Barriers to Co-Governance: Examining the “Chemistry” of Home-Care Networks in Germany, England, and Quebec

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This article aims at studying the dynamics of organized home care and particular problems in the delivery of social services, analyzed against the background of the international recasting of welfare systems. Challenging an influential academic discourse on the advent of new forms of network governance thought to improve service provision, three jurisdictions—Germany, England, and Quebec—are compared with regard to how home-care networks are actually configured and the rationales which appear to shape the interaction between network members. The article argues that notwithstanding the extensive literature extolling the virtues of network governance or the possibility of reconciling different governance modes, home care operates through arrangements embracing conflicting rationales. Rather than providing for mutual adjustment and shared perspectives, contemporary home-care networks tend to produce tensions and outcome problems as a result of the “biased” interplay between various steering rationales within given institutional arrangements and different meta-governance regimes.

KEY WORDS: mixed governance, welfare systems, home-care services, comparative social policy

Introduction

Appropriate management of care services for the elderly is a growing concern in many developed countries. Demographic and social changes have put strain on existing patterns of long-term care provision, based on both families and professional services. Accordingly, many observers assert that existing long-term care systems are unfit for the future and stress the need for a fundamental restructuring of service provision (OECD, 2005). Indeed, in most Western societies, whereas the traditional care model—grounded mostly on women caregivers—is being eroded and long-term residential care appears both unpopular and difficult to sustain financially, service provision has become ever more pluralistic than before, involving a plethora of actors, thus more fragmented and difficult to manage. A common theme across countries has therefore been the demand for more and better coordination among service providers, between funding agencies and suppliers, and between users and professionals.
This connects with a growing body of literature on social policy governance, which has raised questions over the adequacy of conventional steering mechanisms in the public welfare sector—traditionally broken down into hierarchies, markets, and networks (Evers, 2005; Radcliffe & Dent, 2005; Thompson, Frances, Levacic, & Mitchell, 1991). In a context marked by the spread of “wicked problems” (Rittel & Webber, 1973), the command-and-control mechanism of policymaking and implementation has been criticized from very early on for its alleged ineffectiveness. As a result, (quasi-)markets were introduced in social policy governance throughout many jurisdictions with the intent, among other things, of enhancing service coordination through micro-economic “incentives” and delivering the promise of “value-for-money.” Again, however, doubts have been raised as to whether this governance mode is exempt from functional biases (Clarke, Newman, Smith, Vidler, & Westmarland, 2007; Flynn, Williams, & Pickard, 1996; Knapp, Hardy, & Forder, 2001).

More recently, routines of joined-up government and network-based steering, or “co-governance,” have been considered as an overall superior alternative “in dynamic and complex situations” of social or public service provision (Kooiman, 2003, p. 97). In essence, co-governance relies on different sets of actors put on an equal footing and involved in a collective undertaking on the basis of reciprocal lines of communication and common agreements; it is often deemed a steering mode typical of partnership-based (organizational) networks. But the emphasis on this steering mode has not gone unchallenged either, as introducing—and sometimes mandating—intersectoral collaboration in the provision of public services has proven problematic as well (Goldsmith & Eggers, 2004; Hudson, 2004; Kirkpatrick, 1999; McGuire, 2006). That said, co-governance is widely seen as having the potential for remedying a range of problems associated with fragmentation and lack of coordination in service provision (Lowndes & Skelcher, 1998).

Yet what about the place of co-governance in contemporary social care systems? Recent reforms in these systems, while moving the pendulum in the direction of one or another form of governance, have usually contributed to a process of sedimentation whereby hierarchy overlaps with (quasi-)markets and networks, or co-governance (Bode, 2006; Evers, Lewis, & Riedel, 2005; Kooiman, 1999). Against this background, it has been argued that the challenge for those interested in the improvement of social care systems is not so much finding the one-best-way or “ideal type” of governance, but rather managing the coexistence of competing forms of governance (Rhodes, 1997). Moreover, it is contended that although mixed governance may be problematic, some form of “reconciliation” between rationales (Perri 6, Leat, Seltzer, & Stoker, 2002) or “satisficing approach” might be achievable (Jessop, 1999).

This article seeks to more closely examine the nature of this challenge. In delving into the issue of mixed governance, Keast, Brown, and Mandell (2006, p. 38) have argued that “a better understanding of the optional models that underpin the three modes” (mentioned above) is required since “through this understanding, policy decision-makers are able to better . . . match the various components.” Taking this idea further, we posit that what is actually needed is a deeper understanding of the very association of the rationales which underlie forms of mixed governance in
particular policy domains and contexts. In our view two issues are of particular relevance here. Firstly, as stated by Tenbensel (2005, p. 268) “if we are interested in the mixture of modes, then some thought needs to be given to the ... tensions between different modes” (emphasis added). Secondly, assuming that a governance mix is prone to follow an overarching meta-logic (Jessop, 1998), we hold that a deeper understanding of how mixed governance “works” presupposes a comprehension of this meta-logic.

This perspective seems widely unfamiliar to the research community concerned with the analysis of eldercare systems. Granted, problems of coordination within these systems have been addressed by many scholars (Brown & Cullis, 2006; Davey, Levin, Iliffe, & Kalpa, 2005; Le Bihan & Martin, 2006; Leichsenring & Alaszewski, 2004; Moore, West, Keen, Godfrey, & Townsend, 2007), and the issue of hybrid governance has been dealt with by some—mostly in a theoretical and speculative manner (Rhodes, 2006). However, few studies have thus far tackled the organization of home-care services in ways that connect theoretical arguments on mixed governance with more pragmatic analyses of elderly care systems. Yet to appreciate the problems related to these systems, we need a thorough, field-grounded analysis of the logics of interaction which structure the relations between different actors participating in these systems. Such an approach should also lay the ground for the evaluation of how renewed forms of governance, as established in different contexts, impact on service delivery (Exworthy, Powell, & Mohan, 1999).

More specifically, this article investigates mixed modes of governance in the area of home care—a key component of eldercare. Assuming that both the nature of home-care networks and the meta-logic steering their functioning vary according to a given (national or sub-national) institutional configuration, we embark on an international comparison of eldercare systems, embracing three different jurisdictions: (West) Germany, England, and Quebec. The comparison should enable us to ascertain what kind of institutional configuration appears to produce which sort of tensions within these settlements, translating into which type of “barriers” to co-governance. Notwithstanding the fact that in the three jurisdictions tensions may adopt a highly localized character, we assume that some recurrent institutional properties can be identified within each of them, allowing for the definition of national models and typical problems.

The remainder of this article is organized into four sections. The first one reviews recent work on networks drawn from different strands of the wider literature. Thereafter, we introduce the conceptual framework used for our analysis. In the third section, the three national jurisdictions are analyzed with an eye to the governance rationales underlying them. This section also includes a comparative assessment of the mixed governance of home care in the three case studies as a means to identify tensions surfacing in the governance process. We continue by mapping the different configurations, including those critical barriers which appear to set limits to current attempts to instill more co-governance into eldercare services. Finally, we elaborate on the meta-logic prominent in the governance mix of the different care systems as well as on wider theoretical and policymaking implications of our overall findings.
Mixed Governance and Eldercare Coordination

Synthesizing the vast amount of research conducted on the topic of policy governance would be an ambitious undertaking, far beyond the scope of this article (for an overview see Treib, Bähr, & Falkner, 2005). Some basic points should be raised, though. Thompson et al. (1991, p. 17), some of the first scholars to have looked at the issue, argued in a seminal work that “any actual social analysis of coordination will usually involve the employment of [governance] models in combination or in a comparative framework.” Along similar lines, Rhodes (1997) added that “it’s the mix that matters.” Indeed, it has often been suggested that the plurality of governance modes is not an uncommon phenomenon—even though, as Andresani and Ferlie (2006) are right to note, it may be the case that in a particular time and place, one governance mode will prevail over others. Moreover, some authors have drawn attention to the fact that beyond the traditional partition of governance into three predominant modes, other forms may also be present, adding complexity to any regulatory effort on the part of government. Newman (2001), for example, introduced the concept of “self-governance” to identify a form of steering based on peer-group accountability and interdependence among professionals. Likewise, Tenbensel (2005) suggests that “collegiality” or professional governance should be seen as separate from network-based cooperation. By the same token, the literature has paid attention to governance processes based on voluntary action (Kooiman, 2003).

Acknowledging the reality of mixed governance modes, a few scholars have highlighted the inherent inconsistencies of such mixture, as well as the difficulty in anticipating how different modes may interact with one another, especially from a normative perspective. Some authors, though alert to the challenges that managing the plurality of governance modes commonly entails, have explored the possibility that different coordinating rationales could coexist and get aligned or “reconciled” with one another. In this context, Exworthy et al. (1999, p. 20) liken the mix of governing structures to something of a “chemical reaction” in which “elements may react in different ways under different circumstances.” Along similar lines, Rhodes (1997, p. 47) claims that some governing features “may mix like oil and water.” Obviously, there is uncertainty in the dynamics of mixed governance modes as “the execution of hierarchical and contractual systems is by no means predetermined” (Exworthy et al., 1999, p. 20). It follows that attempting beforehand to selectively “pick and mix” the best components of each governance mode so as to define the “right chemical combination” may represent a difficult, if not elusive, policy endeavour.

Two other considerations from the literature on mixed governance appear of particular importance here. Firstly, it has been argued that the (in)compatibility between different governance modes would be largely contingent on the institutional configurations and dynamics of a specific policy domain and place. In this regard, Kümpers, van Raak, Hardy, and Mur (2002, p. 2) assert that the performance of a particular form—and by extension mix—of steering is inextricably linked to its context; governance modes, they contend, are generally “embedded in and shaped by the national configuration, and so are its outcomes.” In other words, a particular
institutional settlement would appear to induce a particular governance dynamic and, as Newman (2001) has argued, structural tensions. Analyzing the working of mixed governance modes for the sake of policymaking or system design then implies acknowledging the multi-faceted institutional background behind these dynamics, especially in situations where a wide range of actors are involved in service delivery and coordination is essential to the effective functioning of service provision.

Secondly, it has been suggested that in a given time and place it is possible that one governance mode may prevail over others—both in rhetorical and practical terms (Tenbensel, 2005, see also Lowndes & Skelcher, 1998, or Andresani & Ferlie, 2006). A particular steering approach—rooted in a distinctive “world of governance,” for instance private business—may indeed influence the way different modes of governance are interrelated within a given system of public service provision. Thus, market governance may set the overall “terms of trade” and tend to subordinate (albeit not eradicate) the remaining modes of governance (Bode, 2007). Contiguous to this perspective, a strand of research has looked into the idea of meta forms of governance—what some term the “government of governance.” Jessop (1998, pp. 42–43) argues that “meta-governance does not amount to the installation of a monolithic mode of governance. Rather, it involves the management of complexity and plurality,” in ways that are consistent with government’s wider interests and motives. Somerville (2004), in a similar vein, claims that depending on how different governance techniques are arranged within a given policy environment, different “regimes” can be singled out. Pushing this reasoning further, it could be argued that such arrangements vary not only historically but also nationally; different countries would develop different meta-governance regimes to be taken into account when studying a particular policy domain.

If we now focus on the literature on eldercare systems, it is striking to note that these two dimensions of mixed governance—the role of institutional contexts conducive to particular “network settings” on the one hand, and the existence of meta-governance regimes regulating the association of the various steering rationales on the other—have hitherto barely been addressed. True, enhancing coordination has been the subject of much concern and experimentation over the last decade. However, research undertakings concerned with this question have mostly centered on the technical and applied aspects of “joint-care” (see Billings & Leichsenring, 2005; Burau, Theobald, & Blank, 2007; Gage et al., 2004; Leichsenring & Alaszewski, 2004; Moore et al., 2007; Nies & Berman, 2004; van Raak, Mur-Veeman, Hardy, Steenbergen, & Paulus, 2003; Reed, Cook, Childs, & McCormack, 2005). Some authors have also examined how institutions and culture may shape the implementation and operation of integrated eldercare systems (Demers, 2005; Kümpers et al., 2002; Tamsma, 2004). Others have explored the range of structural features that appear to either facilitate or hinder service coordination (Goodwin, Perri, Freeman, Posaner, 2004) as well as collaboration in partnerships (Johnson, Wistow, Schulz, & Hardy, 2003; Kendall et al., 2003). Finally, some scholars have considered how the outsourcing of service provision has altered relationships among local actors, or how the shift in favor of cooperative governance has affected the capacity of central government to orient policy at the local level (Forder et al., 2004; Johansson & Borell, 2003).
1999; Matoševic et al., 2001; Osborne, 1997). Yet, few studies have tackled the structural hybridity of home-care governance in the light of both institutional contexts and meta-governance regimes, including its implications for policy and practice.

All in all, the current literature has not approached the topic of mixed modes of governance in a way that relates theoretical debates on the "chemistry" of these modes with a field-based analysis of how particular institutional contexts, and related governance mixes, may weigh in on coordinating efforts, or what their impact on service delivery may be. The possibility of reconciling the conflicting rationales characteristic of different governance modes by means of a meta-logic, though suggested by some, remains a postulate largely unexplored in the context of a specific policy arena such as the care system for the elderly.

A Conceptual Framework for Assessing Mixed Governance in Eldercare

Conceptually, this analysis is informed by a definition of governance as proposed by Héritier (2002), who assimilates it to a set of instruments employed by the state to attain particular goals in a given domain of intervention. Accordingly, we subscribe to the principle that in trying to regulate and guide policy, "the state can apply different types of [...] instruments in order to achieve certain societal outcomes: command and control, incentive and supply, information, deliberation and persuasion, as well as all forms of social influence and control" (Treib et al., 2005, p. 6). "Co-governance," understood as a partnership-based and mutually agreed process of intervention, is therefore considered to be but one particular approach used alongside other ones in the steering and coordination of sectoral policy.

In adopting this perspective, we also take into account that, as pointed out by Anttonen and Sipilä (2005), the development of organized eldercare throughout all advanced Western societies has given way to the setting up of multi-tiered systems. As a result, different providers are incorporated into "organisational networks." The structures of these organizational networks, however, vary considerably according to the socio-political foundations of welfare systems, including their regional configurations, but also on the basis of societal traditions vis-à-vis self-organization, collective action, and civic engagement. Thus, in the same manner as governance, organizational networks are embedded in—and should be examined with reference to—particular institutional contexts.

Drawing on Goodwin et al. (2004, p. 13), such networks can be defined as a "moderately stable pattern of ties or links between organizations or between organizations and individuals, where those ties represent some form of recognisable accountability [...], whether formal or informal in character, whether weak or strong, loose or tight, bounded or unbounded." Importantly, from our perspective, appealing to the notion of organizational networks does not imply that network governance, rather than hierarchical or market governance, is the prevailing mode of coordination in these settlements. Rather, we explicitly include in our definition of organizational networks the dynamics of cooperation established between strategic competitive actors, as well as other types of interorganizational dynamics of interaction, as outlined below.
Our grid of analysis comprises two levels. We first look at key structural features of organizational networks (i.e., the actors involved, their relations to the periphery, the centrality of actors, the degree of autonomy enjoyed by members, the type and diversity of services provided, and dominant public debates surrounding the networks); and second at the rationales which appear to shape the interactions between network members—each rationale associated to a particular mode of governance. Our aim is to make inferences about the operation of networks and related tensions through the comparison of our three cases, and to develop hypothesis which might be applicable to more than the countries selected for this study.

Four different types of rationales are identified as underlying the logics of interaction within a given home-care network, namely:

1. **Welfare-bureaucratic**—prominent in public administration and led by considerations of universal standards and equitable resource allocation. For instance, when governments set up a social care program, this is commonly based on assumptions regarding a citizen’s needs, collective entitlements established to cover them, and a budgeting process ensuring that these needs are met, irrespective of the extent to which a claim might be made.

2. **Professionally oriented**—motivated by ethical codes of conduct and the well-being of clients, rooted in the educational system, and largely based on collegiality (in the sense of Tenbensel, 2005). This rationale is usually at play when semi-autonomous specialists, working for a social care program, engage in an open-ended interaction with clients during which needs and services are determined on a case-by-case basis.

3. **Association-based**—related to the practice of groups of citizens directly involved in the shaping and provision of services, but also to (often value-based) initiatives of such groups when it comes to public debate and policymaking. Thus, in many Western countries, voluntary agencies and non-profit associations are involved in social care provision with a remit not only to complement professional services but also to publicly raise issues on behalf of users.

4. **Market-oriented**—focusing on the competition for resources and the value of reputation within different forms of markets (quasi-markets based on a purchaser-provider split, or consumer markets based on open provider competition). A notable characteristic of these markets, as established in the field of eldercare, is the fact of having transformed return-on-investment into a key reference for service providers, often at the expense of the contents and meaning of care work.

Each rationale relates to a specific mode of governance. We will argue that it is particularly as a result of the conflicting nature of these rationales—together with a meta-logic structuring their overall association—that tensions affecting the delivery of services often arise.

A cross-national comparison provided a powerful means to investigate the interaction among rationales in different home-care institutional settings and the role
played by the “meta-governance logic” prevalent in each place. The cases of Germany, England, and Quebec were selected for the study because of their similarity with respect to the fragmentation of eldercare services and the coexistence of several forms of governance, but also their contextual differences. The three cases differ with respect to welfare state traditions, the spread of quasi-market governance, and the role played by various collective actors in the functioning of home-care networks. Overall, the choice of three jurisdictions and the approach followed allows for a qualitative “thick description” of cases (Strauss & Corbin, 1990), and a comparison in accordance with the principles of a “most different systems design” (Ragin, 1987). The article builds on evidence from a number of relevant studies, reports, and grey documentation; part of which are cited throughout. A thorough literature review, based on the grid of analysis described above, was conducted for the purpose of gathering information on the subject and identifying knowledge gaps. In addition, the article draws on primary data from case studies carried out by us (see Bode, 2007; Fermon & Firbank, 2002; Firbank et al., 2005). These case studies examined home-care arrangements in particular respects (e.g., the role of voluntary agencies and quasi-market contracts, the functioning of lead agencies, the organizational and quality problems of home-care service networks). Individual country sections of the article were presented at various public forums, thus benefiting from input by specialists in the field.

Institutional Contexts and Network Dynamics, Three Jurisdictions Compared

Germany: Acute Fragmentation in a Semi-Corporatist System

The Institutional Setting and the Structure of Governance. In spite of the increase in the demand for formal services, in Germany the bulk of home care is still provided by relatives who are encouraged to do so through direct cash benefits granted by the long-term care insurance scheme (*Pflegeversicherung*) (as regards the structure and recent developments in the German long-term care system, see Evers & Sachse, 2003; Roth & Reichert, 2004; Rothgang & Igl, 2007; Theobald, 2004). This mandatory scheme, introduced in 1995 as an independent subunit of (non-profit or private) sickness funds, has a quasi-public status and reimburses expenditures for a variety of professional providers, albeit on the basis of capped budgets and a limited number of hours accredited for service delivery. Basically, it grants benefits to users with severe and longer-term impairments. Sickness funds cover domiciliary nursing for shorter periods of time when the services to be granted are prescribed as part of a preceding medical treatment.

A person applying for public support from the long-term care program is required to present a demand to the particular sickness fund he or she is enrolled with. Benefits are granted following an assessment by the medical (control) department of this fund (called *Medizinischer Dienst der Krankenkassen, MDK*). There is a classification of beneficiaries in three levels of care need. Beneficiaries are entitled to choose between a cash allowance (geared for the most part at compensating family caregivers), services in-kind, or a combination of the two. Benefits in-kind mainly
consist of nursing services and a limited volume of personal care (especially house-
keeping work). Further services are provided on a voluntary basis by the munici-
palities or non-profit agencies, or purchased on the “free market.”

Regarding home care, services are delivered by a network of competing
private for-profit and non-profit providers. Most of the latter belong to the
so-called “welfare associations” (Wohlfahrtsverbände), set up to federate various
service providers at local level. In eldercare, many of these (often faith based) asso-
ciations run “social centres” (Sozialstationen) in charge of supplying a diversity of
support services. These agencies are frequently linked to other service providers of
their associational family, including hospitals. Units of the welfare associations are
also sometimes entrusted by local authorities with the running of counseling agen-
cies. Welfare associations had in the past enjoyed a quasi-public status and received
a preferential treatment from public authorities, a configuration often referred to as
“corporatist.” This configuration has however been waning with the introduction
of provider competition. While private for-profit providers are usually smaller size
organizations, they made up three-fifths of the 12,000 home-care providers in
2006.

The bulk of home-care agencies also offer non-reimbursed services such as
housekeeping or shopping. Volunteers are involved in the area of befriending and
leisure activities, predominantly managed by the aforementioned welfare associa-
tions. In most places, frail persons can order meals-on-wheels against a user fee,
delivered either by non-profit agencies, contracted by local authorities, or by private
firms specializing in home catering. Finally, experiments with direct payments are
underway, with case managers helping users act as “consumers” of care packages.
Since 2002, all agencies delivering reimbursed care services are subject to a quality
inspection by the aforementioned MDK on the basis of some hard data (based
mainly on inputs) and interviews.

Against a background of intense financial pressure put on care providers, the
quality issue has been high on the political agenda over the last years. Moreover,
the public debate has addressed the limited (capped) provision of care services,
especially for the very dependent and those without family support. Providers’
associations have strongly voiced such concerns in the public sphere and at national
roundtables. In 2003 and 2007, revisions made to the Care Insurance Act led to the
creation of a special allowance for people afflicted with dementia and introduced a
price-indexation of benefits as well as improvements for those in intermediate care.
The revisions also brought some kick-off funding for establishing or backing local
“care support points” (Pflegestützpunkte) entrusted with interlinking all parties
involved in the care process. The long-term care insurance funds were authorized to
contract with individual carers not covered by a collective agreement; moreover,
they were obliged to employ case managers with a remit to provide systematic
counseling to beneficiaries.

Nevertheless, the steering of the eldercare system continues to rely on a multitude
of actors: the long-term sickness funds (in charge of decisions over benefits and the
counseling of users), the MDK, the municipalities (to which law has conferred
the responsibility for coordinating local infrastructures), and the federal states (the
Länder, responsible for cofinancing investments in service facilities). Also, collective agreements entered between (both non-profit and commercial) provider associations and the different care insurance funds are of considerable importance. The agreements list all reimbursable care services and fix prices per time unit. On this basis, competition among service providers is promoted. Otherwise, the governance process comprises: decisions over benefits and the licensing of providers by the care insurance funds; the quality inspection of the MDK; the organization or commissioning of complementary services by municipalities; the coordination of services within locally federated Wohlfahrtsverbände; loose communications between different actors with regard to the planning and oversight of infrastructures; and, finally, market interactions.

There is no focal point in this system. The most tangible form of coordination can be found at the level of the Sozialstationen, which may offer a variety of services or collaborate with other providers (hospitals, complementary services, befriending groups) within their own associational family. The long-term care insurance funds are responsible for providing basic information to claimants, but they barely conform to this mission (although this may change with the new regulations). Local bodies try to coordinate services. Thus far, this was mostly confined to stimulating interagency exchange, offering legal advice to users, and running or commissioning complementary services (such as meals-on-wheels, emergency call service, or counseling), with considerable regional variability in the extent to which this actually happened. Following the setting-up of the aforementioned “care support points,” this may improve in the future although funding for them is scarce.

The Role of the Various Rationales. Given the heterogeneous landscape of the care sector in Germany, it is not possible here to provide a single representation of network governance with regard to home care. Rather, we will draw on some typical dynamics, as evidenced by several studies (such as Enquete-Kommission des Landtags, 2005; Geller & Gabriel, 2004; MDK, 2007; Smolka, 2006).

Firstly, it is obvious that the setting up of care packages, quality inspection and, to an extent, the provision of additional services, all conform to welfare-bureaucratic rules. The strategies adopted by users and care providers are largely shaped by decisions of the MDK, which appears to be driven by a need-oriented allocation of resources, albeit within the context of capped budgets. Likewise, personal care services are often resourced and/or designed by local authorities. Associative action plays a role as well. As already noted, German home-care networks exhibit a “corporatist” character which materializes in the aforementioned contracts between provider associations and the long-term care insurance funds. Also, relations between local authorities and voluntary agencies responsible for the provision of personal care are often based on negotiated agreements. Furthermore, within an associational family, interventions of volunteers may be deliberately linked to professional services. Associative action also has an impact where providers of home care and other actors from the field (municipal authorities, voluntary organizations) meet to discuss problems related to the organization of services at local level. The
same holds for “roundtables” at the national level where summits on quality inspection have had some impact through the definition of guidelines for “good practice.” Notably, agreements established in such meetings are not binding for anyone. Moreover, the organization of home care is shaped by different professional rationales, which are not always converging. For example, volunteer groups involved in eldercare often hold that non-professional interventions accomplished by “lay people” are more sensitive to the life-world problems of those they care for. While the nursing profession dominates in the everyday functioning of the professional units, municipal agents and social workers claim responsibility for case-management activities which, however, are still poorly developed in Germany.

Having said all this, the market rationale plays an important role in the German home-care system. Non-profit organizations and commercial firms coexist, with some being all-round service providers. The market rationale is most prominent where care agencies compete for clients. When it comes to the orientation of users into services, referrals by those who provide advice or offer emergency services (mainly hospitals or agencies providing short-term nursing on behalf of the sickness funds) may be driven by economic concerns and marketing interests. Where interfirm collaboration occurs, it often adopts the form of a strategic alliance, bringing together selected hospitals, home-care providers, and agencies offering additional services, whose objective is to outperform less coordinated competitors. Micro-economic considerations are crucial, then.

Against this background, the four rationales discussed above confront each other in particular ways. The coexistence of various welfare bureaucracies involved in home care translates into a fragmented system of accountability. In addition, there is no particular regulatory mechanism bringing the divergent rationales employed by the involved professionals into line. The long-term health insurance and the MDK are infused with a somatic understanding of eldercare while other rationales (social work, lay intervention) remain situated at the periphery. All this connects with the particular role the market rationale has come to play in the German home-care system. Within care-providing organizations, the professional rationale is under pressure. Given the market agenda, most providers concentrate on their own survival—a practice prone to provoke the violation of professional rules, as illustrated by recent quality reports (MDK, 2007). Moreover, attempts aimed at promoting the exchange of information between the involved parties or at the planning of infrastructures under the lead of municipalities find a limited echo. The few existing planning and advice-giving agencies have very little factual data on the quality of service provision. Furthermore, under conditions of increasing demand, capped budgets have precluded provider associations and insurance funds from negotiating more need-oriented agreements. Government initiatives aimed at fostering boundary-spanning coordination between providers have long been confined to pilot schemes with a limited duration. Welfare associations try hard to foster cross-sectoral cooperation within their “family,” yet with limited success. In the political sphere, however, they bring their civic voice to bear, with their aim being to promote new political regulations on quality norms and related public funding, for instance.
England: Quasi-Market Governance With Comprehensive Top-Down Regulation

The Institutional Setting and the Structure of Governance. In England, the provision of domiciliary care is funded by cash-limited government grants to local authorities and to agencies of the National Health Service (NHS), with the budget for personal care not being earmarked13 (concerning the structure and recent developments of the system see Comas-Herrera, Wittenberg, & Pickard, 2004; Means, Richards, & Smith, 2003; Netten, Darton, et al., 2005; Rummery, 2007; Wanless Report, 2006). Moreover, relatives of the frail elderly are encouraged to provide care through direct cash benefits stemming from National Insurance. Professional home care is shaped by a division of labor between social service departments of Local Authorities and “Primary Care Trusts” (PCT) of the NHS. While the remit of the NHS has increasingly been confined to specialized nursing, almost half of the elderly dependent population is receiving personal care. The latter represents the bulk of home-care provision and increasingly embraces acts previously provided by nurses. It is mostly organized through “packages of care” to be delivered by independent providers. Nursing is free of charge, while personal care is subject to means-testing, with three-quarters of users paying charges.

Further to the introduction of quasi-markets in 1990, local authorities widely withdrew from service provision while maintaining a high degree of autonomy in their purchasing and funding roles. Eligibility criteria, assessment of needs, and budgetary arrangements are determined locally. There is a remarkable heterogeneity in eldercare provision throughout England, even though social service departments have become accountable to central government by means of a National Performance Assessment Framework, which allows for the allocation of reward grants to Local Authorities in cases of good performance. Through a fixed-term contract with the purchasing department of a Local Authority, most providers commit themselves to provide care acts on a price-per-case basis or for an anticipated amount of care acts.

A person in need of public support usually contacts the local social service department. In many cases, referrals are made by hospitals, though. Benefits are normally granted after a needs assessment is conducted by a care manager and a health worker, leading to the classification of persons into four need-related groups. The assessment may imply nursing care to be delivered by the NHS. As to personal care, beneficiaries can choose between services in-kind or a direct payment, with most people choosing the former. Over the last few years, access to services has increasingly been limited to those in need of intensive care. Most services are delivered by small private businesses or voluntary agencies. When entering contracts for service delivery, providers usually face the purchasing body as isolated organizations. Central government, however, encourages Local Authorities to stimulate inter-agency collaboration, and provider associations are invited to meet Local Authority officials to discuss issues pertaining to infrastructures. A Local Strategic Partnership Board exists in most regions to ensure that the preferences of service users are better taken into account when it comes to the planning of infrastructures. In addition, a limited number of local arrangements, based on pooled budgets between health and social service authorities, have been set up as a means to facilitate the provision or commissioning of integrated services.
The quasi-market in home care is subject to considerable public regulation. This includes provider registration and quality oversight, both of which are carried out by a centralized “Commission for Social Care Inspection” drawing on a range of “hard” and “soft” quality standards. Results are made public on the Internet. The renewed interest in enhancing quality resonates with an ongoing public debate in which concerns have been raised about the adequacy of staff skills and the availability of care for those not entitled to public benefits. There is also the issue of service rationing. In response to concerns over poor coordination, government has recently introduced a mandatory single assessment process, followed by an individual care plan involving health and social care services as required.

As regards the overall steering of the eldercare system, local Authorities together with the PCT act as lead agencies. The social service departments manage the assessment phase of service delivery, with a helping hand from NHS professionals. Their remit ranges from purchasing care packages and related support services to the coordination of all actors involved in service provision, including the planning of the care infrastructure. When negotiating the conditions for service delivery, they display a considerable power through their purchasing capabilities. That said, purchasing and management strategies differ widely across Local Authorities. Relationships among service providers are generally poorly formalized. In fact, most of the 3,000 registered home-care providers—the majority of which have a for-profit status—are only loosely interconnected through local and national provider associations which do not include providers from further levels of the care system (e.g., hospitals). Voluntary organizations lobbying for older people (such as Age Concern or Help the Aged) also provide advice to service users and sometimes deliver (often locally commissioned) care services on their own, especially in the field of day care or respite care. This is the area in which volunteers are involved in service provision on a larger scale.

Altogether, active coordination occurs most visibly during the assessment procedure, in connection with the purchasing process, which entails service arrangements between purchasers and providers. Apart from that, coordination is not systemically organized, though the growing involvement of providers in the inspection regime seems to strengthen the vertical integration of the system given that it facilitates communication on quality issues between care specialists and providers. Where services are not reimbursed by public bodies, providers can be almost entirely disconnected from the governance process.

The Role of the Various Rationales. In Britain, too, assessments as well as decisions on care packages are largely shaped by welfare-bureaucratic routines. As previously mentioned, the public sector is responsible for assessments and resource allocation. It also has a service provision role, primarily for nursing care. Although the interface between health and personal care is rarely formalized either structurally or contractually, a number of bureaucratic rules apply to the accomplishment of most activities. As to personal care, both the care management and purchasing processes underlie a welfare-bureaucratic rationale in that services are expected to be allocated according to perceived needs and economic and family circumstances. This rationale is
endorsed by regulations aimed at standardizing service delivery through inspecting, blaming, and sanctioning bad practice.

There are also various professional rationales at work. While social workers play a role within the social service departments of Local Authorities, PCTs are dominated by the medical and nursing professions. Associative action comes into play as well (Kendall, 2003, pp. 159–85). Volunteers are involved in day care mainly. Voluntary sector organizations involved in personal care often have their own professional philosophy when promoting a greater role for lay people from the community within the process of care provision. Moreover, they attempt to act politically, for instance within alliances of home-care providers confronting local authorities with their own perspectives. In addition, specialist associations representing elderly people at national level participate in the deliberative processes by exerting “persuasive” influence on politics.

Having said all this, the English care system is heavily shaped by quasi-market governance, with service providers bidding for contracts. Concerning contract management, there is a bargaining process between commissioners and providers, yet this process tends to be asymmetric due to the purchasers’ monopolistic position. The rules of the quasi-market often also apply to additional (low-skilled) services contracted out to voluntary organizations. Moreover, given the performance regime in force in the English public sector, an economy-driven style of interaction can also be found to influence case management, as performance targets (aimed, among other things, at avoiding referrals to care-homes) promote a competitive atmosphere among managers and between Local Authorities.

Like in Germany, the different rationales confront each other in particular ways. Professional boundaries are still considerable, although recent reforms have widened the scope for interprofessional collaboration through pooled budgets and single assessments. Moreover, interagency exchange tends to be limited to common strategic interests, for example in cases where provider associations discuss infrastructural issues with Local Authorities. The policy emphasis on partnership between layers of the eldercare system is often not followed by a truly deliberative practice on the part of welfare bureaucrats. This translates into critical voices from voluntary sector organizations who blame bureaucrats for their top-down governance approach in the public sphere but have no say in the steering process dominated by these bureaucrats.

Importantly, in an environment altogether driven by (quasi-market) performance management, funding responsibility is an area in which NHS agencies and Local Authorities often clash, for instance when it comes to the issue of hospital discharges. This goes alongside a division of labor between case managers and contracts departments implying that the former at times rely on scant information communicated by the latter with respect to the quality of a given service provider. Also, the fact that independent providers may be primarily motivated by, or condemned to, rent-seeking sits uncomfortable with the orientations of welfare bureaucracies, keen to maximize the response to declared needs (within budget constraints). In turn, while individual providers may try to maintain a certain degree of flexibility in contracts so as to be able to respond to unforeseen changes in the
user’s situation, purchasing bodies would often try to keep prices down and define prices and other contractual terms in relation to services fixed units. Also, given that providers are often financially dependent on purchasers, problems with users may tend to be concealed by fear of their impact on the maintenance of contracts.

**Quebec: State-Run Delivery With Increasing Devolution to Private Providers**

_The Institutional Setting and the Structure of Governance_

The provision of health care services in Quebec is regulated by the Canada Health Act (CHA), which defines a set of criteria provinces must fulfill in the establishment of their publicly funded health insurance plan, namely: administration of the plan by a public authority on a non-profit basis; comprehensiveness of services insured; universality of the population covered; and accessibility of services on a uniform basis and free of charge. Provinces’ compliance with such criteria, however, is variable, particularly concerning the so-called “extended health care services,” including long-term care. Coverage for the nonmedical, support aspects of home care has been subject to interpretation; as a result, access to these services is not uniform across Canada and is conditional on other criteria being met, such as lack of income or informal support.

While the CHA offers the framework for the establishment of health care services, provinces have full control over their organization and form of delivery. This becomes plain when looking at the situation in Quebec (see Duval, Fontaine, Fournier, Garon, & René, 2004; Gagnon & Saillant, 2000; Lémieux, Bergeron, Bégin, & Bélanger, 2005; Tousignant, Dubuc, Hébert, & Coulombe, 2007; Vaillancourt, Aubry, & Jetté, 2003). As elsewhere in Canada, most home-care services are funded by the province (the Ministry of Health and Social Services, MHSS), with partial support from the federal government—although this mix of funds is far from covering existing needs. Provision of home care has traditionally been assumed by the public sector as well, through local service providers, known as local community service centers (CLSC)—in recent years merged into larger structures known as CSSS. The CLSC is responsible, within a given geographical area, for the provision of a range of front-line health and social services, including home nursing care and assistance, medical consultations, physical therapy, housekeeping, and social support. Most CLSCs are relatively large organizations regrouping a variety of professionals.

Other providers, such as volunteer-based community organizations (CO), social economy enterprises (EESAD) and, to a lesser extent, private for-profit agencies are also involved in the delivery of services. Private agencies are concentrated in the main metropolitan areas and, with a few exceptions, are small family-run businesses whose clientele is mostly made out of referrals from the public sector. EESADs are relatively new players in the field, which came into existence in the mid 1990s as a result of government policy aimed at the same time at job creation and the provision of homemaking services at a lower cost. The services they deliver are subsidized by the provincial government through a home-care tax exemption program.
provide a range of personal home-care services and receive grants from a Health Regional Board on a continuing basis. Associations representing the interests of a particular type of provider or seniors’ groups are not directly involved in the provision of services and, although sometimes may be consulted by government or act as pressure groups, play only a marginal role in the functioning of local networks.

In order for an impaired elderly to receive government-funded home-care services, a request must be put before a CLSC (now part of a CSSS) which proceeds to evaluate his/her care requirements and either arrange for the direct provision of home-care services or refers users to the appropriate agencies. Especially in remote rural areas, a cash benefit (allocation directe) can be provided to users for the purpose of privately hiring a home support worker. CLSCs in urban areas often sub-contract home support services from an EESAD or private agency as a means to compensate for a seasonal increase in demand or to diminish the cost of service provision. The recourse to private for-profit agencies has never been systematic, though. However, a home-care policy drafted by government in 2004 (MSSSQ, 2004) stipulates that, with the exception of complex cases requiring resource-intensive care and short-term users, homemaking and personal care services should be outsourced, and offered by EESADs and voluntary organizations. In addition, only people with low income should be entitled to free homemaking and personal care services according to the same policy.

The CLSC has traditionally played a pivotal role in the governance of home-care networks, acting as a gateway between users and services providers, and defining links between the public, private, and community sectors. An ongoing restructuring of the health and social services field in Quebec has modified the CLSC’s functioning within the network, although the new structures that are being created (the CSSS) will retain much of its responsibilities. Various mechanisms are involved in the interaction between the CLSC and other provider organizations in the sector. With regard to COs, for example, these organizations have always been tacitly commissioned by government to be responsible for the provision of a variety of support services. In addition, most COs have sought to construct alliances with CLSCs.

The development of EESADs has tended to modify the governance dynamics of the home-care sector. EESADs work in close collaboration with the CLSCs, sometimes formalizing their interaction through service protocols aimed at improving the exchange of information and better coordinating their efforts. EESADs depend on CLSCs for accessing a pool of clients. In turn, CLSCs, confronted with a growing demand, are heavily reliant on EESADs for the provision of home support services. In comparison to other providers, private for-profit agencies have traditionally played a secondary role within the network. Given that much of the agencies’ clientele is made out of referrals from the public sector, the financial viability of many of them is tied to the CLSCs and the signing of service contracts. Overall, an actual quasi-market for home-care services has not developed in Quebec, as competition between public and private providers has never been officially encouraged.

That said, the CLSCs’ increasing outsourcing of services has added to the structural complexity of the network, contributing to a gradual dissociation between the different sub-sectors of the home-care network. Accreditation, either through federal
or provincial health care bodies, has been made mandatory for the CLSCs since 2003, but not for independent providers. Even though specific accreditation programs have been established for EESADs and other community providers, up until now very few among them have taken such a step. Moreover, service contracts passed between CLSCs and private agencies rarely include provisions for quality assurance.

Thus far, coordination of services within the network, traditionally incumbent on the CLSC, has concerned itself with different types of professionals working within these agencies, rather than the activities of a range of care providers. Regional “roundtables,” gathering local health and social services organizations, have been created in a number of places to help bring into line the actions of various service providers. Likewise, different demonstration projects have been implemented in various regions of Quebec to link-up and enhance cooperation among services providers involved in eldercare (Hébert, Durand, Dubuc, Tourigny, & The PRISMA Group, 2003). Overall, however, public authorities at top level confine themselves to defining policy and budgeting, and to settlements about the formal division of work in the network, leaving CLSCs (now the CSSS) with a day-to-day muddling-through agenda.

The Role of the Various Rationales

Based on the previous sections, it appears that in Quebec, as in other jurisdictions, different rationales coexist in the home-care sector. However, the rationale traditionally instilled in Quebec’s welfare bureaucracy proves very crucial. The public sector maintains a dominant role in the financing and delivery of home care, relying to a large extent on a traditional hierarchical mode of governance. That said, the idea of “partnerships” with associative actors has been used, at least rhetorically, to convey the particular type of regulation and public/private interaction that is promoted by government. To the extent that a diversity of providers are being merged into single structures (known as CSSS), and that local service networks—embracing, inter alia, a range of community organizations—are promoted in all regions, the involvement of associative actors is being stimulated.

In practice, however, it would appear that partnerships in the home-care sector, far from being a mechanism for generating cooperation among fairly autonomous (albeit interdependent) actors, ends up being a discretionary strategy used by government to outsource services for the purpose of cost reduction (Gagnon & Saillant, 2000). Thus, the influence of associative action appears limited. Voices from various citizen groups do not impinge very much on the choices made. COs provide services through the work of volunteers, many of them seniors themselves; however, the higher dependency profile of seniors receiving services at home has built up pressure on COs, and their activities have become less voluntary in nature and increasingly “professionalized.” Regarding professionalism, the CLSC embraces a variety of professional approaches, the relative influence of which is determined at the local level. EESADs, on the other hand, rely on a low-skilled workforce that has little to do with the culture(s) of professionalism. Hence, professional boundaries are an issue here as well.
Furthermore, although the delivery and the financing of services have been partially privatized, especially as regards the provision of homemaking and personal care services, up until now the introduction of full-fledged (quasi-)market-governance has been rather circumspect. Competition between providers is minimal and may sometimes occur among for-profit agencies, when seeking a service contract from a CLSC. In general, agencies are selected as much on the basis of service cost and reputation as on familiarity with their management personnel.

As in other jurisdictions, different governance rationales confront each other in particular ways. The recent reorganization is supposed to disrupt existing coordination schemes and unsettle informal professional and managerial forms of cooperation. Partnership arrangements are (paradoxically) mandated by law, and local cooperation among providers, including the particular roles of member organizations, will be firmly regulated by means of government-defined service protocols. Thus, the hierarchical but mechanistic steering approach of top-level welfare bureaucracy sits uncomfortably with the other rationales relevant to the care network.

**Different Modes of Governance, Different Tensions**

In this section, we look at the interplay between institutional arrangements and tensions in a comparative perspective. Regarding the key features of the organizational networks in the three jurisdictions, a number of differences are clearly apparent. First of all, the extent to which funding, needs assessment and service allocation planning, and provision of services are aligned varies considerably. In England, there is a “three-way split” between these functions: funding is granted by separate government agencies, assessment and service planning is done (somewhat cooperatively) in different settings (PCTs or social service agency or hospitals), whereas a range of providers is charged with the delivery of services. In Germany, funding and assessment are the responsibility of two subunits of the social insurance funds, while planning is ensured by regional and local governments; service delivery is incumbent on a wide range of providers freely competing for clients. In the case of Quebec, the three functions are more closely aligned: most funding comes from a single government agency, whereas assessment, service planning, and delivery are not decoupled; services are subject to outsourcing, though. Overall, however, there are more actors (providers and stakeholders) involved in Germany, where the home-care network is comparatively looser and wider than in Quebec and, to a lesser extent, in England. Hence there are differences in the homogeneity of the networks, with different degrees of fragmentation in welfare bureaucratic steering.

In addition, both the involvement of for-profit actors and provider competition are substantially more developed in England and (albeit in a different way) in Germany than in Quebec. As a result, network governance in eldercare is subject to different degrees of privatization or marketization. Also, the contracting-out routines applied in the three jurisdictions are not comparable. Quebec has left these routines largely unregulated, while in England public authorities have developed a fairly sophisticated scheme of contractualization. In Germany, regulation has devolved the
provision of services to a pool of providers operating in a “free market” that, all the same, act under conditions agreed upon between the care insurance funds and provider associations.

A further source of disparity lies in the different practices of interprofessional collaboration: Such collaboration is formally facilitated by the lead-agency character of the CLSC (CSSS) in Quebec and, to a lesser extent, by routines of joint assessments in England; whereas in Germany, the personal care dimension is not given much institutional weight within the network structure. Finally, the role of volunteers and of non-profit actors—hence, the chance of “civic voices” being heard in the governance process—also differs. In the field of low-threshold services, volunteering can be found in all countries. Concerning the political influence of associations, the latter appears much more prominent in Germany than in Quebec or England (where associations are nevertheless organized around a strong senior lobby). Different patterns of associative action are therefore noticeable, which relate to particular traditions on how the public and non-profit sectors interface.

Against this background, a number of tensions can be inferred from our analysis; tensions whose prevalence varies according to the characteristics of a given institutional context. In all countries, disagreements are likely to occur among groups of practitioners, for instance, between health and social care personnel with different professional allegiances, or between (high-status) licensed professions and (low-status) not-licensed ones (like home-helpers), or between lay workers (such as volunteers) and professionals. Yet while the conceptualization of home care as being partially rooted in lay work has more influence in Germany than in England, and especially Quebec, the principles of team-work and cross-professional work seem to be more firmly rooted in the Canadian province and, to a lesser extent, in England than in Germany. Moreover, in spite of government rhetoric, the involvement of associative action is less common in the hierarchical system of Quebec and the marketized network structure of England, whereas the remainder of German “corporatism” entails greater formal participation in the governance of home-care services, including at national level.

Some tensions seem structural in kind and differ markedly between the jurisdictions under study. In the Canadian province, a focal or hub organization exists in the home-care network with strong links to (highly integrated) professional providers at the local level. However, there is contracting out. Somewhat paradoxically, the Quebec public sector, given its dominance within the home-care network, has not advocated the enforcement of standardized routines for services contracted-out to private organizations, provisionally engaged to fill gaps in public care services. No efforts have been made either at establishing benchmarks for service provision, at reinforcing systems of accountability, or at defining a regulatory framework for how public providers are to outsource services—with a balkanization of practices as a consequence. At the same time, the dominance of a particular welfare-bureaucratic rationale based on budgets and input regulation brings about problems of power sharing, accountability, and legitimacy and sets limits to associative action within the governance mix. It may also curtail the capacity of service providers for innovation and to cope with dynamic needs. Thus, in Quebec one sees a structural tension
between the “dirigisme” of a central welfare bureaucracy, on the one hand, and the rationales of professionals and civic stakeholders, on the other—with professionals being highly integrated and civic forces being largely marginalized.

Within the more marketized eldercare systems of England and Germany, the potential for conflict is greater between, on the one hand, the rationale of associative stakeholders and professionals in charge of defining criteria for service provision and, on the other hand, the market-based orientations guiding the activities of commissioning agencies and independent providers. In Quebec, such tensions are less relevant—although they may appear “through the backdoor” in connection to unregulated, outsourced service provision. There is, however, an important difference between England and Germany concerning the influence of the market rationale: Whereas the German settlement is built on an open provider competition, the British configuration stands out by the prevalence of quasi-market governance, impinging on both provider-purchaser relations and public sector management. Thus, in England, there is a structural tension between the “commissioning and benchmark approach” of public agencies, on one hand, and the rationales guiding a (semi-integrated) professionalism and (widely uncoordinated) associative forces, on the other. In turn, the German configuration is shaped by a structural tension between a “laissez-faire care market,” on the one hand, and a (relatively) dispersed professionalism as well as comparatively strong associative forces, on the other.

Conclusion

What are the lessons to be drawn from our portrayals of three home-care systems and their governance mixes? First of all, our analysis, while underscoring the fact that all three systems operate through organizational networks embracing different rationales, is consistent with previous research on governance (Kümpers et al., 2002) in that it reveals how the interplay between rationales is contingent on the institutional set-up of these systems, regarding not only patterns of public steering and professional collaboration, but also the degree and forms of marketization and the involvement of associative (or civic) actors.

Also, as hypothesized at the outset and in line with the work of Newman (2001) and Tenbensel (2005) and others, it is shown that across the different jurisdictions, the mix of rationales and governance modes is at the source of tensions affecting the operation of service networks; however, such tensions are quite singular in nature and tied as much to the inherent antagonism between rationales as to the type of mix or “governance chemistry” prevalent in each place. Hence, whereas in Quebec one can single out a hierarchical form of network architecture leaving little space to associational actors and to interactive cooperation among the involved parties, the German configuration exhibits an extraordinarily hybrid pattern of interactions exposed to an open provider competition and embedded in a corporatist framework which, however, sees its scope curtailed. The case of England presents a configuration shaped by a strong public input control which operates through top-down quasi-market governance ensuring coherent bureaucratic control but tending to squeeze providers and setting limits to the role of associational actors.
Moreover, the study provides evidence that the interplay between different governance rationales appears to follow a distinctive overarching logic endemic to each of the institutional configurations. In this regard, and perhaps at the risk of oversimplification, one can make out different meta-governance regimes, which adopt a distinctive character according to the institutional environment they are embedded in. These meta-governance regimes, it could be argued, each exhibiting a distinctive orientation or gravitational center, set particular structural limits to co-governance as they all engender distortions in the interplay between the various rationales relevant to eldercare networks. Accordingly, the “dirigisme” form of steering characteristic of Quebec can be referred to as a meta-governance regime in which the gravitational center is located at the macro level. This regime favors budgeting and formal role allocation, both not very open to flexible and need-oriented patterns of interprofessional and interorganizational recalibration. The “commissioning and benchmark approach” inherent in English quasi-market governance is situated more at the meso level, as it is service purchasing agents, case managers, and providers (as co-contractors) who tend to abide by a meta-logic largely ignorant to voices coming from further stakeholders of the field. Laissez-faire competition in Germany makes market governance a strong force at the micro level, with providers being enticed to a philosophy of rent-seeking in the very production process, instead of mutual adjustment between and across network partners.

Based on the analysis of tensions and meta-governance regimes, it appears that the three systems have the potential to generate particular “outcome problems”: Quebec may see the risk of “imploding collaboration”—a state where the different rationales are noticeably uncoordinated—as the influence of associative action is marginal whereas the micro-economic rationale hardly impinges on the strategies deployed by network actors, even though it may operate “subsurface” as private home-care agencies or social enterprises sometimes feel prompted to “make money” or have to take steps to achieve a sound balance sheet. The German system faces the inherent risk of (competition-driven) over-fragmentation, irrespective of the impact semi-corporatist traditions may have over the confrontation of different rationales. In the English case, a major risk lies in the proliferation of uncontrolled “exit-behaviors” due to market and regulatory pressures, given that welfare bureaucracies there have often one-sidedly adopted the “market doctrine,” while civic and professional voices find it hard to express their concerns from within the system. Table 1 summarizes our overall findings.
While the evidence reviewed here does not allow us to rank order the three systems in terms of best practices, it would appear that the very concept of co-governance and the possibility of finding the “right chemical combination” of mixed governance modes, referred to by a number of scholars (Keast et al., 2006; Perri 6 et al., 2002; Tenbensel, 2005), remains an “empty shell” unless it is contextualized with regard to its institutional setting and the “government of governance” prominent in each place, as both the particular setting and its government do make a difference to how joint-up service provision works. Whatever the type of meta-governance regime, however, it seems that the leeway left to members of care networks to negotiate softer, trustworthy, non-hierarchical forms of coordination has narrowed down, and, under these conditions, attempts to better integrate home-care systems exhibits the overall and in-built tendency of making tensions grow rather than being tamed. Hopes set in the contribution of co-governance, viewed by many as the “silver bullet” to manage social care in the future, may therefore turn out to be disappointed.

Finally, the study can be read as a part of a road map to be used in the delineation of integrated eldercare networks. Indeed, while this article has not embarked on discussing ready-made public management options, our analysis helps decision makers better comprehend problems associated with the organization of home care, as it illustrates, inter alia, that particular network settings produce particular governance challenges. More generally, those interested in the design of integrated care systems and their performance should look twice—that is, at the formal and technical aspects of these systems as well as at the institutional frames and regulatory meta-logic inhabiting them, since these may impede the establishment of shared perspectives and mutual adjustment, both deemed indispensable for balancing out the different rationales at work in contemporary eldercare networks.

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Notes

1. That the coexistence of different modes of governance is at the source of tensions has also been put forward by a number of previous theory-led analyses (Kirkpatrick & Ackroyd, 2003; Kümpers et al., 2002; Newman, 2001).

2. In spite of the proliferation of research on governance, only a few scholars, often UK based, have tackled the issue of “mixed governance.” Among German and Canadian academics, the issue has not been given much attention thus far. In reviewing the existing (widely Anglo-Saxon) literature, our idea is to index what has been said on the subject and to use findings from these materials as a starting point for our study based on three jurisdictions.

3. Some argue that in actuality “only hybrid forms may be found since one mode of governance always entails elements of other modes of governance. Otherwise, effective steering and coordination would not be possible” (Treib et al., 2005, p. 5; see also Bradach & Eccles, 1991).
4. Perri 6 et al. (2002, p. 83), for instance, make a case that the “reconciliation” of various forms of interorganizational activity should be possible through the identification of “settlements between these basic rival solidarities and their conceptions of how organizational relationships work, that acknowledge something of what each offers and claims, while recognizing that none holds more than a portion of the truth, and any settlement can only be temporary.”

5. Dominant themes within this line of research have been the changing of organizational structures and functional linkages to improve vertical and horizontal collaboration, the introduction of new working arrangements to foster interdisciplinary team-work, the identification of “boundary spanners” able to link interorganizational work and responsibility for client follow-up, and the comparative performance of different partnership models.

6. Concerning Canada, we confine our analysis to one of its most important provinces. It should be noted that sharp differences exist across Canadian jurisdictions with regard to the configuration and steering of eldercare systems. Equally, we explore the situation in England rather than the UK, as with devolution, Scotland, Wales, and Northern Ireland have built their own, particular, care systems. As regards Germany, there are (slighter) differences between East and West, so we concentrate our analysis on the Western part of this country.

7. Consistent with a case study approach, multiple techniques were used in each study for the purpose of assembling empirical materials and analyzing them, including the examination of organizational documents, semi-structured interviews with key informants (i.e., managers of care organizations or their umbrellas, heads of regulatory agencies and academic experts), focus and nominal groups with home-care professionals, and participant observation. For a more thorough description of the methods used in each case study refer to Fermon and Firbank (2002), Firbank et al. (2005), and Bode (2007).

8. Half of those with entitlements to publicly regulated support prefer cash benefits over professional services. It is noteworthy that 10 percent of the population is covered by mandatory private insurance as a result of being enrolled in private sickness funds. The long-term branch of the latter imposes a tight regulation of the sector, though.

9. The benefit guarantees only a basic provision of care and is intended to be supplemented either by unpaid informal care, the purchase by the elderly or their relatives of other services, or by means-tested social assistance (falling under municipal responsibility).

10. In theory, these contracts can be passed between one single provider and one long-term care insurance. This rarely happens, though. It is noteworthy that all suppliers are permitted to deliver services according to stipulations in a contract signed by an insurance fund and a provider organization.

11. Licenses are given to providers only after they provide evidence of employing nursing staff with the required skills.

12. However, one should also mention the particular roles of the “carer for the aged” (Altenpfleger), a profession established already in the sixties and intended to improve social quality in eldercare.

13. To fund services, local authorities can also make use of local tax revenue.

14. Where PCTs have been entrusted with joint commissioning for a number of eldercare-related services, for instance, social workers on PCT boards tend to argue that their professional perspective is often marginalized.

15. Health and Social Services Centres.

16. This program, known as PEFSAD, can cover up to two-thirds of the cost of services depending on the users’ income. Tax credits for home-care services are also available to people 70 years or older. As well, a Compassionate Care Leave Benefit for working family caregivers who look after a dying relative has recently been instituted by the federal government.

17. Following the latest reform, new local service providers are being created in all regions from the merging of one or more CLSCs with long-term and residential care facilities and, in most cases, a regional hospital. The new structures are responsible for the provision within their territory of a complete range of health and social services to seniors, including home care. In addition, the CSSSs are mandated to develop a local network with other community and private providers (i.e., EESAD, COs, private agencies, private nursing homes) and to formalize their links by means of particular agreements and service protocols. Case-managers, based on a CSSS, will be entrusted with the responsibility for the follow-up and coordination of services provided to seniors by network member organizations.
18. Regional Boards define some of the parameters for how COs operate within the network, since they are responsible for their licensing at the same time that they constitute their main source of financing.

19. Also, cash benefits (the allocation directe) concern only a limited number of dependent elderly, and while commercial insurance usually offers some coverage for acute home care, benefits for long-term services vary considerably from plan to plan.

20. This tendency has already had a considerable impact in the residential sector (see Netten, Williams & Darton, 2005).

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