed conditions that must be met regarding the home care that is delivered. However, a dual regime governs the sector, with very long accreditation systems and stable providers in home care, and lighter accreditation rules for new actors entering the (housework) voucher sector.

Overall, this paper demonstrates that competition has had an impact in the parts of the private home care market that are not regulated by the state. The low level of state-regulated “in kind” provision and the increased use of “cash for care” payments has meant that users have been encouraged to behave as consumers exercising choice in a care market. Competition among providers has mostly been pursued by diversifying out of basic services that are guaranteed or regulated by the public sector, and into new service areas which are not. In this latter segment of the market, providers’ freedom to set prices has faced families’ income constraints. In some cases, the labour cost has been reduced through voucher schemes (Belgium) or the reduction of social contributions by the individual (Germany, Italy). Faced with higher prices, increasingly families have turned to the irregular market to buy cheaper services (mostly basic home care) not covered by the “public” umbrella. The quality of care and of employment remain unsolved and key issues in these unregulated markets.

- Note on publicly funded home care schemes: key features -

We refer throughout this report to the different publicly-funded home care systems currently in place in the four countries covered by our research: England, Italy, Germany and Belgium. To assist readers, this section presents descriptions of the key features and components of each scheme. Table 1 summarises these different characteristics and includes information about eligibility criteria, a topic that is discussed in Chapter 2.

1. England

English support for dependent older people operates as two parallel systems: locally run, means-tested social care; and centrally administered universal disability-related social security benefits.

1.1. A highly standardised, “in kind” provision of social care, operating as a quasi-market

In England, local authorities have been responsible for providing home care to frail older people since the early 1970s. Up until the 1990s, the bulk of services were provided in-house, with non-profit organisations playing a minor role and not reaching the dominant place achieved by their counterparts in mainland Europe (Means et al., 2002). Moreover, while other parts of the English welfare state were shaped along the principles of universalism, social care services have traditionally been related to the ability to pay, with state support confined to the poorest sections of the population (Glendinning & Wilde, 2011).

More recently, major reforms since 1993 have made the English social care system one of the pioneers in Europe of quasi-markets in this sector. Home care services, in particular, have seen this mode of regulation introduced vigorously (Means et al., 2002, Newman et al., 2008; Knapp et al. 2005). As a result of reform, local authorities now themselves directly provide only a very small proportion of services, and their main role, in addition to assessing the needs of individuals, is now to commission services and oversee the proper functioning of local care markets (Malley et al., 2010). Typically, providers are selected by local authorities following a public tendering process for the purchase of home care service. The resulting care system is both highly competitive and strongly regulated, since it is based on multiple providers and generalised quality standards that are established and overseen by national bodies.

1.2. The rise of Personal Budgets

Over more than a decade, there has been an emphasis in England on the use of consumer-directed care models, starting with the introduction in 1997 of Direct Payments. Although originally only available to working-age adults, Direct Payments were extended to older people in 2000 and to their carers in 2001. This mechanism enables users freely to purchase the services they need and choose, reflecting a policy shift towards a “*personalisation agenda*” (Fernández et al., 2007). Following disappointing uptake levels, Personal Budgets were introduced in 2008, offering a wider range of options whereby users could exert control over their allocated resources. These included the possibility of receiving a combination of cash and services “in kind”, and of having the budget managed on behalf of the user by a third party (family, friends, or even the local authority).

Given the now predominant role of independent providers in the English social care system, home care services are currently regulated through a set of “essential standards” combined with an inspection regime led by the joint health and social care regulator (the Care Quality Commission). The emphasis on the personalisation of the care system and the associated growth in the take-up of Direct Payments could lead, however, to a polarised support system with, on the one hand, a regulated traditional formal provider sector and, on the other, an unregulated supply of support from personal assistants.

1.3. Social security cash allowances

Considerable public resources are distributed to dependent older people in England through the social security system.

Since 1991, older people needing help with personal care or supervision because of illness or disability have been eligible for Attendance Allowance (AA) or (if claimed before the age of 65) Disability Living Allowance (DLA). They can also claim Severe Disability Premium, a top-up to the means-tested income support social security benefit, Pension Credit. The third type of benefit, introduced in 2002, is the Carers’ Allowance, paid to carers of people with disability. These cash benefits do not impose any obligations on the beneficiaries and can be spent as they choose. In general, social security benefits are targeted on a wide range of disability levels, in contrast with the social care resources, which are concentrated on the most dependent. Furthermore, AA and DLA are universal benefits, whereas social care is heavily means-tested (Wanless et al., 2006).

2. Italy

As in other Mediterranean countries, families in Italy constitute the central pillar of the support system for older people with social care needs; formal home care services are relatively underdeveloped. In this context, the core of the support for people with social care needs in the community is provided through cash allowances.

2.1. The central role of cash for care allowances

The main cash allowance for disabled people, the Attendance Allowance (*Indennità di accompagnamento*), was introduced nationally in 1980. It was originally intended for young adult disabled people, but was extended to cover older people in the mid-1980s. It is a national cash benefit scheme paid by the National Social Security Institute to people assessed as being unable to perform the basic activities of daily life. Beneficiaries are free to spend the money as they choose, and there is no need to agree a care plan.

In contrast, the Care Allowance (*Assegno de cura*), which was introduced nationally in 2000, is managed and financed by regions and municipalities, which has led to very significant geographic variations in the rate of uptake. This allowance can be received as a cash payment – like the Attendance Allowance – or as a voucher which is used to buy home care services. Although recipients of the *Assegno de Cura* are theoretically entitled to an individualised care plan, Italian local authorities have experienced significant problems in their implementation due to the lack of appropriate needs assessment processes and the poor monitoring of care plans following assessment.

2.2. Incentives to regularise home care workers

The reliance on cash allowances to support older people in Italy has led to a shift from a model based on informal, unpaid family care to one based on informal, paid care provided by an irregular, immigrant care worker – the so-called “migrant in the family” (Saraceno, 2009). Recently, efforts have been made to introduce financial incentives in order to regularise the significant number of these home care workers operating in the grey economy. In 2005, the Italian government introduced two policies: firstly, a tax benefit (max €399/year) to the employer worth 19% of the salary paid to a home care worker assisting an older person; and, secondly, a tax benefit (from a minimum of €356 to a maximum of €666/year) for the employer linked to the deduction of the social security contributions paid by the employer up to a maximum annual expenditure of €1,549.37. These tax benefits are limited to the families whose income does not exceed 40,000 euro and pay taxes.

Together with the *Assegno de cura* care vouchers, Italy’s social care policy has thus focused in recent times on the use of “conditional monetary subsidies”, that is, monetary subsidies tied to the use of a care service.

2.3. Fragmentation of the home care market

In addition to the financial mechanisms outlined above, home care services for disabled older people in Italy are provided by both the local health and social service authorities.

Since the Seventies the regions have been given a prominent role in health and social care. While the general legislative framework remained with the state, the specific legislation,

promotion and development of the policy were devolved to the regions, and the organisation and provision of services to Local Authorities (in the first instance the municipalities). The Legislative Decree 30.12 1992 n. 502 introduced the accreditation of providers, whereby the authority (in this context the region) certifies that an organisation conforms with the specific requirements (called standards of qualification) and can consequently appear on a list of registered providers. Other organisations can draw on this list to provide services to users, including those basic services that are part of essential medical assistance (*Livelli Essenziali di Assistenza – LEA*) and which are the responsibility of the health service, *Aziende Sanitarie Locali* (ASL). The introduction of reform to social services (“*Legge quadro per la realizzazione del sistema integrato di interventi e servizi sociali*”, n° 328/2000), and the subsequent modification of Title V of the Constitution (regulating the decentralisation of various tasks to the regional level), confirmed the primary roles of regions and municipalities in the governance and implementation of welfare policies. In Italy, the 328/2000 Act promoted home care for dependent persons, envisaged ways of bringing in a diversity of actors to provide service (private for-profit, social cooperatives, volunteers, religious organisations, etc), and introduced new instruments, such as voucher and care allowances, managed by regions and which have been increasingly used in recent years

The 328/2000 Act defines the range of services to be provided by local health authorities through the “integrated care system”. On one hand, home health and home care services are supposed to be provided by municipal social services that are managed by the ASL health service through the Integrated Domiciliary Care system (*Assistenza Domiciliare Integrata - ADI*). In practice, these services almost exclusively provide home health care support, and the care packages consist essentially of home nursing. So, in addition, municipalities provide social care support (e.g. home help and personal care) through their social services departments (*Servizio di assistenza domiciliare - SAD*). In most cases, local authorities use public tendering to commission the bulk of SAD services from social cooperatives. Public procurement is subject to cost and quality control, and the service providers selected are those who submit tenders which are deemed to be the most economically convenient.

The Italian model of care has seen a transition from a model based on informal, unpaid family care to one based on informal, paid care provided by irregular immigrant carers, partially funded by cash for care allowances and “tied cash” incentives designed regularise the grey market in homecare workers. The regions and municipalities are largely autonomous in their implementation of the provision of “in kind” services. This has led, on the one hand, to a fragmentation between geographic areas and, on the other hand, to the emergence of heterogeneous quasi-markets.

3. Germany

3.1. Long term care insurance: tied cash fostering a regulated para-medical care

With the introduction in 1995 of long term care insurance (*Gesetzliche Pflegeversicherung*), Germany became another pioneer in the reform of long term care in Europe. Overall, the aim was to achieve a more universal system which would reduce the need for dependent older people to rely on means-tested public assistance in order to meet the costs of their care.

A care package is suggested, following a needs assessment carried out by public agencies. Users may then have to choose the elements they consider most relevant (this is because in many cases the insurance payout will not cover the entire package). The assessment of care needs is focused on para-medical care rather than on home care. Thus the suggested care package usually focuses on personal care, while home help tends to be poorly covered. In practice, users and their families negotiate with service providers on the elements of the care packages and the conditions under which they are delivered. Once the care package is agreed, users and their families sign a contract with the care supplier confirming the support arrangements. The beneficiary can also choose cash for care benefits (*Pflegegeld*). In this case, the insurance pay-out is lower than the one awarded for formal “in kind” care; some beneficiaries choose to combine a partial cash payment with some in kind formal services.

Under the insurance system, approximately 90% of the adult population pays contributions through the payroll based on their salaries (with employers also contributing) and, as mentioned, the amount paid out by the insurance fund is based on an individual’s assessed needs. Importantly, the resources funded through the long-term care insurance system are not meant fully to cover the care needs of the individual, who is therefore expected either to: co-finance their care with their own funds; receive support from informal caregivers; apply for means-tested social assistance; not to receive the entirety of the assessed care package (i.e. to be left with unmet needs).

3.2. Heavy reliance on informal care networks

The value of the cash payments (*Pflegegeld*) offered is approximately half of the value of the services “in kind” option, yet a large majority of users opt to receive solely cash or a combination of cash and services “in kind”. Generally, the cash is then used to compensate family members for the informal care support they provide.

It could be argued that by setting the insurance payouts below the level needed to pay for the full assessed support package the German system makes significant demands on informal carers to support dependent people. Furthermore, the cost of the insurance system is “buffered” by the significantly discounted cash option, favoured by approximately four fifths of insurance beneficiaries in the community and available only to those individuals with informal carers.

3.3. A complement to long term insurance: means-tested local “in kind” provision

Prior to the introduction of the insurance system, support for long-term care (*Hilfe zur Pflege*) was provided through means-tested social assistance. Although still available, the social assistance system has been updated in order to reflect its residual place in the post-insurance support world. Run by local authorities, social assistance can grant services and cash to frail people unable to meet the residual costs of their home care services. Local authorities are in control of the means testing, with various types of income being taken into account (including the long term care insurance payment itself). In theory, social assistance should cover all the services deemed indispensable by the welfare department. When not cash, local authorities either themselves provide the services or develop local partnership with non-profit provider organisations.

3.4. Conditional cash benefits as incentives to regularise home care workers

As in Italy, the German state has recently introduced financial incentives aimed at regularising the large home care workforce operating in the grey market. In 2009, national legislation introduced tax deductions worth 20 per cent of care costs up to €4,000 a year for the regular, standard employment of care workers, and up to €10 a year for employment with lower social security standards (so-called “mini-jobs”) (Theobald et al., 2011). The system also provides tax deductions for individuals employing immigrant workers on a 24-hours-basis for periods of up to 3 months. That said, all these tax deductions are of limited utility for households with a lower income which are paying little tax, or no tax at all.

4. Belgium

Both national and regional levels must be taken into account to understand the Belgian home care system. Historically home care in Belgium has been regulated at the national level, but it has become increasingly decentralised since the 1980s. Cash allowances, embedded in the national security system, remain at the federal level, and a national voucher system was implemented in 2004, which aims to subsidise the cost of housework services among the general population. But since 2001 the Flemish region has implemented its own (cash based) long-term care insurance scheme.

4.1. A tutelary regulation of home care services

Home care providers in Belgium are regulated by regional authorities through a “tutelary” system. Developed over the years, first at national and then at regional level, the system supports the provision of personal care services by allocating public funding to providers who comply with a set of standards and requirements, mainly regarding inputs. To be entitled to public support, providers must belong to the public or “not for profit” sectors (association).

The quality of the service and employment provided is also heavily regulated: care workers must have attained a minimum level of training and hold a specific certificate; intensity of workers' supervision is fixed by the law; and an assessment of the user's needs is required. The user pays according to his/her income, the scale being set by law. The programme is budget constrained and the distribution of the funding among accredited providers has remained quite stable over the years, restricting the level of competition.

4.2. Cash for care allowances

Two major cash benefits are targeted at supporting services users' financial costs of non-medical care-related expenses. At the federal level, the "Allowance for help to older people" (*Allocation pour l'aide aux personnes âgées - APA*) and the "Allowance for handicapped people" (*Allocations aux personnes handicapées*) provide financial support to older dependent persons. The level of the cash benefit varies with the level of dependency and the financial circumstances of the applicant. At the regional level, the Flemish Care Insurance is a separate Flemish long term care insurance system (*Vlaamse zorgverzekering*) that provides a universal monthly allowance to dependent people in Flanders. Both the care allowances and the payments from the Flemish Care Insurance do not impose any conditions on how the beneficiaries use the funds received.

4.3. The service voucher: a quasi-marketisation of housework

In Belgium, the 20 July 2001 Act established a service voucher (*titre-service*) at the federal level. Driven by the objective of generating employment, the service voucher is primarily aimed at supporting help with housework rather than personal care. The scheme benefits a wide range of service providers, including those from the public, private for profit and third sector (non profit organisations, work integration social enterprises etc), and aims to integrate low qualified people into the workforce. In contrast with similar voucher models in France, the Belgian service voucher excludes direct employment contracts between the provider and the client.

Table 0.1: Key targeting-related characteristics of community support schemes

	Cash or in kind	Entitlement	Eligibility	Means tested	Needs tested	Carer blind	Care manager	Care Plan requirement	Co-payment
Belgium									
Social security benefits: Allowance for the help to older people (Allocation pour l'aide aux personnes âgées - APA)	cash	yes	national	yes	yes	yes	no	no	-
Social security benefits: allowance for handicapped people (Allocations aux personnes handicapées)	cash	yes	national	yes	yes	yes	no	no	-
Flemish long term care insurance (Vlaamse zorgverzekering)	cash	yes	regional	no	yes	yes	no	no	
Social care in kind (services d'aide aux familles et aux personnes âgées)	in kind	no	regional	yes	yes		yes	no	yes
Voucher (Titre-service)	in kind	national	national	no	no	yes	no	no	yes
Italy									
Social security benefits: Attendance Allowance (Indennità di accompagnamento)	cash	yes	national	no	yes	yes	no	no	-
Care Allowance (Assegno de cura)	cash or voucher	no	region and municipalities	yes	yes		yes	limited	-
Integrated Domiciliary Care: home nursing/care (Assistenza Domiciliare Integrata - ADI)	in kind	no	local health authorities	yes	yes		yes	yes	sometimes
Home care (Servizio di assistenza domiciliare SAD)	in kind	no	municipalities	yes	yes		yes	yes	yes
Tax benefit	-	yes	national	no	no	yes	no	no	-
Germany									
Long term care insurance (Gesetzliche Pflegeversicherung): home nursing/care or cash benefits (Pflegegeld)	either	yes	national	no	yes	yes	yes	yes	no
Social assistance (Hilfe zur Pflege)	In kind	no	regional	yes	yes	no	yes	yes	yes
Tax incentives for “mini” jobs	-	yes	national	?	no	no	no	no	
England									
Local authority social care (day care, home care personal budget)	either	no	local	yes	yes	no	yes	yes	yes
Social security benefits (Attendance Allowance, Disability living allowance, Carers' Allowance)	cash	yes	national	no	yes	yes	no	no	no

- Chapter 1 -

Reflecting on discourses at times of reforms: The main rationales mobilized in debates around home care (1990-2010)⁹

1. Introduction

This chapter aims at reconstructing “rationales” that emerge as “*programmatic conceptions and idioms used in political debates*” about elderly care and reflect the way in which care-related “*social relations (...) in society are perceived*” (Bussemaker, 1998: 72). Rationales around reforms, either criticizing or justifying the transformations that have occurred, are interesting elements for contextualizing on what basis decisions and political orientations are made in home care. They highlight the choices that were made at a particular moment and give indications of what is considered “best care” by various actors.

In the following sections we will present the main rationales that are active in Belgium, England, Germany and Italy. We studied a series of official documents as well as grey literature. Rationales either preceded or accompanied reforms but they can be considered to some extent still “active” and preparing for further transformations in the care sector. This chapter focuses particularly on the arguments in favour of reforms (“Why reform?”) and on how normative issues characterizing the respective role of welfare states and families were dealt with (“Best care”). We will first show that the ageing process is a central concern in all countries. Not surprisingly, the much-illustrated evidence of the increasing number of older people has been and still is an important argument in favour of taking action in the care field. It articulates with rationales like “empowering” the user, “diversifying care sources” and getting “best value for money”. These arguments are obviously related with the widely acknowledged dominance of the New Public Management ideology that has marked public policies by introducing efficiency and performance assessment as guiding principles of public policy. However, we will show in this chapter that these arguments vary significantly between countries and areas of care. Values at the origin of the Welfare State like justice or equal access remain present. Finally, we will question the empirical material in order to highlight what role family care, informal care and professional care are given in the definition of “best care”.

⁹ The sections of this chapter are largely drawn from the “Rationales” reports compiled by each national team: Brice Champetier and Florence Degavre for Wallonia, Jef Breda and Stephanie Peeters for Flanders, Juliette Malley, Jose-Luis Fernandez and Vivek Padvetnaya for the UK, Ingo Bode and Sébastien Chartrand for Germany and Annamaria Simonazzi and Sara Picchi for Italy.

2. Methodology¹⁰

The EU has no competence in terms of long-term care (LTC) at the national level. However, in this chapter, we explore the idea that the political process of decision-making in the field of home care, which is sometimes leading to deep transformations in national care regimes, is influenced, among other things, by LTC discourses at the European level.

A first step on observing rationales was made by analysing five transnational reports on LTC in Europe from the OECD and the European Commission.¹¹ Six recurrent themes were identified: “*maintaining a high level of informal care and fostering community based care*”, “*job creation for workers at risk of unemployment*”, “*generating new and innovative services for older people*”, “*fostering the implication of a greater variety of actors (private, from civil society, etc.)*”, “*developing the decision-making capacity of the user via needs assessment and information*”, “*elaborating care continuums between hospital – or medical – care and home care*”, “*fostering equality between men and women as regards care giving and access to care*”.

In a second stage, a selection was made for each country of local, regional or national documents from public bodies (decrees, laws etc.), official reports related to care policy as well as grey literature from organized care providers (such as the “Mutuelles”¹² in Belgium or informal carers’ organizations). The selected documents cover the period 1990 to 2010. They were analysed in the light of previously identified themes. The objective is not to see how rationales have evolved over time or to make a historical analysis of discourses. Rather, on the basis of the documents selected for each country, the following sections examine whether major issues from the European level are present at the national level and how they are formulated in different contexts. It is then possible to delineate more precisely the major rationales in home care for frail adults in the German,¹³ Italian,¹⁴ English¹⁵ and Belgian¹⁶ contexts. Table 2 synthesises the information available.

¹⁰ For more methodological details please refer to the “Methodological guidelines” in the annex.

¹¹ European Commission, 2009. *Ageing Report. Economic and budgetary projections for the EU-27 Member States (2008-2060)*; European Commission, 2009. *Long-term care in the European Union*; Giuseppe C., Costello D., Guardia N. D., Mourre G., Bartosz P., Salomaki A., 2005. *European Commission economic papers. The economic impact of ageing population in the EU 25 Member States*; European Commission. 2008. *Biennial Report on social services of general interest*; European Commission. 2004. *Review of preliminary national policy statements on health care and long-term care*.

¹² Mutual health organizations, hereafter referred to as “mutuals”.

¹³ The documents under study for Germany are a) Enquête-Kommission des Landtags (2005). *Situation und Zukunft der Pflege in NRW*. Düsseldorf, Landtag Nordrhein-Westfalen (EPN) b) Bundesministerium für Familien, Senioren, Frauen und Jugend (2006). *Stellungnahme der Bundesregierung zum Fünften Altenbericht*. Berlin (C5A). c) Neuhaus, A., M. Isfort, Weidner, F. (2009). *Situation und Bedarfe von Familien mit mittel- und osteuropäischen Haushaltshilfen*. Forschungsbericht. Köln, Deutsches Institut für angewandte Pflegeforschung e.V., Köln. (Neuhaus et al.).

¹⁴ The following documents served as a basis for Italy: Commissione Onofri, *Commissione per l’analisi delle compatibilità macroeconomiche della spesa sociale*, febbraio 1997; Ministero del Lavoro e delle Politiche Sociali, *La vita buona nella società attiva – Libro bianco sul futuro del modello sociale*, maggio 2009, Ministero del Lavoro e delle Politiche Sociali, Ministero per le Pari Opportunità, *Italia 2020. Programma di azione per l’inclusione delle donne nel mercato del lavoro*, dicembre 2009, Ministero del Lavoro e delle Politiche Sociali, *Rapporto sulla Non Autosufficienza 2010*.

¹⁵ The following documents served as a basis for England: a) Commission for Social Care Inspection (2006). *Time to Care?* An overview of home care services for older people in England 2006. London: Commission for Social Care Inspection. b) Several documents from the Department of Health (1989 to 2010) (see bibliography). c) Her Majesty’s Government (2007). *Putting people first: a shared vision and commitment to the transformation of adult social care*. London: The Stationery Office. d) Her Majesty’s Government (2009). *Shaping the Future of Care Together*, CM 7673. London: The Stationery Office. e) HM Government (2008). *Carers at the heart of 21st century families and communities*. “A caring system on your

3. Why reform?

3.1. The centrality of the “ageing” argument

Arguably, the main factor pushing for reforms is the ageing process. It is seen in all countries as driving LTC expenditure upwards because of the increase in the volume of older people in need of services. This increase corresponds on the one hand to a significant rise in the (absolute and relative) number of older people in society, and on the other to changes in the age-specific prevalence of disability (Robine et al., 2005). Whether the prevalence of disability among successive cohorts of older people will increase or not is particularly important, because the effect on service demand of the predicted rises in the number of older people could be more than offset by a significant reduction in the prevalence of disability. For demographers working for public authorities, the key question is whether the extra years of life that new cohorts of older people enjoy are spent disability-free or not. Changes in the prevalence of disability among older people vary across countries, and more evidence is required to predict likely future trends with confidence, but overall it does not seem likely in Western European countries that a hypothetical drop in disability rates will offset to a significant degree the increase in demand linked to population ageing.

In Italy, population ageing is viewed as an irreversible process, which will weigh heavily on care and health spending. In addition, all reports explicitly refer to the pressure exerted by the global market on social spending, calling on governments to contain public debt. In England, the pressure of increased demand on the LTC budget is also driving the need to develop innovative services, although this argument is rarely made explicit in policy-making. The

side. A life of your own”. London: Department of Health. f) HM Government (2010a). *Building the National Care Service, CM7854*. London: The Stationery Office. g) HM Government (2010b). *The Coalition: our programme for government*. (ed. Cabinet Office). London: The Stationery Office. h) Ministers, Local government, NHS, Social care and Professional and Regulatory organisations (2007). *Putting people first: a shared vision and commitment to the transformation of adult social care*. London: The Stationery Office. i) Royal Commission on Long-term Care (1999). *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, Cm 4192-I. London: TSO. j) The Commission on the Future of Volunteering (2008). *Report of the Commission on the Future of Volunteering and Manifesto for Change*. London: The Commission on the Future of Volunteering. k) United Kingdom Homecare Association (2006). *A Fair Price For Care. A UKHCA position statement. Maintaining the capacity of the independent homecare sector*. London: United Kingdom Homecare Association Ltd.

¹⁶ The following documents were examined as empirical material for Wallonia: a) *Accord cadre du non marchand privé wallon 2000-2006*, b) *Accord cadre du non marchand privé wallon 2007-2009*, c) *Balises n° 22, 2007*, d) Bureau Fédéral du Plan, *The Belgian long-term care system*, e) *Contact n° 112 à 116, 2007-2008* f) *Déclaration de politique régionale du gouvernement wallon 2004 and 2009*, f) Dexia, *Vieillessement de la population: impact et enjeux pour les collectivités locales*, 2010, g) *Echo Mutualiste*, 1er trimestre, 2005, h) *Ecouter les aidants proches pour mieux les soutenir, Aperçus quantitatifs et qualitatifs de la question*, Fondation Roi Baudouin, 2007, i) *En Marche, Quel avenir pour les personnes âgées?*, j) *En Marche, Un accord social dans le non marchand en Région Wallonne*, 2007, k) Flora, *Titres-services: à utiliser avant...*, 2009, l) *MC-Information 229 and 237*, m) *Memorandum du CESRW*, n) *Projet de décret relatif aux services d'aide aux familles et aux personnes âgées, Rapport présenté au nom de la Commission de l'Action sociale et de la Santé par Mme I. Simonis*, o) *Projet de loi relatif au développement des services et de l'emploi de proximité, 2001* Vieillessement, aide et soins de santé en Belgique, rapport pour le SPF Sécurité Sociale, direction générale politique sociale, 2004.

The following documents served as empirical material for Flanders a) *Decree on the certification and financing of the Flemish home care agencies* of 14/07/1998 (Decree houdende de erkenning en de subsidiëring van verenigingen en welzijnsvoorzieningen in de thuiszorg), b) *Implementing Decree of the Flemish Government on the certification and financing of home care agencies* of 18/12/1998 (Besluit van de Vlaamse regering houdende de erkenning en de subsidiëring van verenigingen en welzijnsvoorzieningen in de thuiszorg), c) *Decree on Residential and Home Care (Woonzorgdecreet)* of 13/03/2009, d) *Implementing Decree of the Flemish Government on the programming, certification and financing of residential and home care agencies and of organisations of users and informal caregivers* of 24/07/2009; e) Breda, J., Pacolet, J. Hedeboom, G. and Vogels, J. (2010), *Programming home care and elderly agencies: final report – research commissioned by the Flemish Government (Programmatie thuiszorg- en ouderenvoorzieningen: eindrapport - Onderzoek in opdracht van de Vlaamse Overheid)*, Leuven, Department of Wellbeing, Public Health and Family, p 114.

main reason given for the development of new and innovative services is to meet the higher expectations of future generations and provide personalized services rather than a “one size fits all” service (Department of Health, 1998; Department of Health, 2005; Her Majesty’s Government, 2009; HM Government, 2010a; Her Majesty’s Government, 2007). Key developments have been Direct Payments and newer forms of consumer-oriented care which aim to give people more choice and control over how their needs are met using public money. It is often argued that such schemes will improve outcomes and lower costs as service users will make better choices, increasing efficiency (Clark et al., 2004; Fernandez et al., 2007; Riddell et al., 2005; Spandler and Vick, 2006). One area of innovation that is strongly supported is technology. The rationale for promoting technology is its low cost relative to other services where the costs are predominately labour costs, the fact that it can enable people to self care so enabling people to feel more in control and remain independent, and the potential for it to make people feel safer and so remain in their own homes for longer (HM Government, 2008; Department of Health, 1999b; Her Majesty’s Government, 2009; HM Government, 2010a).

In Belgium, population ageing is seen as a cost rather than as an opportunity. In one of its publications, the Federal Plan Bureau states that *“given the projected share of elderly persons in the population in the decades to come, the overall financial burden of the [Belgian LTC] system will become a major challenge”* (Bureau Federal du Plan, 2010: 26). It was the increasing ratio of dependency (people older than 65 in the total population) that served as a catalyser of public opinion in the late 1990s, as it was immediately associated with less people working and financially contributing to the pensions budget. In this context, the Flemish and Walloon regions share one main concern, which is to provide a sufficient supply of services and to ensure a sufficient level of funding for the existing services. In Germany as well, documents show concern that the workforce will need to expand significantly and also to develop new skills to meet the specific needs of people with more complex conditions. Both countries express strong concerns that people living to older ages –especially women – will be more likely to suffer from illnesses such as dementia, which require intensive support in the final stages.

3.2. Seeking “best value” as a driver of reforms

“Best value” is not a dominant rationale in Belgium, Italy or Germany. It is interesting, however, to note that Belgian mutuals and federations of home care providers have tried to integrate this type of rationale by asserting the cost-effectiveness of the services they provide and their ability to develop new services within their members’ organizations. Non-profit organizations insist on the fact that the care and health system already delivers “best value” services: *“our health care system is not only efficient but it is also more competitive compared to a privatized system and probably the main argument is that it is a remarkable and irreplaceable tool for social justice”* (Echo Mutualiste, 2005: 3).

In England, for some time now, the concept represented by the terms “value for money” or “best value” has been at the heart of commissioning decisions in the sector (Department of Health, 1998; Department of Health, 1989). Given the limited resources available, the system emphasizes maximizing the return on investment by targeting the neediest (in financial terms and in terms of needs), by delegating control over the commissioning of resources to care users themselves in order to stop the “one size fits all” approach, and by attempting to coordinate health and social care resources.

The exact mechanism used for commissioning services varies between Local Authorities, but they all need to comply with the principle of “best value”, which requires them to ensure that the services commissioned are the most cost-effective and efficient in improving users’ wellbeing.

3.3. The opportunity to enhance user’s empowerment

In addition to increased pressures on public provision, policy makers around the world have been reacting to important shifts in social attitudes and expectations. In addition to changes in the willingness to provide informal care (described below), users’ expectations about the amount and quality of the support they are prepared to receive have changed, with successive cohorts of older people becoming increasingly assertive and demanding. These rising expectations, linked to general greater wealth and improving living standards amongst the older population in Western economies, are increasingly echoed in the political arena due in part to the growing relative representation of older people amongst the voting population. The concern for “empowerment” has to be understood in the context of older people as an assertive electorate demanding improvements in the quality of the services and potential “user/clients” whose choices and preferences “matter”. However, “empowerment” is not necessarily understood in the same way and is not (yet) considered an urgent matter in Germany, Italy and Belgium, whereas it is a top priority in England. Empowerment is usually understood as “to buy (care) is to choose” (with the exception of Wallonia, where choice is not “yet” identified as a desirable option): users and their families need accessible and reliable information to be able to make the best decision. England has the most refined conception of “empowerment,” where it is intimately linked with the personal budget idea which aims to introduce a better balance of power between caregivers and care receivers.

3.3.1. Users’ empowerment mainly understood as accessible information in Germany and Italy

The information available to users and their families has been an issue informing public policies over the last years in Germany. For instance, the provision of “unbiased” information was a rationale instilled in regional care policies. A widespread concern for the *Länder* is that counselling services should be available across the whole territory. At national level, the latest care reform in 2008 took the same route as it obliged the “public partners” involved in the

administration of the care system (long-term care insurance funds, and welfare departments of municipalities) to create “one stop counselling points” (*Pflegestützpunkte*) in urban agglomerations and rural districts. Such information points, based on temporary public funding, have a remit to provide basic information to users and relatives, but not to oversee the process of care provision by different suppliers.

Services address the needs of users’ relatives first. Arguments put forward in favour of improved “consumer information” referred to the underuse of special care services (respite care, temporary residential provision, etc.) and “provider jungles” in urban agglomerations. Developing users’ choice has not been very prominent in this debate, however.

In Italy, several studies have stressed the positive effects of centralized access points for information and guidance in the long term care services network.¹⁷ Users’ empowerment is not targeted as such, but one can see that the Punto Unico d’Accesso is intended to inform dependent people *and* to ensure continuity of care pathways. Among other reasons mentioned for promoting information is that the argument that the organization of long-term care *systems* should meet complex needs, combining information and directing individuals within the services system, simplifying and reducing bureaucracy, in order to respond to demands for the personalization of assistance paths and for quality at every stage.

3.3.2. Personalization as a synonym of empowerment in England

The personalization agenda as pursued in England can be seen as a way of subsuming empowerment arguments under “best value” objectives, in the sense that more choice and control for users will result in better outcomes. It is argued that service users will be able to use their resources more imaginatively to meet their needs, optimizing the deployment of resources and delivering better value for money (Clark et al., 2004; Fernandez et al., 2007; Riddell et al., 2005; Spandler & Vick, 2006). Personalization is also framed as a way of maximizing independence and empowerment, and possibly reducing costs and preventing abuse of frail or dependent people.

The push towards the personalization of care could, however, run counter to quality improvement objectives if the new services commissioned by users failed to meet minimum standards, due for example to insufficiently trained personal assistants.

3.3.3. Exercising “voice” as a way to empower users in Belgium

Decision-making and quality evaluation by care receivers is, very discreetly, emerging as an issue in Belgium. People from the voluntary sector were the first to raise the issue. Various organizations were at the origin of some very innovative projects (on participatory homes for

¹⁷ Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS), Punto unico d’accesso, presa in carico e continuità assistenziale, AGENAS, 2008

example) and are conscious of the importance of giving elderly people a “voice” and proper and independent structures to exercise it on the way they are treated or cared for. The argument has not yet been developed or heard on a very large regional or national scale but it definitely has a future. A conference was organised in 2009 by Social security’s institutions on the empowerment of elderly people. “Freedom of choice”, “autonomy” or “power of decision” in a situation of dependency were mentioned as key issues. The Resident Assessment Instrument (used in the US since the 80s) is also a new topic that was launched on National Elderly Day in 2009. It is a standardized instrument to enable elderly dependants, with the help of their various care providers, to evaluate properly their position, their needs, and the risks they face. The RAI also provides incentives to evaluate the quality of care. The federal government also wants to stimulate “self care” as a way to prevent (too) early use of formal care. Self care is based on the idea that dependent adults should do everything possible in terms of disease prevention and loss of autonomy.

3.4. Discourses supporting “diversification” of providers and funding

Documents show that “diversification” is a recurrent term in discourses and texts. This section reveals the many meanings of the term. In Germany and Wallonia, it is understood in the context of introducing (more) market mechanisms. In Italy, diversification is usually associated with increased legitimacy for care provision by non-profit organizations and with the phenomenon of migrant workers. Volunteering and a diversification of funding mechanisms are seen as important issues in the so-called diversification debate in England. In Flanders, informal carers are very much treated as co-partners of care, able to meet the many diverse needs of care users.

3.4.1. Marketized solutions: pro in Germany, contra in Belgium

Marketized solutions are well accepted in Germany. Moreover, the welfare market character of the domiciliary care system, that is any kind of organized care outside the family sphere, seems to be taken for granted too. Given the long tradition of a welfare mix in the German care sector, the involvement of commercial players has not provoked a more long-standing, severe critique from stakeholders already present in the care system (non-profit providers) or from local politicians. The lack of individual users’ case management and the end of what could be seen as a (timid) investment in a planned and coordinated infrastructure of community care in the 1980s have been marginal issues in the wider debate, as witnessed by the documents reviewed for this report and by many other papers and statements, too. That said, most stakeholders do adhere to a highly-standardized system of professionalized care, including some elements of home help, and endorse both the major institutional lever for this, long-term care insurance, as well as policies directed towards the improvement of service quality. Despite concerns over an increasing number of poor senior citizens unable to pay for formal care (EPN: 103), there is no class or gender bias to this endorsement.

In Belgium, privatized care and health-care solutions have appeared on several fronts: (1) the development of private for-profit health insurance schemes, (2) the development of big and influential pharmaceutical groups, (3) the arrival of for-profit providers with the service voucher scheme, (4) a strong rise in the number of private for-profit rest homes in Wallonia. As will be shown later, the home care sector is not very marketized yet in Belgium and, in contrast to Germany, the non-profit sector argues strongly against the introduction of market principles, competition and even diversification, seen as a market mechanism. Belgium is indeed the country where diversification is seen as an utterly ambiguous term as it is associated with the “danger” of the dominant (non-profit) actors of care having to compete with for-profit providers. These arguments are put forward in particular by the “mutuals”, in the name of efficiency and also of equality and justice. The mutuals argue that, before taking any further step towards privatization, an impact assessment should be conducted, through the introduction of pilot projects and their evaluation from the point of view of (potential) *“disadvantages in terms of accessibility, quality, solidarity and efficiency, which are important principles in order to guarantee the fundamental right of access to health care services.”* (MC-Information, 2007: 7). The same type of argument was developed about the service-voucher scheme. One of the federations of home care services explains in an editorial that they decided to enter the voucher scheme in order to put a halt to the development of measures that risk transforming home care into a “commodity.”

3.4.2. Non-profit as a recognized partner and informal migrant carers as answering the need for more flexibility in care provision

In Italy, the observation of arguments on “diversification” should be included in a more general discussion about the Italian welfare system, in which LTC benefits are above all monetary transfers paid only to the extremely fragile or highly dependent elderly (Onofri Commission, 1997). The Libro Bianco (2009) recognizes that dependent older people have new needs and that these new needs should be addressed.

Thanks to the influence of the European Union, the introduction of the subsidiarity principle became a first important step for the legal recognition of the status of non-profit organizations within the Italian welfare system. From the early 1990s in Italy, horizontal subsidiarity increasingly became a widely accepted principle framing the relationship between public and private (especially non-profit) actors in the social policy field. Non-profit organizations are regulated by Law 266/91 and Law 381/91, although only as far as volunteering organizations and social cooperative societies are concerned, so that they are allowed to provide services to public institutions. The full recognition of non-profit organizations – in discourses and in practice – as partners for public organizations in the planning and management of welfare provision was mainly due to some innovative sector-specific policies (e.g. Law 285/97), and then generalized by the framework law on social policies (Law 328/00). Law 328/00 puts an end to the old hierarchy considering private actors as subaltern to public providers, building up a new, plural and mixed welfare system.

Besides, some of the documents under study also show that the *badante* (migrant female carer) phenomenon is not ignored in public debates. State support towards their regularization is often justified with the argument that informal care by migrant care workers is not so much due to a lack of public structures but rather to the need for more flexible care giving schedules and the desire to keep older family members in their homes, where they can be supervised by their relatives as long as possible.

3.4.3. Encouraging volunteering and diversification of funding in England

In England, there is already a diversity of community-based service providers. This is largely the result of the quasi-market reforms from the early 1990s. In recent years policy makers have, however, become increasingly interested in expanding the role of the voluntary (third) sector in the provision of public services. A major review of volunteering in Britain was published in 2008 (The Commission on the Future of Volunteering, 2008) and a paper containing policy recommendations with regard to the involvement of volunteers in health and social care services was also published in 2010 (Department of Health, 2010). It stated that *“This is not about replacing paid professionals. It is about re-imagining how services interact with the people who encounter them and the communities they serve”* (Department of Health, 2010: 6). At present, arguments in favour of volunteering are centred on creating stronger communities and designing innovative and more personalized services. A large volunteer workforce, however, will obviously lower the costs of service provision. Keeping individuals in the community for as long as possible is still perceived as the best way to care for dependent people. In order to achieve this goal, the state increasingly recognizes the need to support informal carers, in particular by providing possibilities for breaks from care duties, through respite care and day care services. Produced by the previous government, the most recent White Paper acknowledged that involving volunteers “frees up paid staff time” although it has not been recognized as an explicit policy objective (HM Government, 2010a: 102). However, it is hard to believe, given the timing of the review of volunteering and the enthusiasm with which politicians across the party spectrum have embraced this policy, that financial concerns are not one of the drivers of this policy.

Besides, diversification of funding is observable in England, where there has been a debate for some time around what is the best funding solution for both residential and non-residential LTC (Royal Commission on Long-term Care, 1999; Wanless, 2006; HM Government, 2010a). This debate is driven by concerns over the future sustainability of the current system, the lack of risk-sharing in the current system (such that people are not protected from potentially very high care costs), perceptions that the current system is underfunded, and issues around equity and fairness. Political parties have tended towards their favoured solutions for the sources of new funding: thus the previous Labour government eventually came out in favour of a largely state-funded universal system (HM Government, 2010a). In contrast, the Conservative party is in favour of promoting private insurance options, which currently have extremely low levels of take-up in England. Innovative solutions such as equity-release schemes have also been suggested as possible ways of drawing on private

resources. There is also interest in alternative solutions ensuring that informal carers can continue to provide support. The Coalition government has announced that a Commission will be set up to come up with a solution to the problem.

In Italy too, diversification of funding is an issue, but there are no policies to foster it. The Italian Libro Bianco emphasizes that *“Taking into account limited public funding, public and private resources have to be combined by allowing specific forms of private insurance, as well as, where possible, the exploitation of public and personal savings”* (La vita buona nella società attiva – Libro bianco sul futuro del modello sociale: 51).

3.4.4. Family carers as co-experts, mainly in Flanders

In Belgium it is usual to hear that *“informal family care is there or is not there, but it is difficult to create it”*. In the light of the reviewed documents, one can see that efforts have been made in recent years towards support for potential informal carers, which makes this observation sound obsolete. In parallel with the trend of growing needs in home care, there came an interest by the government in Flanders in the 1980s for informal carers. In the 1990s the position of informal carer was regulated and authorized by the Flemish government. According to this regulation, the informal carer needs to be adequately supported in his or her care for the ill or elderly person. The home care decree (1998) was based on the notion that formal and informal carers are partners in care; informal carers are seen as co-experts. This decree intends to acknowledge the essential contribution of the family care environment in the home care and give it an honourable place (Geerts and Breda, 2007: 152-155). The decree states that formal care needs to act only when there is not enough informal care or when this care is overburdened. This implies a system of subsidiarity of formal care: self care and the natural and available care environment are the primary care resources; professional care is complementary. Informal care is also considered better tailored to the needs of the client as it combines flexibility and responsibility.

The issue of combining elderly care and work has been put on the political agenda by Flemish policymakers but the fact that this combination is taken on predominantly by women – among whom a large proportion are working – is not perceived as a challenge to be addressed. For a large part of public opinion, women seem to be more willing to care, and combining elderly care and family responsibilities is not mentioned as a key issue by the women’s movement (see chapter 7).

The interest in informal care is older in Flanders than in Wallonia, where the pioneering research *“The voice of the home environment”*, sponsored by the King Baudouin Foundation, was the immediate cause of the establishment of the first informal carers’ association in 2007. The ageing process and the growing needs in long term care will probably necessitate further reforms and transformations and we can make the hypothesis that the federal authorities are trying to make informal (family) care a “sustainable” option.¹⁸ The challenge here, as

¹⁸ A law was proposed on 10/02/2011 but has not yet been voted.

identified by the public authorities, seems to be to stabilize the existing level of informal care and to see how to encourage caregivers already there (and other potential caregivers?), through different support mechanisms, to keep caring. Many local initiatives have now been taken in Wallonia but Belgium still lacks a comprehensive informal carers' policy (Masuy, 2010).

4. What is “best care”?

4.1. Issues of solidarity and equal access

The field of home care services is increasingly becoming a field of tensions and compromises between different economic behaviours. The market can be a source of efficiency in resource allocation, but it takes any externalities poorly into account. These – positive or negative – externalities can be internalized by the public authorities, through mechanisms of taxation and redistribution. However, the functioning of public authorities can become bureaucratic. Associations are particularly able to create proximity relations but they can be limited by localism. Domestic production is able to maintain the family and is seen as crucial in countries where public support is at a low level. But it can imply domestic closure and gender inequalities.

The political project underlying the idea of a plural economy argues for efficiency and justice in the equilibrium between these different logics. Nevertheless, the plural economy does not imply that the different actors are interchangeable. Their mission is different and they will also mobilize different arguments and strategies in favour of their development. A capitalist enterprise aims at the maximum return on investment. It can integrate some collective benefits only if the public authority imposes this. The public sector should be the ultimate responsible actor for the regulation of the general interest, taking into account collective benefits. Associations have an objective of service to their members or to society but they are also privileged forms enabling the expression of civil society and the exploration of alternative forms of solidarity, at the borderline of the institutionalized world. The dominant position of the public (23% in Wallonia) and non-profit sector (73%) in Belgium (in contrast with the dominant position of for-profit in England (76%) and Germany (45%)) (see Chapter 4) could explain to some extent the prevalence in that country of arguments of justice and solidarity. As mentioned earlier, the non-profit sector in Belgium seems to understand “diversification” as a way towards marketization. Accordingly, this sector is mobilizing an (already ancient) rationale of justice and solidarity: the criteria of access to care at a decent price might not be respected if the system moves towards more privatization.

In countries like Germany or Italy, the rationale of solidarity is mainly understood through the prism of family solidarity and it is very strong. This value will probably evolve over time as the availability of informal support is changing significantly. Some countries, for instance, are experiencing a decline in the number of households shared across generations, due for example to reduced numbers of older people living with their children, and to higher divorce rates among new cohorts of older people. This decrease in generational cohabitation rates is

particularly important, because co-resident carers are typically those who provide the most intensive levels of support. In some countries, the reduction in the life expectancy gap between men and women has offset to a limited degree the overall decline in informal care supply, and led to small increases in informal support provided by older men to their dependent spouses.

In addition to changes in the availability of “potential” informal carers, expectations and attitudes towards informal care have been shifting. Whereas it is still the case in many Southern European countries that the family is expected to provide the bulk of the care required by older people with physical or mental disabilities, some countries have recently experienced a decline in the willingness to provide informal care. The size of these effects varies across European settings. The results from the 2007 social attitudes survey on health and long-term care carried out by the European Commission revealed very broad and widespread European support for the idea of state-provided services for older people with social care needs (European Commission, 2007). They suggested, however, varying public support for the notion that close relatives should care for dependent people even if that meant that they would have to sacrifice their careers to some extent: whereas only 25% of Belgian, 30% of British respondents agreed with the statement, 35% and 48% did so in Germany and Italy, respectively.

4.2. Achieving “best care” through reforms: family in relation with other types of providers

4.2.1. “A carer at home”: plea for a strong familial care effort in Germany

Considering the rationales underlying the societal organization of home care and related (policy or expert) discourse in Germany, it proves tricky to figure out something like a narrative that is coherently shaping both the institutional set-up of the elderly care system and the approaches of the various stakeholders involved in this system. However, although professional service provision has been on the rise during the last 20 years, the role of the family as major coordinator, if not provider, of care to dependent older people does not appear to be contested in principle and the recently adopted *Familiepflegezeit*¹⁹ appears to confirm this. “A carer at home” is an unchallenged consensus. Officially, this reflects an alleged preference of a large majority of dependent older people to live at home as long as possible. Elderly care is also considered an intergenerational solidarity that the family has to assume. Over several decades now, the discourse of all relevant stakeholders has stressed the inconvenience, if not cruelty, of residential care. Most care-dependent people, it is said, could not imagine living in residential care. Overall then, given that the very popular cash for care option is not questioned by most stakeholders and commentators in the public sphere, the family care model – maybe with a supplement of domiciliary (body-related) professional services – appears deeply engrained in the welfare culture of the country. Rather, there is a

¹⁹ The *Familiepflegezeit* was adopted in January 2012 and enables workers in charge of family care duty to reduce their working time without losing the equivalent income. This partial leave can last two years.

debate about the conditions under which families may be able to take on this responsibility without becoming overburdened. In the official discourse, the caring role of women is depicted, but allusions to the role of the family in elderly care are no longer gendered in an obvious manner.

When it comes to the question as to what typical stakeholders may see as the best way to care for frail senior citizens, the mainstream opinions in Germany stress the merits of hybrid structures. This firstly applies to the funding scheme, which combines quasi-universal entitlements to basic services. These services are initiated by professionalized assessments and overseen by administrative quality checks. At the same time, they are subject to what might be referred to as “informal governance”, including at least a coordinating role of families, but in most cases considerable practical efforts of relatives as well. Secondly, the preference for hybrid structures is reflected in the taken-for-granted character of the contemporary provider landscape in which non-profit and commercial providers coexist quite peacefully. Thirdly, there is hybridity in that the mainstream welfare state machinery, namely long-term care insurance, can be complemented, if necessary, by a social assistance scheme which provides full coverage in domiciliary provision to those who have used up their savings (or never had any). Fourthly, the very idea of what is “good service provision” appears hybrid too, since it draws on both a highly professionalized, mostly well-educated workforce (geriatric nurses and health care nurses) on the one hand, and a mixture of informal work, undeclared (migrant) employment and petty jobs, for the personal care part, on the other. It is these different kinds of hybrid structures that seem to inform public policies and the discourse of many experts in the German configuration.

4.2.2. *Family is “the primary nucleus” of any welfare plan in Italy*

The Libro Bianco places family at the centre of the new welfare model, by asserting that family “is the primary nucleus of any welfare plan, in order to protect the weak through the exchange of protection and care: because it is a system of relationships in which the subjects are not only bearers of needs, but also of solutions, stimuli and innovations.” The Libro Bianco emphasizing the economic and moral role of the family affirms once again one of the distinctive characteristics of the Italian system of welfare: the central position assigned to the family as the major actor called upon to deliver resources (economic and relational) to its own members and to society as a whole. As the document underlines, “*in our country the condition of the elderly person is still strongly sustained by family relations more solid than in other countries. This bond must be encouraged and nurtured.*” The document then introduces the concept of “subsidiary welfare.” The subsidiarity principle has taken on great importance in Italy following two events. First it has been included in the Maastricht Agreement as a founding element of the European Union institutional architecture. Subsequently, the reform of Title V introduced into the Italian Constitution an explicit reference both to vertical subsidiarity as a criterion of division among the different levels of government, and horizontal subsidiarity as regulating the relationships between public administration and civil society in all of its expressions. This means that horizontal subsidiarity has also become a fundamental

reference in the definition of the relationships and mutual responsibilities between public actors and family.

4.2.3. *“Keeping the elderly in the community” through personalization*

England is in an original position regarding the definition of best care. Clearly, the current policy is framed by the “personalization” agenda and the transfer of control over the commissioning of services to individuals. Best care is defined as the one that the care receiver him/herself chooses. This is framed as a way of maximizing independence and empowerment, and possibly reducing costs. However, given the limited amount of state resources available, this “best way to care” is, in reality, concentrated on the neediest, with more and more authorities only providing services to individuals with very high levels of disability.

In addition, keeping individuals in the community for as long as possible is still perceived as the best way to care for dependent people. In order to achieve this goal, the state has increasingly recognized the need to support informal family carers, in particular by providing them with breaks from their caring duties, through respite care and day care services. Family care remains “taken for granted” in the documents while it is obvious, according to the same documents, that voluntary care should be more present with informal carers getting support (respite, training) and compensation.

Furthermore, increasing efforts are being made to improve the coordination of health and social care services in order to prevent people from needing intensive care services, and to maximize the cost effectiveness of the resources available.

4.2.4. *Belgium: “family is the main link in a wider (formal) care chain” in Wallonia and the “main partner in the supply of care” in Flanders*

In Wallonia, as mentioned earlier, the literature that was explored shows a recent but growing interest from the care sector itself and from the authorities in informal family carers, who are very often called “*aidants naturels*” (“natural caregivers”), and their specific needs and problems. They are recognized as playing a crucial role in home care: “*Without these carers, their presence and their help, keeping elderly people at home is almost impossible*” (En Marche, 2007). The presence of the family is also being recognized as essential for the well-being of the care receivers. However, their presence is seen as part of a wider formal care chain: care arrangements are not a choice between “formal” or “informal family care”; rather, best care is seen as an articulation of both.

As mentioned in section 2.3, the family remains very important as a caregiver and its presence is taken very seriously when it comes to diversifying care supply. Official documents show a concern for articulating (more) formal supply with family carers (benefiting from more external support). In Flanders, more emphasis is put on the family than in Wallonia, probably because of the influence of informal carer organizations. Family care is often seen as the best

way to ensure a tailor-made care arrangement, closer to the user's needs and preferences. Another tendency gaining ground in Flanders is that of "self care," which, paradoxically, also includes family care. According to the decree of 1998, elderly people should be allowed to rely on self care, taking their own capabilities *and* those of their informal carer(s) into account. The personal independence and self-responsibility of the frail elderly and their informal carer(s) need to be supported and stimulated. In the new 2009 decree, these two objectives are also emphasized. The home care agencies should offer activities of general informative, educational and recreational character to strengthen the social network of the client, supported by local associations. This discourse is, however, parallel to the discourse of the quantitative and qualitative increase in home care services.

4.2.5. *Family: lead role or central character in "best care"?*

Not surprisingly, the family remains more or less central in the definition of "best care" in all four countries. However, one can ask whether this relative centrality is comparable given the differences in each system, notably in terms of organization and compensation for family care. In Flanders for instance, the family seems central but this has to be analysed in a context of significant formal care supply, contrasting with the Italian case where public opinion seems to be unanimous on families' central role in providing care. Besides, the role of the family, important as it may be, does not necessarily refer to identical responsibilities or tasks in all four care systems. Nuances should probably be introduced as to who is considering family as central: the family is sometimes at the centre of what can be defined as a cultural or collective representation of "best care" but is not necessarily central in policy documents. Sometimes, as in Italy, the care system is bathed in family and familial values but programmatic documents target the *badante* rather than the family itself. The distinction made between "lead role" and "central character", borrowed from cinema terminology, can be of some help here in grasping the scope of the importance of the family, to put it in its right place. The lead role in what is defined as "best care" is the most visible and the most acknowledged form of care, in particular in policy or programmatic documents. It is often the main target of social policies in terms of financial efforts. The central character is less visible than the lead role but is acknowledged (in official documents as well as in "grey literature") to play a crucial role in the day to day care arrangements. As in a play, the relation central character–lead role is one of "impulse giver", which is not identical to a relation of subsidiarity. These categories are of course "discursive" categories, deduced from the selected documents. We do not claim here that they correspond to any statistically sound reality.

Table 1.1: Lead role and central character in “best care”

	Lead role	Central character
Belgium	Formal care	Family (informal family care in Wallonia, semi-formal family care in Flanders)
Italy	Semi-formal and informal non-family care (<i>badante</i>)	Family
Germany	Family (informal and semi-formal care)	
England	Individual care receiver	Community (care manager, family and volunteering as informal and semi-formal carers)

In Belgium, formal care is has the lead role but the family is seen as the main coordinator of care provision. It is normal to consider that family bears the responsibility of the care arrangement, even if family members do not deliver care themselves. In Germany, lead role and central character are identical: it is widely accepted that families should care, and the LTC insurance scheme supports the idea that the family has to play the lead role. Formal care neither has the lead role nor is it the central character. It is accepted that it has more a “supporting role”. In England, it is very clear from the revised documents that it is the individual in need of care who has the lead role in defining “best care”. The community – ambiguous as this term may be – is considered the central character in the care regime. The lead role in Italy was traditionally taken on by families and it is still very important. It is the central pillar around which the support of the State is built but the rationales accompanying reforms show that the phenomenon of migrant female carers has become a very important concern in the Italian care debate. This justifies its place in the lead role, while the family has shifted to be the central character influencing the Italian care regime as a whole.

5. Conclusions: tensions in the care regimes revealed by their rationales

The aim of this analysis in terms of “rationales” is to reconstruct the combination of “*basic arguments (...) deployed by various social actors*” in the process of policy determination and implementation (Bussemaker 1997: 73). There are sometimes contradictions between the rationales prominent among policy makers and those shared by the wider public; there are clear tensions concerning what these rationales imply altogether. Welfare state responsibility for elderly care is widely acknowledged for instance in Germany, yet benefit retrenchment leaves observers with many open questions, given that most observers know about the reluctance of elderly Germans to resort to social assistance thus depriving their children of their inheritance. Tensions are also related to gendered questions, such as how to concretely enable care giving women the opportunity to enter or stay in the labour market. Despite women’s full labour market participation being a core EU policy objective widely advocated by political and economic elites, care policies still draw on ideas such as “a carer at home” (in Germany) or “family as the primary nucleus” of care (in Italy). In countries where formal care is considered the main target of care policies (as in Belgium, but also in England), families

nonetheless remain central. True, the number of informal carers who are themselves retired is increasing. As the mainstream policy in Europe goes towards postponing the age of retirement, however, this tension is anything but resolved. As to the welfare-market in elderly care, the discourse stressing freedom of choice clashes with concerns over how little transparent this market sometimes is. Besides, are “freedom of choice” or “empowerment” realistic objectives, given that professional care is becoming ever more taylorized, so that few opportunities exist for suppliers to make a difference, maybe with the exception of below-average wages for those they employ?

The overall increasing pressure on quality of care provision, including the management of transitions from hospital to home and the transmission of information across the domiciliary sector, goes alongside further sorts of tensions. In countries where quasi-markets are very important, demands for quality assurance sit uneasily with a discourse stressing competition and the consumer-centeredness of the care system, as suppliers are sometimes urged to neglect quality wherever this is not detected by users and, ultimately, to invest in marketing instead of better quality. At the end of the day, the typical policy maker will want everything: full labour market participation of men and women on the one hand, a high level of informal carers’ engagement in care on the other; competition among professional care providers on the one hand, smooth transitions, integrated services and quality care for everyone; and, last but not least, limitation of public spending on elderly care on the one hand, the universal respect of human dignity and solidarity for an increasing number of people on the other.

Society’s capacity to meet the future demand for social care services will depend on its wealth, both in terms of the ability of individuals in need to pay for their care packages, and of society’s ability to fund a collective care system. Internationally, there is evidence suggesting that newer cohorts of older people enjoy greater financial resources, through for instance the indexation of their pensions to earnings, and in particular through the revalorization of wealth accumulated in housing stocks. As a result, it is possible that in the future a greater number of older people will find themselves in a better financial position to face some of the costs of care, and that this in turn will alleviate to some extent the financial burden on state budgets. However, the financial crisis as well as permanent high unemployment rates should temper this optimistic perspective and one should remain vigilant regarding equal access, redistributive justice or gender equality objectives, which do not seem to predominate, according to the reviewed documents.

Table 1.2: Rationales related to care reforms as expressed in national contexts

		Italy	Germany	England	Wallonia	Flanders
Why reform?	Consequences of ageing process	The ageing process challenges the system that was helping only the neediest and most fragile	Concerns about insufficient care supply.	Positive approach, increased demand, driver of technology innovation	Concerns about high costs and insufficient supply	
	Enhance empowerment understood as...	Medium priority. Developing the decision-making process of the care receiver via centralized information points.	Medium priority. “To buy is to choose” via improved consumer’s information for families (users = caregiver and care receiver).	Top priority. “To buy is to choose” via user-led services (direct payment, needs assessment with free choice of cash or in kind, personalization agenda) to improve autonomy. “User knows best” to stop “one size fits all” approach. More user’s choice = “best value” and efficiency. Prevents adult abuse which is a risk in the personalization agenda	Choice is not an issue (choice is considered as already possible in the system)	“To buy is to choose”: access to information Develop self care to enhance autonomy
					Low priority for government but high on informal caregiver’s association agenda	Medium priority as some initiatives have already been taken.
	Promote “Best value”	Not a dominant argument yet	Not a dominant argument yet	Dominant argument, at the heart of commissioning process and personalization agenda.	Not a dominant argument yet.	
	Improve coordination of health and care	<i>Punto Unico d’Accesso</i> is a possible instrument but evaluation reveals mixed results	Long term care insurance and social assistance in combination.	High priority. Improves the well-being of the user, lessens pressure on healthcare	Top priority. Pilot experiences are encouraged.	Top priority. Achieved through the 2008 decree on Coordinative Initiatives at First.
	Diversification in funding, support and providers	Horizontal subsidiarity: desire expressed by authorities to build home care on private for-profit (insurance), non-profit, patrimonial and public resources.	“Welfare market” as a peaceful co-existence of for- and non-profit providers, informal governance (and big efforts) by families. Consensus about universal funding schemes.	Volunteering is encouraged. Competition is taken for granted. Self care and technology is seen as a way to postpone family and professional intervention.	Informal care is seen as a potential source of care	

Norms and values	Value of care work (formal and informal)	Low status, low on prestige scale, ethnic niche.	High symbolic value given to informal family care. Medium prestige for body related care, low prestige for personal care.	No real concern. Quality of care rather than quality of jobs. Government expressed intentions to “raising standards of the workforce”, “development of the workforce” and “retaining staff”. Carer’s credit and support is seen as a compensation for carer’s contribution to society.	“Professional care is insufficiently attractive” is a political consensus. Informal caregiver’s association make pressure to insure (symbolic and financial) recognition of informal care	
	Gender equality	Modernized familism; “intergenerational pact of mutual care” (elderly caring for young ones, sharing pensions, daughters (-in law) caring for elderly); “valuing (gender) difference” more than “equal opportunity” by improving female carer’s condition via a flexible and open employment market.	Financial autonomy of women is recognized as a legitimate request and a source of tension (unavailability of informal female carers). Professional care is seen as an excellent part-time job opportunity for women. Preference for female carers.	Timid claim for more diversity in the workforce. Acknowledgement that women will need more care in future because of longer life expectancy. Acknowledgment of a (female) “sandwich generation” that leaves carer without resources.	Not present in care issues as such but concerns are expressed about how to reconcile longer women’s careers and need to care.	
	Justice, equal access and perimeter of solidarity	Not a dominant argument. Family is considered the main source of solidarity	Not a dominant argument Family care expresses intergenerational solidarity	Needs assessment insures vertical and horizontal equity (same needs=same support, more need=more support) Concerns about the difficult access of people of the middle class.	Non-profit against privatization of care in relation with risk of care being expensive and inaccessible	Concern for a “minimal access for all senior citizens” (Bismarckian logic)
Best care	Family care should be...	“the primary nucleus of any Welfare plan” Unchallenged consensus. “(family) bond must be encouraged and fed”	“a carer at home” Unchallenged consensus. Key-role in enabling older people to stay at home, family is provider and coordinator of care	Taken for granted but (other sources of) informal care are also considered as natural, like volunteering.	“the main link in a wider formal care chain”	“Main partner in the supply of care”. Unchallenged consensus.
	Other sources of care should be...	“a family-inspired care”, flexible and affectionate. State is subsidiary. Long presence, high preference for women. Technical skills are seen as crucial only for heavy cases.	“subsidiary”. Preference for “Hybrid structures” with family caring and/or coordinating care	help to “keep the elderly in community” with a large part of informal care that could get support (respite, training) and compensation. Personalization is considered the best way to achieve “best care”	Sufficient formal care with informal non-family care as a potential future source of care	Sufficient and “tailor made”: important formal supply articulated with (more supported) family carers

- Chapter 2 -

Variations in the targeting of home-based support for dependent older people across Europe

1. Introduction

Over the last 20 years, the field of long-term care policy analysis has gained considerable attention internationally. Across Europe, a large number of countries have begun a process of reform of their support system for people with long term care needs, both in terms of the nature of the support provided and the mechanisms for financing the help (Fernández & Forder, 2010; Fernández, Forder, Trukeschitz, Rokosová & McDaid, 2009; Colombo, Llena-Nozal, Mercier & Tjadens, 2011). Overall, it could be argued that the policy attention paid to the long term care field responds to two interrelated processes. On the one hand, the challenge to public purses of the significant growth in the demand for long term care services linked amongst other things with the ageing of the population. On the other, the associated enhanced political weight enjoyed by the growing number of older people in Western European societies, who represent by far the largest “consumers” of long term care services.

Faced with the changes in society, a large number of European countries have embarked in the reform of their social care systems (see for instance the reforms in UK, Germany, France, Italy, Belgium, Austria and Spain). Overall, it could be argued that the two main (and contradictory) objectives of such reforms have been to increase the coverage provided by the state in order to respond to the demand for greater and better state support by new cohorts of older people, whilst at the same time aiming to contain the rapid increase in expenditures associated with social care services. In addition, countries such as France and Belgium have focused significant attention on the potential for social care to contribute employment opportunities, and particularly for low-skilled workforce.

In this context, the paper examines the recent evolution of the state offer of home care support, as well as the role of home care in relation to other forms of “social care” support (including disability-related cash benefits) in order to provide a comprehensive picture of the offer for state support available in each national setting. The paper compares national processes for setting and implementing (needs and means-testing) service eligibility policies and their implications in terms of quantitative indicators of population coverage and intensity of provision. In addition, the analysis contrasts key features of the support provided, such as whether the resources are provided in cash or in kind, the extent of user choice over the type of service and of provider commissioned, and the existence of systematic processes for assisting individuals to design their support plan.

We present a brief summary of the key components of the system in each of them in turn, and then turn to a comparative analysis of their key features.

2. Methodology

The study examines the arrangements in four Western European countries exemplifying three of the traditional social welfare models: Bismarkian, Anglo-Saxon and Southern care models. Although the paper does not aim to compare the characteristics of the funding systems in the countries explored, it touches on some of their main aspects in order to understand the patterns of state sponsored service provision observed.

The analysis compares *indicators* of:

Eligibility criteria, and the processes and responsibilities in place for carrying out the needs- and means-testing of state support. The analysis compares quantitative indicators of population coverage and intensity of provision among care recipients. An important element of comparison across the systems explored is the degree to which individuals are given entitlements to services (with the understanding that everyone who fulfils the eligibility criteria - regardless of available budgets - must be granted benefits) or whether the state “offer” is conditional on the level of resources available at a given point in time.

Nature of provision, including whether support is provided in cash or in kind, the extent of user choice over the type of service and of provider used, and the existence of systematic processes for assisting individuals to design their support plan.

The analysis of the quantitative data is built around the evidence summarised in Figures 1 to 5. In each figure, a set of bar charts depicts the proportion of the older population covered by different types of state-funded support (illustrated by the width of the column along the horizontal axis of the diagrams) and the average intensity of the support provided (among recipients), indicated by the height of the columns. Whereas the figures cannot be used to determine the total proportion of the older population receiving some support from the state because of the potential overlap in the targeting of the different schemes depicted. However, the areas and shapes (width and length) of each column can be used to compare the targeting of each service type, and the total area covered by all the services in each country can be used to compare the overall levels of resources spent supporting dependent older people across countries. We have aimed to cover all social care services. However, we do not report the figures when those services cover less than 0,5 per cent of the older population.

Although the analysis excludes (para)-*medical* services, it is important to point out that it is sometimes difficult to disentangle health and social care support using the available national statistics, and that there exist differences between countries in the definition and classification of services.

Using the evidence in Figures 1 to 5, the analysis explores possible links between differences in the “offers” of support in each country and differences in their cultural and socioeconomic characteristics.

3. Key components of National systems

Main characteristics are summarized in Table 1 inserted in the introductory note of this report.

3.1. Belgium

When examining how home care is supported by public authorities, we must take into account that a significant proportion of older people in Belgium live in residential care (5.8 % and 8.3% of the older population in Flanders and in Wallonia, respectively). At present, residential care has been a shared responsibility between the national and the regional levels authorities, and is to become entirely decentralised following the last round of reforms in 2011. This high institutionalisation rate is partly due to the top down nature of the planning process in Belgium, which means that public bodies set each year the maximum number of beds which can be supported by public financing. In that sense, the level of residential care activity is predetermined by the authorities who decide the maximum amount of public funding which can be spent every year. In addition, the state contributes a considerable €5,500 per month per residential care user. Given the substitutability between the two services, the significant proportion of older people living in residential care is likely to generate a lower need for home care services in Belgium than in other countries, other things equal.

Public supported home care is based on 3 pillars: home care, voucher system and social securities benefits.

Home care services are regulated by regional authorities, through a “tutelary” system, which supports the provision of personal care services by allocating public funding to public and non-profit providers. This program is a budget constrained program. Every year, each region sets the maximum number of hours of services which can be provided by each provider.

Users’ needs are evaluated through a “social survey” carried out by a social worker - which could be considered as a care manager - belonging to the organisation which will provide the service. In some cases, the user can ask for additional assistance with the coordination of the different home care services (housework, homecare, meals on wheels...). The law stipulates that professional home care must be granted to those with the greatest needs and in the worst financial position. However, no legal criteria are provided to define this eligibility. The co-payment is set by law, according to the “household earner” in Wallonia, and according to five parameters in Flanders (net monthly income, household size, dependency level and duration and intensity of the service provided). A cap of a maximum of 200 hours per trimester per user operates in Wallonia but not in Flanders.

Surprisingly, the proportion of the older population covered by the service is roughly the same in Wallonia and Flanders (around 5.5%). However, the intensity of support differs significantly: the monthly average public expenditure per user is €66 in Wallonia and €65 in Flanders. This difference reflects, most probably, the greater level of economic prosperity in Flanders and the fact that a greater proportion of the older population is supported in

residential care in Wallonia. Although at present it only covers a few hundred individuals, the level of day care provision has recently been rising, in particular in Flanders.

Around 7% of the older population buys vouchers (“*titres service*”) to hire the services of a home helper, with an average intensity of 10 hours by month and an average public monthly cost of €55. The voucher system was not targeted on dependent people (anyone in Belgium has got access to the scheme) but its use is limited to support with housework tasks. The scheme cannot be used therefore to obtain support with personal care tasks, which are considered to require more skilled inputs. However, the fact that most home care providers also offer services through this voucher scheme clearly indicates that the services commissioned through vouchers plays an important role supporting dependent people. Public expenditure on the voucher scheme is not budget-constrained, and the scheme is neither means nor need tested. There is, however, a cap in the level of use per individual, which is limited to 500 vouchers per year for the general population and to 2,000 vouchers per year for dependent people. The price per voucher is set by law and does not depend on the user’s income.

Given that state funded home care is concentrated on dependent people with low income and that access to the vouchers is open to everyone and restricted in terms of its use for support with personal care tasks, it is likely that there will be important differences in the population of older people using each of the two types of support. However, given the budget constrained nature of the home care programme, it is also likely that help commissioned by the voucher scheme is being used to cover some of the needs for personal support of individuals that may not have access to publicly subsidized home care.

Tasks allowed by law to be carried out by home care workers

- a) Assistance with daily life for dependent persons: help with mobility, shopping, housekeeping, preparation of meals, etc...
- b) Tasks related to health, hygiene, comfort and personal safety excluding all (para)-medical tasks
- c) Educational role: organisation of the household, evaluation and stimulation of the potential for person to become in control of his/her daily life.
- d) Relational help: identification of problems, support and dialogue...
- e) Social assistance: support with administrative procedures and organisation of the budget, signposting to specialized organisations...

Tasks allowed by law to be carried out by voucher workers

House cleaning, washing and ironing of clothes, little sewing jobs and preparation of meals.

Approximately 7.5% of older people in Belgium (8.2% in Flanders and 7.5% in Wallonia) receive an allowance for the help to older people (*Allocation pour l'aide aux personnes âgées*) worth an average of €274 per month. Approximately 1.4% of older people receive an allowance for handicapped people (*Allocations aux personnes handicapées*) worth on average €07 per month. Both of these national entitlement programs are means and needs tested (through a medical evaluation). They are significantly targeted on the neediest older people living at home, but they do not require the agreement of a particular care plan and of recipients are free to spend the money as they wish. Moreover, 14.6% of Flemish older people receive a flat cash allowance of €30 from the Flemish Long –Term Care Insurance (*Vlaamse zorgverzekering*). This entitlement program is not means-tested and is targeted on people from above a certain level of dependency (the assessment is carried out, by a GP, on the basis of an official scale which measures the severity of (Instrumental) Activities of Daily Living limitations) living in residential facilities or at home.

3.2. Italy

Like in other Mediterranean countries, families constitute in Italy the central pillar around which is built the support that the state provides for older people with social care needs. In recent years, however, the Italian care model has shifted from a model based primarily on informal, unpaid care provided by the family to one based on informal, paid care provided by irregular and regular immigrant minders, partially funded by cash for care allowances and tied cash under the form of tax incentives to regularize homecare workers.

3.2.1. The central role of cash for care allowances

The main cash allowance, the Attendance Allowance (*Indennità di accompagnamento - IDA*), is a national cash benefit scheme paid by the National Social Security Institute to people assessed as being unable to perform basic activities of daily living (following a medical evaluation). Everyone meeting the eligibility criteria is entitled to a flat allowance of €470 per month. Approximately 9.5% of the older population receives IDA. Beneficiaries are free to spend the money as they want, and there is no requirement to agree a care plan.

Although introduced nationally in 2000, the Care Allowance (*Assegno de cura, AdC*) is managed and financed by regions and municipalities, a feature which has led to very significant variations in the rate of uptake across regions – which range from 3.5% of the older population in the Bolzano Province to zero in some southern regions.²⁰ In Italy overall, approximately 0.6% of the older population receive AdC, worth on average €98 per month.

Access to AdC is both needs and means tested, and requires the presence of an informal care support network or the commitment to hire a professional caregiver with the resources

²⁰ Source: Network Non Autosufficienza (NNA) (eds) (2009), “L’assistenza agli anziani non autosufficienti in Italia”, Rapporto 2009, in Maggioli Editore (l’invecchiamento RpdI-IplAnped).

allocated. Originally a measure to compensate family caregivers (mostly wives and daughters), in the past decade AdC has become a mechanism for remunerating privately contracted caregivers, especially in order to facilitate the regularization of their contractual position. Indeed, most Italian regions have linked the allowance to the regularization of family caregivers on the basis of a work contract of at least 25 hours per week.

AdC can also be received as a vouchers for home care services. The level entitlement can be fixed (for example in Emilia-Romagna and Sardinia, at €160 and €250 per month, respectively) or variable depending, for example, on the care burden and on the user's income, (for example to between €50 and €260 per month in Veneto, and between €120 and €200 per month in Friuli-Venezia Giulia).

Although recipients of AdC are theoretically entitled to an individualized care plan, Italian local authorities have experienced significant problems in their implementation due to the lack of appropriate needs assessment processes and the poor monitoring of care plans following assessment.

Recently, efforts have been made to introduce incentives for individuals to regularise the significant amounts of home care workers operating in the grey economy. Hence, in 2005, the Italian government introduced a tax allowance worth 19% of the salary costs of home care workers assisting older people and a reduction of social security contributions.

3.2.2. *Fragmentation of the home care Services*

In addition to the financial mechanisms outlined above, a limited amount of in kind home care services for dependent older people are provided in Italy by the local health and social services authorities.

The Integrated Domiciliary Care (*Assistenza Domiciliare Integrata - ADI*) is a care service supervised by local health authorities which in principle includes both social and health care. Needs assessments are generally done by a multidisciplinary evaluation unit who defines an individualised care plan (*Piano Individualizzato di Assistenza*) which reflects physical dependency but also on the availability of an informal support network. In practice, these services provide almost exclusively home health care support, and the care packages consist essentially of home nursing. The health care element of ADI is free of charge, but in some localities the home care component (if provided) is subject to user charges which vary with the user's need and financial resources. Approximately 3.2% of the older Italian population receives home *health* care through ADI, and a much more limited 0.6% receives ADI sponsored *home* care. Of the average monthly public expenditure per ADI recipient of €45, only €7 are spent on home care services.

Municipalities provide means-tested home care (*Servizio di assistenza domiciliare, SAD*) through their social services departments. These services are targeted on the most dependent and include personal care (personal hygiene, help to get up and go to bed, to eat meals,

bathing, transport and relations with doctors) and housework. In some regions of North Italy, the enforcement of regional provisions has enabled the integration between social services (SAD) offered by municipalities on the services provided by the local health authorities (ADI). Approximately 1.7% of the older population in Italy receives SAD services, with an average intensity of €46 per user per month.

3.2.3. Types of support allowed by law for a home care worker

Non (para)-medical work is carried out by so-called Social Assistance Auxiliaries – ASA (Ausiliare Socio assistenziale) and Socio-Sanitary Operators – OSS (Operatore Socio Sanitario). These professionals provide personal care and housework to older people. The OSS training has a duration of 1,000 hours, including at least 450 devoted to an internship, while ASA courses last a total of 180 hours. OSS is a “new” professional who is designed to be the core of the future integrated system of home care services.

The main tasks of ASA are to provide assistance with activities of daily living for dependent persons (transferring, shopping, house keeping, meals preparation, etc...) and non (para)-medical tasks related to the health, hygiene, comfort and security of the dependent person. ASA encourage older people to maintain their relationship with relatives and neighbors and can provide basic administrative help.

In addition of these tasks, OSS can perform simple diagnostic and therapeutic support, and to take part in activities of re-education, reactivation, and functional recovery of the dependent person. OSS support medical and health care staff to take care of the patient.

3.3. Germany

Germany’s universal social Long term care insurance (*Gesetzliche Pflegeversicherung, SLTCI*) was introduced in 1995, with the objective to treat the risk of long-term care as an existential risk (Zuchandke, Reddemann, Krummacker & von der Schulenburg, 2010). Protection against that risk became the so-called “fifth pillar” of Germany’s social security system (joining unemployment insurance, health insurance, pensions and accident insurance).

SLTCI covers around 90% of the population, and has defined contributions and benefits. The benefits are not intended to cover the full costs of long-term care, and a contribution is expected from individuals’ private funds. A parallel, means-tested social welfare system (*Hilfe zur Pflege*) exists to help with the cost of long term care services those without adequate private resources to cover non-insured costs.

The introduction of SLTCI has encouraged care in the home and community-based services over institutional care. It has improved the situation for many frail elderly (and their carers), and boosted the market for long-term care services (Arntz & Thomsen, 2010).

3.3.1. Long term care insurance

To be eligible, an individual must have required frequent or substantial help with normal day-to-day activities for at least six months. The long term care insurance fund's Medical Review Board verifies and assesses a person's need for care, with the assessment carried out by a physician or nurse using a single national needs assessment tool. The four basic domains of activities of daily living evaluated are personal care, nutrition, mobility and housekeeping. During this process, a person requiring long-term care is assigned to one of three care levels as indicated in Table 1, and this determines the benefits received.

Table 2.1: Definitions of care levels for long term care insurance

	Care Level I (Considerable need of care)	Care Level II (Severe need of care)	Care Level II (Extreme need of care)
Assistance needed with personal care, nutrition or mobility	At least once a day for at least two tasks in one or more areas	At least 3 times a day at different times of the day	Around the clock
Assistance needed with housekeeping and chores	Several times per week	Several times per week	Several times per week
Average amount of <i>daily</i> care provided by informal carer	Not less than 90 minutes, of which more than 45 minutes must be accounted for by basic care.	Not less than 3 hours, of which at least 2 hours must be accounted for by basic care.	Not less than 5 hours, of which at least 4 hours must be accounted for by basic care.

The Medical Review Board also assesses whether rehabilitation measures could avoid or mitigate dependency, and this takes precedence over long-term care. The benefit that an individual receives depends on what care level they fall into, whether they are at home or in an institution, and whether they choose to take cash or care-in kind, or a combination of the two.

The cash payment (*Pflegegeld*) for home care is approximately half the value of services-in kind, but it can be spent on anything and can also be paid to family members. Cash allowances can only be granted when the caring is provided by a third person, i.e. not the recipient him/herself (Thomsen, 2010). Despite the much lower value, cash has always been more popular than services-in kind among home care beneficiaries; in 2009, 79% of recipients opted for cash, with their payments accounting for 62% of SLTCI-funded home care (Bundesministerium für Gesundheit, 2010). A recipient of cash must take part in regular advice meetings with a professional care service (at least once every six months) in order to ensure that their care needs are being met and to monitor quality of care.

Between 1995 and 2008, benefits were not adjusted for inflation and therefore eroded significantly in real terms. A 3-step increase in payments was announced in 2008, with increases in 2008, 2010 and 2012. A summary of the main current and 2012 benefit levels is shown in Table 2. There is a commitment to three-yearly readjustments to payments from 2015 onwards. The 2008 reforms also introduced a specific benefit for people identified with mental impairments, such as dementia. The payment (either €00 or €00 per month depending on severity) is assigned for supervision, but can be spent as the recipient chooses (Arntz & Thomsen, 2010).

Various other types of support are available to support informal carers. When the dependent person choses to take the benefit in cash, payments can also be available to pay for respite care to provide a break for the main informal caregiver (after 6 months of caring). “Day and Night” care (a part-time institutional arrangement) is available when full-time domiciliary care is not sufficient.

In addition, relatives or friends who provide care for more than 14 hours a week and who are not employed qualify for a monthly care allowance and payment by the SLTCI of pension contributions.

Table 2.2: SLTCI benefits in services and cash (monthly, euros)

Care Level	2010	2012
	Home care – benefits in kind	
I	440	450
II	1,040	1,100
III	1,510	1,550
(particularly severe)	1,918	1,918
	Home care – benefits in cash	
I	225	235
II	430	440
III	685	700

Source: *Bundesministerium für Gesundheit 2010*

Overall, it could be argued that the German long-term care system is built with very clear expectations that the informal care networks will take the lion’s share of the responsibility for looking after dependent older people in the community. Despite the fact that informal carers are not explicitly written into the eligibility criteria for support, the arrangements in the German support system are designed to incentivise informal care provision and to minimize state expenditure in the presence of informal care. State insurance payments are set explicitly at levels below the cost of the resources required to meet all the care needs of the person, and an assumption is made that individuals will find additional support from either services commissioned with their own resources or more likely from informal carers. In many instances, the cash option is used by dependent older people to “compensate” financially their

families for the informal care they provide. An additional indication of the reliance of the insurance system on the support provided by informal carers is the fact that contributions to the insurance scheme are higher for people without children, on the basis that they are less likely to have access to informal care and therefore more likely to require support from the state.

At the beginning of 2010, there were 1.6 million recipients of SLTCI-funded home care, approximately nine per cent of the older population in Germany (Haustein & Mischke, 2011)

SLTCI has spurred the development of the long-term care market. Between 2001 and 2007, there the number of working staff (including part-time workers) in licensed long-term care organisations increased by 29% to 236,162 in home care, and by 30% to 573,545 in institutional care. The limited flexibility in the services covered by SLTCI remains an issue, however, for those who opt for care-in kind. These services are pre-defined to relate to the ADL limitations that are assessed by the Medical Review Board. This has led to criticism that they services do not always meet recipients' needs and preferences (Arntz & Thomsen, 2010).

In fact, one of the complicating factors faced when evaluating the targeting of home care services in Germany is the difficulties encountered when disentangling the long-term care insurance resources used to provide health care from those dedicated to provide social care support. In fact, the fact that formal home care workers tend to be health care professionals (Schulz, 2010) and the limited size of the payments made suggests that the majority of the formal care inputs commissioned from the LTCI scheme are health-related.

While many have benefited from SLTCI, the eligibility level for SLTCI-supported care (Care Level I) is relatively high. In practice, the German system operates to constrain costs: nearly 30% of applications for assistance were rejected in 2007, and eligibility was held to about 10% of the population aged 65 and over (Campbell, Ikegami & Gibson, 2010).

As mentioned earlier, for those who do qualify, SLTCI does not cover the full cost of the assessed care. On average, the payment covers about half of the assessed need, and only a quarter of assessed needs for those opting to take the cash option (Campbell et al., 2010).

Approximately 1.6 million people were taken care of at home in 2009. Of them, approximately 1 million received the cash allowance (5.8% of the older population), worth on average approximately £350 per month (Haustein & Mischke, 2011).

3.3.2. *Social assistance*

The increased perception of financial security mentioned above (Zuchandke et al., 2010) is mitigated by the realities of the pressures that many families will face in funding the expected co-payments if they do not qualify for means-tested social assistance (*Hilfe zur Pflege*). Using conservative assumptions about future increases in care costs, Keese, Meng, and Schnabel (2010) found that one-third of individuals covered by SLTCI were likely to face out-of-pocket long-term care expenses after the age of 65 that exceed their total wealth.

As mentioned above, the care insurance benefit rates are not meant to cover the full cost of the care package that is needed, and dependent people buying in care (rather than relying on informal care) must often contribute privately. Those who cannot afford to do so can apply for a means-tested benefit called *Hilfe zur Pflege*.

The introduction of the long-term care social insurance system was designed to reduce the level of such claimants, but there is still a significant number who receive this benefit, particularly among people in residential homes. Approximately 70,000 home care recipients received this financial help in 2009 (approximately 0.36% of the older population) with an average value of €80 per user per month (Statistisches Bundesamt, 2012).

3.3.3. Tax incentives for “mini” jobs

Although not particularly aimed at the long-term care sector, the introduction in 2003 of tax incentives in order to promote the growth of “mini jobs” in Germany added to the range of state schemes available to older dependent people for commissioning the help they need. Unfortunately, it is very difficult to quantify the number of people making use of these tax incentives (and the associated cost to the state) to receive home care support.

3.4. England

As in the other national cases described above, mapping the state support provided to dependent people in England requires examining the interplay between central and regional (in this case local authority) levels. The English support system can in fact be described as operating with two parallel systems: a locally-run, means-tested social care system, and a central, state run universal social security system.

3.4.1. The local social care support system

In England, local authorities have been responsible for providing home care to frail older people since the early 1970s. Local authorities are free to choose, taking into account their own resources, how to target their services both in terms of the proportion and range of needs of the population that they serve and in terms of the types of services that are provided. Although national charging rules for residential care services exist, local authorities determine their own charging arrangements (within general national guidance). As a result, significant variations in most aspects of social care (e.g. coverage, intensity, user contributions, balance between institutional and community-based care) can be found across English local authorities (Fernández & Forder, 2008).

Ever since its inception, the social care system (and hence the home care system) in England has suffered from chronic underfunding. This lack of resources and the policy emphasis on

maintaining people in the community for as long as possible have led to the concentration of home care support on those individuals with the highest needs (Davies, Fernández & Nomer, 2000). Reducing the risk of institutionalisation has been perceived as a way of improving user satisfaction with care (because older people tend to prefer to remain in their own homes for as long as possible) and of minimising state expenditure (because community care packages are usually cheaper than residential care services).

In order to “optimise” the matching of resources to needs, the community care reforms in 1993 brought about the implementation of case management in England (Davies, 1992). This meant that dependent persons in receipt of state support were assigned an individual case worker responsible for the assessment of the needs of the individual and for the design (together with the dependent person and their family) of the care plan. The rationale of these reforms was therefore to introduce mechanisms and incentives which would lead to more flexible care packages which took into account to a greater extent the wishes and preferences of the recipients of care and of their families. However, persisting budget constraints led to the concentration of resources on people with very severe needs (and with limited financial resources) and on the provision of support with personal care activities. In spite of the freedom to choose how to spend their resources, almost no local authorities in England provide currently significant help with tasks such as housework, the preparation of meals or the shopping of groceries. Rather than the consequence of guidelines restricting the range of “legitimate” tasks to be performed by different care professionals, the lack of home “help” type support is the product of the lack of resources and the necessity to concentrate these on the most critical, personal care related activities of daily living (Lewis, 2001).

3.4.2. The rise of Direct Payments and Personal Budgets

Available to working-age adults at first, the scheme was extended to older people in 2000 and to carers in 2001, reflecting the desire to “personalise” the care system (Fernández, Kendall, Davey & Knapp, 2007). In response to disappointing uptake levels of direct payments, Personal Budgets were introduced in 2008, offering a wider range of models of control over the resources to users, including the possibility of receiving a combination of cash and services in kind, and of having the budget managed on behalf of the user by a third party (family, friends, or even the local authority) (Glendinning et al., 2007). The Government expects all community care users in England to receive personal budgets by 2013 (Department of Health, 2010). Although a care plan needs to be agreed with the local authority, recipients of personal budgets enjoy significant freedom in the choice of support services they commission, including the possibility of employing directly a personal assistant. Relatively little is known about what services are actually purchased by people with Personal Budgets due to the recent nature of the scheme, but the evaluation of the national pilots found that a large proportion of users used their budgets to employ personal assistants (Netten et al., 2011).

In the year 2010/11, approximately 240,000 older people received local authority provided home care in England, and 530,000 received some type of community-based social care support (approximately 3% and 6.2% of the older population in England, respectively). A modest 55,000 (0.9% of the older population) received direct payments. Home and day care net state expenditure on older people in 2010/11 reached almost €5bn, equivalent to approximately €7 per older person per month.²¹

3.4.3. Social security disability cash allowances

Although accounting for a smaller proportion of public expenditure than the social care system outlined above, considerable public resources are distributed to dependent older people in England through the social security system: Attendance Allowance (AA) or Disability Living Allowance (DLA) if claimed prior to 65 years of age. They can also claim Severe Disability Premium, a top-up to the means-tested income maintenance social security benefit (Pension Credit). The third type of benefit, introduced in 2002, is the Carers' Allowance, paid to carers of people with disability. These cash benefits are free of any obligations on the beneficiaries, for can use the money as they wish.

Social security benefits are targeted on a wider range of disability levels than the social care resources, which has noted above are very heavily concentrated on the very dependent. The assessment is carried out on the basis of a lengthy self-completed questionnaire, and in some instances involves a face-to-face medical examination. Furthermore, AA and DLA are universal benefits, whereas social care is heavily means-tested, with individuals with assets above €6,000 very unlikely to receive any local authority funded social care support (Wanless et al., 2006). Approximately 15.9% of the older population in England received AA in the year 2010/11. On average, each recipient of the benefit received approximately €9 per week. A further 5.9% of older people received the care component of DLA, with an average value of approximately €7 per week.

4. Inter country differences in home care support

The national descriptions above have indicated important differences in policy emphasis and between the social care arrangements in place across the four countries examined. The impact of such differences on the targeting of support for dependent older people in the community is further illustrated in Figures 1 to 6.

²¹ Source: calculations based on evidence from the UK Information Centre (<https://nascis.ic.nhs.uk/>)

Figure 2.1: Monthly state expenditure on “social care” support for older people, per older person

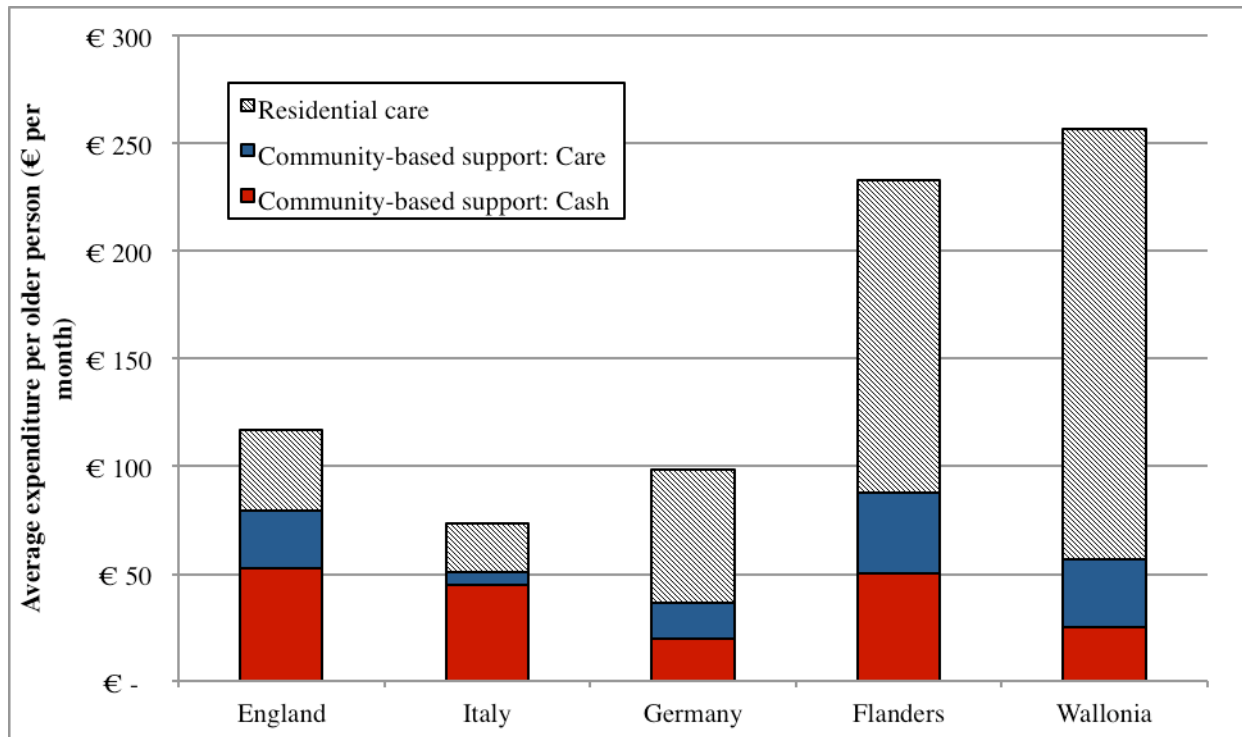


Figure 1 shows very significant variations in the average state expenditure per older person across the four systems studied. These differences are present both in terms of overall levels of expenditure and at the level of individual types of support (in kind or cash, and in the community or in residential care). Overall, per capita expenditure in the two Belgian regions by far exceeds the levels of expenditure in the other three countries considered. To a considerable extent, these differences are driven by very high per capita residential care expenditure levels in Belgium and in particular in the Wallonia region, several times over those in the other countries in the study. As mentioned previously, the very large levels of residential care expenditure in Belgium could be linked to the top-down planning process used for setting maximum levels of service provision.

If we leave residential care outside the picture, figure 1 provides useful evidence about the intensity of public support for both in kind service and cash for care in each of the countries explored. Surprisingly, Flanders and England devote comparable amounts of money, though a little bit higher for the first, to support older people with the same proportion between in kind service and cash for care. This proportion between cash and in kind is similar in Wallonia, if with lower resource levels overall. Then, Italy is following with the majority of public money devoted to cash for care. Of the four countries examined, Italy exhibits the lowest levels of expenditure on in kind support. In contrast with the German case, the limited level of expenditure on community services is not explained by a “substitution” effect linked to high

levels of residential care provision. In fact, overall levels of community and residential expenditure are also lowest in Italy. Finally, Germany appears as the least generous country. This is particularly remarkable given that in kind services mostly provide home nursing, a service which is not included in our assessment of the other countries.

The comparison of Figures 2 to 6 provides useful evidence about the selectivity and intensity of the different schemes in each of the countries explored. In Germany, the support schemes appear to cover a relatively small proportion of the older population. Whereas in England this also appears to be the case for the local authority brokered social care support, social security benefits (AA and DLA) cover a much greater proportion of the population as it is the case in Italy, although with significantly lower average intensity. In Belgium, in kind support schemes appear to cover the largest proportions of older people with a national cash allowance much more targeted.

In England, Italy and Germany, Figures 2 to 6 indicate that locally organised and means-tested support systems tend to be targeted on a relatively small proportion of the population, but to provide more intensive levels of care than more universal benefit schemes. Home care expenditure is bound by the limited resources available to local authorities, and the available support is therefore targeted on those with the highest needs and the lowest financial means. However, this not the case for Belgium, which has the highest covering rate for in kind services. Compared to England, more people receive in kind service but with less intensity.

Interestingly, Figure 1 shows that the universal nature of the German insurance system does not translate into significant levels of per capita expenditure in the community relative to the other countries. In fact, per capita expenditure on community care in Germany appears to be the lowest among the four countries examined. In part, this finding is due to higher levels of expenditure on residential care than in Italy and England, and therefore to the fact that fewer older people with care needs in the community might need to be supported in Germany, other things equal. In addition, the observed relatively low expenditure levels in Germany could be linked to the fact that insurance payments are not meant to cover fully the assessed care costs, in particular in cases where individuals opt for cash payments, worth approximately half of the cost of the in kind option.

It could be argued that a common feature across the four social care systems examined is the relative fragmentation of the support infrastructure. Table 1 (inserted at the beginning of this report) shows that in each country, social care in the community can be obtained from a number of schemes with independent eligibility and assessment frameworks. Also in every country, the responsibility for supporting dependent older people appears to be shared between national and regional and/or local authorities. Arguably, this multiplicity of sources of support might be leading in some instances to problems of fragmentation and lack of coordination of resources.

Three of the countries in the study (Belgium, Italy and Germany) implemented tax incentives which reduced the cost of care for dependent older people. In Italy, the tax scheme was used to incentivise individuals to regularise the support received from irregular, mostly immigrant,

workers. In Belgium and Germany, the introduction of the tax incentives had as objective to create employment among low qualified workers. It is interesting that although they might have had such an effect, it is not clear that in any of the three countries the tax incentives were introduced with the aim of increasing the receipt of care.

5. Policy implications

We have argued that the two main objectives to have driven recent reforms across the countries considered in the study have been to increase the coverage provided by the state in social care whilst at the same time to contain the rapidly increasing state expenditure.

The evidence in the study suggests that there exist a number of options available to policymakers to support dependent older people in the community. How this support systems are implemented will depend on the nature and range of the objectives sought after, such as providing a safety net, maintaining older dependent people in their own homes for as long as possible, or even the creation of employment in the care economy. Furthermore, the translation of these objectives into policy measures and ultimately into organisational structures will be mediated by important cultural values, and in particular by the nature of social expectations about the role of families in the care of their dependent relatives.

Levels of public expenditure vary from one country to the other. Of the national systems explored, Belgium is the country which has favoured the most in kind mechanisms for supporting dependent people (across home care, housework and residential care) open to a large spectrum of the population. Public cost of residential care will most probably be under pressure in the coming years. Cash distributed by the national security is seen as a supplementary allowance targeted to the neediest. England is characterized by a locally run, means-tested in kind system reflecting Poor Law principles and a central, state run universal social security system based on cash transfers. However, the rise of personal budgets may imply a shift from in kind provision to cash for care at the local level, too. This, in turn, could lead to an increasing role of families.

With almost no in kind home care provision, Italy distributes as much cash as England does through its national security system and in a smallest proportion at the local level fostering a shift from a model based on unpaid family care to one based on informal, paid care provided by irregular immigrant minders. The German system appears to rely very heavily on the contribution of informal carers, and the relatively low levels of public expenditure are also likely to reflect the cultural expectations about the role of family members in the care of dependent people.

As always when attempting the challenging task of the international comparison of social care systems, it is important to recognise some of the caveats and uncertainties of the analysis.

To a significant extent, the correct interpretation of the differences in the levels of support provided across countries relies on our capacity to disentangle between types of state

expenditure. In some instances, it is difficult to distinguish which services provide support with Healthcare needs and which provides support with “social” care needs. In Germany, for instance, a majority of the formal in kind help financed through the national insurance system is likely to be destined to paramedical support, but we were unable to quantify the extent to which this is the case.

Furthermore, our mapping of the range of state financed mechanisms for supporting dependent older people could not include the complete gamma of existing support schemes. For instance, we could not cover exhaustively the range of services aimed at supporting informal carers. Also, other mechanisms such as the pension system are likely to be important contributing factors to the ability of older people to purchase the support required to meet their needs. Our analysis has not examined differences in the pension systems across countries.

Finally, the analysis was carried out with the implicit assumption that the levels of per capita need are equivalent across the different countries, and it is possible that some of the differences highlighted could be the product of national differences in actual levels of need. Bearing the above caveats in mind, it is nevertheless unlikely that some of the stark differences identified in the analysis would be simply due to the inherent limitations of the analysis.

Figure 2.2: State support (average net expenditure and percentage of the older population covered) for dependent older people in Flanders

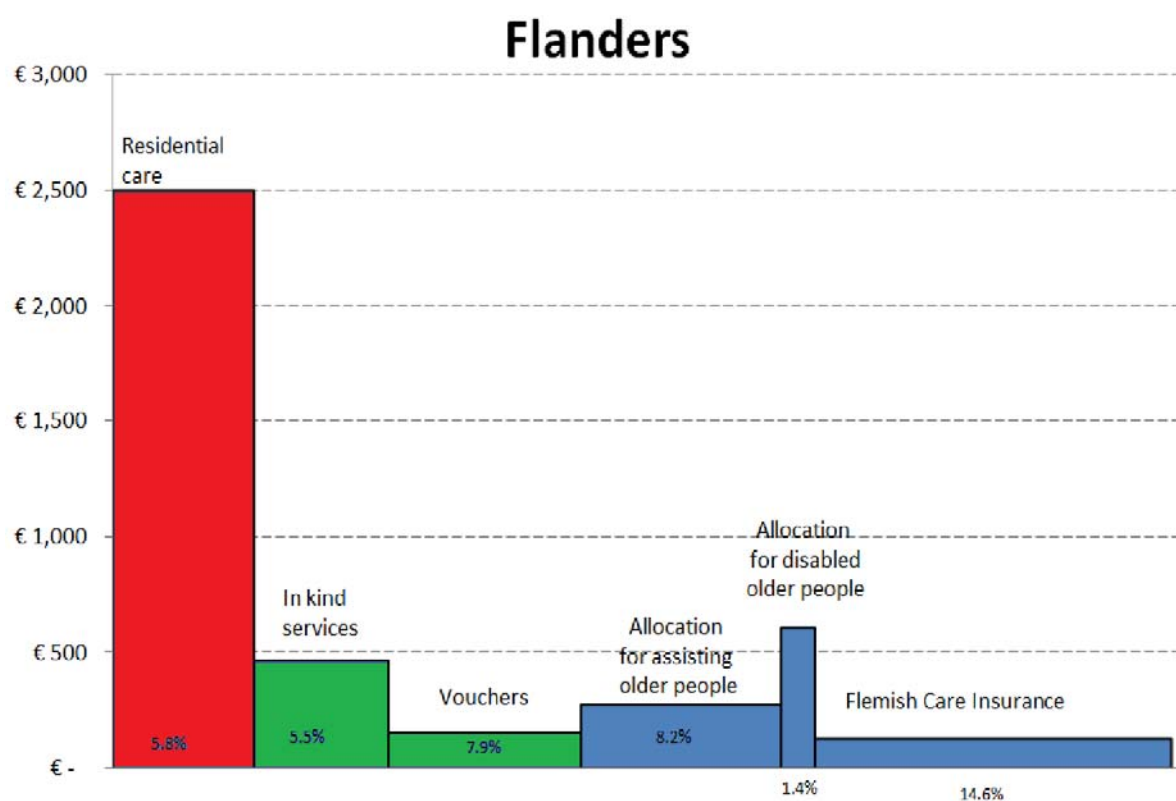


Figure 2.3: State support (average net expenditure and percentage of the older population covered) for dependent older people in Wallonia

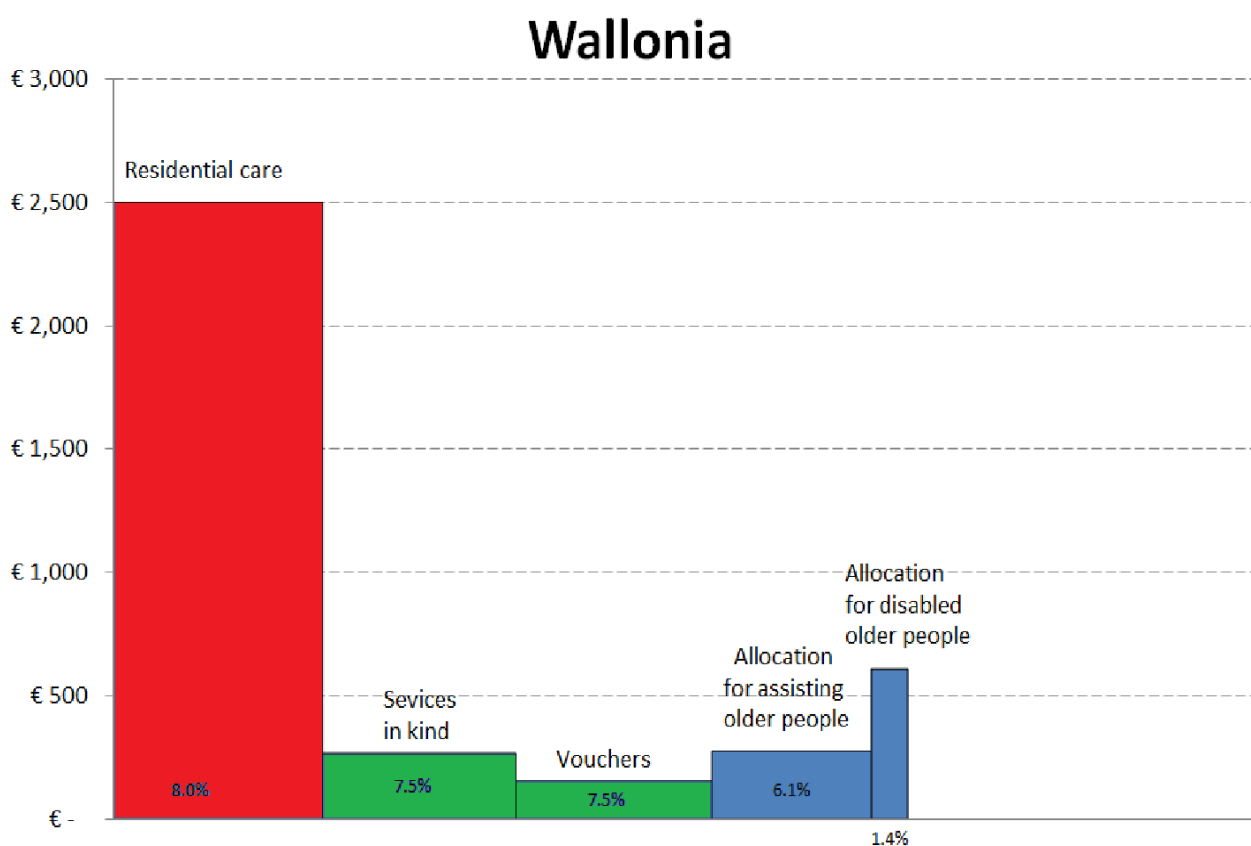


Figure 2.4: State support (average net expenditure and percentage of the older population covered) for dependent older people in Italy

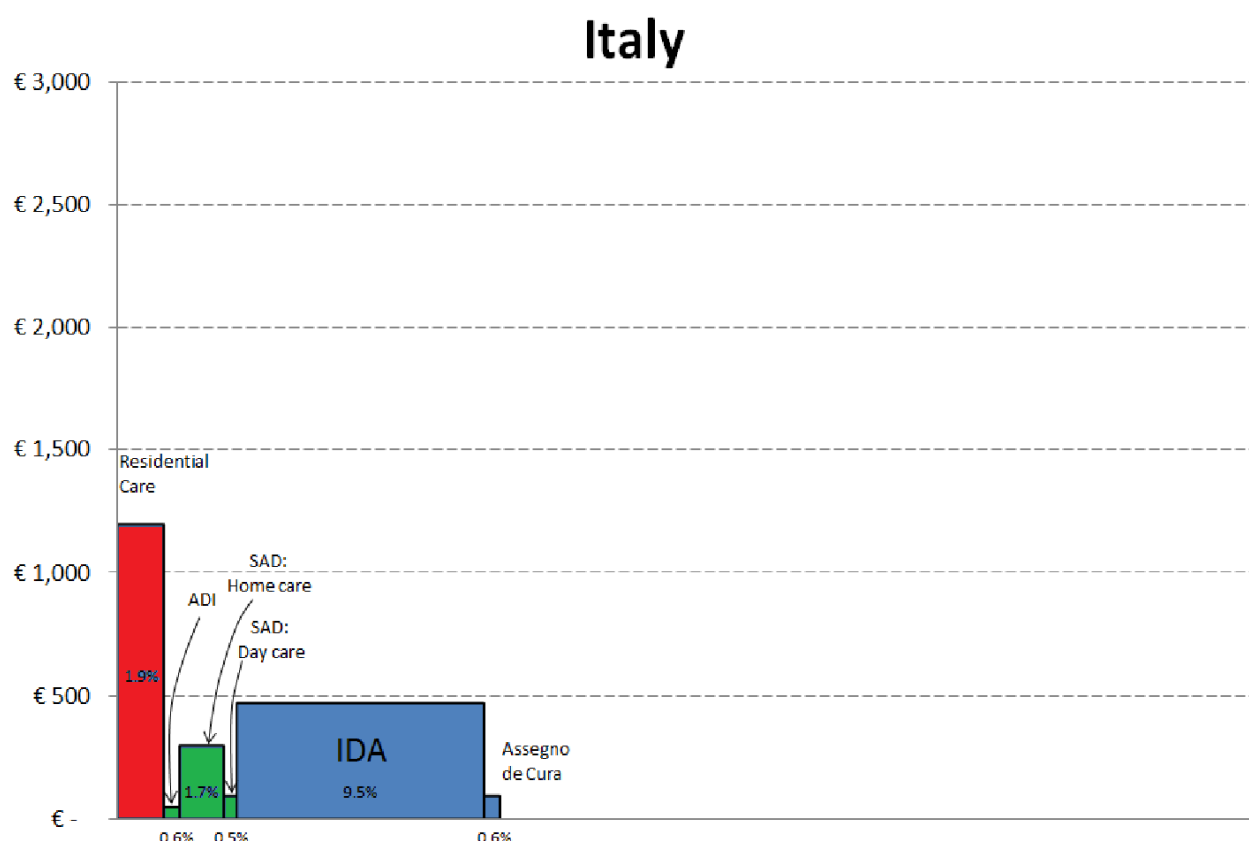


Figure 2.5: State support (average net expenditure and percentage of the older population covered) for dependent older people in Germany

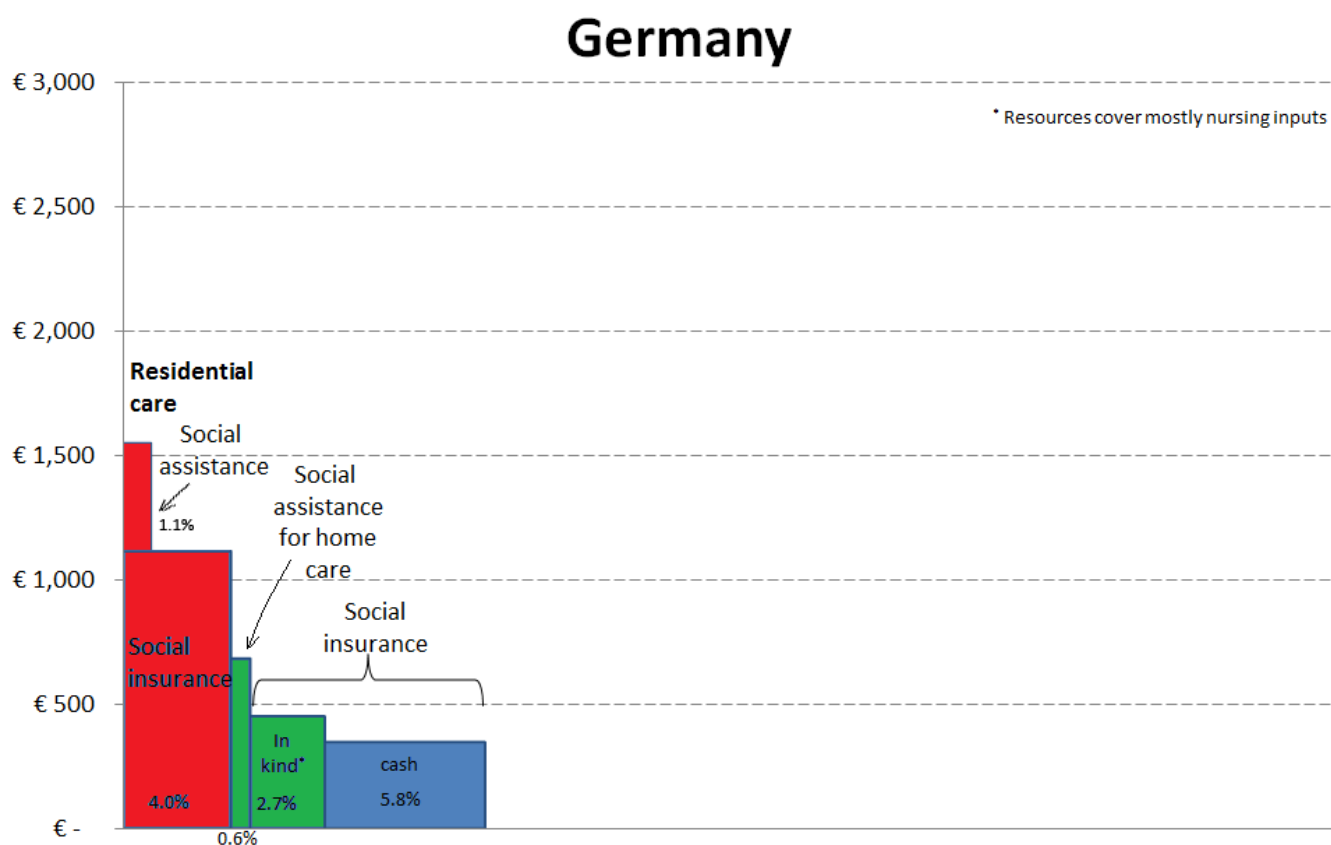


Figure 2.6: State support (average net expenditure and percentage of the older population covered) for dependent older people in England

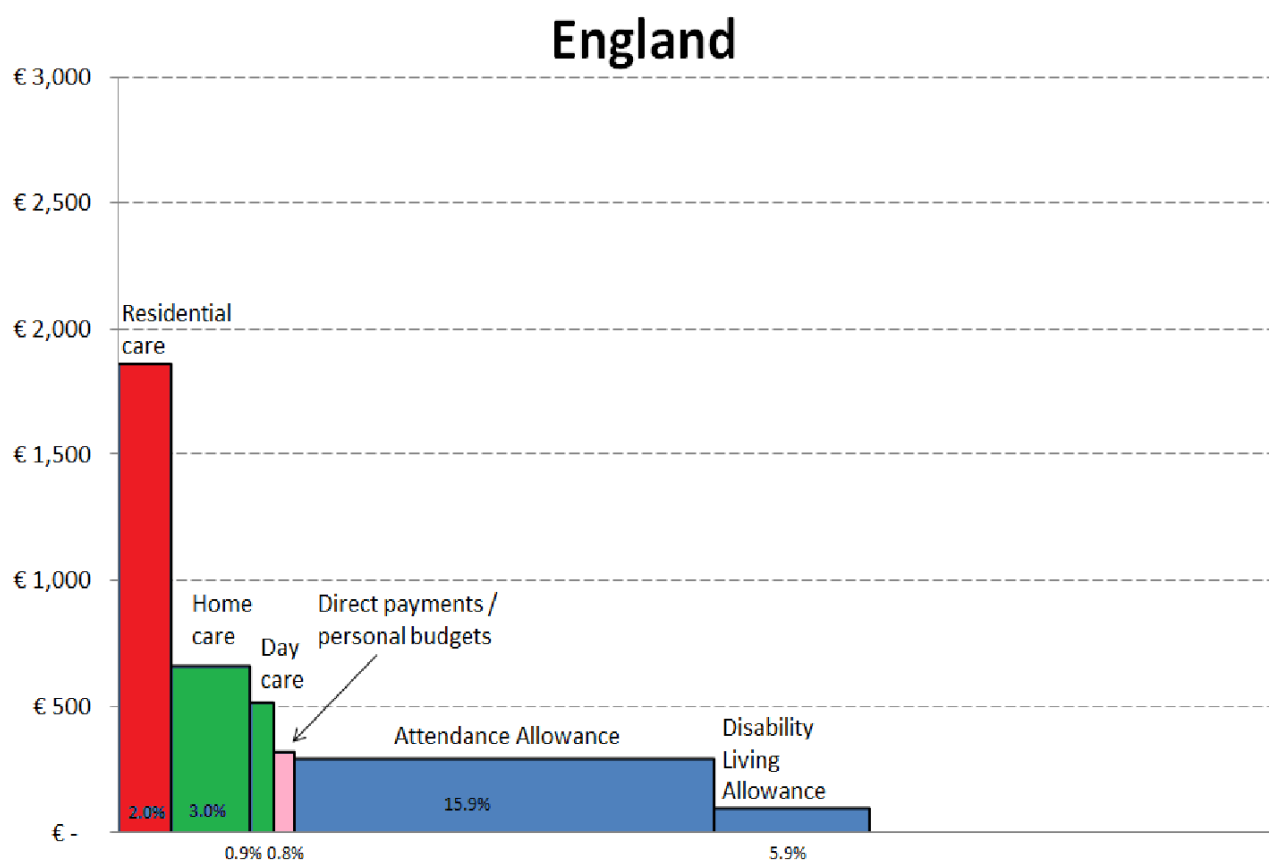


Table 2.3: Data sources: Belgium

	Coverage	Intensity	SS
	(%> 65 years)	(by month, euros)	
Allocation for the help to older people (2008)*			http://handicap.fgov.be/docs/vouwfolder_2009_overzicht_cijfers_fr.pdf
Flanders	8,2%	274	
Wallonia	6,1%	274	
Allocation for handicapped people > 65 (2008)*			
Flanders	1,4%	607	
Wallonia	1,4%	607	
Flemish long term care insurance (2009)	14,6%	130	CROME REPORT (based on the Flemish Agency of Care and Health, s.d.: http://www.zorg-en-gezondheid.be)
Home care in kind Wal. (2008)	5,7%	266	Rapport d'activité 2008 DGASS, p. 133.
Home care in kind Fl (2008)	5,5%	465	CROME REPORT Flemish Agency for Care and Health: http://www.zorg-en-gezondheid.be/v2_default.aspx?id=21847&linkidentifier=id&itemid=21847 e-mail from ilse.goossens@wvg.vlaanderen.be, 6 januari 2012
Voucher (2008) *			
Flanders	7,9%	155	Idea consult
Wallonia	7,5%	155	
Residential care (2008)*			Ancien report based on http://stats.oecd.org/Index.aspx?DataSetCode=SHA , Willemé P. (2010)
Flanders	5,8%	2500	
Wallonia	8,0%	2500	
Day care centre (2008)			
Flanders day nursing centre	0,1%	676	Flemish Agency for Care and Health http://www.inami.fgov.be/information/fr/statistics/health/2008/pdf/statisticshealth2008all.pdf
Wallonia day nursing centre	0,04%	676	Rapport du conseil du troisième âge, 2009
Wallonia day centre	0,1%	100	Rapport d'activité 2008 DGASS,
Flanders day centre	189 Local Services	2800 by center	Flemish Agency for Care and Health
Wallonia short stay	0,1%	NA	Rapport d'activité 2008 DGASS,
Flanders short stay	0,03%	NA	Flemish Agency for Care and Health

* Hypothesis: same intensity by region

Table 2.4: Data sources: Italy

	Coverage	Intensity	
	(%> 65 years)	(by month, euros)	
Residential care (2004)	1,9%	1195	ISTAT (2005) and ANCIEN REPORT (TEDIOSI, GABRIELE, 2010) for the cost based on NNA (2009)
Indennita di accompagneto (2008)	9,5%	470	http://servizi.inps.it/banchedatistatistiche/vig9/index.jsp
Assegno de cura (2007)	0,6%	94	ISTAT, Interventi e servizi sociali dei Comuni e dei singoli associati, 2010
Assistenza Domiciliare Integrata (ADI, nursing and home care services (2007)	3,30%	245	For coverage (2008) ISTAT L'assistenza residenziale e socio assistenziale in Italia, ANCIEN report, p 15 For intensity: Age.na.s.(2009), "Rilevazione dell'attuale spesa pubblica per l'assistenzasociosanitariaaglianziani non autosufficienti e quantificazione del fabbisognofinanziario per garantirelivelli standard", Relazione Finale, Rome.
ADI (only home care services) (2007)	0,60%	47	ISTAT, Interventi e servizi sociali dei Comuni e dei singoli associati, 2010
SAD (2007)	1,70%	146	
Day care (2007)	0,5%	93	

Table 2.5: Data sources: England

	Coverage	Intensity	Source
	(%> 65 years)	(€/month)	
Residential care (2010/11)	2.0	€1,863	UK Information Centre: http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information
Home care (2010/11)	3.0	€61	
Day care (2010/11)	0.9	€14	
Direct payments (2010/11)	0.8	€20	
Attendance Allowance (AA) (2011)	15.9	€294	Department of Work and Pensions (DWP): http://statistics.dwp.gov.uk/asd/index.php?page=tabtool
Disability Living Allowance (DLA) (2011)	5.9	€6	

Table 2.6: Data sources: Germany

	Coverage	Intensity	Source
	(%> 65 years)	(€/month)	
National long term care insurance Residential care (2010)	4.0	€1,115	Bundesministerium für Gesundheit (2010). Selected Facts and figures about Long-Term Care Insurance, August 2011. Available at http://www.bmg.bund.de/fileadmin/dateien/Englische_Dateien/110923_Factsheet_Long-Term_Care_Insurance.pdf
National long term care insurance cash allowance (2010)	5.8	€347	
National long term care insurance home care (2010)	2.7	€451	
National long term care insurance Day care (2010)	0.6	€326	
Social assistance Residential care (2009)	1.1	€436	Statistisches Bundesamt (2012). Statistik der Sozialhilfe: Hilfe zur Pflege - 2009.
Social assistance In the community (2009)	0.6	€684	

- Chapter 3 -

Multilevel governance of long term care: does it induce lower coverage rates and so hinder innovation?

1. Introduction

The current, accelerating rate of ageing in Western Europe's population has caught the attention of politicians and researchers alike. Two central questions emerge from their discussions: the relationship between informal and formal care as well as the design of a well functioning formal long term care (LTC) system. In a difficult economic context where austerity seems to have become a necessity, two developments have an impact on the performance of any system.

One is the appearance of a private market mechanism in the organisation of services for needy elderly persons, backed by political and ideological preferences. The second development relates to a tendency towards more decentralisation in the governance of the welfare state. Care policy is also affected by this reshuffle of public policy governance. In particular, the question arises as to whether decentralisation may have a deleterious effect on the performance and coherence of the formal care system.

The allocation of the authority to plan, regulate and fund is a basic issue in the governance of a given policy domain. The orthodox fiscal position argues in favour of the central level, yet evidence has been gathered for many years which points to decentralisation of the authority in specific circumstances. Particularly in times of austerity, the issue of centralisation or decentralisation becomes the context in which necessary cuts in public finance are to be realised. In the context of the growing ageing of society a fundamental choice has to be made concerning which type of long term care system should be installed: a service-oriented or a cash benefit one where the family remains the main actor and where services or cash can be spent in a more or less regulated market.

In the specific domain of LTC for elderly persons, four issues seem to collide: the level at which a certain policy is made; the role of the family; the state; and the market in the context of a new social risk. The theory of fiscal federalism (Pettersson, 1995) postulates that the solidarity in social insurance is best guaranteed with a geographical circle as large as it can be. Costs are broadly spread and scale advantages arise. Because labour and capital are mobile in the territory, regional and local governments who distribute better advantages will attract people representing a high risk and low risk people will move towards cheaper territories. In this way, a process of downward social competition will start and social dumping will arise.

Authorities will become hesitant in the promotion of cultural capital via education and culture, so economic growth will be hindered in the long run. In fact, in many federal states, the most redistributive sectors of the social security system remain at the central level whereas education, welfare and health are shared with and or assigned to sub-national levels (Cantillon, 2010: 72-77). But mobility is not always a threat and a lot of different considerations are being made which argue for more decentralisation. Needs can be very different in the concerned regions as well as the preferred solutions. If potential decision making is difficult at the highest levels because of divergence in opinions, an easier means of deciding can be realised at a lower level and immobilism can be circumvented. Innovation seems to become easier and so the variety increases. Occasionally, a local or a regional system can be set up that is cheaper or which can be more easily managed. Communication with and participation of the population becomes easier. Such contextual elements are to be taken in consideration when deciding where to allocate the authority to govern a given domain. Of course, the policy of lower level governments can run against the interest of the central ones. The relationship between the different levels then becomes a further institutional question. The risk of conflicting policies arises and coordinative efforts become a necessity together with a true space for initiatives on a lower level.

Decentralisation can possibly appear as a kind of a smokescreen behind which an upcoming low performing system is built, and the appearance of a new policy level with new funding, planning and implementation regulation adds complexity to the system.

A recent publication puts the question into sharp focus. Kazepov's (2010: 282-283) main thesis is that regional variations in service levels with an unequal and unbalanced supply will come together with the growing importance and autonomy of the regional authorities, particularly if the national state no longer has a broad mandate or legal framework in the care field. This is particularly relevant in a context of fiscal retrenchment, when the process of decentralisation could lead towards closer targeting efforts and a more restrictive policy in the concerned regions.

When there are no central regulations and regional authorities comprise the sole responsible level, it can be expected that the resulting variety is a function of preferences (more or less professionalised, more or less family-oriented), and sometimes a function of needs but as Kazepov (2010: 252, 302, 308, 311) puts it many times, also a function of the resources which the regional authorities have at their disposal. Regional variety can also be influenced by decentralised discretionary assessment systems (as in Italy, but not in Germany).

Kazepov's research results clearly showed that the supply of services is lower in the regions and states that are more decentralised (2010: 309), especially if compared to Scandinavian social democratic welfare states. But they did not analyse the cash instruments and, therefore, isolated the service component. Neither did they enquire about the de facto regional variation in the take-up of national schemes and benefits. In fact, the main differences were found between countries and states wherein the type of welfare state regime seems to be determinant.

We investigated another set of countries and looked for regional variations on all levels and for all care policy instruments. Our research questions induced the following concepts and their empirical form. Performance of a LTC system is defined, in this chapter, as a high level of coverage of a service or of a financial transfer. Specifically, the regional variation in a country is analysed in order to test the “Kazepov-hypothesis”. Do decentralised authorities systematically perform less well? A second research question relates to the matter of coherence in the policy structure. Do decentralised care policy structures induce complex decision structures and complex choice structures for individual consumers and their families?

2. Long term care systems

It gradually became clear that in the Western world there emerged two different main instruments in the long term care policy, one based on services and the other on financial transfers. Individual countries create their own particular combination of these instruments and privilege one above the other. Services can be distinguished into home care and residential care. Medical home nursing is a part of the medical care system. Cash based systems can be further divided into cash for care whose benefits are intended to support care at home or in an institution. In some cases, cash for care and in kind services are included in the same scheme and claimants have to make the choice between cash for care or services or a combination of both. In other cases, cash benefits are a financial support for needy persons, designed to cover additional financial expenses of the cared for or of the informal carer.

Cash for care systems are mostly nationally based (funded and regulated at the national level) and they rely exclusively on need access criteria. Service based LTC systems are frequently planned and (co-) funded at regional levels. Sometimes these regions acquired money from the national government but – in Italy and Germany – these transfers are not so dedicated and clearly not funded highly enough. Services are sometimes delivered on an income-related basis, next to the need criterion (see Chapter 2). Cash-based systems are more open to familiastic purposes, as the delivered benefits are not earmarked for (professional) care and therefore can be distributed to family members or to external people (as in the grey market, e.g. in Italy and Germany). The cash formula then leads to a kind of commodification, paid semi-formal care work. Services are more universally defamilialisation oriented and more professionalised. Cash benefits fortify these developments towards de-professionalisation.

Most cash systems are funded and regulated at the national level. Regional and local authorities have a much greater say in the service sector. Sometimes they have general jurisdiction and in other contexts they are co-funders and implementers.

3. European Care states and regional variation

The CROME-project focuses on four European core states and their regions: Belgium, England, Germany and Italy. This set contains one “liberal” welfare state (England) and three corporative countries: Belgium, Germany and Italy. This last state is, however, increasingly characterised as a familiastic welfare state wherein a passive subsidiarity exists concerning the state supply of services and financial transfers. Germany is basically a “Bundes-state” whereby a lot of responsibilities are allocated to the Länder, as there are some domains which remain in federal hands e.g. social insurance. Belgium and Italy have both realised major decentralisation operations so that a considerable number of activities are regulated, funded and implemented at that level. England is perhaps the most centralised country but it allocates rather broad autonomy to the local authorities. All in all, the four countries demonstrate quite a lot of institutional variation, even if they belong to the “old core states” of the European Union.

Based on published administrative sources, an overview has been created of the coverage rate of specific services and cash transfers for persons aged 65 and over. We present data for home care services and residential services and for cash for care transfers, either as alternatives or as complements to services. The data are presented at the national level in each instance.

4. National coverage rates in the different countries

As is illustrated in the graphics in chapter 2, Belgium has both a high rate of home care as well as residential care. Home care is entirely regulated, funded and implemented by the regional governments. The residential services are funded and regulated by the national authorities and implemented by the regional government. Belgium has no mixed scheme where elderly persons can chose between cash for care and in kind services but has quite extensive “pure” cash systems (National Social security benefits and Flemish LTC insurance). This national system is need and means-related but the less generous and more frequently used Flemish system is only need related.

Similarly, England also had no significant mixed scheme yet, but this is changing with the sharp rising of personal budgets. It does have an extensive cash system which distributes benefits to a significant part of the elderly population. Services are regulated and funded by the central governmental level but local authorities have flexibility in the implementation. They co-finance the system.

Germany has a central long term care social insurance instrument that distributes cash for care to needy elderly persons. People can choose either for this cash or for services. Domestic services seem to attract less demand than the cash option.

Italy is something of a counterpart. It has a broad national cash for care system (Attendance Allowance) which is need-tested (and a limited regional care allowance). Services are entirely under the authority of local and regional governments.

5. A comparative analysis of the coverage rates

The structure of the LTC-regimes can easily be detected: Germany developed a mixed scheme regime. The majority of beneficiaries opt for cash for care. Italy as a very low level of development of in kind services. The main LTC-instrument here lies in the national cash instrument and consequently the coverage rate of home and residential care services there are quite low.

Belgium and England originally emphasized the service instruments. In practice they have now developed a relative high level of services and cash transfers, mainly for elderly who cannot always afford their contributions for formal service use or as support for the household income of informal caregivers.

The influence of the welfare state types is not straightforward. England, nevertheless exhibits the classical characteristics of a liberal kind, with strong targeting intentions, for the provision of in kind services, based on income (and need) and distinct types of financial support. The corporative states are all more need and less income oriented, but the group is internally divided by their choice of their LTC-regime. Consequently we see an enormous difference in the coverage for services without “compensation” in the level of cash for care coverage rates.

All the cash-instruments are funded and regulated at the national level (with the Flemish long term care insurance and the Italian regional care schemes being exceptions). In all corporative states, services are regulated and (co-)funded by decentralised authorities and local authorities also co-finance these services in England. Choosing a type of LTC-regime is also to choose an authoritative level. But these levels do not seem to have so much impact. We also see in table 1 that national instruments (cash schemes) are somewhat differently implemented in the regions and the more decentralised instruments (services) do not show a greater variation than their cash counter parts. The overall variation is moderately limited in general, except in Italy where there is a high systematic variation between regions in the national as well as in the regional instruments.

Kazepov’s hypothesis does not seem to fit the data for our four European care countries. It does not matter whether instruments are conceptualised and implemented at distinct levels. We see that regional governments can produce high levels of home care coverage, e.g. the two Belgian regions. However, the home care coverage levels are very low in the strongly decentralised states of Germany and Italy and nationally based residential care is also very high in Belgium. Kazepov (2010: 302) also formulated that regional variations would be greater for services than for cash, which seems not to be true in our data and that of each country.

Table 3.1: National Long Term Care System: mean and regional variation in uptake by 65+ of Care In Kind and Cash benefits in the four countries

	N	Minimum	Maximum	Mean	Std. Deviation	Variance
Belgium *						
Net Income (€)	2	16623,8	19460,2	18042,000		
% Uptake Home Care 65+	2	5,5	5,7	5,600		
% Uptake Residential Care 65+	2	7,1	8,6	7,850		
% Uptake Belgian Social Security Benefits 65+	2	6,1	8,2	7,150		
% Uptake Flemish Long Term Care Insurance 65+	1	14,6	14,6	14,600		
England						
Net Income (€)	9	14965,3	23115,1	17589,422	2658,3721	7066942,277
% Uptake Home Care 65+	9	2,9	5,1	4,014	,7308	,534
% Uptake Personal Budget 65+	9	,3	1,2	,584	,2945	,087
% Uptake Social Security Benefits (Attendance Allowance) 65+	9	13,0	17,5	15,368	1,4721	2,167
Germany						
Net Income (€)	16	14945,5	23459,0	18266,056	2564,5445	6576888,491
% Uptake Home Care (nursing and social) 65+	16	2,3	4,6	3,475	,6688	,447
% Uptake Residential Care 65+	16	3,8	5,3	4,253	,4078	,166
% Uptake Long Term Insurance 65+	16	5,0	8,2	6,413	,9835	,967
Italy						
Net Income (€)	21	11876,6	20600,7	16631,505	3203,9077	1,027E7
% Uptake Integrated Domiciliary Care (nursing and social, ADI) 65+	21	,4	7,3	3,129	1,9181	3,679
% Uptake Residential Care 65+	21	,5	4,9	2,129	1,3346	1,781
% Uptake Regional Cash for Care (Assegno de Cura) 65+	13	,2	3,5	1,015	1,0180	1,036
% Uptake Social Security Benefits (Indennita di Accompagneto) **	21	2,1	12,5	6,676	1,9305	3,727

* Since the Belgian data is based on two observations, no Std. Deviation and Variance is calculated.

** The % Uptake Social Security Benefits for Italy is applicable for the whole population, not only 65+.

Is there another explanation for the coverage level? We tentatively observe an interaction between the chosen LTC-regime and the welfare state type. Once a corporative regime has chosen a service-type LTC-regime, its internal structure is need-oriented and so becomes pushed towards a generous level of coverage and a generous but residual means-tested extra cash instrument. A cash for care LTC-regime based in a corporative country has to limit the height of the cash benefit but can distribute it more widely than their services. The mean cash in Italy and Germany is certainly much too low for the household expenditure for a residential place or a permanent service at home. However, it can be a part of a private solution wherein family members or cheap labour can be combined at home. The coverage rate of in kind services in England also seems to converge towards a liberal welfare state. Services there are directed to the needy and a generous extra cash system is available to support the dependent elderly.

6. The relationship between regional resources and performance

Is there a relation between the resources of regional entities and the coverage of cash benefits and services in kind? And can we ascertain whether a different picture appears when we look at cash and/or services designed at the national or at the regional level?

Following Kazepov (2010), we hypothesize that regional authorities with more means can and will distribute more services, especially when their regulation and funding depends heavily on regional authorities. The distribution of cash may not be influenced by the regional resource level, especially when the cash system is nationally regulated and distributed. This means that the variation in service level will be influenced by regional income but the variation of cash level will not.

We collected data in four countries: England, Belgium, Germany and Italy, at the regional level. For each country, we used the mean income of a household as an indicator of the resources available for the regional authorities. We assume that a higher mean income of persons in a region will generate more tax-based income for the concerned regional authority. A mean higher income will therefore produce a higher service level but no clear-cut relation to the distribution of cash benefits for the elderly.

A visual inspection of table 1 however, offers a more nuanced picture that resonates with national patterns. The regional variation of service and cash levels is quite restricted in Germany (and in the service level of Belgium, however as shown in chapter 2, if the coverage rates are similar, intensity varies a lot). Italy, however, generally has a much higher variation both in cash and in service distribution. England has a rather low regional variation in services but not in national cash benefits.

The distribution of income is not so different between English and German regions but the income variation of regions is considerably higher in Italy.

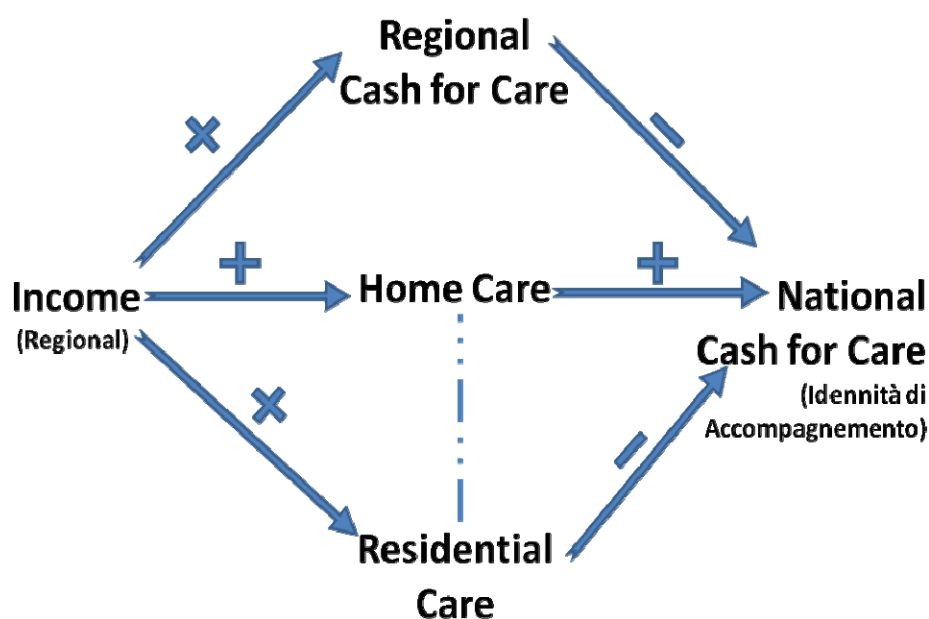
We designed a basic model to explore some of these variations. We use the income variable as an independent variable into regression analysis, where the different level of cash benefits use or service levels function as the dependent variable, in each separate country. We then check whether there are interrelationships between the coverage levels: is there a relationship between the level of cash and the services use e.g. more cash corresponds with fewer services or vice versa? Is more ambulatory care associated with less residential care? And, finally, is there still a correlation between income levels and the different patterns found in the distribution of regional cash and services?

The technical parts of the regression analysis are presented in Appendix 2.

In England and Germany we find no relationship between the different income levels of the regions and the regional level of care in kind, nor in the variation of use of the cash for care (Direct Payments and Pflegegeld). We hypothesize that the regions (or Länder) with higher levels of income level would be lower in their use of both types of services. But this seems not to be true. In England, there is also no income effect regarding the use of the national cash benefit (Attendance Allowance). The real but modest variation between the regions in services and cash are not related to resource levels but have to be accounted for by other mechanisms (see Appendix 2 for the regression analysis results).

We already noted that the variation in incomes as well as in services and cash levels is generally higher in Italy. Our analyses reveal that there is a systematic positive relationship between income levels of the regions and the variation in services and regional cash measures. Poorer regions have lower levels of both service and regional cash use. The Kazepov hypothesis seems to be validated here. But there is no direct relationship between regional income levels and the use of the national cash benefit. However there are divergent relationships between the service and regional cash measure levels and the use of the national cash benefit. Higher levels of home care use induce a positive relationship: the regions with more home care supply, based on higher incomes, do increase the use of the national cash measure. Using regional services induces them to look for national cash. But regions with higher levels of residential care supply and with higher regional cash benefits do lower the use of the national schemes. These inverse correlations probably contribute to the aforementioned insignificance of the relationship between regional income levels and the national cash measures.

Figure 3.1: Correlations Italy



See appendix 2 for the regression analysis results

In sum, the Kazepov hypothesis is not always true: the relationship is only confirmed in Italy (more resources mean directly more in kind services). For other benefits and countries, there is no relationship evident between income and distribution of cash and services. There exists everywhere a certain variation in cash benefits and in kind services uptake but these are not systematically related to the divergent income levels of the concerned regions.

The design and elaboration of these services and cash measures seems to be influenced by other mechanisms as e.g. ideological preferences or a historical pattern. They are certainly influenced by the type of LTC chosen and the general design of the national welfare state.

7. Growth and innovation at regional level and national levels

Both Belgian governmental levels - regional as well as national - show growth and differentiation. Regional governments invested in day care centres, service flats and quality systems, and the federal level adapted the health system and stimulated employment in universal services at home with a generous voucher scheme. The other cash schemes which were created in the nineties further matured and expanded. Occasionally, both levels independently took similar initiatives in the same domain (e.g. coordination plans), sometimes they negotiated (e.g. in the residential sector). Federal initiatives also influenced the home delivery of services, which is constitutionally allocated to the regions indirectly. The national government took, with its voucher scheme, an employment measure and so more than

doubled the coverage rate of home care services in both regions. It was not designed as a care policy measure but as an employment initiative and seems to be the most important home care change in the concerned period.

As a built-in element of the care system in England, the debates on LTC were central and very intense in the past decade. Local authorities have autonomy and this can be observed in the variability of the coverage rates. It is, however, the national government who lays down the basic rules and objectives. They were concerned with the fairness of the funding structure, the market structure of the service supply, the quality of the services rendered and the care professionals, accessibility and participation as well as with the monitoring of the deployment of the services and financial transfers. They started to integrate the health and care sector, set up coordination projects and the personalisation with budgets. Central government was dynamic and innovative. Local authorities exhibited quite a broad variability in their coverage of services with a tendency towards more intensive home care packages instead of more coverage.

The basic structure of the German LTC - system was defined in the nineties – with the national care insurance system and the regional supply of services – and was further elaborated in the concerned period. The system as a whole is slowly growing, with a stable number of users opting for cash for care but a moderate growth in the service option shows an increase and a differentiation. The service sector underwent a mayor change in the supply structure with an enormous growth in the private suppliers of services. At the national level, two developments can be identified. A serious attempt has been made to integrate the accessibility of care insurance with the health sector and further refining of the basic elements of the insurance has been taken place: the benefit levels are more differentiated and heightened, assessment methods are detailed, care counselling was made available and better quality control was provided. Social assistance still remains an important element of the system and there appears a grey market and a low paid job segment.

Italy had many national debates on the necessary reform of the LTC-system but they did not result in major reforms. Meanwhile, the coverage rate of the central cash for care transfer increased from 5,5% to 9,5% without an active policy in this matter. A process of maturation seems to be underlying this development. Regional and local authorities now try to control the growth of the subsequent grey immigrant care supply via their regional policies to co-finance the care at home in exchange for a regularised position of the semi-formal carer in an agreed care plan. These strivings seem to increase the enormous regional variability in the cash system as well as in the service coverage level.

The basic structure of the LTC-systems under review was laid out in the nineties and further deepened, refined and rolled out in the first decade. The national level was prominent in innovation and growth in all countries, also in the more decentralised ones. Each country undertook efforts to better integrate health services with care institutions. England and Germany refined the central framework directly. The national level in Belgium also influenced the service coverage level, but through employment policy measures. In Italy, the maturation of the cash for care schemes appeared even without an active national policy.

Regional and local level authorities also introduced innovations into their care system. The supply structure of services has been rebuilt everywhere: in England and Germany by national design, in Belgium via the national privatised voucher structure and in Italy from the bottom-up. Regional governments added more differentiation in the service structure and complemented the national cash measures (In Flanders and Italy). The regional variation we detected throughout that the regimes can be innovative and growth oriented as their preferences and possibilities do allow for such developments. We can so amend Kazepov's idea that the national level is necessary for growth and generous coverage. The national measures are not sufficient for high service deployment but they are for high cash level coverage.

During the concerned period, only England produced policy initiatives at the national level for ambulatory services. Elsewhere, these frameworks were formulated at regional levels. Aside from Italy, in all three other countries the broad LTC policy was an item in national political decision making. In Germany, it concerned only the cash option with an expansion of categories, and the level on payment for services by national social insurance. In Belgium, the residential sector is still largely nationally planned and financed. So, in three countries a national debate took place and this resulted in new legislation and initiatives. Only in Italy did the debates not result in new actions, but meanwhile the national cash system matured. It is quite clear, however, that some (sometimes all) regional authorities in these countries debated on LTC policy which did not result in new initiatives everywhere.

We also detect a convergent tendency towards change in their care system to include both serious service and cash elements. Cash based LTC-systems (Germany and Italy) both strived at their regional levels to improve their service coverage level. However, both saw the appearance of a grey service supply. Service based LTC-systems (England and Belgium) seriously expanded their cash transfers, next to their already higher service level. Decentralised countries can have high service levels as well as high cash levels (e.g. Belgium) dependent on the type of the LTC-system. Decentralised countries with a cash-based system promoted in fact the national level as the most important actor (as in Germany and Italy). Service development is difficult within such a structure.

In sum, the degree of innovativeness in LTC-policy is not so much determined by the distribution of the authority levels but by the LTC-type chosen. Service-oriented countries (England and Belgium) have exhibited considerable policy innovations in the last decade, at the national level in both countries and at the regional level in Belgium where real authority and resources are allocated. Cash-oriented countries (Germany and Italy) exhibit very few policy innovations at the national level but some experimental innovations at the regional levels. In these countries, the medical system nevertheless seems to be more innovative in its attitude towards chronic illness. Policy innovation is a characteristic of the LTC-type and the distribution of policy authority between national and regional level has no enduring effect in the countries studied.

8. The coherence of the policy and the supply for the elderly

In each country the policy and implementation structure of medical and social care diverge. The increase of levels in the structure of the social care, particularly in the corporative countries, is an additional policy level and this can contribute to divergent ideas, instruments and coverage. Cash for care schemes are typically steered towards the national level whereas services tend to be planned and regulated at the regional level.

Policymaking can be very disjointed in the decentralised countries. Regions can go their own way and create divergences, and even at the national level, decision-making can take place without much negotiation with the regions. Each of the policy levels then has to adjust to each other, often resulting in minimal coherence. This seems to be the case in both Germany and Italy. This is also partly true in Belgium: regions took their own initiatives in the cash sector but they occasionally negotiated together, directly with the national state, in the planning and funding of the residential sector. The interaction between residential and home care is so significant in the field that the regions have to adapt to the developments at the central level.

Corporative countries therefore have many more difficulties in formulating and implementing coherent policies. But once they have chosen a developmental path, the height and coverage levels seem to converge in each state, except in Italy. In England variability simply arises from the implementing authorities.

The potential user of elderly care is perhaps most interested in the coverage level and the differentiation of the supply. Medical and social care demands are treated in separate places everywhere. But corporative countries seem to multiply the number of offices where a potential user has to formulate his/her demand: cash versus services, residential versus home care; and frequently a multitude of public and private non-profit suppliers for each of them. Cash for care schemes may induce other consumer obligations to look for external aid, sometimes in the grey market and the migrant care work market.

All in all, the liberal welfare state in England seems to be more convenient for an integrated policy as well as for integrated implementation of the supply. But corporative countries offer the consumer more real options to choose between the many types of suppliers, if the coverage of the services is high, as e.g. in Belgium and its regions.

Therefore, decentralisation systems seem to produce complex decision-making structures and individual choice contexts but they do not directly lead to greater regional variation and lower coverage levels. The basic institutional structure consists of the interplay between the type of chosen LTC-system and the type of welfare state regime. But state particularities do persist, as is evidenced in the case of Italy.

It became clear that there appears a profound difference in terms of coherence between England and the corporative countries. England has both a unified and central policy making structure and a strong and unified local social care implementation structure. Coherence is the result. Belgium, Germany and Italy all have a divided policy structure and a non-unified local implementation system. Belgium has divided policy competencies straight through all

instruments: some cash and services are nationally regulated, others are regional competencies. This leads towards a competitive and occasionally, a context of conflict which induces a more dynamic entity. This system inclines towards higher performance and innovativeness. Germany and Italy have a clearer cut division of social care responsibilities but the chosen LTC-type inhibits its performance and innovativeness. Their systems produce a more static equilibrium. The local implementation structures of the three corporative states all have a complex structure: cash and services are administrated by different agencies and this makes choice difficult for potential users.

9. Conclusion

The division of LTC competencies between national and regional authorities is neither related to the level of performance nor to the degree of innovativeness, but only to the level of (in)-coherence in the policy structure and the local implementations systems. The chosen LTC-type is more strongly correlated with the mentioned performance and innovativeness level in the four countries we studied. The welfare state type also has an influence where means testing occurs (mostly in England, and also somewhat on the national level in Belgium) because it lowers the take up. Where needs testing alone prevails, uptake of services or cash benefits grows.

Kazepovs lament seems to be ill directed and one sided. The territorial division of social care authorities is general not the cause of low performance and innovativeness. It is, rather, the basic choice of the LTC-type that induces or hinders performance and innovativeness. Italy, for example, is a cash-oriented country with a rather low performance and innovativeness and so generally reduces the development of services. The unequal distribution of resources between Italian regions ensures that richer regions have a greater chance of providing services but their overall performance remains comparatively low.

Appendix 1: technical appendix to Table 1

For the four countries the data for the net income is based on EUROSTAT (2008) and is calculated per inhabitant.

1. Belgium

Same source as chapter 2.

2. England

Home Care

The figures for the regional variations for the uptake of Home Care by the elderly persons in England is based on data received (email 05-01-2012 from the London school of Economics (LSE)). The data shows that the regional difference in the uptake of the UK Community Social Services in 2011 varied between 2,9% and 5,1%.

Cash for Care

The figures for the regional variations for the uptake of Personal Budgets by elderly persons in England are based on data received (email 05-01-2012) from the London school of Economics (LSE). The data show that the regional difference in the uptake of the Direct Payments in 2011 varies between 0,3% and 1,2%.

The figures for the regional variations for the uptake of social Security Benefits by elderly persons in England are based on data received (email 05-01-2012) from the London School of Economics (LSE). The data show that the regional difference in the uptake of the Attendance Allowance by the Department of Work and Pension in 2011 varied between 13,0% and 17,5%.

3. Germany

Home Care

We use the data from Statistische Ämter: Der Bundes Und Der Länder (<https://www.regionalstatistik.de/genesis>). These data state that in 2009 the regional difference between the Länder varied from 2,3% to 4,6%.

Residential Care

Again we use the regional data from Statistische Ämter: Der Bundes Und Der Länder (<https://www.regionalstatistik.de/genesis>) which state that 4,2% of elderly persons in Germany (717.279) received residential care, with a regional difference between the Länder which varied from 3,8% to 5,3%.

Cash for Care

The German statistics (<https://www.regionalstatistik.de/genesis>) state that 6,4% (1.065.564) of the German elderly population received cash for care in 2009 and that the variation between the Länder varied from 5% to 8,2%.

4. Italy

Home Care

To show the regional variation in the data for the uptake of Home care by elderly persons in Italy we used the data of the Italian Axis 1 (CROME, 2011 d: 19). The data state that in 2008 3,3% (394.218) of the population aged 65 and over received home care and that the regional variation lies between 0,4% en 7,3%.

Residential Care

The data from the ANCIEN report (Tediosi & Gabriele, 2010: 10-11) confirm that in 2005 2,2% of the population aged 65 and over received residential care. The ANCIEN report (Tediosi & Gabriele, 2010: 13) also shows that the regional variation in 2005 was from 0,5% to 4,9%.

Cash for Care

The data from the ANCIEN report (Tediosi & Gabriele, 2010: 17) state that in 2009 the Regional Cash Benefit for the elderly is received by 1% of the Italian elderly, with a regional variation of 0,2 to 3,5%.

Based on the data of Istat 2008 (received by email on 07-01-2012) the uptake percentage of Social Security Benefits was 6,3% in 2008. The regional variation was from 2,1% to 12,5%.

Appendix 2: technical appendix to the regression analysis

Due to the exploratory nature of the analysis and the limited number of observations, a significant level of ,050 is acceptable but in three regression analysis we also accepted a significance level between ,051 and ,060.

Table 3.2: Regression analysis on Uptake Home Care 65+: England

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	9	5,601E-6	,000 - ,000	,958	,020
R ² -,142					

Table 3.3: Regression analysis on Uptake Personal Budget 65+: England

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	9	1,212E-5	,000 - ,000	,779	,109
R ² -,129					

Table 3.4: Regression analysis on Uptake Social Security Benefits 65+: England

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	9	,000	,000 - ,000	,176	-,524
Uptake Home Care 65+	9	,125	-1,808 - 2,061	,873	,063
Uptake Cash for Care	9	2,240	-2,588 - 7,068	,287	,448
R ² ,125					

Table 3.5: Regression analysis on Uptake Home Care 65+: Germany

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	16	-7,994E-5	,000 - ,000	,248	-,307
R² ,029					

Table 3.6: Regression analysis 1 on Uptake Residential Care 65+: Germany

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	16	-1,413E-5	,000 - ,000	,743	-,089
5. R² -,063					

Table 3.7: Regression analysis 2 on Uptake Residential Care 65+: Germany

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	16	-1,560E-5	,000 - ,000	,741	-,098
Uptake Home Care 65+	16	-,018	-,400 - ,364	,919	-,030
6. R² -,144					

Table 3.8: Regression analysis 1 on Uptake Long Term Insurance 65+: Germany

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	16	,000	,000 - ,000	,204	-,336
7. R² ,049					

Table 3.9: Regression analysis 2 on Uptake Long Term Insurance 65+: Germany

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	16	,000	,000 - ,000	,318	-,265
Uptake Home Care 65+	16	,470	-,341 - 1,281	,231	,320
Uptake Residential Care	16	-,737	-2,008 - ,535	,231	-,305
8. R² ,129					

Table 3.10: Regression analysis on Uptake Regional Cash for Care 65+ corresponding figure 1: Italy

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	13	,000	,000 - ,000	,045	,564
R² ,256					

Table 3.11: Regression analysis on Uptake Home Care 65+ corresponding figure 1: Italy

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	21	,000	,000 - ,001	,060	,695
Uptake Residential Care 65+	21	-,833	-1,878 - ,212	,111	-,579
R² ,093					

Table 3.12: Regression analysis on Uptake Residential Care 65+ corresponding figure 1: Italy

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Net Income (€)	21	,000	,000 - ,000	,000	,844
Uptake Home Care 65+	21	-,162	-,365 - ,041	,111	-,233
R² ,636					

Table 3.13: Regression analysis 1 on Uptake Social Security Benefits corresponding figure 1: Italy

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Uptake Regional Cash for Care 65+	13	-1,278	-2,598 - ,043	,057	-,540
R ² ,228					

Table 3.14: Regression analysis 2 on Uptake Social Security Benefits corresponding figure 1: Italy

	N	B (unstandardised)	95% Confidence Interval for B	Sig.	Beta (standardised)
Uptake Home Care 65+	21	,440	,054 - ,825	,028	,437
Uptake Residential Care 65+	21	-,646	-1,200 - -,092	,025	-,447
R ² ,337					

- Chapter 4 -

The process of marketisation in home care

1. Introduction

This chapter focuses on an analysis of the process of marketisation in the field of home care services. Different market-oriented reforms have characterised the recent restructuring of publicly funded home care: (1) the increasing contracting out of home care services and the consequent shift in the balance of provision between in-house provision and outsourced provision (private “for profit” or “not for profit” providers) (Daly & Lewis, 2000; Pavolini & Ranci, 2008); (2) a shift towards the direct purchasing of care by individuals and their families through the public transfer of cash payments (Ungerson, 2007) or voucher (Bode, Nyssens & Gardin, 2010); and (3) a greater reliance on the private funding of care by individuals and their families (Shutes et al., 2011).

These reforms are leading to increased complexity and cross-country variety in the care mix. As explained in the introduction, countries adopt different approaches when tackling the challenge of the affordability of care, ranging from directly subsidising the cost of paid care, to paying for social contributions, to granting tax credits for families’ care expenditure, to tolerating an undervalued – and under-paid – regular or irregular care labour.

Our analysis starts from the hypothesis that the interaction between these market-oriented reforms and “path dependency” i.e. change in a society depends quantitatively and/or qualitatively on its own past, will have a range of impacts on the process of marketisation.. For example, the process is shaped by the quality and the degree of regulation; the features of the regulatory system determine the change in the weight of the various types of providers, and affect the extent and the forms of competition. Given the elasticity of demand, this in turn affects the quantity and quality of care and its cost for the user.

Section 2 of this chapter explains our methodology. Section 3 analyses the process of marketisation from the perspective of the evolution of the mixed economy of supply, using as a proxy measure the share of the “for profit” sector among the different types of providers. In order to assess its effects on the final user, section 4 investigates how the “market” works: that is, how it is regulated and the role that price and quality competition plays both on the care service market and on the care labour market (including the grey market). Section 5 analyses how the process of marketisation affects the cost paid by the users in the various countries.

2. Methodology

Figure 1 shows the various elements that make up the social care mix, with the yellow boxes indicating the care segments that feed the process of marketisation. These show that marketisation can be activated through two different routes: (1) a direct link from public provision to market, via contracting out and relaxing the regulations, rules and conditions limiting the scope of “for profit” institutions and (2) a direct link from what is paid by the user and/or family, either through co-payment or the direct purchase on the regular, or more often irregular, market, which can be supported by public cash for care or tax credits.

In the case of social care, the social cost for the service usually does not coincide with the cost borne by the actual user, and the way EU countries distribute these social costs among the population differs widely. While the total number of hours of home care is influenced by the degree of dependency and, at a first approximation, is roughly comparable across the countries we look at, it is the scope and intensity of publicly supported care that determines the magnitude of the share of the care that is not funded by the state. Social and economic factors determine both the size of this residual provision and its allocation between family care and market care (regular or irregular).

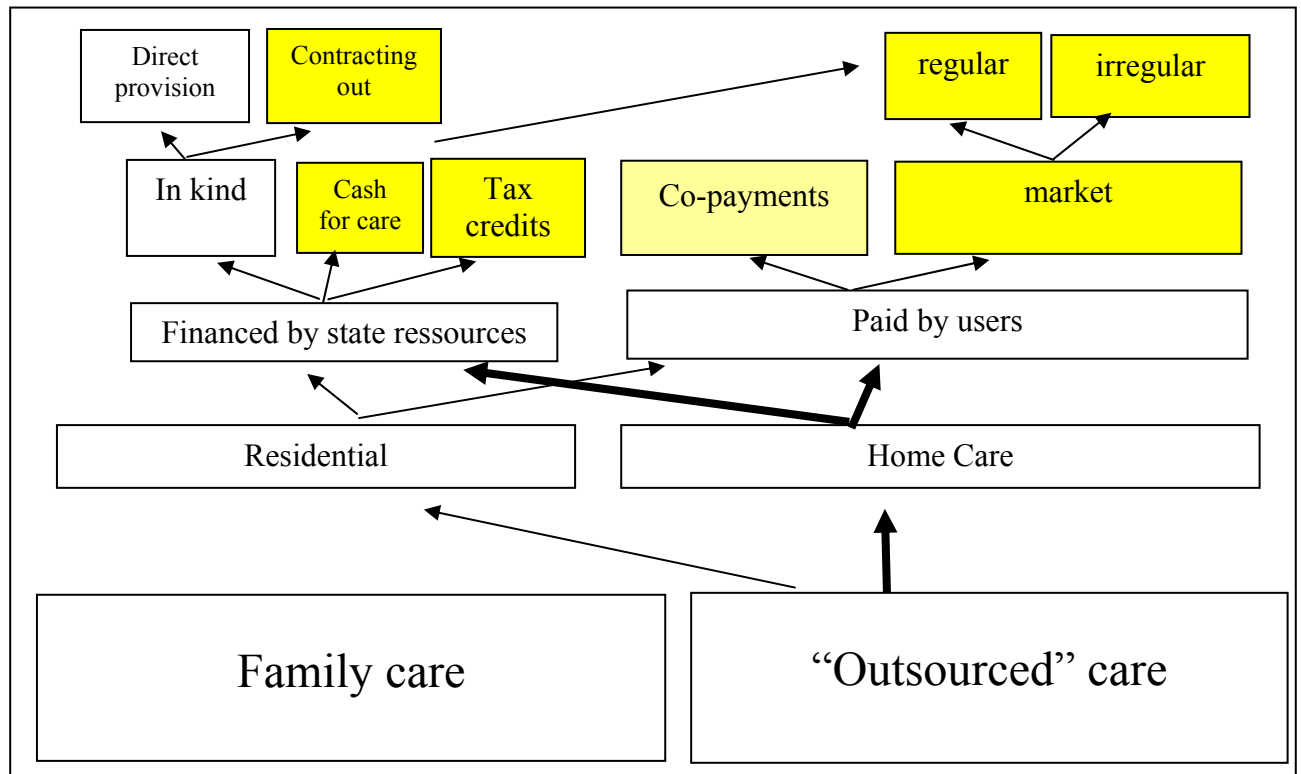
To widely varying degrees, all countries provide basic social assistance or social insurance against the risk of dependency in old age, funded by general taxation or social contributions, or both. The larger the share of LTC costs covered by fiscal revenues, the smaller the part left to users to fund. The monetary cost supported by users is composed of three types of expenditures: the co-payment for subsidised hours, the price paid for the non-subsidised hours in the official market, and the price paid for services on the informal/black market. To these must be added the opportunity cost of informal family care in order to arrive at families’ overall real care burden. However, no reliable statistics are available regarding this cost at the macro level.

It follows that the process of marketisation is affected by several forces, and that each country can offer different options at each of the various interfaces that feed into the care mix. Given the different possible trajectories (see Figure 1), the marketisation process creates different issues in each country.

In those countries where services used to be financed by state resources, contracting out may increase. Where services have been delivered for a long time by “not for profit” organisations, reforms might concern, or affect, the “terms of trade” between public bodies and providers, and between providers and final users. For example, input-oriented funding can be replaced by output-based payments, via fixed-term contracts with providers and benchmark-based evaluation. At the same time, “for profit” providers can be allowed to enter the market. Supply-side subsidies can be transformed to demand side subsidies through cash for care or vouchers, alongside an assumption that the user will be transformed in a consumer acting on a market to make his/her choices. In countries where public involvement has previously been more limited, the shift from family to (black) market provision poses specific problems such as the handling of the transaction cost between users and providers, and/or the regularisation

of workers. In all the countries we looked at, public financial resources have not kept up with the increase in demand for care: economic and financial considerations are leading to an increasing weight of private provision.

Figure 4.1: The process of marketisation



Finally, it is worth noting that the process of marketisation can be slowed down or even reversed by policy or economic developments: for instance, the common trend of focusing publicly-funded care on the most vulnerable older people, compounded by the fiscal crisis, has increasingly left to families the responsibility of taking care of a larger number of less severely dependent relatives. The impact of this trend on marketisation depends on how families choose to cope with this challenge. In practice, the severe effect of the current economic crisis on families' real income (and opportunity costs) can reverse the trend seen in recent years of increased direct purchasing of care by individuals and their families.

In the following sections we analyse the role played by the process of marketisation in determining various outcomes.

3. The mixed economy of supply

The phase of reforms of care regimes began towards the mid-1990s, leading to the entry of “for profit” institutions and the overhauling of the organisation of the sector. A “welfare mix” approach has emphasised the diversity of actors that are now active in the provision of welfare – state, for profit, third sector, carers directly employed by households, and families (Evers & Laville, 2004) – and which has been ushered in by the introduction of market principles in a field that was, before that, dominated by public bodies and associations (Gardin & Nyssens, 2010) or by families. In this context in Europe (Evers & Laville, 2004), the third sector traditionally brings together cooperatives, associations, mutual societies and increasingly foundations, that is all “not-for-profit” organisations (organisations not owned by shareholders), and in some European countries is labeled the “social economy”.

These various actors often complement rather than substitute for other players in their contribution to the total amount of care which is needed, but their presence nevertheless introduces an element of competition into the system. The degree and the forms of competition characterise the way in which market principles have been introduced in the field of care services for dependent people.

If we look at the share of the for profit sector we find very different patterns of marketisation across countries (Table 1).

Table 4.1: The supply of home care services

	For profit		Public sector				Not for profit			
	1999	2008	1999		2008		1999		2008	
Belgium Home care *	-	-	Wal	Fl.	Wal	Fl.	Wal	Fl.	Wa	Fl.
			28 %	17%	27 %		72%	83%	73%	
Belgium Voucher (housework) **	-	64%	-		8%		-		28%	
UK ***	70% (2004)	76%	19 % (2004)		13 %		11% (2004)		11%	
Germany ****	36%	45%	2%		2%		62%		53 %	
Italy ****	n.a	22%	n.a		64%		n.a		14%	

* Gillain, Nyssens, 2001 + CROME Reports, measured in hours of services

** IDEA consult, 2009, measured in hours of services

*** Skill for Care, 2010, measured in home care agencies registered with CSCI/CQC

**** Statistisches Bundesamt, Pflegestatistik 1999 and Pflegestatistik 2007, measured in persons cared for.

**** Fondazione Istud, 2010, Censimento sui servizi di home care

In Belgium, there is no trend towards marketisation, with the exception of the voucher system (*Titre-service*), which is limited to covering housework. “For profit” providers have been, and are still, excluded from home care services, and the regional government’s funding rules have contributed to the remarkable stability of the split between “not for profit” and public providers. “For profit” firms do play a major role within the voucher system, where they control two-thirds of the market. But many public and private “not for profit” service delivering agencies also entered this market niche and offer also these services. Unlike most quasi-markets that emerged across European countries, the Belgian service voucher scheme was not designed as a tool for improving efficiency in the provision of social services. Rather it was a means to expand both the demand for, and the supply of, housework services in order, first and foremost, to fight the irregular labour market and to create a maximum number of “new” declared jobs for low-qualified persons (Defourny et al., 2010). Thus it was not meant to substitute existing provision in the field of home care, where only public or private non profit organisations are accredited and financed by regional authorities. Contrary to the French voucher system, households cannot directly employ the workers. In 2008, over 100,000 persons were working in this field for 560,000 users and employed by 2,000 providers (Idea Consult, 2009).

In Germany, prior to the introduction of long-term care insurance (LTCI, *Gesetzliche Pflegeversicherung*), home care was provided primarily by non profit institutions, with only a minor role for private “for profit” providers, mostly in big cities. Municipalities were allowed to subsidise non profit providers to secure formal care provision, thus giving them a privileged position in home care service delivery. The advent of LTCI in 1994 was inspired by the principle of competition, and its introduction into the provision of publicly-funded care by home care service providers. The LTCI law defined the principles for the regulation and expansion of the professional care structure, stating that it should respond to market principles – competition between providers and cost efficiency – while securing high quality standards and being oriented towards the needs of users. By ensuring freedom of choice to users, the LTCI law opened up the care market on equal terms to “for profit” and “not for profit” providers. Thus, since the introduction of LTCI the share of private “for profit” organisations has steadily increased (from 36% to 45% of total users between 1999 and 2008) and the “not for profit” sector has steadily decreased, though it still retains more than half of the market. Beyond LTCI, citizens can still claim long-term care support (*Hilfe zur Pflege*) under the social assistance act. This had been the key publicly funded scheme prior to the introduction of LTCI and was revamped thereafter, assuming a more residual role within the whole system. In this part of the care system only public and “not for profit” organisations can provide services.

With 76% of market share, England is the country where the “for profit” sector has the biggest role in providing home care services. The private market for the provision of home care has developed mainly in response to the contracting out of care by local authorities, which prior to the introduction of “a mixed economy of supply” had been the primary providers of home care. The reform sanctioned the separation of funding from provision. As a consequence, in 2008, 87% of home care hours were provided by private organisations,

compared with 1992 when 98% were provided by local authorities (NHS Information Centre, 2009). The private sector is relatively fragmented, with a large number of small firms: it includes voluntary organisations and social enterprises (businesses with primarily social objectives whose surplus revenue is reinvested for these purposes); sole proprietors, partnerships and franchises; and limited companies (ranging from single branches to large national organisations). “For profit” providers accounted for 76% of total providers in 2008 (up from 70% in 2004), while the share held by “not for profit” organisations has remained stable at around 11%.

The Italian model of care has seen the spontaneous transition from a model based on informal, unpaid care provided by the family to one based on informal, paid care provided by irregular and regular immigrant workers. It is only recently that Italy has seen the introduction of cash for care allowances (*Indennita di accompagneto*) and “tied cash” (*Assegno de cura*) which can take the form of vouchers, or/and incentives to regularise homecare workers; these complement the much larger cash payments represented by the Attendance Allowance (*Indennita di accompagneto*). The proportion of home care provided by professional agencies remains relatively small, but it is developing as an affordable alternative to publicly provided home care that families directly contract for on the (black) market. This evolution has been encouraged by the contracting out of services by local authorities and by the funds coming from cash for care allowances and vouchers. However, professional agencies remain under constant pressure from the burgeoning black home care market. Against this background, Law 328 / 2000 on the reform of social services has attempted to redesign the boundaries between public and private provision, through a series of measures that define responsibilities and competences in managing local public services.

Care workers employed by families

In Belgium, with the introduction of the voucher system (*Titre-service*), there has been a shift from a system based on irregular workers employed and paid by households to one relying on regular workers employed by firms and heavily subsidised by the state. No reliable data is available for the black market regarding care: a few studies suggest however the existence of migrant workers (Adriaenssens, 2009; Pacolet, 2009)

There is no evidence to date in the UK for a sharp increase in the number of workers directly employed by households, and no data is available regarding the grey market in home care services. However, the emphasis on the personalisation of the care system, and the associated growth in the take-up of direct payments (*personal budget*), could lead in the coming years to an increase in the unregulated supply of support from personal assistants employed directly by users.

Germany introduced so-called “mini-jobs” in 2005. One objective, among others, of the programme was to legalise the employment of undeclared irregular domestic worker and by extension the coverage of work insurance. However, problems remain regarding the working conditions of these jobs and the limited attractiveness of the programme to undeclared

workers. Indeed, there is evidence of an increasing number of migrant carers working as household and care assistants outside the regular care system. Their number is estimated at between 50,000 and 100,000 people, but this may be an underestimate as some experts put the number of Eastern European immigrants alone at 100,000 (Neuhaus, Isfort & Weidner, 2009; Fussek, 2008). The sharp increase that has been seen in recent years could be because the costs of care have increased faster than the fixed LTC insurance benefits (see section 5). As a result, German households have turned to privately purchased care services and, given the high costs of professional care services in both out-patient care and nursing homes, families have increasingly relied on migrant carers to provide home care (Friebe, 2008; Kondratowitz, 2005).

It is Italy, however, that has undergone the most spectacular increase in the number of care workers employed by families, most of them irregular immigrants. By 2010, irregular caregivers were estimated to be about 774,000 of whom 700,000 were foreigners (IRS, 2009).

The Financial Law for 2005 tried to curb the employment of irregular domestic workers by introducing tax benefits for families employing regular workers (not necessarily for care). However, the very limited size of the tax benefit has not represented a real incentive towards regularisation.

In summary, as a result of the reshuffling of the welfare mix, the “for profit” sector now has a larger size than 10 years ago in both Germany and England. In Belgium, however, the growth of the “for profit” sector has been limited to the voucher market (housework), as it remains prevented by law from entering the home care sector. In Germany and England the growth of the “for profit” market has occurred mostly at the expense of the public sector. The share of the third sector appears relatively stable in recent years in England (10%) and Belgium (75% for home care); in contrast it is decreasing in Germany, though still accounts for half of the LTCI sector and dominates provision under social assistance. In Italy, attempts at promoting the regularisation of care workers have favoured “not for profit” organisations (such as social cooperatives) that have tried to take advantage of the system of accreditation. Care workers directly employed by families have an increasing role in Italy and Germany, mostly in the irregular market in the first.

4. The impact of competition: price versus quality.

The process of marketisation need not necessarily conflict with social goals, if the public sector retains ultimate responsibility for the regulation of the market in pursuit of the general interest. Regulation affects the way in which competition works by shaping the role played by the different actors, contributing to the setting of the entry (and exit) barriers, and exercising control over prices, quality and costs (mainly labour costs).

4.1. Entry barriers

Outright prohibition and strict criteria for accreditation, together with the structure of the market, can determine the level of entry barriers. In this regard, Belgium has by far the more restrictive regulation: there is no system of public procurement for home care and every agency must apply for authorisation. The process of gaining accreditation is very long and a new service agreement will only be granted if there are places available within the quota set by the “programming” procedure, plus a lack of service in the specific area. Once a service is accredited, it is in effect funded for an unlimited period (so long as it can keep its level of activity constant). Thus, the risk of an accredited organisation losing public funding or even its funding varying over time is very small. As a result it is very difficult for an outsider to enter the sector; in practice it is very exceptional for a new service to be created. The turnover in accredited providers is mostly related to the process of restructuring (e.g., a merger between two organisations) within the same federation of providers. So it is no surprise that between 1998 and 2008 the number of providers has been quite stable.

Conversely, the voucher system (*titre-service*) is lightly regulated (Defourny et al., 2010): the accreditation procedure is not at all demanding, even though the system is for vulnerable people, either workers - who are likely to be low-skilled, immigrants or the long-term unemployed - or older (and thus potentially dependent) people. The latter represent one fourth of service users (Idea Consult, 2010). As far as the quality of work is concerned, providers are simply required to respect the Belgian labour laws on working conditions.

At the other extreme, in England there are limited barriers to entry and exit, both in terms of the regulatory framework and the necessary investment. Regulation for home care services has undergone significant and frequent changes in recent times. Following the Health and Social Care Act 2008, all home care providers must register with the Care Quality Commission (CQC). However, the registration rules are extremely loose: to register, providers have to declare compliance with standards covering six areas: involvement of service users and carers and information; personal care, treatment and support; safeguarding and safety; suitability of staffing; quality and management; and suitability of management.²² Many of these standards do not actually specify input requirements; rather they are phrased as “outcomes” or aspirational statements.

Though the majority of home care agencies are medium (50-199 employee) and large (200+ employee) sized operations, they typically have a flat structure with a large number of care workers and relatively few central managerial, supervisory and administrative jobs (Skills for Care, 2010). This structure keeps down fixed costs, which explains the high turnover of providers and the high proportion of agencies deregistering and newly registering each year. Some of this turnover may be reducing as a result of local authorities introducing “zoned” contracts and limiting the number of providers they contracted with. In 2011, the proportion of spot contracts for home care was of 43% and block contracts were used by 21% of local authorities (Fernández et al., 2012).

²² <http://www.cqc.org.uk/organisations-we-regulate/registered-services/essential-standards>

The extension of personal budgets is gradually replacing local authorities' purchase orders, thereby creating potential opportunities for new providers to enter the market and for existing providers to diversify into a wider range of services, such as assisting people who want to use personal budgets to recruit and pay personal assistants (Glendinning et al., 2008). However other providers, particularly smaller ones, may find it hard to withstand the increased financial risk and transaction costs brought about by the increase in competition.

Germany and Italy lie somewhere in between, with Germany leaning more towards the Belgium model, and Italy closer to England. In Germany, providers wanting to take part in the insurance-funded care market must have a contract with the LTCI funds and are required to meet certain (mostly input-related) standards agreed with the insurers. In Italy, accreditation was introduced by Legislative Decree n° 502/1992, extended by the decree n° 328 / 2000, and allows for the authority (in this context the Region) to set up a system to certify that a subject conforms with specific requirements (called standards of qualification). Regions are entrusted to set standards and minimum quality requirement, though not all regions have adopted suitable measures so far. Municipalities are entrusted with the task of actually implementing and managing quality control and accreditation. Through this accreditation procedure, providers acquire the status of subjects qualified to deliver health and social services on behalf of the National Health System (*Assistenza Domiciliare Integrata and Servizio di assistenza domiciliare*). Regions also determine the criteria for the price to be paid by Municipalities for the services provided by the accredited organisations. The main shortcoming is in the lack of any clear and national definition of the requirements of accreditation, with a consequent large differentiation between regions.

4.2. Different channels for competition

In Belgium, where home care services are publicly financed and regulated by regional government, there is no competition based on price, as any co-payment is set by law according to the level of the user's income. Competition among providers must therefore focus on other issues such as the quality or the types of services provided. In household services, the introduction and the massive growth of the voucher system created an expanding market for private entrepreneurs, thus setting off a process of marketisation. However, even in this sector of the market, there is no price competition as the price is also set by law. Nevertheless, the more varied landscape of providers – “for profit”, public and private “not for profit” – does put competitive pressures on this market through working conditions and the quality of the services. Voucher agencies are mainly able to pursue a profit by keeping down the labour conditions of care workers (unlike home care agencies whose working conditions are highly regulated by the law). Indeed, empirical evidence shows significant differences in working conditions among agencies and high turnover of staff (Defourny et al., 2010).

For high income users, it can be cheaper to use a voucher²³ than to accept home care funded by regions. Indeed the level of co-payment for home care is, for them, higher than the price of the voucher system. Users can therefore be attracted to this market and may in practice even rely on vouchers to obtain home care – despite the rules that vouchers should be limited to purchasing housework – especially as demand for home care services is much larger than the quota-limited supply.

In England, with most of home care providers depending on local authorities for their business, the latter still retain a huge monopsony power vis-à-vis the private sector. Thus, in care commissioning, local authorities can use their market power to negotiate fees at relatively low (and potentially unsustainable) levels. The fee rates paid by local authorities to their own home care providers are consistently higher than those paid to independent providers (including voluntary providers).²⁴ Some of the gap may reflect differences in the client base, as anecdotal evidence suggests that home care establishments run by local authorities often tend to specialise in particularly complex client groups where the costs of care are likely to be higher. However, differences in the client base are unlikely to explain the entire variations in fee rates. With fees set by local authorities, the search for profit is mainly pursued by keeping down the wages of care workers, while struggling to comply with quality regulations. Commissioning practices by local authorities can create further problems for providers. The wide use of spot contracts hampers the ability of providers to plan ahead and creates insecurity, which often feeds through to staff in the form of temporary and casual contracts (Commission for Social Care Inspection, 2006).

Finally, the recent developments in consumer-directed support (*Personal Budget*) mean that individuals in need of care have greater control and choice over the purchasing of care. Where individuals are receiving Personal Budget, they operate in the market in the same way as private purchasers of care, using their budgets to purchase the care and services they want. Although the numbers receiving these new forms of consumer-directed support are relatively low at present (the majority of older people continue to receive services purchased through public procurements by local authorities), the rhetoric and the expectation is that the numbers will rapidly increase, the aim being that all publicly-funded care clients will have a Personal Budget in the near future. However, there are some implications: the extension of Personal Budgets is likely to reduce providers' reliance on large volume contracts from local authorities, pushing them to market their services directly to potential clients, including potential private purchasers who are not funded by Personal Budget. However, consumers may have only limited capacity to exercise choice in the marketplace, or they may face difficulties in finding the services they want and in hiring the appropriate workers. As the organisation of the care sector moves away from “in kind” services towards cash provisions and Personal Budgets, the power relationship between users and providers will also be affected. Thus, the cost-benefit balance of free choice will depend on the degree and the forms of competition in the private market for care.

²³ However, the government decided in December 2011 to increase the level of the price of the cheque service from 2013.

²⁴ In 2008 the unit cost of LA's home care was £23.20 as against £12.60 for independent providers (NHS Information Centre for Health and Social Care, 2010)

In Germany, since the introduction of LTCI, private providers have been admitted to a sector previously dominated by the “not for profit” providers and have rapidly taken a large part of the market, putting strong pressure on wages and the work organisation of the “not for profit” sector. Within the LTCI system, the prices of services are negotiated between representatives of funders and provider networks, and are then generally binding in a given region²⁵ (Gerlinger, 2010). Providers calculate cost-effective prices and are directly reimbursed by the insurance funds for the proportion covered by the insurance benefit. Care services are funded within the framework of different public schemes; however they may be delivered by the same provider, thereby overcoming the risk of fragmentation while sustaining the development of an adequate or integrated service support for the beneficiaries and/or their families. In 2009, 97% of care service providers held a contract with both the LTCI funds and the Health Insurance funds and were therefore able to provide an integrated long term care and health service (Federal Statistical Office, 2011). They can also offer additional types of services that can be purchased privately by the users. It is noteworthy that many users and their families utilise market competition by bargaining for these additional “grey” services not included in the assessment and official contract. Competition for clients and diversification of services are fuelled by the need to operate at full capacity in order to reduce fixed costs. Given the control over prices for publicly funded services, the pressure on margins is passed on to wage and working conditions (Simonazzi, 2010).

In Italy there is also evidence that new factors are pushing toward greater regulation and competition in the fields of social and health services. In particular, regional regulations endeavour to promote the development of forms of competition among private providers. However, the stiffest competition comes from the irregular market that can compete on price by not paying social contributions, the saving being €150/month for a family assistant working 25 hours a week (Gori, 2009). Against a background of falling profit margins and the need to contain labour costs, regional regulations combined with competition from the irregular market are encouraging the diversification of activities: for instance, social cooperatives that have traditionally specialised in SAD (*Servizio di assistenza domiciliare*) and in residential care, are gradually entering the ADI (*Assistenza Domiciliare Integrata*) sector. In the last few years, in spite of the stiff competition coming from regular and irregular foreign carers in home care, the contracting out of care by local authorities and the increasing complexity of the care services bundle has, as mentioned earlier, led to a steady growth of the staff of private “for profit” and “not for profit” care organisations.

To conclude, the scope of price competition still appears limited, with the possible partial exception of England, where the shift in emphasis from regulation (monopsony of local authorities) to competition through Personal Budgets should cause the market power to shift from the local authorities to care users. However, the consequences on care users will depend on the effectiveness of the competitive process, as well as on the regulatory power of public bodies. In the other countries we have looked at, and to some extent in England as well, private providers who are constrained by price regulation seem to have taken the competition

²⁵ Prices are fixed for various baskets of service acts, including eg. helping beneficiaries getting up in the morning, washing, dressing, etc.

to other fields, either by diversifying into new, unregulated service segments or by focusing on cost containment, which essentially means labour costs. Thus competition is creeping into all care regimes, though only in a limited way through prices. It is emerging more in terms of quality and the range of services, although where providers (and users) can take advantage of loopholes in labour regulations (through access to cheap regular and irregular labour) it seems to operate more in the labour market.

4.3. The governance of the trade-off between price and quality

The process of marketisation, and the increase in price and non price competition, poses challenges for the governance of the possible trade-offs between price/cost and quality. Moreover, with the increasing complexity of the welfare mix and the greater fragmentation of care provision, there is a need for benchmarking among the various providers in order to ensure the homogeneity of results across the various users.

In most countries, policies that aim to ensure the quality of care and care work have focused on the implementation of accreditation procedures and the exercise of control over private providers. However the results have been quite different. In Italy, homogeneity in service provision and minimum levels of service are still far from being achieved. The regions are in charge of regulating the quality of the mix of public and private services: each defines its rules for accreditation, and identifies the agencies in charge of quality control and the most suitable tools and methodologies, while delegating to Local Health Authorities and Municipalities the implementation of quality control. The latter accredit service providers, who must conform to the regional law, and be accountable to citizens for the quality of the services provided. However, there is still no national benchmarking of care services performance. The actual implementation of home care policy is left to each individual Region, with wide geographical disparities persisting in terms of both individual rights and the services provided. Implementation of benchmarking activities among the regions in order to encourage homogeneity in objectives, let alone results, is still mired in the debate over federalism.

Conversely, in Germany the LTCI law had already defined the orientation on quality standards, developed within nursing science, as a precondition for care provision. Access to the insurance care market requires a contract with LTCI funds. In 2002, the law on Quality Assurance and Consumer Protection organised existing regulations on quality measures within a single framework. As a result, providers are required to establish a quality management system that fits their individual situation, to carry out continuous quality checks and to comply with standards fixed at the national level. The Medical Services of the Health Insurance funds carry out the external quality control according to predefined standards, at least once a year since 2011. The reform of the law in 2008 emphasised the transparency of control results and envisaged spot-check quality controls, to be published in a way that users can understand. However, financial considerations may erode some of these controls. It has been argued that, in their endeavour to reduce costs, private providers employ under-qualified

or untrained staff in excess of the maximum rate of 50% of fully-trained personnel (*Fachkraftquote*) per establishment that is fixed by law. As a consequence, the share of unskilled workers and people under-qualified for their jobs has rapidly increased since the introduction of LTCI (Simonazzi, 2010).

The trade-off between cost containment and quality of care and care work seems to loom larger in England. Quality control is entrusted to regulation, while competition (in the form of entry and exit from the market) is deemed important in order to take care of price/cost effectiveness but results in a high turnover of providers and staff. As noted above, evidence suggests that working conditions are indeed poor in the sector, with high rates here too of turnover and difficulty filling staff vacancies. These difficulties appear to be associated not only with the low pay in this sector, but also with terms and conditions that often do not compare well with other sectors (such as the retail trade), with the result many care workers are frustrated by poor working conditions (Commission for Social Care Inspection, 2006). The report of the Commission for Social Care Inspection urged commissioners to focus more on commissioning high quality services and to improve their relationships with providers.

This English organisation of care services could not be more different from the one observed in Belgium. In the latter case, price/cost efficiency does not seem to be a priority, while quality seems to be ensured by strict monitoring of very detailed conditions that must be met regarding the home care to be delivered, staff qualifications, the daily functioning of the agency, infrastructure, the mutual rights and duties of the agency and the users, and the type of programmes for education and training. However, a dual regime governs the sector, with very long accreditation systems and stable providers in home care, and lighter accreditation rules for entry of new actors in the voucher sector.

5. Who pays for care?

A host of factors – the degree of subsidised care, the institutional influence on the wages of care workers, the degree of competition among providers, the share of regular/irregular market for care – all interact to affect how prices are set, and hence govern the final cost paid by the user. It is also the case that higher formal provision of care can also result in a higher monetary cost to users.

The complexity of the care mix implies that it is difficult to arrive at comparable data for different countries on the costs financed by users. Moreover, the varying boundary between health and social care²⁶ means that it is sometimes difficult to isolate the costs that relate specifically to home care. Comparative data should therefore be assessed with care. Yet Tables 2 to 4, showing the proportion of care costs supported by households, suggests that large differences persist among countries in the share of the monetary cost supported by the user.

²⁶ While in all countries the healthcare system is well developed, the systems differ in their definition of care and their demarcation of the (blurred) boundaries between health care and social care.

Table 4.2a: Who pays for home care? Home care expenditure in England for individuals aged 65+ years (absolute and %) (£m)

	General gov		Local authorities		Co-payment		Total expenditure	
	2005	2009	2005	2009	2005	2009	2005	2009
Home and day care	44,9	61,9	1.994,9	2.175,6	224,8	338,4	2.264,6	2.575,9
Direct payments	0,7	2,3	64,7	234,5	3,1	16,0	68,4	252,8
Total	45,6	64,2	2.059,6	2.410,2	227,8	354,4	2.333,0	2.828,8

Source: *The Health and Social Care Information Centre, 2010*

Doesn't include cash for care from social security system

Table 4.2b: Who pays for home care? Home care expenditure in England for individuals aged 65+ years (Per cent of total expenditure)

	General gov		Local authorities		Co-payment		Total
	2005	2009	2005	2009	2009	2005	2005/ 2009
Home and day care	2	3	88	84	10	13	100
Direct payments	0	1	95	93	4	6	100
Total	2	2	88	85	8	13	100

Table 4.3a: Who pays for home care? Long term home care expenditure in Germany and Belgium (absolute) (€m)

	General government		Private insurance		Out of pocket		Total exp.	
	2003	2009	2003	2009	2003	2009	2003	2009
Germany*								
Long-term health home care	8.401	9.783	233	307	1.885	2.077	10.524	12.167
Long-term social home care					1.015**	1.700**		
Belgium*** Long-term health home care	1.462	2.341	132	381	6	10	1.600	2.371

Table 4.3b: Who pays for home care? Long term home care expenditure in Germany and Belgium (%)

	General government		Private insurance		Out of pocket	
	2003	2009	2003	2009	2003	2009
Germany Long-term health home care	79,8	80,4	2,2	2,5	17,9	17,1
Belgium Long-term health home care	91,4	85,73	8,3	13,9	0,4	0,4

Source: OECD, Joint OECD-Eurostat-WHO Health Accounts (SHA) Data Collection - (JHAQ) and OECD Health Data questionnaire; data extracted on 10 Dec 2011 16:33 UTC (GMT) from OECD.Stat

* Don't include cash for care from social security system

** Estimation of private expenditure of LTC based on a survey conducted for Ministry of Family Affairs, Senior Citizen, Women and Youth

*** Don't include cash for care from social security system and social care expenditure

Table 4.4: Long term home care expenditure in Italy > 65 years (absolute and %) (€m)

	General government	Local Authorities	Out of pocket	Total expenditure
Italy - 2007				
Social - health services	2.131 ** (15%)	1.853 ** (13%)	9.800 * (72%)	13.784 (100 %)
Cash benefit	8342 **			

* Rebba, 200, with €3 billion attributed to services purchased on the market (both grey and regular) and €5 billion for co-payments of publicly funded services

** Ragioneria Generale dello Stato

Unfortunately, information that isolates the total expenditure on home care (excluding health care) is only available for England, with 2005 the first year such data is available. The cost of home care is mainly supported by local authorities and their budget rose by 17% between 2005 and 2009 with a sharp increase in Direct Payments (from 2.9% to 9.8% of total expenditure), reflecting the “personalisation agenda”. While services “in kind” still represent 90% of local authorities expenditure, co-payments increased over the years, albeit from a very low basis (and still represent less than 15% of total expenditure). The tendency in England to focus on individuals with the highest needs is well documented (Malley et al., 2010) with fewer users being more heavily supported. The budget for home care is on the rise but more people are outside the system and have to rely on their own resources to organise home care services either through the direct support of family caregivers or through care bought on the market (this feature is not shown in Table 2). Social security benefits (Attendance Allowance, Disability living allowance, Carers' Allowance), implemented at the national level, may cover part of these costs (see Chapter 2).

For Belgium, Table 3 gives a picture only of the heavily subsidised home *health* care. The out of pocket share is very low. Home care (not included in the table 2) is financed by regions, and in 2008 the proportion supported by the user was around 14% of the total cost in Flanders (Breda et al., 2010), and roughly the same in Wallonia. There has been no change to the legislation relating to co-payments in recent years. In terms of the total of volume of home care delivered, there has been an average annual growth of around 1% in Wallonia since 1998, with a similar increase of the number of beneficiaries helped. In Flanders, the number of users grew by 40% between 2000 and 2009, with an increase of 16% of the total of volume of home care delivered (equivalent to an average annual growth of around 2 %). Many more people have been helped, but at a lower level of intensity.²⁷ This faster increase in the population of people receiving help could be, at least partially, explained by a faster ageing population in Flanders. There are also cash for care programs, allowance for the help to older people (*Allocation pour l'aide aux personnes âgées*), allowance for handicapped people (*Allocations aux personnes handicapées*), implemented at the national level, which are means tested and targeted to the neediest living at home to cover their residual care costs. Moreover, the Flemish dependent population receives a flat allowance of €130 from the Flemish Long – Term Care Insurance (*Vlaamse zorgverkering*). For the voucher system, the price paid by the user is €5.25 per voucher. As noted above, this scheme was meant to regularise domestic services workers: in fact, before the implementation of this scheme, users relied on the black market where the price was higher than €5.25 an hour. To conclude, in Belgium co-payments have not risen in recent years. In the context of an ageing population, a process of marketisation might be encouraged if the rise in the public budget were to fall behind the rising needs, thus leading people to buy care on the market. However, there is no clear evidence of the development of such a market.

For Germany, the first line of Table 2 only provides a picture of home *health* care. However, in the German LTCI system, the frontiers between social and health care are blurred, with most of the services provided relating to home nursing. The share of the health component of long term home care supported by the user, though higher than in Belgium (17% of total cost), has been stable over recent years. Total expenditure for home health care has increased much less (15% as against 70% in Belgium between 2003 and 2009), falling far behind the amount required to cover the increasing needs of an ageing population. Indeed, LTCI benefits were not adjusted for inflation between 1995 and 2008 and were thus eroded significantly in real terms. Between 1999 and 2006, the number of beneficiaries of LTCI increased at an average annual rate of 1.1 per cent (Rothgang, 2010).²⁸ The erosion of the real value of the LTCI has been only recently compensated, but at the cost of an increase in the rate of social contributions. For those who do qualify for LTC benefits, LTCI does not cover the full cost of the assessed care need. On average, the payment covers about half of the assessed need (and only a quarter for those choosing the cash option) (Campbell et al., 2010). This helps explain the sharply increasing trend exhibited by total out-of-pocket payments for long term social home care, as these costs are only partially covered by LTC (see second line of Table 2).

²⁷ These data is coming from the Flemish and the Walloon regional administrations.

²⁸ According to Rothgang (2010), figures for 2007 and 2008 are misleading as adjustments in the statistical procedures lead to a slight overestimation of respective numbers.

Beneficiaries either supplement the services covered by the LTCI with informal family care or resort to the regular and/or irregular care market, possibly, partially supported by the cash benefits received from LTCI. As a result, private care (both provided by family member and privately purchased in the market) is playing an increasingly dominant role.²⁹

In Italy (table 4), financial constraints have been invoked to justify central government's inaction in relation to the mounting demand for home care services: the only measure at the national level (*Indennità di accompagnamento*) is a needs-tested cash allowance, indexed to consumer prices, that accounts for 43% of LTC public expenditures. Between 2001 and 2008 the proportion of beneficiaries rose from 5.5% to 9.5% of persons aged over 65. The lack of comprehensive, national policies for home care is variously mitigated by the provision of services, cash allowances and vouchers at the local level. The shortage of home care services and a tradition of family care have led to a major growth in migrant care workers, often illegally employed within the family. There are no official data on private expenditures for home-based care. A recent study (Rebba, 2009) put it at about €8 billion, with €3 billion attributed to services purchased on the market (both grey and regular) and €5 billion for co-payments of publicly funded services. These private expenditures are, at least partially, covered by cash allowances. One needs to stress the difficulty of estimating private contributions to home care expenditures, given the weight of informal care and the blurred boundaries between informal family care and irregular care bought in the market.

To sum up, when looking at out of pocket home care expenditures, we can conclude that co-payments have not increased over recent years. Given that, with the possible exception of Belgium, public financial resources have not kept up with the increase in demand for home care, it is not surprising that the weight of private provision has increased. In England, fewer users are more heavily supported and more people are outside of the publicly funded system. In Germany, the number of beneficiaries of LTCI has slightly increased but benefits were allowed to erode significantly in real terms. In Italy, "in kind" home care provision is still very low (see Chapter 1) but cash allowances support the services purchased on the market (both grey and regular).

6. Concluding remarks

The size of the "for profit" sector has increased compared to 10 years ago in Germany and England, mostly at the expense of the public sector. In Belgium, the growth of the "for profit" sector has been limited to the voucher market (housework services), as it is still legally excluded from the home care sector. In Italy, attempts at promoting the regularisation of care workers have tended to favour "not for profit" organisations that have tried to take advantage of the accreditation system.

²⁹ Resort to privately financed market care is strongly related to income. In a representative inquiry, 8 per cent of the recipients of LTCI said they purchased professional home-based services with private means, a proportion that increases to 18.6 per cent for beneficiaries with a monthly income of €500 or more. High costs have also been cited as one reason for the low use of semi-residential services. (SGB XI, § 41; MDK Bayern, 2008).

The introduction of market principles in the home care sector has not lead to price competition in the parts of the care market subject in some way to regulation, either because of legal entry barriers or price controls. Where fees (subsidies and co-payments covering the cost of the services) have been set at levels deemed too low by providers, the pressure on margins has been passed on to wages and labour conditions (and sometimes to quality of care) (England and partly Italy and Germany). Thus for the part of the home care sector supported by the state, the process of marketisation has not resulted in an increase in the price (through co-payment) paid by users. Competition and efficiency thus seem to have had more influence on the cost side, with costs variously shared by the state (in terms of subsidies), by firms (in terms of pressure on margins), or by care workers (in terms of lower wages and poor working conditions). It may also have affected users indirectly, where it entailed lower quality of care or a reduced coverage of services or of vulnerable older people.

Public financial resources have not kept up with the rising need for home care. At the same time, the increased use of “cash for care” has meant that users have been encouraged to behave as consumers exercising choice in a care market. Competition has had an impact in this segment of the private home care provision, not regulated by the state. Competition among providers has mostly been pursued by diversifying out of the basic services guaranteed or regulated by the public sector. In this segment of the market, providers’ freedom to set prices has faced families’ income constraints. In some cases, the labour cost has been reduced through voucher schemes (Belgium) or reduction of social contributions (Germany, Italy). Faced with higher prices, increasingly families have turned to the irregular market to buy cheaper services (mostly basic home care) not covered by the “public” umbrella (Italy).

- Chapter 5 -

The use of formal and informal care by dependent older people: Empirical evidence from the Share database on individual care arrangements

1. Introduction

Comparative literature on care regimes has demonstrated that European countries vary considerably in their social care organization. Each national care system has its own organization in terms of financing (who pays?) and provision (who cares?) (Szebehely, 2005). The previous chapters of this report have highlighted the level of public expenditures for home care, targeting principles and coverage rates in Belgium, England, Italy and Germany, and then given an overview of the shares of market-oriented (or “for-profit”), public and non-profit care providers. In this chapter, a macro-level “welfare mix” approach is presented, which improves the characterization as well as the understanding of care regimes after the reforms that took place in the 1990s. This chapter aims at examining care arrangements that dependent older people patch together in order to fill their needs. We will turn from a macro-level to a micro-level analysis of the welfare mix and explore care arrangements at the level of the individual by using a synthetic indicator of the use of care and looking into the main determinants of such arrangements. The main question driving the analysis is to see whether there are significant differences between countries regarding individual care arrangements, as observed at the macro-level.

The first section aims at giving a theoretical base to different kinds of care as observed in individuals’ arrangements. Based on Karl Polanyi’s (1944) approach to socio-economic principles as applied to our field of interest, individual care arrangements will be presented in terms of the welfare mix they represent, i.e. through the lens of the different monetary and non-monetary resources they mobilize. Care providers will be identified as responding to certain socio-economic logics (redistribution, reciprocity, domestic administration and, finally, the market principle). We will then discuss methodological issues in order to transfer these different categories into proxy variables, and finally explain how we constructed these variables as well as the sample based on the Survey on Health, Ageing and Retirement in Europe (Share) database. Our methodological design is very much inspired by Geerts’ paper (2009) on the use of formal and informal care by elderly people. Her objective was to give evidence for country differences in the use of care as well as to find out what were the main determinants of the use, which is also the objective of this chapter. Section 3 presents the findings with regard to care arrangement indicators and Section 4 discusses the results of the statistical model for the three countries under study. Public policies defining the outlines of care arrangements in each country will be mentioned throughout these sections.

2. Individual care arrangements: a welfare mix approach

The individual level is important as it is a good indicator of how LTC is implemented in each country and how “real” dependent people experience care regimes and are actually coping with difficulties and receiving care.

Care arrangements at the individual level reflect the diversity of actors providing welfare: government, enterprises and families (Evers and Laville, 2004). The existing competition between care providers is one of the main manifestations of the introduction of for-profit organizations (and thus, the market) into the field of care services for dependent people, in particular in countries such as England or Germany. Paradoxically, this trend fosters the recognition of a “welfare mix” as the main feature of home care (Gardin and Nyssens, 2010). The institution of this welfare mix is not the consequence of the acknowledgement of the existence of a third sector as such, or of the democratization of the market economy. On the contrary, the recognition of a plural economy has come with the introduction of market principles into a field previously dominated by public bodies and non-profit organizations.

If a plurality of actors is now recognized in the field (associations, families, state, for-profit), as a consequence, economic principles in the field cannot be limited to market behaviours. Polanyi (1944) proposed three other principles that have a high heuristic value for understanding the socio-economic logics of care.

Redistribution is the principle whereby the production of care is handed over to a central authority. This presupposes the existence of a mechanism defining the rules for raising and allocating taxes. In this way, a durable and compulsory relationship is established, between a central authority and the agents subject to it. In modern societies, this falls primarily under the framework of the Welfare State, combining (i) a modern form of redistribution sustained through compulsory deductions; (ii) the payment of cash benefits; and (iii) the provision of social services.

Reciprocity constitutes an original principle of economic activity. It is defined by Polanyi as an “interdependence” principle which relies on the gift as a basic social mechanism, which calls for a counter-gift in time, and hence takes the form of a paradoxical obligation whereby the group or individual who receives the gift has the opportunity to exercise its freedom by giving back. It expresses the sense of “belonging” to a group and it is only meaningful when there is a desire for social bonding among stakeholders. This cycle of reciprocity is opposed to market exchange as it is an integral part of human relationships that brings into play the desire for recognition and power. It differs, however, from redistributive exchange in that no central authority imposes it. Regarding gender, reciprocity can be analysed from the point of view of a so-called preference of women for the gifts/counter-gifts because of less market resource.

A special form of reciprocity is practised within the basic family unit, which Polanyi calls *household administration*. For Polanyi, it involves the autarchic production of an institutional unit such as the family. The family is a major provider of care and its role within care giving is to varying degrees conditioned by public policies, the labour market and gender.

Definitions

Care is *formal* if there is an explicit and recognized contract in the public sphere between the cared-for and the care-giver (direct employment) or between the cared-for and the home-care service.

Care is *informal* if it is the object neither of an explicit contract nor of any recognition in the public sphere (help given by a member of the household or a close relative outside the household, for example).

Care is *semi-formal* when it is provided by previously so-called “informal carers” that receive compensation as care providers either through cash for care schemes or tax benefits.

Care is *remunerated* if the care-giver receives a payment on an hourly base or regularly, or in a fixed way at one moment of the year. This payment is made by the cared-for person or his/her family or any person close to him/her, or it is provided by the state (directly or indirectly). Care is also considered remunerated if it is the object of a payment without any recognized or declared link with the type of care or with the amount of care (in the case of a gift, donation of the parents or grandparents, or the sum paid to volunteers in Belgium).

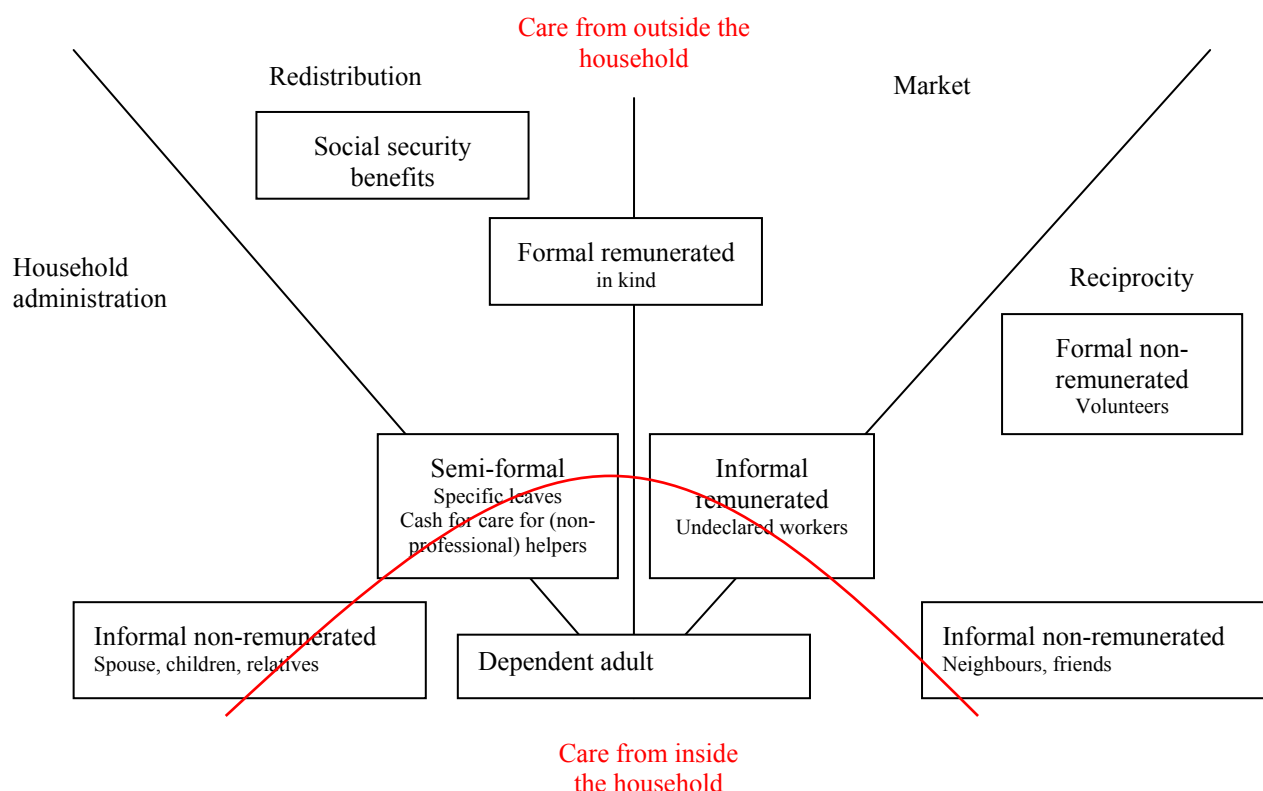
Care is *non-remunerated* if there are no money transfers of any kind between the cared-for and the care-giver.

Care *arrangements* designate the concrete mix of care resources as made by individuals, taking into account the formality or informality of the arrangement, if it is remunerated or not, and the kind of resources sustaining the care provider.

Figure 1 provides a representation of the various types of care as social constructs built on distinct socio-economic logics and actors all of which operate within these logics.

Professional workers (“formal remunerated,” “in kind”) are present in all three countries under study. This is care in kind: employees of private profit or non-profit organizations, public service organization. In order to function properly, these organizations mobilize distinct socioeconomic resources. These resources are state-related (redistribution) but they usually also rely on a fee paid by the care receiver for a service purchased on the care-market.

Figure 5.1: Care arrangements: a welfare mix approach



Care can be provided either from inside or from outside the household

Social security benefits are cash delivered by the state (local, regional, federal) and correspond to “redistribution.” The Belgian *Allowance for the Help of Dependent or Handicapped Persons*, the Italian *Indennità di accompagnamento* and the English *Attendance and Disability Living Allowance* fall into this category as well. These can be means tested (except for the *Indennità di accompagnamento*) but they are not related to the obligation to draw up a care plan with a care manager. Another type of cash or tax incentive, also coming from redistribution by the state, is specifically linked to the provision of care, such as the Italian *Assegno* or the German *Pflegegeld*. Through cash for care, social protection mechanisms recognize certain categories of familial care as work and provide allowances. This type of cash feeds “semi-formal care,” as carers can be relatives or non-professional carers. Semi-formal care is financed by “redistribution” which often partially compensates for previously informal non-remunerated care (“household redistribution”).

Unpaid care performed by relatives falls under the category of household administration and is called “informal non-remunerated.”

Volunteer work, which is increasingly encouraged and will probably be one of the big challenges for the next decade given the scarcity of family resources, could also provide opportunities for reciprocity (“formal non-remunerated”). This kind of unpaid work arises when individuals become involved as volunteers through non-profit organizations (as in the case of a service providing transport for persons with disabilities). This kind of care giving is

more frequent in England than in other countries but the goal of encouraging volunteering seems to be present as a policy objective in Flanders as well (see Chapter 1). Volunteering (“formal non-remunerated”) and domestic work (“informal non-remunerated”) cannot be treated equally. Both are unpaid work but the (gender) social relations at the heart of this work are not of an identical nature and result in a different quantity (as well as quality) of work.

As indicated in the figure, we assume that undeclared or clandestine employment straddles the market and reciprocity spheres (“informal remunerated”). Profit motive (market) as well as the gift-counter-gift movement (reciprocity) can both explain transactions between care-receivers and illegally working care-givers. While the work performed by irregular home care workers falls within the sphere of market logics, they also often tend to have close, long-term relationships with their care-receivers (Lewinter, 2003). Household administration may also be present in this case. As a result of this important relational aspect, the exchange seems not to be limited strictly to a profit motive.

3. Methodological aspects and sample description

The different types of care provision presented in Section 1, and their uneven prevalence across national contexts, are representative of different regimes of care, understood here as the mix of socio-economic principles driving care providers. The next step is to translate these complex categories into operational variables (proxy variables) in order to examine their prevalence statistically.

In the following sections, we examine data from the Share database in order to explore care arrangements at the individual level. As mentioned earlier, we followed Geerts’ approach to analyse the use of different types of care. Her analysis includes macro and micro determinants of care, including, on the macro level, some cultural characteristics of the country, and also eligibility criteria of the LTC system. The following analysis present a simplified model but the intentions are the same: to show country differences in the use of care on the basis of the updated Share data from 2006 and to test for individuals’ determinants.

3.1. The Survey on Health, Ageing and Retirement in Europe (Share)

This analysis is based on data from Wave 2³⁰ of the Share, collected in 2006/7. The Share dataset contains information on the individual life circumstances of 31,115 persons in Wave 1 (2004-2005) and 33,281 persons in Wave 2 (2006-2007) aged 50 and over in 11 European countries.³¹ Topics surveyed include different aspects of adults’ living conditions and wellbeing before and after retirement. In particular, Share provides details about respondent’s health, the provision of formal care to dependent older people, and mutual aid between adults,

³⁰ Release 2.3.0

³¹ Austria, Belgium, Switzerland, Germany, Denmark, Spain, France, Greece, Italy, the Netherlands, and Sweden plus Israel, which did not participate in Wave 2. In addition, three new countries joined in Wave 2: the Czech Republic, Poland and Ireland. England is not part of Share.

i.e. informal home care/help between family members, close relatives, friends, etc. In addition, the cross-national dimension of the data allows us to compare results across countries that differ in terms of long-term care regime.

3.2. The target population

In line with the objectives stated earlier, this empirical analysis focused on dependent older people (aged 65 and over) living in Belgium, Germany or Italy. The term “dependent” is usually used for people experiencing difficulties in their daily lives and requiring care provision (Ageing report, 2009: 245). Only health-related difficulties or physical problems experienced in the last three months or more were taken into account.

So-called “dependent” respondents were identified via questions on difficulties experienced in carrying out their daily activities (see below “independent variables”). Only persons who have at least one difficulty (out of the difficulties as listed in questions ph048 and ph049) were taken into account. Of course, there are people with some form of difficulty who do not need or want any care or help. However, we assume that all the people experiencing difficulties as listed in the Share questionnaire are potentially in need of care provision (whether they either receive it or not).

3.3. Variables of interest

3.3.1. Dependent variable

The outcome variable is the type of care used by dependent older people. The Share database allows to distinguish between professional or paid care and help from others. As will be shown, it was impossible to find perfect equivalents with the above-mentioned categories of care, not to mention with the initial Polanyi principles. However, building variables that are as close as possible is worth the effort as it will still enable us to test for national differences in individuals’ care arrangements. Efforts should be continued as we are persuaded that the very nature of care as promoted by governments is best rendered through the relative prevalence of redistribution, reciprocity, market or household administration.

Table 1 summarizes the Share variables used as proxy for each type of care (see Annex 1 for the phrasing of the questions). “Formal care” was measured with one variable measuring whether professional or paid care was received during the last twelve months. Concerning “informal care,” it was possible to differentiate mutual aid between individuals of a close circle of acquaintances living *outside the household* (friends, neighbours, family) and mutual aid *within the same household* (spouse/partner, children). We have these three main proxy variables: “formal care” (F), “informal care from inside” (II) and “informal care from outside” (IO).

It is important to keep in mind that these proxy variables for formal and informal from inside or outside can refer to different tasks and be delivered with slightly different frequency (as is shown in Table 1). While the question on “formal care” is asked at the level of the individual, questions on “informal care from outside” were asked at the household level and question on “informal care from inside” were asked at the individual level. To get an evaluation of “informal care from outside”, it was decided to impute answers given by the household reference person (HRP) to all members of the household.³² “Informal care from inside the household” is about care on a regular basis while questions on “formal care” and “informal care from outside the household” do not mention any time basis (see annex 1).

For lack of data, it was also not possible to identify semi-formal care (the proportion of informal carers being paid via cash for care schemes like paid relatives or friends for example). Given that there are well-developed cash for care schemes in the countries under study allowing people to pay for family care, this information would have been crucial.

The tasks covered by the proxy variable are not entirely homogeneous. It can be seen that “informal care inside the household” includes personal care only while “informal care from outside” *also* includes practical household help and administrative tasks. The way the question was formulated hides an important part of domestic work (which often increases with dependency) carried out by live-in partner (especially the wife) or child. This under-reporting is also acknowledged in the literature (Masuy, 2011: 211, 384). *Irregular* personal care (i.e. not received on a daily basis) from a partner or a child inside the household could not be captured since the questions only cover care carried out on a *regular basis*. For this reason, there is a high probability that the “informal care from inside the household” category is underestimated. The extent of underestimation will differ between countries. It will probably be higher in countries with a high cohabitation rate of older parents and their adult children. It is important to keep this in mind in the interpretation of the results.

Table 5.1: The proxy variable for formal and informal care

During the 12 past months	From inside the household	From outside the household		
	Informal			
	Personal care (washing, getting out of bed, or dressing)	Personal care	Practical household help	Administrative tasks
	On a regular basis to respondent	To household by family, neighbours or friends		
	Formal			
		Personal or nursing care	Home help	Meals on wheels
		To respondent by paid or professional carers ³³		

³² We are aware that this could lead to a kind of gender bias as HRP are more often men than women. Because of the gendered role in society, we may expect that men’s perception of “help received” from outside is not the same as women’s.

³³ See Annex 1.

It is also important to note that “formal care” always includes nursing, which is not within the scope of our study. It was not possible, however, to identify the proportion of nursing included in “formal care.”

On the basis of these proxy variables, a synthetic indicator of type of care was created. It gives information about the presence of the three types of care alone (informal inside the household, informal outside the household, formal) or combined (informal inside and informal outside, informal inside and formal, informal outside and formal, informal inside, informal outside and formal, no care). Eight possible combinations of care arrangements in total were obtained. This indicator is thus a categorical variable that will serve as a dependent variable in the model. These combinations are probably not equivalent in terms of preference, either for the individual him/herself and his/her own preference nor in terms of public spending, population coverage, etc...

As “informal care from inside” only counts 1,885 observations (while the total population is 2,638)³⁴, we have imputed this variable on the basis of a multiple imputation technique. The imputation of “informal care from inside” was based on a series of variables including type of care, age, living situation and number of difficulties with activities of daily living (ADL) or instrumental activity of daily living (IADL).

3.3.2. Independent variables

To select our independent variables, we followed the work of Geerts (2010), which takes needs into account (difficulties with ADL or IADL) as well as enabling variables (such as people in the household of a dependent person) and predisposing variables (age, gender, level of education). Needs as expressed through difficulties and household composition seem to be the two best predictors of care use, according to the literature reviewed by Geerts (2009).

Share has two specific questions about permanent difficulties (lasting more than three months) experienced. Respondents were presented with a list of 23 items covering difficulties with mobility (walking, climbing stairs, etc.), difficulties with activities like shopping, cooking, etc., as well as cognitive problems (managing money, reading a map etc.). Discussing the type of care people receive relative to the nature of the difficulties experience is beyond the scope of this research. The option was taken to build a cumulative index of difficulties in order to test the use of care regarding the scale of difficulties. There are of course people with difficulties who can live a very independent life and, in consequence, receive no care.

As mentioned, living arrangements are also known to be an important predictor of care use. Living alone seems to be related to the use of care services, while parents living with their children, are less likely to use care from outside the household (Geerts, 2009). Consequently, an indicator of living arrangements was created, with four categories: “single,” “married or

³⁴ This is because of question routing. The question on informal care from inside has only been asked of persons having limitations.

single with children” (i.e. living with a partner or not but with children), “married” (living with a partner or another adult but without children) and “other.” The emphasis is put on the presence of children in the household: we are interested to see whether this presence significantly decreases the probability of receiving no care and whether it increases the probability of receiving informal rather than formal care.

Level of education was captured by the number of years people had spent in full-time education. The variable was made up of four categories: 0 to 6 years, 7 to 9 years, 10 to 11 years, 12 to 25 years.

Two age groups were specified, 65-74 and 75 or over, as 75 is close to the mean and the median and so divides the sample into two relatively equal groups

The country of residence and the gender of the respondent were also controlled for in the model.

3.4. Methods

3.4.1. Imputation process

We performed an imputation step in order to reduce the number of missing values for “informal care from inside.” The multiple imputation process adopted the chained equations method (Rubin, 1987, 1996) and was performed using the STATA command *ice*. This step reduced in particular the number of missing values regarding informal care received by a family member.

3.4.2. The model

All the results included in the estimates and in the descriptive tables were weighted using the calibrated individual weights³⁵ provided by the Share database.

The analysis contains two estimation models. The first model aims to explain the main determinants and associations with the type of care (“at least formal care,” “informal care only” and “no care”). It includes among the covariates gender, age group, country of residence, number of difficulties, education and living arrangements. Due to the categorical nature of the outcome variable, the estimation is performed using a multinomial logit regression. This method allows us to understand the factors associated with the prevalence of a specific type of care with respect to a baseline category.

The specification of the first model is:

$$(1) \text{ Care type}_i = f(\text{Age}_i, \text{Country}_i, \text{Gender}_i, \text{Living conditions}_i, \text{Education}_i) + \varepsilon_i,$$

³⁵ The name of the weighting variable adopted is *wgtaci*, computed by the Share team.

Where the index i represents the individuals included in the estimation sample and ε is the measurement error.

The second model includes as a dependent variable the presence of “any care” versus “no care” at all. In this specification “at least formal care” and “informal care only” are therefore merged into a single category. This model contains a similar set of covariates and is estimated with a logit regression. This method allows us to model the probability of receiving “any care” given the covariates included in the specification.

The specification of the second model is:

$$(2) \text{ Anycare}_i = f(\text{Age}_i, \text{Country}_i, \text{Gender}_i, \text{Living conditions}_i, \text{Education}_i) + \varepsilon_i,$$

which contains the same covariates as the first model.

3.4.3. Hypothesis

The previous chapters of this report have shown, at the macro-level, how national care regimes vary according to the respective places of the state, the market and the family and how recent reforms have impacted the respective place of each actor. The statistical model is set up to test whether care arrangements vary significantly at the micro level as well but it is unfortunately not able to test for any transformation in time. Our main hypothesis is that there are significant differences, even when individual variables are controlled for (H1).

The characteristics of care regimes as analysed earlier can help us to go deeper into what differences one can expect. Figure 1 of Chapter 2 shows for instance that Italy spends more money per capita for “social care” (cash + in kind) than Germany but much less than Belgium. It can be expected that in countries where more money is spent per capita on care (cash/in kind), the probability of receiving at least formal care versus informal care only should be higher than in countries where less money is spent (H2). That means that in Belgium the probability of receiving at least formal care versus informal care only should be the highest. It should also be higher in Italy than in Germany.

In countries where the family plays an important role, the probability of receiving no care versus informal care only should be lower than in countries where the family is not at the centre (H3). However, this hypothesis could be countered by the fact that in countries where the state supports dependent elderly people well, as in Belgium, the proportion of people receiving no care at all is in any case lower.

The probability of receiving any care should be the highest in countries with significant state support covering the population aged over 65 (as shown by Figures 2 to 5 in Chapter 2) and an important rationale in favour of family (H4). That means that either Belgium or Germany should have a higher probability of receiving any care than Italy.

3.4.4. Non-response

Not surprisingly, most of the non-response occurs at the household level, and the response behaviour of individuals within a household is strongly and positively related. When one looks at the reasons for household non-response, refusal to participate in the survey is the main reason (28.9% globally, for the 11 countries), although in some countries a non-negligible fraction of non-response is also due to non-contact and other non-interview reasons (14.2% in Germany respectively). Calibrated cross-sectional weights were computed by Share to compensate for unit non-response and for sample attrition and grossed to population size by age group and gender in each country. In Italy, more information was used.

3.5. Sample description

3.5.1. Difficulties experienced by dependent older people

Table 2 provides information about the sample. More than 60% of people aged 65 or above in the sample experienced difficulties. Prevalence rates are significantly higher in Italy (68%) than in Germany (62%) and Belgium (61%). Irrespective of the country, among the population aged 65 and over, women are significantly more likely than men to experience difficulties (more than 70% of women in each country).

Table 5.2: Sample description

	Germany		Italy		Belgium	
	Males	Females	Males	Females	Males	Females
At least one adult aged 50 or over in the household	3346		4614		4190	
Interviewees	2568		2983		3169	
65 and +	1230		1483		1406	
	595	635	729	754	629	777
Encounter difficulties (“Dependent older people”)	751		1011		876	
	316	435	430	581	340	536
% among 65+	56.3%	74.5%	62.1%	79.9%	54.2%	70.1%
Receive help	506		385		533	
% among 65+ with difficulties	208	298	136	249	187	346
	64.5%	68.3%	34.3%	47.7%	54.1%	65.2%

Data source: Share 2006, Z-tests for differences in proportions were performed. All differences are significant at the .05 probability level.

Considering now people over 65 with difficulties (the row in grey in table 2), it is interesting to note that the proportion of individuals receiving help is highest in Germany (64.5% of men and 68.3% of women). In Belgium, 54% of men and 65% of women receive help, while only 34.3% of Italian men and 47.7% of Italian women receive help, which could be explained by the fact that the LTC system in Italy targets the neediest among dependent adults (see chapter 2). Women receive more help than men and the differences are statistically significant.

Dependent older people in Italy experience on average 5.87 difficulties, whereas German frail adults experience 5.62 and Belgians 5.05. The standard deviations are, however, large. Women experience at least one difficulty more than men in all the countries.

Table 5.3: Number of difficulties by country and gender (weighted)

	Mean	SD	Obs.
Germany			
Male	4.92	5.07	316
Female	5.99	5.27	435
All	5.62	5.23	751
Italy			
Male	5.12	5.15	430
Female	6.30	5.25	581
All	5.87	5.24	1011
Belgium			
Male	4.05	3.77	340
Female	5.60	4.79	536
All	5.05	4.52	876
Total			
Male	4.96	5.05	1086
Female	6.10	5.25	1552
All	5.69	5.21	2638

Data source: Share 2006

The whole sample encounter significantly more difficulties with activities of daily living: more than 50% of the population have difficulty with “Stooping, kneeling or crouching” and with “Climbing several flights of stairs without resting” (except for Belgian men). 50% of the population experience difficulties with “Climbing several flights of stairs without resting.” The proportion of women experiencing difficulties is usually higher than that of men (Table 4).

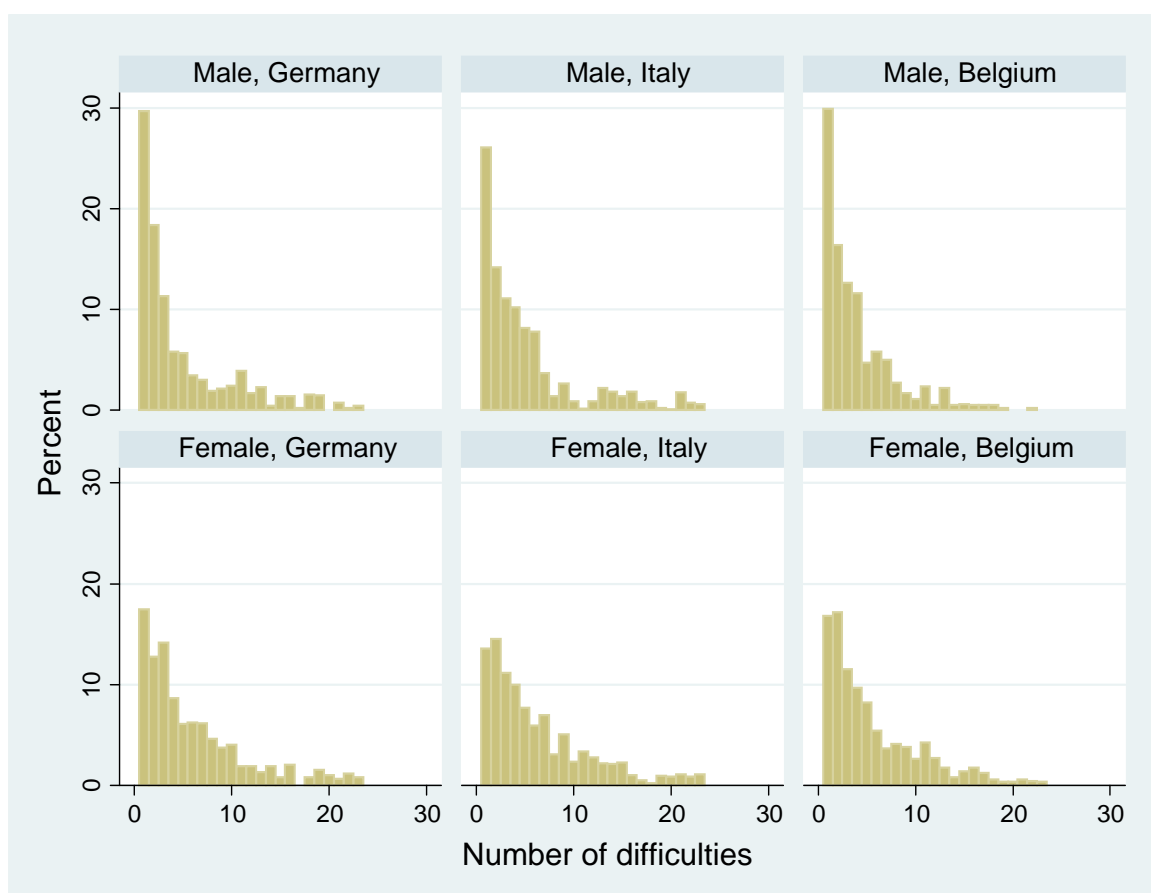
Table 5.4: Difficulties encountered by adults 65+ by sex and country (in %)

	Germany				Italy				Belgium			
	M	W	p-value	Sig.	M	W	p-value	Sig.	M	W	p-value	Sig.
Mobility items												
Walking 100 metres	26.8	30.7	0.25	-	24.7	36	0.000	***	24.3	27.8	0.253	-
Sitting for about two hours	24.2	26.7	0.45	-	22.5	23.4	0.742	-	18.1	21	0.286	-
Getting up from a chair after sitting for long periods	46.7	50.3	0.328	-	34.8	46.8	0.000	***	29.4	39.3	0.003	***
Climbing several flights of stairs without resting	52.3	60.1	0.033	**	64.2	68.8	0.129	-	49.3	53.1	0.280	-
Climbing one flight of stairs without resting	24.1	31.6	0.024	**	39.4	42	0.406	-	21.2	30.1	0.003	***
Stooping, kneeling, or crouching	64.1	69.8	0.107	-	64.8	74	0.002	***	61.6	65	0.312	-
Reaching or extending your arms above shoulder level	17.8	26.1	0.006	***	17.1	28.3	0.000	***	10.8	22.9	0.000	***
Pulling or pushing large objects like a living room chair	28.4	44.5	0.000	***	25.8	38.8	0.000	***	27.4	45	0.000	***
Lifting or carrying weights over 10 pounds /5 kilos, like a heavy bag of groceries	33.2	59.8	0.000	***	44.4	64.1	0.000	***	26.9	56.6	0.000	***
Picking up a small coin from a table	9.8	9.5	0.886	-	9.7	12.3	0.187	-	6.9	8.3	0.449	-
Basic ADL (first 6) and IADL (next 7)												
Dressing, including putting on shoes and socks	22.4	19	0.2571	-	16.8	18.7	0.427	-	18.9	19.7	0.772	-
Walking across a room	9.0	7.2	0.3848	-	6.7	7.4	0.660	-	3.6	5.7	0.135	-
Bathing or showering	18.2	20.3	0.468	-	17.1	21.4	0.086	*	16	27.7	0.000	***
Eating, such as cutting up your food	8.9	10.2	0.545	-	5.4	4.5	0.531	-	2.3	4.2	0.103	-
Getting in or out of bed	10.1	10.7	0.792	-	7.7	9.6	0.275	-	6.0	9.8	0.038	**
Using the toilet, including getting up or down	9.2	7.7	0.459	-	4.8	6.6	0.228	-	1.9	4.1	0.050	*
Using a map to figure out how to get around in a strange place	11.2	20.4	0.001	***	21.4	33	0.000	***	11.4	21.2	0.000	-
Preparing a hot meal	12.4	13.5	0.634	-	13.7	8.2	0.006	***	12.3	12.3	0.983	-
Shopping for groceries	17.3	24.9	0.011	**	17.8	23.7	0.022	**	13.2	23.8	0.000	***
Making telephone calls	4.5	6.4	0.240	-	7.3	6.9	0.791	-	5.0	5.4	0.787	-
Taking medications	6.8	8	0.548	-	10	6.4	0.040	**	3.1	4.6	0.254	-
Doing work around the house or garden	25.7	30.5	0.153	-	21.7	31.2	0.001	***	29.9	38.5	0.009	***
Managing money, such as paying bills and keeping track of expenses	9	11.4	0.272	-	14.4	18.1	0.112	-	5.4	13.7	0.000	***
Obs.	316	434			430	580			338	352		

Data source: Share 2006. In bold: more than 50% of the population encounter the difficulty.

The distribution of the number of difficulties is different by gender (Figure 1). Around 30% of men declare only one difficulty while less than 20% of women declare one difficulty. This is not surprising as we already know that men experience on average a lower number of difficulties.

Figure 5.2: Number of difficulties by gender in Belgium, Germany and Italy



Data source: Share 2006

3.5.2. Living arrangements

More than the half of the sample is living with someone at home. Statistics show indeed that 44% of frail adult are married (i.e. living with a partner) and 12% are married or single but living with child. 41% of the sample is single.

Table 5.5: Mean proportions (%) of living conditions by country and gender (weighted)

	Married	Married or single with children	Single	Other	Obs.
Germany					
Male	70	4	23	3	315
Female	32	6	60	3	434
All	45	5	47	3	749
Italy					
Male	58	20	19	3	429
Female	33	24	39	4	581
All	42	22	32	3	1,010
Belgium					
Male	70	6	19	5	340
Female	43	7	46	3	535
All	52	7	37	4	875
Total					
Male	65	10	21	3	1,084
Female	33	13	51	3	1,550
All	44	12	41	3	2,634

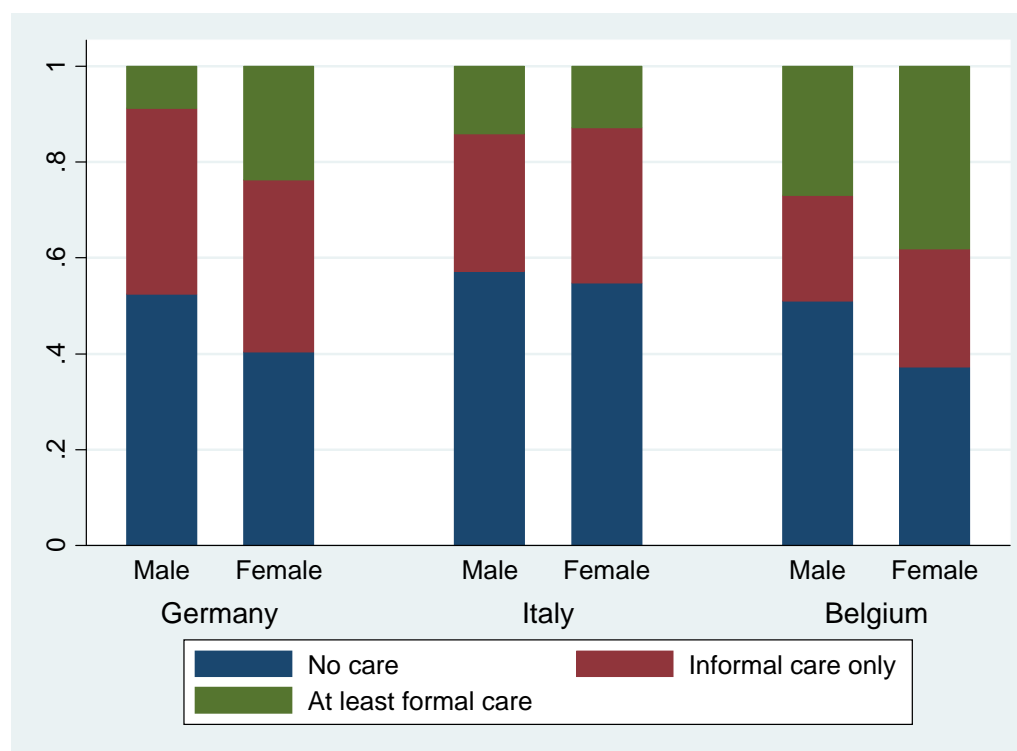
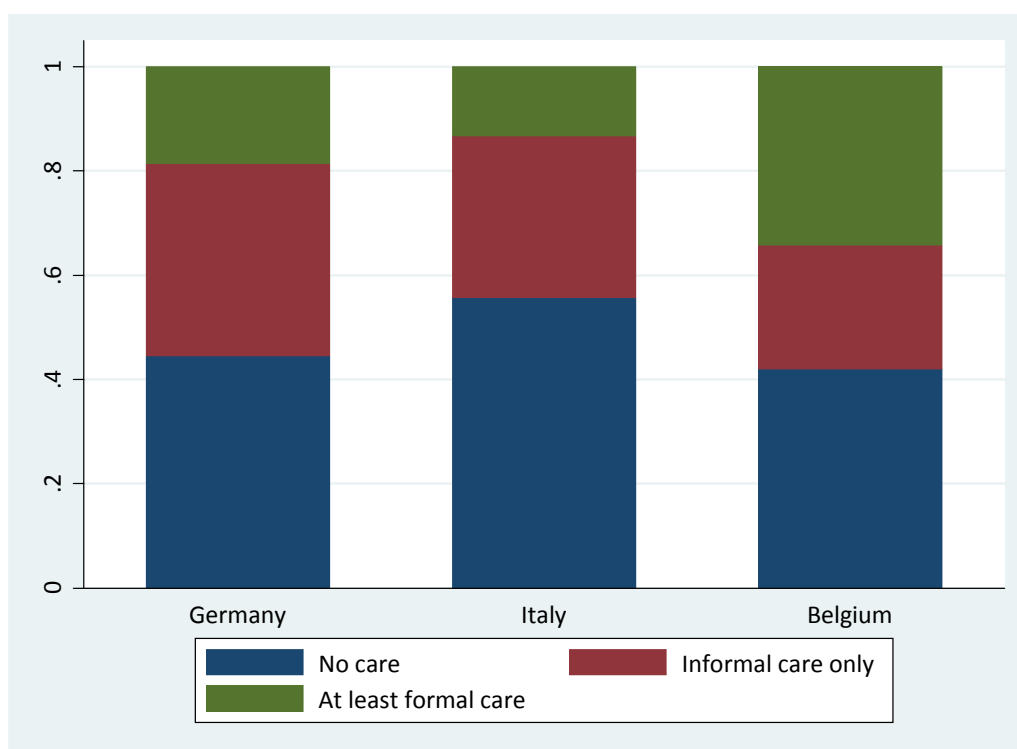
Data source: Share 2006

The proportions are very different when considering men and women separately, as 60% of the women in Germany are single, 46% in Belgium and 39% in Italy. Single people are more likely to be in need of external help and this observation could be one explanation for the fact that women also tend to be more dependent on informal care from outside than men, as will be shown later, as well as on formal care combined with informal care.

4. Care arrangements in Belgium, Germany and Italy

In this section, we will observe the use of formal and informal care by dependent older people in Belgium, Germany and Italy and its determinants. We will examine whether people who have difficulties (“dependent older people”) receive care or not and if care arrangements differ between countries. In order to describe the use of care in each of the countries under study, we have built three main categories of care arrangements out of the eight possible combinations mentioned earlier: “at least formal care” (which includes care arrangements with only formal care and those where formal care is combined with informal care from outside, inside or both inside and outside the household), “informal care only” (inside, outside or both) and “no care.”

Figure 5.3: Care arrangements (% , total and by sex)



Data source: Share 2006

4.1. No care

A large proportion of dependent older people with difficulties do not receive any care at all (Figure 2). More than 40% of people in Germany and Belgium declare they receive no care at all. This proportion is even higher in Italy (more than 50%).

4.2. Informal care only

People receiving care in Germany and Italy rely mostly on “informal care only” (respectively 40% and 30%). It is interesting to note that in Germany people receive more “informal care only” than in Italy. In Belgium, only 20% of dependent older people receive “informal care only” (Figure 3).

Figure 3 shows that “informal care from outside the household” is the main source of care for men and women in all the countries examined. In Germany, one man in four and one woman in three receive informal care from outside the household. In Italy, informal care from inside is a relatively important resource for both sexes. It is an important source of care for German women as well.

As mentioned in the previous chapters, in Italy, the public authorities support dependent older people by providing non means-tested money transfers (*Indennità di Accompagnamento*) and informal live-in migrant care is a widespread phenomenon, which can be linked with the relatively high proportion of dependent older people using “informal care only,” as shown in Figure 2. The relatively high proportion of care from inside the household in Italy (compared to Belgium and Germany) can also be linked with the fact that older people, especially women, often live in their children’s home (Table 5 above shows that 22% of dependent older people in Italy live with their children).

Care of frail adults remains a family responsibility in Germany and a large proportion of people use the *Pflegeversicherung* direct payment scheme to pay informal carers rather than buy professional care. Formal care is moderately developed. From Figure 3, which shows more detailed statistics, it can indeed be seen that Germany has the highest score with regard to the use of informal care from outside the household (more than 20%). Of course, this informal care is not always remunerated.

4.3. At least formal care

Belgium stands out by its use of formal care, whether used alone or in combination with informal care (from inside or outside the household). It has the highest proportion of people using at least formal care, in particular women.

Italy has also developed programmes encouraging formal care through services in kind (with regional variations, however), which has led to an increased offer of formal professional care (see “note on Publicly-funded home care schemes: key features”). The difference between the levels of different formal care usage (exclusively formal care or together with informal care) is not as important as in the German case.

Other chapters in this report show that home help or specific tasks are now increasingly being purchased from professionals in Germany. LTC insurance seems to be increasingly used to buy a mix of informal care from outside the household and formal care. People benefiting from both formal and informal care (“at least formal care”) amount to 20% in Germany.

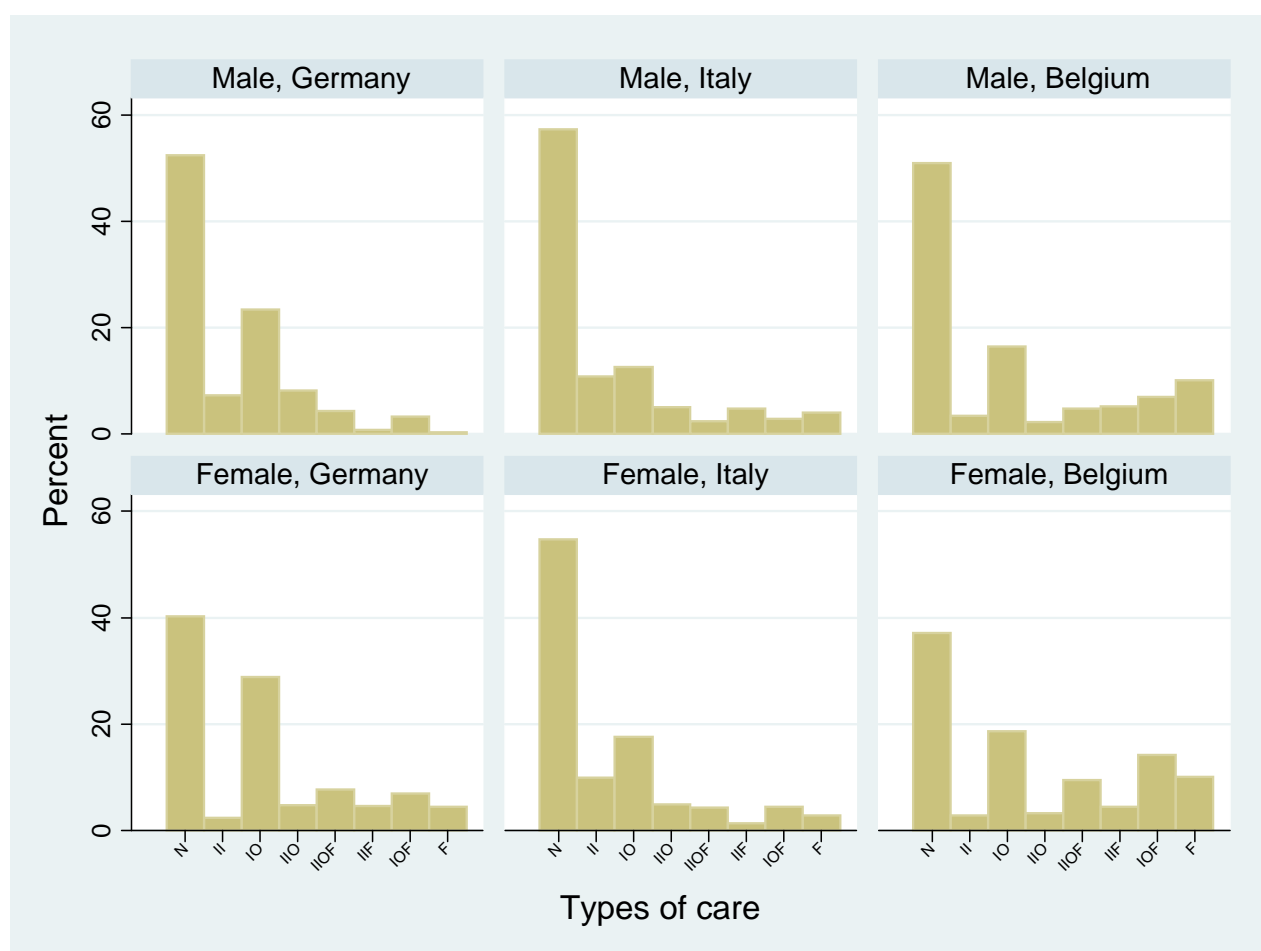


Figure 5.4: Detailed care arrangements

Data source: Share 2006

Key: N: no care; II: Informal care from inside the household; IO: Informal care from outside the household; IIO: Informal care from inside and outside the household; IIOF: Informal care from inside and outside the household and formal care; IIF: Informal care from inside the household and formal care; IOF: Informal care from outside the household and formal care; F: Formal care only.

4.4. Use of care and gender

In Italy, men and women benefit from more or less the same kind of arrangements. In Germany, the picture is slightly different. Men receive less care than women (respectively 50% and 40% respectively) and when they receive care, it is “informal care only” for more than 40%. 10% benefit from “at least formal care.” Women receive up to 22% of “at least formal care” and 38% of “informal care only.” In Belgium, men receive globally less care than women and proportions are very much similar in Germany and “Informal care only” counts for 20% of all care arrangements when men and women are examined together. Belgium really stands out with regard to the use of “at least formal care.”

Germany is definitely the country where men and women receive “informal care only” the most: 40% of dependent older people (men and women) receive “informal care only,” while this proportion is approximately 30% in Italy and 20% in Belgium. In Belgium and Italy, the use of informal care only is not very “gender marked.” “At least formal care” it is used by 23% of men and 38% of women in Belgium. In Germany, 22% of women but only 10% of men receive “at least formal care.” Differences between men’s and women’s use of “at least formal care” are high in Belgium and Germany while they are low in Italy (14% of dependent older people).

5. Determinants of care arrangements

We will now look into the influence of individual characteristics on care arrangements. As mentioned earlier, the explanatory variables considered here are country, sex, level of education, dependency level, age and household composition.

We designed a first regression model which estimates the relationship between care arrangements and a set of covariates describing socio-demographic information on the dependent people included in the sample. As the outcome variable includes more than two categories (no care, at least formal care, only informal care) the model has been constructed using a multinomial logit regression. In Table 6 we show the results in terms of Relative Risk Ratios (RRRs) in order to have a more direct interpretation. Relative risk ratios represent a measure of the strength of the association between a covariate and the outcome variable. In terms of interpretation of the coefficient, an RRR greater than 1 represents an increased probability of the covariate being associated with the outcome, while when its value is less than 1 the association is less likely to occur.

The reference profile assumed in our model is an individual in Italy, aged under 75, male, married or single with children and with a number of years of education between 0 and 6. The only non-categorical variable included in the specification is represented by the number of difficulties.

Table 6 shows that our first hypothesis is validated: country differences are significant.

Interestingly, we can see that gender does not show a significant effect on the care type arrangement. However, the care type arrangement seems to be influenced by age. In fact, the probability of receiving at least formal care (rather than informal only) almost doubles when individuals are aged over 75. By contrast, people aged over 75 have a lower probability of receiving no care versus informal care only, although this coefficient is significant only at 10%. The probability of receiving formal care rather than informal care only increases with years of education, by 3 to 6 times. However, it seems that education has no impact on the probability of getting no care against informal care only.

Table 5.6: Multinomial logistic regression model for care arrangement

	At least formal care versus informal care only		No care versus informal care only	
	RRR	Std. Err.	RRR	Std. Err.
Age				
65-74	1		1	
> 75	1.84***	0.42	0.77*	0.10
Country				
Italy	1		1	
Germany	0.35***	0.13	0.52***	0.09
Belgium	2.22***	0.67	0.64***	0.11
Number of difficulties	1.17***	0.02	0.84***	0.02
Gender				
Men	1		1	
Women	1.49	0.38	1.14	0.16
Living arrangements				
Single or married with children at home	1		1	
Married without children	1.95*	0.70	1.51**	0.28
Single	5.79***	2.08	0.83	0.18
Other	1.00	0.67	1.6	0.57
Education				
0-6	1		1	
7-9	2.77**	1.13	1.28	0.28
10-11	5.75***	2.65	1.07	0.25
12 <	5.47***	2.41	1.15	0.25
Obs.	2603			
Wald chi2(22) = 372.97 (p-value=0.000) ³⁶				
Pseudo R2 = 0.197				

Significance levels: *** 1% ** 5% * 10%.

Data source: Share 2006

³⁶ In order to validate the model we use the Wald test. Log-likelihood based statistics are not available for this model as STATA computes weighted estimates by using a Log-pseudolikelihood approach.

In Belgium, dependent older people have a higher probability of receiving at least formal care rather than informal care only with respect to Italy and Germany (H2). Those in Germany have the lowest probability of receiving at least formal care rather than informal care only. This result differs from the result obtained from the first wave of Share (2004) by Geerts (2009), who concluded that older people were more likely to receive formal care in Germany than in Italy, but it is coherent with differences in social care expenditure as observed in Chapter 2 (Table 1).

Looking at the second column of Table 6, we can see that in Belgium and in Germany the probability of receiving “no care” against “informal care only” is about half that in Italy. The probability of receiving no care versus informal care only is higher in Belgium than in Germany (H3) but it is even higher in Italy. The third hypothesis is partially validated.

Living alone increases the probability of receiving at least formal care versus informal care of almost 6 times if compared to people living with children. Being married without children at home increases the same probability by a factor of only 2. The presence of a child has a positive effect on receiving informal care and it decreases the probability of receiving at least formal care. Interestingly, we can observe that the probability of getting “no care” versus “informal care only” increases by a factor of 1.50 for married individuals with no children when compared to married or single individuals with children.

Table 5.7: Probability of receiving any care (Logit Model)

Any care	Coef.	Marginal effect	Std. Err.	Sign.
Age				
> 75	0.36	0.09	0.13	***
Country				
Germany	0.43	0.11	0.19	**
Belgium	0.75	0.18	0.16	***
Number of difficulties	0.21	0.05	0.02	
Gender				
Women	-0.07	-0.02	0.13	
Living arrangement				
Married without children	-0.33	-0.08	0.18	*
Single	0.52	0.13	0.21	**
Other	-0.50	0.12	0.36	
Education				
7-9	-0.036	-0.01	0.21	
10-11	0.30	0.07	0.23	
12 <	0.23	0.06	0.21	
_cons	-1.62		0.21	***
Obs.	2603			
Wald chi2(11) = 262.67 (p-value=0,000)				
Pseudo R2 = 0.185				

Significance levels: *** 1% ** 5% * 10%.

Data source: Share 2006

Table 7 contains the estimated results of a logit model exploring the probability of receiving any care (formal or informal) at all. The results are interpreted in terms of marginal effects on the probability.

The covariates included in this model replicate the structure of the specification presented in Table 6. We can observe that being over 75 increases the probability of receiving any care by almost 10%. Living in Germany and living in Belgium also increase the probability of receiving any care by 11% and 18% respectively compared to Italy. The probability of receiving any care is higher in Belgium than in Germany and higher in Germany than in Italy. Our fourth hypothesis is validated.

Also in this specification we can see that gender does not seem to affect significantly the care received.

On average, for each additional difficulty, the probability of receiving formal or informal care increases by 5%; however, this result might not apply near the tails of the distribution. As regards living arrangements, being single increases the probability of receiving any care by 13% while the same probability for individuals married with no children falls by 8%, although this last result is only significant at 10%. The reference category is again in this case being married or single with children. Education levels do not seem to affect significantly the probability of receiving any care.

6. Conclusions: some methodological issues raised by the analysis

The vast majority of comparative literature on care regimes is concentrated on the policy level of analysis. Comparison implies situating the Welfare State according to typologies of policy measures or LTC solutions or cultures of care (familialism, individualism). We have tried here to add to the understanding of care regimes by exploring how “real” people develop their own care arrangements in their national context. We have built on a recent tradition that is made possible, *inter alia*, by new qualitative research centred on the study of family configurations (Le Bihan and Martin, 2008) and on the availability of a database such as Share and its development (Geerts, 2009).

We have opted here for an innovative, albeit experimental approach, consisting in the translation of the “welfare mix approach of LTC” (which mobilizes types of funding, organization and regulation) into a “welfare mix approach of individual care arrangement.” We are aware that the operationalization of this translation is still work in progress, due to theoretical difficulties and empirical limitations linked to the design of the Share database. Beside the fact that questions on care use in Share do not systematically cover the same field (Table 1) and that it is not yet possible to identify whether professional care is provided in kind or funded through cash for care, there are additional difficulties due to the use of a single Polanyian frame that has to fit very different national or regional mechanisms. Further discussions are needed about the assignment of cash for care mechanisms into the categories of the redistribution market, etc., and, accordingly, also into “formal, semi-formal or informal

care”: “long-term care insurance” in Germany is presented here as “semi-formal care” and as implying redistribution but it is also the insurance that finances the whole professional sector. The *Assegno di cura*, in the Italian system, is also considered here as “semi-formal care,” but for some authors (e.g. Pavolini) its objective is to bring previously informal care into the formal sphere.

Despite these limitations, some of the research questions that were asked in this chapter have found answers; inter-country differences at the level of policy are reflected at the level of the individual use of care. Individual determinants (age, difficulties) have proved to be significant, unlike gender or age, which do not seem to play a role. The results obtained by the multinomial regression show coherence with the main characteristics of the care regimes that were studied. Most of the hypotheses that arose from the macro-level information at our disposal were validated. However, it is worth stressing here that the methodological issues of the translation of macro-level information into micro-level hypotheses have not been addressed and are indeed not much present in the literature either. This might be a challenge for future research as well.

Annex 1: Questions used in the Share questionnaire

1. Difficulties encountered

PH048 HEALTH AND ACTIVITIES Please look at card 11. We need to understand difficulties people may have with various activities because of a health or physical problem. Please tell me whether you have any difficulty doing each of the everyday activities on card 11. Exclude any difficulties that you expect to last less than three months. (Because of a health problem, do you have difficulty doing any of the activities on this card?) IWER:PROBE: ANY OTHERS? CODE ALL THAT APPLY 1. Walking 100 metres 2. Sitting for about two hours 3. Getting up from a chair after sitting for long periods 4. Climbing several flights of stairs without resting 5. Climbing one flight of stairs without resting 6. Stooping, kneeling, or crouching 7. Reaching or extending your arms above shoulder level 8. Pulling or pushing large objects like a living room chair 9. Lifting or carrying weights over 10 pounds/5 kilos, like a heavy bag of groceries 10. Picking up a small coin from a table 96. None of these

PH049 MORE HEALTH AND ACTIVITIES Please look at card 12. Here are a few more everyday activities. Please tell me if you have any difficulty with these because of a physical, mental, emotional or memory problem. Again exclude any difficulties you expect to last less than three months. (Because of a health or memory problem, do you have difficulty doing any of the activities on card 12?) IWER:PROBE: ANY OTHERS? CODE ALL THAT APPLY 1. Dressing, including putting on shoes and socks 2. Walking across a room 3. Bathing or showering 4. Eating, such as cutting up your food 5. Getting in or out of bed 6. Using the toilet, including getting up or down 7. Using a map to figure out how to get around in a strange place 8. Preparing a hot meal 9. Shopping for groceries 10. Making telephone calls 11. Taking medications 12. Doing work around the house or garden 13. Managing money, such as paying bills and keeping track of expenses 96. None of these

2. Proxy variables for informal care from inside

SP020 SOMEONE IN THIS HOUSEHOLD HELPED YOU REGULARLY WITH PERSONAL CARE | | And is there someone living in this household who has helped you regularly during [the time since the last interview/the last twelve months] with | | personal care, such as washing, getting out of bed, or dressing? | | IWER:BY REGULARLY WE MEAN DAILY OR ALMOST DAILY DURING AT LEAST THREE MONTHS. WE DO NOT WANT TO CAPTURE HELP DURING SHORT-TERM SICKNESS. | | 1. Yes | | 5. No

3. Proxy variable for informal care from outside

SP002 RECEIVED HELP FROM OTHERS | Please look at card 38. Thinking about [the time since the last interview, that is since/the last twelve months][month year previous | interview}/{empty}], has any family member from outside the household, any friend or neighbour given you [or/or/or/or/{empty}/{empty}] | [your/your/your/your/{empty}/{empty}] [husband/wife/partner/partner/{empty}/{empty}] any kind of help listed on this card? | 1. Yes

4. Proxy variable formal care

| HC032 RECEIVED HOME CARE IN OWN HOME | | Please look at card 17. During the last twelve months, did you receive in your own home any of the kinds of care mentioned on this card? | | IWER:CODE ALL THAT APPLY | | 1. Professional or paid nursing or personal care | | 2. Professional or paid home help, for domestic tasks that you could not perform yourself due to health problems | | 3. Meals-on-wheels | | 96. None of these

- Chapter 6 -

Measuring and improving performance in home care services: A four country comparison

1. Introduction

The late 20th century saw a proliferation of performance measures and the promotion of performance assessment as a basis for public sector improvement in OECD countries (Hood 1995; Pollitt and Bouckaert 2004). This trend coincided with other public sector reforms – notably managerial, regulatory and market-inspired – which took place to varying extents across different countries. This introduction of management techniques, explicit standards and measures of performance exemplified a new form of public administration that came to be known as “New Public Management” (NPM). However, the adoption of performance management techniques, such as benchmarking, audit and inspection, has varied between countries and by policy area (Pollitt, 2007). The aim of this paper is to explore how widely performance measurement and assessment techniques are being used within one specific area of policy – home care – and to analyse their use in the context of differing system objectives and structures. In this way we seek to demonstrate how variations between countries can be understood as responses to the political contexts and features of individual systems.

This chapter is divided into three sections. First we set out some of the important theoretical and conceptual issues involved in measuring and assessing the performance of home care. Second we present four case studies incorporating the evidence collected from the selected countries (Germany, Belgium, England, and Italy). Finally, we review these findings, comparing variations in performance measurement, assessment and management, and exploring the extent to which these can be understood as responses to observed differences in the political context and organisation of home care in the four countries.

2. What is performance?

The performance of a home care service cannot be assessed without considering the quality of the care it delivers. But for a service to perform well it must deliver care efficiently and, arguably, where the service is public there should also be equity of access to, and delivery of, care (Allin et al., 2009; Pollitt, 1986).

It is important to draw a distinction between “performance” and “quality”, as they are often mistakenly used interchangeably, which causes two related analytical problems. The first problem concerns the appropriate level of analysis: when we assess *performance* we are necessarily looking at a home care service or system, and assessment therefore occurs at the aggregate level. In contrast, when we assess the *quality* of home care we can make the

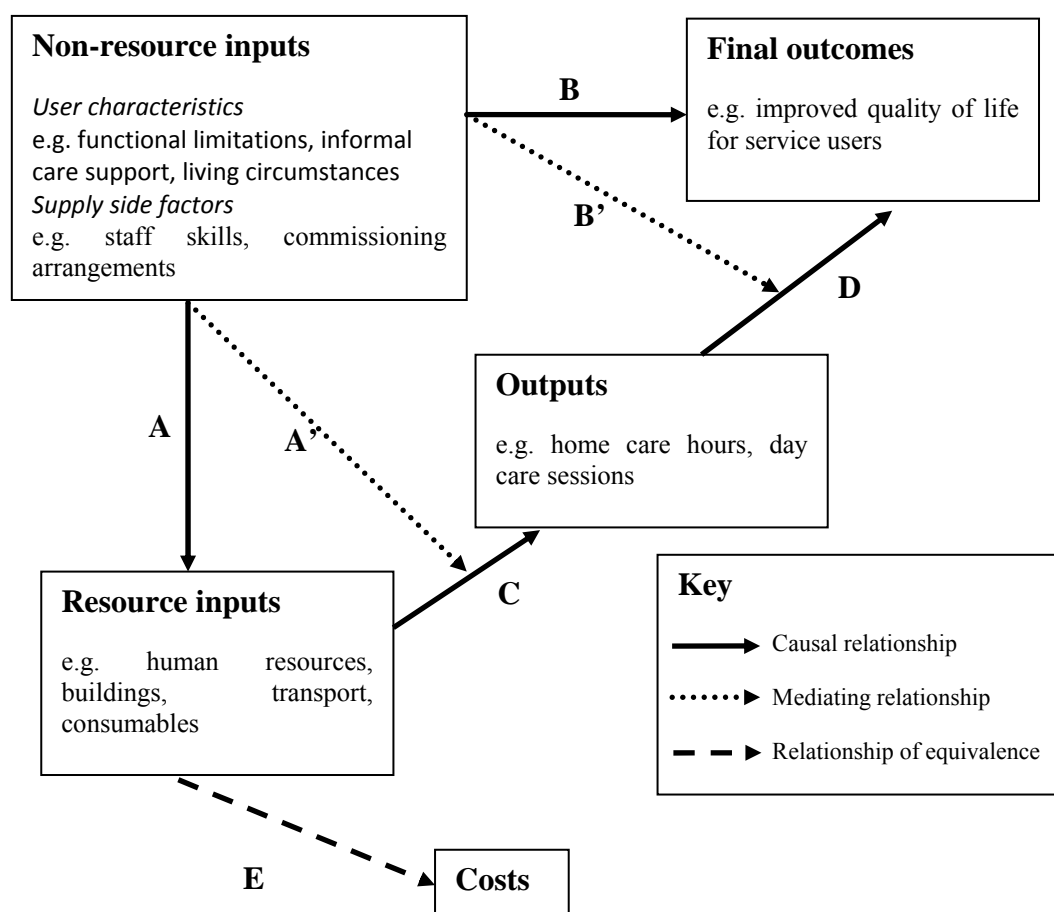
assessment at a number of levels, depending on whether the interest is in the home care system, the service or the care delivered (Arah et al., 2006; Donabedian, 1980; Schalock, 2004). We have argued elsewhere that when we examining quality of home care it can be particularly useful to focus on the service user-carer relationship and the care delivered, since this ensures that assessments of quality are not divorced from the practice of caring (Malley & Fernández, 2010). However, if we focus on the service user-carer relationship when examining performance we would miss important elements, in particular from an aggregate perspective.

The second problem arises because a focus on quality may limit our appreciation of other important aspects of the home care service or system performance. Key among these is that quality comes at price. In a world of scarce resources a service would be unwise to go on inexorably providing better quality at any cost, since those purchasing the service have limited budgets. Purchasers (whether individuals or the state) must make decisions about the quantity and quality of goods to select and there are opportunity costs involved in choosing to put all available resources into purchasing ever higher quality care. In addition to quality assessment, performance assessment of a home care service or system must therefore include an appreciation of the production process and the costs involved in producing home care, in order to identify efficient services.

A framework for comparison of performance assessment

If we are to compare performance assessment approaches across countries it is important to do so in a structured way. A useful framework within which to conceptualise the performance of home care services and systems uses “Production of Welfare” (POW), which has been applied in English academic studies to analyse various aspects of performance, including equity and efficiency (Clarkson & Challis, 2002; Clarkson et al., 2010; Davies & Knapp, 1981; Davies, 1985; Knapp, 1984). Figure 1, adapted from Knapp (1984: 26), summarises the set of factors relevant to POW in home care, together with the main relationships between them, as postulated by this approach. Arrows C and D represent the central production process, whereby inputs are converted to outputs and outcomes. In keeping with the tendency in English studies to focus on service users (and their informal carers), staff are considered as resource inputs. Staff time along with other resource inputs are transformed into units of service (home care hours) to be consumed by recipients of care. Arrow D represents the effect of consuming these units of service on final outcomes, such as the wellbeing of users and carers. It is the conversion of inputs to outcomes, and not outputs, that is central to productivity assessment. This is in line with Gadrey’s argument in which he underlines that most productivity measures in the field of services are still limited to indicators of outputs, locating the productivity debate at the wrong level (Gadrey, 2003).

Figure 6.1: POW diagram



Of importance to performance assessment is the set of factors summarised collectively as non-resource inputs. These include various service user, provider, staff and area factors that moderate the conversion of inputs to outcomes. As Figure 1 illustrates, non-resources inputs are postulated to intervene in four ways in the production process to affect outputs and final outcomes. First, as illustrated by vector A, non-resource inputs directly affect the choice and mix of resource inputs. For example, social and market conditions will affect the labour supply and demand for home care. Second, non-resource inputs have a mediating effect on the conversion of resource inputs to outputs shown by arrow A'. For example, staff-related factors such as qualification levels, the amount of training, as well as motivations affect the precise relationship shown by arrow C. Thirdly, as vector B illustrates, non-resource inputs related to the characteristics of the service user, such as functional status, physical and mental health and informal support, have a direct effect on final outcomes since these characteristics limit a person's capacity to benefit from home care. Fourth, vector B' represents the mediating effect that non-resource inputs related to the service user, such as the design of

their home or severity of disability, have on the productivity of home care. Many of these effects can be controlled by the service, for example providing more training or changing employment procedures; but many others are beyond the control of the service, such as the availability of informal care and the level of need of the service user.

The fact that outcomes from home care may be influenced by factors other than those directly under the control of the provider has implications for how we conceptualise and measure quality. Although we may sometimes think of the quality of care in terms of the way care is provided (e.g. whether care workers are timely, gentle, and competent), quality of care must ultimately be assessed in terms of the results of care, or its outcomes. However, given that many factors other than the care provided may influence outcomes, it would be misleading to focus on outcomes without “controlling” for the variability due to differences in inputs that are beyond the service’s control. To do otherwise would be to make an attribution error.

Furthermore, quality is not always measured by looking at outcomes. Following Donabedian (1980), it is useful to distinguish between outcome, process and structural quality indicators since all of these types of indicators are commonly used to assess quality. Structural quality indicators, refer to the “*relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organisational settings in which they work*” (Donabedian, 1980: 81). For home care services, structural indicators could include the qualifications of staff, and the training levels of the workforce. Process indicators refer to the activities that take place within and between care workers, informal carers and service users. Examples could include methods for assessment, lifting, feeding or bathing and punctuality. Outcome indicators refer to the desired (and undesired) results of the care activity, which could include the functional status of individuals, their satisfaction with care and quality of life. Although, these descriptions are framed with the service user as the focus of performance assessment, the categories are also applicable where the care network or care workers are the subject of assessment. For example, where the care worker is the focus, structural indicators could include annual training. Process indicators would refer to activities between the employer and employee, as well as those involving the cared for person and their care network. Examples could include the extent of supervision or support, and travel arrangements. Outcome indicators might relate to pay and benefits, general well-being or job satisfaction.

Although not clear from the POW model, ideally we would want to assess the outcomes for everyone affected either directly or indirectly by the home care service. Those involved directly include the care worker(s) and the service user; since both participate in the production process, benefits (and disbenefits) can accrue to either party. Home care services also produce externalities: support for a person living in their own home is often provided by a mixture of formal services and informal help from a wider care network composed of family members, neighbours and friends. Formal support can enhance the well-being of the wider care network, by giving them a “break” from the often very significant demands of caring; home care can also harm the well-being of the same network when poorly organised or ineffective.

Although the POW model has been developed for analysing the outcomes of service users, it is equally applicable for assessing the benefits realised by members of the care network or service staff. The same groups of indicators will be relevant, although the range and location of factors within each broad category may vary. For example, where the aim is to assess the performance of a scheme in improving user outcomes, staff and their pay are resource inputs; where the aim is to assess the performance of a scheme in generating good jobs, staff are outputs and their pay, wellbeing, or other measures of the “goodness” of the jobs, are the final outcome. Exactly how the POW model is specified therefore will depend on the exact nature of the service being assessed and on the object of interest.

3. Case Studies

Evidence about the state of performance assessment in each of the four countries was collected by a dedicated country team and is presented here as separate case studies set in their political and historical contexts.

We used a very broad interpretation of performance assessment and included performance monitoring, systems of performance audit, inspection and oversight, (quasi-)experimental evaluations, accreditation and evaluation, and system evaluations and reviews (Leeuw & Furubo, 2008). It should be noted that the focus of data collection by the CROME teams was at the national level, except for Belgium, and therefore this is our focus here. Since much of the responsibility for home care is devolved to regional or local areas in the four countries studied, there is considerable regional and local variation in the utilisation of performance assessment and management tools. However, mapping the extent of this variation is beyond the scope of this study.

3.1. Belgium³⁷

In Belgium there is a strong welfare state but institutional fragmentation in terms of sources of funding and governance. The welfare state is characterised by “tutelary” type regulation, in which social services provision is supported by the allocation of public funding to public or non-profit providers who comply with a set of standards and requirements, mainly regarding inputs. The state therefore acts as a “tutor” towards the user, taking on the responsibility of supervising the quality of the service (Gardin & Nyssens 2010).

Regulation of home care is now performed by the regional authorities. The quality of care for users is assured primarily through controlling care inputs and it is therefore the structural aspects of quality that are assessed. The regional governments strictly control entry to the market (from which for profit providers are excluded) through accreditation: only providers meeting certain requirements regarding the workforce (e.g. employee qualifications and their

³⁷ The description developed here is largely drawn from the Wallonia performance report compiled by Marthe Nyssens and Brice Champetier, and the Flanders performance report compiled by Jef Breda and Stephanie Peeters.

ongoing professional development) and the organisation of the service itself (e.g. an assessment of the user's needs is required and the intensity of workers' supervision is fixed by the law) are permitted to operate and receive a government subsidy. The Flanders government has recently introduced an additional policy which is more oriented towards results (Bode et al., this volume). To adhere to the new decree, organisations must produce "quality manuals", which set out their strategic vision and include the findings of annual self-evaluations of the quality of services. These evaluations are required to take place in dialogue with users and include, on a triennial basis, a satisfaction survey. Despite this development, structural indicators continue to have a central role in assuring quality in Flanders.

Besides administrative reports to send to the administration on a regular basis, on-site inspection and auditing are also used to ensure that providers meet regulatory requirements. However, the results of these inspections are not made publicly available in either Wallonia or Flanders, and nor are the results in the new Flanders quality manuals. At present the main audience for the outcomes of the reviews is the authorities. Should the inspectors find providers to be in breach of the regulations they can impose fines, remove accreditation.

In Belgium, the quality of work is a central issue, and is discussed between social partners (representatives of employer and employees). Although family help services are mainly funded by the regions, the workforce is still partly funded through federal employment policies. In 2005, an evaluation (the "Proxima" evaluation) was commissioned by the Federal Ministry of Employment, Work and Social Dialogue on the quality of employment in "family help" home care services (Ver Heyen & Vandenbrande 2005). The federal government also commissions an annual evaluation at the federal level of the service voucher ("titre-service") scheme, which has been conducted by Ideaconsult for many years now. The service voucher scheme was established in 2001 and aims primarily at supporting housework rather than providing personal care. It was introduced to expand both the demand for, and the supply of, housework services in order, first and foremost to address the irregular labour market and to maximise "new" declared jobs for low-qualified persons. It was not a tool to improve efficiency in the provision of social services.

In these federal-level evaluations a range of data on workers is collected. The Proxima study explored the well-being at work of family helpers in the Belgian home care sector. Examples of measures include process measures, such as the content of work (e.g. kind and complexity of tasks performed, variety of tasks), working conditions, work environment, and work relations, as well as outcomes measures like job satisfaction, resignation intentions and burnout. The Ideaconsult study focuses primarily on the cost, quantity and quality of employment, gathering a range of process and outcome indicators of employment quality. In both studies the unit of observation is not the services but the sector as a whole, either the home personal care sector, or the housework sector organised by the "titre-service". Consequently, relevant non-resource inputs concern general trends in Belgian society (e.g. ageing, unemployment, poverty) and Belgian politics (e.g. immigration policy, family policy). Some attempt was made in the evaluations to explore the relationship between these factors and work quality, but only in a rudimentary fashion through cross-tabulations. Although

workers are the main focus, in some years Ideaconsult have also gathered data on the quality of care for service users, focusing on their experiences of aspects of care and satisfaction. This is a sign that public bodies no longer see the service voucher scheme only as an employment policy but also as a policy that improves the life of the user of the system. Both evaluations are targeted at public bodies.

Information about programme costs, inputs and outputs (such as volume of care delivered, numbers of service users, and numbers of workers) are collected regularly by the regional administrations (for home care) and federal departments (for the titre-service). Cost information has been used to audit in one-off studies (by the Court of Audit of Belgium, which supervises the public finances of the different governments) the distribution of subsidies to home care providers in Flanders and to the titre-services providers in Belgium (The Court of Audit of Belgium, 2007, 2009). Cost data is also used, each year, to explore the sustainability of the service-vouchers scheme (Ideaconsult, 2008); cost is a key issue since one aim of the policy was to reduce the costs of unemployment. The evaluation therefore explores the gross money spent by the state in providing service vouchers. . The evaluators also estimate the net cost, by taking into account money saved by the state due to, for example, not having to pay unemployment benefits and additional revenues (from tax and social security contributions). However, no precise information is given regarding the methodology (for example, no control group has been included in the estimation) behind these estimates, despite their importance for assessing the scheme's sustainability.

Overall, in Belgium, marketisation in the home personal care sector is limited. There is no system of benchmarking, and performance assessment relies, most of the time, on activity reports focussed on intermediate outputs (such as volume of home personal care hours, number of users, etc) which are sent to the regional administration and annual administrative inspection. Evaluation or reviews of home personal care programmes and the housework scheme (titre-services) are also conducted. The services provided are not subject to an assessment of final outcomes for the user. Providers have “an obligation to means” rather than “an obligation to results” i.e. to be accredited they must comply with input-related standards. There is, nevertheless, some concern for final outcomes, but this relates to workers rather than users and the focus is not on providers but the system as a whole. The aim of the performance reports is not to provide information to users or the general public but to inform public authorities about the quantity and the quality of the jobs or services created, and also about the costs of the system for the State. Performance assessment thus seems primarily to provide accountability between levels of the bureaucracy.

3.2. England

Non means-tested social security benefits for disabled people can be used to purchase care in the home, but the most visible form of public support for home care comes from the means-tested, locally-administered system. In the 1990s this public support system moved away from the traditional bureaucratic delivery model, replacing it with a quasi-market for home care in

which the purchaser and provider functions of local authorities were separated and a diversity of supply was promoted. More recently there has been a shift from the provision of services “in kind” towards cash payments, in an effort to promote personalisation and choice. Although there are no controls around the type of provider, entry into the market and continued operation is strictly regulated, with personal care providers required to meet minimum standards of quality and safety in order to register and operate.

A national arms-length statutory body, the Care Quality Commission, regulates the quality of home care. Unlike the situation in Belgium where providers are required to meet very specific input standards, in England the regulations are broadly specified and have been interpreted by the regulator into 28 standards that focus on user outcomes. This is the case even where the regulations concern processes and inputs, such as fees, staffing, and management. For example, standard 4 on the “care and welfare of users”, which in the regulations is about the delivery of safe and effective care, is translated into the statement that people who use services should “*experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights*”. Standard 14 on “supporting workers”, which in the regulations is concerned with the provision of appropriate training and professional development, is translated to require that people who use services “*are safe and their health and welfare needs are met by competent staff*” (Care Quality Commission, 2010). The outcomes focus reflects policy, which actively promotes a concern for results (Department of Health, 2006, 2011).

Annual inspections are used to monitor compliance with the standards and sanctions are available to CQC against providers that fail to comply, including in the most serious instances de-registration and criminal charges (Malley et al. forthcoming). The results of the inspections are made publicly available in the form of inspection reports and the judgements are also published on the CQC website. An online care directory has been developed recently with the aim of supporting user choice. Following the adoption of a new set of regulatory standards in 2010, the quality “star” ratings system has been abandoned. Instead, the directory now provides a high-level summary of the most recent compliance judgements for each provider and more detailed inspection reports are also available. There is evidence that the star ratings were used, albeit to a limited extent, by service users to choose services and by local authorities for commissioning purposes, although it is not clear whether this had the effect of improving quality (Commission for Social Care Inspection, 2009; Malley et al., forthcoming). It remains to be seen what use will be made of the new data for choosing and commissioning services.

Local authorities have to report annually a wide range of data about public programme costs, inputs and outputs (such as volumes of care delivered, numbers of service users and numbers of workers) to the NHS Information Centre (NHSIC, a statistical agency for health and social care). In the past, central government also required that local authorities report additional quality data as part of the Performance Assessment Framework (PAF), which was used by central government to control the behaviour of local authorities and drive improvements. The PAF contained around 50 measures covering national priorities and strategic objectives, cost

and efficiency, effectiveness of service delivery and outcomes, quality of services for users and carers, and fair access. Despite intentions, the efficiency indicators were measures of unit costs, while the effectiveness indicators focused on activity (output indicators), and the quality indicators largely measured process and structural aspects (e.g. the timeliness of care, the state of the infrastructure, adherence to procedures, user-reported quality of care). Some of the PAF indicators denoted targets and annual reports were published that rated and compared performance across local authorities using these measures (Clarkson et al., 2009; Malley 2009).

The Coalition government has recently abandoned “target” and “ranking” systems in favour of an “intelligence” approach to performance management (Hood, 2007), whereby indicators collected by the NHSIC are used for public accountability rather than to control the behaviour of organisations. A new set of indicators, known as the Adult Social Care Outcomes Framework (ASCOF), has been developed which contains fewer indicators but concentrates on outcomes, such as the number of safeguarding referrals for abuse, and user-reported measures from the new annual Adult Social Care Survey (ASCS) of publicly-funded social care users. This survey builds on the social care user experience survey programme and provides a source of user-reported outcome measures, including satisfaction with services and social care-related quality of life, as well as user-reported process measures relating to access to information (Department of Health, 2011; Netten et al., forthcoming). A similar survey has been developed for informal carers, which will run biennially. This provides carer-reported outcome measures, including a measure of carer-reported quality of life and satisfaction with services, as well as a large number of carer-reported process measures, such as access to information (Department of Health, 2011). Various process measures also remain regarding the timeliness of assessments and care provision.

It is relatively common in England for new home care schemes to be piloted before being rolled-out nationally and for these pilots to be evaluated using experimental and quasi-experimental designs.³⁸ In recent years there have been two major evaluations. The Individual Budgets Pilots Evaluation (IBSEN) assessed a new form of cash for care scheme whereby the allotted cash could be managed by the local authority so that recipients did not have to take on all the employment responsibilities that came with a pure cash Direct Payment (Glendinning et al., 2008). The Partnerships for Older People Projects (POPP) evaluation covered a variety of pilot programmes all aimed at delivering low level forms of support (Windle et al., 2009). In these evaluations the outcomes for the service user was the focus, although often attempts were also made to explore carers’ outcomes (Glendinning et al., 2009). Issues around the attribution of outcomes were considered within the study design and analysis stages, the latter using regression techniques. In addition, a key component of the work was cost effectiveness analysis, and thus an attempt was made to explore productivity.

³⁸ Fully randomised assignment of subjects to control and intervention groups is rare, but such an experimental design was used in the Individual Budgets pilot. A more common design is that used in the POPPS evaluation where data is collected only for those receiving the intervention and a quasi-control group is developed from other data sources. GLENDINNING C. et al. (2008), “Evaluation of the Individual Budgets Pilot Programme. Final Report”, York, Social Policy Research Unit, University of York; WINDLE K. et al. (2009), “National Evaluation of Partnerships for Older People Projects. Final Report”, Canterbury, Kent, Personal Social Services Research Unit, University of Kent.

In addition to these evaluations, there are broader reviews of the “state of care” produced by the regulator and presented to Parliament in accordance with legal requirements. These reviews examine the quality of care provided, drawing on data collected by the Information Centre as well as that collected through CQC inspections, and focus primarily on outcomes for service users. There are also regular reviews of the “state of the care workforce”, which look to some extent at the quality of employment, but these are less prominent (Eborall et al., 2010). Care workers tend to be viewed as inputs to the production process, rather than the subjects of research, as is evident from the evaluations (e.g. Glendinning et al., 2008; Windle et al., 2009). In addition, data about the numbers of workers employed by independent providers is incomplete since these collections are voluntary and completed by only a subsample of providers (Eborall et al., 2010). Workers are rarely the focus of performance assessment and data is limited.

Overall, in England, marketisation in the home care sector has been a dominant trend. Much activity focuses on providers and is oriented towards improving the efficiency of the market, either using regulation of minimum standards or by providing information about quality. The focus is on outcomes for service users, although attention is also given to the effect of services on informal carers – a sensitive issue in England given that the availability of informal care is taken into account in needs assessments. Government requires the collection of data, and mandates regular reviews of the state of the system. The rationale for all forms of data collection about commissioners is now primarily to provide accountability to the public, rather than to control behaviour, with the assumption that this will drive improvements. In addition, in England the evidence-based policy movement has been influential given the number of high profile evaluations of policy initiatives.

3.3. Germany³⁹

The German system is known for its long-term care social insurance (LTCI) scheme, which provides the main source of support for home care. Prior to the introduction of LTCI in 1995, public support was limited to some personal care funded by special public programmes, health care insurance and, more broadly, means-tested, regionally-administered social assistance. Social assistance continues to be available, but its role is now largely to supplement LTCI, providing those with limited means with aspects of care not covered by LTCI. The introduction of LTCI stimulated the development of a market through an expansion in the number of home care providers (Rothgang, 2011). Concomitantly, there has been a greater focus on the quality of provision over the last few years. New providers are required to meet certain (mostly input-related) standards agreed with the insurers. Within the home care market, providers compete for contracts with users, but primarily on quality since prices are fixed regionally (Bode & Firbank, 2009). It is noteworthy however that many users

³⁹ This section draws on the German performance report compiled by Ingo Bode and Sebastien Chartrand. See http://www.uni-kassel.de/fb01/fileadmin/datas/fb01/Institut_f%C3%BCr_Sozialwesen_ISOSD/Dateien/CROME_Rapport_Germany_01.pdf

and their families utilise market competition by bargaining for additional “grey” services not included in the assessment and official contract.

The 2008 reform of LTCI included significant changes to quality regulations. The frequency of inspections by the health and LTC insurers’ Medical Boards (Medizinischer Dienst der Krankenversicherung - MDK) of home care providers was increased to annually (Bode and Firbank 2009; Buscher 2010). Assessments are carried out against 142 items which cover structure, process and outcome quality indicators in line with Donabedian’s tripartite categorisation. There is now a stronger emphasis on outcomes for the service user (Buscher, 2010). In addition, publication in a format understandable to the lay person is required. Thus 49 of the 142 items are summarised into four separate measures, and into an overall composite measure, all of which are published on the internet for each provider. A six -point rating scale based on the German school mark system is used to aid comprehension. The full inspection results are available to the MDKs, which can require improvements if they have concerns. Should no action be then taken by the provider, insurance funds can reduce reimbursement and in severe cases cancel contracts (Buscher, 2010).

The four summary measures available on the internet cover nursing care (based on 17 items), activities prescribed by a physician (based on ten items), management and organisation (based on ten items) and a user survey (based on 12 questions asked to a small sample of service recipients). The first three types of measures (i.e. not the user survey results) are summarised into the composite overall grade. It is clear from the headings of these summary measures that much of quality assessment has a clinical focus. Indeed, during the inspection the physical condition of the cared for person is assessed (the condition of their skin, fingernails, toenails, hair and so on), and many of the measures are derived from expert standards in areas such as pressure sore prevention, pain management, incontinence care, and nutrition management. The quality of the non-technical aspects of caring seem to be primarily assessed through the survey of beneficiaries, which captures perceptions of various aspects of the care process including involvement in decisions, continuity of care and the behaviour of care workers, and includes a measure of satisfaction. The clinical focus reflects the nature of the care funded under LTCI, which is mostly nursing care and a limited amount of personal care (Bode & Firbank, 2009; Fernández & Nyssens, this volume).

In addition to inspections, overview reports of a specific health or social care scheme, such as LTCI, are common (Federal Ministry of Family Affairs, 2002; Federal Ministry of Health, 2008; Medizinische Dienst der Spitzenverbände der Krankenkassen, 2007). As in England and Belgium, these reports are mandated by law or government and are designed to provide recommendations for future policy development. The overview of the system-wide state of quality is produced triennially and is similar to the annual “state of care” reports in England: it is compiled from the inspections of providers and draws on these data. The federal statistical agency also regularly collects input and output data regarding the workers and beneficiaries of LTCI. The data are drawn on to compile the report on LTCI along with data from inspections, of which the latter concentrate primarily on quality and general outcomes for service users. Some assessment is made of the economic situation (income and available resources) of

private caregivers in the overview quality report and of the labour market in the LTC insurance report, but this assessment is limited to aspects such as contractual terms, turnover and training.

Overall, in Germany performance assessment focuses largely on providers, and has developed in recent years, with more thorough inspections. This together with the publication of quality information for the benefit of users, points to the logic of much of this activity, since all of this effort appears designed to improve market efficiency, either through quality control or through stimulating competition on grounds of quality. These mechanisms coexist with a drive to move performance assessment away from inputs towards results for users. In all of the aforementioned activities, user outcomes are assessed. There is little focus on the workforce and informal carers are neglected despite their prominent role in caregiving (Bode & Firbank, 2009).

3.4. Italy⁴⁰

In Italy, public support for home care is limited and provision is geographically fragmented, since responsibility for home care lies with the regions (and municipalities) which enjoy significant autonomy (Tediosi & Gabriele, 2010). Local authority home care is means tested and a quasi-market operates, with local authorities awarding tenders to accredited providers through public procurement mechanisms; these arrangements also have a regional flavour. Historically, the family has been the main source of support for people, although in recent years Italian families have taken advantage of irregular, mostly migrant, workers to provide care. These arrangements are supported by care allowances and tax-based incentives designed to regularise these workers (Network per la Non Autosufficienza, 2009).

Following the Law n. 328 / 2000, providers must be authorised to function and must be further accredited to tender for contracts with local authorities. The regulatory minimum requirements for authorisation and accreditation are set by the regions (although accreditation is administered by the local authorities) and concentrate on structural indicators, such as staff/managerial requirements and care plan documentation for users (Di Santo & Ceruzzi, 2009). The regions also have responsibility for ensuring that the requirements for accreditation continue to be met, but the regional governments do not seem to actively oversee this. Data collected at accreditation is not publicly available.

Some data on costs, inputs and outputs (such as the number of workers by home care programme and the number of service users or programme beneficiaries) is collected regularly by government departments and the national statistical agency (ISTAT). We identified two reports that drew on these statistics to assess the performance of home care services (Agenzianazionale Per I Servizi Sanitari Regionali, 2009; Bettio & Verashchagina, 2010; Network per la Non Autosufficienza, 2009, 2010). Data on costs is analysed to consider sustainability, but productivity is not examined. The report by the self-sufficiency network

⁴⁰ This section draws on the Italian performance report compiled by Sara Picchi and Anna Maria Simonazzi.

also examines users' perceptions of affordability (Network per la Non Autosufficienza, 2009, 2010). Workforce is a significant focus of both reports, which is probably in part a response to the large numbers of irregular, and frequently migrant, care workers or "badante" that work in the sector and the need to understand their situation and working conditions. Certainly, migrant labour is a significant focus of these reports. Quality of care for the user is not generally considered.

Overall, performance assessment is very limited in Italy, both in focus (only activity, cost and input data is available) and in the types of activities undertaken. There is, similarly to Belgium, a focus on workers, but in Italy this probably reflects the high levels of irregular immigrant labour. Performance assessment relies on accreditation and to a more limited extent on activity data, which is compiled into reviews by non-governmental organisations. Other forms of performance assessment, including evaluations, do not appear to take place at the national level in home care services, and developments around benchmarking of quality within health services – the Civil Audit – have yet to cross into social services. There is significant regional and local variation, however, with more performance assessment activity in the north of the country (Di Santo & Ceruzzi, 2009). Since responsibility for home care lies with the regions and local authorities it is likely that this fragmentation explains the regional heterogeneity and lack of national activity.

3.5. Summary

As is apparent from these case study descriptions, there are significant differences in the extent and manner in which performance is assessed in the four countries.

Table 6.1: A summary of performance assessment across the four countries

	Belgium	England	Germany	Italy
Focus, depth and breadth of measurement	<p>Activity (output) data and input data collected regularly</p> <p>Cost of the system</p> <p>Quality data collected for evaluation studies only. Where outcomes are measured, workers are the focus</p>	<p>Activity (output) data and input data collected regularly, but workforce data partial</p> <p>Cost of the system</p> <p>Quality (including outcome measures) data for service users collected regularly, and measures are largely user-reported; less regular collection of quality (including outcomes measures) data for carers</p>	<p>Activity (output) and input data collected regularly</p> <p>Cost of the system</p> <p>Quality (including outcome measures) data for service users, but measures are largely clinical (body-related care acts)</p>	<p>Activity (output) and input data only collected regularly</p> <p>No specific quality information</p>
Subject of quality assessment	Workers, and to a lesser extent service users	Service users, and to a lesser extent carers	Service users	Primarily workforce
Legal requirements/standards	Providers must comply with standards. These are framed in terms of inputs and are narrowly specified	Providers must comply with standards. These are framed in terms of outcomes and are broadly specified	Providers must comply with the standards. These are framed in terms of inputs and outcomes, and are narrowly specified	Providers must comply with minimum standards, but these are set regionally and weakly monitored
Methods used	<p>Accreditation</p> <p>Administrative reports</p> <p>Limited use of provider inspections</p> <p>Evaluations/reviews of key programmes</p>	<p>Registration</p> <p>Regular provider audits/inspections</p> <p>Evaluations/reviews of the sector</p> <p>Experimental & quasi-experimental evaluations of pilot schemes</p>	<p>Accreditation</p> <p>Regular provider audits/inspections</p> <p>Evaluation/reviews of the sector and key programmes</p>	<p>Authorisation/Accreditation</p> <p>Weak and fragmented use of audit and inspection by regional authorities</p> <p>Reviews of the sector</p>
Target audience	Regional and federal bodies	Parliament, local and central government, prospective and current consumers, general public	Bundestag, regional governments, insurers, current and prospective consumers (more recent)	Local, regional and national government

4. Discussion

The case studies demonstrate that there are significant differences between the four countries in terms of the extent of performance assessment and the methods employed. There are also some similarities, with certain methods, such as accreditation, audit and inspection, used in several countries. However, these similarities are somewhat superficial as there are generally differences in implementation. Our thesis is that these differences can be explained by the way a country organises its home care system and the political context.

Marketisation creates a clear rationale for certain forms of performance assessment. Where provision is organised within a bureaucratic or tutelary model (as in Belgium for the home personal care sector) there are close and longstanding relationships between purchasers (in Belgium regional bodies) and providers, with purchasers exerting direct control over providers. These models can all too often be criticised for relationships between the state and (long-standing) providers that appear too “cosy” and foster an environment that does not drive providers to perform to the highest standards.

In contrast, where there are quasi-markets, relationships are likely to be of a shorter duration, more business-like and based less on trust. In this situation purchasers lack mechanisms of direct control, having to rely on legal contractual means. Thus some form of oversight is necessary to gather data about the providers’ operations for the purposes of quality assurance and accountability for public expenditure, including assessing effectiveness through measuring service user outcomes.

There are also significant differences in the extent of home care provision. While England and Italy both have means-tested systems, they differ significantly in the extent of provision. England has many more providers and its system supports many more people than Italy, where there are significant problems with supply. Home care is also rationed in Belgium and has some degree of means and needs testing, but the programme supports a very large number of people in comparison to Germany, England and Italy. Although the German LTCI system is a significant and high profile public programme, it does not support that many people (Fernández & Nyssens, this volume). Variations in both of these features – marketisation and the extent of home care provision – are important in explaining the observed differences in the use of accreditation, audit and inspection.

In support of this view, both England and Germany, which have relatively developed markets where users exercise choice and providers compete, also exhibit the greatest use of inspection and focus on outcomes. In addition, in both these countries regulatory information on quality is publically available, with an emphasis on its role in supporting user choice.

However, Italy does not fit this pattern. Although there is a quasi-market for home care, there is limited use of inspection and the focus at accreditation is on inputs. So why Italy does not see a need for national legislation to support a rigorous and outcomes-focused audit and inspection regime? The most likely explanation is the limited use of formal provision in Italy. Only 2.3% of people are supported by publicly-funded home care compared to 3% in England, 5.5% in Flanders, 5.7% in Wallonia and 3.3% in Germany (Fernández & Nyssens,

this volume). This limited public provision is due to a shortage of supply, explained in part by the dominant role of the family but also by benefits that support a large irregular, frequently migrant, workforce. In Italy the amount of public money spent on direct home care provision is small, particularly in comparison to that spent on social security benefits and tax breaks for people needing care. So there is less need to assure quality, account for expenditure or assess service effectiveness. It is more important politically to focus on problems associated with the irregular workforce, since they dominate the market (Da Roit, 2002; Gori, 2004).

Evidence from Germany and England supports this explanation for Italy's limited and input-focused use of accreditation, audit and inspection. In England, registration and inspection of home care providers has been implemented only since 2003. Prior to the 1990 market reforms, there were very few independent home care providers, and their numbers grew very significantly following the 1990 reforms. It was this expansion in the role of the independent sector that led the government in 2000 to introduce legislation requiring the registration and inspection of home care providers against National Minimum Standards. As outlined above, in the first instance these were largely input and process based, but over time they have become outcomes-focused as the regulator and government recognised the need to monitor effectiveness (Malley et al., forthcoming).

Similarly in Germany, the introduction of LTCI led to an expansion of provision and the inspection regime duly became tougher, with inspections that became more frequent and more focused on outcomes (Rothgang, 2011). In both countries, there has therefore been a shift towards the model of audit and inspection "needed" by a market system, and in both instances this was stimulated by an expansion of home care provision. It is therefore reasonable to ask whether a similar increase in supply in Italy would see the same changes in inspection and assessment.

In Belgium, the introduction of the voucher system has not been accompanied by strong regulatory requirements for accreditation in spite of the fact that services are provided on a competitive basis. The likely explanation of this "light touch" approach to the voucher system in Belgium might lie in its focus on labour market outcomes, rather than on the improvement of the quality of services provided and/or the provision of services specifically for dependent people (as indicated above, the voucher scheme is not meant to be used for commissioning personal care support). As it happens, a significant proportion of the users of the vouchers are individuals potentially at risk of abuse (e.g. frail older people) and issues of the regulation of the quality of the services might emerge in the near future.

Politics also plays a part in the differences observed across countries. Both Belgium and Italy focus on workers, which in Italy is, as already suggested, likely to be due to the large, irregular, and mostly migrant, workforce. In Belgium the large numbers of people supported and the concomitant size of the workforce is likely to be a factor, since the welfare and well-being of a large, organised workforce is politically important. Indeed collective agreements in Belgium have improved working conditions and training opportunities. In contrast, in England and Germany the focus on service users is less political and more a response to the market organisation of home care which serves users not workers.

Services may also provide relief to informal carers or be provided for informal carers, but it is only in England that performance assessment activities focus on informal carers and data is regularly collected about their well-being. This is despite the large numbers of informal carers in Italy and Germany. It may be that the challenge associated with collecting data about informal carers is the barrier. Indeed in England it is only a subsection of informal carers – those who have had an assessment of their needs by local authorities – for whom data is collected. The situation of carers who have refused an assessment or have no contact with local authorities is not recorded, even though they may receive “carers’ allowance” through the social security system. The same is true for Germany and Italy, where cash payments to people in need of care may be used either to pay family carers or put towards the household budget if the carer lives with the person they look after.

Quasi-experimental (and experimental) evaluations of pilots of new policies initiatives have become commonplace in England but are not observed in the other countries. This development has been associated with a drive towards evidence-based policy making, particularly in the field of UK healthcare (Black, 2001), which has had a spillover effect in social care. These evaluations are detailed, consider issues around attribution (both through their design and analysis) and also examine cost-effectiveness. They are the only evaluations we identified where issues relating to productivity were addressed directly and in a sophisticated manner. While other countries may have much to learn here, it is also important to recognise that this development has had limited success. There are many reasons discussed in detail by Cameron et al. (2011) but a key one is the disparity between research and political timescales meaning, for example, that a national roll-out in England of Individual Budgets (recast as Personal Budgets) was announced before the evaluation had even concluded.

An important question that we have not yet addressed is whether the different approaches to assessment support good performance. While we cannot answer this question definitively, we can consider the problems that arise. In England and Germany, perhaps the most significant problem associated with the outcomes-based approach to performance measurement is the notorious difficulty in measuring outcomes because so many other factors may intervene, the so-called attribution problem. In England, these problems have been circumvented to some extent by allowing inspectors to take mitigating circumstances into account when assessing compliance with standards. Indicators collected as part of ASCOF, however, tend to be presented without adjustment for attribution, although there are plans to change this (Department of Health, 2011). Despite the complexity of the task, the US experience suggests that some form of adjustment is feasible provided the necessary data is collected; for instance the quality indicators on its Home Health Compare website are all risk-adjusted to take account of patient mix (Murtaugh et al., 2007).

The difficulties with measuring outcomes have led some people to suggest that it is more sensible to concentrate on structural or process measures of quality. Indeed in both Germany and England process and structural measures are still collected and used to, for example, monitor quality in Germany and assess providers at registration in England. However, neither country relies on input measures in quite the same way as Belgium. One problem with

structural measures is that their relationship with outcomes, and therefore with the effectiveness of services, is uncertain as structural characteristics tend to be relatively stable. They may therefore not be the best measures of quality. There is, however, good evidence from the US to suggest that the staff-patient ratio in nursing homes is associated with good quality care (Sangl et al., 2005), and a system that concentrates on ensuring high standards regarding inputs may achieve good outcomes. In Belgium a lot of money is spent on home care (and long-term care more widely), and working conditions are an important issue. This can be explained by the importance of social dialogue between representatives of employers and employees in the Belgian system. What is uncertain is how a system that concentrates on inputs would fare under significant pressure to contain costs. Specifically, would politicians begin to question the effectiveness (and indeed cost-effectiveness) of services and therefore demand a focus on outcomes?

Outcomes approaches to performance assessment may also be essential where services are diverse. The “personalisation agenda” in England encourages providers to meet the needs of their users in innovative and unconventional ways and the policy of Personal Budgets allows users to purchase services entirely outside the formal system. In such an environment a focus on the structural characteristics of providers could restrict their ability to innovate and therefore threaten their survival; by contrast a focus on outcomes recognises that there may be multiple ways to achieve the same end.

Finally, as mentioned, in addition to extensive oversight regimes, England and Germany publish information about the quality of providers to support users. The assumption is that informed choice will improve the efficiency of the market. As yet, there is a lack of good evidence about the extent to which this information is actually being used for this purpose in these two countries (Buscher, 2010; Malley et al., forthcoming), but research in the US suggests that the publication of information has had a positive effect on the nursing home market (Castle, 2005; Clement et al., 2012; Werner et al., 2010). Where markets operate, it is essential for users to have access to information about quality to avoid the problems associated with information asymmetries. Indeed for this reason, it is hard to divorce questions about the effectiveness of oversight and the publication of information from the central issue of how effective markets are as a tool for delivering home care. There are, of course, challenges associated with presenting information on quality to users, and it is right to question the current measures and their presentation.

We should consider carefully the conditions necessary for the success of the quasi-market model when applied to the home care area, in particular in view of the complex and relational nature of the service, the fact that users themselves are sometimes limited in their capacity to exercise free choice and the continuous nature of the choice “process” given the long-term characteristic of the need for care. For instance, Le Grand & Barlett (1993: 18) have pointed out that given the complexity and length of receipt of most of social care services, the use of “voice” by emphasising user choice may be preferable to incentives based on market “exit”. In this context, personal and informal assessment devices which establish or strengthen trust among stakeholders can contribute to improving the coordination of the market. Similarly, the

use of standardized tools of evaluation can fail to reflect important dimensions of service quality. Processes which incentivise the participation of users, informal carers and workers and professional networks in the development of services can help incorporate subjective dimensions of quality which are often beyond standardized and impersonal evaluation processes (Fraisie & Nassaut, 2010).

5. Conclusion

Performance assessment is playing an increasing role in the governance of home care services in Europe. We have argued that the introduction of quasi-markets has contributed to the development of performance assessment. Where the logic of markets exists, and in the context of the growing role for independent sector home care providers, the collection and use of service performance related evidence could be critical to guaranteeing the efficient functioning of the care market by helping to address problems of incomplete and asymmetric information. Performance assessment is thus, in the first instance, a tool for the prevention of market failure. Important questions remain, however. First, to what extent performance assessment frameworks, in particular based on highly standardised measurement processes, can fully capture the complex array of factors contributing to defining good quality and good service performance in the home care sector? Second how the different approaches to performance assessment support informed choice and improve the efficiency of the market? Due to these difficulties and the different degrees of marketisation of the system, we have seen that performance is not always measured by looking at outcomes. Process and structural quality indicators are still commonly used in the different countries, even if they provide a limited picture of the performance of the whole system.

In addition to the marketisation of the care sector, other factors have played a key role in the development of performance assessment frameworks across the four countries explored in the study. Chiefly amongst those are the financial implications for the public purse of the growing demand for the services, and the requirements for an effective oversight of the use of public resources.

- Chapter 7 -

A cross-national analysis of the gendered aspects of care reforms Towards different worlds of defamilialization⁴¹

1. Introduction

1.1. What is defamilialization?

The literature on gender⁴² and Welfare State regimes has been increasingly concerned with the impact of social policies on men and women and on the power relations between them (Daly and Rake, 2003: 12). The degree of “women-friendliness” of Welfare States finds an efficient measure in the concept of “defamilialization” (Lister, 1994; Lister 1997; Bamba 2004, Bamba 2007), which targets “*the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or through social security provisions*” (Lister, 1997:173), or more specifically “*the extent to which the welfare state enables women to survive as independent workers and decreases the economic importance of family in women’s life*” (Bamba, 2007: 327). Indeed, an important question that feminists have long been addressing is whether the Welfare State – as a set of social policies and political rights – allowed financial autonomy for wives and mothers (Lewis, 1997). Interest in the autonomy of daughters (as children or daughters-in-laws caring for an older dependent person) came later but is now another crucial issue in an ageing society (Rummery, 2009). As a consequence, and not surprisingly, typologies constructed to characterize the caring dimension of Welfare States reflect the assumption that social policies should be emancipatory for women on both fields.

1.1.1. Radical versus pragmatic conceptions of defamilialization

The way defamilialization has been operationalized in the abundant empirical research devoted to the topic is, however, confusing. As applied to the field of care policies, defamilialization has been understood in either a “radical” or a more “pragmatic” way. In the first perspective, the assumption is that “*care is a profoundly oppressive institution*” (Walker, 1992: 44 cited by Brewer, 2001: 227). In such a perspective, the main challenge is to multiply the possibilities of unburdening caregivers and “*taking away care responsibilities from the family*” (Leitner, 2003: 358). Defamilialization-related indicators used in cross-national comparative studies often take into account policies aimed at unburdening caregivers, such as

⁴¹ The sections of this chapter are largely drawn from the “Gender contract” reports compiled by each national team: Brice Champetier and Florence Degavre for Wallonia, Jef Breda and Stephanie Peeters for Flanders, Ludovica Gambaro for the UK, Ingo Bode and Sébastien Chartrand for Germany and Annamaria Simonazzi and Sara Picchi for Italy.

⁴² Gender can be roughly defined as standing for “power relations between men and women”. It is based on the idea that these relations are determined by society rather than nature and that they have historically been unequal. Gender is used to study the historicity and variability of the categories “man” and “woman” and the way they interact in a hierarchical relation. Gender is a heuristic concept and, as such, is used by social scientists to make inequalities between men and women intelligible in many socio-economic spheres.

sufficient in-kind elderly care services or the proportion of people in residential elderly care (Rummary, 2009). Eligibility criteria for receiving care or the average hours spent with a dependent older person by a professional carer are also mentioned as being good indicators of the degree of defamilialization. This perspective seems close to the first part of Bamba and Lister's definitions, which emphasizes the emancipatory dimension of women's paid professional work.

Since care regimes also offer cash for care, defamilialization as applied to the analysis of care policies is increasingly understood in a more "pragmatic" way, in the sense that money transfers are seen as a way of recompensing and reinforcing family caregiving "that is already there". The fact that care is being compensated does not necessarily mean that care is seen as a positive experience (as the perspective of the ethics of care would suggest, for instance), but it does mean that a part of the oppression can be alleviated through direct or indirect transfers and that it is not caregiving *per se* that is oppressive, rather the invisible and unpaid aspects of it: "*we can conceivably argue that giving women the opportunity to engage in that work for payment, even if the payment is low, is possibly opening up citizenship opportunities in a way that is preferable to some of the alternatives available*" (Rummary, 2009: 644). In fact these issues are rarely raised as such in the "pragmatic" treatment of defamilialization. In the pragmatic approach, indicators such as paid carers' leave, cash transfers to family carers, social security benefits, etc. enter into consideration and are regarded as an improvement of the informal caregiver's condition (Le Bihan & Da Roit, 2009). This latter perspective seems closer to Lister's definition, which also includes "social security benefits" or *any* means other than work enhancing women's economic independence vis-à-vis the family.

These two approaches to defamilialization reflect the ambivalent effects of caregiving on family caregivers as described in the literature on care. Calasanti refers to the "*dialectical nature of gender relations*" in the context of care, as it can also be an asset in some circumstances (Calasanti, 1999 cited by Brewer, 2001: 219). She argues that care activities as performed by women allow the development of social networks that can act as a support in the event of widowhood. For Walker, "*Caregiving can contribute to a person's sense of connection (...) but it can also reflect fear and obligation*" (Walker, 1992 cited by Brewer, 2001: 227). For example, the literature on the care burden (Brody, 1985; Brody, Hoffman, Kleban and Schoonover, 1989) shows that it generates stress and health problems. On a more material level, care giving is difficult to reconcile with paid work and can thus threaten caregivers' financial autonomy.

The two approaches resemble the so-called "*contemporary variant of the Wollstonecraft dilemma*" (Lister 1994: 19) raised by feminist scholars: is it preferable to pursue equality by compensating women for the care they provide to relatives (thus basing women's social citizenship rights on their roles as carers), or rather to encourage Welfare States to socialize care and to ensure sufficient public provision of care services? It is beyond our scope to examine these specific aspects but it has to be borne in mind that these ambiguous and complex effects of care on women's lives are crucial to finding one's way through the literature on defamilialization. Although "gender" was initially an invisible topic in policy

reforms, this chapter aims to show that the reforms have produced significant gendered outcomes and that these are not limited to the effect on caregivers.

1.1.2. Whose defamilialization?

The way care regimes defamilialize (or fail to do so) can also be examined from the perspective of care receivers and professional care givers. While the defamilializing potential of public policies has been extensively examined from the perspective of family care givers, it is less documented for care receivers and professional carers. For care receivers, issues of autonomy vis-à-vis the family are also at stake: money transfers give the opportunity to choose (to opt for another form of care than that delivered by close relatives for instance) and to rely less on the willingness of a relative; to receive (more or less) professionalized care or, if this is not available; to be able to give (money) in exchange for the care received and, in a sense, to reciprocate for family care (Grootegoed, Knijn & Da Roit, 2010). From the perspective of professional carers, issues of defamilialization are mainly related to the fact that paid work in the formal care sector enables workers to maintain a “socially acceptable standard of living” themselves.

In this chapter, we will discuss the three-fold defamilialization effect of care reforms. This effect is only interpretable taking into account nationally specific contextual elements. After a brief presentation of this background, we will argue that the defamilialization effect of care policies cannot be described as uniform between and within countries. We will distinguish between weak (or strong) defamilializing effects for professional care-givers with precarious (or regular) working conditions, weak (or strong) defamilializing effects from the perspective of the cared-for who need affordable services, but strong (or weak) effects from the perspective of the families, who are offered more (or less) possibilities for externalizing their care “duties”. Some individual characteristics (like social status or income) can also be of importance in assessing the defamilializing effects of care policies. All these elements contribute to shape what we call “composite worlds of defamilialization.”

We will first give some information on the background to the reforms in order to understand the context of defamilialization. It is not possible to understand the extent of the transformations that have occurred in care systems without establishing some of the main features of the “gender contract” and the reforms. In a second stage, we will examine the measures supporting the informal unpaid caregiver and the possibility he/she gets to be either replaced by formal care or remunerated. Then, we will discuss the professional paid carer and the conditions in which he/she performs care work, to see if a “socially acceptable standard of living” is achieved. Finally, we will also briefly discuss the care-receiver perspective and offer country-specific conclusions by presenting the worlds of defamilialization thus identified.

2. The gendered background of the reforms

Pfau-Effinger (1993) refers to the “gender contract” as a fundamental historical compromise (albeit unwritten) assigning productive and reproductive roles to both sexes. This “contract” embodies a cultural and social reality that has shaped major social policies throughout the past 20 years, in particular LTC policies.

2.1. Main features of the “gender contract”

Earning and employment patterns and the division of paid and unpaid work give a clear indication of the “defamilialization horizon” within which cash for care schemes operate.

2.1.1. Dual earner, female part-time carer in Belgium

Despite the increase in unemployment and the economic crisis, feminine activity has continued to increase since the 1980s, accompanied by a strong rise in atypical forms of employment, such as part-time work. During this period, Belgian employers also started to look for more flexible forms (Alaluf, 1990: 19).

Women’s participation in the labour market is concentrated in atypical jobs, but another type of segmentation is related to the concentration of women in certain activity sectors. Indeed, it is interesting to note that more than a quarter of employed women in Wallonia working in the health and social care sector, where working schedules are more fragmented, requiring the availability of the workers at night, during weekends, and several moments of the day (IWEPS, 2010: 59). It is the sector that employs most salaried women. This sector has seen a sharp rise in the last ten years (Figure 1).

Regarding the legislation on combining work and family in Belgium, employment policy is drawn up mainly by the Federal Government, in a constant dialogue with the social partners (trade unions and employers’ representatives). Since 1997-1998, Federal Governments have used inter-branch agreements as a way of developing employment policy (Arcq, 2005: 6). In 2001, the Government persuaded the social partners to conclude an inter-branch agreement that would allow a better balance between work and family (Arcq, 2005: 30). This accord contained three principal measures (Conseil national du travail, 2001): (1) the introduction of a right for employees to a “time-credit”; (2) a specific system for special leave (parental leave, palliative leave, etc.); (3) updating of the career-break system.

A recent study has analysed the scope for use of these reconciliation measures by part-time workers (Demeur, 2010: 54-55). The flexibility given to part-time workers to take thematic (e.g. palliative or parental) leave is less than for full-time employees. Those employed for less than three quarters of full time only have the opportunity to suspend their work completely for a year throughout their career, while their full-time colleagues can also reduce their work by one fifth under the “diminution” measure, and reduce their working time to part time under

the “time-credit” measure. According to Demeur, *“Such discrimination is likely to be based on the assumption that part-time workers have enough free time to devote to their private lives not to seek a reduction of activity”* (2010: 55). This tends to indicate that the opportunities for part-time workers to be compensated for caring for an elderly parent are limited.

2.1.2. The family gap and the differentiated male/female attachment to work in England

The UK has a high employment rate for women, well above the EU15 average female participation rate (Table 1). Employment among women has increased dramatically in the last three decades, a trend driven by the entry into the labour market of mothers of small children. Indeed, during the 1980s and 1990s, mothers of pre-schoolers substantially increased their participation in paid employment (Gregg, Gutiérrez-Domènech and Waldfogel 2007).⁴³ More recently, single mothers have joined the workforce in greater numbers. Overall then, women have narrowed the employment gap with men, and indeed the overall gender employment gap is rather small compared to other European countries.

Yet, despite their relatively high participation rate, women in the UK are not in paid work on the same terms as men: part-time work remains almost exclusively the province of women, and of mothers in particular. In contrast to other EU countries (e.g. Sweden) part-time work in the UK is highly penalized: women in part-time jobs earn, on average, 22% less than women in full-time jobs. The main reason for such a heavy penalty is that part-time jobs are almost exclusively to be found in low-paid occupations. In other words, part-time employment overlaps with gender occupational segregation (Manning and Petrongolo, 2004; Gregory and Connolly, 2008). In addition, part-time work in the UK tends to be of low quality, in terms of social security and pension contributions, thus penalizing women’s economic position also in old age. The fact that a large proportion of mothers work part-time raises the issue of the “family gap,” i.e. the difference in work behaviour between women without children and mothers. In the UK the employment gap between mothers and childless women is especially high: among women aged 20-49, only 62% of those with children were in employment, compared to 83% of those without children (Lewis, Campbell and Huerta, 2008, Table 2; Paull, 2006). This indicates that the presence of children remains strongly correlated with lower participation rates among women; the opposite is true for men, with fathers more likely to be in employment than men without children. Labour market attachment is stronger for women with higher wages, in higher-level occupations, with better qualifications and longer employment tenure. Indeed, British women with tertiary education are almost as likely as men with similar education to be in employment. By contrast, the employment rate for women with lower secondary qualifications is well below the employment rate of men with similar qualifications.

⁴³ This trend stalled, however, in the second half of the 2000s and may be reversed by the economic crisis which is likely to affect women in the next few years because of the large cuts to public spending – a larger proportion of women relative to men are employed in the public sector.

In the UK mothers earn considerably less than fathers: among individuals aged 18-54 with children, women earn on average 66% of men's earnings (Paull 2006). More specifically, mothers incur such a heavy penalty because they are more likely to work part-time and to have interrupted careers, although the explanatory power of these two mechanisms is diminishing as women's employment patterns converge with men's, while the gender pay gap fails to close.⁴⁴ In short, the position of women, and mothers in particular, on the labour market is substantially different from that of men, because British mothers face substantial wage losses when they try to combine paid work with family responsibilities.

This situation is mirrored, at the household level, in the disparity between the financial contributions made by men and by women. Indeed, although the majority of all couple households in Britain are dual earners, only one fifth of households with children under 15 contain two full-time earners (Lewis, Campbell and Huerta. 2008). The incidence of the male full-time/female part-time family type remains strong in the UK, where this model accounts for one quarter of all families with children (Lewis, Campbell and Huerta, 2008). Yet, because of the stark pay penalty incurred by mothers working part-time, differences in financial resources brought to the household by men and women remain large.

Data on time-use differences between the sexes broadly match the gendered pattern of employment described so far, with women spending more time in care activities and men allocating more hours to paid work (Table 2).

2.1.3. The Italian “non-employment” perspective

One conceptual analysis of data collected should be the so-called “non-employment perspective,” which is particularly suited for exploring the Italian division between reproductive and productive work, which are strictly interrelated and deeply gendered (Lombardo and Sangiuliano, 2009). The “non-employment perspective” assumes that policies construct some subjects (usually men) as more legitimately accepted as employed (full-time), while other subjects (usually women) are more legitimately accepted as non-employed, or part-time employed, in order to care for people and households. Welfare services that make reconciliation between family and work possible – such as childcare, elder care, parental leave, or domestic work provisions – impact on the more or less unequal ways in which paid and unpaid work are distributed between women and men. Policies on retirement age and pensions, as well as tax/welfare policies that take the individual or the family as the unit for tax and benefit systems, thus create different dependent and independent subjects and also construct legitimate states of non-employment that regulate different labour market entry and exit paths for men and women.

Italian non-employment policies construct specific categories of subjects by reproducing traditional gender stereotypes concerning the division of productive and reproductive work,

⁴⁴ In the UK wage dispersion is higher than in other European countries. Because wages are not compressed at the top, an especially visible manifestation of the gender pay gap occurs in the financial sector, where women working full-time earn annually 55% of what men working full-time earn (Equality and Human Rights Commission, 2009).

thereby politically articulating intersections of gender with class/ethnicity/age and generating further disadvantages for women. For Italian women, especially those in the lower and middle classes, the life-path begins with the difficult process of entering the labour market, often having to accept unstable and low-level positions, in a context that does not encourage women's employment. As soon as they become mothers, a series of mechanisms encourages them to exit the labour market. This is caused not only by a "protectionist" system of social assistance, exemplified by the mandatory five-month maternity leave and a system of parental leave that does not encourage men's involvement, but also by the lack of services for childcare and elderly care.

In concert, these factors in effect encourage Italian working mothers not to re-enter the labour market. Once women are out of the labour market, the mechanism of means-tested social services and allowances based on family income makes it more convenient for women (at least those not married to high-earners) to remain economically dependent on their partners, to access social services, pay lower taxes, and be eligible for state benefits. In this case, the need to protect poorer families visibly prevails over gender equality considerations. If, alongside the means-tested benefits for families, we also include the insufficient offer of childcare and other care services, as well as these women's usually unstable jobs, it is easy to see how Italian women are "pushed" into a situation of "non-employment." Men, on the contrary, are constructed here as primary breadwinners, legitimately employed independent subjects. An Italian woman will either never manage to accumulate enough contributions to be eligible for a pension, or, if she has succeeded in going back to work after maternity, she will be able to retire five years earlier than men, further widening the gap between her pension level and her partner's. Here, the political articulation of the intersection of gender and class inequalities leads to the progressive feminization of poverty.

Furthermore, public policies put pressure on ageing women in two opposite directions: on one side, they lengthen women's working lives, hindering early retirement; on the other side, they implicitly demand care work from grandmothers to make up for the deficiencies of Italian childcare services. Ageing Italian women are paradoxically asked to be employed as well as non-employed, with the further aggravating circumstance that their care work, from which the state greatly profits, is not treated as employment and thus does not entitle them to any social benefits such as leave, holidays, etc.

In spite of quite advanced legislation on parental leave, the only two concrete solutions for reconciliation are represented by recourse to the extended family (parents and grandparents) for help in care responsibilities and, increasingly, part-time work. However, firms are reluctant to offer part-time jobs, especially when "collaborators"⁴⁵ offer a cheaper way of combining women's demand for part-time work with firms' pursuit of lower costs. According to Muehlberger and Pasqua (2006: 11–12), 72% of "collaborators" working part-time are

⁴⁵ Over the last decade Italy has seen a strong increase in the number of workers on the border between self-employment and employment. Depending on the data source the *parasubordinati*, i.e. workers with a "contract of continuous collaboration" (collaborators) represented between 1.8% (ISTAT, 2004) and 5.3% (Alteri and Oteri, 2004) of the Italian labour force (http://ideas.repec.org/p/wpc/wplist/wp10_06.html).

women (84% among employees): while 43% of them decided to work part-time to reconcile work and care, another 47% did so because they could not find a full-time job.

2.1.4. Germany's dual earner-female carer model

The traditional West German mainstream model was a division of labour in which women raised children at home while men were the “breadwinners” for the whole family (Pfau-Effinger, 1993). Major social and legal institutions endorsed this family model (Bureau et al., 2007: 104-112). Concerning social protection schemes, the informal work role of women in the family, including care to both children and the elderly, was endorsed by a parental benefit scheme and the generous cash for care option included in the long-term care insurance system (Leitner, 2009). Change is nonetheless underway concerning both the family model and the institutional set-up regulating it. The activity rate of women, including mothers with younger children, has considerably increased over the last twenty years or so. The new mainstream model is men being in full time employment with partners working part-time or in “mini jobs” (see Chapter 2) during the early years of their children. According to Pfau-Effinger (1993), the traditional gender contract has left its mark in the “care regime” taking shape from the 1980s onwards, including the way women were entering the labour market. Women were attracted by work in the personal service sector not least because it offered part-time employment opportunities, i.e. the means of satisfying women’s supposed “wish” to be in both gainful employment and a domestic care role. Social protection schemes have both consolidated the ancillary economic function of women (since the role of the carer has been acknowledged by reforms, e.g. in the pension system, providing carers with some additional entitlements) and promoted the double income family by extending childcare facilities and making parental leave dependent on previous income from gainful employment. Moreover, public employers and big companies have taken steps to attract the more qualified female workforce through family-friendly employment policies (childcare at the workplace, flexible working time). In quantitative terms, this movement is still in its infancy, but at the level of discourse, the days of the traditional family model are over.

However, the lower classes not only hold more strongly to the old family model, they are also affected much more by social problems impeding a less gendered work-life balance. The current situation is encapsulated in a social configuration featuring an (upper) middle class family hiring a female domestic worker on a precarious basis (low wage, no or limited social security, mini-part-time etc.) in order to make full dual earning possible for both partners while leaving the domestic worker with the opportunity of providing some extra money to a male breadwinner-led family.

Table 7.1: Female earning and employment model

	Italy	Germany	UK	Belgium
Earning model	(Eroding) male breadwinner	One and a half earners, women's wage as "complementary"	One and a half earners, women's wage as "complementary"	One and a half earners
Main earner (among couples, %) *	Dual earners: 36 Male: 31 Female: 12 No: 8	Dual earners: 47 Male: 18 Female: 7 No: 3	Dual earners: 50 Male: 16 Female: 3 No: 5	Dual earners: 56 Male: 17 Female: 3 No: 6
Gender pay gap ⁴⁶ **	14.02	25.74	18.80	12.87
% men and women in lowest wages ⁴⁷ ***	M: 11.5 W: 16.2	M: 15.9 W: 28	M: 15.6 W: 30.6	M: 4.8 W: 12.8
Employment model	"Non-employment perspective for women"	Class biased	Family gap and highly differentiated labour market attachment for m/w	Eroded high norm of female FTE (following the increase in atypical and flexible work)
Female employment (ER)**** part time (PT) (%)*****	ER: 46.6 PT: 29.9	ER: 62.9 PT: 39.2 Reason for part-time Children: 11.3 Other family reason: 17.3	ER: 66.3 PT: 38.6	ER: 54.9 PT: 32.9 Reason for part time Children: 8.8 Other family reason: 13.6

* Source: LIS Waves 5 and 6 (Harkness, 2010).

** O'Dorchai (2011) based on ESES 2006.

*** Source: Europe in figures - Eurostat yearbook 2010: Labour market (tables and graphs)

**** OECD, 2008. Employment Outlook, p. 338. (Data for year 2007, "ER"= persons [women] aged 15 to 64 years who are in employment divided by the working age population.)

***** OECD, 2008. Employment Outlook, p. 351. (Data for year 2007, "PT"=part-time employment as a proportion of the total population.)

⁴⁶ The unadjusted Gender Pay Gap is defined as the relative difference, in percentage, between the average gross hourly earnings of women and men.

⁴⁷ Low-wage earners among full-time employees.

Table 7.2: Elderly care obligation is placed on women

	Italy		Germany		UK		Belgium	
Women in elderly care (% of carers)*	75		73		58		70	
% men and women involved in caring activities (any care)**	W 50-64: 25 65-74: 15 75>: 11	M 50-64: 16 65-74: 10 75>: 9	W 50-64: 15 65-74: 12 75>: 3	M 50-64: 9 65-74: 8 75>: 16	W 50-64: 18 65-74: 17 75>: 10	M 50-64: 11 65-74: 19 75>: 15	W 50-64: 16 65-74: 10,5 75>: 8	M 50-64: 11 65-74: 7 75>: 14
Daily hours of unpaid care (preparing meals and self-care excluded)***	M: 1.1 W: 3.51		M: 1.52 W: 3.11		M: 1.54 W: 3.28		M: 2.15 W: 3.52	

Source:

* *Facts and figures on long term care in Europe and North America (2009), p.57*

** *<http://www.oecd.org/dataoecd/52/27/47884865.pdf>, p 89). Percentage of the population declaring themselves carers, by gender and age group.*

*** *Source: Eurostat, Comparable time use statistics - National tables from 10 European countries, 2005.*

2.2. Gender equality in LTC: a rationale for reform?

It is clear that a certain number of normative cores were active during the reforms (Rummery, 2009: 640) and Chapter 1 has shown how “empowering” the user, “diversifying care sources” and getting “best value for money” have accompanied care regime transformations. Gender equality was not an explicit driver of reform (Rummery, 2009: 641), except for England, where the debate around the carer’s credit as brought up by the government itself included the need to alleviate the negative consequences of caring on women’s financial autonomy (HM Government, 2008; Department of Health, 1999b). Women were indeed mentioned among the objectives, but not in terms of equality, rather to their detriment. The report on Ageing in Belgium by the Social Protection Office gives a good example of women being uncritically reinforced in their role as carers. It is suggested that enhancing “self-care” (an important rationale in Flanders) can contribute to postponing a proportion of the difficulties to be dealt with to a more advanced age, in order to await the availability of retired women (daughters, daughters in law etc.) to be able to care: *“The shift in the morbidity and needs of the elderly to a later age can have the consequence that the needs of the elderly will only have to be dealt with when (these) women have passed the retirement age”*.⁴⁸ This might be the way for Belgian society to reconcile women’s relatively high rate of participation in employment with the (transnational) trend towards removing obstacles to finding more informal care, but not in the direction of gender equality. What remains largely unquestioned here is women’s desire to act as carers after their professional career and whether men will be willing to participate as well.

Another striking trait of debates is the discreet – one might even say embarrassed – presence of feminist movements on the scene of LTC. In Belgium, the women’s movement has observed the progressive rise of the demand for a carer’s status. This latter cannot be heard, however, as most women’s organizations in Belgium are historically committed to gender equality issues in the workplace like the gender pay gap, insufficient state supported child or elderly care or job quality. There has been a vast mobilization around the poor quality of jobs in the voucher system, but other issues related to LTC are hardly taken up. Speaking in favour of an informal carer status or on a sphere that is seen by the majority of the Belgian feminists as oppressive is not a priority. The Belgian care regime is also perceived as being quite satisfactory since formal care is well developed compared to other countries.

In Germany and Italy, major feminist contributions to the public debate come from feminist academics. In Germany, Leitner (2005) expresses a feminist position as she states that the “cash for care” option in the German care regime does after all not empower female care givers. Power is given directly to the cared-for since the benefits are awarded to him or her, and not to the (mostly female) caregiver caught in the intricacy of the family relations. Furthermore, Leitner argues, benefits are too low to guarantee carers an average standard of living. In Italy, it was the right of migrants (carers) that mobilized the feminist movement while only some feminists in academia showed concern about how “natives” were trapped in the non-employment perspective because of (elderly) care.

⁴⁸ http://www.socialsecurity.fgov.be/docs/fr/publicaties/vergrijzing/rapport_vergrijzing.pdf, p.519.

3. Sustaining the unpaid informal caregiver

Women still make up the vast majority of informal carers for elderly people. Female carers in Italy provide 75% of such care, 73% in Germany, 70% in Belgium and 58% in the UK (Table 2). They also provide the majority of the heavy care tasks (Huber et al., 2009: 56). As shown in Chapter 1, unpaid informal care performed for a family member has gained political attention, as it is considered a source of care with a high potential, in terms of quantity and quality. Measures supporting unpaid caregivers involve a mixture of services, entitlement to time to care and cash benefits either through “routed wages” (Ungerson, 2005) or direct cash to the carer. All three forms of policies are necessary to sustain carers’ choice, and in particular their ability to combine care with paid work (Lewis and Giullari, 2005).

3.1. Combining elderly care and work

When looking at employment status, being economically inactive increases the probability of being a carer, among women in particular. Although the incidence of carers among those who were not in employment was particularly high, it is not clear whether people become inactive because of caring responsibilities or become carers because they are not in employment. Informal carers comprise a small share of the workforce at any point in time. However, longitudinal data indicate that a substantially higher proportion of the workforce is likely to provide informal care at some point in their working life. Indeed Pickard (2004: 4) reports that, in the UK, “*it is estimated that 53% of women and 40% of men will have provided at least one spell of care of 20 hours or more a week before reaching retirement age (Hirst and Hutton 2000)*”. The likelihood of looking after an older person was especially high among those aged 45-64. Within this age group 27% of women and 19% of men were carers (Pickard, 2004). In Belgium, 16.4% of women aged 45 to 65 provided informal care while 10.3% of men did so.

Several studies have described the difficulties in combining caring and employment (e.g. Arksey, 2002; Laczko and Noden, 1993). Caring responsibilities are found to reduce the level of labour market participation in a number of ways: withdrawal from employment (often through early retirement), reduction of the number of hours worked, or movement from full-time to part-time (Pickard, 2004). Consequently, carers’ earnings are likely to be negatively affected, either because of reduced hours, or loss of promotion opportunities or loss of seniority due to breaks in employment. Finally, lower lifetime earnings have repercussions on pension levels, with carers usually cumulating fewer years of contribution.

Caring in older ages: the “gender twist”

Regarding the activity of caring (any type of care) when getting older, the picture is interesting as “*men seem to catch up*” in later years in *some* countries (Huber et al, 2008: 58). In Germany, where family care represents a very important part of elderly care, the proportion of men among informal carers is higher than women’s after 75 (65% of carers) (table 2). In the UK and in Belgium, this “gender twist” (in the respective proportion of men and women in the informal carers groups) is less spectacular but interesting to notice as well: British men represent 35% of the carers aged 50 to 64 but 45% of the carers aged more than 75, while Belgian male carers represent resp. 40% (50-64), 35% (65-74) and up to 50% of the carers aged 75 and more. The older groups of informal carers thus include more men than “less old” groups in the UK, Germany and Belgium. In Italy, women all constitute the vast majority of the informal carers, even after 50 (around 70%).

Regarding the total population, the proportion of men in the total population that declares a caring activity in Belgium and Germany, diminishes at 65 and increases after 75. While “only” one tenth of men in Belgium declare themselves as carers between 65 and 75, they represent approximately 25% of the male population aged more than 75. This is even more than the female population of the same age group. The literature is unanimous on the fact that there is no gender difference in the probability to provide (spousal) care after 65 (Masuy, 2011). Identically, German men aged 75 or more are 30% to take care (more than women of the same age group) while they are less than 15% between 65 and 74. In the UK, this second “gender twist” (the proportion of men in the total population taking up care activities) starts at 65. 20% of men aged 50 to 64 are taking up caring activities. They are 30% in the group aged 65 to 74 and this remains stable after 75. In Italy, the proportion of carers in the male population remains stable in all age groups at a lower level (around 18%). In all four countries, the proportion of female carers in the total population decreases slowly after 65. Universal explanations for this second “age twist” are hard to give as the increase in the proportion of caring men in the total population starts in the UK when men leave work (65) but it only starts after 75 in Belgium and Germany. Besides, there is no specification of the type of care that is given (it could be elderly care or grand-child care) nor on the intensity of caring.

Evidence about the impact of starting caring on employment status indicates that co-resident carers are more likely than extra-resident carers to give up paid employment to undertake caring responsibilities (Arksey et al., 2005). This coincides with the fact that co-resident carers are more likely than extra-resident ones to provide care for more than 20 hours a week and to carry out a wider range of caring tasks. As regards gender differences, women are found to be more likely than men to have left a paid job in order to provide care. Not surprisingly, women in routine or semi-routine jobs are those more likely to leave paid employment (Henz, 2004).

A number of factors affect carers' decisions around employment: the intensity of caring required, the relationship with the person cared for, the need to earn high salaries and the nature of the job (Pickard, 2004; Arksey et al., 2005). Carers' decisions about employment are best seen as an on-going process, rather than a discrete event. Indeed caring responsibilities are likely to change unforeseeably, thus requiring a constant review of previous decisions and frequent adjustments.

There are important differences between the needs of those caring for children and those caring for older people. Fixed periods of leave – like maternity leave – may be of little use to those caring for older people because the length of the caring spell and the trajectory of the care recipient's condition are likely to be unpredictable. Instead, good schemes are those that allow carers to take time off to deal with emergencies (care leave) or to work flexible hours.

Germany, the UK and Belgium give the possibility for family caregivers to take care leave or to work flexible hours. Scope for flexibility in working patterns varies across employers. In particular, in the UK, the Employment Relations Act (1999) gave employees the right to take time off for emergency family reasons and the Work and Families Act (2007) has given carers of dependent adults the right to request flexible working. However, the effectiveness of these measures is limited by their discretionary nature: employees have the right to make a request, but not appeal against or otherwise challenge the employers' decision. Carer's leave is available mainly in the public sector and especially for those employed by local authorities. Indeed, in 2000, 80% of Local Authorities were found to provide "leave to care for others" and in 46% of the cases the leave was paid (Pickard 2004). Formal leave arrangements are, however, available in relatively few private sector organizations. This is also true for Germany (Eurofamcare, 2005: 40). As for the effectiveness of carer's leave, evidence points to low take-up, due to lack of information and the complexities of the policy guidelines. In England, even in the public sector, carers were found to take annual leave, rather than carer's leave, in order to deal with emergencies or to accompany the cared-for to hospital or doctor's appointments that had to be scheduled during working days (Pickard, 2004).

Combining elderly care and work through care leave or work arrangement does not seem to be a sustainable solution. Elderly care-friendly policies are rare and observations suggest that they are not really effective. While a certain recognition of family care is symbolically given through leave or flexible working hours on paper, defamilialization does not find its way through these schemes in any of the countries.

3.2. Incentivizing informal care through routed wages and carer's allowance

Monetary transfers affect the care/employment trade-off through income and substitution effects (Simonazzi, 2009). Untied cash benefits soften the budget constraint, leaving the relative cost of formal to informal care unaffected. Conversely, tied monetary transfers (e.g. vouchers) reduce the market price of care, making paid care more affordable. There may thus be different effects on the formal/informal division of care according to the conditions regulating the disbursement and utilization of cash transfers.

The amount of the subsidy is clearly a crucial factor. In the case of untied monetary transfers, a flat-rate subsidy – like the *Indennità* (€470) or the LTCI in Germany (€347) – will be most effective in discouraging the market participation of women on low incomes, since even a low subsidy may compare not too unfavourably with the wage that they could earn on the market. The flexibility of working times (which is very limited in Italy but fairly scarce as well in other countries), the possible wage penalty related to caring obligations, the need to resort to some form of paid care, combined with the old age of the carer, are likely to tilt the choice in favour of caregiving in Germany and Italy. The aim then is to recruit informal paid care and encourage women on the fringes of the labour market to enter caregiving.

For lower middle-income families, however, the subsidy may be decisive in turning the choice in favour of buying the services in the market in the case of untied cash. A large availability of cheap care labour, combined with unconditional cash allowances, can open the market opportunity also to a large share of lower middle-income families even at relatively low levels of subsidies. All things considered, cash transfers are unlikely to be the key factor capable of changing the trade-off between care and paid work, but they may affect the care labour market by favouring the emergence of a low-pay, largely irregular supply of paid carers.

In Italy both the state and families perceive the various allowances as forms of income subsidy that can be freely used to complement the family budget (the Attendance Allowances – *Indennità di Accompagnamento*). The idea was to make caring more attractive, so that caregivers, especially women of working age, would continue to care rather than enter the labour market (Morel, 2007). Given their generally low levels, cash allowances are unlikely to be the decisive factor in freeing up unpaid carers to participate in the labour market. They are more likely to be seen as an income subsidy which rewards previously unpaid carers or subsidizes the cost of formal carers. However, when combined with other sources of income, such as the dependent elderly person's pension, unconditional cash allowances can help in meeting the cost of paid care.

In the UK, the social security benefits (attendance allowance, disability living allowance) are paid to the disabled person who can use them as he/she likes. Eligibility for Attendance Allowance is governed by the need for help or supervision, but the claimant does not actually have to be in receipt of such support (Comas-Herrera et al., 2010: 23). Only 27% of Attendance Allowance claimants paid for either state funded or privately funded social care. Some 29% were receiving neither formal nor informal care (Wanless, 2006, p. 94 cited in Comas-Herrera et al., 2010: 23).

The idea behind the Carer's Allowance and other benefits (HM Government, 2008; Department of Health, 1999b) is to compensate loss of earnings for carers who are working on the labour market rather than to provide a wage for caring. Its rate (as of November 2008) is set at £50.55 a week. In order to be eligible, carers need to attend a severely disabled person for at least 35 hours a week and to have earnings limited to £100 a week. The care allowance therefore targets carers on low income, and its design reduces carers' incentive to find better-paid jobs or to increase their hours of work. However, there have also been reforms, such as

the carer's credit, which aims to recognize the contribution that carers make to society. The carer's credit is a national insurance contribution and aims to ensure that women (or men) who spend their working lives caring for others are not unfairly penalized on reaching retirement age because they have patchy contribution records. The carer's credit means it is now possible to qualify for a full basic state pension through caring (HM Government, 2010a).

Direct payments in the UK cannot be transferred to family caregivers; they are intended to replace formal care rather than family care (Rummary 2009: 638). Not employing kin does not, however, mean that "family terms" are excluded, as many studies report the care worker saying "*I feel like I'm part of the family*" (Ungerson, 2005: 64).

Table 7.3: Tools to support informal carers : summary

	Italy	Germany	England	Belgium
Time to care	No, but use of part time work and "collaborator status"	Care leave (up to 2 years), (limited) flexible working patterns or part-time.	Care leave, (limited) flexible working patterns or costly part-time	Care leave with replacement income (1-3 months) Flexible working patterns (limited)
"Routed wage" (for family or non-family members)	Yes (<i>Indennità di accompagnamento, Assegno di Cura</i>)	Yes (LTCl)	Yes (CA, AA, DLA, PB)	Yes (LTCl, Fl)
Cash benefits directly targeted on the family carer	No	No	Carer allowance (50,58/week, needs and means tested)	Some (variable) allowances by municipalities in Flanders Carer's status in discussion
In-kind services	Respite services (rare) Day care (patchy)	Respite services (Day care (patchy)	Respite services (very well developed) Day care	Respite services, (very well developed in Flanders, limited in Wallonia) Day care

The existing cash benefits to support carers in Flanders and Belgium are the Flemish Care insurance (€130 a month) and the Allowance for Care to Elderly Persons (≈ €274 a month, but means-tested) and these are not high enough to employ a professional carer or to induce a worker to start caring. The cash benefits can be used by the needy to compensate their

informal carers “already there”, but these allowances are not very high and thus do not have much impact on the financial autonomy of the informal carer, nor are they sufficient to attract new informal carers. Next to the flat fee, Flemish informal carers can also receive a premium from the provincial or municipal government as an appreciation and acknowledgement of their work. The government believes that this appreciation keeps informal carers more persistent. Several municipalities and provinces already have such a premium, but certainly not all. The amount of the premium and its regulation can differ for each municipality and province (Flemish Government: Department of Welfare, Public Health and Family, n.d.).

In Germany, the system is arranged in such a way that it incentivizes family care provision. The period running from the 1970s to the 1990s saw “*a shift towards formalization of caring work provided in private households by family members, neighbours, or friends*” (Behning 2005: 82); the “cash for care” option has endorsed private home care provision, with long-term care remaining an affair of private households rather than residential provision so that the family remains the key actor in the care regime. That said, the overall institutional development has brought an official recognition of (female) informal care work and its value, and given some kind of choice to women as regards becoming or remaining a (full time) private carer or not. However, the “cash for care” option does not ultimately foster the autonomy of female caregivers (Leitner, 2009). Firstly, it advantages the cared-for at the expense of the caregiver because the money is awarded to the former and not the latter. The caregiver (a vast majority of them being daughters or spouses) continues to depending on the cared-for for her financial autonomy. Secondly, in many cases the benefits paid are not sufficient to guarantee financial independence, let alone a standard of living comparable to that achieved through waged employment.

4. The professional paid carer’s autonomy

4.1. Care markets

4.1.1. Poor conditions and bad perceptions of care in England

The care workforce is made up predominantly of workers providing direct care and support (72%), while only a small proportion are employed in professional, managerial or administrative jobs. Care workers are overwhelmingly women, and the level of gender segregation is particularly pronounced among direct caregivers (between 85% and 95%).

The independent sector (private and voluntary sectors combined) dominates every form of provision, in particular between 70% and 80% of care and nursing homes and domiciliary care agencies belong to the private sector. This sectoral divide coincides with a stratification of the workforce. Professional jobs are concentrated in the public sector, either in council social services or the NHS. In addition, direct care workers enjoy better working conditions and pay when employed in the public sector. Indeed Eborall et al. (2010) indicate that pay in 2009 was invariably higher among council workers: care workers’ estimated median gross hourly pay was £6.00 in the private sector, £7.03 in the voluntary sector and £7.73 in

councils. For senior care workers the corresponding figures were £6.70, £8.08 and £10.69, and for community, support and outreach workers £6.50, £7.90 and £9.80.

Eborall et al (2010) report that since 1999 the number of jobs in council social services has constantly fallen and this trend reflects the reorientation of councils away from direct provision. Because the distinction between public and private sector drives much of the variation in the wages of women employed in low-paid occupations, this trend has important consequences on the pay levels of care workers (Dolton & McIntosh, 2003).

The care sector is characterized by low pay, low status and lack of advancement opportunities. An indicator of these poor working conditions is the high level of turnover: 40% of care workers have been in their job for less than 3 years. The turnover rate is especially high in the home care sector. In addition, qualification requirements are generally minimal: workers without either accredited vocational training or formal educational qualifications can be employed. This is revealing of the widespread notion that many care services involve “*low-skill activities which anyone (more accurately any woman) can do*” (Yeandle, 2002: 487). In this context, care workers’ opportunities for financial autonomy are rather limited, and their prospects of career advancement even more so.

As for the experience of care staff employed by Direct Payments users, the evidence collected so far points to a general level of satisfaction of both employers and carers. However, this section of the workforce may be particularly vulnerable since they occupy a position between the formal and informal care workforces (Glendinning, 2009), as is somewhat confirmed by the high share of Personal Assistants coming from non-employment (IFF, 2008). In addition, there is no employment regulation addressing the power balance between care worker and care recipient. This may leave workers vulnerable to the whims of their clients (e.g. in setting the hours of work). Indeed, a third of the Care Assistants surveyed by the IFF reported that they worked unpaid extra hours. Furthermore, employment regulation would ensure that carers derive social rights from the employment contract (e.g. social security benefits), thus enhancing their financial autonomy.

Finally, friendliness, amiability and flexibilities appear to be the attributes most valued by Direct Payment users. This is in line with previous findings about the aspects of quality most valued by elderly people receiving home care services (Francis and Netten, 2004). This attitude, together with the lack of regulatory requirements concerning the registration or qualifications of Personal Assistants, may discourage the development of formal training and career advancement for this group of workers.

Overall care work appears to have become more complex and demanding: current developments seek to promote forms of caregiving that respond holistically to the needs of elderly people, who are increasingly understood as active subjects making choices. Carers seem to appreciate such holistic and home-based approaches to care users’ needs. In this context however the needs of caregivers are liable to remain marginal, possibly compromising their autonomy and empowerment. In addition, this approach may overlook the problem of the low level of remuneration attached to care work.

Poor working conditions and negative perceptions of social care work have led to problems in recruiting and retaining staff. The reasons put forward for these problems focus on issues such as pay and conditions in the sector, which make the jobs uncompetitive with unskilled jobs in other sectors, but also on aspects such as lack of career development opportunities (Department of Health, 2004). Another problem is the low status of social care work (Department of Health, 2009). Social care is poorly understood, social workers are often maligned in the press and services are often experienced by people and presented by the media as of poor quality (Platt, 2007; Department of Health, 1998).

Various strategies have been presented to improve recruitment and retention of workers. The aim of the workforce strategy is to develop “*a confident, enabled and well-equipped adult social care workforce*” (Department of Health, 2009: 5). Part of the solution is investing in training opportunities for employees and solutions around career development, as discussed. However, significant resources have also been injected into a recruitment campaign, with advertisements across the national media. The aim of this campaign was to raise the profile of careers in social care and promote the sector as an attractive place to work. The hope is that the campaign will draw in more talent from all sections of the community, including people from a wide base of cultures, with different skills and personal attributes (Department of Health, 2009).

4.1.2. A flourishing submerged and unregulated care market sector in Italy

The co-existence of a minority of regular workers and a large army of irregular/informal foreign workers is by far the most important feature of the market in elderly care services. Highly regulated segments of the market (for instance workers in the public sector) coexist with informal/irregular/ under-regulated segments. Hence, pay and working conditions differ widely, varying with the employer status, the type of contract, the geographical context and personal characteristics (nationality, religion, language). In Italy, irregular carers' pay is often extremely low compared with that earned by a regular worker, though much higher than what they could earn in their home countries. Foreign carers are much cheaper than other solutions. The very low cost of a live-in carer in hourly terms derives from the round-the-clock character of the care provided. If the weekly average full cost to the family of a co-residing carer is divided by the “likely” hours of work, including being “on call” at night, the hourly cost is very low. With the foreign carer solution becoming somewhat “institutionalized” and widely accepted among families, the premium enjoyed by native/regular workers over foreign/irregular carers has been gradually eroded: wage setting in the formal and the informal market have become more interconnected.

Social cooperatives are located between the informal/semi-formal care market and the public sector. They provide good guarantees but pay low wages. Collective agreements are usually strictly applied, but working conditions are very poor: rigid shifts, physical and psychological stress, frequent injuries and professional illness wear out workers after 8-10 years of work in residential care. Solinas et al. (2006) provide a description of the working conditions in a

fairly representative social cooperative, active in the district of Modena. Unskilled workers in the elderly care segment are hired with a temporary contract usually to fill temporary gaps, such as replacing a worker on maternity leave; they get 3-5 days of training working with an experienced worker; after some time in the cooperative they will be usually offered a permanent contract. Training on the job is fairly high in the various segments covered by the social cooperative (elderly care, handicap, education and health), because it is explicitly required in public tenders; it is, however, lowest in elderly care (about 10 hours per year). Vertical mobility is quite limited, but horizontal mobility is used to ease situations of heavy stress: by rotating people from nursing homes, where working conditions are arduous because of the high level of guests' disabilities, to domiciliary or day care. There is no mobility between the various segments of personal services provided by the cooperative because of differences in skills. Workers try to exit from this labour market segment towards the public sector in search of better working conditions. Turnover is very high but lower among permanent workers. It is highest in the elderly care sector, especially in nursing homes. It has been decreasing lately partly because of worsening opportunities in the labour market and partly in response to the cooperatives' greater efforts at improving personnel policy and training. Flexibility is obtained through temporary contract workers and part-time. Social cooperatives have started to employ foreign female workers, usually former private carers who have managed to up-grade out of irregular or round-the-clock work into a regular occupation.

73.3% of *badanti* earn between €750 and €1,000 per month (14.8% earn less than €750 and 11.5% earn more). For *badanti* working on a per hour contract, 53.5% earn between €750 and €1,000; but 25.7% earn more than €1,000 per month. 21.7% earn less than €750 per month. One in three *badanti* has a regular contract.⁴⁹ A new national contract for domestic workers (in March 2007) raised the cost to a family of a live-in elderly carer on a regular contract to a level roughly comparable to average female net earnings in industry and services (€1,000 to €1,300 per month for the live-in carer, in addition to board and lodging costs, compared to €950 to €1,250 for the industry wage). Taxes and social contributions add another 33%-56% to the labour cost. With these new wages, even if social contributions can be deducted from tax, the regular carer solution is no longer sustainable for lower middle-income families, which used to rely on the extremely cheap supply of informal carers, and it is no longer competitive with residential care, especially if the latter receives a state subsidy.

The risk is therefore that this form of work will be pushed back into the black market. If this is to be prevented, both the level and the conditions regulating the provision of monetary transfers need to be monitored: the level should be in line with what is considered a fair wage in the care market, and the transfer should be earmarked in order to guarantee that conditions are met.

⁴⁹ PASQUINELLI S., RUSMINI G. (2008), *Badanti: la nuova generazione. Caratteristiche e tendenze del lavoro privato di cura*, Milano, Istituto per la ricerca sociale, p 32.

4.1.3. Regulated care market for workers of in-kind services in Belgium

Professional carers in the formal care sector have relatively good work protection, and training, but a very modest income. Historically, workers under the Joint Convention (JC) competent for private hospitals and care homes, but also domiciliary health care have received the best protection of all the JC of the private non-profit sector (Davagle 2003). Thus, home nurses and health helpers, working in family help services, get greater protection (in particular better pay scales) than other workers (family helpers, home keepers, etc.). House cleaners working for other private services than family help organizations depend on the sub-JC, bringing together voucher service workers and interim workers. Within the JC mentioned earlier, a health worker with one year of seniority “with no certificate or diploma qualified for a higher rate” would get €11.02 (gross) per hour (Convention collective du travail, 26 January 2009) while, within the sub-JC, a voucher service home cleaner with one year of seniority would get €9.85 (gross) per hour (Convention collective du travail, 14 July 2009).

The Belgian home care sector is mainly composed of associations (i.e. voluntary sector providers). There is a good penetration of trade unions in the voluntary sector organizations in Wallonia (of which “family help services” are an important part). During the last ten years, trade unions have been able to improve the terms and conditions of the home care workers (salary, training, unconventional hours, transportation, etc.). Nevertheless, inequalities persist in the field and may constrain the workers’ economic autonomy. Three points can be emphasized in this regard: first, home care “formal” workers depend on different joint committees, which may induce inequalities; secondly, there has been movement to improve the working conditions of the less favoured segment of home care staff, but with limited success; thirdly, the extent of part-time work, even if it has a relatively reduced impact on pay, may put single female workers at risk of poverty given the very low levels of income. Working time can be quite low in voucher service organizations. In Wallonia, nearly 50% of the part-timers working as family helpers, house cleaners and night keepers work between 46% and 55% of full-time in the same organization, i.e. between 17.5 hours and 20.9 hours a week.⁵⁰

The prevalence of a working time of around 50% of full time may have an impact on the working conditions of the workers and consequently on their lives. If a working time of 15 to 20 hours became the norm in family help services, it would introduce a flexibility that could respond to the specificity of home care work. This kind of work (and that is what makes its specificity) is performed in the home of the user; consequently it requires availability and employers often use part-time as a tool for human resource management (Degavre and Nyssens, 2008: 93).

⁵⁰ Steunpunt WSE data (Deeltijds werkende loontrekkenden naar sectorgroep, paritair comité en aandeel deeltijdarbeid in het Waals Gewest, 30 juni 2009) <http://www.steunpuntwse.be>

4.1.4. A dual market in Germany

Until recently, the provision of professional elderly care has barely been explicitly discussed in the context of employment policies in Germany. Importantly, as personal care is not seen in this country as an autonomous professional field but as a small appendage to body-centered service provision, employment policies and the public debate about them have rarely addressed home help to the frail elderly as an area where jobs could be created on a larger scale, including for disadvantaged workers.

There are, however, some exceptions to this rule. First of all, the creation of service-pool enterprises has been understood for some time as a policy to replace undeclared work by formal jobs, especially for low-skilled (mostly female) workers. Regional labour market policies, for instance in North Rhine-Westphalia, have been drafted with this objective in mind. Secondly, a training policy initiative has been launched since 2008 offering long-term unemployed citizens the opportunity to complete a short-term training course (160 hours plus internship over two weeks) teaching skills for the attendance and company of elderly persons affected by dementia. This was funded by the long-term care insurance funds. While the programme, concerning more than 15,000 workers by 2010, was focused on residential care settings in the first instance, an increasing number of domiciliary care providers do meanwhile recruit people from this new workforce. While policies of that kind are welcomed by some stakeholders in the non-profit sector (Neuhaus et al., 2008: 98), the fact remains that the bulk of professional care work in Germany is generally viewed as being incumbent on skilled personnel (nurses or geriatric nurses having completed a three or to years' professional education).

Since wages are low and (scattered) part-time employment is widespread throughout the domiciliary care sector, many observers refer to the care labour market as a precarious one. Trade unions draw attention to this from time to time in the public media while official reports (EPN: 149, 313ff) would stress the high psychological and physical burden of care work, rather than the precarious character of the occupation as such. Regarding wages, deemed a serious lever (or obstacle) for the development of the sector's workforce, employer organizations, responding to an initiative taken by the German government, have very recently agreed on the introduction of a minimum wage. Against the backdrop of salaries paid to care workers which are among the lowest throughout the country, trade unions, major political parties and the mass media have all demanded a national policy initiative in that direction. Employers, including those in the non-profit sector, were reluctant to follow this initiative, arguing that their income from long-term care insurance and other sources was insufficient to award higher wages. They have however finally accepted the new minimum wage entailing limited pay rises (to €7.50 per hour in the East and €8.50 in the West).

To summarize the context of the care market in Germany as well as the development in related care policies, there seems to be a tension between, on the one hand, acknowledgment of personal care needs not covered by long-term care insurance (and informal support arrangements) which seem to justify, in the eyes of many, the recruitment of this low-paid,

temporary workforce, and on the other hand, concerns over the impact of wage dumping due to home help provided by immigrants.

The German care regime is strongly gendered as both the informal carer and the elderly care sector professional is usually a woman. Women working in the care sector are working on a part-time basis (Behning, 2005). Voges (2002) makes a connection between the fact of the sector being “feminized” (including the role of female immigrants) and the limitations set on professionalization, resulting in working conditions poorer than those of many other, male-dominated employment sectors.

4.2. Migrant carers in paid care

Until recently, there was no evidence on involvement of migrants working in a grey market for care in Belgium. However, on-going studies tend to confirm that there are new signs of such this involvement. But regular service work – in home care agencies or service cheque enterprises – is a real option for many EU-migrants (from Poland, for example) and second generation Moroccan women. The different waves of regularization have not enabled migrants to be regularized on the basis of their involvement in care work.

By contrast, in the UK, there has been a large increase in the share of care workers born outside the UK since the 1990: in 1998 only 8% of the care workforce was foreign-born, whereas the share had jumped to 18% by 2008⁵¹ (Cangiano et al., 2009; Eborall, Will, and Woodrow, 2010). Foreign care workers have come to the UK via the work-permit system, and, to a much larger extent, because of EU enlargement. The relevance of the work-permit system to the care work sector has, however, been limited: only senior worker positions could be filled by sponsored non-EU nationals, and this entry channel has been increasingly restricted. Although there are no data on the immigration status of foreign workers, estimates by Cangiano et al. (2009) suggest that by 2007/2008 only 19% of foreign-born care workers held a work permit. We can expect this proportion to decrease in the next years, unless the point system relaxes some of the restrictions on the employment of non-EU senior care workers. In addition, restrictions for students and migrants on other visas could further curb the numbers of foreign care workers.

Despite the lack of official data on this question in Germany, it seems that the level of foreign illegal workers in private households is high. The expansion of the EU towards Eastern Europe in 1990 had a significant impact on the influx of foreign workers into the care sector. According to estimates, 100,000 workers are occupied in the field at present. The bulk of these are non-declared workers. However, there are a number of legal migrant employees, mostly from Eastern Europe, hired by private households for periods up to three months and admitted to this market on a tourist visa. These employees then leave the country for six months and can take up domestic employment again for another three months. Moreover, a reform of the immigration act (*Aufenthaltsgesetz*) in 2005 permits foreigners to provide

⁵¹ The share of foreign-born workers in the overall labour force is 13%.

domestic work on a full-time basis for up to 3 years unless EU citizens are available to provide care to a very dependent elderly person.⁵² This contract includes social insurance coverage, but is rather expensive for employers.

Although the impact is limited, the reform of the *Aufenthaltsgesetz* has had an impact. Today, more than 65 agencies offer around-the-clock home care provided by citizens from Eastern Europe. It also appears that undeclared domestic work is tolerated by public institutions in Germany. Inspections are rare, and social workers and care professionals learning of a foreign worker in a dependent elderly's home rarely inform the employment authorities. There is concern about the fact that care by migrants is usually cheap and that there is a risk of social dumping on the care market.

Table 7.4: Working in care: summary

	Italy	Germany	UK	Belgium
Income	€1,000-1,300 p.m. (regular market)	Minimum wage per hour (€7.50 per hour in East, and €8.50 in West)	£6.00 p.h. (private sector), £7.03 p.h. (voluntary sector), £7.73 p.h. (councils)	Family help: €11 p.h. Voucher: €10 p.h.
Working conditions	Uncontrolled commodification of informal care with precarious status of <i>badante</i> in a non-professionalization logic. Poor protection, no regulation	Double standard job market (mini-jobs in personal care, highly professionalized nursing)	Commodification of informal non-family care on a regular care market (assistants recruited through a mix of local networks and agencies). Poor protection	High professional standards in in-kind services, part-time employment. Low professionalization in voucher system
No. of migrants in care workforce	700,000 (women, large proportion is clandestine/undeclared)	100,000 (women, mostly clandestine/undeclared)	18% of the workforce in care	Important part of migrant female workers in the formal services

With management of care overwhelmingly entrusted to the family in Italy, elderly care has attracted large flows of care migrants, ushering in a new division of labour among family carers (mainly women), female immigrants (*badanti*) and skilled native workers. Migrant care workers privately employed by Italian households are overwhelmingly women (Pasquinelli

⁵² <http://dejure.org/gesetze/AufenthG/21.html>.

and Rusmini, 2008); up to 90% of all registered foreign care workers are women (Di Santo and Ceruzzi, 2010)⁵³.

The already difficult life-path of the Italian woman is interconnected with that of the more disadvantaged migrant woman, who, at the stage of the hypothetical life-cycle that we are sketching here, is likely to be the carer of our aged native wo/man. As she is not a citizen and works in the informal economy, she is not entitled to the parental leave and benefits that help the native woman to cope with reconciliation but also discourage her from re-entering the labour market after maternity. The migrant woman is instead pushed to be mother and worker at the same time, all the while being paradoxically treated as “non-employed” for two reasons.

First, because most migrant women arrive without a permit or visa, due to the restrictive Italian law on migration, their job situation is therefore precarious as they may only be legally employed either through “amnesty” measures for migrants or through so-called “entry quotas” which expose them to an uncertain situation that can push them into non-employment at any time. If employers are dissatisfied with migrants’ work they can simply dismiss them, thus converting them back into illegal individuals facing expulsion.

Secondly, the elderly pensioner she cares for may have such a low pension she might very well not be given a regular contract. In short, she is likely to be “informally” employed as a carer, without any legal safeguards, and thus officially “non-employed,” a contradictory status painfully typical of migrant women in Italy.

A complex segmentation of the market along gender and ethnic lines has thus arisen from an abundant supply of cheap migrant labour combined with a limited supply of specialized public services, raising issues of social equity and long-term sustainability. To sum up, analysis of Italian debates on the division of labour between the sexes reveals that policies tend to construct different categories of women as legitimately “non-employed”: working mothers discouraged from working by social security provisions, informal carers of all ages, migrant women working in the informal economy or regularized by emergency legislation to work in the care and domestic sectors, women with “flexible” or unstable jobs, penalized pensioners.

4.3. Defamilialization alongside deprofessionalization?

Since the second half of the 1990s, besides the increasing pressure of the social demand related to demographic change, several European countries have introduced a series of reforms aimed at providing support for the care needs of the elderly. These public programmes shared the objective of providing monetary transfers instead of services for

⁵³ Recent data, however, seems to suggest the increasing presence of a “‘care niche’ of male migrants, especially from Southern American countries, hired to assist older Italian men, [...] (Santini et al., 2010)” (Rostgaard et al., 2011: 140).

dependent persons, who could use the money received to employ care workers directly. The introduction of these programmes influenced the vanishing or the “blurring” – particularly in the field of home care – of the dichotomous distinction between unpaid informal care and formal paid care work. In this sense, the progressive delivery of public monetary transfers in favour of informal carers, the so-called “commodification” of care, have fostered this process. One of the main effects of the introduction of these programmes has been the development of “hybrid” forms of work and care. This was the consequence of two factors: on the one hand, the impact of monetary transfers in the informal relationship between cared and carer, mainly based on affect and emotion, and on the other hand the influence of love and feelings on the employment relationship, usually based on money and economic transactions.

Thus, the final result was that families became employers, but without any sense of the consequent responsibilities. Beneficiaries enter in the dynamics of the labour market, selecting care workers and influencing the structure and the characteristics of this segment of employment.

Analysis of these schemes can start from a theoretical distinction based on two hypothetical axes. The first concerns the type of provision (tied/untied money transfers) the second concerns the beneficiary (informal carer/not self-sufficient person).

Regarding the first analytical dimension, there are highly regulated cash for care schemes, with public programmes designed to ensure care workers are covered and protected for their social and contractual rights. In parallel, public control is provided through rules on the use of cash transfers received by beneficiaries.

On the other hand there are other cash for care programmes that allow a “free for all” situation. Beneficiaries who receive monetary transfers are not monitored in relation to the use of public resources obtained. These programmes, characterized by an almost total absence of regulation, foster growing use of illegal and/or irregular employment, which is not expressly prohibited or sanctioned. In this context, workers are frequently exposed to processes of marginalization and “entrapment” in precarious jobs characterized by high turnover and low wages, a working condition in which care workers’ social rights (e.g. the benefits related to employment status) are denied while they are exempt from social obligations and responsibilities (e.g. payment of taxes) as well. It should also be noted that some of the schemes considered, providing public resources to family members and/or relatives who were previously informal and unpaid carers, provide means by which care work is gradually being recognized and rewarded. Where it is possible to receive money transfers to support charitable activities undertaken by them, informal caregivers gradually take on characteristics similar to those of care-workers.

5. Issues regarding defamilialization of the cared-for

One of the main issues associating care with gender is *access* to LTC for men and women and in particular to formal domiciliary care. While in most European countries, women are more likely to be in residential care than men, they are also the main formal care recipients in the countries studied here. One obvious reason is that women live longer and more frequently on their own than men in their old age, they experience also more difficulties (chapter 5). They are also in less healthy condition than men. Access to affordable care, good in quality and sufficient in quantity is thus crucial. Yet barriers to accessing LTC are likely to be higher for women for various financial reasons.

On a strictly financial level, providing care has a direct impact on access to work and to career development. In her article Kotsadam (2011) argues that informal care performed by women has a negative impact on women's employment, and caring during working age can affect the ability to be cared for at a later age through a low level of pension. The individual risk of poverty for women is higher than for men in all four countries and women over 65 or retired are also massively overrepresented in the first deciles of income, their pensions being lower than men's.⁵⁴ These facts are likely to affect the level of take-up of paid care by women. As part of the low-income group, women over 65 evidently experience difficulty in accessing care, certainly when services are available on the basis of a (partial or total) out-of pocket payment. And yet, they are more in need of care from outside the household since unpaid informal care from inside seems to be less available for women, for demographic reasons.

In this context, cash for care with a free-use option (as in Italy) can be a real “top up” on low incomes and give a certain freedom to disabled people to have control over how they spend the money for care. The literature on cash for care schemes has focused on analysis of the impact of these programmes in terms of building choice capacity for users (empowerment). In particular, through the possibility of using the economic resources received to recruit workers directly, the beneficiaries would have a tangible and positive incentive to use tailor-made solutions, in an autonomous and independent way from the formal system and from the “rigid” supply of public care services (Morris, 1993). Potentially, however, cash for care can also be a multiplier of inequalities as it will be used more optimally by people able to exercise an enlightened choice (and also “exit” if needed) rather than vulnerable people or minorities, and by men rather than women in couples with a longstanding unequal gender relation (Rummery, 2009). It can also create a gap between those having already enough to buy a highly qualified offer at a high price on the market and those using cash as “routed wage” for relatives.

⁵⁴ See: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Income_distribution_statistics

Table 7.5: Principal characteristics of the defamilialization process

	Italy	Germany	UK	Flanders	Wallonia
Whose role is being reinforced?	Migrant women on the irregular market NPO	Women/family as carer and coordinator of care FPO Informal carer is more “compensated”	FPO Volunteers	Stable NPO for personal care and FPO for house help FPO (on domestic work) Informal carer	
Nature of the process:	<i>Pragmatic defamilialization with poor means, modest radical defamilialization through contracting out (family become employers) and commodification of care</i>	<i>Pragmatic defamilialization with modest means, efforts towards radical defamilialization through contracting out (family become employers) and FPO</i>	<i>Pragmatic defamilialization with poor/modest means, efforts towards radical defamilialization through contracting out (family become employers) and FPO</i>	<i>Radical defamilialization through commodification of housework alongside modest/strong radical defamilialization through NPO, growing interest in pragmatic defamilialization</i>	
family caregiver	Poor compensation but incentive for low skilled women to stay in care Poor support for combining work and elderly care	Modest compensation Unequal support available for combining elderly care and work	Some support available for combining work and elderly care	Some support available for combining work and elderly care	
professional/paid caregiver	Low state regulation Poor income	Partial regulation of the care market, poor income	Regulated professional; unregulated personal assistant, low income	High state regulation for in-kind, low income Efforts on regulation for vouchers	
cared-for	Affordable prices on the grey market but high dependence on family relations As consequence of the “non-employment” perspective, women are highly disadvantaged in their care “purchasing power” Some choice	Increased offer on body care Increased choice	Affordable for neediest through targeting Increased choice	Affordable through means-tested in-kind Increased supply Choice is not (yet) an issue	

6. Conclusions: Towards composite worlds of defamilialization

The other parts of this report have focused mainly on examining the measures governments have taken to increase the mass of care in response to growing care needs and in their attempts to contain the so-called “cost disease” (Baumol, 1967). These reforms have raised a concern for the way women will be affected by the choices made. Quasi markets and the related “commodification” of care may not amount to complete defamilialization from either of the sides that have been explored (Table 5).

We have made a distinction between “pragmatic” defamilialization (paying for care “that is already there” or to compensate for family care) and “radical defamilialization” (contracting out through services for potential personal assistants). In adopting this distinction, it is probably not sufficient to say that “the cash for care option defamilializes less than in-kind services” (which was our first research hypothesis). One has to distinguish between “radical” and “pragmatic” defamilialization and between “weak”, modest” or “high” levels of defamilialization in both universes.

Pragmatic defamilialisation has been a clear option for Germany, England and Italy, while efforts have been made in Belgium and particularly in Flanders. Countries have assigned more or less means to achieve this pragmatic solution and one has to bear in mind that inadequate means given to informal carers (“pragmatic defamilialization”) may have dramatic effects in the absence of any other more radical solutions and would end up, possibly, in “re-familialization”. This scenario is likely to happen in Italy and the UK (see also Chapter 8).

From the perspective of the family caregiver, the policy context is not very favourable to an efficient combination of caregiving and paid work, given that the “pragmatic defamilialization” scenario as it is currently being implemented has a very low emancipatory potential in all the countries under study. The set of measures involved in compensating for care or allowing carers to combine care and work seems to fall short of enabling “genuine” choices. Services for carers are still far from universal, thus reducing the possibility of adapting care-giving patterns not only to the needs of care receivers, but also to the needs of care givers. In relation to time for care, flexible working arrangements are discretionary and care leave is usually unpaid, characteristics that limit the effectiveness of these measures in enabling individuals to combine paid work with care responsibilities. Finally, the financial support directly available to caregivers is rather limited and consists essentially in the Carer’s Allowance in the UK and in Flanders. This income maintenance measure comes with very low social protection and is not compatible with well-paid work. However, the German long-term care insurance (LTCI) has had defamilializing effects for family carers as it implies an increased role for marketized home care services. Prior to the introduction of LTCI, families had fewer options, mainly involving considerable out of pocket expenses (or recourse to social assistance) or total withdrawal from gainful employment. Partially, the services available in the German care sector liberate family members from the full responsibility for care, but in-kind services do not cover all needs. In particular, domestic work is poorly covered. Moreover, as the time slots awarded are very short in the home care sector, activities at the heart of elderly care, such as providing emotional support and keeping company, are

widely left to the private or informal sphere. Of course, professional services unburden family members more than “cash for care” does. In general, collective funding is another way of unburdening families.

From the perspective of the paid carer, a trend towards more personalized services has not been accompanied by improvements in the status and pay associated with care jobs. This in turn restricts the autonomy of care workers, especially in the current context of active labour market policies that see wages as the best form of welfare. Regarding professionalization, German female care workers leave the domestic sphere to work in someone else’s private sphere, which implies a status quo in terms of the gendered ideas associated with healing, caring and helping (Voges, 2002). In other words, it induces a “normalisation” of the fact that the vast majority of personal services workers are women, caregiving being seen as incumbent on women as a matter of principle.

From the perspective of the care receiver, there is a host of issues regarding the extent to which relatives continue to be needed in order to coordinate care provision or fill gaps in formal provision. The growth of the service sector activated by the introduction of LTCI in Germany has triggered a process of defamilialization as the care receiver is no longer dependent exclusively on the family, but can also hire a helping hand from outside. Overall, the elderly in need of care can choose between hiring a professional caregiver and asking a member of the family to provide the care. But the genuine choice of care arrangements is focused on the needs of the cared-for, not on the informal unpaid carer. Tailor-made care as encouraged by the personalization agenda and, in general, by the rationale for user empowerment that is gaining audience in Europe, is likely to put pressure on the informal unpaid carer.

- Chapter 8 -

Transnational path departure An “open method” of comparing change in European home care regimes

1. Introduction

The comparative assessment of welfare systems has until recently been dominated by work that classifies various “*worlds of welfare capitalism*” according to the famous model of Esping-Andersen (1990). This approach – which is still very influential (see Montanari et al., 2008; Starke et al., 2008; Schustereder, 2010) – suggests that a welfare state as a whole exhibits a particular social logic, labelled for instance as “liberal” or “conservative”, which provides a long-standing macro-cultural rationale that infuses any given institutional set-up with path-dependency (Piersons, 2001). While the possibility of institutional change is not excluded, these set-ups have been viewed as exhibiting considerable inertia regarding their basic building blocks.

For some time now, however, there have been doubts over the utility of this approach. First, the comparison of entire welfare systems has been considered a futile undertaking since their internal differentiation is high (Mangen, 2004: 309; Harris, 2007: 3), plus there are problems with depicting entire nations as a “dependent variable” (Clasen, 2007). Secondly, welfare state models have been criticised for neglecting historical dynamics occurring beyond individual societies, that provide for “transnationality” in the design of social welfare provision (Kettunen & Petersen, 2011). Finally, critics have bemoaned that typical classifications of welfare systems do not account for what has been referred to evolutionary “contingency” (Kettunen & Pettersen, 2011: 7) or path departure (Pfau-Effinger, 2008; Ebbinghaus & Gronwald, 2011). The latter term denotes a movement by which contemporary welfare systems adopt features from other regimes. This reading is consonant with early observations on perceivable “*pathways of change*” (Daly & Lewis, 2000: 291) in the field of social service provision. More generally, it chimes with recent work on paradigmatic institutional change in various societal sectors (Streeck & Thelen, 2005; Mahoney & Thelen, 2009), and on what has been coined by Hall (1993) as “third order change” in a given field of public policy, that is, change going beyond gradual adjustments of a given welfare scheme and beyond a mere evolution of policy contexts.

In this report, we contribute to this line of reflection by arguing that, in the light of transnational political, economic and social transformations, contemporary dynamics of change do not, to some extent at least, follow the traditions of a given national framework. This may lead to international convergence, but also to new welfare mixes that maintain some distinctive properties while losing others. To endorse this hypothesis, we use the example of domiciliary care for frail older people in four European welfare systems and explore path-breaking change(s) over the last three decades or so. We refer to such a system as a home care regime shaped by a systematic interplay of institutional, organisational and cultural practices.⁵⁵ There are three reasons for choosing home care as an area for investigation: it sidesteps the “cash bias” of conventional comparative research on welfare systems; it permits us to address a distinctive sector, which facilitates comparative enquiry; finally, home care is a relatively recent branch of Western welfare systems, tightly connected to social change (e.g. evolving family models) and particularly dynamic because it is less entrenched in long-standing social policy traditions.⁵⁶ For the sake of simplicity, we consider the whole array of existing types of elderly care – nursing, additional personal care support, home help and befriending – and do not systematically differentiate our argument with respect to how the type of older people’s care is influenced by any given policy change.

Our methodological approach is inspired by what has become known as “open method of coordination” (OMC) in European social policy making. Basically, this approach is (meant to be) a technique to encourage representatives of nation states to embark upon a dialogue on public policy options across Europe; it is part of a normative agenda geared towards soft policy-making “that works”. While not delving into this normative agenda, we borrow from this approach in order both to retrace major movements of change in the aforementioned care sectors and to cross-check the nature of developments found in the different countries under study. By contextualising change before embarking on comparative analysis, we grasp transnational dynamics without losing sight of cultural specificity. This enables us to explore the degree of internationalisation (Europeanisation) of the welfare area under study.

The article is organised into three sections. We start by elaborating on the challenge of comparing (branches of) welfare systems in respect to the nature of their contemporary development. This section includes thoughts about the added value of the “adapted” OMC-approach for scientific enquiry, especially given the limitations in the comparative literature on evolutionary patterns in welfare systems. Secondly, we compare key traits and developments in four Western European home care regimes by providing “case studies” drawing on the national reports produced for, and discussed within, the aforementioned European research network. These case studies contain the most striking dynamics of change in a given country over the last three decades or so and feed into a cross-country assessment reviewing these dynamics in the light of the findings across all four regimes. The conclusion summarises our findings and discusses wider insights that can be inferred from this “open method” of comparing change.

⁵⁵ See Bettio et al. (2005). We are dealing with a “regime” as this interplay exhibits regularities and entrenched behavioural patterns, forming a particular “culture” which may evolve over time however.

⁵⁶ They may indeed be less heavily structured by these traditions than, say, the curative parts of the health care sector.

2. Comparing evolving welfare systems with an open method

Path dependency has been a widespread assumption in comparative welfare state analysis and remains a major rationale for analysing the evolutionary logic inherent in (branches of) welfare systems (see Cox, 2004; Ross, 2007; Trouvé et al., 2010). However, the political economies of major Western societies have evolved in very similar ways over recent decades, with new distributions of power and of economic influence as major features (Peters, 2011). The advent of the “competition state” (Cerny, 2010) and neoliberal discourse have left their foot-prints everywhere, regardless of remaining national idiosyncrasies (see e.g. Kus, 2006). Concomitantly, a number of social policy concepts have taken centre stage internationally, such as “activation” (Berkel et al., 2010), “mixed economy of welfare” (Powell, 2007) and “marketising” social protection (Frericks, 2011). Furthermore, the infrastructure of the welfare state has been remodelled internationally according to fashionable templates such as “New Public Management” (see e.g. Pollitt & Bouckaert, 2009). Last but not least, Europe has seen common patterns of social change, epitomised by what some refer to as the emergence of post-industrial social risks, especially those linked to changing (and more fragmented) models of family life (Bonoli, 2007).

In the light of this, the fate of national welfare models has to be scrutinised much more thoroughly, with such investigation going beyond statistical analysis (i.e. expenditure, replacement rates, generosity of allowances etc.). As mentioned earlier, there have been some attempts to conceptualise path-breaking change in welfare systems. Streeck & Thelen (2005) have argued that, nowadays, avenues to such change do exist although, in their eyes, various “deviations” were needed to make it happen.⁵⁷ An interesting question is whether such change makes welfare systems adopt characteristics which are alien to their national traditions – whether that is through the process of “policy learning” from abroad or through reforms imposed as a result of strong international (economic, political) pressures. The field of social care has sometimes been viewed as being particularly exposed to such mutations. Thus, Daly & Lewis (2000: 291), reviewing a number of welfare systems, not only saw an “*increasing significance of care as a sphere of social policy*”, but also what they referred to as a “marketisation” of something that for a long time had been organised outside the market sphere. Pfau-Effinger (2008), in her review of German family policies, equally found radical change in that the institutional set-up of the 2000s was no longer (fully) predicated on the traditional family (breadwinner) model. Instead, there was a creeping departure from this model.

That said, path-breaking change in home care regimes has overall not been a major subject of scientific, let alone, comparative, enquiry. So how are we best to assess path departure in this field? In methodological terms, the comparison of societal arrangements is fraught with the difficulty that nations represent complex cultural entities in which a social phenomenon (such as home care) has multiple backgrounds (Oyen, 2004). This particularly applies to social care sectors in which domiciliary care for older people is an integral part. These sectors are

⁵⁷ Such as: marginalised institutions becoming dominant; old institutions being “enriched” and transformed by new elements; and, institutional drift (or conversion) of (allegedly) non-working institutions.

embedded in a highly culturalised “life world” in which the understanding of taking care of someone, of assuming responsibilities, of providing “good” professional services etc. is very context-specific (Harris, 2007). Major dimensions of this complexity are both the role of family members in a given national culture and societal expectations regarding who is responsible for, or capable of, providing professional care. Thus, standardised research tools (especially large scale surveys), that reduce social life “*to a limited number of more or less objective variables*” (Valkenburg & Lind, 2002: 187), risk missing the important details required to make things comparable. Rather, context-sensitivity is needed when the aim is to develop a theoretical argument applying to more than one nation. “*Social phenomena must be studied in their specific national state context, and then compared with the same phenomena in other countries, taking into account that they must be interpreted in their own institutional setting and configuration of institutions*” (ibid: 192).

Context-sensitive comparison implies an “*inductive-exploratory strategy which combines discovering the relevant variables of the theory with the process of its confirmation*” (Nowak, 1989: 40). Our work started with such a theory, that is, regime change as path departure. The theoretical hypothesis was “tested” by both semi-structured investigation on evolving national care regimes and a “transposition” of findings from one national setting to other ones. Granted, this test does not conform to the requirements of quantitative models. However, while statistical data help understand the extent of institutional change, the distinctive nature of the latter has to be grasped by a process of enquiry in which knowledgeable researchers familiar with a specific cultural context are involved.

Interestingly, such an undertaking resembles an approach used at European Union (EU) level for triggering political dialogue between nation states about their particular traditions and prospects in social welfare provision, the so-called “open method of coordination” (OMC) (see Trubek & Trubek, 2005 or Büchs, 2007). Its purpose is to make governments engage with policy learning and streamlining their strategies across Europe. Created in 2000 as a working tool for EU institutions, the “open method of coordination” is geared towards generating shared knowledge and perspectives regarding existing welfare systems.⁵⁸ OMC includes the mapping of (evolving) institutional arrangements by indicators, with the identification of “best practice” as one objective. Typical instruments are national reports (sometimes feeding into “Action Plans”) and peer reviews, i.e. an evaluation of the provided information, with this type of investigation being orchestrated by committees or special working groups.

An essential element in this process is mutual consultancy, that is, the discussion of contextualised knowledge by experts from several countries. The eventual objective of OMC is to generate, at EU level, the convergence of ideas not only on “what works best” but also on what is valuable in terms of policy goals.⁵⁹ While this obviously is a normative agenda, it is predicated on the aforementioned “inductive-exploratory” inspection of institutional

⁵⁸ The method has been, or was to be, applied to various parts of the welfare system, that is, employment policies, social inclusion, pensions, education and health care provision.

⁵⁹ This is referred to as “soft law” as it is through this convergence of ideas, and not by hierarchical power, that guidelines based on a “new social policy vision” (Trubek & Trubek, 2005: 346) are formulated and implemented.

configurations and their evolution. In this sense, the idea behind OMC is useful for analytical purposes, too. Based on systematic intercultural exchange, this approach avoids the typical pitfalls of large scale comparative enquiry, e.g. non-sensitivity to the existence of functional equivalents regarding notions, concepts, actors and practices across different societies (see Mangen, 2004: 313). To grasp the distinctive traits and dynamics of care regimes accurately, the combination of this dialogical mode of knowledge sharing with a multiple case study design, both aimed at answering “how questions” (Yin, 2009), appears particularly promising.

In the European research project from which this article has emerged, an international group of researchers embarked upon such enquiry. The undertaking started by national experts mapping each given care regime to produce a (context-sensitive) “case study”, based on a number of mutually agreed research questions. While the information used for composing these studies was often quantitative, the research process included qualitative assessments of the meaning behind the (often highly culture-dependent) data. The group then proceeded to the second stage – the comparative analysis – by cross-checking the characteristics “synthesised” from the information provided by these case studies. This was accomplished by research colleagues from other countries discussing the national “case studies” during joint seminars. The researchers involved exhibited great sensitivity to unfamiliar welfare cultures, partly because they were foreigners living in the countries under study, and partly because they had been working in academia abroad.⁶⁰ Moreover, the research team was multi-disciplinary, thus ensuring an inter-linkage of approaches from economics and sociology.⁶¹ Hence, the international team embarked upon a variety of observations of the care regimes in other countries (Barbier, 2002: 195) in order to map cultural differences within a common analytical framework.

3. Home care regimes on the move: National case studies and their comparative message(s)

Home care has become a well-researched branch of Western welfare systems. The range of issues under study includes: developments in governance (Burau et al., 2007; Pavolini & Ranci, 2008; Gingrich, 2011); the socio-political organisation of home care including the regulation of care work (van der Boom, 2008; Haas, 2010); and the action of citizens and other stakeholders of (public) programmes for care provision (Le Bihan & Martin, 2006; Emilsson, 2009). The fruits of this research include valuable insights into the overly (pluralistic) architecture of the various home care regimes across Europe. Few studies, however, have focused on the nature of change occurring throughout these regimes, let alone comparatively.

⁶⁰ Even if English was the communication language, several members of the network had knowledge of other languages. The multiplicity of experiences within the consortium considerably helped clarify notions and detect functional equivalents.

⁶¹ While economists tend to adopt more of a “universalist” point of view – understanding the social phenomenon under study as related to inter-relationships independent from (national) cultural issues – their sociological counterparts are often geared towards interpreting facts within their encultured societal environments. Comparative research benefits greatly from combining these two perspectives (Barbier, 2002).

This section aims to synthesise the evolutionary dynamics in each of the four home care regimes of the countries under study and to explore how they relate to developments in other regimes, including those that do not have the same “traditions”. Synthesising movements of change means identifying basic developments without elaborating in greater detail or exploring their wider origins (both of these facets being covered in work published elsewhere by group members’).⁶² The analysis is confined to a small number of countries exhibiting different welfare state traditions. The sample includes most (but not all) of those welfare regimes that, in the well-known “worlds-of-welfare-capitalism” or “families-of-welfare” accounts, appear as distinctive models: England (often deemed a “liberal” welfare state); Germany (representing a “conservative” or “corporatist” tradition); Belgium (which, in terms of social service provision, demonstrates a second type of corporatism); and Italy (the “Mediterranean” model). The Nordic case, abundantly studied by the existing literature, is not included in our comparison. This lacuna⁶³ should, however, not prevent us from demonstrating the utility of our approach and from “testing” our theoretical argument.

We will first provide brief sketches of the four home care regimes under investigation. These sketches are presented as “case studies” organised according to the open method depicted above. Four questions have oriented our investigation: Who provides care? Who pays? How is care organised and controlled? Which kind of substantial change is observable, including evolution in institutionalised “social practice”? In a second step, we review the findings from our case studies comparatively and explore the extent to which path departure, involving the adoption of elements found in another “family-of-welfare”, can be observed in the different countries.

3.1. Germany⁶⁴

Family-provided care for older people has always been a prominent feature in Germany. Based on a “breadwinner” model that is deeply entrenched in the culture of the country, the bulk of the frail older population traditionally received care from spouses and daughters, with residential care provision being viewed as a solution of last resort. While this societal arrangement – often referred to as conservative (corporatist) – remains anything but outdated⁶⁵, the last 20 years have seen some important institutional developments. From the 1970s onwards, professional domiciliary care, provided by municipal or (often faith-based) non profit agencies, began to be available to some sections of the population (mostly those without local family relations). From the mid-1990s onwards, an ever greater proportion of senior citizens obtained access to domiciliary care provision.⁶⁶ A major trigger was the introduction in 1995 of long-term care insurance (Gesetzliche Pflegeversicherung). This

⁶² See e.g. Fernandez et al. (2007), Bode (2008), Simonazzi (2010), Nyssens (2010) or Breda et al. (2006).

⁶³ This is due to the team structure of our research project

⁶⁴ This section largely draws the CROME report for Germany (Bode & Chartrand, 2011). An encompassing overview of the German system (including key figures) is provided by Rothgang (2010).

⁶⁵ In 2009, 45.6% of those receiving benefits from long-term care insurance were cared for by relatives exclusively – against 55.9% in 1995.

⁶⁶ Between 1999 and 2007 the number of users increased by about 20%.

scheme draws on the corporatist model but introduced “capped” lump sum payments for care packages awarded in line with assessed needs. Thus, care services provided by professionals vocationally trained in (ordinary or geriatric) nursing became more widespread.⁶⁷ Hence the German care regime has seen a process of partial professionalisation.

Services have remained concentrated on personal (body-related) care, while home help is poorly developed. Even today, household-related assistance is widely organised via casual jobs or in the grey labour market. Such jobs also cover the monitoring of older people affected by dementia, although long-term care insurance has since 2008 funded some hours of domiciliary attendance and there are government plans to extend this further from 2013 onwards. Where 24-hour provision is needed, illegal immigrant care workers have grown in number. Importantly, long-term care insurance offers a cash for care option (Pflegegeld), making Germany an international forerunner in the creation of largescale direct payment schemes. Although family support still prevails, these payments are increasingly used to pay professionals for a specific selection of care services. The overall trend, therefore, has been fuzzy defamilialisation.

Only the very poor enjoy enhanced public coverage on the basis of means-tested social assistance (Hilfe zur Pflege), managed at local level (mostly by contracts with established care providers). For most individuals in need of home care, the situation now is very different from what was on offer in a few places during the 1980s,⁶⁸ when funding was available for a large(r) range of services (including home help and befriending) through block grants to provider organisations holding a local monopoly. This type of provision was abandoned in 1995 with the introduction of long-term care insurance. Since then the overall trend has been towards a more universal, albeit capped, funding system that requires considerable private co-investment (in cash or as informal care from a family member).

Users or families looking for professional support are now able to contract a provider of their choice. There is a fragmented landscape of non profit and for-profit providers, with the latter representing 60 per cent of the market in terms of number of providers. The economic risk lies with the suppliers, which are independent as regards their market strategy but have to respect a number of formal standards (minimum skill levels for staff; provisions relating to the care packages; documentary obligations etc.). In earlier times, social services in Germany were mostly delivered by non profit agencies, after mutual deliberation with local welfare departments and with considerable financial security for these providers. This was typical of a “corporatist” mode of governance (Bode, 2011). In contrast, today all providers are exposed to competitive pressures, with a permanent risk of incurring a financial loss. There is detailed public regulation, including a highly formalised system of quality control (with provider visits, standardised output checks, school marks etc.) carried out by public agencies. Overall, the major trend has been controlled marketisation, due to the deregulation of the supply structure.

⁶⁷ Less than 10% of all workers in domiciliary care have no formal qualification.

⁶⁸ Germany has a highly localized welfare state when it comes to the provision of social services. The introduction of long-term care insurance put an end to this in the field of elderly care (except for those on lowest incomes).

It is clear that the German configuration exhibits important dynamics of change. In the light of what has been emblematic of the corporatist model elsewhere in the welfare system, and what has initially influenced the architecture of older people's care provision, path departure becomes discernable. We can identify: (fuzzy) defamilialisation; partial professionalisation; a collective funding scheme featuring capped benefits and private co-investment; and controlled marketisation. All of these appear (more or less) alien to major traditions of the German welfare model, especially if compared with the health care system.

3.2. England⁶⁹

Home care in England exhibits a long-standing professional base, with municipal care plans⁷⁰ and domiciliary support systems, as well as home nursing (delivered by the National Health Service (NHS)). Hence, as early as the 1960s, provision of personal care including home help ceased to be left to the family, although most publicly funded services were targeted at the poorer sections of the population. This approach is typical of "liberal residualism" in social welfare provision. With an employment rate of women above the European average, the traditional model of family care was less common than, for instance, in Germany and Italy.

Funding for professional services (and direct payments) in England comes from the central state, with entitlements to domiciliary care (apart from NHS home nursing) being means-tested at the local level. Beneficiaries must often contribute co-payments, and wealthier citizens may have to organise and fund services on their own. In recent years, the provision of publicly-funded personal care has concentrated on individuals with the greatest need, including those living alone. Hence, private responsibility has been extended, especially for households with an income (just) above the poverty level. Moreover, in line with a policy agenda that emphasised "consumer choice" during the 1990s (Comas-Herrera, 2010: 380), citizens entitled to publicly funded services became entitled to opt for a "direct payment" (personal budget) which could be used to employ a personal assistant other than a relative, instead of receiving services arranged by a local authority case manager. This type of direct payment is currently on offer to all care users through the "personal budget" scheme, which also allows for case managers to persist in their role as counselling agents or even to take on employer responsibilities. With those eligible for public benefits free to "purchase" the assistance of their choice, they may prefer lay help (neighbours, friends, personal assistants) over formal services which would lead to further deprofessionalisation. Moreover, support under this scheme resembles other forms of informal care insofar as it is not necessarily organised as full-time employment covered by more than basic social protection schemes (such as pensions etc.). Thus, after a period shaped by a shrinking burden left to relatives, a general tendency towards re-familialisation (and "informalisation") has appeared in the English home care regime.

⁶⁹ This section draws the CROME report for England, see also Comas-Herrera et al. (2010).

⁷⁰ Local authorities remain responsible for organising the care system, although many national standards apply.

Until the 1990s, services were primarily provided by local authority (in-house) providers as a part of the public sector. Importantly, the community care reforms of the 1990s had brought a pluralisation of the provider landscape which is nowadays dominated by the “for profit” sector. Nowadays, suppliers compete for both free-market clients and for (mostly spot) contracts with care commissioning bodies run by the local authorities. That said, this development of quasi-markets has gone alongside the establishment of standardised top-down control of providers. Thus, the Care Quality Commission was created as an independent regulator with a remit to register care providers and organise monitoring and inspection. Meanwhile, given the aforementioned trend towards personalisation, government-run user surveys are meant to provide a key mechanism for outcome control. Altogether, the quality inspection policies drafted in England bear witness to enhanced interference of the welfare state in the process of care provision even though the recent personalisation approach may set limits to this.

Regarding the dynamics of change, some of the aforementioned developments sit uneasily with the liberal tradition of the UK welfare system. This was the case with the devolution of care provision onto a pluralistic set of providers, given that direct state responsibility for providing welfare to the poor had always been endemic to this tradition. Path departure is even more obvious regarding tendencies towards re-familialisation and growing statutory interference in the area of quality control. On the other hand, the deregulation of the supply structure via the creation of quasi-markets and the extension of individualised budgets can be viewed as a radicalisation of the liberal model.

3.3. Belgium⁷¹

In line with a “corporatist” organisation of social welfare provision, home care in Belgium has seen strong opposition towards explicit forms of deregulation or liberalisation. The organisations that still dominate the landscape, mostly associations linked to mutual benefit societies, historically provided home care to large working class families. In the 1980s, they started to focus more on older people’s care.

The sector is largely shaped by the supply side. Regional governments grant an annual subsidy to agencies admitted to the system. Historically, the repartition formula has favoured the big monopolistic “not for profit” organisations. Since the 1980s, new criteria have been introduced, but the expansion of the sector has been controlled by public authorities which set strong limits to competition between providers. This overall configuration can be referred to as a “tutelary regime”. The accreditation procedure implies that providers have to belong to the public sector or to the “not for profit” sector (association) and are subject to a number of explicit quality (input) norms, including for the quality of employment. Care workers must complete a minimum level of training and have obtained a specific certificate. Moreover, an assessment of the user’s needs (done internally by the provider) is required. In the north of the country, a quality assurance scheme has been introduced (with mandatory service

⁷¹ This section largely draws on reports the Belgium teams have drafted for the CROME project.

documentation and inspections), obliging providers to implement self-evaluation procedures. There is, then, a movement, until now limited to Flanders, towards stronger output control through the imposition of quality assurance schemes on providers.

Regarding employment quality, at the end of the 1990s, home care suppliers became allied with other providers in order to build a (common) private non profit sector able to speak with a common voice and to negotiate with regional authorities over issues such as funding and the improvement of working conditions. With the involvement also of trade unions, these tripartite negotiations lead into a collective agreement through which the salary of a home care worker was raised significantly.⁷²

Moreover, a service voucher scheme (Titre-service), focused on home help was introduced in 2001. Its strong take-up during recent years is at odds with the corporatist legacy of the system of social care provision in Belgium. At the same time, it conforms to the concept of formalised care, since the Belgian scheme (unlike the one created in France) excludes direct employment contracts between the provider and the client. The home care provision thus exhibits a two-tiered structure with the voucher scheme on the one hand and the traditional mode of regionalised care provision, on the other.⁷³ While the voucher scheme reinforces formal care provision, it does create a new care labour market based on low skills and modest pay.⁷⁴ In the regionalised care provision, a marketisation of home help has taken place.

Following the introduction of the voucher system, the arrival of “for profit” providers in the home help sector means that the sectoral monopoly of the traditional providers has been broken. When home help staff are recruited by an accredited provider and via the service voucher scheme, no formal qualification is required. Thus, Belgium has seen the rise of a casual job care market, in a situation where job quality among workers in the traditional segment of the home care sector was already under pressure due to professional fragmentation.⁷⁵ Given that a Federal Care Allowance (Allocation pour l’aide aux personnes âgées) has already existed for several decades, a further innovation in the sector is the introduction of cash payments that allow the recipients to employ their own personal assistants (Vlaamse zorgverkering) (Breda et al., 2006: 155). This measure opens the possibility of using the “natural” care environment as the primary resource, with professional care coming on top of this. To date, this development is limited to Flanders, however.

⁷² The status of the “home care worker” is achieved after 1000 hours training. Non-profit providers (mostly associations) have been very keen to create this norm and to make it recognised by regional authorities.

⁷³ This corresponds to the distinction between the status of a “home care worker” and the one of the “voucher worker”, with the latter not requiring any formal training.

⁷⁴ When the voucher scheme was launched, the employer could sign an unlimited number of fixed term contracts and hire workers for less than three hours per day. Collective agreements have since been set up, but the working conditions are still modest (in particular regarding work seniority which is limited to two years).

⁷⁵ In addition to the traditional “home care worker”, new professions have been created, specialising in paramedical treatment, home keeping or house cleaning. As a result, the labour market has been segmented. With the invention of “health care assistants”, most of those willing to be trained as care workers prefer the health care assistant qualification since it permits access to institutional and hospital care as well.

3.4. Italy⁷⁶

Public intervention in the field of long-term care has traditionally been limited in Italy, with the bulk of care responsibilities being incumbent on families. However, since the beginning of the 1990s, there has been a shift from informal unpaid family care to informally paid care services. As Bettio et al. (2006: 282) argue, a “*complex division of labour has developed whereby family carers (mainly women) provide coordination, while the task of minding is entrusted to the female immigrant, and more skilled as well as prevalently native workers – private or public – take on paramedical tasks where and when needed*”. It is this strong reliance on the grey labour market that characterises the “Mediterranean care regime” overall. The importance of informally paid home care, and the distinctive characteristics of such a care market, materialised most clearly when a general amnesty for undeclared immigrants was decided in 2002/2003.⁷⁷ New legislation introducing stricter rules on the residency of non-EU foreigners in Italy had created a need for such an amnesty to cover those illegal immigrants already working in the country, both in industry and domestic work.

Whereas illegal workers have always represented a significant proportion of the overall labour force in Italy, the role played by migrant carers had become conspicuous in the years preceding the implementation of the amnesty.⁷⁸ Following the new legislation, 750,000 applications were submitted, half of which concerned care workers. As the number of registered workers in the domestic sector in 2002 amounted to less than a third of this, the prominence of the grey labour care market was made very explicit. The proliferation of foreign personal assistants has been an important “push factor” regarding new career opportunities for two traditional categories of care workers.

Since the 1990s, the issue of older people’s care has been increasingly high on the political agenda. A policy that has spread across several regions (especially in Central and Northern Italy) has been to grant direct payments to older people living at home, in order to reduce the demand for both institutional care and for home care services. This is a care allowance (Indennità di Accompagnamento) which is needs-tested and funded by the central state. Local care allowances (Assegno de Cura), which are in addition to the national allowance, have always been means tested, although a variety of eligibility criteria exist. Assegno de Cura may be distributed through voucher program and a tax-refund scheme, both used to regularise irregular workers. Hence we can spot an incremental movement, with high diffusion in the Centre-North regions, towards the “normalisation” of semi-formal home help in private households. While this monetary support has not been a perfect remedy for care-dependent older people, it has provided some relief, given the low availability of formal care services in this country.

The existing formal care provision is organised around the ADI (Assistenza Domiciliare Integrate), which is meant to ensure both the delivery of health care services (including

⁷⁶ This section is largely based on analyses provided by the Italian research team involved in the CROME project.

⁷⁷ This concerned 316,000 people.

⁷⁸ In the tax-deduction scheme applying to “declared” domestic services (introduced by the Italian Financial Legislation), a carer on a regular contract would cost about 40 per cent more than an irregular worker, a percentage that varies depending on the tasks, nationality, working time, and the conditions prevailing in the grey market.

medical treatment, nursing, rehabilitation) that are managed by local health agencies, plus some elements of social support (home care, meals on wheels, etc.) that are provided by municipal service agencies. Since the 1990s, Italian municipalities have tended to organise home care services (SAD Servizio di Assistenza Domiciliare) by public tenders, thereby contracting-out service provision to social cooperatives (non profit organisations). In order to foster competition, there have been considerable efforts to develop both a training market for family assistants and an accreditation procedure that applies to all sorts of providers. Thus, the Italian care system exhibits a tendency towards a quasi-market model of older people's care provision, alongside demand-driven privatisation through the voucher scheme.

Table 8.1: Key characteristics and developments in European home care regimes

	Germany	England	Italy	Belgium
Who provides?	families and (to a lesser extent) independent providers	independent providers; families/informal or semi-formal carers	families and workers in the grey labour market; organisations (to a lesser extent)	formal non profit providers for home care; independent providers for home helps
<i>Dynamics of change</i>	more professional domiciliary body related care	extension of private and family responsibility (<i>re-familialisation/informalisation</i>)	"normalisation" of informal care work in the family, some professionalisation	blurring boundaries between home care and home help; fragmentation of care occupations
Who pays?	long-term care insurance (sometimes plus social assistance)	the national state and municipalities (for poorer sections of the population)	the national state; municipalities (at low level)	regional funds (home care); national funds for vouchers and attendance allowances
<i>Dynamics of change</i>	growing but capped funding	growing focus on high need cases and on cash for care	increasing use of cash for care (national level) and (by local authorities) of care allowances as tied aid aimed at encouraging the regularisation of irregular carers	diversification of public funding and more direct payment in Flanders
How is care organised and controlled?	quasi-market with free consumer choice (non-profit/for-profit provision)	Free individual agency and quasi-market run by local authorities (non-profit/for-profit provision)	grey market economy; public sector and quasi-market	"tutelary" provision for home care; quasi-market for the voucher scheme (regarding home help) for others
<i>Dynamics of change</i>	deregulation of supply structure, with increasing market governance	stronger statutory (quality) regulation (following marketisation), shrinking coverage	marketisation (accreditation; provider competition) and "normalisation" of grey work	self-evaluation and quality insurance (Flemish Region); "normalisation" of grey work (voucher scheme)

Overall, the Italian home care regime has developed a semi-formal model endorsed by monetary transfers to families and some increasingly quasi-market service supply. Thus far, the system of professional long-term care services fails to cover the care needs of large sections of the population. Middle-class users in particular, whose income is not low enough to be eligible for support from local public programmes and for whom the existing professional long-term care services are neither adequate nor affordable, are left to the private care market. The overall system is therefore heading towards one where cash and “tied cash” will play a greater role in dealing with the grey market.

3.5. Evolutionary dynamics from a cross-country perspective

The key characteristics and dynamics of change found in the “case studies” (see Table 1) can be compared from a cross-country perspective, using our “open-method approach” (Table 2). It is clear that the home care regimes that we have studied nowadays embrace elements that belong to different traditions from those normally associated with each individual welfare system. Thus, Germany has adopted the “market-friendliness” of the liberal model, including limits to the collective responsibility (e.g. capped funding) and a deregulated supply structure. At the same time, its home care regime exhibits movement towards the defamilialisation seen in liberal (and other) worlds of welfare capitalism – although this movement appears imprecise, not least because the shrinking role of family provision is partly compensated for by the “Mediterranean” approach to grey informal care. Simultaneously, Germany has seen a marked tendency towards professionalisation, with institutionalised home personal care, delivered by qualified (older people’s care) nurses, clearly expanding and recently covered by a minimum wage regulation. In this respect, it approaches (corporatist) Belgium where the role of professional care was strong from very early on.

The English care regime, traditionally based on public intervention for poorer sections of the population, has seen a movement towards greater state interference in one particular respect, namely quality regulation. Here, functional equivalence with the (corporatist) Belgian “tutelary regime” is discernable. Furthermore, the pluralisation of the provider landscape, the creation of cash for care payments and the tendency towards refamilialisation all make the UK care regime approach the German tradition that is corporatist but familiaristic. In England, the care sector has faced difficulties in recruiting native workers since vacancies have been mostly for jobs characterised by low pay and limited job quality. These jobs have often been filled by foreign-born workers. This situation comes close to the Mediterranean model, and starts to mirror the high fragmentation and poor regulation in the Italian care labour market, with low qualifications and specialisation among care workers, especially foreign immigrants providing “undeclared” support.⁷⁹ That said, care employment is often illegal in Italy, in contrast to England.

In Belgium, there is neither a system of quasi-market commissioning nor any procedure for benchmarking suppliers for home care. However, quality assurance schemes have been

⁷⁹ See Simonazzi et al., 2011: 4.

imposed on the latter in Flanders. This *de facto* is a first step in towards quasi-market public tendering and epitomises the influence of the liberal (English) model. The same holds for the introduction of the voucher scheme (for home help), creating a large unskilled labour market. This overlaps with the more recent Mediterranean approach towards semi-formal care work in private households, which is driven by the intention to regularise the greater part of the irregular workforce. Moreover, in the search for ways to become more entrepreneurial (in terms of organisational innovation), Belgian providers, like their German counterparts, are also becoming exposed to increased economic risks.

Regarding Italy, the goal of containing or “civilising” the grey care market, has led to attempts to create a regulated quasi-market for the employment of family assistants. To this end, the use of vouchers and cash allowances by local authorities, and the increased role of training, reminds us of the liberal model. At the same time, when it comes to the still small segment of professional care providers (often social cooperatives), the creation of new and longer training routes *de facto* draws on strong corporatist employment norms such as those in Belgium. Moreover, the emphasis on providers’ accreditation indicates a tendency towards greater provider diversification which is symptomatic of the German approach to professional care provision.

Table 8.2: Dynamics of change in a cross-country perspective

Adopting from:	Germany	England	Italy	Belgium
Germany		market-based regulation including quality control; <i>(initially)</i> <i>de-familialisation</i>	grey care work	professionalism (in personal care), together with (partial) <i>defamilialisation</i>
England	provider pluralism and direct payments, <i>re-familialisation</i>		low-quality jobs; “home care industry”	some more professionalism (by quality control)
Italy	involvement of the non -profit sector, direct payments	quasi-market control over care provision		professionalisation of formal (social cooperative) care workers
Belgium	hybrid form of (non-profit) care providers, direct payments	output quality control (Flanders)	“normalisation” of grey work (home help)	

4. Conclusion

Is there a case that a transnational movement towards path departure from long established welfare state traditions has occurred in the countries in our study? By embarking on an “open”, network-based comparative investigation, this chapter has provided a comparative assessment of four different home care regimes, with a particular emphasis on the recent dynamics of change. While our analysis has not dwelled on the distinctive historical trajectories of each care regime, it has demonstrated the additional value of moving away from comparisons geared towards the discovery of different national (regime-type) patterns and related classifications. Based on a context-sensitive and interactive research process, it has provided evidence of path dependency being overlayed by path departure transnationally. This not only pertains to the international rise of welfare markets and related cash for care schemes, but also to fundamental organisational issues including the role of professionalism and informal care.

The overall evolution appears quite indistinct. Thus, Belgium maintains the orientation towards professionalised care while introducing low-quality jobs in some segments of its care regime. English care policy remains eager to control quality while at the same time leaving assistance tasks to low-professionalised providers or, more recently (with the transition towards individualised budgets), to lay people. Moreover, a given movement of change that at first glance appears to resemble developments in other countries does not necessarily exhibit the same characteristics when considered in more detail. There are different varieties of marketisation, defamilialisation and (de)professionalisation in Europe, with varying impacts on care provision.

However, the development of home care regimes is at some point indicative of path departure in all countries under study here. Sometimes, this departure is partial and tentative (Italy and Belgium); sometimes it is more obvious (Britain and Germany). A case in point is Germany facing defamilialisation (together with partial professionalisation), marketisation and an emphasis on private responsibility (including consumer choice) in older people’s care – with all these shifts indicating some fundamental differences with traditional sections of the country’s welfare system. England seems to be moving towards factual refamilialisation (or informalisation) which may be interpreted as path departure as well. The same holds for the partial intrusion of the state into care service provision for individuals other than the poorest in the population, especially through the regulation of service quality. As to Belgium, part of the home care sector is moving towards a quasi-market environment for home help services, while Italy has seen attempts to develop both diversified professional services (partly in a quasi-market environment) and semi-formal, defamilialising, employment in private households, with the former representing a more obvious path departure. Overall, there seems to be an incremental movement towards European convergence. At the very least, our findings help to assess in qualitative terms “*in what ways ... welfare states (are) becoming more similar*” (Starke et al., 2008). Among those characteristics that have crossed borders, the proliferation of both cash for (market) care schemes and of a certain level of formal (more or less professionalised) services are most salient.

This is not the place to elaborate on the precise reasons behind the blurring of (welfare) regime boundaries. The elements mentioned earlier, such as transformations in the political economy and social change related to the gender contract (both international in kind), may play an important role. While the conceptual borrowing from OMC in this article was not predicated on the idea that transnational path departure originates in transnational (European) policy making, OMC may contribute to engendering a “cognitive consensus” (Jacobsson, cited by Trubek & Trubek, 2005: 351) over how to (re)organise long-term care. Indeed, “*soft law may be harder than you think*” (ibid: 356) in the sense that regulatory concepts become denationalized and popular internationally. At the least one can say that the contemporary agenda for reorganising home care regimes seems to be largely international in kind.

- Annex 1 -

Methodological guidelines of the research

1. Introduction⁸⁰

Over the last twenty years there have been two trends of very different nature in most European countries which, combined, have deeply influenced social policies in the field of home care. The first concerns the phenomenon of “ageing in ageing” (Eggerickx et al., 2001) that has led, in the space of a generation, to the emergence of new needs in terms of care for people and to an increase related demand for services (Deliège et al., 2005). The second is the generalisation in terms of governance, of the injunction to “new public management” (Pollitt, 2007). This term refers to the ongoing reforms since the 1980s that were translated in different ways across Europe; with an introduction of market principles within the public sector, such as the client-based approach in public services or the management of services and organisations via an ex-post results’ evaluation (outputs), instead of a management through the ex-ante allocation of funding (inputs). Indeed, this latter type of funding as well as these organisational arrangements were criticized for generating productive inefficiencies (too many resources used for the system’s administration), allocative inefficiencies (inadequate consideration of the users’ interests) and unfairness (McMaster, 2002). In this context, quasi-markets is considered as an instrument targeted to greater efficiency of the public service. Although the concept of quasi-market is far from being monolithic in the literature (Bode, 2007), it is mainly characterised by a separation between the roles of funder and provider (Le Grand, 1991): the State often continues to assume the financing of services, but it is no longer the single provider. Other providers, belonging to the public or the private sector, whether for profit or non-profit, can provide the service.

Definitions

In this research, **care** designates the activities and relations involved in meeting the physical and emotional requirements of dependant adults and children. Those requirements can be temporary or permanent, as in the case of individuals whose condition requires constant supervision (long-term care).

Long-term care is defined as “*a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL) (...)*” (Source: OECD Health Data, 2009).

⁸⁰ For a more detailed landscape, see: Gardin L., Nyssens M., (2010) Les quasi-marchés dans l’aide à domicile: une mise en perspective européenne, *Annals of Public and Cooperative Economics* (To be published).

In this study, we will focus on all services - except the pure medical ones - and public schemes which contribute to maintain frail adults at home: home care (including house work and meals on wheels), coordination structures, day care, home nursing and services supporting care-givers, cash for care schemes...

In the field of services to frail adults, quasi-markets have led to a reorganisation of the supply. The UK has been a pioneer in introducing quasi-market regulation in its home care services but all European Welfare States have experienced, at varying degrees and in original ways, this trend in their social policies. Quasi-markets are now a widespread institution across Europe. One can identify the following transformations.

2. The establishment of tenders for service providers

2.1. A highly standardised home care quasi-market in the UK

In the UK, since the major reforms implemented in the 1990s, a central role has been assigned to the 150 English local authorities, who are now responsible for managing social services and particularly home care' services. To do this, they receive income from a national fund, plus resources from the local taxes. The care manager, cornerstone of this scheme (Knapp et al., 2001), is responsible for assessing the needs and resources of the user and then to develop an appropriate response plan, funded in part by local authorities and partly born by the user according to his/her financial situation. Local authorities are issuing tenders to select the service providers, whether public, private for-profit, or private non-profit. Since 2004, these providers must meet standards set at the national level by the "Commission for Social Care Inspection" (replaced now by the Care Quality Commission), which provides unified and standardised norms regarding the management of the quasi-market. In 1996, a system of direct payments has also been introduced, funding allocations to users rather than providing direct services. This system being underutilised, the Government introduced a pilot program of "individual budgets" in 2006. It allows the user to receive a mix of cash allocations and services in kind.

2.2. The marketization of home care based on informal care and on heterogeneous local quasi-markets in Italy

In Italy, the 328/2000 Act defines the framework of the "integrated social services system" and the respective roles of central government, regions and municipalities according to a principle of subsidiarity. This law promotes, among others, home care for frail adults and

provides a series of procedures in order to involve a diversity of actors in the service (private for-profit, social cooperatives, volunteers, religious organisations, etc).

However, large areas of autonomy have been left to regions and municipalities, especially in the implementation of the services. The regions are responsible for the distribution among municipalities of funding from the central State (which they possibly complement), as well as for the conditions for the approval of service providers. Municipalities, alone or in partnership with other municipalities, establish the budget, the type of services to provide and are responsible for tendering. They define the criteria for selecting the providers and signing contracts with the accredited providers. The system is thus characterised by the fact that the municipality is responsible for regulating and funding social services, which are then outsourced, for the majority of them, to social cooperatives.

Monetary benefits (“*assegni di cura*”), from the budget of the National Fund of Social Policies, are targeted to low-income families who take care of a dependent person beyond 65. Municipalities are involved in their management, particularly regarding the allocation of the budget. The unequal and fragmented distribution of this system has led to the development of a large sector of services financed by the user – private for-profit and non for profit service, including undeclared work provided most often by migrant workers – which is by far the greater part of the industry of home care.

3. The establishment of competition between providers through the funding of the demand

Belgium and France are experiencing the introduction of competition between service providers generated by a funding of the demand. However, the targeted services as the financing arrangements of this type of quasi-market are not identical in each country.

3.1. The service vouchers (“*titres-services*”) in Belgium: a quasi-marketization of house work embedded in a tutelary regulation of home care services

In Belgium, the 20 July 2001 Act established the service voucher (“*titre-service*”) at the federal level. This Act is driven by an objective of job creation. The service voucher targeted primarily at house work activities, that is to say those with low relational dimension. A variety of providers coexist in this field from the public sector, the private profit, or the social economy (non profit organisations, social enterprise, etc) , pursuing goals of integration of low qualified people or home help of frail adults. A noticeable difference with France is that the Belgian service voucher excludes direct employment contracts between the provider and the client.

But the objective of the implementation of such a quasi-market, unlike other countries, is not, at least in principle, to replace home care services targeting vulnerable users for which access is conditional to a needs' assessment. In this field of home care, providers (non-profit organisations or municipalities "Public centers of social action") are regulated through a tutelary regulation by the regional level based on the inputs' regulation. This regulated activity is limited by a quota far below the demand, so there is, de facto, no competition between the providers. Some of these providers decide to enter the voucher service market, wishing to be present in order to watch a potential deregulation of the sector of home care (Nassaut et al., 2008). They are thus at the crossroads of tutelary regulation and quasi-market regulation.

A special feature of Belgium is its dynamics of decentralisation. If the service voucher is located at the federal level (because it is related to the employment policy), home care for dependent persons is a regional responsibility. In this context it is interesting to analyse how regional dynamics are combined with federal regulations. Flanders, for instance, has introduced care insurance in 2001, funded as a special risk.

3.2. Dependency insurance in Germany, establishing a regulated market of care – primarily para-medical – services

With the introduction of the dependency insurance in the mid-1990s, Germany has been a pioneer. About 90% of the population pays contributions according to their wages, while premiums are paid according to the needs assessed by para-statal agencies. The socialisation of risk is only partial since the insurance only covers part of the expenses, to pay the uncovered part, the users may, in some cases, may require welfare assistance.

The law introducing dependency insurance has broken down the monopoly of non-profit providers, opening the field to for-profit providers. Users choose their provider. However, providers' negotiate at regional level, with government's or semi-public bodies conventions establishing standards of quality and pricing that are identical on a given territory. It should also be mentioned that the allocation in cash to caregivers at the home is extensively used in this country (Bode, 2008).

The current debate focuses on the question of quality of home care service funded by the dependency insurance and provided as a standardized service that focuses on para-medical care at the expense of the needs of non-para-medical care, which is only slightly covered by the existing system. Inspection of providers has been strengthened to better control the quality of the provided service. In addition, it is planned to change the evaluation system of the needs to take better into account the non-medical needs of frail seniors.

4. Analytical framework and research questions

In this context, the main objective of the research is to study the response of European states to the needs of home care, starting the analysis from the reforms they have undertaken over the past decade in this field. We want to identify patterns of evolution of contemporary *regimes of care* in light of these recent changes and, more specifically, in relation with the context of growing marketization.

Care regime

Care regimes bring “*care (caregiving and carereceiving) at the center of analysis of Welfare State*” (Knijn & Kremer 1997: 328) and can be considered as a kind of “*general picture of the infrastructure of care*” (1997: 329). Care regimes are the “*caring dimension of the Welfare State*” (1997: 335). This dimension includes the right to receive care (measures in favour of home based care) and the right to time for care (exemptions from the obligation to work, payments for care, care leave, part-time work (in order to ensure work-life balance). For Kofman and Raghurma “*care regimes can be conceptualized as the institutional and spatial arrangements (locations) for the provision and allocation of care*” (2009: 4).

The analytical power of the concept of care regime comes from putting side by side: public policy measures directly or indirectly oriented towards care; and informal practices. It permits to underpin an overall consistency in terms of strategy of each country in terms of care organisation and regulation. It also seems particularly effective for making comparisons between states and, according to their similarities or differences on various levels - from practices to institutional regulations -, to facilitate their classification within a typology.

Care regimes, in an early article by Lewis & Hobson (1997), refer to the situation of single mothers in different welfare states in Europe in terms of socio-economic resources. Bettio & Plantenga (2004) extend the concept which now covers all actors and devices that contribute to provide assistance to people. They distinguish care regimes by their preference for formal or informal care. Although the border between the two is porous, informal care refers to activities in support of relatives without legal contract and generally unpaid, and to undeclared paid care work. The formal care work is governed by a legal contract and generally framed in a social policy in the field of care. The care regimes have therefore a strong institutional dimension, to the extent that they incorporate the set of measures developed by public authorities to “produce” care: Care regimes reflect care strategies which are implemented in various countries.

Therefore, the research relies theoretically on the concept of “care regime” and intends to operationalize it. Indeed, if the term is increasingly present in the literature, it remains to a

large extend not operationalized. We will implement care regimes through **four axes that are further detailed in these guidelines**:

1. Plural economy and welfare mix
2. Gender contract
3. Rationales of care reforms
4. Performance of care

The central research question can be unfolded according to two lines. **First**, the aim is to better grasp the evolution of care regime influenced by this general movement of marketisation. Indeed, an empirical effort is still required to better understand the impact of the above mentioned reforms. More precisely, we are interested in the following questions:

- Try to better indentify the forms of marketisation (see below):
- Does the trend of marketisation take a different configuration according to the tradition of care regime?
- Which type of diversification of care providers (informal, formal, families, public, non profit and for profit) can we observe?
- What is the articulation between central and regional levels of government? Is there a fragmentation in the supply of care or is there standardization?

Marketisation

We suggest that marketization in the field of care be evaluated through:

- the increase of the part of the cost paid by the user,
- increase of privately (not framed by public policies) funded care,
- the greater competition between care providers,
- contract oriented processes (commissioning),
- increase of the share of for profit providers,
- the benchmarking of care services performance.

On a more normative level, we would like to understand how care regimes contribute to maintain frail adults at home. We have identified four questions/indicators to evaluate this contribution of care regimes:

- Do care regimes foster a universal provision of care services?
- Do they help a more equal provision of care services between gender and between classes?
- Do they improve the quality of care and employment?
- And finally do they foster “best value” for money in care delivery?

Axis 1: Plural economy and welfare mix

1. Definition

The approach of “welfare mix” emphasises the diversity of actors providing welfare: government, enterprises and families (Evers & Laville, 2004). The competition that exists now between a diversity of care actors is one of the main manifestations of the introduction of market principles in the field of care services for dependent people. Paradoxically, this trend fosters the recognition of a “welfare mix” (Gardin & Nyssens, 2010). The institution of this welfare mix is not the consequence of the acknowledgement of the existence of a third sector as such, or of the democratisation of the market economy. On the contrary, the recognition of a plural economy has come with the introduction of market principles in a field that was, before that, dominated by public bodies and associations.

If a plurality of actors is recognized (associations, families, state, for-profit), as a consequence, economic principles in the field can not be limited to market behaviours. Polanyi (1944) introduces three other principles in order to understand the socio-economical logics of care. *Redistribution* is the principle whereby production is handed over to a central authority responsible for distributing it. This presupposes the existence of a mechanism defining the rules for raising taxes and allocating them. In this way, a relationship is established, for the duration, between a central authority, imposing an obligation, and the agents subject to it. In modern societies, redistribution falls primarily under the welfare state, combining (i) a modern form of redistribution sustained through compulsory deductions; (ii) the payment of monetary allowances; and (iii) the provision of social services. Feminist theory has discussed at length the role of the welfare state in women’s access to paid work and autonomy, as well as its role in reproducing sexual hierarchy.

Reciprocity constitutes an original principle of economic activity based on the gift as a basic social fact; it calls for a counter-gift, which takes the form of a paradoxical obligation whereby the group or individual who receives the gift has an opportunity to exercise their freedom. It only has meaning when there is a manifest desire for a social bond among stakeholders. The cycle of reciprocity is opposed to market exchange because it is an integral part of human relationships that brings into play the desire for recognition and power. Yet, it is different from redistributive exchange because no central authority is imposing it. Regarding gender, reciprocity can be analysed from the point of view of the rules that lie behind the gift and counter-gift and how they oblige or liberate the one and the other sex.

A special form of reciprocity is practised within the basic family unit, which Polanyi calls *household administration*. For Polanyi, it involves the autarchic production of an institutional unit (such as the family). Household administration deserves discussion and clarification based on a feminist analysis of gender relationships in the family. The family does not constitute a sphere which has no contact with the public sphere, but, rather, is an institution

“located at the boundary between the public and the private spheres, a boundary whose position and definition are constantly changing” (Pitrou, 1995: 194). In this sphere, the roles are, to varying degrees, conditioned by public policies, labour market and gender.

Definitions

Care is *formal* if there is an explicit and recognized contract in the public sphere between the cared-for and the care-giver (direct employment) or between the cared-for and the home care service.

Care is *informal* if it is the object neither of an explicit contract nor of any recognition in the public sphere (help given by a member of the household or a close relative outside the household for example).

Care is *paid* if the care-giver receives a payment on an hourly base or regularly, or in a fixed way at one moment of the year. This payment is issued from the cared-for or its family or any person close to the cared-for- or provided by the State (directly or indirectly). Care is also considered as paid if it is the object of a payment without any recognized or declared link with the type of care or with the amount of care (in the case of a gift, donation of the parents or grandparents, or of the amount paid to volunteers in Belgium).

Care is *unpaid* if there is no money transfer of any kind between the cared-for and the care-giver.

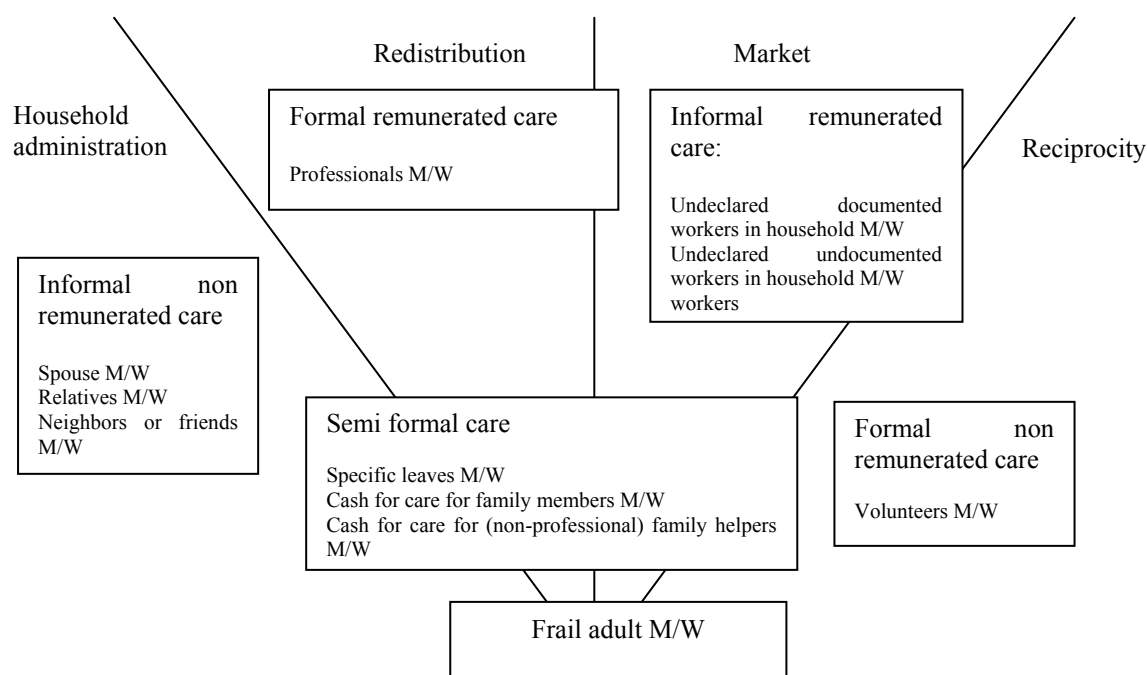
In Belgium, professional workers are generally employees of non-profit organisations or a public service organisation. In order to function properly, these organisations mobilize different socioeconomic rationales which can be analysed through the financial resources they use. These resources are often State-related (redistribution) but they usually also rely on a fee paid by the care-receiver (market) and on the availability of a close relative that helps or organises the help that is provided by the organisation (domestic administration).

Care performed by a relative falls under the category of household administration. However, the redistribution principle can also play a role in this family context when social protection mechanisms recognize certain categories of familial care as work and provide allowances for them: it is then semi formal as it is redistribution (which tends to be associated with formality) that targets a previously informal situation, that was totally under domestic administration. When family care-givers leave their job in order to provide care, they may also be able to draw on redistribution resources, such as those available within the framework of labour market policies. Belgium’s social security system allows people with a very sick relative to take leave of up to one year (“congé pour maladie grave d’un membre du ménage ou de la famille”) or leave of one to two months for palliative care (“congé pour soins palliatifs”).

Volunteer work could also provide opportunities for reciprocity. This kind of unpaid work is generally utilized when an individual gets involved as a volunteer through a non-profit organisation (such as a service providing transport for dependent persons). Volunteering and domestic work cannot be treated equally. Both are unpaid work but the (gender) social relations at the heart of this work are not of an identical nature and result in a different quantity (as well as quality) of work.

Undeclared or clandestine employment straddles the market and reciprocity spheres. Neither the profit motive nor the gift-counter-gift movement completely explains transactions between care-receivers and illegally working care-givers. While the work performed by clandestine home care workers falls within the sphere of the market rationale, they often have close, long-term relationships with their care-receivers, and this important relational aspect of the exchange seems not to be limited strictly to a profit motive. Figure 1 here after shows how care is a social construct built on various socio-economical logics.

Figure A1.1: Care as a social construct



The field of care services is increasingly becoming a field of tensions and compromises between different economic behaviours. Market can be a source of efficiency in resources' allocation, yet it badly takes into account social benefits and costs. Those social benefits and

costs can be internalized by public authorities, through mechanisms of taxation and redistribution. However, the functioning of public authorities can become bureaucratic. Associations are particularly able to create proximity relations but they can be limited by localism. Domestic production is able to maintain family links but can imply domestic closure and gender inequalities.

The political project underlying the idea of plural economy is pleading for efficiency and justice in the equilibrium between these different logics. Nevertheless, plural economy does not imply that the different actors are interchangeable. A capitalist enterprise aims at the maximum return on investment. It can only integrate some collective benefits if the public authority imposes so. The public sector should be the ultimate responsible for the regulation of the general interest, taking into account collective benefits. Associations have an objective of services to their members or to society but they are also privileged forms allowing the expression of civil society and the exploration of alternative forms of solidarity, at the borderline of the institutionalised world.

2. Operationalization

To organise the analysis, we suggest you to take as a unit of analysis each type of regulation and we indicate a plan of study of each type of regulation, i.e. regulation in kind and regulation in cash.

Take the relevant level of regulation: central/federal/national, regional, local:

- Regional level in Belgium
- National level in the UK (England)
- Regional level in Italy
- Federal level in Germany

Some items could be irrelevant in your country/region, others could be added.

Sources

For the purpose of the research on this axis, we ask you to select the relevant reports/official texts about the thematic of care and ageing in your country/region, the relevant scientific articles published, the relevant websites online (health care insurers/mutual insurance companies, federations of services, government bodies, legal databases, etc).

If you encounter difficulties collecting some information, interviews with relevant informants (i.e. service administrators, services coordinators, regulating bodies' civil servants, etc) can give you a new insight about the problems you are studying (see Gubrium & Holstein, 2001, for further reading about interviewing strategy and tactics).

The period covered by the documents should be limited to the last ten years. Please cite the source(s) from which you have collected each argument you are putting forward

Preliminary questions:

- a. What are the legal obligations (in the law on marriage for example or any law regarding the inheritors for example) of the members of the family of a frail adult: has any change occurred during time?
- b. When you have defined the relevant level of analysis, please indicate for this geographical area (please indicate statistics by gender):
 - i. The number of inhabitant
 - ii. The number of people aged 65 and more
 - iii. The number of people aged 80 and more
 - iv. The number of people (share of the people aged 65 and more or 80 and more) staying in residential care
 - v. The medium income of people aged 65 or more
 - vi. The medium level of State Pension income (or more detailed statistics on income if available like the average pension income for blue collars/white collars etc..)

2.1. Regulation of in kind services

In case a variety of regulation, please provide separate sets of answers for each.

Before starting filling these templates please send the list of measures you will study to the UCL team in order for them to have a general overview of the measures that are chose by each partner. Some modifications may be asked.

For each measure, please indicate clearly:

- a. The name of the regulation
- b. The reference documents for this regulation

2.1.1. Types of provision

- a. Type of services which are regulated (home-help, home-nursing, home-care, etc)
- b. Type of providers legally allowed (public, non-profit, cooperatives, for-profit, etc.)

- c. Specific conditions or requirements the provider is subject to (according to the law or national standards):

- About the users:

- i. What type of users has priority access to the service?
- ii. How are eligibility and entitlement's criteria defined? How are their needs defined/evaluated?
- iii. What is the role of the user in the definition and the evaluation of the service, both in individualised forms (contracts, etc) and collective forms (participation to the board, to specific committees, etc)?

- About the workers:

- i. Which are the different kinds of staff and their responsibility (management, senior careworker, volunteer, social worker, case manager, etc)? For each type, are the working contracts regulated? What is the wage level? Is it regulated?
- ii. Is there any regulation of the type of contract that has to link
- iii. What kind of qualification and training (initial and continuous) should have the staff? Is there a structured and publicly financed vocational training for these jobs?
- iv. How are long working hours/working at night and during week-ends regulated?
- v. What protection does it give for the vulnerable workers or cared-for in case of an abuse (like abuse of authority, bad treatment or sexual harassment etc...) of the one on the other?
- vi. What is the role that volunteers are expected to have in the organisation, if any?
- vii. What are the motivations of the workers? Is there a high turnover?

- About the evaluation:

- i. What are the modalities (type, quality tool framework, periodicity, foreseen by the law, for evaluating/monitoring the performance/quality of the service)?
- d. Describe the procedure of choice of providers by the public authority and the responsibility of each public actor concerned by this procedure (at the national, regional, local level, etc)
- i. Is the general level of activity of the sector set by public bodies?

- ii. Is it a public procurement procedure (open tendering or awarding procedure launched by a public authority for the purchase of a social service)? If, yes, please explain the different steps
- iii. If it is not a public procurement, explain what is the procedure and the responsibility of each actor

e. The regulation in practice

Please briefly highlight the main differences between regions/*Länder*/local authorities, if any.

Please also detail the main differences between legal prescriptions and practices. Indicate (when the relevant information is available):

- i. What are the practices/strategies of the providers to access the sector?
- ii. What kind of providers more easily conforms to the conditions of agreement/procurement?
- iii. Which legal conditions/public authority guidelines are less frequently implemented in practice?

2.1.2. Funding as organised by public authority (1 page)

a. Indicate how the service provision is financed (by whom and at which level), specifying the different importance of the following sources of funding

- i. Public funding (national, regional, local level)
- ii. The user/consumer
- iii. Donations
- iv. Volunteer work

b. For public funding, indicate

- i. What are the criteria to define the level of public funding of the provider?
- ii. What is the maximum number of hours funded?

c. For the price paid by the user, please specify

- i. Does it vary according to the user's resources (means testing)?
- ii. Is it related to the healthcare insurance and the state pension income of the user?

d. Funding in practice

- i. What are the practices of the providers to secure an adequate level of funding?
- ii. Which type of providers does have more facility/difficulty to secure the adequate level of funding?
- iii. For what kind of users is it more difficult to pay the price of the service?
- iv. Please highlight whether the differences between regions/Länder/local authorities/municipalities are important or not.

2.1.3. Quantitative data (1 page)

For the regulation that you have analysed, please answer the following questions for the years 1998 and 2008. **Please give statistics by gender when possible.**

Detail:

- a. The number of careworkers (FTE for the observed year, repartition men/women if available)
- b. To what extent has it served to employ migrant carers? Women or men? From which countries?
- c. The number of administrative and management staff (FTE for the observed year, repartition men/women if available)
- d. The volume of hours of carework accomplished under this regulation by the providers (total number of hours for the observed year)
- e. The number of recipients (for the observed year, repartition men/women if available)
- f. The volume of funding of services (in £ or €, making a distinction between the price paid by the state and the price paid by the users)

Using the data collected, make a distinction between the providers according to the different types of providers:

- Public providers
- Cooperatives
- Private non-profit providers
- Private for-profit providers
- Etc.

2.2. Cash allowances

This part includes:

- Cash for care programs (voucher, direct payment, etc)
- Respite care (allowances for care-givers...)
- Social security allowances (dependency insurance and other allowances that can be employed by the elderly person to fund care needs)
- Employment policies related to care

Before starting filling the templates, please send the list of measures you will study to the UCL team in order for them to have a general overview of the measures that are chose by each partner. Some modifications may be asked.

For each measure please indicate:

- The name of the regulation
- Reference documents for this regulation

2.2.1. *Cash allowances users and providers (2 pages)*

a. Eligibility and entitlement criteria of the user

- i. Which kind of users is eligible to the program? Specify the criteria...
- ii. How is the level of financing decided and is there a maximum of cash allowed to be allocated?
- iii. How are eligibility and entitlement criteria defined? How are the needs defined/evaluated?
- iv. Who is responsible to decide on the three previous points?
- v. To which type of services is this cash allowance giving access?
- vi. How do people get to know about the program?
- vii. How is the user followed over time (periodical visit, contract, etc)?
- viii. Are these criteria independent of the civil status of the user?

b. About the service/carer

- i. If the access is limited to accredited providers, what are the requirements?
Please see point 2.1.1.

- ii. How is the quality of the work of the carers regulated in those “cash allowances” schemes?
- iii. Level of turnover in care organisations using these measures
- iv. What are the motivations of careworkers employed under these measures
- v. What protection does it give for the vulnerable workers or cared-for in case of an abuse (like abuse of authority, bad treatment or sexual harassment etc...) of the one on the other?

2.2.2. *Quantitative data (1 page)*

Please indicate:

- a. Number of users (repartition men/women if available)
- b. Medium level of cash paid by the users
- c. Wage/income level of the care-givers
- d. Volume of hours (for the observed year)
- e. Does this measure have an impact on the hiring of migrant labour for care work in your country? (regulation on the licence to work for foreigners etc...)

Please do the exercise for the years 1998 or for the first year of implementation (if after 1998) and 2008.

In one or two paragraph, indicate the importance of the variation:

- between regions/local authorities/*Länder*
- between municipalities inside each region/local authorities/*Land*.

3. **Conclusions and important issues**

Make a general analysis of the data you have collected about in kind regulations and in-cash regulation. Please underline the issues at stake concerning:

3.1. **Care marketization**

Now that you have studied in depth several types of regulation in the field of home care and long-term care, please indicate:

- a. How far goes the marketization of care? (Care marketization indicators are: increase of the part of the cost paid by the user, increase of privately (not framed by public policies) funded care; greater competition between care providers, contract oriented processes (commissioning); increase of the share of for profit providers; benchmarking of care services performance.
- b. Is it overvalued by the scientific literature?
- c. What is the real degree of choice of the users?

3.2. Care decentralisation

Now that you have analysed in depth the interplay between different levels of power in care regulations, please indicate:

- a. How far the inequalities between regions/Länder/local authorities go
- b. To what degree the division of work between central/federal level and regional/Land/local level is something fixed/moving over time
- c. What the impact of care decentralisation on the supply of care is
- d. Is there a movement of fragmentation in the supply of care or of standardization?

3.3. Diversification of care providers

- a. For these measures, we would like to evaluate to how far it is intended to replace formal paid or informal paid/unpaid care?
- b. Do we see an evolution in the share the different actors in providing care: families, public, non profit and for profit?

3.4. Normative criteria

- a. Do these regulations foster a universal provision of care services?
- b. For these measures we would like to evaluate to how far it is accessible for low incomes? Are the measures in Axis 1 cheaper than the “old” arrangements (including informal paid care by an undeclared worker?)
- c. Do they help a more equal provision of care services between gender and between classes? How far do the measures you analysed contribute for women and men to choose

to care or not to care when there is a frail adult in their household/family/close relation? Are there any incentives for men to take up more care, for men and women to take special leaves to care for frail adults or respite leave?

- d. Do these regulations take into account the quality of care and employment? To how far do these measures encourage “professionalization”: the development of managerial tasks, skills recognition, recognition of seniority and service? Do they tend to limit the high level of turnover in care organisations? Is it possible for care workers to exit the work/measures without penalization (this can be the case if the measures are related to activation policies)

4. Further readings

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Axis 2: Gender contract

This part of the Guidelines defines and operationalises the concept of Gender contract (GC). This concept has been developed initially by the Swedish historian Yvonne Hirdman ([1991] 1994), the Finnish sociologist Rantalaaho (1998) and then by the German Sociologist Birgit Pfau Effinger (1993). Pfau Effinger recently complexified the concept and reframed it under the term of “Gender arrangement” (GA) (2005, 2008).

GC/GA serves here as a theoretical approach to our empirical work. It will help us to conduct a comparative study on the characteristics of home and long term care and, eventually, to give a picture of the gendered basis of care regimes in Belgium, Italy, Germany and the UK. In some aspects, GC can be seen as an important part of the societal context of care regimes. GC and care regimes interrelate: the objective is to help define how, in a historical perspective, the GC has shaped the contemporary care regime and how transformations that occurred the last ten years in public policies shaping social and long term care have had an impact in terms of the gender (un)balance.

Division of work between the CROME teams in this axis:

- In this axis, some questions will be answered exclusively by the UCL team. The UCL team would then send its analysis to the other teams and ask them to comment what is written.
- Some questions will be answered by all the partners (U. Roma 1, U. Kassel, LSE, U. Antwerp and UCL teams).
- In the case of statistics, the UCL team will provide them and ask the other partners to provide one page “societal argument” to interpret them.

1. Definition

GC (Hirdmann, 1994, Pfau Effinger, 1993) can be represented as an “*invisible compromise*” at the level of the social actors and focuses on practices and representations embedding women and men in productive and reproductive roles.⁸¹

⁸¹ Productive and reproductive roles are generally associated in the literature with respectively work and family activities. It will also be the case in this document, even though we are conscious that this can be subject to a mere conceptual discussion.

Gender contract: definition by the EU

“A set of implicit and explicit rules governing gender relations which allocate different work and value, responsibilities and obligations to women and men and is maintained on three levels - cultural superstructure – the norms and values of society; institutions - family welfare, education and employment systems, etc.; and socialisation processes, notably in the family” (European Commission, 1998).

Hirdman sees the construction of a GC as a complex process (1991: 190) or an abstract phenomena based mainly on perceptions on how women and men ought to behave in many fields of life, like employment, family, sexual life, political commitments etc., and on what is acceptable for a certain time and space.

The use of the term “contract” is controversial however. GC is not a formal organized contract. It brings together in a virtual way the group of men and the group of women as well as the State who is impulsing its public policies according to that contract (1998:48 in Gerhard, Knijn & Lewis, 2002: 117). Besides, the fact that there is a contract does not mean that it is balanced or that the parties to the contract are equal (Gerhard, Knijn & Lewis, 2002). Hirdman has precisely built this concept in order to challenge the sex role theories that were avoiding the idea of *power relations* as a mere feature of the social structure in general and gender relations in particular (Kalabamu, 2005: 247). Indeed, the approach behind the GC admits the idea of gender as the result of social and power relations between the sexes that contributes to their differentiation (women and men are distinct in all spheres of society: and hierarchisation (the male position being the dominant one). In doing so, the approach recognizes two main assumptions: the first one that women and men occupy different positions and roles in society that are disconnected from their biological or physiological condition (in this sense it is a constructivist concept).⁸² The second one is that historical evolution only can not account for the contemporary sexual hierarchisation (in this sense it is anti-evolutionist). The mechanisms behind the processes of differentiation and hierarchisation are precisely what we try to grasp in our attempt to operationalise the concept.

For Rantalaiho, a GC articulates implicit and explicit aspects as it is *“a pattern of implicit rules on mutual roles and responsibilities, on rights and obligations, and it defines how the social relations between women and men, between genders and generations, and also between production and reproduction are organized in our societies”* (1998:47, in Gerhard, Knijn & Lewis 2002: 116). GC is, consequently, directly related to care, as it regulates the commitment of both women and men in paid and unpaid work.

⁸² This assumption is much discussed within the feminist literature and no consensus can be found on the possible role of biological factors in explaining women and men’s respective position or attitude.

Pfau Effinger's GA *"stands for the specific profile of gender relations within a society"* (2005:44). She clearly refers to the GC approach of Hirdman but the GA varies from the GC by the importance accorded to culture: *"Gender arrangements may be characterised according to the respective cultural models on whose basis they were created according to the respective degree of cultural and social integration"* (44). This obliges her to distinguish, inside the GA, between a "gender order" and a "cultural model".

Gender order

Gender order is close to the previous notion of GC: *"the gender order (...) describes the actually existing structures of gender relations and the relations between the various social institutions with respect to the gendered division of labour"* (Pfau Effinger, 2005: 43). According to Pfau Effinger, *"For the gendered division of labour in modern Western societies, the following institutions are particularly relevant: the labour market (and the education system), the family/household and welfare state, and the non-profit or "intermediate" sector, which represents a sphere between these institutions (Effinger, 1993, Evers/Ol, 1996)"* (Pfau Effinger, 2005: 44). This means that Gender order reflects the way Welfare States and other institutions intervene in delivering well-being.

Cultural models

Cultural models reveal the "deep normative cores" (Sabatier, 1999 in Rummary 2009: 4) underlying GA. Pfau Effinger distinguishes 5 dimensions to gender "cultural models" (2005: 54-55) underlying the GA. We try to put them in relation with what they could mean in the field of care.

1. Societal ideas about the main spheres of activity of women and men - unpaid care, professional life etc... - and about the nature of the relationship between these spheres (symmetric or complementary).
2. The social value assigned to these different spheres in society (equal valuation or hierarchy in valuation of these sphere): the way society attributes value to employment and care influences the quality of the work and the status of the individual working in these spheres. Moreover, this attributed value is the subject of the power relations.
3. The cultural notions about old age and the relations between the generations, i.e. childhood, motherhood, fatherhood as it influences "who cares". We would add here also the specific point of the "best way" to care for frail adults.
4. The way dependencies between women and men are constructed (autonomy or mutual/one-sided dependency) and the cultural priority is on women's autonomy or not. These ideas can help interpret the absence of individual rights in social protection which, in turn, influences the level of living potential care amount one can receive in old age.
5. The cultural significance of the (heterosexual) family in comparison to other lifestyles.

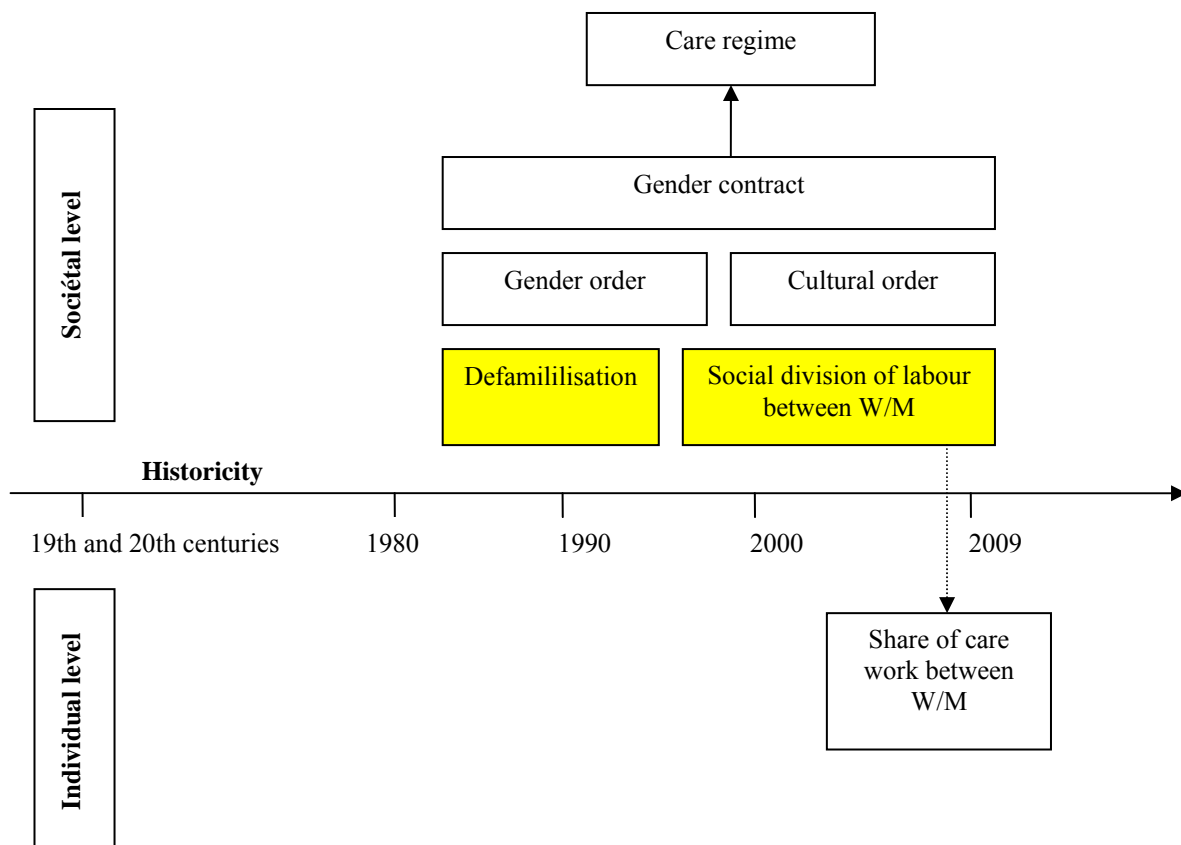
Pfau Effinger also states that “*within the gender arrangement of a society, one or several of these cultural models can predominate*” (2005: 56), meaning that social groups can refer to different cultural models but still fit (more or less) the societal GC.

2. Operationalisation

For Pfau Effinger, a theoretical framework based on the concept of GA enables “*an analysis of the interaction of cultural and institutional conditions within the scope of the labour market, the family and the Welfare State*” (2005: 8). This is why GC/GA is interesting for the analysis of care regimes. If care regimes reflect the strategies of States vis-à-vis care (cf. introduction to these guidelines), GC will serve here as a tool for understanding some of the cultural elements (“cultural models”) and institutional elements (“gender order”) behind this strategy.

According to the definition that we discussed earlier, three dimensions become apparent in GC: its *historicity* (including how the “deep normative core” were implemented in the *longue durée* and to what they are due to), the *division of labour between women and men* it lies upon and to what extent it follows an objective of *defamililisation*. These three dimensions are detailed in this section: they serve as a way to organize optimally empirical observations on GC at a societal level.

Figure A2.1: Operationalisation of the concept of gender contract through three dimensions and two levels



GC are also subject to negotiation at the level of the household or between individuals. We will identify, in disposable statistics (SHARE), the main cares and how, concretely, family combine different forms (formal, informal) and types (home care, home-help, nursing) of care, identifying each time the distribution among sexes.

2.1. Gender contract: the societal level

This part of the guideline shows how the concept can be operationalised through more concrete dimensions - social division of labour between sexes, defamilialisation, historicity - and indicates how these dimensions can be illustrated through questions on (quantitative) variables or (qualitative) facts.

2.1.1. Historicity

The *historicity* of the GC is an important aspect and is linked with the presence of the “path dependency” idea in our research hypothesis. It is thus important to shed light on historical aspects of the GC, in order to grasp the profound changes as well as the elements of a possible continuity since changes have occurred. **Here, we are referring to the history of the 19th and 20th century.**

The process of construction of formal equality

GC have always existed, states Hirdman (1994), they evolve in time and are parallel to the transformations of capitalism. She insists on the importance of the historical perspective on understanding the GC and on focusing on the way the State responded to issues of equality through time. Precisely, Letablier uses a concept very similar in its idea to GC, the “conventions of equality” (*conventions d'égalité*) where she stresses the central role that the historical process of acquisition of (women's) social rights played in achieving equality. Her work illustrates the link between female professional commitment and social rights: “*equality conventions refer to diverse forms of social contracts between sexes (Fouquet et al., 1999), who lay on forms of commitment in professional activities for women and on various forms of social right acquisition, whether those are resulting from labour market participation or that they derivate from the recognition of the maternity as a work*” (2009: 104, our own translation).

The predominance of the housewife model in time

In some European countries (the Netherlands), the family in the form of a married couple with children seems to be considered as a homogeneous cultural ideal and forms the core of society since the 17th century, and even some groups within the women's movement saw the housewife model as desirable (“maternalism”). In other countries (France, UK), where the hierarchical stratification was more important, there seems to be quite different cultural units in society and, according to these units, also different norms related to the role of women and men in the

family and to the relation between parents and child (Pott-Buter, 1993:48; Schama, 1988, cited in Pfau Effinger, 2004:104). In accordance, the cultural influence of the housewife model was more ambiguous.

The specific role of women's movements in shaping social protection and care

Social movements and in particular women's movements play an important role in GA and in their transformation. According to Pfau Effinger (2005), *"As they regard themselves as representatives of the interests of women or certain groups of women, women's organisations and the women's movement play a special role in the processes of change in the gender arrangement"* (46).

These following questions are related to the three previous themes under historicity. They will be answered first by UCL team and then revised by partners.⁸³ UCL team will work on the basis of articles specifically related with:

- **the history of social protection in a gender perspective in each country/region**
- **the ideological fundamentals of social protection in a gender perspective in each country/region**

- a. What are the historical fundamentals of the social protection of women? Did women organize their own social protection or were they included in a development of social security initiatives organized around family?
- b. To how far were/are social rights connected to female employment and/or to maternity?
- c. Was/is there a strong or a weak individualization of social rights?
- d. What is the relative cultural dominance of the housewife model (or "familialistic ideology") as regarding to history?
- e. How do women's movements shape the actual discourse/practices on elderly care and are the arguments taken up by political parties? Please select one or two women's organisation that have specifically worked on the issue of ageing and make a list of claims or arguments around the care to frail adults. Give also an idea of the weight of these arguments on the public debate and on the discussion that are conducted at the decisional level.

⁸³ Partners are encouraged to indicate any relevant article they know on this topic.

2.1.2. *The social division of labour between sexes*

The social division of labour between sexes and consequently, the state of the division of paid and unpaid work of women and men in a society, is one of the main dimensions of the GC. The concept of social division between sexes was first used in a context of complementarity between sexes by anthropologist but feminist research in the 1970's gave the concept a new content by demonstrating that it was better translated by "power relation between sexes" than by the idea of complementarity (Mathieu, 1994; Guillaumin, 1992; Tabet, 1998). It generally rejects the association of female and male tasks with physiology or any other biologically related explanation. It has been frequently used in the literature on gender and is an analytical instrument used to observe and understand the mechanisms underlying the tasks/role performed by women and men in different societies in different times (Collin, 2000).

Social division of labour between sexes (as well as the all structure of the GC) operates according to the principle of division (men's tasks and women's tasks) and the principle of hierarchisation (some tasks have more value than others and male activities generally "count" for more).⁸⁴ It rests upon a general hypothesis inspired by the Marxist-feminist strand of research articulating patriarchy and capitalism: family structures (and domestic work) and the productive sphere (of remunerated labour) are connected in a same system and the first is crucial for the functioning of the second (Collin, 2000: 38).

Aspects of labour force participation ("division")

In order to inform the quantitative aspects of the social division of labour between sexes, we will examine different aspects of the labour force participation. Please select the relevant statistical reports and, if possible, give the data for 1980, 1990, 2000 and 2009 (or the latest available data). If possible, answer the question by highlighting also the situation of migrants (women and men).

These following questions will first be answered by UCL team on the basis of databases and then revised by partners in the form of an interpretation/"sociological argument".

- a. Global overview of the trends in labour force participation of women and men.
- b. The inequalities in paid and unpaid activities that women and men undertake:
 - i. use of time
 - ii. employment
 - iii. activity rates

⁸⁴ This echoes Hirdman's own ideas on the gender system characterised by the logic of separation between genders and the logic of male norm (Hirdman, 1994: 190 in Martsenyuk, 2007: 105)

- iv. wage gap
 - v. temporary/full time work
 - vi. time credit
 - vii. wages within the family
- c. The increasing individualization and the erosion of the assumption of female dependency on male wage:
- viii. divorce rates
 - ix. rates of unmarried motherhood
 - x. proportion of lone mother families

Ideas about male and female activities (“hierarchisation”)

Expressing the social division of labour between sexes is more than just observing indicators of inequalities. Indicators of inequalities are of course a starting point but the social division between sexes implies to go beyond a quantitative approach that remains descriptive and to give a more complex picture of how societies, at a certain time and in a specific space, organize and legitimate (or, in the inverse, transform and delegitimize) sexual division and hierarchisation. As a consequence, the decision for women to work depends on structural factors as designed by State intervention, the family, the state of the labour market but also on cultural factors (Pfau Effinger, 2004: 7): *“it can be assumed , however, that not only government policy but also women’s behaviour with respect to employment relate to a considerable extent to cultural models on the desired, “correct” division of labour between the gender”* (idem).

At this stage, it is difficult to evaluate the feasibility of this item.⁸⁵ UCL team will look into the literature and identify:

- one or two scientific articles (in the field of the sociology of work for example) dealing with discourses on male/female employment in one or two particular sectors, preferably related to care.

- one or two articles out of the literature on intersectionality and the labour market for your country.

If there is sufficient and accessible material, UCL team will start answering the questions. They’ll be revised/commented by the partners.

⁸⁵ Partners are encouraged to indicate any relevant article they know on this topic.

- a. What cultural ideals (of the family, the feminine, the masculine) seems to determine the gendered division of labour based in a historical perspective?
- b. What is the value attached to productive and reproductive activities the symbolic level: take examples in some emblematic discourses (political parties, trade unions...) on “women” and “men” work, abilities: there may also be surveys or opinion poles on values and moral norms linked to (care) work.
- c. Can you give some elements on the social division of labour according to social groups (according to their class, ethnic and religious/cultural background) and more specifically on the way care work is gendered and ethnicised?

Level of (un)satisfaction linked with the process of separation/hierarchisation

More over, Hirdman and Kabeer both insist on the fact that the GC is not fixed and is subject to contestation and negotiation (Hirdman, 1994: 191, Kabeer, 1999: 438, in Kalabamu, 2005: 248). The GC is thus involved with issues of “voice” that are expressed on the social division of labour between the sexes.

These following questions will be answered by each partner (U. Roma 1, U. Kassel, LSE, U. Antwerp and UCL) (+/- 1 page)

Select one measure developed under Axis 1 and answer the following questions.

- a. Please indicate the major feminist or women’s movement claims/arguments on this measure as formulated by one or two relevant organisation(s) in the field (for example: the gender budgeting movement in Italy or the struggle for “credit-temps” in Belgium)
- b. Additional information if possible: please give some elements giving an idea of the degree of institutionalization of the feminist movement in your country/region (ex: is there à Gender Institute, a State’s secretary for equality, gender mainstreaming etc...)

Impact of migration policy/regulation of migrants working in the home care sector

The integration of migration policy/regulation in the analysis of the institutional arrangement and on the social division of labour between sexes is still a mere challenge for the conceptualization of care regimes (Sainsbury, 2006). Indeed, an important strand of the literature on care underscores this tendency towards a sexual division of labor between North and South: in Europe, care work is often undertaken by migrant and low paid women, an important part of them being undocumented (Mediterranean Institute for Gender Studies, 2008). Italy seems very representative: despite the opening to East-european countries of the Union, many of the carers have no declared contract with the families they care for (Bettio et al., 2006, Simonazzi, 2009).

These following questions will be answered by each team (U. Roma 1, U. Kassel, LSE, U. Antwerp and UCL) (+/- 1 page)

- a. Please give a brief summary of the key decisions in the migration policy of your country/region during the last 15 years.
- b. Among these measures, detail the ones that, to your opinion, had a significant impact on the organisation of care at a national level.

2.1.3. Defamilialisation

In this section, we will focus on the impact that some of the measures under scope in Axis 1 have had in terms of the defamilialisation of the informal unpaid care-giver (husband/spouse/child), the formal (professional) care-giver and the cared-for.

Defamilialisation

Defamilialization is “*the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or through social security provisions*” (Lister, 1997: 173).

Concerning the *informal unpaid care-givers*, the objective is to question the effects of the new measures on the improvement of his/her work/life balance and to question to how far these measures are opening up a choice for him/her to take up care or to refuse to care (or to take only one part of the care).

This aspect can not be grasped through quantitative indicators. It requires having an access to qualitative research/reports where informal unpaid caregivers using these measures for their frail parents for example are enquired and to have a general discussion on the possibility of “relieve” they offer. Please discuss (one page) this question if possible (i.e. availability of the mentioned documents)

Defamilialisation is also implicated with the type of work provided in the care sector for formal *professional care-giver*. The objective here is to question the financial autonomy/possibility of career etc... allowed by the jobs created under the measures that are studied.

For one “in kind” and one “in cash” regulation, please give some element on the financial autonomy/possibility of career of the care-giver in the jobs that are created. This discussion will be conducted by each partner (one page) on the basis of question 2.1.1 c (worker), 2.2.1 b and 2.2.2 of Axis 1.

Regarding the *cared-for*, it is interesting to look into the choice that he/she has to be cared-for by a person of his/her choice, be it formal or informal.

This issue will be dealt with indirectly, via questions in part 3, through the lenses of the rationales on best value and choice. UCL team will start a discussion (one page per country) and send it to the partners for revision.

2.2. Operationalisation: the level of the individuals

This section will be handled by the UCL team. However, we consider it is useful for the partners to have an idea of our intentions on the operationalisation of the GC at the level of the individuals and households. The objective is to give a statistical evaluation of the “care as social construct” figure presented in Axis 1 (Figure 1). We explore the extent to which data from SHARE can be used. Therefore, we will discuss about the proxy variables from which our variables of interest could be obtained⁸⁶.

3. Conclusions and important issues (1 page)

These questions will be answered by each partner (U. Roma 1, U. Kassel, LSE, U. Antwerp and UCL teams) (+/- 1 page).

Make a general analysis of the data collected. Please underline also the issues at stake concerning the link between marketisation and defamilialisation:

- a. Do you think the measures of Axis 1 are more or less defamilialising than the “old ones”?
- b. Do you think “cash for care” defamilialises less/more than the mechanisms “in kind”?

⁸⁶ In order for this to be the case, the proxy variable must have a close correlation, not necessarily linear or positive, with the inferred value.

4. Further readings

GC (level of the social policies)

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http://www.socialpolicy.ed.ac.uk/_data/assets/powerpoint_doc/0013/20524/Pfau-Effinger_Birgit.ppt

RANTALAIHO L. (1993), "The Gender Contract" in Vasa H. (ed.) *Shaping Structural Change in Finland: the Role of Women*, Helsinki, Ministry of Social Affairs and Health.

RUMMERY K. (2009), "The Role of Cash for care in Supporting Disabled People's Citizenship: Gendered conflicts and dilemmas in social citizenship", *Social Policy and Administration*, vol 4, n°6, p 634-648

SAINSBURY D. (2006), "Immigrants social rights in comparative perspective: welfare regimes, forms of immigration and immigration policy regimes", *Journal of European social policy*, vol 16, n°3, p 229-244.

SIIM B. (eds.) (2007), *Contested concepts in gender and social politics*, Northampton, MA: Edward Elgar Publishing, p 105-140.

SIMONAZZI A. (2009), "Care regimes and national employment models", *The Cambridge Journal of Economics*, vol 33, n°2.

TABET P. (1998), *La construction sociale de l'inégalité des sexes. Des outils et des corps*, Paris, L'Harmattan.

YEANDLE S. (1999) , "GCs, Welfare Systems and "Non-Standard Working": Diversity and Change in Denmark, France, Germany, Italy and the U.K", in Felstead A. and Jewson N. (eds.) *Global Trends in Flexible Labour*, Basingstoke, MacMillan, p 95-118.

Axis 3: The rationales of care reforms

1. Definition

This Axis 3 focuses on the arguments of the reforms of the regulations we identified and analysed in Axis 1. We are thus interested in reviewing the major hypotheses leading the reorganisation of long-term care in each country, particularly in relation to the European guidelines.

To do this work, we rely on Bussemaker's reflexion about the construction of social policies (1998). This author understands rationales as important influences of social policies. To her, *"the programmatic conceptions and idioms used in political debates do not simply precede actual policies, but they determine in part and interact with these policies; they give shape to the way in which social relations (...) in society are perceived"* (Bussemaker, 1998: 72). According to this definition, rationales are seen as discourses used by a range of social actors in different situations of the policy process. The aim of an analysis in terms of "rationales" is thus to reconstruct the combination of *"basic arguments (...) deployed by various social actors"* in this process of policy determination and implementation (idem).

For instance, her study of the rationales of child-care reforms in the Netherlands in the period 1960-1980, shows:

- that the consensus among political parties during the 1960s about state-funded child-care was related to a fear of state control that has to be understood in terms of the Dutch tradition of pillarization (each pillar being autonomous from the state),
- that the further constestation of this position from women of the Labour Party in 1969 was also simultaneous of a new discursive framing of interest, which emerged with regard to the social development of children, and which permitted part-time play-groups for moms and toddlers to become an integral part of social policy.
- that the interest of feminists groups such as Dolle Mina for a public funded child-care declined quite fast during the 1970s, because their attention moved to other issues (abortion for example) and, also, because there was no discursive space to question the political hegemonic discourse on children's interest. Bussemaker uses here a 1974's report from a governmental body that highlights the centrality of this children's interest and that connects children's interest to the non desirability of fostering the entrance of women on the labour market.

In this Axis 3, special attention has to be paid to the articulation of regional, national and European debates. Indeed, the political process of decision-making in each level of authority

in a country is conditioned by changing regulations at the European level. For instance, the services of general interest guidelines impose public authorities either to entrust providers with a specific mission of general interest or to organize public procurement procedure outsource certain types of provision. Another example concerns the articulation of reforms with the aim of increasing the participation rate of women under the Lisbon Treaty and the importance given to the objective of equality between men and women and to the reconciliation between professional work and family activities.

An objective of this axis could be, to make visible “*a range of potentially contradictory policy logics*” (Adam and Padamsee, 2001: 3). For instance, in the field of care, a potential tension comes from the contradiction of the arguments in favour of an increase of the women’s level of professional activity and those in favour of the recognition of informal carework within the family.

According to this definition of a “rationale”, we have constructed a list of six rationales after reading several reports from the European Commission related to the topics of social and long-term care. These reports are:

- the 2009 Ageing report,
- the 2008 Biennial report on social services of general interest,
- the 2008 Long-term care in the European Union report,
- the 2005 Health care & long-term care review, and
- the 2005 Economic impact of ageing populations in the EU25 Member States report.

The rationales that we have listed out of these reports may be more or less relevant for your country and may or may not be taken up in discourses. We will discuss this at the seminar.

This list was also elaborated with the aim to deepen the analysis already made in the Axis 1. “Welfare mix and plural economy” of this project. In Axis 1, we studied the regulation of in kind services and the regulation of in cash services. Such topics, like the type of providers, their resources, their accreditation by the State, the types of users of these services, or the conditions to employ careworkers, etc, were analysed. In this Axis 3, we will look into the debates accompanying the elaboration and the restructuration of these regulations.

2. Operationalisation

In the European reports we have reviewed, one can detect several arguments behind care reforms or several types of incentives to reform this field:

1. maintain a high level of informal care and to foster community based care ?
2. create jobs for the workers at risk of unemployment

3. generate new and innovative services for older people
4. foster the implication of a greater variety of actors (private, from the civil society, etc)
5. develop the decision-making capacity of the user via needs assessment and information
6. elaborate care continuums between hospital - or medical - care and home care
7. foster equality between men and women

For this axis, we ask you to select three emblematic documents published during the last 10 years about long-term care reform and justify in two/three paragraphs why you made this choice. Then we ask you to answer the following questions relating to each rationale indicated above.

2.1. Support of informal family care (+/- 1 page)

In the European reports about long-term care, preservation of an informal family care is seen as crucial to meet the challenges faced by an ageing society. This argument is related to the high costs of formal care, to fears that public policies in favour of childcare formal care provision and of reconciliation between professional and private activities would reduce informal care provision, and fears that participation of women to the labour market would diminish the availability of such informal family care.

High costs of formal care and its negative impact on the family budgets

According to the European Commission, formal care represents high costs for family households, thus informal care is needed: “[The long-term care sector] relies heavily on the participation of private households, which still provides the bulk of care in all Member States and often has to shoulder a large financial burden in cases where out-of-pocket payments and co-payments for formal care are required”. (Biennial Report on Social Services of General Interest, 2008: 7)

- a. In the debates under study in your country/region, what arguments are/were related to the necessity to maintain a high level of informal family care due to the high costs of formal care?

Fears of decrease of informal family care due to the development of formal childcare provision

The European Commission makes strong ties between the participation of women to the labour market, and social policies in favour of formal childcare. (The Commission associates rarely the participation of woman to the labour market and social policies in favour of formal eldercare.) These social childcare provision policies could in consequences have a “perverse” effect of a decrease of informal family care: *“Whether the projected increases in female employment rates materialise in practice, or are even exceeded, may in part depend on supportive public policies or collective agreements being put in place, such as policies to promote access to affordable childcare, to reconcile professional and private lives and to achieve gender equality”*. (Economic Impact of Ageing Populations in the EU25 Member States Report, 2005: 25)

- b. In the debates under study in your country/region, what are/were the arguments about the risk of decreasing of informal (family) care provision due to the implementation of formal social child care provision?

Fears of the decrease of informal family care because of women participation to the labour market

The European Commission is concerned by the fact that a higher professional activity of women could constrain the level of care that is needed by ageing people: *“On top of an ageing population, this gap [between the need and the supply of care] could further grow as changes in the family structure and the growing participation of women to the labour market may constrain the future supply of informal care provision within households and families”*. (Ageing Report, 2009: 25.)

- c. In the debates under study in your country/region, what are/were the arguments about the fear that higher women participation to the labour market would diminish availability of care for older people?
- d. In the debates under study in your country/region, what are/were the arguments about the necessity to keep older people in the community and to place them in residential care?

2.2. Developing care jobs in priority for workers at risk of unemployment (+/- 1 page)

Care is more and more seen as a source of employment. It is seen as a source of employment for workers at risk of unemployment, and, broadly speaking of precarious workers (A), but fears are emerging of an influx of migrant workers to occupy those jobs (B).

Care as a field of employment for workers at risk of unemployment

The European Commission states that care industry has a potential to attract more fragile workers in the labour market (i.e. women, older workers, low qualified workers, etc). *“[Social and health services] have contributed significantly to job creation in the EU, especially*

among women and older workers”. (Biennial Report on Social Services of General Interest, 2008: 6)

- e. In the debates under study in your country/region, what are/were the arguments linking care industry with job creation potential? What kind of labour force is/was presented as a priority public (i.e. undeclared workers, unqualified workers, etc) for these newly created jobs?

The bad quality of the jobs

The European Commission highlights the bad quality of care jobs: “[*Regarding social and health services*] *Part-time work is widespread [...], turnover is high [...]* and the influx of workers from non-EU countries has increased”. (Biennial Report on Social Services of General Interest, 2008: 6)

- f. In the debates under study in your country/region, what are/were the arguments about the influx of precarious workers in these care labour markets because of the bad quality of these jobs?
- g. Is there any rationale of policy reforms that tackles the fact that home care jobs are low paid jobs?

2.3. Increase of the ageing population and the expansion of needs (+/- 1 page)

The decreasing (or the stagnation) of the level of formal care services and the growing demand for care from ageing people are seen as producing a huge area of unmet needs.

According to the European Commission, there is an insufficient level of care service compared to the important needs of care of ageing people: “[*The growing demand for long-term care is*] *a major policy challenge for many Member States, since supply is already considered to be insufficient to meet the present needs*”. (Biennial Report on Social Services of General Interest, 2008: 7) “[*Without policy changes in the provision of long-term care, a growing gap may occur between the number of citizens with disability who are in need of care and the actual supply of formal care services*”. (Ageing Report, 2009: 29.)

- h. In the debates under study in your country/region, what are/were the arguments about the growing needs of care of ageing people and the necessity to create new and innovative home care services for them?
- i. What is the main rationale behind the creation of these services?
- j. In the debates under study in your country/region on the expansion of needs, what is the importance of the argument that “best value for money” either in terms of cost of care or of consumer’s choice should be the principle leading in the answer to these needs

2.4. Fostering the diversification of actors and the privatisation of care provision (+/ 1 page)

Welfare pluralism can be seen as a move towards the involvement of a greater variety of actors in the provision and the supervision of welfare services. It means in particular, the implication of actors from the civil society, the entrance of private-for-profit providers in the care market and the implementation of competition between providers, and the fostering of a greater diversity of resources of each provider and a greater provision of care provision.

The implication of actors from the civil society

The European Commission sees the diversification of the actors involved in the care services as an important issue. In particular, a greater role of the civil society, local representatives and users (and their representatives) is thought as an important step towards the modernisation of care services: “*Modernisation entails [...] new forms of user participation, civic involvement and dialogue with civil society*”. (Biennial Report on Social Services of General Interest, 2008: 69) “[*The new form of social governance*] embraces a diverse range of actors: social partners, local authority representatives, social entrepreneurs and others NGOs as well as community based groups, voluntary organisations and self-help initiatives”. (Biennial Report on Social Services of General Interest, 2008: 69)

- k. In the debates under study in your country/region, what are/were the arguments in favour of the greater involvement of civil society, community groups, local groups, and groups of users in the supervision and design of care services?

The fostering of competition between providers and the privatisation of care providers

The European Commission states that “[...] *competition among providers and among insurers is seen as a mean to reduce costs of care and to enhance quality*”. (Health Care & Long-Term Care Review, 2005: 5.)

- l. In the debates under study in your country/region, what are/were the arguments in favour of competition between providers of care services?

The diversity in the funding of care services

According to the European Commission: “[*In the field of social and health services*] *financial constraints may explain the search for complementary financing and for increased efficiency, which are two of the driving forces behind the modernisation of these services*”. (Biennial Report on Social Services of General Interest, 2008: 7)

- m. In the debates under study in your country/region, what are/were the arguments in favour of the diversification of care resources (direct funding from the users, donations, volunteer work, etc)?

2.5. Developing the decision-making capacity of the user: needs assessment and information (+/- 1 page)

Choice has become an important dimension of long-term care services. Greater consumer choice is seen as a way to improve the performance of these services. This choice, more and more, depends on the correct assessment of the needs of the individual and also on the correct information of the user about the services available.

According to the European Commission: *“Public authorities see increasing patients’ choice (...) as a way to improve the responsiveness of the system”*. (Health Care & Long-Term Care Review, 2005: 19.) *“The assessment of those needs and the provision of the various services must be carried out in a way that respects the choice and dignity of the person in need of care”*. (Long-Term Care in the European Union Report, 2005: 19.)

- n. In the debates under study in your country/region, what are/were the arguments in favour of the implementation of needs assessment programs? Does the development of the decision-making capacity of the user is/was seen as an important issue? What are/were the arguments about the necessity to correctly inform the user about the services available, and, more broadly, to develop her/his capacity of choice by providing information?
- o. Do you see any rationale of concentration of formal care work on heavy cases?

2.6. Implementing care continuum between medical care and home care (+/- 1 page)

Care for ageing people is in great part medicalized (i.e. biomedicine has exercised a major influence in the field of gerontology). The surveillance of the trajectories of older patients after their discharge from the hospital is understood as a crucial issue. Home care is thus seen in connection with medical care.

The European Commission draws attention to the bad effects of a fragmented provision of care after hospital discharge: *“[...] fragmented provision of long-term care services [...] can reduce the accessibility of long-term care services. For example, hospital discharge ought to be followed by tailored home care provision or care within a community setting”*. (Long-Term Care in the European Union Report, 2008: 19.) *“Care coordination is crucial in the provision of a care continuum for individual patients. The care continuum approach aims at promoting a uniform and coordinated provision of services”*. (Long-Term Care in the European Union Report, 2008: 28)

- p. In the debates under study in your country/region, what are/were the arguments in favour of a greater continuum (or coordination) between medical care and home care?

2.7. Fostering equality between women and men

In some countries, the reforms that were implemented have a link with gender equality (or a related topic, like work/life balance). It is thus possible to identify either if gender is mobilised in the previous rationales and/or if it is a rationale of its own.

On the basis of the documents you have selected,

- q. Try to evaluate whether equality is one of the rationales of the reforms. If yes, how is it formulated? Through the question of work-life balance for cares? Of equal access to care for frail adult, men and women?
- r. Does gender intervene in defining the best way to care for frail adults?

3. Conclusion (+/- 2 pages)

Make a general analysis of the data you have collected (what kind of coherence can be identified, what contradictory character of the welfare state it highlights, etc). According to this analysis, what was/is the discourse in terms of the best way to care about frail people? Which rationale is dominant: universal provision of care services? equal provision of care services between gender and between classes? quality of care and employment? “best value” for money in care delivery ?

Are there any tensions or contradictions among these rationales?

4. Further readings

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Axis 4: Performance

1. Definition

Care services for the frail elderly potentially create both individual benefits such as empowerment of users and collective benefits, for the society as a whole such as creation of jobs for low-skilled people, a decrease in gender inequalities, a contribution to local development, the strengthening of social cohesion. In some countries, care services and governments have begun to think more accurately how to evaluate these collective benefits (Devetter et al., 2009). Other aspects such as the quality of the service or the quality of the employment are also starting to be evaluated. When evaluating the quality of the service, it is important to highlight the fact the particular nature of the activity that is at stake. Aspects of relationships and trust are, for instance, hard to measure although they are crucial in terms of service provision.

Another central issue regarding the evaluation of the performance of care provision is to grasp the “net contribution” of these services; in other words, what is the added value for the beneficiaries (users and workers) of these services such as the length of stay at home of a frail elderly thanks to the provision of the service or the exit of the black market for a worker who is hired by a care provider... These net outcomes are very difficult to measure as they depend, not only from the action of the provider but also from the profiles of the beneficiaries (i.e. disability levels, health problems or the presence of informal support) which are out of the provider’s control.

The situation of evaluation is very different from one country to the other. If in UK, we can see some quality frameworks/tools which are developed at a national level, in a country like Italy, it seems that the question of the measure of the performance is not even yet at the agenda. So our aim is not to compare the performance of care provision between different countries but to analyze how the debate about performance is framed in each country.

In order to fulfil this goal, we suggest to adopt the analytical framework known as the “Production of Welfare” (POW) approach which has been applied in English academic studies to the analysis of equity and efficiency in social care services: *“This analytical framework strives to contextualise the specification of research questions, analysis tools, and interpretation of results, by taking into account the lessons gained from a wide range of research disciplines and traditions”* (Malley & Fernández, 2010).

Figure 1, adapted from Knapp (1984b: 26), summarises the set of factors relevant to the analysis of performance in social care services, together with the main relationships between them, as postulated by the POW approach. It categorizes the key factors in the production of welfare process into the following groups:

Non-resource inputs are outside the control of social care policy makers and are likely to explain a majority of the variations in outcomes. They can be divided between two main groups. One group consists of client characteristics, and particularly of need-related circumstances such as disability levels, health problems and the presence (or lack) of informal support. The other consists of characteristics of systems (for instance, the characteristics of organisations, care environment, staff attitudes or prices of inputs).

Resource inputs represent physical units of social care service resources; for instance, numbers of hours of inputs of types of staff, building space units, or vehicle miles.

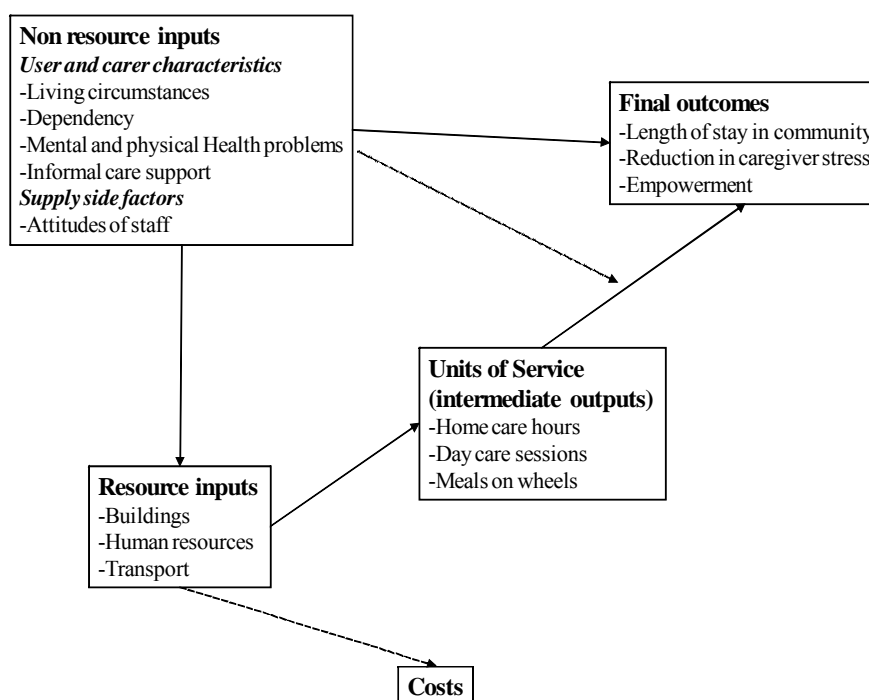
Costs constitute aggregate indicators of resource-inputs. They measure the value of physical units of inputs in monetary terms, applying opportunity cost principles, so that estimates of cost reflect the best possible alternative use of resources (see for instance Drummond et al, 1987: 54-67 and Netten & Beecham, 1993).

Intermediate outputs correspond to units of service activity which are produced (from resource inputs) in order to produce final outcomes.

Final outcomes are the effects on the beneficiaries of the production process.

In addition to specifying key groups of indicators, Figure 1 postulates a set of relationships between them. To fully appreciate the performance of the social care system – and so to be able to make recommendations about ways to improve it – research ought to evaluate each of the arrows in Figure 1. However, the central emphasis should be on final outcomes, and thus on the relationships between non-resource inputs and units of service and final outcomes (Knapp, 1984b).

Figure A4.1: The set of factors relevant to the analysis of performance in social care services



Source: Malley and Fernández, 2010

The question is thus to see, in each country, which indicators are available in the different official reports and/or quality frameworks/tools and where you can locate them on this scheme.

2. Operationalization

The objective of this axis is **to compare practices of evaluation and values underpinning these practices.**

In order to respond to the following questions, select three emblematic evaluation reports and provide separate sets of answers for each of the them. Explanations for the choice of the selected reports should be provided.

These should be evaluation reports:

- i. By at least one public/government actor (more if there is a diversity of regulations)
- ii. -and at least one “other” key stake holder(s)

We expect:

- +/- 3 pages of analysis for the study of each report,
- +/- 2 pages of conclusions.

If you encounter difficulties to retrace the evaluation process, an interview with a key informant can give a better insight on how to gather the relevant data (see Gubrium & Holstein, 2001, for further reading about interviewing strategy and tactics). Key informants could be: civil servants working for public authorities collecting evaluation data, individual inspectors/evaluators, and coordinators of home care services federations.

The list of questions above is presented to help you to summarize the relevant information. Don't answer to each bullet point, but instead work on the formulation and the writing in order to produce an adequate picture of how performance evaluation is conducted in your country/region.

2.1. Framework of the evaluation

- a. Identify the actor that has put in place the evaluation: public authority (which one?), umbrella organisation, scientific body
- b. Who funds the evaluation?
- c. Indicate the methodological approach that has been followed for the development of the framework/tool and specify clearly to what extent service users, workers and other stakeholders have been involved in the definition and development of the evaluation framework/tool
- d. Indicate the actors to which the framework/tool is addressed
- e. Who is evaluated? Providers as a whole? Some specific professional (carers, informal carers, volunteers, managers of, first line carers, managers of public bodies, case managers, etc.)?
- f. Specify through which procedures this evaluation has been put in place and its frequency
- g. Indicate who conduct the evaluation (delegation to scientific centres, consultants, public bodies, inspections, etc.)?
- h. What kind of methods is used (administrative reports, audit, benchmarking, econometric estimation, action-research...)?
- i. Are users, workers and other stakeholders involved in the process of evaluation?

- j. Specify if the evaluation is legally enforceable or if it is not legally binding (as it is the case e.g. for codes of practice/conduct and voluntary non statutory arrangements)
- k. What kinds of changes imply those results (the withdrawal of the approval of a provider, the diminution of the financial contribution of public funders, etc)?
- l. Are the results of this evaluation public? Who are the targeted stakeholders for the diffusion of information (public bodies, users ...)?
- m. What are/were the reactions when those reports are/were made public?

2.2. Scope of the evaluation

Intermediate indicators

In the majority of the reports, measures are restricted to intermediate indicators (indicators of volumes).⁸⁷

- a. Which are the intermediate indicators available?
 - i. Regarding service: volume (numbers of users, of hours),
 - ii. Regarding employment: volume (number of workers, FTE)
 - iii. Regarding type of providers (market share ...)

Costs indicators

- a. What kind of indicators are/were developed (cost for one hour of home care, costs for the family of the user, administrative costs, etc).
- b. Is there any evaluation regarding the sustainability of services?

Final outcomes indicators

- a. Which are the indicators available?
 - i. Regarding the user: quality of the service including service accessibility, discrimination; adequacy of the population targeted, adequacy between demand and supply, indicators of satisfaction of users, continuity of care, empowerment of the user, participation of the user, social care-related quality of life measure
 - ii. Regarding employment: quality indicators (turn-over, type of contract, duration of contract, transition to the labour market and to other jobs, training, etc), net placement rate of workers

⁸⁷ This type of information is the one you should have collected in the axis 1 (quantitative data).

Non resource input

- b. As “non-resource inputs” are outside the control of social care policy makers and are likely to explain a majority of the variations in outcomes, is there any consideration in the evaluation report about them?

3. Conclusion

Make a general analysis of the data you have collected. How far performance evaluation is centralised or decentralised in your country? Which values are underpinning the evaluation processes: efficiency, quality of service or employment, availability of information for user (to enhance the capacity of choice of the user...). Are some of them reflect of a trend of care “marketisation”?

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