Journal of Social Intervention: Theory and Practice –
2009 – Volume 18, Issue 4, pp. 43–61
URN:NBN:NL:UI:10-1-100151

ISSN: 1876-8830
URL: http://www.journalsi.org
Publisher: Igitur, Utrecht Publishing & Archiving
Services in cooperation with Utrecht University of
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Received: 23 January 2009
Accepted: 31 March 2009
Review category: Research

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MARKET INCENTIVES IN THE DUTCH HOME CARE DEBATE: APPLYING THE LOGICS OF CARE METHOD

ABSTRACT

Market incentives in the Dutch home care debate: Applying the logics of care method
Since the 1990s, politicians and policymakers have emphasized the benefits of market incentives to the Dutch home care sector. During this time, waiting lists and other problems

have determined the standing of the sector. In this article, the author presents the logics of care method, with which he explores the underlying logics and dilemmas of the marketization of home care. On the basis of 443 text extracts (selected from Dutch political bodies, employers' organizations, professional organizations, labour unions, health insurers and customer organizations), the author shows that four competing logics of care have manifested themselves in the debate on market incentives: economic, political, familial, and professional logics of care. While some actors point out the conflicts and incompatibilities among the logics, others emphasize their mutual complementarities. The latter is relatively rare, but where the parties *do* emphasize the mutual complementarity of the logics of care, they also manage to develop policy lines on the basis of which effective solutions to home care problems could be provided. This observation suggests a connection between the debate and actual policy and operational practice.

Keywords

Home care, the Netherlands, logics of care, market, profession, family, state

SAMENVATTING

Het debat over marktwerking in de Nederlandse thuiszorg: Toepassing van de zorglogica-methode
Sinds de jaren negentig hebben politici en beleidsmakers vaak gehamerd op de voordelen van marktwerking in de Nederlandse thuiszorg. Sinds die tijd ook, roepen wachtlijsten, personeelstekorten en overige problemen negatieve publiciteit over de sector af. In dit artikel presenteert de auteur een methode, waarmee hij de onderliggende logica's en de dilemma's van marktwerking in de thuiszorg onderzoekt. Op basis van 443 documenten (afkomstig van de Nederlandse overheid, politieke partijen, sociale partners, beroepsgroepen, verzekeraars en patiënten- en consumentenorganisaties), toont de auteur aan dat in het debat over marktwerking, vier concurrerende zorglogica's aanwezig zijn: de economische, politieke, familiale, en professionele logica's van zorg. Waar sommige actoren wijzen op de conflicten en tegenstrijdigheden tussen de verschillende logica's, benadrukken andere hun wederzijdse complementariteit. Dit laatste gebeurt overigens relatief heel weinig, maar áls de partijen de onderlinge complementariteit van de zorglogica's benadrukken lijkt de kans op een gezamenlijke en effectieve aanpak van de thuiszorgproblemen toe te nemen. Deze observatie suggereert een verband tussen het debat enerzijds en de concrete beleids- en uitvoeringspraktijk anderzijds.

Trefwoorden

Thuiszorg, zorglogica's, markt, professie, familie, overheid

INTRODUCTION

Since the 1990s successive market incentives have been introduced into the Dutch social care sector.[1] Sociologists, public administrators and political scientists often see the introduction of market principles into the public domain as a form of "institutional combat", in other words, a result of conflict between institutions and the diverse parties that these institutions represent (see Esping-Andersen, 1990; Pierson, 1994; Powell & Hewitt, 2002). This article is also based on the conflict model. However, its emphasis is on the discursive nature of the conflict: the arguments that have been put forward concerning the introduction of market incentives into care, and the underlying friction and dilemmas in relation to the nature and organization of care services.

In particular, I am interested in the course of the Dutch home care debate in the mid-nineties and subsequent years. Other examples might also have served as a starting point for the analysis – other service sectors (education, welfare, social services, et cetera) or other periods. However, the Dutch home care debate has been selected because it was one of the first public sectors in which market incentives were introduced. This took place in a period during which waiting lists, staff shortages, image problems and quality deficits determined the standing of the sector (Swagerman, 1997). According to some parties in care services, marketization was the cause of this, but others see marketization as the solution to these problems. Home care is ideally suited to an analysis of the conflicting views of market forces in care.

The additional aim of this article is to demonstrate the value (or lack of it) of the method currently in use. This method is known as the logics of care method, by which discourses can be analysed (Knijn, 2000; Verhagen, 2005). Discourses presuppose an "inherent logic", not existing primarily in the coercive power of particular groups, but underpinning the ways in which decisions are framed through the rationales and legitimating frameworks of different forms of knowledge (Clarke & Newman, 1997; Foucault, 1972; Hortulanus, 2000). What logics do we find in the debate on market incentives in care, and how do they relate to each other? Does the logics of care method provide *reliable* and *valid* insights into the debate on home care, and are valuable insights into the actual performance of home care obtained? If this is the case, other sectors and other periods can be analysed and systematically compared with each other in a similar manner in the future.

FOUR LOGICS OF CARE

Knijn (2000; 2004) found that the public debate on the Dutch care system to the end of the eighties was shaped by three arguments, or – in her words – logics of care: the familial, political and professional logics of care. These logics of care, which Verhagen (2005) expounded further, arise partly from the compartmentalized Christian Democratic infrastructure, and partly from the state-managed social democratic infrastructure. Each of the logics has its own motives and principles, on the basis of which the nature and organization of home care are, or may be, defined. Home care is consequently a hybrid and disputed domain, one in which three logics were simultaneously manifest to the end of the eighties:

1. The *political logic of care,* according to which the government is responsible for the distribution of care to its citizens. Whether a liberal, socialist or Christian Democratic government is concerned, the allocation of care always takes place on the basis of equal rights and without discrimination.
2. The *professional logic of care,* which is founded on professional interpretations, standards and values, and based on expert knowledge and skills. This logic assumes the presence of a discretionary professional domain in which professionals take decisions concerning the care that should be provided according to their own judgement and expertise.
3. The *familial logic of care,* which is based on principles that "spontaneously" prompt family or community members to practice reciprocity among themselves. Personal involvement and/or a sense of obligation towards nearest and dearest play a decisive role in this logic.

Since then, according to Knijn, a fourth logic has been added: the economic logic of care, based on the free-market mechanism. This is an interesting addition, since a framework of *four* competing logics of care is not yet distinguished in the conventional sociological approaches. Strikingly enough, scholars of the welfare state recognize the care offered by welfare regimes as integrating only three of the four logics: the political, economic and familial logics of care, determined respectively by the institutions of the state, market and family. Some add voluntary or non-profit regimes and replace the "welfare state triangle" with the "welfare state diamond" (Pijl, 1994). By contrast, sociologists of the professions distinguish three logics giving direction to public services: the bureaucratic, the professional, and the managerial (Freidson, 2001).

The framework of *four* competing logics of home care is based on the following arguments (cf. Knijn & Verhagen, 2007). First, the term "professional" is added to the providers acknowledged

in welfare state studies. Though care workers are often low- or semi-skilled workers, they too are professionals, whose decisions are based to a certain degree on specialized knowledge and skills. Moreover, "the family" is included in the framework as a main provider of care, in contrast to the "sociology of the professions" approach. Finally, voluntary or non-profit organizations are eliminated from the framework as providers having their own specific logic. After all, in the post-war period these organizations have lost their specific corporatist characteristics (Anheier, 2001). Since the 1970s, they have become part of state bureaucracies, and to the degree that they escaped this centralizing trend, they turned into private, for-profit corporations in the 1990s. For this reason, in this article four logics of care are distinguished, with the economic logic of care being the most recent offshoot.

The economic logic of care is based on the free-market mechanism which in turn is determined by the private and commercial exchange of commodities. A requirement for participation in the market is the redefinition of care services as commodities that are exchanged under conditions that permit full competition and the maximization of profit. External coercion may regulate this exchange but cannot intervene in the exchange process itself. According to the economic logic of care, full competition is a condition for the exchange of care commodities, since only then are supply and demand optimized. Hence, market incentives promote the effectiveness of home care. The savings that can be realized with this, in theory at any rate, can benefit the availability and quality of the sector, so that waiting lists and other consequences of shortage might be a thing of the past. On the basis of this argument, in 1994 the Dutch Minister of Health, Els Borst-Eilers, admitted twenty-five private home care bureaus into the collectively financed care sector, with the intention of eventually handing over one hundred percent of the home care budget to free market operation. No additional investments in collective care were made, which might have been another option for meeting care needs.

METHOD OF DATA COLLECTION AND ANALYSIS

How have the various parties in care reacted to the introduction of market incentives to home care, and to the policy measure by minister Borst-Eilers in particular? What tensions between the logics of care underlie the reactions, and how successful have the parties been in making the relations between these logics of care productive?

I will try to answer these questions on the basis of a logics of care analysis, in the form of an analysis of public documents, including parliamentary documents, proceedings, memoranda,

letters, conference reports, journals, press reports, annual reports, et cetera. The period of data collection is 1994–2004. That is the period from the commencement of minister Borst-Eilers' measure to the point when discussion of the advent of private/commercial suppliers more or less ceased. An analysis of public documents is the obvious course since it is the appropriate method of analysing substantive positions, public standpoints and underlying tensions. Participative observations and interviews are more suitable for studying informal and non-public issues, and could therefore have provided interesting insights into what occurred behind the scenes. However, in this article I am interested in the *public* debate on the Dutch care system and in the possible connection between this debate and actual policy and operational practice.

The documents collected for this analysis were issued by the parties involved in care who have the most influence on and/or the biggest responsibility for the availability and quality of home care. These are 1) Dutch politicians, 2) employers/suppliers, 3) employees/professional groups, 4) health insurers and 5) customer organizations, which in turn are subclassified into a total of sixteen actors (Table 1). For the sake of clarity, I will restrict myself in this article to the five main parties.

Table 1: Parties and actors in home care.

Parties	Actors	
National politics	1	Government
	2	Dutch Senate and House of Representatives
Employers/Suppliers	3	Landelijke Vereniging voor Thuiszorg ( ) [National Association of Home Care Providers]
	4	Branchebelang Thuiszorg Nederland ( ) [Dutch Home Care Sector Interest Group]
Employees/Professional Groups	5	[Carers National Association]
	6	'91 [National Association of Nurses]
	7	Landelijke Vereniging Wijkverpleegkundigen ( ) [National Association of Community Nurses]
	8	Dutch Association of Nurses and Care Workers ( )
	9	AbvaKabo (public sector labour union)
	10	union for public and care sector personnel)
Health insurers	11	Netherlands Health Insurers ( )
Clients	12	Nederlandse Patiënten Consumenten Federatie ( ) [Federation of Patients & Consumer Organizations]

Parties	Actors
	13 Landelijk Overleg Cliëntenraden ( ) [National Association of Clients' Participation Councils]
	14 Client and Quality Foundation
	15 Consumers' Association
	16 Landelijke Organisatie Thuisverzorgers ( ) [National Association of Home Care Providers]

All the documents that were collected appeared between 1994 and 2004 and concerned waiting lists and other problems in home care (personnel shortages, image problems, quality shortfalls). For the government, these problems were the reason for introducing market forces. There are 1,121 documents in total: 121 government texts and 1,000 documents from fourteen civil society organizations (numbers 3 to 16 in Table 1). The documents were collected via the search engine of the Dutch Senate and House of Representatives, the library of the Ministry of Health, and from the various archives and libraries of the fourteen civil society organizations. Subsequently, all documents were imported into the qualitative analysis programme
1.2.

Secondly, a selection from the above-mentioned documents was made. All (extracts from) the documents that are relevant to tensions between logics of care were selected. This was done by using a coding system constructed from two hierarchically arranged main categories.
The first main category is entitled "Problems" and has four sections: waiting lists, personnel shortages, image and quality problems. Within these sections, a distinction is also made between the "solution", "cause" and "other aspects" of the problem concerned.

The second main category is called "Logics of Care", of which there are four: the political, economic, familial and professional logics of care. Each of these also has three subcategories (ideology, institution and definition of caregivers and care receivers), but a detailed description is beyond the scope of this paper (for a full description, see Verhagen, 2005).

How can the four logics of care be operationalized? After all, it is characteristic of these logics of care that they never manifest themselves *as such* in the documents. The logics I defined in the preceding section concern ideal types, which are never found in their pure theoretical form in practice. Logics of care are manifest, however, in all kinds of mixes, such as mixes between "total

liberalization of the market" on the one hand and "total regulation by government, family or profession" on the other.

How can such mixed forms be traced, operationalized, coded and analysed in the documents? To start with, I have profiled the ideal-type representations of logics of care by compiling four lists of words with which they can be expressed. Words such as "market incentives", "liberalism", "consumer", "competition" and "business", for example, belong in theoretical terms to the economic logic of care. I have based these words on literature that is relevant to the logic of care concept. In a similar manner, I have profiled the three other logics of care. Words such as "government", "regulations" and "legislation", belong to the political logic of care; words such as "professionalization" and "informal care" fit the professional and familial logics of care, respectively.

The result is a division into four logics of care with an average of fifty root words per logic and multiple extensions, such as "liberal", "libertarian", "liberalism", "liberalization", et cetera (for the complete list of words, see Verhagen, 2005). This division then enabled me to encode the mixed forms in which the logics of care occur in the documents. To be more exact: the division enabled me to encode text fragments in which words or word combinations that belong to one or more logics appear. With one press of a computer key, I was thus able to obtain answers to such questions as:

- Do the documents contain a reference to the cause of (or a solution to) the problem of waiting lists?
- Where in the document is the cause of (or solution to) waiting lists linked to the economic logic of care?
- Is the cause of (or solution to) waiting lists linked to the economic logic of care and to one or more of the other logics, and if so, where?
- Which parties comment on these kinds of issues and when do they do so?

The most interesting passages are those which have been encoded as belonging to more than one logic of care. In these passages, the *relationship* between the logics of care is or could be under discussion. In total, this appears to concern *N*=443 passages. In these passages, the research actors comment on the relationship between the economic and the other logics of care *being in or out of balance*. Sometimes they do this implicitly, sometimes explicitly, although they seldom use the term "logic of care" in doing so. Below there are four examples of how the relationship between the economic and political logics of care may manifest themselves in texts (in italics, S.V.):

Explicit:

Out of balance	– "Currently the market is *out of balance*. It finds itself in transition from the old rigid situation with monopoly positions of the home-care institutions, into a situation whereby suppliers have free entry" (Policy memorandum from minister and state secretary, 15-04-1996, 23235, no. 11, p. 3).
In balance	– "More marketization does not necessarily have to be at the expense of solidarity (…). In fact, a *new balance* might be achieved with increased effectiveness and increased solidarity" (Care Insurers Journal, no. 07, 19-02-1998, p. 6).

Implicit:

Out of balance	– "Marketization of home care *is not working*. Illegal competition is being promoted by the government" (press release, 21-02-1995).
In balance	– "Social enterprise, *a bridge between* public and private enterprise" (Discussion document , March 2000, p. 1).

THE RESULTS: MARKET INCENTIVES IN RELATION TO THE OTHER LOGICS OF CARE

Below I set out how market incentives have related to the other three logics in the documents. In this, I make a distinction between the period up to May 1997 and the subsequent period, up to around 2004. Do the logics conflict, according to the parties involved? Or do they believe them to be complementary? What shifts have appeared over the period? In brief, it appears that some logics of care have barely played a part in the debate on the marketization of home care, while other logics have made their presence felt. The analyses also show that the logics of care have fulfilled a very disparate role in the home care debate. While some actors point out the conflicts and incompatibilities between the four logics, others emphasize their mutual complementarities. The latter is relatively rare, but where the parties *do* emphasize the mutual complementarity of the logics of care, the chances of a collective and effective approach to home care problems increase. This observation suggests a connection between the debate and actual policy and operational practice.

Economic and political logic of care: dominant and variable

Up to May 1997 (I will come back to this date) the parties involved in the debate described the relationship between the economic and political logics of care as being "out of balance",

"conflicting" or "contrary". Such terms are found in 87 percent of the text extracts. The reason for this can be traced to the negative effects that appeared following the advent of private/commercial suppliers in 1994 (prior to 1994, home care was the exclusive domain of public suppliers). Some private suppliers appeared to provide customers with only the profitable part of the home care package, while public organizations were obliged to supply the entire package. Other suppliers did not comply with the Collective Labour Agreement; still others only supplied home care to profitable and lucrative customers.

However, the way in which the parties brought the perceived imbalance to light differed strongly from one to the other. Arguing from the perspective of the political logic of care, the Dutch Labour Party, GroenLinks (Green Left), (Socialist Party) and the National Association of Home Care Providers ( ) asserted that the situation in home care had taken a wrong turn because of the number of motives associated with the nature of market forces. With free competition, the profit element would play a part and the effects of market forces (injustice, unfairness and inequality) would be counterproductive. The private organizations would focus on the profitable and affluent customer, instead of supplying the entire care package to every citizen with a legitimate need for care. In short, according to these parties the *customer friendliness* and *effectiveness* of home care would decline rather than increase. "True" customer focus should consist of home care as a basic provision, one that is means-tested and available to everyone.

An argument that was exactly the opposite was made from the perspective of the economic logic of care by the (People's Party for Freedom and Democracy), (Christian Democratic Alliance) health insurers and the commercial employers' association . Rather than market incentives, it was the mismanagement of the market incentives that caused the admittedly sometimes poor performance of the market. The advent of private enterprise itself was regarded as effective, but inadequately controlled and regulated by the government. According to these parties, market incentives had in fact enhanced the *customer friendliness* of home care. Under the pressure of competition, public care providers were far more conscious of the need to empathize with the customer's perspective than they had been previously. Moreover, market incentives had a positive influence on the *effectiveness* of the sector. According to these parties, the increased incentive of competition had overcome the traditional, stagnant funding structure of home care.

Typical of this period is the incompatibility of the standpoints of those in favour and those against marketization and the ideological way in which they conducted the debate. The parties appeared to consider the issue as a "make or break" question, emphasizing the advantages (but not the

disadvantages) of their own perspective (cf. Mastenbroek, 1989). At any rate, in this period it was impossible to create acceptance for any approach to home care issues. In fact, the care sector was deadlocked, described by Hemerijck (1995) as "immobile corporatism" (cf. Scharpf, 1988). The typical Dutch entanglement of government and civil society organizations, which might have led to shared power structures, cooperation and acceptance, had a paralysing effect during this time. In the expectation of a fundamental discussion on the question of how the marketization of home care was to proceed, the cabinet decided to postpone making any decisions on the subject.

Since May 1997, however, there has been a gradual turnaround in thinking. Pragmatic arguments rather than ideological motives have increasingly been setting the tone. Logics of care analysis shows that from that date[2], advocates of both market forces and of government intervention have sought alternatives for encouraging marketization without allowing its negative effects to come fully into play. They have sought, for example, alternatives for improving the effectiveness and customer focus of home care through market incentives, without it being at the expense of less-affluent customers. The belief took hold that a strong market can be combined with a strong state, provided that the right conditions are in place.

One of the reasons for this turnaround in thinking was the future memorandum presented by the health minister in May 1997. In this memorandum, the "truth in the middle" was opted for explicitly, i.e. the view that home care would benefit from a well-considered combination of government administration and market elements. Another, more important reason, I believe, was presented by the growing problems affecting care, which included expanding waiting lists, image problems and increasingly open unrest. These roused the willingness of the parties to look beyond the bounds of their own interests and break the deadlock. There was a growing sense of urgency, and with that a collective will to find a creative way out of the impasse.

Text extracts in which the parties typify the relationship between the economic and political logics of care as being "in balance" or "complementary" appear at least 7.5 times more often after May 1997 than in the previous period, taking into account the number of documents collected in these two periods. From this period, both the advocates of market incentives and those of government regulation sought ways of making the relations between the economic and political logics of care productive. They sought a formula for a *different type* of market and a *different type* of government involvement, whereas at the beginning of the nineties they had sought a formula for more or less government involvement. For example, they sought new *instruments* (benchmarking, output financing, performance agreements), new *alliances* (cross-regional cooperation, care chains

providing home care, healthcare and nursing services) and new *actors* (the government as market superintendent, the organizations as social enterprises). Care suppliers, for example, were expected to behave increasingly as market-driven, customer-oriented businesses, but *on the condition* that they would assume public responsibility for their activities. And on the condition that they would supply the entire care package to every citizen with a legitimate need for care (known as the duty of acceptance).

The turnaround in the debate was accompanied by a turnaround in actual policy and intervention implementation. While the debate moved in this direction (market discipline *and* regulation, liberalization *and* control, competition *and* cooperation), the actual performance of home care showed signs of improvement. In 2000, the parties began to emphasize the complementarity more often than the incompatibility of the economic and political logics of care. Notably, waiting lists also started to decline. The waiting lists for home care declined by 35 percent in 2000, while the demand for care increased by 8 percent. This trend continued in subsequent years.

There is a question, of course, of whether it was the new, more complementary relationship between the economic and political logics of care that changed the policy and intervention implementation, or whether it was the changed implementation that gave the parties the energy to make the connections between the logics of care. I am not in a position to cite a cause in this issue based on the data. It seems reasonable to conclude that both processes have strengthened each other.

Economic and professional logics of care: relatively absent and static

In comparison with the relationship between the economic and political logics of care, the relationship between the economic and professional logics of care has been much less apparent in the home care debate. Figures from the 443 text extracts show only 26 percent coded as "economy" *and* "profession". To compare: as many as 53 percent are coded as "economy" *and* "politics". Besides, there have been relatively few developments in the relationship between the economic and professional logics of care. Over the entire period of 1994–2004, the relationship between the economic and professional logics of care is largely cited by those in politics and in the field as obstructive, corrupting or "out of balance". Even in the most "favourable" year, such terms are found in 71 percent of the extracts. The belief that the economic logic of care might play a useful role in the care sector by strengthening the professional logic of care rather than

obstructing it is barely evident in the standpoints of the various parties. The professional groups, in particular, are pessimistic about this direction.

Logics of care analyses show that almost all the parties involved believe that, from the perspective of the professional logic of care, the introduction of private/commercial suppliers has had negative effects. It forced public home care organizations to defend their market position, and the competitive battle that ensued was expressed as pressure to employ cheap, rather than expensive, labour. In order to survive, organizations handed nursing tasks over to (cheaper) family care givers, and family caring tasks to (cheaper) unqualified home help. The result was an increasing number of *unqualified* care suppliers, and with that, at least according to the professional logic of care, a loss of professional autonomy and professional expertise on the part of the home care employees. According to the professional logic of care, home care workers deliver home care based upon discretionary power, at least partially founded in a professional claim of distinctive expertise, knowledge and skills (Freidson, 2001). According to this logic, professionals know what is in the best interest of the client and have the expertise to perform the work that has to be done. For this reason, the professional autonomy of home care workers was said to be diminished when the introduction of market incentives made home care suppliers look for the cheapest options, such as unqualified home help.

This observation was a source of discomfort, particularly to professional groups. They pointed out that too great an emphasis on financial considerations undermined the foundation of healthcare: motivated, professional care providers. According to the professional logic of care, home care employees should be able to expect a realistic level of demands for care from care-dependent customers and be able to provide appropriate, expert solutions. However, since the advent of private suppliers (and the government cutbacks that preceded it), the competitive position and "rate of production" have been given priority. From the perspective of the professional logic of care, this means not only that the "soul" is being driven out of care, but also that the incentives for professional practitioners have been set aside (Knijn, 2000; Tonkens, 2003; cf. Vulto & Morée, 1996).

The synergy between the economic and political logics of care that arose at the end of the nineties did not change the situation to any significant degree. Whereas, at the end of the nineties, the parties felt a sense of urgency with regard to reversing the obstructive tension and friction between the economic and political logics of care and creating a fruitful relationship, hardly any comparable acceptance was generated for the idea of doing the same with respect to the economic and

professional logics of care. This was probably the case precisely *because* the emphasis lay on the economic and political logics. Both, after all, are based on what Grit (2000) calls "vormdenken" (management thinking). A feature of this thinking is that the production process is valued more than professional quality. In the production process the emphasis is on performance management, on making results transparent, on monitoring and creating protocols of quality, on benchmarking organizational processes on the basis of standardized indicators and on all kinds of other activities, which are aimed not at the content of care provision, but at its management, monitoring, accountability, measurement and/or effectiveness.

Therefore, in the area in which the parties did manage to ameliorate the tensions between the economic and political logics of care, it is notable that in the period in question barely any consensus between the economic and professional logics of care was reached. This is understandable, since the emphasis was on management, accountability and monitoring, but it might discourage consideration of the fact that positive alliances between the economic and professional logics of care are possible. The fact that, as the Raad voor Maatschappelijke Ontwikkeling (RMO [Council for Social Development], 2002) explains, market forces might also lead to variety and differentiation within and between public organizations is barely touched on in the relevant text extracts. Market incentives, according to the RMO can evoke excellent and superior behaviour in professionals, *provided the right preconditions* are formulated. In the documents examined for this analysis, however, this line of thought does not appear to occur.

Economic and familial logics of care: resounding silence

Wherever synergy has been created between the economic and political logics of care and wherever this synergy is absent in relation to the economic and professional logics of care, the relationship between the economic and familial logics of care in turn is notably absent. Logics of care analyses show that politics and the field have only weighed in on the relationship between the economic and the familial logics of care in an unremarkable 2 percent of the text extracts analysed. As to the question of whether the actors involved believe that the introduction of market incentives into the realm of social care undermines or complements the familial logic of care, there have been hardly any statements.

Nevertheless, the familial logic of care might theoretically have been present in the documents surveyed for this analysis. In fact, in view of the optional nature of home care, and the consensus that the social network should be consulted before institutional care is considered, I had expected

to see it appear with more frequency. How do we characterize the empirical absence of the familial logic of care? Firstly, its absence makes it clear that very little has been said in the public debate concerning the *relational* and *people focused* dimension of home care. Where, for example, from the familial logic of care perspective waiting lists exert a primary influence on the social functioning of people and on their family relations and personal concerns, in the field the waiting list debate is shaped primarily in terms of capacities and systems. Secondly, the absence of the familial logic of care in the debate illustrates the marginal position of customers and customer organizations. The fact that these organizations have barely any say in the home care debate demonstrates their lack of authority in the field and the difficulty they apparently have in introducing the consequences of marketization to the informal, familial care provision in the debate. Potential problem areas thus remain undiscussed.

CONCLUSION AND REFLECTION

In this article I have presented the results of a logics of care analysis of 443 text extracts concerning the introduction of market incentives into home care, and in particular concerning the advent of private/commercial suppliers in the mid-nineties. The extracts were selected from over 1,000 texts and were collected from Dutch political bodies, employers' organizations, professional organizations, labour unions, health insurers and customer organizations. The extracts demonstrate the sometimes shifting positions these parties have taken with regard to market forces. In sum, it appears that some logics of care have barely played a part in the debate on the marketization of home care, while other logics have made their presence felt. The analyses also show that the differing logics of care have played very disparate roles in the home care debate. While some actors point out the conflicts and incompatibilities between the four logics, others emphasize their mutual complementarities. The latter is relatively rare, but where the parties *do* emphasize the mutual complementarity of the logics of care, they are also able to develop policy lines, on the basis of which effective solutions to the problems of home care are provided. For a thorough overview, refer to the results section.

Where sociologists, management experts and political scientists largely approach the introduction of market forces into social care as an institutional process (with the institutions as units that can overlap only with difficulty), in this article I have examined the underlying logics and tensions between logics that have circulated in debates concerning the marketization of care. Since logics can emanate from institutions and can attach themselves to other institutions (cf. Foucault, 1972), these logics can be mixed freely together (Mol, 1997). The logics of care approach is an attempt

to show the relation between institutional change and discursive change. Institutional change, as Fairclough (1992) states, often has its starting point in the problematization of conventions and clarification of underlying contradictions and dilemmas. Furthermore, institutional change is encouraged by attempts to resolve these dilemmas. People resolve dilemmas by being creative and by adapting existing conventions in new ways, and so contributing to institutional change. Examples in this article are the new *instruments* (e.g. benchmarking), new *alliances* (e.g. cross-regional cooperation) and new *actors* (e.g. the government as market superintendent) that have been introduced to resolve the dilemmas that arose when controversial market forces manifested themselves in the social care sector.

A principal reason for examining the discussion of the marketization of home care in the Netherlands is that it was one of the first public sectors in which market principles were introduced. How did the parties involved react to this new situation? How was marketization perceived in relation to the other logics that have traditionally been shaped the discussion of home care? I have tried to answer these questions, not by proving whether the introduction of market forces in social care is a "good" or a "bad" thing, but by providing some insight into the debate on this complex subject. "Science cannot resolve moral conflicts", said Pagels in a well-known quote (1988, p. 1), "but it can help to more accurately frame the debates about those conflicts". In this article, the four logics of care constitute the frame.

A second reason is methodological: to my knowledge, there have been no previous attempts made to test the four logics – or similar models – *empirically*. I believe the way in which this is carried out in this article to be valid and reliable. The analyses are valid because they incorporate the texts *as they are*: the parties' documents are established and the content cannot be influenced or distorted by the researcher. They are reliable because there are clear indicators of which data has been analysed, and by which means, so that other researchers can repeat the calculations. Having said this, the research results could have been even more reliable if additional assessors had been recruited to perform the same analyses.

It is interesting that the tensions between logics of care are also manifest in other sectors, both in other care sectors and in service sectors such as labour supply, education, welfare and social services. There is relevance here for those other sectors, all of which are active in the four domains and confront similar tensions. While I have focused on the domain of home care in the Netherlands in this article, moreover on a specific period, logics of care analyses can just as well be carried out in other sectors, other periods or home care regimes in other countries. If the logics of care method

is indeed reliable and valid, it will be possible to carry out systematic comparisons between periods and domains. These may lead to intriguing new insights into both current debates and actual policy, as well as the intervention practices that are partly determined by the debates.

NOTES

1 This article is based on my PhD thesis: *Struggling logics of care. Home care and its discontents explained* (Verhagen, 2005).

2 May 1997 can seem to take on almost mythic proportions through constant repetition. However, this date does not mark a one-off event, but the beginning of a gradual development that culminates in the year 2000. In my PhD thesis, I outline this development in greater detail than is possible in this article.

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