



Quasi-marketisation in domiciliary care: varied patterns, similar problems?

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Abstract

Purpose – This paper seeks to explore various types of quasi-market governance in domiciliary elderly care with an interest in both the institutional variety of these governance arrangements and their assumable consequences, against the twofold background of the EU care policy agenda and the Nordic experience.

Design/methodology/approach – Based on evidence from four Western European countries, the paper examines how recent reforms have changed the provision of domiciliary care, including the shape of vertical and horizontal governance arrangements. Moreover, summarizing results of previous research and drawing on theoretical reflections rooted both in economics and sociology, the paper discusses the wider impact of these reforms.

Findings – The analysis points to country-specific limitations of the quasi-market approach regarding issues such as the work-life balance of carers and the access to adequate services.

Originality/value – By combining different scientific approaches and exploring several institutional contexts, the paper offers new insights both in problems of quasi-market governance and their cultural colouring.

Keywords Governance, Elder care, Western Europe

Paper type Research paper

1. Introduction

This paper raises questions related to the evolution of governance arrangements in domiciliary elderly care systems. By showing to what extent, and in which ways, these systems have been affected by the transnational movement towards quasi-marketisation, we will demonstrate that this movement exhibits different forms but sets general (though nationally coloured) limits to a socially-balanced provision of elderly care. In the official European Union (EU) discourse, this balance is established through governance arrangements that endorse need-responsive provision, improve the quality of care work and engender a sound work-life balance for carers (European Commission, 2008).

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This vision overlaps with the universalistic Nordic model of care provision that is based on generous care provision (including household-related services) within a strong public sector and with a minimal burden left to informal carers. A question is how European domiciliary care systems evolve with ongoing marketisation, against the background of both this EU agenda and Nordic universalism.

Our starting point is the European Commission's stipulation that "competition among providers and among insurers" can be deemed "a means to reduce costs of care and to enhance quality" (European Commission, 2005, p. 5). This contention is at the core of the quasi-market model, which represents a mode of governance shaped both by (more or less) public regulation (including funding) and by competition-based interaction. We will explore the developments of these quasi-markets internationally and challenge the afore-sketched contention by drawing on different strands of socio-economic and sociological theory. Putting a particular emphasis on what is generally labelled internationally as personal care[1], we will describe these developments in four non-Nordic European nations – Britain, France, Belgium and Germany – that exhibit different frameworks for domiciliary care: a long-established purchaser-dominated social care market (Britain); a consumer-led home care system (Germany); and institutional arrangements where "welfare-bureaucratic" regulation coincides with household-based forms of "marketised" care supply (Belgium and France).

We commence by a quick foray into the history of the four domiciliary care systems and their governance structures. We understand governance to be the multi-actor processing of a given societal activity and view both contractual partnerships between purchasers and providers[2] and arrangements between formal and informal care as ingredients of horizontal governance. While free market interaction can also be considered to be horizontal in kind, we refer to vertical governance as the interplay of regulatory forces located at different hierarchical levels of the institutional architecture of a given care system (e.g. central government funding or in-house provision by local authorities). In the second section, we explore how quasi-markets have transformed these systems and how they have affected horizontal and vertical governance arrangements across the four countries. We then develop some theory-based observations about the quasi-market's implications in terms of governance structures and outcomes. The concluding section summarises the argument and offers a brief outlook for the future.

2. The creeping institutionalisation of domiciliary care – some historical considerations

Domiciliary elderly care services were long incumbent on the domestic sphere. Over the course of the twentieth century, however, domestic responsibilities became partially "outsourced" – first with the creation of associations and then, more vigorously, with welfare states involvement (Katz and Sachße, 1996). Elderly care became subject to top-down (vertical) regulation (public norms, state funding) while being simultaneously based (in the horizontal dimension) on a division of work between informal carers and formal service provision, on the one hand, and on non-profit service delivery, often in collaboration with local authorities, on the other. In the Anglo-Saxon world, this welfare mix was encapsulated by the concept of "community care". However, this (partial) institutionalisation of elderly care proceeded in different ways (Laville and Nyssens, 2001; Burau *et al.*, 2007). Roughly, it developed in line with national welfare regimes (Esping-Andersen, 1990) and the "defamiliarisation" of social protection schemes.

Depending on the degree of this defamiliarisation, women had varied options to transcend their (inherited) family role through exercising social rights (Lister, 1997), including with respect to social services required for the care of family members.

In Belgium and France, the typical pattern of the twentieth century, besides family care, was formal provision relying on partnerships between the welfare state and the non-profit sector. These partnerships formed a “corporatist” setting (Bahle, 2003) in which home care, though being (partially) funded by the state or by social security funds, was delivered mainly by non-profit organisations (associations) entrusted with a public service mission under direct welfare-bureaucratic oversight (*tutelle*). Public authorities governed the sector on behalf of users by setting professional norms and (some) quality standards. Non-profit organisations remained the main providers of personal care and had considerable influence on these standards and on the way services were being provided. By this arrangement, at least conceptually, the role of informal carers was supposed to be reduced.

At first glance, things were quite similar in Germany. The twentieth century saw the rise of huge service-provider non-profit agencies (called *Wohlfahrtsverbände*), entrusted by the state with public service provision including elderly care. However, in stark contrast with its Western neighbours, because of strong family traditions the German system never embraced a broad supply of formal personal care. Services supporting elderly people at home were always low on the agenda of both the non-profit sector and the welfare state. Where frail citizens did not have the benefit of family support, church-based and volunteer services were available, albeit with limited capacities. During the 1970s and 1980s, municipalities stepped in occasionally with the intention of providing integrated home care services. However, they did not become the lead agencies of the (largely nursing-centred) home care system taking shape with the long-term insurance scheme established in 1995. Overall, it was never intended here to provide the full range of home care services.

Britain was different in that local authorities were long seen as being responsible for covering all needs of the (less wealthy) frail elderly, including the supply of personal care. This coverage was organised on the basis of central state funding and with limited (legal) family obligations. The bulk of services were provided by in-house agencies of municipalities while non-profit organisations played a role as a junior partner and never achieved the same institutional status as their counterparts in mainland Europe (Means *et al.*, 2002). In contrast, residential provision was long endorsed more vigorously. Moreover, while the British approach was blended with a universalistic colour, services were often confined to poorer sections of the population. Overall, then, the UK system, while being less family oriented than the German one, placed a considerable burden upon private households as well.

In all four countries, post-war national and regional laws on social (and health) care, together with growing public funding, made home care increasingly subject to vertical governance. Yet this movement did not cover the whole range of elderly care needs. Moreover, given the intensive collaboration between local public authorities and non-profit agencies, on the one hand, and the persistent division of labour between formal(ised) care, whether provided by local public authorities or non-profit agencies, and family support, on the other, considerable space was left to horizontal governance during this period.

3. Quasi-markets on the rise, yet in varied forms

From the 1980s onwards, most Western societies have seen the proliferation of new public management (Pollitt, 2007). This movement embraced the introduction of

quasi-markets into social (and health) care, although in various forms (Burau *et al.*, 2007; Bode, 2008). The NPM mantra turned users into consumers and shifted statutory authorities into the role of purchasers in a competitive supplier market (Le Grand, 1991). Input-oriented funding was replaced by output-based payments, via fixed-term contracts with providers and benchmark-based evaluation. This was meant to eliminate both (alleged) inefficiencies arising from bureaucratic administration and poor responsiveness to users or payers (McMaster, 2002).

In some countries, the idea of separating purchasers and providers proved a key trigger for institutional change. Whereas municipal (in house) providers had been strong, governments sought to disconnect them institutionally from their funding departments or to out-source their activities. Elsewhere, the “terms of trade” between funders and providers were transformed by rewriting the contracts to be agreed upon by funding agencies and independent providers. Beyond this, care recipients (or their families) were invited to behave like consumers by using public allowances or vouchers to buy services according to their own preferences – although within a framework of norms and standards set by statutory authorities. Whatever the regulatory approach, however, provider competition became a crucial element (Table I).

Britain has been among the pioneers of quasi-market governance in Europe, with home care being one of the sectors where this mode of regulation was introduced quite forcefully (Means *et al.*, 2002; Newman *et al.*, 2008). The current care system is both highly competitive and strongly regulated since it is based on provider competition and on generalised quality standards that are established and overseen by national bodies. Local authorities have remained the focal points because they manage both commissioning and case management schemes, including need assessments and care plans, according to the financial situation of the users (Malley *et al.*, 2010). Providers are selected after public tendering, including price inquiry. Moreover, direct payment schemes have been introduced to enable users to freely purchase the services they need (Fernandez *et al.*, 2007). While, in accordance with policies geared towards downsizing residential care, the volume of home care hours granted by local authorities went up considerably during the 1990s, the number of recipients fell sharply[3]. Thus, compared to the past, there are less entitled users, but more extensive services concentrated in those most vulnerable. This implies a growing role of informal care in some sections of the system. A national “Commission for Social Care Inspection” has implemented a standardised “star rating” scheme based on a systematic review of outputs (Clarkson *et al.*, 2009). The bulk of home care services are nowadays purchased from non-statutory agencies, mostly from for-profit firms[4]. This preference for the independent sector connects with lower prices and greater flexibility regarding open hours, etc. but it comes at the price of marginal working conditions for many professional carers and high staff turnover (Newman *et al.*, 2008, p. 533).

Germany has seen similar developments. Following the introduction of long-term care insurance, a vibrant provider market developed and for-profit providers took centre stage (Bode and Firbank, 2009, pp. 332-5; Rothgang, 2010). The non-profit sector, which meanwhile represents only 45 per cent of the market in terms of persons cared for and 39 per cent in terms of involved agencies, was seriously challenged for its leadership position (Statistisches Bundesamt, 2009). Domiciliary provision remained focused on nursing care, although a small personal care package and, more recently, extra-benefits to organise attendants for those affected by dementia, were added. Households eligible to receive additional social assistance (less than 10 per cent of those receiving long-term

Table I.
Major characteristics
of quasi-market based
elderly care
arrangements

	UK	Germany	France	Belgium
Traditional regulation of domiciliary care beyond nursing	State-led universalistic services for the poor, provided by local authorities	Public-non-profit partnerships for a dispersed and random provision of local services	Public-non-profit partnerships for a broader provision of services	Public-non-profit partnerships for a broader provision of services
Quasi-market arrangement	Replaces traditional regulation	Largely replaces traditional regulation	Coexists with the traditional regulation	Coexists with traditional regulation
Particular background of the arrangement	Focus on increasing cost-efficiency (and quality) by quasi-market commissioning	Focus on free user choice (including of taking out care allowances), with benefit caps	Focus on job creation and some user choice	Focus on job creation
Major pattern	Public tenders implemented by local authorities and direct payments (cash for care)	Care allowance (cash-for-care) permitting private purchase	Service voucher	Service voucher
Access for users	Conditional on income and level of dependency	Full personal care conditional on income	Care allowance (cash-for-care)	Service voucher: open to everybody
Nature of providers				
	69% for-profit 19% public 12% non profit Local inspection of input characteristics Systematic review of outputs, standardised and centralised	60% for-profit 38% non-profit 2% public (besides that: low-level jobs created privately) Admission based on some input norms Systematic inspection of outputs, standardised and centralised (but focused on nursing care)	Care allowance: conditional on level of dependence Service voucher: open to everybody 80% directly employed by users 20% contracted by organisations (80% associations, 11 % public authorities, 9% for-profit) Nothing for direct Employment Admission based on some input norms for all types of providers Limited output control for some formal care providers	Service voucher 56% for-profit 27% associative 18% public (traditional domiciliary care: 75% public associations 25% public) Service voucher: almost inexistent Traditional domiciliary care: control of inputs, standardised and centralised

care benefits) are offered additional home help services. Recent reforms have brought systematic quality inspection the results of which are used to publish a star-rating report focusing largely on nursing care. Marketisation has made itself felt most clearly in cases where care recipients use their insurance benefit – which rarely suffices to meet a frail person's needs as defined by the assessments – to select a provider from the wide range of local suppliers. Provider competition is unrelenting, however, entailing considerable pressures on wages and working conditions (Slotala, 2010). Importantly, care insurance benefits are still being largely taken out as a care allowance that is used to remunerate spouses or daughters. In 2010, more than two-thirds of those eligible for these benefits took this option[5]. Thus, personal care is frequently organised on an informal basis, with care-providing households sometimes using their allowance for employing home helps at the lowest level possible.

In Belgium and France, home care provision has become exposed to a particular pattern of market pressure. Paid care work subsidised by the state via a voucher system was seen as the silver bullet both for combating unemployment and improving formal home care provision. Regarding the public discourse, a further driving force behind these policies was the growing public expectation regarding the work-life balance of families.

In France, several reforms have sought to make private households, including those providing personal care to frail elderly people, employers of home helps (Marquier, 2010). Major incentives included tax exemptions and the introduction of pre-paid service vouchers that were deemed to ease the administrative burden associated with the recruitment of private employees. A legal avenue was created to give existing (and new) non-profit agencies the opportunity to embark in this market as brokers[6]. A new care allowance (allocation personnalisée d'autonomie), granted to the frail elderly after needs assessment by the Départments (the largest territorial divisions in France), brought additional change in 2002 (Le Bihan and Martin, 2010). Beneficiaries became entitled to use the allowance for hiring private employees or selecting a supplier (where possible). Meanwhile, all types of service providers (including for-profit ones) are admitted to the field, provided that basic input standards are respected. These standards are more demanding when the service addresses vulnerable people but are, overall, lower (in terms of required skills, accountability rules, etc.) than under the traditional model (*tutelle*). Recent reforms also contained measures (e.g. increased training) to foster professionalisation[7]. Although competition is still its infancy and commercial firms hold only 2 per cent of the market (Devetter *et al.*, 2009, p. 21), numerous providers have embarked on aggressive market development campaigns.

In Belgium, there is a marked distinction between home help and domiciliary care targeted to frail adults. The former, deemed to require (modest) technical skills only, is highly marketised while the latter has remained under direct welfare-bureaucratic oversight (*tutelle*). In 2001, the federal state created a service-cheque scheme resembling the French model. However, this scheme only addressed tasks for which the social bond between workers and recipients was assumed to be weak. In this area, providers are quite varied, including for-profit firms and public agencies, but also voluntary sector organisations, such as “work integration social enterprises”[8]. In stark contrast to France, the service-cheque scheme excludes the hiring of private employees directly by the users. Moreover, as far as the most vulnerable citizens were concerned, quasi-markets did not replace home care services under welfare-bureaucratic regulation. Services must always be approved by regional public authorities, and

strict procedural norms and high quality standards apply. Demand is higher than supply, and there is no provider competition. Thus, Belgium has resisted the NPM agenda in one important section of its domiciliary care system[9].

4. Horizontal and vertical, public and private: dynamics and variety

Looking at the most recent period (1990-2010), the four care systems have undergone considerable change. Formal care provided by salaried workers on the whole has been strengthened, although informal care remains essential. As to the vertical organisation of the four domiciliary care systems (that is, the way these systems are steered “from above”), the advent of “market care” has brought a multi-faceted evolution. Here, and there, the role of public authorities has been strengthened through case management schemes – with some countries (UK and France) going further than others in this respect. The instigation of a national Commission for Social Care Inspection in the UK and the creation of the countrywide long-term care insurance scheme in Germany suggest a similar tendency. The scope of public control is, nonetheless, reduced by quasi-market arrangements since public oversight does not take place within the confines of a coherent, information-rich organisational setting. While public authorities generally appear to be more extensively involved than in the past, a good deal of their role now consists of setting context-related rules (quality standards, purchasing procedures, administrative devices, etc.). Local service provision is, in many respects, subject to an open-ended “market game”. Vertical governance is weakened even more clearly where users are encouraged to directly employ home helps or select a provider on their own (in France and Belgium).

Regarding horizontal governance, that is, coordination without the interference of hierarchical power, the evolution of the four care systems exhibits a complex nature as well. First of all, the collaboration among different care agencies has become very complicated. The “Berlin walls” between personal care and nursing, unskilled home help and qualified care work, and domestic and formal care have been anything but dismantled. Rather, additional pillars have been created, such as home helps directly employed by private households in France or dementia-related care services in Germany.

Second, there are changing ways to deal with users. The aforementioned choice options, more or less prominent in the four countries, alter the roles of care recipients and their relatives. A new role is conferred to the domestic sphere as, given the pluralisation of service supply, informal carers increasingly operate as coordinators of services (and not just as informal providers), for instance through recruiting providers or home helps. In mainland Europe, the role of non-profit providers has also evolved appreciably. Their link to the user has been remoulded according to the consumer model. Many users are “shopping” in volatile markets, particularly in those sections of the domiciliary care system that are based on direct payments.

Concomitantly, the distance between provider organisations and public authorities has grown under quasi-market arrangements (tenders, competitive evaluation, etc.). It is true that non-profit providers still try to preserve their “standing” by drawing on their distinctive public legitimacy and capacity in order to mobilise inputs from volunteers. They also continue to participate in the definition of public policies (Gardin, 2006)[10]. In Belgium and France, social enterprises promoting the labour market integration of disadvantaged citizens (employed as carers) receive public subsidies precisely because of this social mission (Defourny *et al.*, 2010). In Germany, non-profit providers participate in setting public quality standards. Likewise, the 2002 law on social services in France,

urging providers to respect a certain number of quality standards, has been refined considerably following negotiations between the Government and the biggest national umbrella of the social care sector (UNIOPSS) (Gardin, 2008). In the UK, organisations such as age concern have had an important lobbying role in the national polity (Vincent *et al.*, 2001). On the whole, however, public-non-profit partnerships are less embedded in trust-based relations and horizontal governance is increasingly “marketised”.

Finally, the division of labour between informal (domestic) and formal care has evolved throughout the four countries, though in different ways. The relative weight of formal provision has grown proportionally as elderly care increasingly centres on paid work. This follows wider social trends, including a foreseeable shortage in informal carers (non-working women). While the latter remain strongly involved in the care process (Comas-Herrera *et al.*, 2004; Dammert, 2009; Le Bihan and Martin, 2010), in Belgium and France there is a growing acknowledgment that personal care should be provided by paid workers.

5. Problems associated with marketised governance in the four care systems

As mentioned earlier, there is a rough consensus in the EU about what elderly care systems ought to deliver, including good quality and a better work-life balance for carers. This pledge embraces an “offer” to women to enter the formal labour market more smoothly than in the past. However, “marketised” governance in elderly care entails structural, sometimes nationally coloured, problems that sit uneasy with the “universalistic” promise inherent in the EU discourse and also in the traditional Nordic model.

To be sure, throughout modern welfare states, transactions in elderly care systems are carried out within a societal definition of what are viewed as collective benefits (e.g. universal, family-friendly access to care services). However, since market players are driven by their own self-interest, they tend to ignore such collective benefits. As a result, under-provision and/or poor quality are likely to occur. This is why public norms (quality standards, fixed prices, etc.) and statutory funding have persisted in all domiciliary care systems, and why we are concerned with quasi-market governance here.

That said, the existing regulations have some shortcomings. First, redistributive issues matter. If equal access is a key policy objective, the incomplete coverage of home care needs, observable in all countries under study here, sets limits to it. Access, partially based on private co-payment, connects with the users’ position in the income hierarchy. However, there is international variation. In France and Belgium, personal care is, at least partially, provided without checking a household’s income. This is much less the case elsewhere. British households that are not eligible for public personal care after means testing are left with a enormous care burden or have to buy services on the “free market”. Wherever tax exemptions are an important means of funding personal care (like in France), high-income households have an advantage over poorer ones. This is much less salient in cases where quasi-universal long-term insurance systems cover the bulk of care services, yet, like in Germany, the personal care package can be quite thin. This raises the question of the balance between formal and informal care.

Second, the existing quasi-market frameworks create distinctive patterns in the division of labour between domestic carers (families) and formal care, and (more or less) impede the improvement of the citizens’ work-life balance (Degavre and Nyssens, 2008; Simonazzi, 2008). Cash-for-care programmes like the German one work to keep the

involvement of families high[11]. The development of in-kind services, including a voucher system such as in Belgium and France, buttress formal service provision and female labour market participation. However, women may also be affected as care employees. Where public policies promote a quasi-market largely based on unskilled home helps working in private households, the quality of work is generally poorer than in conventional work settings where the secular trend towards greater professionalism has continued, such as in Germany, Belgium and France. Public policies geared towards reintegrating unemployed citizens into the regular labour market, prominent in Belgium and France, barely address this. Hence, there is considerable ambiguity in the current professionalisation of domiciliary care systems.

Third, quasi-market actors are rarely on an equal footing regarding informational opportunities. It is hard to control providers who seek to exploit their informational advantage and attract clients through biased marketing promotions. Moreover, users who intend to recruit a private employee often have to resort to “word-of-mouth” recommendations (Messaoudi, 2007), given that care outputs largely depend on the individual quality of a worker who usually has low formal skills but diverse informal capacities. More generally, the quality of personal services can be assessed only after having embarked on a contract. Purchasers, be it users selecting a supplier or an individual worker, or public commissioners, operate at a great distance from providers. Case managers (as in the UK) often have insufficient resources for scrutinizing quality on the ground, and in the absence of case managers (as in Germany and Belgium), the onus lies with relatives who might have limited insights into the entire care process[12]. Even where users or case managers observe poor quality and are dissatisfied, the psychological costs of changing a carer or a provider can be high, particularly, for the most vulnerable.

In order to deal with these problems, public quality inspection has been strengthened in all four countries. It can be achieved through an admission procedure based on the evaluation of inputs (which is the dominant mode in France and Belgium) or be incumbent on public agencies to check national standards as part of a comprehensive evaluation procedure (such as in the UK and Germany). However, under a quasi-market framework, quality norms imposed from, pose a permanent challenge to other provider goals such as making a profit or winning a contract with a minimum of effort. Moreover, if the violation of quality norms is revealed, sanctions and closures may make users the main victims. Also, a purchasing agency’s interest in good quality cannot be taken for granted because case managers might face pressures to choose less expensive providers over those with a better-skilled workforce. Most importantly, quality inspection remains generally weak where informal care is prevalent (as in Germany) or where home helps engaged directly by households are widespread (as in France).

Finally, quasi-market governance risks eating into the social cement of a particular home care system. In contemporary welfare states, the subjective needs of a frail individual are expected to be the starting and end point of institutionalised social support. In the past, several social worlds contributed to make this need orientation become a leading normative reference for all actors involved in the welfare mix. These social worlds embraced, first of all, families in which care became defined as “labour of love” (Graham, 1983), notwithstanding that this labour was embedded in unbalanced (and gendered) social obligations. Furthermore, these social worlds included charitable agencies that also took human needs as a key reference, regardless of the often ideologically biased framework that coloured this reference. The same applies to welfare

bureaucracies that stepped in at a later historical stage – although their protagonists often defined care needs in a residualistic manner (body-centred, with little respect of individual preferences, etc.).

Quasi-markets challenge this approach by stressing a completely different logic – market success. Although market success may coincide with care needs being met, that is far from guaranteed. Therefore, the logic of needs is no longer accompanied by a clear-cut cultural framework, that is, by a set of consistent normative references (Bode, 2008). It is possible and admissible that the involved actors, including non-profit providers, are motivated by the profit motive or by an interest in surviving under economic pressure. This also applies to relatives who seek “cheap” solutions through the market or take quality risks in light of the aforementioned information problems and temporal limitations in their work-life arrangements. Hence, the day-to-day care market business sits uneasy with those public norms on which market regulations are built.

6. Conclusion

Drawing on evidence from four Western European countries, this paper has delineated changes that have followed the rise of quasi-markets in domiciliary care. Altogether, the four care systems exhibit a transformation located somewhere between cross-country convergence and national path dependency. Public sector-based or welfare-bureaucratic regulation has been replaced by a more market-oriented governance approach, although this movement has proceeded on dissimilar routes. Public bureaucracies have remained important co-players in France and Belgium. Also, although the very core of the care system has been subject to substantial marketisation in Britain and Germany, traditional policy objectives persist in these two countries as well: Germany has introduced a social insurance model that creates social rights for large sections of the population while Britain has introduced strong quality regulations.

With regards to the existing governance arrangements, considerable changes have occurred in the vertical steering of domiciliary care systems. Public authorities appear to be more extensively involved than in the past, although mostly through the stipulation of context-related rules (quality norms, standards for contracting, benefit schemes, etc.). Local management, largely irrelevant for Belgium, has remained important in the British context and become less crucial in Germany, while in France, the regional level has become more influential. As to horizontal governance, care systems have seen, not only a greater role for market interaction, but also for the emergence of additional pillars of formal care provision. This is most obvious in France and Belgium where home help to private households has become an important pillar of the care system. Concurrently, the involvement of informal actors has not diminished as they now have adopted the roles of coordinators and purchasers. This is most noticeable in the German system that is based principally on direct payments while it is less apparent in the British system with its preference for professional case management (at least for those covered by local authority provision). France and Belgium are located somewhere between these two poles.

In all four countries, quasi-markets have developed along with the expansion of formal care provision, including (more or less) far-reaching proportions of personal care. In some countries, new funding schemes have brought extensive entitlements and also new jobs. However, in a number of respects, quasi-market governance constrains a more universalistic service supply. Generally, it has challenged the welfare mix inherited from the twentieth century in that it makes market success a cultural reference along with

need-orientation. Social equity, including the gender dimension, is a crucial issue here. Quasi-markets have had an ambiguous impact on gender equality because they promote low-quality jobs carried out primarily by women. As all care systems witness this (partial) “vulgarisation” of professional work, new social divisions are likely to proliferate. Thus, middle and upper class women might see their care burden being alleviated while their lower class counterparts are susceptible to being caught in a new social hierarchy. Quality issues matter as well. While market regulations (inspections, etc.) are meant to ensure better quality for those using formal care, albeit without providing users with an institutional guarantee, they avoid informal care provision and home help schemes. On the whole, then, the promise of the European Commission that “competition among providers and among insurers” can be “a means to reduce costs of care and to enhance quality” has been only partially met and the four care systems under review here have remained very different from the Nordic countries.

In these systems, quasi-markets in elderly care have produced greater uncertainty as the prevailing governance arrangements became more complicated. While many actors populating these systems are not driven by for-profit motives and stick to the sector’s inherited cultural logic, competitive pressures intrinsically encourage a mentality of thinking in terms of “selling and buying”. Thus, overall, social behaviours surrounding elderly care have become more diverse and less reliable. In the long run, it cannot be excluded that this movement undermines the very social foundations on which European domiciliary care systems have been built during the twentieth century.

Notes

1. In most Western countries, the borderlines between personal care and nursing are anything but clear-cut (Devetter *et al.*, 2009; Emilsson, 2009; Simonazzi, 2008; Burau *et al.*, 2007). We conceptualise care as human-centred long-term support to frail individuals, and we refer to domiciliary care as the generic variety of which personal care (including house-keeping work, day-to-day social support, etc.) is one major ingredient.
2. Juridically, devolving care provision onto non-statutory providers may go along with strong (vertical) public control that makes it appear as if providers are operating on behalf of the state (like in France and Belgium, see below). However, non-statutory providers are formally independent and have to agree to collaborate (and its terms of trade) with public authorities. In that sense, we are dealing with a horizontal arrangement here.
3. Home care service hours under the administration of local authorities almost doubled between 1998 and 2008, while the number of users entitled to public support went down, despite an overall increase of the older population (Malley *et al.*, 2010).
4. In 2009, 19 per cent of services was still provided directly by the local authorities. The remaining 81 per cent was purchased by municipalities from private providers, mostly for-profit (Malley *et al.*, 2010).
5. In 2007, 2.25 million citizens received long-term care benefits. Of these, 1.5 million were living in their homes. Only 500,000 beneficiaries had opted for formal domiciliary care provision (Statistisches Bundesamt, 2009).
6. As of mid 2006, about 1.2 million workers were employed by private households. 783,000 (66 per cent) of them held a direct contract, 166,000 (14 per cent) were engaged with a broker association (association mandataire) and 233,000 (20 per cent) were employed by a traditional provider, mainly associations (DARES, 2008).

7. However, this was confined to the “accredited” agencies that represent only a limited proportion of the non-profit care sector in this country.
8. In 2008, the service cheque scheme embraced more than 100,000 workers of whom 56 per cent were employed by for-profit firms, 27 per cent by non-profit agencies and the remainder by the public sector (Henry *et al.*, 2009; Defourny *et al.*, 2010).
9. It should be noted that, due to the high degree of decentralisation in this country, regional policies are the central regulatory mode in social care.
10. Generally, non-profit organisations are bound to social goals, given the non-distribution constraint through which profit maximisation is ruled out institutionally – although this status may provide poor incentives to become (more) cost-efficient.
11. In France, beneficiaries of the APA can employ somebody from his/her family – except spouses.
12. Especially, when they are at work during the service.

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