- Introduction and executive summary[1] -

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 Management[2] 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.

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[1] 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.

[2] 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.

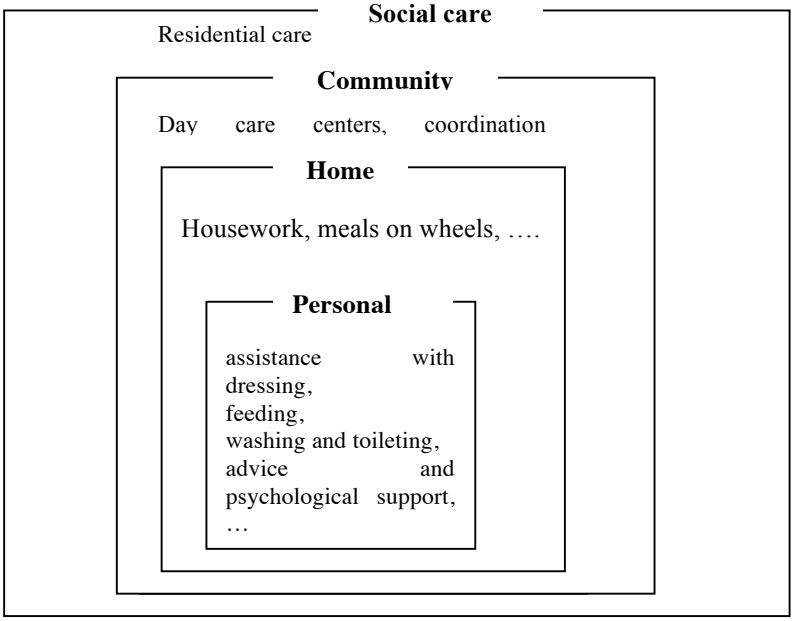
"Home care" (sometimes also called "domiciliary care") covers all activities that are undertaken in the home where the dependent older person usually lives, with the objective of enabling "*people to stay in their own homes as long as possible*" (Jamieson, 1991: 7). We take the term to cover both "personal 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.[3]

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.

[3] *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 Higgens (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.[4] 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.

[4] 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.[5] 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.

[5] 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 collection[6]:

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.

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[6] 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.[7]

[7] 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 caracterising 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 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. 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 or 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. The side of the cared-for and that of the professional carer is less documented. 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 defamililising 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 "Mediteranean" 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.