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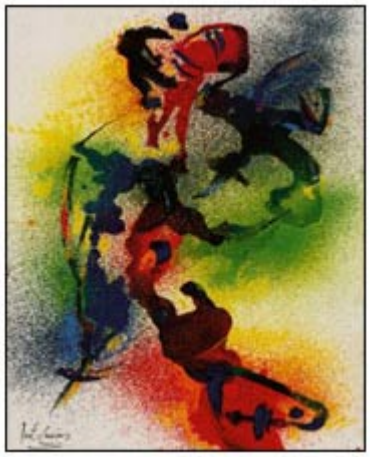

Contested professionalism and the quality of home care

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CONTESTED PROFESSIONALISM AND THE QUALITY OF HOME CARE

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Introduction

'If provision is sub-standard, the right to care becomes an empty concept, and care services will be unable to pay for themselves. Care is not a market good because it too closely concerns the most intimate needs of human beings' (Bettio & Prechal, 1998: 43). Bettio and Prechal make this straight statement in the report *Care in Europe* in which they map care provisions and care regulations for children and elderly on behalf of the European Commission. Not many people will deny that sub-standard care is careless and hardly anyone is prepared to pay for low quality care. But what does sub-standard care mean? And how bad should care be before we call it sub-standard? In other words, does any agreement exist about criteria for the quality of care?

This article focuses on declining professionalism in home care for the elderly and the meaning of this decline for the quality of care from a recipients perspective on the one hand and the care workers view on the other. First, by mapping various forms of care for frail elderly in European countries we will expound that professional home care is only one possible provision available for frail elderly and that this is in competition with other arrangements, not in the least with cash benefits. Secondly, we offer an explanation for the changing position of professionals in general and of semi-professionals, like home care workers, in particular. This sets path for a theoretical, ideal-typical exploration of the logics of the market, the state and the family that encroach upon the logic of professionalism (paragraph 3). What this theoretically means for the quality of care is outlined in paragraph 4. Here we will focus explicitly on the particularities of professionalism as one of the logics framing the demand and supply of home care; how is professionalism related to the institutional pillars of the welfare regime and in what respect does the logic of professionalism differ from the logics of the state, the market and the family? Finally we will consider if there are any reasons to plea for maintaining professionalism in this service and why professional home care did not succeed in becoming the most attractive service for frail elderly or as the best care provider from a public governance perspective.

Cash for care

Home care historically has developed into a professional, though low skilled, service, embedded in publicly financed institutions and conditioned by settled agreements. In the report *Care in Europe*, home care is defined by Bettio and Prechal (1998) as 'a variety of services delivered at home by public institutions and/or publicly supervised non-profit organisations (for a fee or for free)'. Recent developments in the Netherlands, Britain and Sweden (Knijn, 1998; Szebehely, 1998; Ungerson 2000) learn that home care also can be delivered by for profit organisations that are nevertheless publicly funded and supervised. However, home care is only one of the many forms of care for frail elderly. Several authors have developed an overview of the variety of care services and regulations and most of them recognise that most care is still given for free by relatives and – to a lesser degree – volunteers. In addition they distinguish three main categories of care: services, work-related incentives and cash benefits (Lewis, 1998; Bettio & Prechal, 1998; Daly, 2002; Standing, 2002).

Services, the oldest form of formal care, nowadays can be split up in residential care, home care (on a profit or non-profit basis) and private or publicly financed domestic services, the latter only available in France. Leaves for caring for frail elderly are currently in the making but they seldom offer a long-term perspective for carers and care recipients, they mostly have a limited duration. Such leaves exist in Belgium and Finland for all workers and in Germany and Luxembourg for workers in the public sector only.

Cash benefits for care are rapidly developing in many European countries to date, while it was already introduced in Britain in the 1980s where they were paid to carers as a kind of compensation for their limited ability to find a proper job (Ungerson, 2000). As Evers et al. (1994) have said in the beginning of the 1990s, there is, especially in the continental European countries, an increasing tendency towards cash benefits, mainly by way of payments for care dependants. In the 1990s Luxembourg and Ireland followed the British example by paying care allowances to carers. Germany has its social insurance-based Soziale Pflegeversicherung since 1995. This long-term care insurance gives those who qualify for insurance provisions a choice whether they accept professional care or a cash benefit with which they can either pay family members and neighbours or purchase (home) care providers from the profit or non-profit sector (Ostner, 1998). Also in the 1990s the Netherlands introduced and extended its Personal Budgets, paid by the already existing Exceptional Medical Expenses Act (AWBZ) and offering those who qualify for care the same choice as the German long-term care insurance. France slowly implements since 1997 an allowance for

frail elderly in need of care who need help to stay in their own homes but do not have the financial resources to buy care on the private market, called 'Prestation Specifique Dependance' (PSD) (Martin, Math & Renaudat, 1998). In addition also Austria has recently developed forms of cash benefits for those in need of care (Bettio & Prechal, 1998). Cash benefits are offered by way of flat rate allowances that seldom are high enough to compensate for the loss of income.

For professional home care these tendencies are not without implications; whereas professional care in the past mainly replaced informal carers that were not any longer able or willing to provide care, it nowadays has to compete as well as to cooperate with paid informal caregivers for delivering services. People in need of care who can decide what kind of care they will buy with their 'care money', now have the opportunity to set criteria for good quality care and to decide whether their neighbour, their daughter in law or professional home care is the best service to get. By consequence home care offices will have to prove that their services are of better quality and should not be replaced by informal paid care. In addition professional home carers will increasingly be expected to co-operate with paid informal carers (Van der Lyke, 2000). Given the option that each will perform only a part of the care package, professional and informal carers will meet as equals who will, in negotiation with the care recipient, have to agree about who is doing what part of the care package and what standards of care have to be met.

Contested professionalism

The tendency towards payments for care in many European countries already started in the beginning of the 1990s. The background of this tendency is well-known and well-documented; a greying population in all European countries – about 45% of the population will be 75 or older in 2010 - combined with less women available for giving care for free (Bettio & Prechal, 1998). One option to solve this problem would have been to put large investments in professional home care, a way to cope with care that avoids the expansion of residential care. Extension of professional home care would stimulate low skilled women's labour market participation, one of the ultimate goals of the European Union and the OECD for solving social security and pension deficits. Interestingly enough, only in the Nordic countries these arguments resulted in increasing budgets for home care (Denmark) or the extension of care leaves (Sweden and, Finland) (Jamieson, 1991; Szebehely, 1998; Sipila, 1997). Most continental European countries and Britain try to cope with the misbalance in care by way of cash benefits, the cheapest alternative. Efforts to reduce debts by limited

investments in the public sector in combination with under-valuation of women's employment probably are reasons for trying to bind women to informal care by payments for care.

But there is more; the political choice for cheaper and informal, mostly familial forms of care is embedded in two tendencies that characterise the last decade of the previous century: economic liberalism and communitarianism (Clarke and Newman, 1997; Knijn, 1999; Exworthy and Halford, 1999; Freidson 2001). Comments on the spoiling, inefficient and expensive welfare state gained easily ground from the 1980s on, and cleared the way for the introduction of market based principles in public provisions such as care services. Neo-liberalism found entrance in the public sector by what Clarke and Newman (1997) call 'managerialism' and its rhetoric. Words as efficiency, consumer's choice, behaving business-like, a client-oriented attitude and competition became part of the vocabulary of politicians of all parties, civil servants and the managers in public services alike. Managerialism did prove to be more than rhetoric only, in the name of competition and efficiency, professionalism saw their protected position weakened and the staffing and governing of professional care institutions profoundly changed.

> 'It is charged that professions have monopolies which they use primarily to advance their selfish economic interests while failing to insure benefit to consumers, that they are inefficient, their work unreliable and unnecessarily costly. Strip away their protective licenses and credentials, urge some, and let there be truly free competition. Open the market to all who wish to offer their services. Consumers will separate the wheat from the chaff in such a market so that the best services and products will emerge at the lowest cost.' (Freidson, 2001: 3).

In addition to economic comments on the public services, moral arguments came up that pointed at the paternalistic attitude of professionals towards their clients and, moreover to the increasing power of professionals in the public domain. By using terms like expertocracy (Van Doorn and Schuyt, 1978), bio-politics or the disciplinary power of professionals (Foucault, 1978) disabling professions (Illich, 1977) social scientists and philosophers set the tone for a decade during debate about the power of professionals, their tendency to privilege their own interests above the common good, to behave elitist by using professional jargon, to disrespect their clients and to deny their client's knowledge and needs. These comments indeed hit the professional specialists in the public domain, medical specialists, lawyers, psychiatrists as well as teachers and social workers, at their weakest point at a period in which the culture of liberation from traditional hierarchies and social values dominated. In reaction to these comments at the cultural level a revitalisation of communitarianism gained ground.

> ‘First, people have a moral responsibility to help themselves as best as they can. (…) The second line of responsibility lies with those closest to the person, including kin, friends, neighbors, and other community member. They are next in line because they know best, what the genuine needs are (they are much less likely to be cheated than are welfare bureaucrats) and are able to tailor the help to what is required.’ (Etzioni, 1993, 144).

It is the irony of the 1980s and 1990s however, that pleas for individual autonomy, community based self-help and clients’ own choice and responsibility mixed up with neo-liberalism and its belief in the market. The right wing critics on the overspending welfare state met the left wing critics on the paternalistic professionals and together they paved the way for the restructuring of the welfare state’s public services by introducing market principles in these services as well as by re-familialisation of the provision of basic needs (Knijn, 2000). And although the neo-liberal and the communitarian commentators share aversion to the welfare state and its professionals, their assumptions about the position of the recipient, the mechanisms for supplying support as well as on how to meet demands fundamentally differ. In addition professionals no longer seem to be able to dominate the public sector as they did in the heydays of the welfare state.

> ‘>From the early 1980s onwards, calls for managerialization, marketization and liberalization have become widespread and forceful. Though calls for the introduction of general management can be traced back as far as the 1920s in *some* parts of the public sector, these have been effectively stalled by arguments in favour of professional control and autonomy.’ (Exworthy and Halford, 1999: 5).

Notwithstanding difference between nations and historical periods, this seems particularly true for the so-called ‘semi-’, ‘quasi-’. ‘pseudo-’ or ‘sub-’ professions like social work, school teaching and nursing. Numerous studies on managerialism, the restructuring of the welfare state and professionalism until now have analysed the changing positions of professionals in the public sector, but most of them focus on highly specialised professions such as medical specialist, lawyers, engineers or university professors (Krause, 1996; Freidson, 2001). We share the theoretical assumption that professional autonomy is declining as state power and/or market forces encroach upon it, but add that, in the case of semi-professionalism also the specific responsibility of the institution of the family (and the community) is at stake.

This can be illustrated very well by analysing a semi-profession like home care. In contrast to ‘real’ professions, home care is neither fully established nor fully desired (cf.

Etzioni, 1969). Characteristic for low-skilled home care is that its professional expertise is much less defined than the expertise of high skilled professions.

> 'Their training is shorter, their status is less legitimated, their right to privileged communication is less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than 'the' professions.' (Etzioni, 1969: v).

By consequence home care may appear to be quite mundane or 'everyday' and therefore has a diffuse borderline with family or community care. What belongs to the profession of home care and which demands and needs can be replaced by informal care is therefore politically contested. This position as a 'weak' profession sheds some theoretical light on why home care services and its professionals have been rather vulnerable to communitarian as well as neo-liberal comments. But is it also possible to more systematically clarify how the quality of (professional) care has been modified by these interfering comments?

In the next paragraph we will explore a theoretical framework in which professionalism is analysed as an alternative logic to three other logics: the state, the market and the family logic. Each logic is described ideal-typically[1] as to serve as a rational structure against the rational/irrational empirical world. We will first show that each of these logics has its own set of assumptions and therefore its own 'translation' of good quality of care, and secondly what it means for the quality of care if professional home care is submitted to the logic of the market, the state or the family/community. In the concluding paragraph we will, given the inherent tensions between these struggling logics, reason that payments for care seem to be convenient to care recipients, but have rather disapproving consequences for caregivers and their work conditions.

The logic of the state, the market and the family.

The ideal-typical democratic state deals with collective interests in the public domain, sets objective and controllable criteria for intervention and regulates private relationships by law and provisions without arbitrariness. By way of the bureaucratic administrative apparatus the state sets criteria and divides public goods on impersonal grounds, which does not mean that no categorisation of needs and social categories is made. Actually the interpretation of needs and the categorisation of clients is the main activity of the post-war welfare state as Nancy

[1] We will follow Weber's definition of an ideal type: 'An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct (Gedankenbild).' (Weber, 1971: 63).

Fraser (1990) rightly states. The main principle is however that the state focuses on the common interest of all citizens and is able to legitimise its criteria for intervention, its regulations and laws, its demands and support for the public forum. By consequence citizens in a democratic state are able to know their rights and duties, know what they can expect in return for loyalty and have a voice in setting the criteria for governance.

> '[I]n the ideal-typical state bureaucracy, allocational decisions are made through public policies that are enforced, with the ultimate backing of the state's monopoly on legitimate coercion, by civil servants striving to satisfy their dominant interest in career advancement and bureaucratic stability, on subjects which strive to avoid punishment; both to do so by minimizing risks and maximizing predictability through following agreed-upon procedures and regulations. The system "works" if it is successful in protecting all actors from domination by external actors and in affording equitable and predictable treatment to all.' (Streeck and Schmitter, 1985: 6).

Of course different types of welfare states exist and residual or liberal welfare states have a more limited definition of the relationship between the state and society, between public and private interests and between common and individual goods, than full, social democratic welfare states have. Nevertheless both – extreme – types of welfare states have in common that they have responsibility for equal treatment of all its citizens who have guaranteed rights and duties that can be enforced by state coercion. Applied on the quality of care and care work, in an ideal-typical state this is based upon bureaucratic-administrative principles: the state is responsible for an impersonal, objective and equal treatment of (categories of) citizens in the framework of objective and transparent laws and regulations that can be controlled by a democratic public forum.

The market is a quite different institution, ideal-typical characterised by the private and commercial exchange of commodities. A condition for participation in the market is the freedom of exchange of goods and services under the condition of maximising profit. External coercion may regulate this exchange but cannot intervene in the exchange process itself. Furthermore, full competition and availability of product information are conditions for the ideal-typical exchange of commodities, because only then demand and supply are optimised. In contrast to the state logic, the market logic is indifferent with regard to the participants of the market relations; producers, salespersons, consumers and customers are not categorised on basis of needs and interests, what counts is their exchange value and their individual performance on the market. This goes for the labour market as well as for the market of goods, no matter what the specific shape the market economy takes; being it a laissez-faire or

a strictly regulated market economy. Customers on the market therefore can rely on an indifferent attitude; the market will not judge their specific needs and interests. They also can make a free choice between the offered goods, services and products as long as their exchange value is sufficient. With respect to the quality of care and care work, the ideal-typical market first of all involves an indifferent and impersonal relationship between buyers and sellers of goods and services. Conditioned by fully informed consumers and based upon free competition, transparent information and for profit exchange of commodities, the logic of the ideal-typical market will deal with the quality of care and quality of care work on basis of its exchange value.

Like the market, the family (and the community) are based upon private relationships, but unlike the market these private relationships are not commercial and do not have the objective of maximising profit. The logic of the family is the logic of kinship, reciprocity, normative claims and bonding and by consequence family relationships are inclusive as well as exclusive. The definition of family boundaries is decisive for who is acknowledged to be a member of the kinship group and who is not, having consequences for who is legitimised to get and give support. Loyalty and solidarity depend on parochial criteria for belonging. In addition, the wider private relationships, such as social networks and communities, are based upon criteria for belonging, whether they are defined on bases of geographic criteria (the neighbourhood), of identities (religious, ethnic, by gender or age) or of just friendship. If family members, friends or neighbours support each other they do so on basis of principles of inclusion and loyalty. By consequence family relations are per definition arbitrary and in contrast to the logic of the state and the market they never are indifferent, objective and impersonal. Members of the family and the community deal with this logic on basis of solidarity, showing loyalty in the context of the particular set of normative criteria that characterises their specific family or community. They do so by expressing commitment to their kin or affiliates on basis of reciprocity and moral bonding. In addition, family relationships and in particular inner-family care relationships are still over-determined by gender, implying that moral imperatives result in unpaid care work by female kin (Finch, 1989). It is this logic that will define the quality of care and the quality of care work from the perspective of the family.

The state, the market and the family each have their own logics to approach the quality of care and the quality of care work. The professional logic deviates from these three logics in that it is neither based upon exchange value, or on equal distribution of goods and services or on parochial commitment. Professionalism needs some monopolisation while such is a

disruption of the market logic. Professional discretion also contradicts the equal distribution and the administrative logic of the state. Finally, the methodological, systematic and (in a specific way) impersonal professional approach does not fit very well with the arbitrary and personal family logic. In the next paragraph we will explore the specific characteristics of the professional logic as a basis for discussing the issue of substandard care. The heuristic value of the logics of (home) care will, in accordance with Freidson, be proven by the statement that:

> '[T]hose having propagated **the community** and/or **the market** have failed to defend **professionalism** as essential part of a larger whole whose logic and outcome is distinctly different from those of the market, community and state. Professionalism cannot be handled, without touching the whole; essential parts of professionalism cannot be removed without seriously damaging the whole.' (cf. Freidson, 2001: 3).

The professional logic of care

> 'In the most elementary sense, professionalism is a set of institutions which permit the members of an occupation to make a living while controlling their own work.' (Freidson, 2001:17).

It is with this firm statement that Freidson starts his book about professionals as a third logic besides the logic of the market and the state. He envisions all other aspects of professionalism, like discretionary power and autonomy, specialised skills and knowledge, and their commitment to the common good as vehicles for maintaining occupational privilege. This so-called power approach (for an overview, see Van der Krogt, 1981; MacDonald, 1995) succeeds the functionalist approach in which professional specialisation and occupational organisation was perceived inherently useful for a modernising society (Durkheim, 1992; Parsons, 1954; Etzioni 1969).

Whether professions exists by right of their power to present themselves as essential institutions, or that they really are indispensable for the common good, is not an issue that can be answered in general. What is at stake here is that a profession like home care can neither present itself anymore as (fully) essential, or as necessarily professional. Exworthy and Halford (1999) for instance suggest that de-professionalization is an ongoing process, occasioned by consumerism, the rising education of clients who no longer take professional expertise for granted and by submission of professionals tot bureaucratic organisational structures. By consequence professional home care is losing it's legitimacy in competition with commercial, managerial and (paid) informal care.

Both the complicated relationship of home care professionalism to the institutions of the welfare regime and the decrease of professional legitimacy will be considered as arguments for the devaluation of professional home care. We will consider the professional ideological and institutional logic as well as the logic of the relationship between the care recipient and the care worker. In doing so, we will be able to trace the comments on each of these logics from the perspective of professionalism in general and the profession of home care in particular.

- *Ideology*

The ideology of professionalism is based upon its discretionary power founded in its claim of distinctive expertise, knowledge and skills (Freidson, 2001). Applied to home care this implies that the home care worker has the discretion to decide how the care work should be fulfilled. The home care worker is trained in setting a diagnosis of what the client needs, has knowledge about what is in the best interest of the client and has the expertise to perform the work that has to be done. Claiming expertise based on training, knowledge, skills and experience as well as commitment to client's needs and the common good form the basis of professional privileges and supports the idea that professionals should be trusted. It are these claims that distinct the logic of professionalism from the logic of informal care. While professionalism is logically based upon a combination of distance and expertise, of involvement with parts of the clients needs (only those that are relevant for treatment) and the process of maintaining or improving the clients condition, informal care is logically based on a combination of intuitive knowledge and personal commitment to the client as a significant other.

These ideological aspects also set the logic of professionalism apart from the logic of the state and the market that only can deal with the division of the provision of home care and not with *how* it should be provided. While the market provides care on basis of the potency of making profit, and competition is its main drive, professionalism is based upon the potency of improving individual and social conditions and substitutes competition by professional agreements. While the state delivers care on basis of a justified distribution of provisions to those categories of the population that are accepted as having legitimate claims, professionals not only diagnose, on an individual basis, *who* should receive care, but also claim to know *how* their clients should be treated: professionalism guarantees that each treatment is based upon the particularities of this client's needs.

When applied to the quality of care and care work this ideology implies that home care workers guarantee the quality of care on basis of educational training, knowledge, skills, expertise and experience. They will treat clients as unique individuals having particular needs that can be dealt with in a committed though impersonal way. By focusing on the improvement of the condition of their clients they feel committed to make choices for their clients, though always in the best interest of the client (Knijn, 1999; Freidson, 2001)[2]. Concerning the quality of care work, home care professionalism is more ambivalent. On the one hand, home care workers will, like other professionals, claim privileges, autonomy and discretion, on the other hand however, they, also like other professions will claim that they 'work more for the satisfaction gained in performing their work well than for its role in providing them with a good living' (Freidson, 2001:108). We will see that it is exactly this ambivalence in a weak female profession that contributes to the devaluation of professional home care.

- *The institute: autonomy and ethics*

Ethics and autonomy, institutionalised rules and regulations justify the performance of a profession and underline professionalism. By right of professional organisations' directives, guidelines and codes and thanks to its certificates, acknowledged education and continuous schooling programmes, professions are able and allowed to maintain their occupational distinctiveness as well as their privileges. These institutional capacities also protect the members of a profession in practising their skills in an autonomous way; it underlines their discretionary power.

Home care workers have problems in maintaining their professional status and their occupational uniqueness. In some historical periods and in some countries they succeed in presenting their profession as a set of skills and knowledge indispensable for providing good quality care, while in other periods and in other countries they hardly are able to defend this status. Van der Boom et al. (2001) roughly state that the degree of institutionalisation and professionalism in Denmark, the United Kingdom and the Netherlands is relatively high compared to Belgium, France and Germany. For example, in the first relatively high institutionalised cluster of countries the largest amount of home nurses is working on a salaried basis in public or private organisations, while in the second cluster of countries a fee-for-service basis (in private, mostly for-profit practices) is a very common form.

[2] This claim of knowing what is 'in the best interest of the client' is criticized by Illich (1977), Foucault (1978) and De Swaan (1983) as being paternalistic, disciplinary and undemocratic.

This corresponds to the fact that in Denmark, the United Kingdom and the Netherlands autonomy of home care nurses is *not* limited by medical referrals: clients can contact the home care organisations themselves; while clients in Belgium need a referral from the general practitioner for the settlement of nursing activities, and clients in France and Germany need a physician's prescription for the assignment of all types of home care (Van der Boom et. al., 2001: 8; cf. Kerkstra and Hutten, 1996). Finally, there are country specific ways in the amount of jurisdiction that home care workers hold:

> 'In Denmark and the United Kingdom, needs assessment is performed by a first level nurse (…) which means the assignment of home care is decided on within the sector itself. In the Netherlands, however, since recently special assessment teams of bureaucratic bodies decide on the assignment of home care (…), as health insurance companies demand more standardised and objective assessment methods. These bodies [are] more or less external to the care-giving sector (…). In France, assessment of needs is performed by the doctor prescribing home care, which implies the content of the work is determined by professionals working outside the home care sector' (Van der Boom, 2001: 8/9).

When applied to the quality of care this implies that professional home care institutions exist by virtue of qualifications, credentials, professional codes and norms. Delivering good quality care is a relatively central motive by virtue of which professional home carers organise themselves, like for example religiosity, learning or leisure are inherent *qualities* that provided a basis for social grouping like preaching, teaching or social working. How successful home care work is defended as a profession relates to several institutional aspects. First of all it depends on the recognition of home care as something else than ordinary housekeeping that can also be provided on basis of the familial logic of care. If home care is defined as work that can be given intuitively and on basis of personal commitment instead of as work that needs distance as well as social and communicative knowledge and specific organisational capacities, it will not succeed in maintaining it's professional status (Vulto & Moree, 1996).

Second, the success of defending home care as a profession relates to the capacity of the profession itself to maintain the quality of care. If home carers do not succeed in maintaining the quality of the care they provide, it will be impossible to defend their specific additional value in relationship to familial care. Finally, both issues need occupational and professional organisations of home care workers; if these are weak organisations, for instance because most home care workers have part-time jobs or are not a member of a trade union, they will

not succeed in maintaining professional cohesion, a professional ethic and they will loose their institutionalised power. 'This control by rule and raising of moral standards can be established neither by the scientist in his study nor by the statesman; it has to be the task of the groups concerned.' (Durkheim, 1992: 31).

-The relationship between the care recipient and the care worker

The logic of the relationship between a professional carer and a care recipient exists in a mixture of individual but impersonal support and control from the side of the care worker and a person whose identity is partly classified as 'being in need'. Professional expertise as well as professional responsibility demands that professionals can deal with a client's justified, but also with their unjustified claims and that they cope with its implications (Lipsky, 1980). Professional decisions affect their clients' life chances if only by defining whether the clients needs are legitimate or not and by deciding what kind of treatment their clients will get. On the other hand, people with particular needs are defined as clients, patients or care recipients and as such they depend on particular professional skills in order to improve their life chances. By consequence there will be an inherent tension between the support and control aspects of providing and receiving professional services.

Providing professional home care further demands systematic treatment of a clients needs, this contrasts the familial care that by definition will be arbitrary and related to personal intentions and normative family codes. Whether a professional likes or dislikes a clients should not influence the way care is provided, nor should a professional be influenced by the self-diagnosis of a client. In addition, those in need of care might prefer informal familial care because they feel more comfortable by a personal treatment, or because they have a greater say when they contract the informal care worker themselves. In contrast to the market logic of care, a professional carer should not be influenced by the wealth or poverty of a client and irrespective of the state logic a professional should treat each client as a person who needs support[3].

Having discretion with regard to their client's needs improves the home care workers self-respect and self-esteem and vice versa; having no discretion goes at the cost of the quality of care, as well as of job satisfaction. However, from the perspective of the care recipient it is not uncontested that professional experts are the best providers. A tension between the

[3] That is why professionals like teachers, general practitioners, medical specialists and lawyers continue to support for instance asylum seekers who, by state decision don't have any right to such support because they are not considered citizens of the nation.

expertise based but probably also controlling professional home care on the one hand and care delivery by commercial or familial care providers by claims of care recipients is probably one of the backgrounds of the devaluation of professional home care. Care recipients might demand more coercion by the state to control the discretionary power of professional home carers. While in general professionals will be more committed to individual client's needs than bureaucratic civil servants are, clients may experience professional decisions or methods as unsatisfactory and plea for either more client autonomy or for more regulation of professional treatments by the state.

Figure 1: logics of care

	Ideology	Institute	Caregiver	Care recipient
Professional logic	Specialised knowledge and skills/ Discretionary power	The specialised profession	Expert/ Specialist/ Professional	Client/ Patient
Market logic	Individual freedom	The commercial market	Seller	Consumer/ Customer
Bureaucratic logic	Bureaucratic equality/ Control and rules	The legislative state	Government/ Minister of health/ Public servant	Citizen/ Taxpayer
Family logic	Family bonding/ Group solidarity	The reciprocal family/community	Informal caregiver/ Lay person	Care dependant relative, friend or neighbour

6. Sub-standard care?

In the previous paragraph we have pointed at the fact that the professional logic is the only logic that can claim expertise based on knowledge, skills and experience in the area. The other logics do not and cannot make such claims. However, in order to have this claim recognized, professionals need an institutional basis either a professional one (professional organisations, recognized professional status and training) or one that is provided by institutions that belong to the other logics. The history of professional home care shows that exactly this institutional support has disappeared during the past decades. On the one hand professional home care proved to be a too weak profession in many European countries, its professional organisations not strong enough to defend their claim for expertise. On the other hand the profession did not succeed in maintaining support from the bureaucratic nor the market logic to maintain its discretionary power and to guarantee the quality of care work. Both logics, the market and the state, in contrast perverted the professional logic by submitting it to their own institutional rules, respectively efficiency and managerialism. And by doing so, they redefined the character of and the conditions under which professional home care is provided. In addition

the tendency to transform professional home care under the criteria of efficiency and productivity (taylorisation) results in increasing work pressure, work dissatisfaction and de-professionalization (SCP, 2002). Professional home care by consequence will offer reduced quality care, resulting in dissatisfaction among care recipients who became sensitive for alternative forms of care provision that promise them better quality, more autonomy and free choice. Furthermore, neo-liberal as well as communitarian policies placed the family logic back on the agenda by encouraging and enforcing members of the family and community to take responsibility for one another.

It is by these processes that a reduction of professional home care has resulted in a struggle between the quality of care from a recipient's perspective and the quality of care work from the care workers' perspective. This brings us back to the question what good quality, sub-standard quality and non-quality care means from the perspective of respectively the care worker and the care recipient. Evers et al. (1994) see some positive aspects of the tendency towards payments for care, but these only favour care recipients; if they are the ones that get the money they get more independence and free choice, they can decide to compose their own care package in stead of being dependent on one kind of service. Continuity of the care work is often mentioned as a potential positive aspect, but studies in Britain (Ungerson, 1997; Qureshi and Walker, 1989) show in contrast that not many informally paid carers perform their work for more than one year. On the other hand Evers et al. (1994) have predicted in the beginning of the 1990s, when the tendency towards payments for care was only very rudimentary, three negative aspects of payments for care: 1) they result in irregular jobs for care workers earning too less money to live from without having regular secondary working conditions (social security, pensions etc.), 2) the quality of care is not guaranteed, the care worker is not accountable, 3) governments may use payments for care as trade-off against services, thereby de-professionalizing care services. Also Daly (2002) gives some criteria to judge the quality of care from both perspectives. Starting with the right to give and receive care as forms of citizenship (see also Knijn and Kremer, 1997), she mentions as quality criteria for care recipients free choice and the informal character of the care relationship. Criteria for the care worker are the opportunity to provide high quality care, emotional and financial security, the conditions of work and resources whereby the care worker can care for him/herself (Kittay, 2001). According to Daly, and in line with our previous remarks, public services serve both care workers and care recipients, while cash payments and care leaves mainly satisfy the recipients.

7. Conclusion

In this paper we have explored the development of payments for care as an alternative for the further development of professional home care. We wondered why professional home care did not succeed in filling the care deficit that has resulted from the combination of substitution of residential care and the decrease of informal unpaid care workers. Instead European welfare states increasingly seem to intend to solve the care deficit by several types of payments for care, that is by paying informal care workers, either directly (via national insurance) or indirectly by personal budgets. We have analysed this issue by focussing on the strengths and weaknesses of professional home care in the light of the characteristics of the professional logic and compared this logic with the logic of the state, the market and the family.

Even if one does not subscribe to our viewpoints as regards the consequences of the restructuring of the welfare state to care recipients and caregivers, we presume that the introduced 'four-logics-framework' provides sufficient basis to discuss this possible disagreement. On the one hand we expounded how professionalism relates to the institutional pillars of the welfare regime and in what respect the logic of professionalism differs from the logics of the state, the market and the family/community. On the other hand we, in line with Freidson (2001), set forth that professional autonomy is declining as state power and/or market forces encroach upon it. We have added that in the case of semi-professionalism also the specific responsibility of the institution of the family (and the community) is at stake.

>From the perspective of the care recipient, for example, the state, market and family logic each contribute to inherently different perspectives on the quality of care than the professional logic does. If the care recipient is positioned as a citizen, coercion seems to be the best strategy to control the quality, the accessibility and the distribution of care. Coercion should result in quality control as well as sufficient budgets for care, at least in a well-developed welfare state. If the care recipient, in contrast, is positioned as a customer, the logic of the market is the best option. According to that logic customers can buy the care they need for the price they want to pay. Care, then, is assumed to be a product and the care professional will guarantee the best quality care at the best price in order to keep or extent her share of the market. Information and competition are crucial mechanisms in such a market of home care (Mol, 1997). If the care recipient is positioned as a relative, the family is the best provider of care. The familial logic of care defines the quality of care as in terms of the informal, personal and committed care relationship: instead of the impersonal and systematic expertise of the

care professional there is the spontaneous and emotional bonding between the care recipient and his kin (cf. Van der Lyke, 2001).

However, despite the fact that payments for care are able to meet care recipients needs, they seem to have rather negative consequences for care workers and their work conditions. At issue here is a developing contradiction between the rights and needs of care recipients and the rights and needs of care workers by way of reducing professional care services. The neo-liberal and communitarian critics on the welfare state started off the restructuring of the welfare state's public services by commending these services under the auspicion of the market and the family. Though this improved the position of care recipients, it simultaneously resulted in irregular, low-status and de-professionalized jobs for care workers. Given the inherent tension between the four logics, at least there is the risk it will continue to do so.

But there is more, professional home care not only did not succeed in maintaining its claim for expertise and the quality of care work, it also did not react adequately to the comments on its paternalism. If indeed care recipients nowadays feel the need to have a greater say on the kind of care they receive, its quality and timing, if care recipients also feel that their relatives, or paid informal care workers better satisfy these needs, and finally if indeed the reserve army of such informal paid carers decreases, than this should be a challenge for professional home care. If they, via the vote of care recipients, strive for re-establishing the quality of care work and by consequence the quality of care, a process of re-professionalization of home care is still possible.

Literature

Bettio, F. and Prechal, S. (1998), *Care in Europe. Joint Report of the "Gender and Employment" and the "Gender and Law" Groups of Experts.* European Commission.

Boom, H. van der, Stevens, F. and Philipsen, H. (2001), *Cross-cultural Comparison on the Institutionalisation and Professionalisation of Home Care in Six European Countries.* Paper presented for the Interim Conference of ISA Research Committee Sociology of Professional Groups, Lisbon.

Clarke, J. and Newman, J. (1997), *The Managerial State. Power, Politics and Ideology in the Remaking of Social Welfare.* London: Sage.

Daly, M. (2001), Care policies in Western Europe, in: M. Daly (ed.) *Care Work. The Quest for Security.* Geneva: International Labour Office, pp. 33-56.

Doorn, J.A.A. van and Schuyt, C.J.M. (Eds.) (1978), *De Stagnerende Verzorgingsstaat.* Meppel: Boom.

Durkheim, E. (1992 [1957]), *Professional Ethics and Civic Morals.* New York: The Free Press.

Etzioni, A. (1993), *The Spirit of Community. Rights, Responsibilities and the Communitarian Agenda.* London: Fontana Press.

Etzioni, A. (1969), *The Semi-Professions and their Organization: Teachers, Nurses and Social Workers.* New York: Free Press.

Evers, A., Pijl, M. and Ungerson, C. (Eds.) (1994), *Payments for Care. A Comparative Overview.* Aldershot: Avebury.

Exworthy, M. and Halford, S. (Eds.) (1999), *Professionals and the New Managerialism in the Public Sector.* Buckingham: Open University Press.

Finch, J. (1989), *Family Obligations and Social Change.* Cambridge: Polity Press.

Fraser, N. (1990), Struggle Over Needs: Outline of a Socialist-Feminist Critical Theory of Late-Capitalist Political Culture. In: L. Gordon, *Women, the State, and Welfare.* Madison: The University of Wisconsin Press.

Foucault, M. (1978), *The History of Sexuality*. New York: Pantheon.

Freidson, E. (2001), *Professionalism. The Third Logic.* Cambridge: Polity Press.

Illich, I.D. (1977), *Disabling Professions*. London: Boyars

Jamieson, A. (Ed.) (1991), *Home Care for Older People in Europe: a Comparison of Policies and Practices.* Oxford: Oxford University Press.

Kerkstra, A. and Hutten, J. (1996), A Cross-National Comparison on Home Care in Europa: Summary of the Findings. In: J. Hutten and A. Kerkstra, *Home Care in Europe. A Country-specific Guide to its Organisations and Financing.* Aldershot: Arena. pp 1-40.

Kittay, E. (2001), From Welfare to a Public Ethic of Care. In: J. Hirschmann and U. Liebert (Eds.), *Women Welfare. Theory and Practice in the United States and Europe.* London: Rutgers University Press. pp 38-64.

Knijn, T. and Kremer, M. (1997), Gender and the caring dimension of welfare states: toward inclusive citizenship. *Social Politics. International Studies in Gender, State and Society*. vol. 4. no.3. Special Issue: p. 328-361.

Knijn, T. (1998), Social Care in the Netherlands, in: J. Lewis (ed.) *Gender, Social Care and Welfare State Restructuring in Europe*, Aldershot: Ashgate. pp. 85-110.

Knijn, T. (1999), Strijdende zorglogica=s in de kinderopvang en de thuiszorg: marktprincipes in de sociale zorg. In: C. Brinkgreve en P. van Lieshout, *Geregelde gevoelens. Collectieve arrangementen en de intieme leefwereld.* Maarssen: Elsevier/De Tijdstroom. pp. 93-110.

Knijn, T. (2000), Marketization and the Struggling Logics of (Home) Care in the Netherlands, in: M. Harrington Meyer (ed.) *Care Work*, New York: Routledge Press. pp. 232-248.

Krause, E. (1996), *Death of the Guilds. Professions, States, and the Advance of capitalism, 1930 to the present.* London: Yale University Press.

Krogt, T. van der (1981), *Professionalisering en collectieve macht. Een conceptueel kader.* 's-Gravenhage: Vuga-uitgeverij.

Lewis, J. (ed.) (1998) *Gender, Social Care and Welfare State Restructuring in Europe*, Aldershot: Ashgate.

Lipsky, M. (1980), *Street-level Bureaucracy. Dilemmas of the Individual in Public Services.* New York: Russell Sage Foundation.

Lyke, S. van der (2000), *Georganiseerde Liefde. Publieke Bemoeienis met Zorg in de Privésfeer.* Utrecht: Jan van Arkel.

MacDonald, K. (1995), *The Sociology of the Professions.* London: Sage.

Martin, C, Math, A. & Renaudat, E. (1998) Caring for very young an dependent elderly people in France: Towards a commodification of social care? In: J. Lewis (ed.) *Gender, Social Care and Welfare State Restructuring in Europe*, Aldershot: Ashgate, pp. 139-174.

Mol, A. (1997), Klant, burger, zieke. Het goede in drie talen. In: M. Verkerk (Ed.) *Denken over zorg. Concepten en praktijken.* Utrecht: De Tijdstroom. pp. 139-150.

Ostner. I. (1998), The politics of care policies in Germany. In: J. Lewis (ed.) *Gender, Social Care and Welfare State Restructuring in Europe*, Aldershot: Ashgate, pp. 111-138.

Parsons, T. (1954), Professions and social structure. In: *Essays in Sociological Theory.* Glencoe, IL: The Free Press.

Qureshi, H. and Walker A. (1989), *The Caring Relationship*. London, Macmillan.

SCP (2002), *Sociaal en Cultureel Rapport. De Kwaliteit van de Quartaire Sector.* Den Haag: SCP.

Standing, G. (2001), Care work: Overcoming insecurity and neglect, in: M. Daly (ed.) *Care Work. The Quest for Security.* Geneva: International Labour Office, pp. 15-32.

Sipila, J. (1997) *Social Care Services: The Key to the Scandinavian Welfare Model*. Aldershot: Ashgate Publishing Limited.

Streeck, W. and Schmitter, P. (Eds.) (1985), Community, market, state – and associations? The prospective contribution of interest governance to social order. In: W. Streeck and P. Schmitter, *Private Interest Government. Beyond Market and State.* London: Sage. pp. 1-29.

Swaan, A. de (1983), *De mens is de mens een zorg. Opstellen 1971-1981.* Amsterdam: Meulenhoff.

Szebehely, M. (1998), Changing divisions of carework: caring for children and frail elderly people in Sweden. In: J. Lewis (ed.) *Gender, Social Care and Welfare State Restructuring in Europe*, Aldershot: Ashgate, pp. 257-283.

Ungerson, C. (1997), Social Politics and the commodification of care. *Social Politics*, *International Studies in Gender, State and Society*. Special Issue 4 (3), 362-381.

Ungerson (2000), Cash in Care. In: M Harrington Meyer (Ed.), *Care Work. Gender, Labor and the Welfare State.* London: Routledge. pp 68-88.

Vulto, M. and Morée, M. (1996), *Thuiszorg als professie. Een combinatie van hand, hoofd en hart.* Utrecht: De Tijdstroom.