9th Annual ESPAnet Conference

Sustainability and transformation in European Social Policy

Valencia, 8-10 September 2011

Stream 13: Social and health care

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Cash or care?
The exploration of social care concepts in the context of the Flemish cash-for-care schemes.

Paper annual ESPAnet Conference 2011 - Social and Health Care

Abstract:

Social policy regarding persons with disabilities has mostly focused on income protection and access to health care, while access to and use of social care is less well documented. At the same time there is an international tendency in the long-term social care toward 'personalization', 'de-familisation' and 'de-professionalization' in a shifting system of market regulated social care, 'marketization', and person-centred support models. The paper focuses on the findings of an experimental research project with 'Personal Budgets', known as the Persoonsgebonden Budget, for persons with a disability in the Flemish Region of Belgium. It gives an insight in the effects of cash-for-care schemes versus the care-in-kind-system.

The methodology of the research is a pretest-posttest comparison group design over a period of 14 months. The comparison group design made it possible to compare the experimental budget-system with the specialised care-in-kind-system for persons with a similar disability. The pretest-posttest design enabled us to measure the effect of each system on the behaviour regarding the composition and managing of different care combinations.

Results show that, with regard to more personalization, care-budgets are more flexible in terms of care use than care-in-kind-systems. Though they are complicated to manage and therefore less accessible and usable for persons with a mental disability. De-familization is surprisingly hardly obtained in the ambulant care-in-kind system, while cash-for-care schemes realise some. The use of care-budgets leads to a certain substitution of unpaid informal care to paid personal assistance but unpaid family care remains an important care provider in both systems. Regarding to de-professionalization the findings indicate that there is little take-up of specialised care in the budget-system due to the fact that most care needs can be resolved by general basic care, although there are some important differences depending on the type of disability (mental vs. physical). The research results reveal important pro's and con's within the two different care systems and the way towards a more person-centred care model. This is clearly a more complex issue than just choosing between cash or care.

Key words:

social care, cash-for-care, personalization, de-familization, de-professionalization, marketization

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1. The convergence of different social care concepts and the arising of cash-for-care schemes

Social policy regarding persons with a disability has mostly focused on income protection and access to health care, while access to and use of social care is generally less documented. Nevertheless, social care is a concept that is used increasingly as a category of analysis in relation to the welfare state. Daly and Lewis (2000) point out that social care is very much a 'mixed economy of welfare', involving the state, the market, the family and the voluntary sector (Evers and Svetlik, 1993, Riddell et al., 2006), that lies on the intersection of public and private; formal and informal; paid and unpaid; and provision in the form of cash and services. They refer to social care as a multi-dimensional concept that can be defined as a meta concept. The concept social care is, in that sense, an inherent dynamic that makes it suitable for studying change in the social welfare state (Daly and Lewis, 2000).

An aspect that frequently appears in the debate of social care as part of the social welfare mix is the trend towards 'marketization' whereby the role of the market in the provision of care is growing and competes over prices and quality of care services. Many European countries have adopted a market discourse and/or form of 'marketization' of social services in the 1980's (Kremer, 2006, Daly and Lewis, 2000, Kemp and Glendinning, 2006). This trend towards 'marketization' is generally well accepted by governments because of it's promise to reduce or eliminate certain social care costs, mostly overhead costs. But the rising of the market discourse did not come on it's own. At the same time there was a trend towards greater self-determination of the care users by 'personalization' and 'de-professionalization', above all carried out by the Independent Living Movement (Kremer, 2006, Kodner, 2003, Galvin, 2004, Wiener et al., 2003). Leadbeater (2004) describes personalization as: 'putting users at the heart of services, enabling them to become participants in the design and delivery of services', whereby users have greater choice and control over the way their needs are met (Arksey and Baxter, 2011, Ferguson, 2007). According to Ferguson (2007) this implicates the rejection of paternalism in social work and the promotion of the de-professionalization of social work. But is the link between personalization and de-professionalization unambiguous? In order to elucidate this debate we implement more empirical definitions of personalization and de-professionalization of care where 'choice' is a core concept. In this context *'Personalization is the phenomenon that care users exercise (more) choice in order to develop their own, flexible care package according to their own preference'.* Hypothetically, this can implicate de-professionalization but, because the care user exercises choice, is not necessarily the case. Thus, '*De-professionalization is the phenomenon care use tends to go away from professional care providers towards non-professional care providers as the care users choose to do so in practice'.*

The convergence of the ideas of 'marketization', 'de-professionalization' and 'personalization' in the domain of people with disabilities led to a common social policy in many developed countries since the 1990's: the introduction of cash-for-care schemes in their long-term care system (Da Droit and Le Bihan, 2010). A budget system driven by consumers choice would shape the possibility for more competition in

the social care market as well as take away control from care professionals and give it to the care users (Da Droit and Le Bihan, 2010, Kodner, 2003, Arksey and Kemp, 2008). Hence, the philanthropic notions of choice, control and autonomy of the service user, carried out by the Independent Living Movement, appear to be the main ideas behind cash-for-care. In reality the more pragmatic value of cost reduction of social care, which was less pronounced, appeared to be a crucial element when governments introduced cash-for-care schemes (Galvin, 2004, Evers, 1994, Yeandle and Ungerson, 2007).

In this paper we also want to focus on another concept in the social care debate: 'de-familisation' or 'de-familialisation'. De-familisation is seen as the reduction of a person's dependence on the family and is often defined in relationship with the status of woman's presence in the labour market (McLaughlin and Glendinning, 1994, Lohmann, 2008, Esping-Andersen, 1999). Orloff (1993) speaks in that sense of a parallel between the concepts 'de-familisation' and 'de-commodification', i.e. for woman de-familisation is generally a precondition for their capacity to 'commodify themselves' (Esping-Andersen, 1999). Western European welfare states are in different stages of the 'de-familisation' process, that is to what extent it is becoming legitimate tot externalise caring functions traditionally confined to the family and woman. Generally spoken the degree of 'de-familisation' in all the social democratic (Scandinavian) welfare regimes as well in Belgium and France is high, which means that much care work is performed outside the family (Lister, 1990, Esping-Andersen, 1999).

Why do we also focus on 'de-familisation' in the context of cash-for-care schemes for persons with disabilities? In the 1980's feminists claim that care is 'unpaid work' and that the constraints imposed on woman's participation in paid work should be compensated. This idea was also taken up by the Independent Living Movement, consequently some cash-for-care schemes have the objective to recognize and encourage informal care (Ungerson, 1997, Glendinning and Kemp, 2006). Literature regarding cash-for-care schemes refers to this phenomenon as the 'monetarisation of informal care' whereby family care becomes commodified (Ramakers and Van den Wijngaart, 2005, Kremer, 2006) or as the introduction of the market logic into the family logic (Knijn, 2000, , 2004). What is de-familisation in this sense? Does a person's dependence on the family reduce when the family care becomes commodified due to the use of a cash-for-care scheme? Or is this some sort of re-familisation because family obligations are strengthened through formalisation (Ungerson, 2004, Kremer, 2006)?

Thus, literature about social care and more specifically cash-for-care schemes has brought many social welfare aspects into discussion though seldom, as far as we know, based on evidence from empirical data. The aim of this paper is to explore the concepts of 'marketization', 'personalization', 'de-professionalization' and 'de-familisation' on the basis of empirical research data from Flanders[1].

2. The Flemish cash-for-care schemes in its international context

In the first place it is important to define what kind of cash-for-care scheme we bring into discussion. Many comparative research on cash-for-care schemes demonstrates there is not such a thing as *the* cash-for-care scheme, but there are vast differences among them (Arksey and Kemp, 2008, Pijl, 2007, Da

[1] Flanders is the Northern region of Belgium and has his own government with the policy authority concerning social care for persons with a disability.

Droit and Le Bihan, 2010, Ungerson, 1997, Ungerson and Yeandle, 2007, Wiener et al., 2003, Townsley et al., 2010). We describe the international context of the cash-for-care schemes by some characteristics/typologies we find in literature. It seems useful, before debating the above presented concepts, to define the Flemish cash-for-care schemes according this presented typology. As research results for the Flemish cash for care scheme will not necessarily apply for other cash-for-care schemes in other long-term care policies.

2.1. The international context of cash-for-care schemes

To grasp the type of cash-for-care scheme and the research results it brings along, it is helpful to frame the Flemish system in a broader international context. As a basis we refer to the typology of cash-for-care schemes made by Da Droit and Le Bihan (2010). Interesting about their typology is that they put the cash for care schemes in the broader institutional frameworks, i.e. the long term care policies, of the countries. We focus on three countries apart from the Flemish context, namely the Netherlands, Germany and England. The latter was not included in Da Droit and Le Bihan's work but it seems useful to take up a cash-for-care scheme of a 'liberal welfare regime' because of its conceivable particular practice in comparison to applications in 'social democratic' or 'conservative/continental welfare regimes' (Esping-Andersen, 1990). In order to give a brief context of the different cash-for-care schemes we will focus on three topics in relation to the long term care policies: (1) the development of cash-for care schemes; (2) the organisation and regulation of the cash-for care schemes and; (3) the care-use and more specific the policy on and use of family care.

(1) As already pointed out, cash-for-care schemes were developed within different long-term care policy contexts with as a result that *the* cash-for-care scheme does not exist. The Dutch '*Persoonsgebonden Budget' (PGB)* and the 'Direct Payments' (DP) in England were introduced as an instrument, among others, to reform the long-term care policies that were already in place. The Dutch PGB was implemented in the national social insurance system '*Algemene Wet Bijzondere Ziektekosten' (AWBZ)* in 1995 and the English DP was introduced by the 'Community Care (Direct Payments) act' of 1996[2] on a national level, but is implemented by the local authorities. Especially the English cash-for-care scheme had the outspoken objective of marketizing and modernising the existing care system (Riddell et al., 2006).

In contrary, the German cash-for-care scheme has been used as the basis for the introduction of a completely new national insurance for people with long-term care needs. In 1994 the *'Pflegeversicherüng'* was set up which gave the care user the opportunity to choose between a care budget, care in kind or a combination of both (Pijl, 2007, Schneider and Reyes, 2007).

(2) Cash-for-care schemes exist under different conditions, regulations and organisational structures. Da Droit and Le Bihan (2010) define three entitlement criteria to cash-for-care schemes: age, need and income. We add another important issue to compare the schemes: the absolute height of the cash benefit as it may have an important impact on the labour market behaviour, the relation to the state, the household situation and the gender aspect of caring (Ungerson, 1997).

[2] Direct Payments were further expanded by the 'Health and Social Care Act' of 2001

The Dutch PGB has no age limits and is needs tested by a national assessment. It is financed by national premiums in the social security system (AWBZ)[3] and has an income-related reduction of the benefit which remains small in comparison to the overall budget. The average budget is about 11,000 euro/year (Ramakers et al., 2007). The amount of PGB users has increased spectacularly during the last decade from 22,600 users in 2000 to approximately 130,000 people in 2011 (VWS, 2011)[4].

The English Direct Payments system has neither age limits nor a single assessment because of it's local implementation. It is a means tested program which is designed and operated by local governments but funded by the national government (Wiener et al., 2003). Because of it's local implementation the average height of the cash benefit differs between local authorities. Anderson et al. (2007) estimated the average DP for 2006 at about 12,000 euro/year. Like the Dutch PGB the number of DP users has also increased enormously from only 5,300 users in 2002 to approximately 115,000 users in 2009 (CQC, 2010, CSCI, 2008).

The German *Pflegeversicherüng* has neither age limits and is needs tested by a medical grid that distinguishes three levels. Different from the Dutch and English manner, the German has no income nor means test. It is funded by the national government through the national social security system. This results in three categories of relatively low budgets (2,460 – 4,920 – 7,980 euro/year) that are about half of the value for the same ambulant care by professionals. In Germany the number of cash-for-care users has been relatively stable at almost one million users (BMG, 2011, BMG, 2008).

(3) The different policy contexts and regulations of the cash-for-care schemes have consequences for the care use and more specifically, the ideology and use of family care.

The Dutch government broadened in 2003 the aims of the PGB, since it has as one of its objectives the recognition and compensation of unpaid work by informal (family) carers. The result is an openly commodified family care whereby the family carer is contracted by the budget holder in an employer-employee relationship. Although, some restrictions have been introduced by the notion 'common care' (*gebruikelijke zorg*) which implicates that the cash-for-care scheme does not assign benefit for daily care by parents, partners and children that is thought to be given anyway (CIZ, 2005). About two third of the budget holders contracts one or more family members.

The English cash-for-care scheme is, as a rule, less flexible towards the payment of family carers. The aim of the DP is above all the payment of formal care, but local authorities can make occasional exceptions. Here the care manager acts as a 'gatekeeper' for social care. In practice these exceptions appear to be very common with as a result that payments of family carers is a general practice. Hatton (2008) estimated that about 46% has family or friends as a contracted carer, mostly combined with a paid professional.

In Germany family support has a long tradition and its cash-for-care scheme is especially designed to invest in family caregivers through a cash payment. Many analyst therefore define as a main goal of

[3] Since 2007 there is also a local cash-for-care scheme, namely the PGB-WMO that is implemented by local authorities and can only be used to buy household assistance.

[4] Today (July 2011), the Dutch government discusses the preservation of the PGB. Due to cut down expenses the government intends to reduce the PGB to only the most needed. This comes down to a drastic reduction of 90%, to 13,000 PGB users.

the German cash payment the prevention of the erosion of informal care in the future (Wiener et al., 2003).The height of the cash payment is much lower than the care-in-kind, therefore the idea is not to buy professional care but above all to pay informal family care with the budget. The payments are so low they can't even be seen as a real payment but must be considered as a financial bonus for the family carer (Arntz and Spermann, 2004, Pijl, 2007). Therefore no contract between the carer and budget holder is involved which tends to favour the growth of a grey market in the care sector (Da Droit and Le Bihan, 2010).

Wiener et al. (2003) speaks with regard to the payment of informal carers as a 'trade-off between equity and efficiency'. The German cash-for-care scheme can be justified on an equity basis in that they make family carers better off. But from an efficiency perspective, the long-term care insurance program is spending a great deal of money without a resulting major change in behaviour. The Dutch and English cash-for-care schemes are more moderate in this trade-off. They recognize the family carers and offer compensation, but they do not exclusively promote it like the Germane scheme does.

2.2. The Flemish PAB and PGB

In Flanders we can distinguish two types of cash-for-care schemes. A first cash-for-care scheme is the so-called 'Flemish care insurance' (*Vlaamse Zorgverzekering*), which is set up apart from the general (Belgian) social insurance system. This obligatory insurance system, which started on the first of October 2001 by the decree of 30 march 1999 (1999), provides one fixed amount of 130 euro/month for people with long term care needs. This implicates mostly elderly but also persons with disabilities (Rottiers, 2005, Breda, 2004). In 2010 about 210.000 persons made use of the Flemish care insurance.

However, this paper will focus on another type of cash-for-care scheme in Flanders, namely the Personal Assistance Budget (*Persoonlijk Assistentiebudget* or PAB) and the Personal Budget (*Persoonsgebonden Budget* or PGB) for persons with disabilities. These cash for care schemes are more individualised than the 'Flemish care insurance' as they provide an individual assigned budget depending on the degree of the disability of the person. In figure 1 we present the Flemish cash-for-care schemes in comparison with the above described schemes in the Netherlands, England and Germany.

In 2001 the Flemish government introduced the PAB for people with disabilities by decree (2000). The introduction of the Flemish PAB is comparable with the Dutch and English manner as it was set up as an extra instrument, besides the existing long-term care policies for people with disabilities. Different from the above described cash-for-care schemes, the PAB is not integrated in the general social security system and exists as an apart endowment fund. Besides, the PAB does have an age limit: it is only available for persons who became disabled at an age of 64 years or younger (elderly are excluded). Also the experimental PGB, which can be interpreted as an expansion of the PAB (see infra), exists aside the already existing long-term care policies with the same eligibility criteria.

An important goal, when introducing the PAB, was to reduce the take-up of (the more expensive) residential care. Although, that goal was never accomplished, the PAB stayed in place as it offered a new option for people with disabilities: the employment of their own personal assistants (Breda et al.,

2004a). Hereby, no distinction is made between informal family carers and other unrelated personal assistants with as a result that, comparable to the Dutch PGB, about two third pays a family or friend as a carer (Breda et al., 2006, Breda et al., 2004b). Thus, also in the Flemish cash-for-care schemes we can talk about commodified family care.

Today around 1,800 people with disabilities use the PAB with an average budget of about 29,000 euro/year. Compared to the other described countries there are relatively few budget users but with a relatively generous budget. Around 5,000 persons are on a waiting list for the PAB, because it gives priority to people with the most severe disabilities (VAPH, 2009). As a result of the waiting lists[5] most people with a disability already have, besides their unpaid family care, some sort of paid care arranged, mostly by regular home care services that are directly available.

Flanders introduced in 2008, as an experiment, another cash-for-care scheme beside the PAB: the PGB. The PGB is generally the same as the PAB, but differs from it that the user has the possibility, besides employing their own personal assistants, to buy ambulant and (semi-)residential specialised care from (non-profit) care agencies authorised by the Flemish government[6]. Consequently the main goal of the PGB is to offer more choice and control for the care user, than the PAB does. Another goal was to introduce the PGB as a new kind of financing instrument for specialised care agencies so they would be triggered, due to the demand of the care user, to lower prices and develop new types of care supply. The PGB was in the experiment, with an average of about 19,000 euro/year for 133 persons with a disability[7], less generous than the PAB because it did not only include persons with the highest care needs. In the beginning of 2011 the experiment was finished and evaluated (Breda and Gevers, 2011). The further research results in this paper are based on this evaluation.

[5] There also exists a waiting list for the care-in-kind system.
[6] The PAB has limited combination possibilities with specialised care, namely: day care centres and specialised home care.
[7] Within this group of 133 persons 30 different payments varying from 4,819 euro/year to 48,176 euro/year were allocated.

Figure 1: Typology of cash-for-care schemes

	Netherlands	England	Germany	Flanders (Belgium)
Cash-for-care scheme	Persoonsgebonden budget (PGB)	Direct Payment (DP)	Budget in the Pflegeversicherüng	Persoonlijk assistentiebudget (PAB) Persoonsgebonden budget (PGB)
Implementation	In the long-term care policies in place	In the long-term care policies in place	Basis for the introduction of a new long-term care system	In the long-term care policies in place
National or local	National legislation, national implementation	National legislation, local implementation (local authorities by way of the care manager)	National legislation, local implementation (Länder)	Regional legislation, regional implementation (Flanders)
Funding	By the national long-term care insurance system (AWBZ)	Designed and operated by local government, albeit largely funded by the national government	By the national long-term care insurance system	By the regional government, not in the national social insurance system nor in the local welfare system
Entitlement criteria	No age limit, National needs test, Income-related reduction of benefit	No age limit, Local needs test, Means tested	No age limit, National medical grid with three levels, No income nor means test	Age limit (64 or lower), Regional needs test, No income nor means test Focus on people with severe disabilities
Average benefit	About 11,000 euro/year	About 12,000 euro/year	Three benefit levels: 2,460 euro/year - 4,920 euro/year - 7,980 euro/year	PAB: 29,000 euro/year PGB: 19,000 euro/year
Number of users	22,600 users in 2000 130,000 users in 2011	5,300 users in 2002 115,000 users in 2009	Almost one million users	PAB: 1,800 users in 2011 (5,000 on a waiting list) PAB: 133 users (experiment)
Ideology about the payment of family care	Recognition and compensation of family care since 2003	No legal recognition but in practice very common	Designed to invest in family caregivers	Recognition and compensation of family care
Actual payment of family care	Two third contracts one or more family members	Almost half contracts family or friends	Almost everyone	Two third contracts a family member or friend

Source: based on Da Droit and Le Bihan (2010), authors adjustments and additions

3. Methodology

The methodology of the research described in this paper is a quasi experimental research, namely the 'pretest-posttest comparison group design' (Campbell and Riecken, 2006, Harm 't Hart, 2003).

In the beginning of 2009 an experimental group of persons with disabilities voluntary started with a personal budget (PGB). They were randomly selected from the waiting lists for specialised care-in-kind or the PAB and asked to participate in the experiment with the guarantee to obtain a PGB. There was a stratified sampling on the basis of three criteria: region (50% urban vs. 50% semi-rural), disability (50% mental vs. 50% physical) and waiting list (50% waiting for specialised care in kind vs. 50% for a PAB). Besides, a control group was selected according to the same criteria. The control group were all persons starting to use specialised care-in-kind or the PAB in the beginning of 2009. Random assignment to either the experimental or control group was not possible due to budget and organisational constraints. The result was an initial experimental group of 171 persons and a control group of 127 persons with more or less the same selection criteria. After drop-outs during the experiment the remaining experimental group using the PGB consisted of 133 persons and the control group of 113 persons. The latter can be split up in 61 persons using the care-in-kind and 52 persons using the PAB.

The comparison group design made it possible to compare the experimental cash-for-care scheme with the specialised care-in-kind-system and budget-system already in place, for persons with similar disabilities.

In the end of 2008, before starting with either the budget (PGB or PAB) or the care in kind, each participant had a face-to-face interview with a structured survey at his/her place of residence. This is the baseline measurement. In case the person with a disability was not capable to respond the survey on his own, a proxy could accompany him or her. The survey gained information about the personal background, care use, social relations, satisfaction with life and care, expectations, etc. About 14 months later, when the person was using either the budget or care-in-kind, each participant was once again face-to-face interviewed by a structured survey. The content of the second survey was mainly identical with the first survey for the experimental as well for the control group.

This pretest-posttest design made it possible to measure the effect of each system on the behaviour regarding the managing and composition of different care schemes, but also on the social integration and the quality of life. Data were analysed to identify common and contrasting patterns over time and between the different groups. Table 1 presents a short overview of each group on some socio-economic indicators. There are significant differences among the groups on some indicators which mostly can be explained by the type of disability. It is clear that in the Flemish long-term care system for persons with a disability the greater part that opts for the PAB are persons with a physical disability who are generally older, have a higher personal income and live in a family with partner and children, while persons opting for

care-in-kind are generally persons with a mental disability who are younger, have a relative low personal income and live often in the parental family (see also Molleman and Boel, 2011). The PGB is clearly a mixture of both groups, as was the aim of the experiment. Therefore we use the type of disability as an explanatory variable in our analyses, as we might expect different results in care use between the group of mental and physically disabled persons.

Table 1: socio-demographic background cash-for-care schemes and care-in-kind group at first interview.

		PGB	PAB	Care-in-kind
Disability (%)* **	mental	42.1	23.1	83.6
	physical	57.9	76.9	16.4
**Age ** **	average	41	50	34
	median	41	51	29
Gender (%)	male	53.4	63.5	60.7
	female	46.6	36.5	39.3
Household (%)* **	living alone	26.3	5.8	9.8
	own family	36.1	57.7	16.4
	parental family	36.1	30.8	54.1
	other family or residential care	1.5	5.8	19.7
Personal income / Month (%) **	less than €1000	27.1	13.5	31.1
	€1000 thru €1746	57.1	44.2	59.0
	€1750 thru €2499	7.5	21.2	0.0
	€2500 or more	1.5	7.7	0.0
	unknown	6.8	13.4	9.9
N=		133	52	61

*Significance: *** P<0.001, ** P<0.01, * P<0.05, ⁺ P<0.1*

4. Research results

We present research results with regard to the above presented concepts: de-familisation, de-professionalization, personalization and marketization for the Flemish context of the cash-for-care schemes PGB and PAB in comparison with the care-in-kind system if relevant. An important explanatory variable we use is the type of disability (mental vs. physical). Hereby we also have attention for the changes within the care use by referring to the first interview moment (baseline measurement) with 'T0' and to the second interview moment with 'T1'.

4.1. De-familisation and the commodification of family care

In the introduction of the paper we presented the discussion that exist in literature about de-familisation within the cash-for-care schemes. It is clear that certain cash-for-care schemes, if not almost all, instigate the commodification of family care. Although non of the cash-for-care scheme has the aim to commodify all family care, not even the German Pflegeversicherüng as the budget is too low. In this part we aim to clarify the dynamic in the family care that comes into existence when using a cash-for-care scheme.

In the cash-for-care schemes of our research population 127 out of 185 persons (68.6%) contracts one or more personal assistants in T1, 75% of them has a physical disability but also persons with a more severe mental disability often use personal assistance. Within this group of 127 personal assistant users about one third has only an externally (not family or friend related) contracted personal assistant; another third has only a contracted family member as a personal assistant (mostly partner or mother). 18% combines an external with a family member as a personal assistant and 8% contracts a friend or neighbour as personal assistant. These results show that about two third of the people contracting a personal assistant in this cash-for-care scheme contracts at least one family member as a personal assistant, which brings us to the provisional conclusion that at least a part of the family care is commodified. But how large is that part of commodified family care and how many family care is not commodified and thus remains unpaid?

As an indicator we put the intensity of personal assistance (contracted hours) in T1 into perspective with the change in the intensity of unpaid family care from T0 to T1. At the outset we distinguish three different groups: The cash-for-care scheme using personal assistance (group 1); the cash-for-care scheme not using personal assistance (group 2); and the care-in-kind (group 3). The latter group uses mainly specialised care in combination with unpaid family care.

In table 2 we present the average hours per week of unpaid family care in T0 and in T1 and the average contracted hours per week with the personal assistants (PA) in group 1. Firstly, we divide group 1 in three categories: only family; only external; family and external personal assistance[8] to examine differences within this group. Secondly, we compare the total average hours of unpaid family care in group 1 with the average hours of unpaid family care use in group 2 and group 3. Significant differences between the average hours of unpaid family care in T0 and T1 for group 1, 2 and 3 is tested by the paired T-test.

Table 2: average hours per week of unpaid family care in T0 and T1 and personal assistance in T1.

	Cash-for-care scheme With PA (1)				Cash-for-care scheme No PA (2)	Care-in-kind (3)
	only family	only external	family and external	total	total	total
Average hours of unpaid family care						
T0	67.1	44.5	61.1	58.7	37.1	53.5
T1	23.4***	33.6	19.1*	26.8***	27.5	47.8
Average hours of personal assistance						
T1	27.6	15.6	26.8	22.7	.	.
N=	45	44	21	110	57	56

*Significance: *** P<0.001, ** P<0.01, * P<0.05, + P<0.1*

A first important observation we wish to make is that in all groups the average hours of care received by the family is drastically reduced (although not always significant) to an acceptable

[8] We disregard personal assistance from friends and neighbours because of the limited number of cases.

level of about 27 hours per week, except in the care-in-kind-group. The number of hours of unpaid family care in the third group remains relatively stable around 50 hours per week. This is a remarkable and contra intuitive result as you might expect that the specialised care-in-kind also brings relief to the unpaid family care. As an explanation we see that the specialised care-in-kind is 'too' specialised whereby it does not bring solutions to the general basic care needs (e.g. daily household) of the person with a disability and therefore does not relief the unpaid family carer(s) from these caring tasks. We come back to this later. This makes us conclude that the care-in-kind system does not succeed to realise de-familisation as the cash-for-care schemes do. Hereby we need to notice that most specialised care-in-kind used in group 3 is ambulant or semi-residential care, in consequence these result do not apply for residential care which is usually a more extended care. Nevertheless, persons using the care-in-kind remain almost as dependent on unpaid family care as they did before using the care-in-kind, while persons using a cash-for-care scheme manage to reduce dependency on unpaid family care.

Analysis within group 1 demonstrates that persons using only external personal assistance, contract these assistants for an average of about 16 hours per week. This is significant less hours than the persons who use only family or family and external personal assistance with about 27 hours. This can be (partly) explained by the level of disability[9] as people who only contract external personal assistance are generally less disabled than those contracting (also) a family member. This is also indicated by the hours of unpaid family care in T0 that is lower compared to the other categories and not significantly reduced in T1. But when contracting (also) a family member, this means that de-familisation of care is not absolute. A part of the unpaid family care, about half of the family care in the category 'only family', becomes commodified. This brings clear evidence that cash-for-care schemes do not lead to *either* de-familisation *or* commodification of care, but the care users select many different combinations. Above all we ascertain that unpaid family care remains an important part of the care package for persons using a cash-for-care scheme and even more in the care-in-kind system. Hereby we share Kremer's (2006) concerns about an imaginable perverse consequence of commodification whereby the rights of informal carers are loosened rather than strengthened and the family carer may become or stays overburdened. In the English manner the care manager acts as a 'gatekeeper' and can restrict choice in individual cases (Arksey and Glendinning, 2007), including the choice for the commodification of family care if family carers are overburdened.

4.2. De-professionalization and the demand for general basic care

In order to explore de-professionalization in cash-for-care schemes we formulate an empirical definition of the concept, that is to say: '*De-professionalization is the phenomenon care use tends to go away from professional care providers towards non-professional care providers as the care users choose to do so in practice'.* First we consider the transitions in actual and

[9] Due to lack of data of the level of disability of the PAB group we could only verify this for the PGB group with personal assistance (n = 80).

preferred care use, followed by some reflexions about the formalisation (paying) and professionalization of care.

Before starting to use the PGB, the 133 persons made up a care plan where he/she could indicate the preferred composition of the care package. The preferred care providers and the intensity of those care providers were registered. Because of congruous measurement, these data can be compared with the registered actual care use of those care providers in T0 and T1. We categorise four types of care providers: unpaid family care, regular home care as there are cleaning and household services directly available for the whole Flemish population, personal assistance and specialised care for persons with disabilities provided by ambulant and (semi-)residential care agencies authorised by the Flemish government. Table 3 shows the transition of care use from T0 to T1 for the PGB users with the care plan as an intermediary step. We consider the absolute intensity (average hours of care per week) per care provider and the relative intensity (average proportion of care per week) per care provider between brackets[10]. Moreover we distinguish persons with a mental and a physical disability as they may prefer and use other care providers.

In T0 the care package is composed of unpaid family and regular home care where unpaid family care, with an average of two third of the provided care, is the most important care provider for persons with a mental as well as for persons with a physical disability. Thus, before using the cash-for-care scheme care use is very much in the family, about a third is already professionalised. Subsequently we consider the preferred care use in the care plan. We observe a vast reduction of the unpaid family care till only an average of 10% for people with a mental disability and about an average of 20% of total care use for people with a physical disability. In terms of formalisation there is a notable difference between persons with a mental and physical disability. Persons with a mental disability prefer to formalise their care by means of specialised care from professional care agencies, while persons with a physical disability tend to prefer formalisation of care by means of personal assistance. The average intensity of total care in the care plan in comparison with T0 is about to triple. Based on the care plan we can expect a complete turnover from informal (unpaid) family care in T0 to formalized (paid) care in T1 in different ways according to the type of disability.

Table 3: hours and proportion of care from different providers in T0, care plan and T1 for the PGB users.

		Average hours of care per week *(Average proportion of total care use)*		
		Mental disability	**Physical disability**	**Total**
Unpaid family care	T0	34.9 *(.68)*	39.1 *(.65)*	37.3 *(.66)*
	Care plan	8.1 *(.10)*	17.5 *(.19)*	13.6 *(.15)*
	T1	26.7 *(.43)*	19.8 *(.35)*	22.7 *(.38)*
Regular home care	T0	3.0 *(.28)*	5.1 *(.33)*	4.2 *(.31)*
	Care plan	13.3 *(.18)*	14.4 *(.20)*	14 *(.19)*
	T1	3.4 *(.15)*	7.8 *(.22)*	5.9 *(.19)*

[10] There are no registered data for the intensity of personal assistance and specialised care in T0 as most people did not use those care providers at that moment.

Personal assistance	T0	.	.	.
	Care plan	20.0 *(.19)*	37.1 *(.48)*	29.9 *(.36)*
	T1	4.8 *(.10)*	14.7 *(.39)*	10.6 *(.26)*
Specialised care	T0	.	.	.
	Care plan	32.3 *(.49)*	3.8 *(.06)*	15.8 *(.24)*
	T1	13.8 *(.31)*	1.5 *(.05)*	6.7 *(.16)*
Total care	T0	17.5 *(1)*	32.0 *(1)*	25.9 *(1)*
	Care plan	76.3 *(1)*	77.2 *(1)*	76.8 *(1)*
	T1	46.1 *(1)*	43.4 *(1)*	44.6 *(1)*
N=		56	77	133

In T1 we observe a reduction of the unpaid family care, though not as pronounced as drawn up in the care plan. On average, unpaid family care remains the most important care provider with an average proportion of 38% of total care. Other care is formalized to mainly specialised care for people with a mental disability and personal assistance for people with a physical disability[11]. Thus, reduction of unpaid family care towards formal care is significant although there are differences between the people with either a mental or a physical disability. The latter reduces the unpaid family care much more in T1 compared to T0, although in the care plan their average reduction was smaller than that of people with a mental disability. Nevertheless we need to take above findings about the commodification of (a part of the) family care in consideration.

This brings us to the discussion if all formalized, paid care is professional care? Apparently, the line is very thin when discussing this topic in relation to cash-for-care schemes. Kremer (2006) argues that only some organised home help, like the regular home care, can be seen as a step towards professionalization. However home helps are hardly ever seen as professionals as their formal educational level is generally low and they are no subject of special laws, unlike e.g. nurses. Delivering home care on a one-to-one basis, like most personal assistants do, does not require professional qualifications. Table 4 shows in which domains the PGB users appeal to care from the different care providers. Important to notify is that unpaid family care, regular home care and personal assistance are generally on the same domains: 'daily household inside and outside the household' and 'mobility outside', while the specialised care is more focused on the 'communication' and 'mobility outside' and less focused on 'daily household'.

Table 4: Domains of care provided by different care providers whereupon PGB users appeal to in T1 (percentage).

	unpaid family care	regular home care	personal assistance	specialised care
Daily hygiene	27.1	38.6	45.0	20.0
Mobility inside	15.8	10.7	31.3	12.3
Mobility outside	**65.4**	39.5	**87.5**	**47.7**
Preparing meals	50.4	33.3	70.0	36.9
Feeding	10.5	2.4	18.8	9.2
Dressing	23.3	29.8	43.8	13.8

[11] A similar observation was made between the PAB and to care-in-kind group, see table 1.

Daily household inside	**62.4**	**87.5**	**72.5**	36.9
Daily household outside	**73.3**	**50.0**	**85.0**	33.8
Communication	48.9	11.4	51.3	**67.7**
Other (> permanence)	18.8	14.5	33.8	20.0
N =	133	88	80	65

Another consideration about professionalization in cash-for-care schemes is the arising of a new sort of professional, namely professional support in planning and administrating the budget. While in the care-in-kind system the planning and administration is usually taken up by the care provider, this shifts towards the care user in cash-for-care schemes. As a result, managing the care budget is experienced as difficult and about half of the PGB users engages an external professional to organise it.

These transitions and considerations give us a nuanced view on the de-professionalization aspect in this cash-for-care scheme: there are signs of professionalization as well as de-professionalization and formalisation of care. The type of disability appears to be an important explanatory variable in this manner. A part of the unpaid family care is substituted by professional care, mainly in the group of persons with a mental disability where specialised care becomes an important care provider. But for people with a physical disability, who mostly switch towards personal assistance taking up the same tasks as unpaid family carers, it is difficult to speak of professionalization as most care stays de-professionalized or commodified in the family. In this group it is better to speak of the formalisation of plain care. But whether care users choose for family care, professional care or formalised care does not matter for the satisfaction with the received care as all care users are (very) satisfied with it. Although we have to mention that professional carers aim to activate persons with a disability, while family carers and personal assistants offer a more passive, in-home care (Breda and Gevers, 2011).

4.3. The personalization of care by means of cash-for-care

As for de-professionalization we also adopt an empirical definition for personalization, that is to say: *'Personalization is the phenomenon that care users exercise (more) choice in order to develop their own, flexible care package according to their own preference'*. A basic principle in this manner is that more diverse care packages are an indicator for exercising more choice in obtaining a flexible care package. To elucidate this concept we compare the composed care packages of the PGB, PAB and care-in-kind. As notified in part two of this paper, the aim of the PGB was to offer more choice for the care user than the PAB does, because combinations with all specialised care is possible in the PGB while in the PAB those combinations are limited. Well, does the PGB offer more choice? For whom? And in comparison to the care-in-kind?

Table 5: Combinations of care providers in the cash-for-care schemes and care-in-kind in T1 (percentage).

	PGB	PAB	Care-in-kind
family care (1)	3.0	0.0	8.2
specialised care (1)	2.3	0.0	4.9
family and regular care (2)	5.3	7.7	4.9

family and specialised care (2)	12.1	0.0	**57.4**
family care and personal assistance (2)	10.6	11.5	0.0
regular and specialised care (2)	3.0	1.9	3.3
regular care and personal assistance (2)	3.0	5.8	0.0
family, regular and specialised care (3)	13.6	0.0	16.4
family, regular care and personal assistance (3)	**30.3**	**53.8**	1.6
family, specialised care and personal assistance (3)	4.5	0.0	1.6
regular, specialised care and personal assistance (3)	0.8	0.0	1.6
family, regular, specialised and personal assistance (4)	11.4	19.2	0.0
N =	132	52	61

Pearson Chi^2= 123.757; df= 22; sign.= .000

Table 5 shows all care combinations that have been made within the PGB, PAB and care-in-kind. In both cash-for-care schemes PGB and PAB combinations of care providers are numerous. About 60% in the PGB and 73% in the PAB use a combination of three or four care providers, while in the care-in-kind it is about 21%. It is clear that the cash-for-care schemes offer more opportunities for combinations than the care-in-kind does and that care users exercise choice and utilize these combination opportunities. Although, it seems as if the PGB opportunities are not much more applied than those of the PAB. But like Da Droit and Le Bihan (2010) signal, choice is made at different levels. Before choosing a care package with different care providers, people in Flanders, as in the Dutch and German manner, have the opportunity to choose for either care-in-kind or for the cash-for-care scheme PAB. As we know that in the PAB most people have a physical disability, while in the care-in-kind system most people have a mental disability it seems interesting to compare those groups together with the PGB, as there is a mixture of mental and physical disabilities. An interesting question besides is which type of disability has the most chance to make new choices and use new care package opportunities with the PGB.

In table 6 we take the PAB and care-in-kind groups together and compare them with the PGB group according to the type of disability. If we focus on the group persons with a physical disability there is no significant difference between those using the PGB and those using the PAB or care-in-kind. Knowing that the latter group are mostly users from the PAB, makes us conclude that persons with a physical disability mostly use their PGB as a PAB, mainly combining family and regular home care with personal assistance. When we focus on the group with a mental disability we observe something different. While most of the persons with a mental disability in the PAB or care-in-kind group combine two care providers (mainly family and specialised care), those in the PGB group have a much more varied care use, also making combinations with regular home care and personal assistance. Further analyses showed that mostly persons with a severe mental disability used care combinations of specialised care with personal assistance and/or regular care. This brings us to the conclusion that it are mostly persons with a (severe) mental disability who exercise choice and use the new care opportunities this experimental cash-for-care scheme, the PGB, offers.

Table 6: Combinations of care providers according as the disability for the PGB; and the PAB and care-in-kind together in T1 (percentage)

	Mental disability[1]		Physical disability[2]	
	PGB	PAB and Care-in-kind	PGB	PAB and Care-in-kind
family care (1)	5.5	7.9	1.3	0.0
specialised care (1)	5.5	4.8	0.0	0.0
family and regular care (2)	0.0	6.3	9.1	6.0
family and specialised care (2)	**25.5**	**50.8**	2.6	6.0
regular and specialised care (2)	7.3	3.2	0.0	2.0
family, regular and specialised care (3)	**21.8**	7.9	7.8	10.0
family care and personal assistance (2)	3.6	3.2	15.6	8.0
regular care and personal assistance (2)	0.0	1.6	5.2	4.0
family, regular care and personal assistance (3)	7.3	4.8	**46.8**	**52.0**
family, specialised care and personal assistance (3)	**10.9**	1.6	0.0	0.0
regular, specialised care and personal assistance (3)	0.0	0.0	1.3	2.0
family, regular, specialised and personal assistance (4)	**12.7**	7.9	10.4	10.0
N=	55	63	77	50

1: Pearson Chi^2= 19,688; df= 10; sign.= .032
2: Pearson Chi^2= 5,365; df= 9; sign.= .801

4.4. Marketization in which market?

About marketization and the existence of a specialised social care market in the Flemish care system we can be brief, there is no market system where profit and non-profit organisations can compete over prices and quality of formal (specialised) care services or personal assistance and the introduction of cash-for-care schemes did not change this so far. With only 1,800 PAB users the demand market is too small to create a social care supply market (of personal assistants) that is based on competition. A goal of the PGB experiment was to trigger care agencies to lower prices and introduce new care models in specialised care. Though we can conclude that care agencies aren't triggered to go into competition, to lower prices or to

develop new care models/combinations when demand is low. They proceed with 'business as usual' and are not keen on competing over prices.

Apart from concluding that there isn't a market for specialised care for persons with a disability we also need to notice that the regular home care market neither suffices to solve the care needs of persons with a disability. As we have seen in table 3, people want to increase the hours of regular home care from an average 4 hours in T0 to 14 hours in the care plan but can only realise an increase to an average 6 hours in T1. This is because the Flemish regular home care is not flexible enough and not able to deliver sufficient hours to resolve the care demand of persons with a disability.

5. Summary and conclusion

The aim of this paper was to explore some often used concepts in the social policy debate in the context of cash-for-care schemes. The concepts in the centre of this debate are: marketization, de-familisation, de-professionalization and personalization. Thereby we used some empirical data of cash-for-care and care-in-kind users gathered during the PGB-experiment in the Flemish region of Belgium.

Figure 2: summary of the social care concepts in the context of cash-for-care schemes and care-in-kind

	cash-for-care schemes	**care-in-kind**
type of disability	Prototypical persons with a physical disability, but the fewer persons with a mental disability perform well in it.	Prototypical persons with a mental disability
personalization	Personalized care Mostly plain care from different care providers	Standardized care Specialised care besides unpaid family care
de-professionalization	Persons with a mental disability mostly professionalize care Persons with a physical disability mostly formalize care	Highly professionalized
de-familisation	Most unpaid family care remains unpaid, part of it becomes commodified (physical disability) or partly substituted by specialised care (mental disability)	Unpaid family care remains unpaid
marketization	Demand driven, but no care market for specialised care and no sufficient regular care as requested	Supply driven, no care market for specialised care

There is clear evidence that the Flemish cash-for-care schemes PAB and PGB offer more personalization, in terms of achieved care provider combinations, than the care-in-kind system does. In the cash-for-care schemes people with disabilities exercise choice and opt for more diverse care packages. The extra choice opportunities that are given in the PGB in comparison to the PAB are mainly used by persons with a (severe) mental disability. This is an interesting conclusion as this group is less inclined to take up a cash-for-care scheme in the Flemish care system.

We also discussed the link between personalization in the cash-for-care schemes and the concept of de-professionalization as some authors argue that personalization implicates the promotion of de-professionalization. Our research results lead us to a more moderate statement concerning this issue, especially when we take the type of disability into consideration. It is evident that persons with a physical disability mostly opt for the formalisation of their unpaid family care trough commodification and/or contracting external personal assistants. While persons with a mental disability do also include professional specialised care providers in their care package. Consequently, there are trends toward formalization of non-professional care as well as professionalization of certain parts of care. Besides, we see a new kind of professional appearing in cash-for-care schemes: care consultants organizing care packages and their administration.

A critical consideration about the care market and the above discussed personalization and de-familisation of care is that in the Flemish cash-for-care schemes and care-in-kind system care users need to rely on the input of unpaid family care to make their care package balanced. As there is no flexible care market with sufficient specialised care supply nor an adequate regular home care it is only by using unpaid family care or commodify family care that care users can come to a personalized, flexible care package. This has important implications to understand the concept of de-familisation in the care system. While cash-for-care schemes succeed to reduce the reliance on unpaid family care, the care-in-kind system remarkably does not accomplish to do so. A lot of care needed is general, basic care that is not provided by the specialised care providers. Due to this, the care-in-kind is too specific while the cash-for-care users can compose a broad care package on different domains as they prefer. But as the regular home care is not adequate enough, people in the cash-for-care scheme often choose for the easiest solution, namely the commodification of (a part of) the family care. As a result this may continue an overburdened family carer in some cases. Combination of a cash-for-care scheme and care-in-kind could be a solution in these cases as the cash-for-care scheme would benefit from more formal care supply while the care-in-kind would benefit from more combination opportunities.

Last but not least we refer to the international context of care systems. Care-in-kind has implemented a rationing strategy for social care in many care systems, but by the introduction of cash-for-care schemes a new dynamic that clearly undermines that rationing strategy appeared in certain care systems. In many countries there is a legal right to care and the cash-for-care scheme is part of the social security system. This results in divers push and pull factors

of the cash-for-care scheme attracting new social care users, which is seen in the enormous increase of cash-for-care users in the Netherlands and England in comparison to the care-in-kind in those countries. Every country tries to handle the (financial) policy problems with its cash-for-care scheme: the German system foresees in low budgets but has a rising grey care market, the English system is decentralised and has a means test, the Dutch system with its enormous growth is going to discard the cash-for-care scheme for the majority of the users in the near future and the Flemish cash-for-care scheme is, in practice, only available for persons with a severe disability.

The Flemish care system for people with disabilities clearly goes into two different directions, as do care systems in other countries. The care-in-kind system, typically used by persons with a mental disability, promotes the professionalization of care but, at the same time, cannot promote personalization and de-familisation. On the other hand there are the relatively new cash-for-care schemes promoting personalization and realizing some de-familisation and de-professionalization. Although these last mentioned concepts need to be nuanced as persons with a mental disability also opt for professional care while persons with a physical disability are more inclined to formalise care by the commodification of family care and contracting external personal assistance by means of the cash-for-care scheme. The debate about cash-for-care schemes as part of the long-term care policies is clearly more complex than choosing between cash or care.

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