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The Provision of Home Care as a Policy Problem

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ABSTRACT *The problem of home care for the growing number of elderly people no longer able to take of themselves has long been overshadowed by the debates on pensions and rising medical costs. Taking the feminist critique of the welfare state as point of departure, this article examines in how far the breadwinner-caretaker model still informs ageing policies in the Netherlands (a prime example of this model) and takes women as carers for granted, despite changes in the family and women's growing labour market participation. Overall, policies since the 1990s have shown remarkable continuity, defining informal care, mainly done by women, as the cornerstone of home care policy, with state-provided care seen as strictly supplementary and rationed to cut costs. This is consistent with the welfare mix of the conservative welfare state, but contradictory to a more individualized welfare state in which women's labour market participation is becoming essential to maintain welfare state benefits in the face of the ageing issue.*

Introduction

The increasing costs of maintaining collective provision of pensions and health care dominate the policy debates on ageing. In the majority of these debates health care is typically reduced to the costs of medical care (''cure''), while provision of long term care necessary for the increasing number of elderly people who are no longer fully able to take care of themselves tends to be marginalized. Welfare states differ as to who provides this care: in conservative welfare states most of this has always been supplied by informal carers[1] within the family (mainly women), the state only stepping in when it was insufficient, while in social democratic ones the state has taken on the provision of care. ''Home care'' is the term that covers both the informal care given by family members and the professional care delivered to clients and patients in the home. This professional care can be state-run or funded; in some countries there is also a commercial market for care.

Home care is currently at risk because of a number of trends. In an era where most welfare states are intent on controlling state expenditure, decreasing the national

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debt and meeting the criteria of the EMU, there is reservation about taking responsibility for the care of the growing numbers of the elderly. In the conservative welfare states, relying on informal care, there are additional problems. Family size has decreased over recent decades, leaving fewer children to take care of their elderly relatives. Increased geographical mobility created distance between relatives, making care on a day-to-day basis impossible. Women are increasingly in paid employment, leaving them with less time to perform their "traditional obligations" of caring. Furthermore, substituting informal care with formal care runs into obstacles of recruiting the necessary personnel, as the decline in the birth rate means there are fewer younger people to take on the work in the formal care sector. Labour market shortages in some countries in recent years have aggravated the problem.

The aim of this article is to uncover to what extent the "breadwinner-caretaker model" (Bussemaker and Van Kersbergen 1994: 20) of the family still informs policy debates on ageing and to show how welfare states, despite restructuring, are slow in responding to changes in the family and women's labour market participation. More specifically it will focus on the policies of home care in the Netherlands, in which adjustment seems to be lacking. The Netherlands features in the literature as one of the examples of the strong breadwinner state (Lewis and Ostner 1991, Lewis 1992), with women mainly cast in the role of housewife, and thus is a prime case to study the consequences of ageing for the provision of home care. The Netherlands was also something of an anomaly in the debates about the typology of welfare states of Esping-Andersen (1990), as Bussemaker and Van Kersbergen have contended (1994: 21–24). Moreover, the Netherlands have always stood out in cross-national European comparison. Having nearly the lowest number of married women in the labour force in the 1950s and early 1960s, it now ranks among the nations with the highest percentage of women in the labour market, a percentage made possible by the fact that most work part-time. Although the breadwinner/caretaker model was originally developed to unearth the implications of welfare state arrangements for the social entitlements for women and focused mainly on women as mothers or workers, it is also a useful point of departure for the analysis of the issue of care for the elderly. Underlying the model is the same gendered division of labour which also structures other types of care than care for children in terms of responsibilities, obligations and opportunities for giving and receiving care, including free-riding and opting out.

The choice for the policy area of home care lies in its neglect by the dominant debates on ageing. Although in public debate the issue crops up regularly, the financial and economic aspects of ageing dominate the debates of the political elites. This also goes for much public policy research on ageing, in which pensions and medical care predominate. I shall be addressing three questions: What proposals and remedies on home care and ageing have been put forward over the past decade? How far do these still assume a gender order in which women are informal carers and men breadwinners, and to what contradictions does this lead when taken in combination with other policies on ageing? What conclusions can be drawn for the theorizing on welfare states and the issue of ageing?

In order to address these questions I shall first discuss the feminist critique of welfare state theory on its neglect of the family and unpaid work. I then trace the development of the ageing issue in the Netherlands, showing how home care is organized and how it featured on the political agenda prior to the 1990s. I shall then

analyze the policies on home care since the 1990s in more detail. In particular I shall focus on the four main policy papers on home care and ageing of the national Ministry of Health and Welfare[2] which structure current policy (Thuiszorg 1991, Thuiszorg en zorg thuis 1997, Zorgnota 2001, Zorg Nabij 2001). These policy papers are official government statements, determining both the direction of the policy and the allocation of funding. They have been debated and sometimes amended by Parliament but on the whole the measures have been implemented very much according to policy intentions. The effects have been deeply felt by the organizations providing homecare (e.g. Meloen 2000), the care givers and care receivers (Vulto and Morée 1996, Van der Lijke 2000, Potting 2001, Timmermans 2003). The policy papers will be analysed by tracing the problem definition, the policy goals, proposed remedies and the core values espoused by the policy makers, followed by a gender analysis of the texts.[3] They will then be compared on these points, as well as on the underlying gender order and the possible changes in policy over time. I then discuss the findings in the context of other policies on ageing in the Netherlands over the last decade and return to my questions, reflecting on the importance of including home care in the analysis of policies of ageing.

Caring and the Welfare State

In the literature on welfare states care provision is often taken for granted. In the 1990s the new feminist scholarship took the original Esping-Andersen model (1990) to task for its blind spots about gender (e.g. Lewis 1992, O'Connor 1993, 1996, Orloff 1993, Sainsbury 1994, 1996, Ostner and Lewis 1995, Daly 2000a). It argued that the typology, by focusing on state/market relations, marginalized the family and other non-market relations within society.

This not only neglects unpaid labour both inside and outside the family, but it also hides the fact that unpaid labour is essential for maintaining many welfare arrangements. Much public welfare, such as caring, is secured by a combination of, largely female, paid and unpaid work (Daly 2000a: 5). Welfare states depend on different mixes between state, market, civil society and the family in their provision of care; they structure what is being paid and unpaid, and they determine where the work is done and by whom (Daly 2000a: 39). In this process, welfare states buttress the gender order, a division of labour between the sexes governed by "norms, principles and policies informing the allocation of tasks, rights and life chances to both sexes" (Ostner and Lewis 1995: 161). The allocation of care is structured by the welfare state mix and this allocation co-determines the gender order. It follows that the gender order also structures the field of home care, as is the case for most other welfare provisions.

A central part of the feminist critique focused on the concept of decommodification, "the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation" (Esping-Andersen 1990: 37). It "occurs when a person can maintain a livelihood without reliance on the market" (ibid.: 21–22). In other words, it is emancipation from dependence on the market. But feminist scholars demonstrated that this was hardly applicable to women who do the unpaid labour in the family and to their emancipation. As Sainsbury (1996: 36) remarks, for women it is vital whether benefits are tied to the individual or to the family. When it is the family, benefits usually go to the "head" of

the household: the husband. For women it is important, however, that they can live independently of family relationships at a socially acceptable level, either by paid work or social security provision, for which Ruth Lister has coined the concept of "defamilialization" (Lister 1997: 173). Caring in the family, even if many women find it a rewarding and pleasurable activity, and the lack of individual (entitlement to) benefits, stands in the way of this process: provision of care by the state (or market) can enable further defamilialization.

Recent feminist scholarship has taken care as a crucial point of access for analyzing welfare states (e.g. Jenson 1997, Knijn and Kremer 1997, Lewis 1998, Sevenhuijsen 1998, Daly and Lewis 2000). On the whole, this work pays much more attention to the issue of child care for mothers; the issue of care for the elderly and the chronically ill is relatively neglected (but see Kremer 2000, Daly 2000a, b, Daly and Rake 2003). All point to the moral obligation for women to care, even if this is detrimental to their financial security or runs counter to their own needs. Welfare states presuppose this disposition and the feminine identities which embody it, but differ in the way they build their caring arrangements. Crucial for women is how far these allow for defamilialization: an independent life and a positive choice whether to provide care or not.

As mentioned, there has been considerable debate about the position of the Netherlands in the typologies of welfare states inspired by Esping-Andersen, who originally placed the country in the social democratic type of welfare state. Bussemaker and Van Kersbergen (1994: 21–24) have argued that it was precisely his neglect of gender and unpaid work that caused the wrong casting: the Netherlands do have a high degree of decommodification, but also a high level of social stratification between men and women, as in conservative welfare states. Social security benefits are generous, but were designed to provide a family income, not because of solidarity or social justice, but to enable the male breadwinner to live a decent life for himself with his family, "under the assumption that women would not engage in wage labour" (ibid.: 23). When it comes to the provision of care the Netherlands should be classified as a conservative corporatist state, operating on subsidiarity. The state only steps in when "the family" cannot provide the necessary care (Kremer 2000). In comparative research on the provision of home care in Western European welfare states, it occupies a modest position in the rankings of how many people receive state-provided home care and for how many hours a week (Rostgaard and Fridberg 1998: 52; see also Anttonen and Sipilä 1996; Rostgaard 2004).

The consequences of the Dutch arrangements for the labour market have been far-reaching; the Netherlands has had notoriously low rates of married women working in paid employment deep into the 1980s. Increases over the last two decades are to a large part due to the explosion of women in part-time work: of all women working, 70 per cent are working part-time. Fourteen per cent of men also work part-time, making the Netherlands world champion in part-time work (SCP 2004a: 293). As women carry the responsibility for care, they cannot work full-time, and in turn the Netherlands can still rely on women to supply informal care. Women form 60 per cent of all informal carers (SCP 2003: 36); most of them are between 45 and 65 years old; and they put in three times as many hours than men, although figures vary, partly due to definitional problems. It is further estimated that informal carers provide 80 per cent of the required home care (SCP 2003: 119). Formal care is provided by local authorities and seen as strictly supplementary, meted out after a

strict assessment of "need" determined by the amount of informal care that can be extracted from the family. The informal carer does not receive a tax credit or allowance for her work; in most cases she is dependent on her husband's income, or on social insurance for her maintenance if she is single. Less than 15 per cent of women between 55 and 65 years hold a (part-time) job. The preference of consecutive governments for informal care as displayed in the policy papers is driven by a powerful financial incentive: it is very much cheaper than state-provided professional care.

Ageing as a Political Issue

The Netherlands is relatively well off in comparison to other European states when it comes to the consequences of the "second demographic transition" – the decline of the birth rate coupled to a large increase of the number of the elderly, as it has a lower elderly dependency ratio.[4] This relatively favourable position is due to the fact that the baby boom after the Second World War lasted for a much longer period of time, giving present-day policy makers some extra time to prepare adequate measures for the inexorable fact of a greying population. The birth rate declined sharply since the mid-1960s – when it was still around 3.2 children per woman – to 1.6 per woman in the 1990s, a figure well below the replacement level of 2.1. The current figure is 1.75 (CBS 2005a: 9), an increase ascribed to higher fertility rates among migrant women. Life expectancy has increased from 60 years (men) and 62 years (women) in 1900 to, respectively, 76.87 and 81.44 in 2005 (CBS 2005b). Currently there are 2.2 million people aged above 65 in the Netherlands; 93 per cent of these are living at home and are the (potential) clients of home care. Even of the 85+ generation, 70 per cent are still living independently (SCP 2004b). Despite two decades of policy to reduce the number of elderly in residential care, the Netherlands still has the highest percentage in residential care among EU states (Kremer 2000: 31).[5]

Old age has been a regular issue on the political agenda since the construction of the Dutch welfare state after the Second World War. In 1956 the state guaranteed a basic pension (*Algemene Ouderdoms Wet* – AOW, General Old Age Law) to all citizens over the age of 65. Until 2006 there was a national health care insurance covering all persons below a certain wage level,[6] and state-funded homes for the elderly. Old age policy has always led to debate about costs; by the mid-1990s "greying" and the burden for future generations were well entrenched as the dominant policy definition. Within this overriding concern there have been shifts in the problem definition of what makes the elderly problematic. Bijsterveld (1996: 67–68) has noted that in the 1940s it was the "urgent needs" of the elderly; in the 1950s their proneness to psychiatric disorders; in the 1960s their loneliness and isolation; in the 1970s their marginalization in society. These definitions had in common that they put the needs of the elderly centre stage, but financial considerations were never far away. Concern among policy makers about the costs of the facilities for care provision was already in evidence during the 1960s, which led to reductions in residential care and the promotion of home care in the late 1970s. With the new demographic discourse about "greying" and the costs for future generations, the needs of old people were no longer the problem, but the *number* of old people were (Bijsterveld 1996: 68–69, emphasis added).

The demographic shift and the issue of ageing started to figure in policy circles in the mid-1980s, when demographers and state agencies such as the Central Bureau for Statistics (*Centraal Bureau voor de Statistiek* – CBS) and the *Social and Cultural Planbureau* (Sociaal en Cultureel Planbureau – SCP) raised the alarm about the consequences of the shift. The Netherlands Scientific Council for Government Policy (*Wetenschappelijk Raad voor het Regeringsbeleid* – WRR) published no fewer than four reports on the issue in the 1990s (Outshoorn 2002). The warnings were soon followed by major policy papers from most of the pertinent government departments. The corporatist network around health care also proved highly prolific on the issue, producing no less than six reports between 1992 and 1997.

The new focus emerged in the policy papers of the Ministry of Health and Welfare on restructuring health care and on the elderly at the end of the 1980s. In 1987 the report *Bereidheid tot verandering* (Readiness for Change) by the Commission Dekker was published. It recommended the introduction of market principles to improve the health care system in the expectation it would provide a better match between supply and demand. Although the incumbent government embraced its principles, the report failed to make much headway. With greying in mind, one of its recommendations was to substitute intra-mural[7] care with extra-mural care, and this extra-mural care was not to be supplied by the state, but by *zelfzorg*, self-care, by people themselves (Meloen 2000: 36). Another attempt to restructure the health care system was made by the Commission Dunning (1991). Its report *Keuzen in de Zorg* (Choices in Care) directly linked the problems of the health care system to the issue of ageing; the elderly – already the major users of the services of care – would increasingly need more care, not just more retirement benefits and the AOW. To maintain the quality of care, the Commission recommended cutting the costs of care and creating more efficiency in the care system. Due to lack of consensus within the incumbent government its recommendations were not followed.

The 1990 policy paper of the Ministry of Health and Welfare on the elderly, *Ouderen in Tel* (1990) (the title denoting both the "numbers" aspect and the idea that the elderly should matter), attempted to redefine the problem of ageing as the need of the elderly to be able to participate more fully in all walks of life. A careful analysis, however, shows that this policy goal was also informed by anxieties about the costs and the organization of care provision, including the matter of the supply of carers (Mossink and Nederland 1994: 46). Under the label of "participation in society", middle-aged women were encouraged to take on more informal care work, although they were already providing the lion's share. By the early 1990s greying and its consequences had lodged itself firmly on the political agenda of the Ministry.

The Structure of Home Care

In the Netherlands home care is financed by the taxpayer under the 1974 AWBZ (Algemene Wet Bijzondere Ziektekosten – General Law Costs Special Medical Needs) which was designed to cover health risks considered to be "not-insurable" for individual persons. Employees pay a certain premium and by principle everybody is entitled to its benefits. Family members were insured for no extra costs through the breadwinner. Its introduction was part of an overall restructuring of the healthcare system in which the state became the central player in planning health care (Maessen

1989). The health care system was envisaged as a two-tier system; the first tier consists of GPs, paramedics (physiotherapists and such) and professional care workers (e.g. district and school nurses); the second tier consists of the medical consultants, hospitals and residential care. Underlying the whole system is informal care and self-care. Home care encompasses both the first tier care workers and informal carers; as an overall term to denote the area, it only came into general usage at the end of the 1970s (Meloen 2000: 15).

This restructuring was a departure from the way care had been provided before. Home care evolved from two earlier traditions of care in the Netherlands: family care and the community nursing system (*kruiswerk*). Family care originated in Christian charity which helped families in crisis, for instance when the mother of a family fell ill. Some municipalities took on this responsibility at the turn of the twentieth century. Since the Poor Law of 1854 local authorities have also provided care for the poor elderly and some medical services such as midwifery. The community nursing system originated from private initiatives in the latter part of the nineteenth century and was later institutionalized along the lines of the *Verzuiling* in a wide array of local and regional associations (Maessen 1989; Thuiszorg en zorg thuis 1997: 32). People joined the associations by paying a small contribution and the associations provided public health services for the members. Later the associations obtained additional funding through state subsidies.

Home care became increasingly important when the state started to reverse its old age policy in the mid-1970s. After the Second World War this policy had set up residential care for the older generations on an extensive scale. Underlying this policy were severe housing shortages: the reasoning was that when the elderly moved into residential homes, younger people could move into the houses they vacated (Kremer 2000: 34). The Den Uyl government (1973–1977) was the first to reverse this policy, aiming to keep the elderly in their own homes as long as possible in order to control expenses more directly. Residential care became strictly rationed by the establishment of a system of ''indications'' to determine eligibility. Moreover, health care policy aimed at an overall shift towards extra-mural care; hospitals started to send patients home sooner after treatment, and many treatments formerly performed during a hospital stay were now performed on an out-patient basis.

Home care was to provide the services to help to achieve this goal, but home care was neither expanded nor modernized. The most important ''innovation'' was the introduction of a new care worker, the so-called ''alpha-helpers'' (*alpha hulp*) in 1977. These carers had a contract (with their clients, not with a home-care organization) for no more than 12 hours a week, so that they could be excluded from social security benefits (Maessen 1989). The idea was to recruit married women, who, in the policy reasoning, did not need benefits as they had a breadwinner who was entitled to family benefits. One of its effects was to make the work less attractive to women; even in the 1980s with its high unemployment, shortages in labour supply remained.

As this measure was not very successful, successive governments in the 1980s started to promote informal care; formal care became defined as strictly supplementary to what ''the family'' could provide in the way of care. The move was ideologically legitimated in terms of the preferences of the elderly themselves; they preferred to stay at home and remain independent as long as possible (Van der

Lyke 2000: 25–26, 49). Informal care also was portrayed as more humane, of better quality and more effective in reducing loneliness than professional care. Policy documents of the early 1980s emphasized informal carers' strength and argued for raising their status in the care system. With awareness of the demographic shift dawning in the early 1990s, policy makers began to worry about the supply of care workers and whether informal carers would be able to take on more care. The focus shifted to the person of the informal carer, which raised the awareness of the gender-specific nature of the work (Van der Lyke 2000: 53–55).

The 1991 Policy Paper

The Lubbers III government (1989–1994) (a coalition of Christian and Social Democrats) took the issue of the rising costs of care seriously and proposed a series of measures to curb the growth. The most important paper about home care, *Home care in the 1990s* (Thuiszorg 1991), set out to provide a future vision for home care. The rising demand for home care was defined as the policy problem. This was caused by the ageing of the population and the processes of individualization and the emancipation of the "citizen", which led to a preference for people to stay in their own home as long as possible (ibid.: 6). At the same time the average size of households was declining and the number of single old people, especially older women, was on the increase. According to the paper, the current supply of home care would not be able to meet demand in the future. Surprisingly, budgetary considerations were hardly mentioned.

The present structure of the health care system, along with its system of financing which obstructs flexibility and co-ordination of services, was constructed as the second problem definition in the document. More attention to home care was essential, but in the view of the government, this would not entail more state responsibility. The state was to step back and limit its obligations to encouraging and supporting other actors in the care sector, such as insurers, care suppliers and consumers/patients in "taking their responsibility" (ibid.: 3). Informal care, defined as care provided by family, neighbours and friends on a non-professional basis, was to be primary; professional care was to be supplementary (ibid.: 5).

The paper noted that home care would be an extra burden to women, as they are the main providers of care at home (ibid.: 10). It also noted that "the growing labour market participation of women has consequences for the availability of informal care. Women will increasingly have paid work and will no longer take it for granted that they should shoulder the work of caring" (ibid.: 11). Along with improved co-ordination and integration of professional services, the policy goal formulated was "maintaining the existing level of this unpaid care provision" (ibid.: 11). Many of the proposed policy measures targeted better organization of the home care sector. The major proposal was the revision of the health care insurance system to include all Dutch citizens, but as the government failed to achieve consensus on this fundamental reform all that remained of the measures were a number of state-supported experiments for linking different types of care provision. All aimed at reducing intra-mural care.

To maintain the supply of carers, the paper proposed several remedies. First, the integration between district nursing and family care was to save money as it would

enable residential care to be substituted by home care. Second, the care sector was to concentrate on eliminating labour market shortages. The work itself was to be professionalized by differentiation in functions and wages and by additional training. The workload was to be reduced (a small budget was provided) and the sector was to improve its image to attract more women workers. Women returners to the labour market were targeted as sources of labour, for whom the paper recommended more childcare (even 24-hour childcare "might" be considered) (ibid.: 28). No concrete proposals to finance this were suggested. Third, to maintain supply of informal care the paper wished to promote voluntary work, which was to be made more attractive by setting up volunteer organizations and providing compensation for volunteers' expenses.

The 1991 policy paper was well aware of the gendered nature of home care, both in regard of the care providers and the clients. It made the necessary distinctions between men and women as a social category, noting the difference in longevity between women and men and that older single women are the ones requiring more professional care, the more so as they receive less informal care. It also had eye for the gendered division of labour, showing that it is women providing the bulk of informal care (ibid.: 10–11). The policy makers did worry that women's traditional gender identity, in which care takes a central place, would erode with their participation on the labour market. Men's traditional gender identity is taken for granted as a role for them in caring is not envisaged for the future.[8]

The core value of the paper was the preference of people for staying at home as long as possible, although this was not backed by any empirical research. With this observation the policy makers side with the clients; whether staying at home is always the preference of the informal carer is never questioned. Care at home was a second core value, portrayed as important and indispensable and, by connotation, also as a haven of warmth, security, intimacy and personal service. In this way a dichotomy is created to professional care, linking it to remote, cold impersonal service.[9] The proposal, by retaining informal care as the cornerstone of home care policy, in no way called the traditional gender order into question, and in fact reinforced it.

The policy intentions were accepted by the major actors in the debate such as the political parties and the top echelons of the formal care sector. A rising feminist opposition, uniting a feminist older women's organization, feminist scholars and two new small trade unions of care workers, protested against the lack of formal home care, but were ignored by the government, the major trade unions and the main parties in parliament (Oldersma and Outshoorn 2007). Throughout all the debates a stronger coalition was impeded by differing interests between groups of women; doing away with the alpha workers and professionalization of home care was in the interest of women workers, but against the interest of most women clients who would not be able to afford the subsequent higher costs of hiring home care.

In line with the policy aims, the formal care sector became subject to a series of reorganizations that aimed to increase efficiency so that it would be able to cope with the increased demand for its services.[10] Different types of home care were centralized into large organizations covering a neighbourhood, a town or even a region. Under the influence of the new management ideology, these new organizations became quite hierarchical, with financial-economic experts moving in to fill the top positions

(mainly men); the female directors of the old system became the middle management. They were the ones who had the shop-floor knowledge and the contacts with the care workers (Meloen 2000). The actual work in the home was being done by the low-paid alpha workers (women), whose work was increasingly standardized by strict guidelines. This turned their work into mainly housework with little time left to pay attention to the social and psychological needs of their clients (Vulto and Morée 1996). The emphasis on informal care can also be traced in other policy papers of the Ministry of Health and Welfare, such as the yearly reports to parliament and various official reports on the chronically ill.

The Ministry further focused on funding research on informal care and supported several experiments in informal care, such as the *persoonsgebonden budget*, a personal budget for a client who could then buy services for care. Researchers and policy makers began to worry about the heavy burden of the informal carer and the risk of stress and burn-out. In order to relieve informal carers, they became the object of policy intervention. They were to undergo training and courses in ''coping'' and were to co-operate with the professional care workers, a co-operation portrayed as an alliance (Van der Lyke 2000: 63–64). Here a process of hierarchization can be discerned, obscured by the metaphor of the ''allies''; informal carers were gradually placed under the tutelage of the professionals to enable them to keep up their useful work. Ironically, the professionals are also mainly women, creating a new conflict of interests in the debate.

The problems were exacerbated by the abortive attempt in the mid-1990s to allow commercial organizations to enter the field of the provision of home care, an attempt to introduce competition and in this way enhance productivity. Some 25 commercial bureaus entered the market, who could select their clients while the state-subsidized organizations had the obligation to take on all clients. Some of the commercials started to ignore the collective bargaining contract (CAO) and refused to pay their workers the union rate, which raised the fury of the traditional home care organizations, the unions and the left wing political parties. Waiting lists for services, high turnover of personnel, high absenteeism, problems in recruiting new workers, bureaucratic red tape and remoteness of top management from the ''shopfloor'' made for newspaper headlines. The successor to Lubbers III, the ''Purple'' Kok I government (1994–1998), a coalition of Social Democrats, Social Liberals and the Liberals, had to face regular parliamentary questions on the hot issue of home care, and to renege on promises made in election campaigns and party programmes about improving the services (Oldersma and Outshoorn 2007).

The 1997 Policy Paper

In 1997 the first Kok I Purple coalition government published a new policy paper on home care, *Home care and care at home* (Thuiszorg en zorg thuis 1997). Its most important measure was to freeze the experiment on introducing competition by privatizing home care. The problem definition of the new paper was the increasing number of elderly, often with chronic diseases, requiring care in the (near) future. Demand was also expected to rise because of the renewed goal of shifting from residential types of care to extra-mural care. The policy was again legitimated in terms of preferences: terminally ill people prefer to die at home which will require

additional home care.[11] Moreover, demand would be qualitatively different; requiring more specialized care as well as more luxurious care demanded by the growing number of affluent elderly. The government did state that the large group of people with only the state old age pension would still require care provided by the state.

The paper noted that most care provided is informal care (only 16% of care is provided by professionals), but that this was under pressure by the decreasing birth rate, the growing number of women in the labour market (the paper noted that, next to partners, it is mainly daughters providing informal care), increased geographical mobility and the rising divorce rate, with children having to look after two parents in different parts of the country (ibid.: 13). Formal care was under pressure as fewer people were attracted to work in the care sector. The number of younger people in the population is declining and fewer of them are choosing to work in the care sector.

As in the 1991 paper, there was a second problem definition; the organization of the care sector which made for fragmented and badly co-ordinated care provision. The Minister admitted that efficiency measures taken in the early 1990s had become counterproductive and that it was not possible to reduce the number of hours per client any further (ibid.: 11). Management had grown disproportionately, causing imbalances between its costs and those spent on the actual work (ibid.: 16); high turnover and absenteeism among the workers were rife. Despite a very strict system of the allocation of care to those who "deserve" care, long waiting lists were endemic.[12]

Still, the policy goal was to follow the route of the 1980s, "to enable people to stay at home as long as possible, or let them return to their home as soon as possible after a hospital stay" (ibid.: 4). The paper praised the worth of the informal care sector and acknowledged that its volume exceeds the professional (formal) care supply. The basic goal of home care policy remained intact however, regarding formal care only as a supplement to informal care. It cannot be that "with the arrival of the professional carer, the informal carer gradually withdraws" (ibid.: 23). Formal carers and informal carers are an "alliance" that needs to co-operate within the home to look after the patient/client (ibid.: 14, 23). The emphasis on informal care ties in neatly with the professed policy goal of bringing care "close to the people – to their homes and neighbourhoods" (ibid.: 5, 18).

For the source of labour supply the paper looked at the growing group of vital young pensioners and early retirers who have the time available to take on informal care and volunteer work. The elderly themselves are living longer and the declining difference in life expectations between men and women would mean that, instead of six years of widowhood, women will only be faced by three years of widowhood on average by 2050. It is "partners" who are to provide the bulk of informal care. The paper noted (with some satisfaction) that men also enjoy this work more than women (ibid.: 13). Resident migrants were seen as potential suppliers of care; they are also favoured to meet the emerging needs of ageing migrants (ibid.: 12). Even the long term unemployed were suggested as possible sources of labour (ibid., 22).

The policy measures were divided into short and long term measures. The most important one, already mentioned in the previous paragraph, was to freeze the introduction of competition in the care sector: no new firms were to be admitted.[13] The short term measures aimed at a more effective implementation of policy, such as

the integration of family care and district nursing (on the agenda since the 1970s!); strict indications for formal care; uniformity in financing care institutions, tariffs and clients' financial contributions for formal home care. The state increased the budget for home care from 2 per cent to 3 per cent per annum to deal with the increase in demand. As to labour market policy, the government left it to the care sector itself, only recommending a more active policy in fighting absenteeism by improving working conditions and training of the low-skilled employees. It did not mention higher pay – this was left to the social partners.

The government also provided a budget for experiments exploring new directions in care provision and for redesigning the first tier of the care system, as well as better co-ordination of types of care to counter the current fragmentation. Care leave was to be promoted so that people can provide informal care for their families. Allowing people on social security to work as informal carer or volunteer in care work without losing their benefits was to be explored. The paper did not take a definite position on the two hottest topics in health care: the structure of health care insurance and the introduction of competition in the overall health care sector. The reason was the lack of consensus on these issues among the three parties making up the government.

As for gender, on the one hand the government was aware of sex differences among the elderly and among the caregivers, 95 per cent of whom were women. Among all employees of the total health sector, 85 per cent were women (Thuiszorg en zorg thuis 1997: 15). On the other hand, however, most of the paper was written in a gender-neutral style, talking about ''people'', ''the elderly'', ''management'', the ''well-off seniors'', ''informal carers'', the ''early retirers'', ''partners'', ''personnel'', ''part-timers'', ''allies'' in home care. It assumed that ''partners'' would take care of each other, ignoring the existence of the growing number of single people. This gender-neutral terminology hides much of the hierarchical gender relations and the gendered division of labour. It also veils the gendered structure of the labour market, with its very high degree of sex segregation when it addressed labour market shortages and recruiting new workers. The paper also reveals traditional cultural gender values. Ignoring pay when talking about making formal care work more attractive assumes that women do not care about money, either because they have a breadwinner, or that they work for social or altruistic reasons. It banked on vital early retirers taking on informal care or volunteer work in the care sector, not mentioning that in the current generation these are mainly men with traditional masculine identities, for whom caring is still seen as feminine. It also banks on traditional feminine identities in assuming that women will continue to take on the lion's share of informal care despite their increasing integration in the labour market.

The core values of the report were solidarity, efficiency, and the central importance of self-care and informal care. Informal care should be the fundament of the care system as people give preference to staying at home in familiar surroundings: if they leave hospital early it speeds up their recovery. It is more humane and comforting and partners want to take care of each other. In this way the paper builds on values traditionally associated with the feminine in Western culture; stressing interconnectedness and altruism. Implicitly informal care is framed in a dichotomy to formal care, where professionalism and efficiency are the central values. Both latter terms have a masculine connotation; despite the fact that informal care is preached as fundamental, a hierarchy is established between the two in which formal care has the

higher status. Informal carers are portrayed as allies of the professionals, and are to co-operate with them. On close reading, it emerges that the formal carers ought to take the lead and train the informal carers, as they have superior knowledge (ibid.: 23). And the informal carers should not try to shirk their obligations – which they might if more formal care is available. One can conclude that this policy paper in no way calls into question the traditional gender order, but instead builds heavily on traditional gendered cultural values and identities.

The debate on the 1997 paper was less consensual than that on the 1991 one; the government had to back down on the privatization issue and the budget cuts on home care. The parliamentary debate focused on the unsuccessful introduction of market principles in the home care sector and the costs of the national health insurance. No party, however, attacked the basic philosophy of regarding formal care as supplementary to informal care, and the debate was carried on in gender-neutral terms (Oldersma and Outshoorn 2007). This was in spite of the fact that the government members in charge of health care and many of the parliamentary parties' spokesmen were women. The lobby by the *Emancipatieraad* (Emancipation Council), the official advisory body to the government on women's status, which had come out against the alpha workers and called for more professional formal care, also failed to change the terms of the debate. In general women's movement organizations gave the issue low priority and only a few feminist scholars joined the opposition against the 1997 measures.

The most important policy outcome of the discussions and protests about waiting lists in home care at the end of the 1990s was indeed the increase in the budget. Attempts to oust home care from state funded social security arrangements were not successful and further attempts to introduce market principles were forestalled, with the exception of personal budgets for clients, which were such a success that the funds reserved for this type of care had to be frozen. The mergers of home care organizations were over by the beginning of the new century.

The 2001 Policy Papers

However, the problems had not disappeared. Waiting lists for home care prevailed and stories about overworked informal carers made it to the press regularly. With national elections due in 2002, several budgetary restrictions on health care were lifted. To meet the continual pressure, the second Purple coalition (Kok II) (1998–2002) produced a *Zorgnota 2001* (Policy paper on Care) (2000) covering the whole health care sector, both "cure" and "care". Its problem definition was the shortfall in the supply of care caused by shortages on the labour market, and the workload of employees in health care. Its goal was to decrease the waiting list and increase the volume of services. This was deemed necessary to meet the increasing demands of the critical consumer for higher quality care. The magical phrase for care was "*zorg op maat*" – customized care. The government proposed a range of measures to make work in the health sector more attractive, but again left most of this to the social partners. In addition, the usual efficiency measures were proposed to improve productivity, including a redistribution of the costs of residential care between the Ministries of Health and Welfare and of Public Housing. Extra budgets were made available to decrease the workload at the level of health

institutions and further training aimed at increasing professionalism among health workers.

It was striking that the government stuck to a gender-neutral frame and analysis. The only reference to gender was that the policy paper notes that 78 per cent of workers in the health care sector are women, and that 73 per cent of all its jobs are part-time – as compared to 44 per cent of all jobs in the Netherlands (*Zorgnota 2001* 2000: 175). Even those returning to the labour market were not gendered, but if one looks at the measures for recruiting them, a woman/mother is obviously in mind: jobs should be close to home, with suitable hours and a limit on the number of hours (ibid.: 187).

As to home care, the basic philosophy about the mix of formal and informal care remained untouched. The government noted that elderly people were staying at home much longer out of choice, but also because there were waiting lists for residential care. This led to higher work pressure for both home and residential carers. The government now offered alpha workers in home care the choice to become employees of care work organizations or retain their old status. The most striking aspect of the paper is that informal care was not discussed. The conclusion must be that the policy makers assume its presence as natural fact of life. But its neglect also reveals the very low value awarded to it, not surprising in a paper where the approach is mainly economic, emphasizing efficiency, quantity and cure.

The policy paper had its first parliamentary reading in November 2000. During the debate no party challenged the basic philosophy on the mix of home care. The Minister did not mention informal care at all, but now there was strong opposition from several women Liberal and Social Democrat MPs. Feminist scholars on the issue had been able to lobby, influencing both the MPs and the women's policy agency, which finally took up the issue in the late 1990s. Formerly it had interpreted care as child care and hence focused on the combination of work and family life for mothers (Oldersma and Outshoorn 2007).

The government responded by drafting the 2001 paper *Zorg Nabij* (Care close to home). This paper tried to redress the insult of the previous policy paper by praising the informal carer for contributing to social solidarity and acknowledging that long term carers are threatened by social isolation and overload. The government stated that an informal carer should be able to participate normally in social life and that the professional home care institutions should not use the maximum hours an informal carer can deliver as the gauge for providing for professional care (Zorg Nabij 2001: 9, 22). The informal care worker, however, was portrayed as a male, since the paper used Dutch masculine nouns and pronouns to denote the carer. The paper did note that twice as many women than men provide informal care, and do so for many more hours (the paper did not specify the exact amount, ibid.: 10). The paper still assumed the traditional gender division of labour, along with women's traditional obligation to take care and women's identities that predispose them to take on the responsibility of providing care. All proposed measures: more volunteers, advice centres for informal carers, weekend takeover when things become a bit too much and "respite" leave are all aimed at preventing the informal carer from calling in the professionals. At the same time the government noted that women's participation in labour market still needs to increase. It supposed that a more

generous future system of paid care leave will enable "working people to take on informal care, and informal carers to work" (ibid.: 17). In no way is the gender order called into question; its impact is more likely to reproduce traditional arrangements and values.

The Purple coalition government lost power in 2002, after the populist revolt led by Pim Fortuyn and the subsequent electoral swing to the right. However, the two ensuing right-wing coalition governments did not alter home care policy, despite the fact that Pim Fortuyn had targeted the waiting lists in health care as one of the major failings of the earlier Purple coalitions. Budgetary constraints are strictly maintained by the Balkenende II government (2003–2007) (a Christian Democrat/Liberal/Social Liberal coalition). The basic philosophy is that people should take their own "responsibility" and not depend on the state for help. The major change enacted in the area of health care is the 2005 *Zorgverzekeringswet* (Health Insurance Law; see note 6) which does not impinge on the home care issue. However, pending is a bill to decentralize a large part of the AWBZ funds to the municipal level, including home care (*Wet op de Maatschappelijke Ondersteuning* – Law on Social Support). It does not alter the basic philosophy underpinning home care but there is much debate on how local councils will implement the law in this area. Many fear that if the funds for the elderly, handicapped and chronically ill are not earmarked, councils will use the money for other purposes.

Discussion

Overall, when we compare the policy papers, there is great continuity in the policy on home care. The problem definition has not changed, neither have the basic policy solutions. Informal care remains the cornerstone of home care policy; state-funded services only step in when informal care fails, and extra-muralization is to be continued on all fronts. In all government policy the policy is legitimated by pointing to the preference of older people for remaining at home as long as possible. The causes of the problem are defined in very similar ways: ageing and the poor organization of services. One must conclude that after 15 years of debates, money and measures there is still a lack of integration, a great deal of inflexibility, and poor co-ordination standing in the way of more and better service delivery. All papers aim at maintaining informal care and limiting formal care, which is to remain supplementary to informal care. The core values of the papers also show great continuity such as the preference of the elderly to remain at home as long as possible, solidarity between carers and care receivers. This goes for the subtext of the documents, that is about costs and efficiency.

Solutions to the problem have proved more varied. In 1991 the government hoped to restructure the sector by a new system of basic health care insurance and the introduction of competition. With the failure of the insurance reform, all hope was then pinned on the maintenance of informal care; in 1997 privatization was stopped. In 1991 informal care was to be provided by volunteers; in 1997 "partners" were the solution; in 2001 the usual suspects as well as migrant women returners to the labour market. In all papers shortages in personnel were to be decreased by making professional care work more attractive (without mentioning higher wages) and by combating staff turnover and absenteeism. While the 1991 paper showed high gender

awareness, the subsequent papers reverted to gender-neutral language, hiding the gendered division of labour. Not obscured is the lasting attachment of policy makers to traditional gender values and gender identities; all policy papers assume they are there to stay and use them as a point of departure.

An important point in the 1997 paper is the very strict rationing of care by a system assessing the amount of informal care for the indication for professional care. This paper is also notable for the relatively generous admission of policy failure by freezing the experiments in privatized home care. Moreover, in contrast to the 1991 paper, the ''necessity'' of reducing state expenditure is no longer hidden in the subtext of the document. The 2001 papers reaffirm the need for strict criteria for the allocation of professional home care.

It is when we contrast the aims of home care policy to other major government goals in the Netherlands that contradictions in ageing policy emerge. The most striking one is in the area of labour market policy. Because of the large number of married women not participating in the labour force, the Netherlands had a very high economic dependency ratio. While OECD reports already pointed out this weakness in the Dutch economy in the late 1970s, increasing married women's labour market participation was not official government policy until 1994. As long as the Christian Democrats, with their strong familial ideology, had the pivotal position in any coalition government, they could effectively prevent any steps in this direction. Measures such as subsidizing child care, reforming the tax system, or abolishing the advantages of the male breadwinner family in social insurance and social security were out of the question.

With the advent of the Kok I government in 1994 (in which the Christian Democrats were excluded from power for the first time since 1918), work became the paramount concern in fighting unemployment and combating the number of people dependent on social benefits. A series of measures to promote (married) women's work, including those with very young children, was implemented to reduce dependency of women on social benefits. In this way the financial base of the welfare state (*draagvlak verbreding*) is to be maintained. Reducing the economic dependency rate also became more urgent when policy makers realized the consequences of the greying of the population. It is this employment policy that contradicts home care policy with its emphasis on informal care to meet the needs of the elderly. Given the fact that it is mainly women providing informal care, it clashes with the proclaimed necessity of increasing women's labour market participation. Policy makers agree that formal care work should be made more attractive to maintain labour supply, but given the goal of reducing public spending and the costs of labour, raising wages in the health care sector is never the preferred policy option.

In the 1980s the Netherlands finally started to restructure its gender order, moving away from the strong breadwinner model to individualization of entitlements to benefits and obligations. This was the result of pressure to comply with the equal rights legislation of the European Union and of the challenges posed by the new women's movement, one of the strongest in Western Europe. In her study of four European welfare states, which included the Netherlands, Diane Sainsbury has provided the necessary empirical evidence to show that the inequalities between men's and women's social benefits and tax allowances diminished; the reform of the old age pension (AOW), a universal scheme, was particularly successful from the

point of view of equal entitlement (Sainsbury 1996: 187). Wife and husband now each receive 50 per cent of the pension, while formerly the pension was paid to the husband when he reached the age of 65. The old breadwinner's advantage is not totally eradicated: a housewife does not pay contributions for the state pension, while a wife who has worked for wages does pay the required premium. With the tax reform of 2000, the remaining advantages for the breadwinner in taxation have also been removed: previously the generous tax rebate for men with non-working wives proved to be an obstacle for their entry into the labour market.

The process of individualizing social benefits has decreased women's financial dependence on their husbands, but at the same time it has worsened the position of those women who cannot earn enough to be economically independent. This is where the obligation of informal care comes in; it is one of the main reasons why women are not acquiring economic independence, and, from the point of view of the state, still present a risk for the volume of social security benefits. Part-time work may seem a solution for procuring informal care (although this is never said in official papers), but it does not contribute much to reducing the economic dependency rate. When it comes to informal care the Netherlands still depends on the traditional gender order, and at the intersection of the contradictions between policies it is women who have to straddle the divide.

Conclusions

Overall, the policy mix on home care in the Netherlands shows little change over the years. Informal care remains the cornerstone of policy, with professional care only issued on a strict system of allocation. The underlying argument of policy makers is that the state should ration the supply of care, as any extra costs will lead to higher insurance premiums for employers and employees, which lead to demands for higher pay, which in turn are detrimental to labour costs and thus to Dutch competitiveness in an increasingly competitive globalizing market. For similar reasons, but also to meet the EMU criteria, the national debt has to be decreased, setting limits on state spending. The legacy is a continual situation of shortages in care, erratic service provision and overloaded workers in both the formal and informal sector, which will continue to plague care givers and care receivers as well as public administrators and politicians.

This case study has also shown that the policy of long term care for the elderly is still predicated on a breadwinner/caretaker gender order and that the provision of care is to be secured by a strict division of labour between unpaid and paid care worker. The Netherlands locates care primarily in the family. The bulk of caring is to be performed as unpaid work, in the home, and by "partners". People have to take on the obligation of caring for their kin, and, given the prevailing gender order, this is most likely to be met by women. It must therefore be concluded that the policy will not lead to defamilization, but to greater dependency of women on the family. The solution is consistent with the welfare mix of the conservative welfare state, but not consistent with the move towards an individualized welfare state where the structure of benefits does not impede women in determining their life course and tie them to unpaid work within the family. Home care is constructed as a family obligation, with minor public

responsibility. Given the rationing of care, the market is already providing some care services for those able to pay. Government policies ignore the fact that increasing female labour market participation will clash with the necessary supply of informal carers. They also tend to ignore that women's traditional identities, in which care takes an important place, and the ideology of moral obligation to care are both in decline.

In policy debates about ageing, home care tends to be ignored as its provision by women is usually taken for granted by policy makers. The outcome of the analysis of the Dutch case, which has uncovered serious contradictions in policies for taking care of the elderly, is highly relevant for the ageing policies of other conservative welfare states predicated on the same gender contract. All of these are faced with the same dilemma as the Netherlands; the case shows that building on informal care to solve the problem of care for the elderly will hardly suffice. Moreover, it is not compatible with states' major policy goals of reducing the costs of the welfare state and boosting women's employment.

The analysis also shows the importance of studying the welfare state from the point of view of care. The demographic shift, with its growing number of elderly people, brings the issue of care to the forefront. As Mary Daly has observed, "the risk of requiring care or having to take care are two major life contingencies for individuals" (Daly 2000a: 68). Welfare states, by changing the welfare mix, determine who has to take the responsibility for care and whether the person who does the actual work will get paid for their services or revert to dependency on their family. Rethinking the welfare state to encompass the need for care of the old and the frail is unavoidable.

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Notes

1. Informal care can be defined as "care that directly ensues from a social relation" (Van der Lyke, 2000: 19). It is care delivered by partners, friends, family and neighbours and originates in commitment (ibid.). The Dutch term used in policy debates is "*mantelzorg*" (lit. cloak care, suggesting the warmth of a cloak or overcoat).
2. The names and tasks of this ministry have changed several times over the last decades. From 1983 it was the Ministry of Welfare, Health and Culture (WVC); from 1994 the Ministry of Health, Welfare and Sports (VWS). For practical purposes I will call it the Ministry of Health and Welfare in this paper.
3. For this analysis I will follow Outshoorn (2002: 18–187). Four layers of gender are distinguished: (1) Gender as a social category distinguishes between men and women: what differences are there and are these taken into account in the text? (2) Gender as a principle of social order looks at the underlying

gender order: what are the explicit/implicit assumptions about the division of labour between the sexes in the text? What does it say about it, and what assumptions are made about behaviour of women and men? (3) Gender as a cultural principle giving meaning at the symbolic level looks at notions of femininity and masculinity, the values can be derived from the problem definition of the policy text and what normative assumptions and how these are gendered? Is it done in a hierarchical way? (4) Gender as identity looks at what identities are ascribed to women and men in the text and what is assumed about these identities.

4. See Van Ewijk *et al*. (2000: 16–17) The elderly dependency rate is defined by the number of people over age 65 as a percentage of 20–64-year-olds.
5. She bases this on figures of 1996, which are likely to report on the situation in the early 1990s.
6. On 1 January 2006 a new law covering all persons for basic health care (*Zorgverzekeringswet*) became effective. The national health system was privatized, but all insured had to be accepted by insurance companies, who cannot select for the basic health coverage (*Basispakket*). Its costs vary little per company in 2006, but are expected to rise after this year. One can also take out extra coverage beyond the basic insurance.
7. Intra-mural is care/cure within a hospital, clinic or specialized institution; extra-mural is care outside of these institutions, usually meaning the home.
8. Van der Lyke (2000: 57–58) maintains that policy started to target men to fill in the deficit. In n.50 (p.166) she refers to a short version of the 1991 policy paper in which men are targeted: this is, however, not to be found in the final 1991 paper. Her other references (n.51, n.52) refer to the policy papers of the women's policy agency, which after much pressure from the women's movement finally started to include men in its papers on the status of women. No traces of this can be discerned in the two policy papers of the Ministry of Public Health analysed here, where home care resides.
9. A similar outcome is described in Morée and Oldersma (1991) who analyzed early policy reports on family care of the 1980s.
10. It started with: Ministerie van WVC/Heroverwegingsgroep, *Van samenwerken naar samengaan; gezinszorg en kruiswerk; naar een geintegreerd aanbod in de thuiszorg*, Rijswijk: WVC, 1990. It expected to save Hfl. 25 million. Subsequent policy papers of WVC also set integration as a high priority.
11. In 1970 19 per cent of people went to a hospital to die; this number rose to 35 per cent in 1995, leading to criticism about the medicalization of the last stage of life (Thuiszorg en zorg thuis 1997: 17).
12. To establish eligibility, during the intake interview the following questions are asked: what can the person still do her/himself, in the household and in personal care? Is informal care available? This is then supplemented by formal home care (Thuiszorg en zorg thuis 1997: 10). The Minister also published new guidelines in 1997 in the so-called *Indicatiebesluit*. The rules for allotting care are followed strictly.
13. The policy paper notes that between 1994 and 1996 no fewer than 25 commercial enterprises entered the market.

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