



# Governing Home Care

**A Cross-National Comparison**

Viola Bureau

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**GLOBALIZATION AND WELFARE**

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# 1. Introduction to the governance of home care

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This chapter introduces home care as a complicated set of activities that transcend a number of boundaries, especially between public and private, formal and informal, and the micro and the macro levels. We discuss the importance of defining care by its location and provide an overview of the different locations that are used to define 'home', as well as the dynamics between different home locations. This chapter also introduces the concept of 'governance' as applied to home care, and introduces the close relationship between the public/private and the formal and informal sectors.<sup>1</sup> It demonstrates that the governance of home care has become highly politicised because of demographic developments relating to ageing populations, societal developments relating to individualisation and changing gender cultures, including changes in the traditional role of families as care givers, and economic developments relating to heightened resource constraints across all policy areas.

This chapter also explains our choice of countries for analysis and offers an overview of the relevant cultural and institutional contexts of home care in each country, which are fleshed out in Chapter 3.<sup>2</sup> Finally we introduce the issue of convergence. At the theoretical level there is currently considerable debate between those who argue that there is a convergence of policy across countries and others who contend that despite convergence, in some arenas there remains considerable divergence due to cultural and structural variation. These latter observers point to the embeddedness of policies in country-specific contexts. Home care governance across these countries serves as an excellent test of the convergence hypothesis.

## DEFINING HOME CARE

The user groups of home care are diverse and reflect the support required at different stages of the life span, ranging from severely ill infants to people at the end of their life. Other beneficiaries of home care include people with mental illness and handicap, physical disability, drug-related disorders and progressive illness (Means et al., 2003). Each of these groups raises a different



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home care across countries we must be aware of the activity not only by the state, but also by associations, the marketplace and the family. Moreover, the instruments of governance will vary not only by locale but also across time, thus explicating the dynamics of home care governance. Chapter 2 will provide more details on the logics and instruments of governance drawn from the literatures of social care and public policy and fill in the blank spaces in Table 1.1.

*Table 1.1 Logics and instruments of home care governance (1)*

Logics of governance	Instruments of governance		
	Funding	Delivery	Rules
State			
Associations			
Market			
Family			

Governance, then, is an umbrella concept covering a broad range of mechanisms for creating order among different actors in the public sector. Governance moves beyond the purely private to collective action. 'Among the issues which governance invites one to analyse are the relationships among local, regional and national levels, the role of the state and its relationship to civil society, the (re)positioning of different interest groups and the framing, orientation and implementation of policies' (Daly, 2003: 115). Moreover, the locale and exercise of power are central to governance and it is especially attuned to the changing set of arrangements between the state and the other logics. As noted by Jessop (1999), the state is more than a political agent; it is also the bearer of certain types of social packages. This latter is a role that is changing as the welfare state shrinks and globalisation intensifies.

As suggested in the discussion of the analytical framework above, there are two routes to governance of home care, a direct route and an indirect one where the policy process acts as a filter. Although we emphasise a comprehensive analysis of the varied logics, the core intervening variable in home care governance is public policy defined here as an action (or non-action) taken by the government or on behalf of it (Heywood, 1997). It is a goal-driven course of action designed to promote, maintain or prevent a particular state of affairs. While other organisations such as medical associations and care societies often make decisions that affect many individuals as well as the home care system, only the government has the



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other countries examined here is the US, with its deliberate constitutional separation of powers among a separately elected president, two houses of Congress and a relatively active judicial system. Despite a great deal of variation in the diffusion of policy-making authority in some parliamentary systems as compared to the US, they all display considerably more concentrated bases of power. Figure 1.2 presents a rough distribution of our case countries in terms of centralisation of institutional power along these dimensions. This distribution corresponds closely to the findings of Lijphart (1999: 189), who classifies Germany and the US as 'federal and decentralised'; the Netherlands as 'semi-federal'; Japan and Sweden as 'unitary and decentralised'; and Italy, New Zealand, Estonia and the UK as 'unitary and centralised'.

Estonia	Italy	Japan	Germany	
New Zealand	UK	Sweden	Netherlands	US
Concentrated				Fragmented

*Figure 1.2 Institutional power in political systems*

The implications of these formal government types for home care governance are likely to be significant. Where power is highly centralised, the government has the formal capacity to make more rapid and comprehensive policy changes. In contrast, the more fragmented the political authority the greater the probability of deadlock and inaction or at best more incremental change. Moreover, in fragmented political systems where competing political parties are able to control particular institutions, there is more likely to be a divided government where one party controls one or several branches or levels and the other party controls others. Although this might contribute towards a more deliberative policy-making process, it can also degenerate into stagnation and gridlock as has been commonplace in the US. Conversely, it might be expected that a highly centralised system such as the UK or Italy produces a policy arena characterised by more frequent and inclusive changes such as major restructuring, often to the detriment of programme stability.

The most obvious dimension of the political context consists of the formal institutions that have been created for making public policy decisions and which define the distribution of power and the relationships among the political players. As such they give distinct advantages or disadvantages to various groups in society. Equally important to understanding governance are the informal practices and structures that have evolved within a particular formal institutional framework. These traditions and rules of the game define a different political logic in each country. They, too, are critical to the



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## **Italy**

The literature often characterises the Italian welfare state as 'conservative-corporatist' but the picture is more complex, especially in relation to home care where welfare arrangements are often 'rudimentary' (Tester, 1996). Informal care by women continues to be the norm, reflecting the strong role of the family in Italian society together with the perception of care as a family obligation (Convery and Cioni, 2001; Österle, 2001). Similar to Germany, at the formal level this expresses itself in the principle of subsidiarity. This is reflected in organisation of formal services where responsibilities are unclear and highly decentralised, public funding is patchy, provision is fragmented and the level of service provision is low (Polverini et al., 2004). In relation to health care, the principle of universalism was never fully implemented and co-payments for services remain high. The same applies to local social services and in home care where private funding solutions are fundamental. At the same time, health care as well as the local social services have seen the introduction of market mechanisms, which have produced a more mixed service provision but further complicated the boundary between the two services (Tester, 1996).

## **Sweden**

Perhaps the clearest example of an egalitarian-type culture is Sweden, which is notable for the very early provision of medical care by the state dating back to the seventeenth century and an extensive range of social services 'from the cradle to the grave'. For instance, early on, towns and cities employed doctors to provide public health care and municipalities operated free hospitals, while in rural areas the central state paid physicians to provide basic care. State involvement in health care was consolidated in the middle of the nineteenth century with the creation of county councils which were chiefly responsible for health care. A considerable expansion of health services only occurred in the post-war period, however, paving the way for the universal health care system as we know it today. In the 1950s, social care services for the elderly were set up as a tax-based universal service organised by the local governments. The historical legacy of public involvement in health and social care is combined with the principle of equality, which is deeply embedded in Swedish society. People have a right to care regardless of income or where they live (Håkansson and Nordling, 1997). This right is part of a person's citizenship and not an individually earned entitlement as in the case of Germany and the Netherlands.



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*Table 1.4 Per capita public expenditure on services for the elderly and disabled (in US dollars)*

	1983 <sup>1</sup>	1988	1993	1998 <sup>2</sup>	Rates of increase
Germany	44	62	111	166	3.8
Italy	21	33	44	42	2.0
Japan	17	24	44	73	4.3
Netherlands	72	77	98	102	1.4
New Zealand	4	4	4	1	n/a
Sweden	202	289	571	791	3.9
UK	54	76	114	116	2.1
US	1	13	15	12	n/a

*Notes:*

1. This is the first year for which figures are available.
2. The figures refer to 1997, the most recent year for which figures are available.

*Source:* OECD (2001b).

demonstrate considerable variation as well. Table 1.5 shows total expenditure on home care as a percentage of GDP ranging from 0.02 per cent in Japan to 0.82 per cent in Sweden. Similar differences are apparent in the public and private distributions for home care and the comparison with spending on institutional care, which in most countries represents multiples of home care spending. Again the limits of the data must be reiterated, however, because they are unlikely to reflect the costs of informal home care supplied by family and friends. These issues will be analysed in more detail in the substantive chapters on formal and informal care givers.

The analysis of available statistics has given a preliminary overview of home care in our countries. In terms of both funding and provision, formalised home care is marginal in these countries, more so in some than in others. At the same time there is no clear evidence for systematic moves away from institutionally-based care. Nevertheless, more public money is being spent on alternative services for older people, such as day centres and home helps. Most importantly, the analysis of the statistics highlights the need to locate home care in the different health and social welfare systems in which it is embedded. While the delivery, funding and rules of home care will be examined in detail in the following chapters, it is useful here to provide a quick review of the complicated nature of governing this amorphous and inclusive area of home care.



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a result of their longer life expectancy, women outnumber men by significant margins in the elderly age cohorts. Furthermore, the sex imbalance increases with age, meaning that as the very elderly cohort expands, the proportion of elderly women will increase. This is particularly crucial for home care, since traditionally women have borne the brunt of home care but now also represent the largest group of users.

## Social Trends

Reinforcing these demographic shifts are the substantial social transformations in modern societies that accompany the individualisation and liberalisation of traditional values. Just at the time when there is an increased need for long-term care giving, social changes have begun to undermine traditional, largely informal and family-based care, mechanisms of care for the elderly. The decline in the extended family and more recently the nuclear family, increased mobility, and trends towards secularisation have undermined traditional support systems and put added pressures on governments to fill the gap.

Moreover, in combination with the economic constraints discussed below, social movements towards equality for women have encouraged more women today to seek fulfilment through a career, with the result in many countries of reducing the supply of informal, unpaid care givers. Within this new cultural milieu, women are less likely than in the past to be willing or able to forgo paid employment to serve as a care giver. Table 1.8 shows the magnitude of the increase of women in the workplace in our countries. Although women continue to provide significant levels of long-term care for family members, coverage is saturated and as a proportion will continue to decrease just when

*Table 1.8 Labour force participation rates of women, 1973–2003*

	1973	1979	1983	1993	1999	2003
Germany	50.3	52.2	52.5	61.8	63.0	64.5
Italy	33.7	38.7	40.3	43.3	45.5	48.3
Japan	54.0	54.7	57.2	61.8	59.5	59.7
Netherlands	29.2	33.4	40.3	56.0	64.4	68.4
New Zealand	39.2	45.0	45.7	63.2	67.4	69.3
Sweden	62.6	72.8	76.6	75.8	76.0	76.9
UK	53.2	58.0	57.2	65.3	68.4	69.2
US	51.1	58.7	61.9	69.0	70.7	69.7

Sources: 1973–93, OECD (1996); 1999–2003, OECD (2004).



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of Sweden). Also it is likely that diversity of provision does not necessarily translate into adequate levels of provision. This gives credence to the more general tenet that in times of cost containment increased diversity of provision often coincides with a targeting of services to those in greatest need or to those without any other means.

Regardless of the policy trends in the provision and funding of services, home care remains overwhelmingly informal women's work. In comparison to formal home care, informal women's work continues to be cheap and readily available in most countries. Irrespective of differences among political systems and cultural attitudes towards the role of women, however, the majority of countries have started to acknowledge the centrality of informal care. This takes different forms, ranging from the gender-blindness of liberal welfare traditions (such as in the US) and gender-specific expectations in traditionally male-dominated collectivist societies (such as in Japan), to the ideology of welfare society (such as in the UK and Sweden), the revival of subsidiarity (in Germany), and payments of carers (such as in Germany and the Netherlands). What has changed is that the marginality of informal home care has come more sharply into focus and the demographic, social and economic pressures for more far-reaching and meaningful governance of this area has intensified.

## CHAPTERS THAT FOLLOW

Chapter 2 explains the foundations of the analytical framework and identifies its innovative features. It defines home care governance as consisting of a range of issues around the organisation of formal care services, the identification of informal care, the definition of the professional territories of care workers and the terms under which care users are included in home care. The chapter explores different approaches of analysing home care governance and presents the social care and the public policy literature as two complementary theoretical perspectives. It uses the questions raised by each body of literature to build a more inclusive conceptual framework for analysing and explaining home care governance across countries. Chapter 3 extends this introduction to the empirical chapters by demonstrating how to conceptualise the context of home care governance, particularly the institutions and ideas that are its key components. It thus provides a systematic analysis of the contexts of home care governance across our countries.

Chapter 4 focuses on formal care services and analyses governance arrangements as related to their organisation. Such governance arrangements are becoming higher on the political agenda in many countries, reflecting the perception that the needs of an increasingly older, and often politically astute, population are confronted with falling resources of informal care and



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## 2. Analysing home care governance: bringing together different conceptual perspectives

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The first chapter began by discussing the specificities of home care and pointed to the fact that home care cuts across different boundaries, especially the boundaries between the public and the private, and between the micro and the macro levels. The chapter then introduced the concept of governance, understood as a combination of different modes of coordination needed to capture the complex nature of home care. On this basis, it presented an analytical framework for studying home care governance from a comparative perspective. The aim of the present chapter is twofold: to explain the source of the analytical framework and, by doing this, to identify its innovative features. This discussion also provides a basis for discussing the contribution of the analysis presented in the following chapters to the existing literature.

The aim of the analysis presented in this book is twofold: first, to systematically map out the governance of home care in relation to a number of areas of governing across our nine countries and, second, to explore the ways in which institutions and ideas (and the interplay between them) shape governing arrangements. This chapter first introduces the notion of governance and discusses how the notion of governance applies to the area of home care. Against this background, it then explores different approaches to analysing home care governance and presents the social care and the public policy literature as two different yet complementary theoretical perspectives.

### CONCEPTUALISING THE GOVERNANCE OF HOME CARE

As Chapter 1 suggests, home care is an area that cuts across many boundaries, especially between the formal and informal and between the public and private. The state is a relative latecomer in relation to home care, and the high degree of societal embeddedness of home care makes for complex forms of coordination. To capture this complexity we use the concept of governance. The concept has become a widely used analytical tool in public policy research (for an overview, see Kooiman, 2000 and Kjær, 2004). The central



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types, whereas the thematic analysis in the following chapters presents a more dynamic picture of changes within the area. Here, Beck Jørgensen and Vrangbæk (2004) suggest distinguishing between three sets of dynamics: changes *within* individual ideal types (for example, in respect to their characteristic features), changes *between* different ideal types (for example, concerning their relative importance), and the existence of *hybrids*, which combine elements of different ideal types.

The instruments of home care governance in turn help to further specify what these logics mean in practice and also suggest that logics vary among instruments. Here, delivery, funding and rules describe distinct sets of instruments of coordinating home care which are also associated with different degrees of involvement or intervention in the case of the logic of the state (see Alber, 1995; Howlett and Ramesh, 2003). In relation to rules, Table 2.1 refers to both the key principle and associated mechanism of governing. Again, the range of instruments of home care governance reflects the different emphases of the two literatures. The social care perspective is particularly concerned with delivery and to a lesser extent funding and the content of rules, whereas the public policy perspective focuses especially on governance through rule setting.

So what are the characteristics of the different types of home care governance? The logic of the state is typically associated with formal and public delivery, and funding following the logic of the state occurs either through taxes or social insurance contributions. Following the principle of hierarchy, rules take the form of command-and-control rules. This contrasts with the logic of associations, where delivery, while still formal, is private, non-profit, and where private funding in the form of donations and membership/professional dues dominates. In this logic, rules are based on the principle of norms and often take the form of negotiations and ethic codes. The logic of the market is related to delivery that is formal and private but for-profit, and private funding in the form of donations and professional dues is prevalent. Rules follow the principle of profit seeking and competition among autonomous actors is the key mechanism of this logic of governance. Finally, the logic of the family is distinct, in that delivery is private but informal, and funding relies on indirect transfers from the family income. Rules are derived from the principle of moral/personal obligation, and tend to take the form of emotional/social relations.

The governance of home care has been conceptualised as different logics and instruments related to the coordination of home care activities. Against this background, the remainder of the chapter explores in more detail different approaches to analysing home care governance. The feminist social care approach is dominant in the field and is most concerned with the (gendered) nature of home care on the one hand, and how the formal institutions of the





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cared for is still an incomplete social right (Knijn and Kremer, 1997; Leira and Saraceno, 2003).

Furthermore, Österle (2001) and Anttonen et al. (2003a) analyse the accessibility of different types of care provision. While Anttonen et al. use the terms 'individualisation' and 'universalisation' as two basic principles regulating the access to care services and benefits, Österle assesses norms related to the level of support using the terms 'equity' or 'fairness'. Individualisation relates to whether and to what extent publicly funded social care services are allocated on the basis of the family status or on the needs of the individual. Universalisation refers to whether and to what extent the allocation of social care is selective, typically based on means-tested procedures or universal availability. On the basis of their approach, Anttonen et al. assign specific care services to certain points in the two dimensions and use them as criteria for the quality of services.

Österle distinguishes three levels of allocated resources that are related to different social policy goals: the first, 'guaranteeing minimum standards', aims at preventing the risk of poverty in the case of care dependency and provides only a minimum level of economic resources or services; the second, 'supporting living standards', grants a level of economic resources or services that prevent the elderly or the informal carers from large drops in their individual living situation; and the third, 'reducing inequality', relates the situation of the individual care receiver or informal carer to the average situation in a society. Here the key issues are the redistribution between the healthy and those in need, for example, through the definition of tax- or insurance-based coverage of the costs or between the wealthier and poorest people in society through the introduction of earnings-related co-payments.

In their overview of the development of social care research, Daly and Rake (2003) criticised this strand of research because of its tendency to focus on key structural characteristics of the welfare state only, and thus to disaggregate the activity social care from the social setting and downplay the key role of gender and power relations in a society. Daly (2002) claims to combine the two strands of research: 'care as a social good' with its embeddedness in gender and social relations prevalent in feminist research and 'care as a public good' with its focus on welfare state regulations on social care. In her research, she discusses the interrelationship between welfare state regulations and societal consequences in respect to the issue of gender equity, the appropriate welfare mix in society, the extent to which care is legitimised, the demand for and supply of labour, the appropriate welfare mix in society and the balancing of the public finances. Bettio and Plantenga (2004) also combine both strands of research and discuss the consequences of different regulations on the employment status and opportunities of women, poverty and fertility rates. Knijn and Kremer (1997) related rights and needs of care givers and care



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### **The Specifics of Home Care as a Policy Subsystem**

The specific features of home care as an area of governance are closely related to its highly gendered nature. The feminist emphasis on the gender specificity of home care governance resonates with the notion of policy subsystems developed in the public policy literature (for an overview, see Jordan and Maloney, 1997). Policy subsystems suggest that policy making organises itself around specific issues or problems because the complexity and specificity of such policy issues requires some degree of division of labour. This also means that the nature of policy issues partly structures politics (as in how policies are made) or as Freeman (1985) puts it, 'policies determine politics'. A policy subsystem is the space where actors discuss a specific policy issue and bargain in pursuit of their interests. Significantly these interactions also occur in the context of sector-specific institutions and underlying ideas (see *ibid.*; Peters, 1992; Parsons, 1995; Howlett and Ramesh, 2003).

So, what are the specifics of home care as a policy issue and what does this mean for the characteristics of the policy subsystem of home care? The review of the social care literature in the first part of this chapter suggests that home care as a policy issue is specific in the three closely related respects: the centrality of gender, the interface between the public and the private, and the close relationship between the macro and the micro levels. This means that home care policies have different meanings and implications for women and men, are characterised by a close co-existence between the private and public spheres of work, and that different levels are tightly related.

The specific nature of home care means that as a policy issue, home care does not fit easily into the public nature of policies precisely because home care stretches the meaning of what public means (Randall, 1998; Waylen, 1998). The fact that home care tends to be associated with the private sphere means that (public) policies of home care are often limited in scope and that women and women's interests in home care are often excluded (Dahlerup, 1987). Yet public policies and the state do impact on home care and women (as carers and cared for) do influence public policies relating to home care. This illustrates the twofold position of the state: the state represents and reproduces gender relations in home care as the more or less tacitly enforced saliency of informal home care demonstrates, while the state is also the key site for renegotiating such relations. Examples of the second aspect are major reform initiatives introducing long-term care insurance in Japan and Germany since the mid-1990s which reflect cultural changes in women's lives, including the greater articulation and recognition of the claim of economic independence through participation in the labour market (see Conway et al., 1998; Briskin, 1999; Charles, 2000).

In terms of the policy subsystem of home care, this has several implications.



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state and possible variations among its different parts, as well as its changeable nature. In a similar vein, Randall (2000) introduces the notion of 'gendered institutionalism' which involves asking questions about the specific politics and policy processes in both historical and comparative perspectives. In contrast, Briskin (1999) highlights the importance of different welfare-state regimes, suggesting that they reflect differences in the political forces shaping countries and differences in more general state-society/public-private relations. Importantly, the gendered statism and institutionalism in feminist writings also points to a broader underlying understanding of institutions. In relation to home care this includes specific institutions (or gender orders, see Pfau-Effinger, 2004) relating to the gendered division of labour, including the labour market, the welfare state and the family.

What are the implications for the comparative analysis of home care governance? As relatively stable structures, institutions point to salient differences among countries and are crucial to explaining home care policies comparatively, not least as institutions enable us to analyse the specific conditions under which home care policies emerge. However, in terms of the range of institutions considered it is important to go beyond mainstream comparisons in public policy, with their focus on the state and the political system as such, and instead also analyse the specific organisational settings and procedures of home care policies as embedded in broader gender orders.

Another way of explaining public policies and variations across countries is to look at ideas understood as traditions, beliefs and attitudes about the world and society (for an overview, see Busch and Braun, 1999; Nahrath, 1999). Views about causal relations and norms form the backbone of institutions and as such also constrain the nature of policy options. At the same time, ideas also serve actors as focal points, ideational prisms or frames that help actors select among different courses of action (see Braun, 1999; Bleich, 2002). As Hall (1993) points out, ideas often constitute a policy paradigm defined as taken for granted assumptions about policy goals, related problems and how to solve them. However, ideas can also change, as powerfully demonstrated by Baumgartner and Jones's (1991) notion of 'punctuated equilibrium'.

The notion that ideas as traditions, beliefs and attitudes play an important role in shaping public policies is also implicit in the feminist literature. However, while the public policy literature focuses on the specific mechanisms by which this occurs, the feminist writings on public policy are more concerned with the substance of the ideas themselves. As the review of the social care literature above discusses, ideas centre around gender. Pfau-Effinger (2004), for example, introduces the notion of 'gender culture' which refers to deeply embedded beliefs and ideas about relations between the generations in the family and the obligations associated with these relations. As Charles (2000) points out, such gender cultures are closely related to the dominant



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## IDEAS

As the discussion of the conceptual framework in Chapter 2 suggests, home care is a highly gendered area of governance. Both formal and informal care are provided mainly by women, and the definition of the border between both types of care giving is related to the mode of participation of women in private and public spheres in society. In terms of the ideas underpinning the governance of care-giving traditions, beliefs and attitudes about the mode of participation of men and women in society and the relations between them are therefore central.

The following analysis uses the concept of gender culture which Pfau-Effinger (2004, 2005) developed in the context of her comparative analysis of female employment and child-care arrangements. Based on different aspects related to the relations and responsibilities between generations and to the division of care work, she distinguishes among different family models and corresponding ideas on gender relations. The family models define societal assumptions about the role of the family compared to other societal institutions in the provision of care, and the underlying values concerning the gender division of labour. Three of the models are particularly relevant in relation to care of the elderly in the home: the housewife model of the male breadwinner family where care is the responsibility of the family and women are the primary carers; the female part-time carer model of the male breadwinner family where women combine care responsibility with part-time work and where care is the main responsibility of the family in part shared with the state, the market and the non-profit sector; and the dual breadwinner/institutional care model where both genders are integrated into paid employment on a full-time basis and where, based on formal care provision, the primary responsibility for care lies with the state, the market or the non-profit sector.

We add a fourth type, the dual breadwinner/female carer model, which in many ways is a liberal variant of the dual breadwinner model. Here the family is primarily responsible for care provision and women are expected to combine care responsibilities with full-time employment. The four models of gender culture point to distinct variations of the divide between the public and the private. Table 3.1 operationalises gender cultures in terms of predominant ideas about the relative state support of formal care services and informal care, respectively, on the one hand, and the relative state support of female labour market participation, on the other.

The predominant gender cultures underpinning the governance of home care across our countries cluster around one set of models: the female part-time carer model of the male breadwinner family and the dual breadwinner/female carer model. Both models assign the main responsibility

Table 3.1 *Ideas underpinning the governance of home care*

Country	What is the predominant model of gender culture?	
	1a. What are the predominant ideas about the relative state support for formal care services underlying government policies?	1b. What are the predominant ideas about the relative state support for informal care underlying government policies?
	2. What are the predominant ideas about the relative state support for female labour market participation underlying government policies?	
UK: Female part-time carer model of the male breadwinner family	1a. <i>Little support</i> Family care to be partly shared with state and especially market and non-profit sector; based on ideas about low (welfare) stateness and 'welfare mix'	1b. <i>Little support</i> Informal care to be acknowledged, but only in part economically; based on idea of mixed economy of welfare within primacy of family care
	2. <i>Little support</i> Women as part/full-time employees; based on ideas about liberalism and 'workfare'	
Estonia: Dual breadwinner/female carer model	1a. <i>Very little support</i> Formal care provision very limited; based on idea of family responsibility for elder care	1b. <i>Some support</i> Economic support for informal care predominate, but only in the case of unavailability of family; based on idea of family responsibility
	2. <i>Little support</i> Women as full-time employees; based on idea of gender equality in labour market but supported by state only in relation to family policy	
Germany: Female part-time carer model of the male breadwinner family	1a. <i>Little support</i> Only limited formal care provision especially by the non-profit sector; based on idea of family care and old/new subsidiarity	1b. <i>Medium support</i> Family care to be supported economically by the state; based on idea of family care and ideas about old/new subsidiarity

<p><i>Italy</i> Housewife model of the male breadwinner family (Southern Italy); Dual breadwinner/female carer model (Northern Italy)</p>	<p>2. <i>Some support</i> Middle-aged women as part-time employees or housewives; based on idea of freedom of choice for women between family work and labour market participation, and idea of family care</p>								
	<table> <tr> <th data-bbox="471 205 897 236"><i>Southern Italy</i></th><th data-bbox="917 205 1323 236"><i>Northern Italy</i></th></tr> <tr> <td data-bbox="471 236 897 381"> <p>1a. <i>Virtually no support</i> Primacy of family care selectively to be shared with market; based on religious family values together with ideas about low stateness</p> </td><td data-bbox="917 236 1323 381"> <p>1a. <i>Little support</i> Family care partly to be shared with state and non-profit sector and especially market (as reflected in employment of personal assistant carers); based on idea of low (welfare) stateness</p> </td></tr> <tr> <td data-bbox="471 381 897 505"> <p>1b. <i>Little support</i> Informal care to be selectively supported; based on ideas of social security/solidarity coupled with welfare mix</p> </td><td data-bbox="917 381 1323 505"> <p>1b. <i>Little support</i> Some regional and local support; based on idea of low (welfare) stateness</p> </td></tr> <tr> <td data-bbox="471 505 897 609"> <p>3. <i>Virtually no support</i> Women not in paid employment; based on religious family values together with ideas about low stateness</p> </td><td data-bbox="917 505 1323 609"> <p>2. <i>Little support</i> Women as full-time employees; dual breadwinner as default option; based on idea of low (welfare) stateness</p> </td></tr> </table>	<i>Southern Italy</i>	<i>Northern Italy</i>	<p>1a. <i>Virtually no support</i> Primacy of family care selectively to be shared with market; based on religious family values together with ideas about low stateness</p>	<p>1a. <i>Little support</i> Family care partly to be shared with state and non-profit sector and especially market (as reflected in employment of personal assistant carers); based on idea of low (welfare) stateness</p>	<p>1b. <i>Little support</i> Informal care to be selectively supported; based on ideas of social security/solidarity coupled with welfare mix</p>	<p>1b. <i>Little support</i> Some regional and local support; based on idea of low (welfare) stateness</p>	<p>3. <i>Virtually no support</i> Women not in paid employment; based on religious family values together with ideas about low stateness</p>	<p>2. <i>Little support</i> Women as full-time employees; dual breadwinner as default option; based on idea of low (welfare) stateness</p>
<i>Southern Italy</i>	<i>Northern Italy</i>								
<p>1a. <i>Virtually no support</i> Primacy of family care selectively to be shared with market; based on religious family values together with ideas about low stateness</p>	<p>1a. <i>Little support</i> Family care partly to be shared with state and non-profit sector and especially market (as reflected in employment of personal assistant carers); based on idea of low (welfare) stateness</p>								
<p>1b. <i>Little support</i> Informal care to be selectively supported; based on ideas of social security/solidarity coupled with welfare mix</p>	<p>1b. <i>Little support</i> Some regional and local support; based on idea of low (welfare) stateness</p>								
<p>3. <i>Virtually no support</i> Women not in paid employment; based on religious family values together with ideas about low stateness</p>	<p>2. <i>Little support</i> Women as full-time employees; dual breadwinner as default option; based on idea of low (welfare) stateness</p>								
<p><i>Japan</i> Female part-time carer model of the male breadwinner family</p>	<p>1a. <i>High support</i> Family care to be shared with state to a considerable extent; based on idea of universalism combined with old/new subsidiarity (as reflected in Gold Plan)</p> <p>1b. <i>Little support</i> Little but increasing support for informal care; based on idea of primacy of support through formal care services</p> <p>2. <i>Some support</i> Women as part/full-time employees; based on idea of increase labour market participation in ageing population</p>								

Table 3.1 continued

Country	What is the predominant model of gender culture?	
	1a. What are the predominant ideas about the relative state support for formal care services underlying government policies?	1b. What are the predominant ideas about the relative state support for informal care underlying government policies?
	2. What are the predominant ideas about the relative state support for female labour market participation underlying government policies?	
Netherlands Female part-time carer model of the male breadwinner family	1a. <i>High support</i> Family care to be shared with state to a considerable extent; based on ideas about universalism combined with old/new subsidiarity	1b. <i>Some support</i> Informal care to be acknowledged and supported, also economically; based on ideas of universalism coupled with new subsidiarity
	2. <i>Some support</i> Women as part-time employees; based on idea about increase of labour market participation	
New Zealand Female part-time carer model of the male breadwinner family	1a. <i>Medium support</i> Family care to be partly shared with state and charitable trusts; based on idea of egalitarianism combined with old/new subsidiarity	1b. <i>Little support</i> Little, but increasing means-tested support of informal care; based on idea of primacy of formal care provision
	2. <i>Some support</i> Women as part/full-time employees; based on focus to increase labour market participation and welfare	
Sweden Dual breadwinner/institutional care model	1a. <i>High support</i> Primacy of formal care services; based on ideas of universalism and individualism, but increasing importance of idea of family support	1b. <i>Little support</i> Based on idea of primacy of formal care provision; little, but increasing support of informal care based on idea of public responsibility for care

US: Dual breadwinner/female carer model.

2. *High support* – Women in full-time employment; based on idea of state-supported dual breadwinner model
- 1a. *Little support* – Family care partly to be shared with state and the non-profit sector and especially market; based on ideas of low (welfare) stateness and ‘welfare mix’
- 1b. *Little support* – Some highly varied and limited support through programmes for indigents under Medicaid, but otherwise little support for informal care; based on idea of low (welfare) stateness and ‘welfare mix’
2. *Little support* – Women as full-time employees; dual breadwinner as default option (as reflected in low social services and health insurance based on employment); based on idea of liberalism

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Sources: – Spencer (1996); Coles and Wickers (1998); Glenshaw (1998); Krige (1998, 2003); Simon and Trifletti (1998); Ashon (2003); Chamberlayne and King (2000); Trydegaard (2000, 2003); Trifletti et al. (2001); Ballock (2003); Campbell and Bergami (2003); Centers for Medicare and Medicaid Services (2003a, b); Means et al. (2003); Saks et al. (2003); Rethin and Phairanga (2004); Japan Ministry of Health, Labour and Welfare (2004a); Plan-Effinger (2004); Polzerini and Lammara (2004); Polzerini et al. (2004); Dahlberg (2005); Fugson (2005); Giulian and Lewis (2005); Saks (2005); Strohbelly (2005); Krivnar and Saks (2006).

for care provision to women within the family framework, despite labour market participation. The only exceptions are Italy and Sweden. In terms of the gendered ideas about the relative state support for formal care services and female employment, Italy is still close to the traditional housewife model of the male breadwinner family. This is especially true in the southern regions, pointing to the continued strength of religious family values together with a long tradition of weak stateness. In the northern part of the country, however, dual career families are more the norm and ideas of non-familial care are stronger (Trifiletti et al., 2001). These extreme geographical divisions reflect salient regional divisions between North and South, whereby a dual polity makes for a dual welfare policy (Fargion, 2005). In Sweden, by contrast, the dual breadwinner/institutional care model continues to be strong, and the predominant ideas underlying governance centre around extensive state support for both formal care services and female labour market participation.

The clustering around one set of models of gender culture, though, disguises interesting differences among countries, and here a distinction emerges between more liberal and more conservative variants of gender culture. Both variants are based on two complementary ideas: the idea of very selective state support directed at those in need and the idea of family care partly shared with the non-profit sector, especially the market. In the more liberal variant of gender cultures, most notably the US and the UK and *de facto* in Northern Italy, this reflects a strong tradition of low (welfare) stateness and liberalism that finds its more contemporary expression in ideas around the centrality of work for (personal) welfare, especially as it surfaces in workfare policies and ideas about the superiority of welfare mix. In Estonia, the idea of low (welfare) stateness concerns care for frail relatives at home only while the state strongly supports the provision of childcare to facilitate labour market participation of women. Moreover, in the US and Estonia this means that the lack of state support for home-based care makes for the *de facto* expectation that women engage in full-time employment while also taking on care responsibilities for frail relatives at home.

In the more conservative variant of gender cultures such as Germany, Japan and to some extent also the Netherlands, ideas around the primacy of the family as the basic unit of society and its responsibilities in relation to welfare provision are central. In its contemporary expression of new subsidiarity this means that the state does in part support women as carers and employees, but first and foremost to maintain the existing model of the female part-time carer.

Finally, there are interesting variations regarding the relative state support of formal care services and informal care, respectively. The two sets of support are closely related and the variations that exist remain under the same model of gender culture. In the Netherlands and Sweden, for example, the ideas about the relative state support have long been primarily centred on formal care

services and have therefore been less strong in relation to informal care. Japan and Germany for their part are interesting examples of the very different ideational foci of newly introduced public funding schemes, with state support of formal care key in one and state support of informal care key in the other.

## INSTITUTIONS

The gendered nature of home care as an area of governance requires us to consider a broad range of institutions, notably both social and political institutions. We use the typology of different care models or care regimes developed by Anttonen and Sipilä (1996) as a starting-point for capturing the social institutions underpinning the governance of home care, and combine this with Pfau-Effinger's (2004) notion of gender orders, which describes the existing structures of the gendered division of labour. This means analysing the prerequisites of such models in terms of the gendered structures of the family, the labour market and the welfare state. More specifically, we distinguish between the extent to which the state supports the delivery of formal care services and informal care giving on the one hand, and the labour market participation of women on the other. The latter type of support is important because many family carers are women of working age and because state support for female labour market participation often takes the form of welfare service employment (such as formal care services). It is interesting that in contrast to child care, the two types of support are often less well integrated in home care. In summary this makes for four models. In the public service model the state supports both types, with formal care services available universally and only some support for informal care. Women's participation in the labour market is high. Under the family care model, state support is low on both counts and the availability of formal care services is very limited, as is the support for informal care. The labour market participation of women is low. In the means-tested model, state support focuses on women in need, and publicly funded services and support of informal care are available only to the deserving (such as lone mothers and the long-term unemployed). Labour market participation of women is relatively high but not explicitly supported by the state. Under the subsidiarity model, state support for formal care services is secondary to other forms of support, especially of informal care, and state support for women's labour market participation is limited. Publicly funded services are limited and meant to support family care, and the labour market participation of women mainly takes the form of part-time employment.

In terms of the political institutions underpinning the governance of home care, the analysis focuses on the policy subsystem and especially the



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Table 3.2 *Institutions relating to the governance of formal care services*

Country	Care regime – predominant regime: Public service model, family care model, means-tested model, subsidiarity model? (in terms of the relative state support 1. for formal care services and 2. for female labour market participation)	Type of policy subsystem – Political power over formal care services: Extent of (de)centralisation and cohesiveness? (in terms of 1. regulation and 2. funding)
UK	<p>Means-tested model</p> <ol style="list-style-type: none"> <li>1. Formal care services: social care services are means tested, scope of health care services is limited; result: considerable reliance on family care complemented by privately paid services</li> <li>2. Female labour market participation: state support only for ‘problem groups’ (such as lone mothers, long-term unemployed); result: middle-range labour market participation with considerable part-time employment</li> </ol>	<p>Centralised and cohesive</p> <ol style="list-style-type: none"> <li>1. Regulation: central government decides on overall framework (such as for quality and performance standards); specification through central regulatory bodies</li> <li>2. Funding: central government allocates funds to local authorities (social care) and care trusts (health care); some local autonomy concerning allocation of funding</li> </ol>
Estonia	<p>Family care model</p> <ol style="list-style-type: none"> <li>1. Formal care services: availability of social and health care services limited, especially in the rural areas; result: heavy reliance on family care</li> <li>2. Female labour market participation: state support limited; result: high female labour market participation and low level of part-time work</li> </ol>	<p>Strongly decentralised and cohesive</p> <ol style="list-style-type: none"> <li>1. Regulation: national government decides on framework regulating social care services and also more specific regulation for health care services; local authorities responsible for more specific regulation of social care services (e.g., eligibility, costs)</li> </ol>



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Sweden	<p><b>Public service model</b></p> <ol style="list-style-type: none"> <li>1. Formal care services: social care services mainly available universally, but increasingly means tested, health care services available universally on the basis of need; result: formal care services but also some reliance on family support</li> <li>2. Female labour market participation: high state support, result: high female labour market participation with high level of part-time employment</li> </ol>	<p><b>Strongly decentralised and cohesive</b></p> <ol style="list-style-type: none"> <li>1. Regulation: national government sets basic norms of societal responsibility on home nursing and social care; local authorities decide on local goals and rules for implementation</li> <li>2. Funding: local authorities decide on funding</li> </ol>
US	<p><b>Means-tested model</b></p> <ol style="list-style-type: none"> <li>1. Formal care services: social care services are generally means tested, scope of health care services is limited; result: considerable reliance on family care complemented by privately paid services or private long-term care insurance</li> <li>2. Female labour market participation: little state support except for targeted groups such as single mothers, school dropouts and long-term unemployed; result: high labour market participation with considerable full-time employment</li> </ol>	<p><b>Highly decentralised and fragmented</b></p> <ol style="list-style-type: none"> <li>1. Regulation: local/state authorities decide on organisation of social care services; federal, state and local governments share decisions on organisation of health care services for elderly with heavy influence of private insurers and medical professions</li> <li>2. Funding: local/state authorities decide on the funding of social care services; state and federal authorities decide on funding of health services</li> </ol>

Sources: Spencer (1996); Coles and Wooten (1998); Glendon (1998); Krjajic (1998, 2001); Trifletti (1998); Albet and Schölskopf (1999); Ashton (2000); Chamberlayne and King (2000); New Zealand Ministry of Health (2000, 2002a, 2003); Trydegaard (2000, 2003); Do (2001); European Observatory on Health Care Systems (2003); Japan Ministry of Health, Labour and Welfare (2002, 2004a); SOG (2002); Bollock (2003); Campbell and Bergant (2003); Centers for Medicare and Medicaid Services (2003a, b); Meunier et al. (2003); Saks et al. (2003); European Observatory on Health Systems and Policies (2004); Polverini et al. (2004); Theobald (2004); Rauch (2005); Ministero del Lavoro e delle Politiche Sociali (2005); Kriess and Scott (2006).



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New Zealand	Means-tested/subsidiarity model	Centralised and cohesive
	1. Support of informal care mainly through care services: some care services are universal and others are means-tested, scope of health care services is broad, ongoing review of local inconsistencies.	1. Regulation: central government decides on overall framework (such as for quality and performance standards); specification through central regulatory bodies
	2. Female labour market participation	2. Funding: central government allocates funds to local authorities; some local autonomy but centralised system of accountability
Sweden	Public service model	Strongly decentralised and cohesive
	1. Predominance of support through public services; economic benefits restricted	1. Regulation: municipalities decide whether to provide economic support and if so, what criteria to use
	2. Female labour market participation	2. Funding: municipalities decide on funding
US	Means-tested model	Highly decentralised and fragmented
	1. Support of informal care through care services: social care services are means tested, scope of health care services is limited; considerable reliance on family care complemented by privately paid services or private long-term care insurance	1. Regulation: local/state authorities decide on organisation of social care services; federal, state and local governments share decisions on organisation of health care services for elderly with heavy influence of private insurers and medical professions
	2. Female labour market participation	2. Funding: no cash payments by government but some long-term private plans include limited cash payments

Sources: Spence (1996); Cusack and Wootton (1998); Glendon (1998); Kräja (1998, 2001); Trifkovič (1998); Alker and Schilling (1999); Ashton (2000); Chamberlayne and King (2000); New Zealand Ministry of Health (2000, 2002a); Trydegard (2000, 2003); Do (2001); European Observatory on Health Care Systems (2001); SOG (2002); Bullock (2003); Campbell and Ragonesi (2003); Centers for Medicare and Medicaid Services (2003a, b); Means et al. (2003); Saks et al. (2003); Bontis and Plantinga (2004); European Observatory on Health Systems and Policies (2004); Fehrmis (2004); Japan Ministry of Health, Labour and Welfare (2004b); Polverini et al. (2004); Thorburn (2004); Rauch (2005); Kivimäki and Sore (2006).



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*Table 4.2 Public and private expenditure on long-term home care as a percentage of GDP, 2002*

Country	Public long-term care expenditures	Private long-term care expenditures
Estonia	n/a	n/a
Germany	0.43	0.04
Italy	n/a	n/a
Japan	0.25	0.00
Netherlands	0.56	0.05
New Zealand	0.11	0.01
Sweden	0.78	0.04
UK	0.32	0.09
US	0.17	0.16

*Note:* The notion of 'long-term care' used in a national context can be substantially broader, e.g., by including residential homes for older people (e.g., Netherlands, Nordic countries). Public costs include all costs incurred by public institutions, municipalities, sickness funds or old-age funds. Private spending refers to out-of-pocket payments or payments by private long-term care insurance when the definitions are available.

*Sources:* Germany: OECD Health Data 2004; US: OECD Health Data 2004; Japan, New Zealand, UK and Sweden: Secretariat estimates based on replies to the OECD questionnaire on long-term care.

formal care services are the area of home care governance that engenders the most political debate for a number of reasons. Funding from public sources and provision by paid care workers means that formal care services are clearly visible and resemble other welfare services. As Table 4.2 demonstrates, with the exception of the US, across our countries public expenditure is by far the main source of funding for formal care services.

The ambivalent position of formal care services in relation to home care as a whole is coupled with a double division within services themselves between health and social care on the one hand and public and private provision on the other. As such, formal care services well encapsulate a central and salient tension in the governance of home care: the tension between integration and fragmentation. This chapter analyses governing arrangements in relation to formal care services in terms of the relative degrees of integration and fragmentation, looking at governing through provision, funding and rules. From a cross-country perspective, the chapter also explores which types of ideas and institutions provide more or less favourable conditions for relatively integrated governing arrangements.



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life and female employment has led to the emergence of a strong element of private provision, often in the form of migrant carers individually employed and paid for by families. Indeed, this has become the second most important pillar in the care mix after informal care (Polverini et al., 2004).

In terms of variations across countries, Sweden emerges as a classical example of the logic of the state, and the integration of delivery is very high. Sweden is the only one among our countries where health and social care services are integrated and where both services are in the hands of public providers. The last aspect resonates with a care regime that gives primacy to formal care service typical of the public service model. In the case of Sweden, this is further strengthened by a gender culture that combines ideas of individualism and universalism. In this model, universal access to formal care services is seen as the central means to secure the independence of individual citizens, both older people and women in paid employment. Additionally, in half of the localities county councils have delegated the responsibility for home nursing to municipalities (National Board of Health and Welfare, 2000). This makes for highly integrated service provision since municipalities also provide social care-oriented home help services. An insufficient increase of funding, however, has limited the development of service integration. Earlier hospital discharge has increased the care needs and this has taken up a much higher proportion of the care resources than anticipated. As a consequence, the municipalities have focused on service delivery for the severely care-dependent elderly and have neglected services for the elderly with only minor needs (Trydegard, 2003). In addition, opening up the care sector for private providers within the framework of an emerging ideology of welfare mix has put the existing system under pressure. The number of non-public providers delivering home care for municipalities increased by 146 per cent between 1995 and 1998 (National Board of Health and Welfare, 2000) although the overall number remains small.

The relative integration of services is less strong in Germany and the Netherlands. Although health and social care services are integrated in both countries, private non-profit providers have traditionally dominated the provision of health and social care services. This mainly reflects the strength of ideas surrounding subsidiarity in the context of a gender culture based on the female part-time care model of the male breadwinner family. Subsidiarity gives preference to care provided by civil society as opposed to public provision by the state. In both countries, the logic of associations is increasingly complemented by the logic of the market, leading to the rise of for-profit providers.

In the Netherlands, the delivery of formal care services is in the hands of non-profit organisations, regional so-called 'Cross' associations. The associations go back to earlier denominational organisations that gradually



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a national framework and complement each other. Under the long-term insurance plan, municipalities as the insurers of the long-term care insurance have the responsibility of promoting the health and welfare of the elderly at home. Nevertheless, municipalities contract with a wide variety of organisations, including private-sector companies, for home care. This reflects a specific design feature of the insurance, notably the fact that care users access services based on an individual long-term care service usage plan and can make use of public and private medical care and welfare services comprehensively. They can choose the type of service and facilities they desire from services provided by various organisations, such as private companies, agricultural cooperatives, livelihood cooperatives, volunteer organisations and so forth.

What emerges is a picture of fragmentation of governing through delivery in the form of variations of the double fragmentation between health/social care services on the one hand and public/private providers on the other. The variations are related to contextual factors that support provision by non-public providers (as the idea of subsidiarity in the case of Germany and the Netherlands) and that means that political power lacks cohesion (adding further layers of fragmentation) as in the cases of Italy and the US.

## GOVERNING FORMAL CARE SERVICES THROUGH FUNDING: VARIATIONS OF THE SETTLEDNESS OF PUBLIC FUNDING

The governance of formal care services through funding centres around arrangements relating to how formal care services are paid. The variants that exist mirror those in other welfare services and include public funding through taxes and social insurance, private funding through private donations (reflecting the logic of associations) and private insurance together with out-of-pocket payments (reflecting the logic of the market). The relative degree of (de)centralisation of responsibility for funding and the relative degree of integration of funding for health and social care services cut across the existing variants. More specifically, the variants of governing through funding make for different degrees of settledness of governing through funding, understood as more or less stable arrangements for funding formal care services that allow for more or less institutionalised access to funding.

What are the possible explanations for different degrees of settledness of governing through funding? The settledness of funding is likely to be higher in the case of public funding either through taxes or social insurance than through private funding, not least as the latter is often based on a portfolio of sources, some of which, like out-of-pocket payments, are potentially unstable.



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