

**NEW PUBLIC MANAGEMENT-INSPIRED PUBLIC SECTOR REFORMS AND EVALUATION:
LONG-TERM CARE PROVISION IN EUROPEAN COUNTRIES**

Hellmut Wollmann

In

Y. Kazepov, E. Barberi, R. Cucca (eds.)

Handbook of Urban Social Policies

Edward Elgar (forthcoming)

Introduction

Since the 1980s, public-sector modernization has been guided and propelled by neo-liberal policy postulates and New Public Management (NPM) maxims, as well as by evaluative assessment of the conduct of public functions. The question as to whether, when and how the sector and its evaluation have been influenced by NPM and underlying neo-liberal policy concepts and measures is explored in this chapter. Specifically, this issue is addressed in relation to the provision of personal social services, in particular eldercare/long-term care (LTC), in European countries. Furthermore, a territorial approach is adopted to examine subnational variations in service provision within each welfare model.

Neo-liberal policy and related NPM maxims have aimed at limiting the role of the public sector, rejecting the predominant primacy of the public sector and its “Weberian” administrative format in fulfilling public functions. Meanwhile, the management of public functions has been “outsourced” through market-mechanisms to non-public, preferably private-sector organizations and actors (see Pollitt and Bouckaert 2017, p.5ff, Kuhlmann and Wollmann 2019, p.52ff). Emerging under Margaret Thatcher’s Conservative government in the UK during the 1980s, and having subsequently spread throughout European countries, neo-liberal policy and NPM postulates have gained further traction through the marketization drive pushed by the European Union’s single market strategy. At the same time, the application of evaluation instruments advanced by NPM, through its underlying management cycle

and its concept of intertwining goal setting, implementation, and results, has made evaluation mandatory (see Wollmann 2003, Wollmann 2007, p.396ff).

Amongst the broad range of public and social services provision that have been impacted by neo-liberal policy and NPM (Wollmann et al. 2016), as mentioned above, this chapter will focus on eldercare /long-term care (LTC) (see Bönker et al. 2010, Bönker et al. 2016) . With an eye on the general theme of this volume, the personal social service sector (notably LTC), seems warranted as an appropriate – if not preferential – candidate for cross-county analysis on a number of scores. For one, the provision of personal social services, including LTC, is at the very core and heart of social policy. Moreover, these services have been, and are being, rendered primarily at the local level, by actors comprising public/municipal, non-public, not-for-profit, voluntary, as well as private commercial ones (see Wollmann and Bönker 2018, Kopric et al. 2018).

This sector is also especially pertinent against the backdrop of the COVID-19 pandemic, which has wreaked havoc worldwide and has taken a deadly toll, particularly on LTC residents (see United Nations 2020). A subsequent section addresses questions and implications that have arisen as to how pandemic has exposed deficiencies across many countries in relation to eldercare / LTC provision, and how this is linked to the theme pursued in this chapter.

From a methodological perspective, the chapter draws on the data and findings of available literature, including the author's own pertinent work and publications. A final caveat must be made, vis-à-vis the complexity of the addressed developments and the envisaged coverage of five countries the article can hardly avoid settling for

some “broad brush” argumentation. The chapter will proceed in four sections. First, country accounts are presented on the provision of personal social services, in particular of LTC in the wake of neo-liberal policy and NPM maxims. Next, related evaluation approaches within each of the countries are discussed. Subsequently, implications of the COVID-19 pandemic are addressed. Finally, some conclusions are formulated.

<c>Cross-country analysis: selection of countries and time frame

The chapter undertakes a cross-country analysis, comprising of the UK, Sweden, France, Germany and Italy. This country selection was guided by the different welfare state regimes to which each of the countries can be assigned.

In describing the various approaches, Esping-Andersen’s (1990) classification is perhaps the most well-known. First, there’s the “liberal welfare state model”, in which the provision of care is essentially left to the private sector and to the market, whilst public support is restrained and means-tested. Second, there’s the “conservative corporatist welfare state model”, which hinges on the family as having primary care responsibility and envisages that the state will intervene only when the capacity of family care is exhausted. Third, there is the “social democratic welfare state model”, inspired by the principle of “universalistic” social rights and equality of the persons in need of care. According to this model, society largely refrains from resorting to the family as caregiver.

Another analytically useful model, put forward by Williams (2012), leans on the distinction as to whether personal services are essentially rendered by formal (public

sector) organizations or by informal (family, etc.) providers. Therefore, two types can be identified. On the one hand, there is the Southern European “familialist care” model, with high levels of informal unpaid care provided by the family and minimal public care provision. On the other hand, there is the “public services model” of Nordic countries, with an egalitarian care regime and high levels of formal public care services (see King-Dejardin 2017).

In the country selection of this chapter, Sweden stands for the “social democratic welfare state model” (as well as the “public service model”); the UK for the “liberal welfare state model” (from the 1980s onwards, having been strongly “public service-based” between 1948 and 1979); France, Germany and Italy represent the “conservative welfare state model”, with Germany having a strong corporatist leaning, and Italy having a pronounced “familialist” accentuation.

In this chapter, a developmental (“over time”) approach is pursued, whereby each country account begins with an outline of the historical origins and developmental lines of service provision in that country. This approach helps to identify the starting conditions from which the respective NPM-inspired trajectories have taken off. Furthermore, a territorial approach is adopted to examine the subnational variations in the service provision within each welfare model.

<c>Definitional and analytical frame (and “glossary”)

In focusing on social service provision, in particular eldercare, it may be helpful to put forward a definitional and analytical frame. This might also serve as a glossary, which

may be particularly useful in this context, since the respective terms and categories vary considerably amongst the countries discussed.

As for the location of care provision, a distinction is made between residential care, provided in care/nursing homes, and home (or domiciliary) care, which is rendered at home. Regarding the institutional contexts of care provision, such services can “in-house”, that is, directly be carried out by personnel of the respective public authority, or externally through alternative facilities, which may variably entail public/municipal, non-for-profit, or private/commercial/for profit facilities. Regarding the status of care providers, a distinction is made between formal caregivers, acting within and for formal organizations, and informal caregivers, particularly family members, peers (such as friends and neighbours) and other (privately hired) helpers. The latter include migrant care workers, frequently engaged as “live-in” helpers (in providing around-the-clock care and living with the cared-for person), often occupying a precarious, unregulated status. Moreover, a distinction is made between care given in-kind, denoting material assistance, such as hands-on help, support in daily life etc., and benefits in cash (cash for care), financially enabling the care recipient to procure and pay for care and support.

To identify the factors that account for and explain the observed institutional developments, our discussion draws on variants of the institutionalist debate (see Peters 2011, Wollmann 2016, 6ff, Kuhlmann and Wollmann 2019, 58ff). The historical variant is employed, as it accentuates the influence of (often path-dependent) institutional, political, and cultural traditions (see Pierson 2000). This approach highlights the origins of conditions from which an observed institutional context has

developed, from holding on to a path-dependent defined trajectory, until perhaps deviating or even breaking from the staked out path. Second, the actor-centred (or rational choice) variant (Scharpf 1997) comes into play, which emphasizes the influence of actors or actor coalitions, and their “will and skill” in decision-making. Moreover, the discursive variant (Schmidt 2008) highlights the salience of discourses (such as political, ideological, etc.) and movements (such as the neo-liberal policy and NPM-inspired modernization). Furthermore, the impact of financial, socio-economic and political circumstances, events and crises need to be taken into account, such as the Wall Street crash in September 2008 or the recent onslaught of the COVID-19 pandemic.

Provision of personal social services in the wake of neo-liberal policy and NPM postulates

<c>United Kingdom

Dating back to the Elizabethan Poor Laws, the local level Boards of Guardian (which were self-standing organizations outside of local government, financed through local taxes) were legislated to be in charge of providing elementary care for needy, disabled etc., persons (see Hill 2003, p.14). Alongside which, not-for-profit charities continued to be important care providers. In 1948, the incoming Labour government passed the National Assistance Act, which assigned comprehensive responsibilities to local authorities (county councils and borough councils) in social services, particularly residential and domiciliary LTC. Not-for-profit organizations lost their traditionally

strong role in service delivery, and the market share of private for-profit providers was minimal. As a result, LTC provision emerged as 'the largest of the activities of local authority social services departments' (Hill 2000, p.317). Thus, turning them into, as it was put (Norton 1994, p.378), virtual 'municipal empires'. Along with the massive nationalization of the energy and water sectors and the creation of the National Health Service (NHS), the UK came to epitomize the public sector-centred provision of public and social services.

After 1979, under the leadership of Margaret Thatcher, the incoming Conservative Party inaugurated and pushed a neo-liberal policy-inspired political agenda, in which the privatization of the public utilities (energy and water) and the marketization of the provision of social services took centre stage (Hill 2000, Wilson and Game 2011, p.368ff). However, the (public, free-of-charge, general taxation-funded) National Health Service (NHS) was conspicuously left unchanged. The 1988 Local Government Act extended compulsory competitive tendering (CCT) to outsourcing a wide range of local authority services, previously supplied primarily in-house by local government personnel. For instance, in the field of LTC, the lion's share of the expanding market of residential (nursing) homes and of the provision of home (domiciliary) care was secured by private, for-profit organizations. Access to publicly funded care is means-tested as well as needs-tested, whilst the provision of LTC largely falls under the responsibility of families; in other words, it is provided through (informal) unpaid care (see King-Dejardin 2017, p.84).

Another crucial shift in the provision of LTC was introduced by the 1990 National Health Service and Community Act, which moved eldercare away from

provision in (public, not-for-profit or private) nursing homes to home-based care (also referred to as “community care”). The concept of, and demand for, replacing “institutionalized” (as it were, “secluded”) care provision with properly attended care “at home” have been advocated in reform debates since the 1960s. In 1990, the legislation promoting community care further stimulated private sector and family involvement.

In still another innovative and consequential policy move, in which the UK was once again a European frontrunner, the “cash for care” payment was introduced in 2000 for persons aged 65 and over in need of care. It was premised on the neo-liberal policy concept of giving care-recipients “freedom of choice” in determining the type of care most suitable to their needs (King-Dejardin 2017, p.84). Options include “buying” assistance from home-care-providing organizations (particularly private, for-profit ones), as well as from “informal carers”, primarily family members and peers remunerated for their work (see Zigante 2018, p.30).

<c>Sweden

In the early 19th century and beyond, elementary social services were rendered, in the then predominantly rural Sweden, by the local parishes of the Protestant (State) church. Later, the municipalities that were formally created in 1832, increasingly took over local service provision. The provision of social services by the local authorities remains a key feature of the modern Swedish welfare state which, under social democratic leadership, have evolved since the 1930s. In the “Social Services Act” (*Socialtjänstlag*), the comprehensive responsibility of the municipalities was laid down

for providing (and largely financing) eldercare (*äldreomsorg*) to all persons needing care, regardless of their financial ability (see Montin et al. 2016, p.99). This “universalistic” outreach of service provision has made Sweden the prototype of the “social democratic welfare regime” (Esping-Andersen 1990, p.28). About 85 per cent of the costs of the provision of LTC are financed from local municipal taxes; the remainder are funded through user fees, which are capped and based on income (Montin et al. 2016).

The NPM-guided modernization debate made a comparatively late entrance in Sweden, in the late 1980s and early 1990s, under the pressure of a budgetary crisis. Hence, the NPM-typical concepts of marketization, outsourcing and purchaser/provider split in service provision found increasing attention amongst local authorities. Some municipalities, particularly those ruled by conservative majorities, have been disposed to outsource the provision of social services, including eldercare, to external (private, commercial or non-for profit) providers. Yet, in line with the public-based service tradition, most eldercare continues to be rendered by the local authorities directly (in-house) or by municipally owned companies. By 2014, approximately 25 per cent of domiciliary care and 21 per cent of residential care were rendered by non-public (not-for-profit or for-profit) providers (Montin et al. 2016, p.100).

In the 2005 Assistance Benefit Act, Sweden too embarked upon a “cash for care” strategy, providing allowances to persons in need of extensive care to employ person assistance, including family members that can get full payment for any help they provide as assistants. Recent legislation (2009) specifies the support of family

carers as an obligation of the municipalities (see Triantafillou et al. 2010, p.42ff). Thus, informal care-givers (nesting in the family) have made their entrance into Sweden's traditionally strong formal provision structure ("in house" provision, municipal providers). Consequently, Sweden's welfare system has been somewhat "re-familiarised" (Zipante 2018, p.35).

<c>France

In France, the historical institutional setting for the provision of social services has experienced a remarkable sequence of changes. Following the Revolution of 1789, the municipalities (*communes*) – which were post-revolutionary creations – were assigned responsibility for providing social assistance, including LTC, through local "welfare units" (*bureaux de bienfaisance*). This municipal task "path-dependently" stayed in place until World War II, during which care provision came to be seen as primarily the responsibility of families. After 1945, as part of the (Gaullist) policy to profoundly modernize post-war France, the provision of LTC (*aide aux vieillards*) was declared a responsibility of the State and was to be carried out by the subnational State offices at the "*département*" level (Borgetto and Lafore 2004, p.111).

In 1982, as a component of France's the secular decentralization, social policy functions — including the provision of social services (*aide sociale légale*) — were made a prime competence and task of the *départements* at the regional self-government level (*collectivités territoriales*). These services, including LTC, were initially provided either directly ("in house", *en régie*) by departmental personnel or through local level *Centres Communaux d'Action Sociale (CCAS)*.

Subsequently, the *départements*, in line with neo-liberal policy concepts, proceeded to increasingly contract out (“outsource”) the provision of LTC to outside residential homes (*maisons de retraites, Ehpad: Etablissements d’hébergement pour personnes âgées dépendantes*) (Borgetto and Lafore 2004, p.137ff), which are operated by public/municipal, not-for-profit as well as private/commercial organizations. In the meantime, about half of the Ehpad are run by private commercial providers and domiciliary care is also increasingly rendered by non-public (often commercial) facilities (see Archambault 1996, p.196, see also Triantafillou et al. 2010, p.40).

In July 2001, a care allowance was introduced (*Allocation Personnalisée d’Autonomie, AP*). Allocated on a means-tested and needs-tested formula, this was meant to support persons aged over 60 who have lost their physical and/or psychological autonomy and need external help to manage everyday life. These cash allowances have come to be increasingly used by older people to hire and pay home helpers for domestic work and personal assistance.

To some extent, domestic work, hitherto done through a “grey market”, largely by migrant workers, has thus been somewhat regulated and legalized (see Triantafillou et al. 2010, p.40).

<c>Germany

Germany ranks prominently as a “Conservative welfare state regime” (Esping-Andersen 1990), historically marked by eldercare being largely provided by the families themselves as well as by non-for-profit (charitable) organizations. The latter’s

traditionally privileged position was grounded in the subsidiarity principle (*Subsidiaritätsprinzip*). With conceptual roots in the in the “Social Doctrine” (*Soziallehre*) of the Catholic Church, the view was that public (municipal) support should take place only if non-profit organizations (complementing family support) failed to render adequate services (see Bönker et al. 2010, p.103). The privileged role of the non-public not-for-profit ‘welfare’ organizations (*Wohlfahrtsverbände*) was legally recognized by federal legislation in 1961.

In 1994, the LTC Insurance Act was added to Germany’s social security system to ensure that everyone is prepared for the eventuality of LTC, whether due to accident, illness or old age. It is financed by an insurance system, funded through wage and retirement income, as well as employer contributions. The 1994 legislation has turned the traditional “conservative welfare state” model into a kind of “mixed model” (King-Dejardin 2017, p.94). It aims, on the one hand, at (albeit conditional) “universalistic” coverage whilst, on the other hand, it is simultaneously inspired by neo-liberal policy maxims.

This neo-liberal slant is evident through two issues. First, the prevalent privilege of the non-public, not-for-profit ‘welfare organisations’ (*Wohlfahrtsverbände*) has been terminated by opening the eldercare market to all providers. As a result, the market share of private commercial service providers in residential as well as domiciliary care has risen dramatically (see Bönker et al. 2016, p.77). Second, the 1994 legislation introduced a long-term cash for care allowance (*Pflegegeld*), which enables those in need of care to stay in familiar surroundings for as long as possible and to remunerate family members or other “informal” caregivers. Consequentially, some 70

per cent of the “*Pflegegeld*” recipients use it for care arrangements in their own homes (Lutz and Palenga-Möllenberg 2011), partly by drawing on formal home (domiciliary) care providing facilities, but more often by relying on the informal assistance from family members and other informal helpers, amongst whom live-in care-givers (who, attending the cared-for person round-the-clock, stay and sleep in that home) loom large.

As the spending of “cash-for-care” (*Pflegegeld*) is not subject to regulated control, it has led many households to turn to live-in, migrant caregivers in private homes (King-Dejardin 2017, p.95). Home-based care workers are most often women from Eastern and Central European countries. The opening of the German labour market to new EU Member States in 2011 has made cross-border movement easier. It is estimated that in the late 2010’s about 115,000 women workers from Eastern Europe worked in the German care sector as “commuter migrants”, regularly returning to their home countries. Some of this work may be undeclared, so no taxes or social insurance contributions are paid (King-Dejardin 2017, p.95). It has been critically remarked that the German care system ‘tacitly depends on [the] informal work of migrants’, and that the government does not seek punishment for people employing undocumented migrant caregivers (Lutz and Palenga-Möllenberg 2011).

<c>Italy

Italy ranks amongst the “conservative welfare state regimes” (Esping-Andersen 1990), with a strong “familialist care” accent (Williams 2012). Traditionally, the care-provision is primarily seen as the domain of families and peers. Meanwhile, charitable not-for-

profit organizations, rooted in the principle of subsidiarity and often affiliated with the Catholic Church, played an important complementary role (Bönker et al. 2010, p.104). The role of municipalities in the delivery of services was “minimal” (Citroni et al. 2016, p.111).

In 1948, the Italian Constitution assigned responsibility for social assistance and social care to local and regional authorities, which resulted in uneven financial capacity and provision of care services across the country (see van Hooren 2011, p.44). The situation changed to some degree in the late 1970s, when the newly established regions were given the power to legislate on social policy and social assistance and to delegate responsibility and financial resources to the municipalities, thus enhancing their role and share in service provision (see van Hooren 2011, p.44). In the absence of a national regulatory framework, throughout the 1980s, each region interpreted the task of regulating local level service provision according to its history, and strategic relationship with local stakeholders. The result was a scattered and fragmented institutional setting, largely dependent on the respective territorial legacies and characterized by huge territorial disparities (between southern, central, and northern regions) in service provision (Citroni et al. 2016, p.111).

Major constitutional and legal reforms ensued in the wake of a deep crisis, impacting Italy’s entire political system during the 1990s. This gave rise to national legislation, which significantly affected local level service provision and paved the way for the introduction of NPM-concepts (Lippi 2003, p.159). Amongst the latter marketization, contracting out and competitive tendering to non-public, mainly not-for-profit organizations and actors loomed large (see Citroni et al. 2016, p.105,

p.111ff). From 2000 to 2009, national intervention in all sectors of social policy was subject to strengthening the “welfare mix” approach, where public and private service providers, as well as families and associations, were expected to interact in the delivery of care services, whilst simultaneously resorting to “means tested” schemes. Between 2008 and 2011 – in pursuit of its fiscal austerity policy – the central government dramatically cut state transfers to local governments for social policies, obliging them to rely mostly on their own (dwindling) resources. Hence, the economic downturn and the budgetary crisis have arguably been a stronger driver of marketization and privatisation of social services than NPM. Consequently, in the field of residential elderly and disabled care, the share of private commercial providers has risen sharply (for figures, see Citroni et al. 2016, p. 113).

Following the 1980 legislation, public support of LTC has been importantly complemented with of a “cash for care” allowance (*“indennità di accompagnamento”*) scheme. It is granted – on a means-tested and needs-tested formula – to older persons in need of care services, which can be purchased directly from the market or employ care workers as they choose. The scheme is not regulated and largely uncontrolled as to how the contributions are spent by recipients. The number of beneficiaries has increased continuously (for figures, see van Hooren 2011, p.45).

Frequently, the “cash for care” allowance has been used to engage migrant care helpers, whose number has grown dramatically (for figures, see King-Dejardin 2017, p.65). In providing around-the-clock care, they are often “live-ins” who work and live with the cared-for persons. Insofar as many of them have an unregulated status, they form a kind of “grey market” of care-provision (see Citroni et al. 2016, p.114).

Evaluation of personal social service provision in the context of NPM-inspired public sector reforms

This section addresses the question as to whether the rise of NPM has, due to its intrinsic evaluative logic, has also propelled the evaluation of the delivery of personal social services.

<c>United Kingdom

In the UK, since the early 1980s, the privatisation of local services was undertaken by establishing a top-down performance management regime. The latter can be 'considered prototypical of a variant of performance management that is central state-directed, mandatory, installed nation-wide, and subject to sanctions' (Kuhlmann and Wollmann 2019, p.278).

Confronted with widespread criticism, particularly from local authorities, the Conservative Liberal coalition government in 2011 abandoned the 20-year-old strategy of centralist performance management. In the same year, the Audit Commission was dissolved that had been set up under the Local Government Act of 1982 to appoint auditors to all local authorities in England and Wales. In line with its "new localism" policy, the government replaced the compulsory *Comprehensive Area Assessment* (CAA) with the *Sector-led Improvement* (SLI) scheme (Laffin 2016, p.58). SLI is a voluntary programme of peer review conducted by local officials. It is based on the

principle that local authorities should be responsible for their own performance and improvement and hence for monitoring and assessing it. The *Local Government Association* (LGA) resumes an outstanding eminent role in the new (horizontal and voluntary) SLI scheme, being in charge of overseeing the performance of the sector and of identifying performance challenges and opportunities (Laffin 2016, p.58).

Besides the decentralised SLI networks, a (central) *Care Quality Commission* was established in 2009 which, in replacing *Commission for Social Care Inspection*, was put in charge of inspecting residential care homes.

<c>Sweden

Historically rooted in an evaluation tradition and a freedom of information culture, forms of performance management and self-evaluation have long been practiced by Sweden's local authorities. This has certainly been the case since the 1960s and 1970s, when Sweden was one of the first European countries to adopt "rationalist planning" and the ensuing managerialist concepts. Hence, concepts like "management by objectives" and "steering by results" (*malstyrelse*) were applied in Sweden's municipal administration and its service delivery practice before NPM made its entry in the early 1990s (Kuhlmann and Wollmann 2019, p.282 ff; Montin 2016, p.95).

In 1987, the Swedish Association of Local Authorities (*Svenska Kommunförbundet*), in cooperation with the Statistical State Office (*Statistiska Centralburan*), initiated a major project that aimed at building a database. Premised on a broad set of indicators, this provided information on the costs of a wide range of locally operated services, including elderly and disabled care in all Swedish

municipalities. As the indicator-based data have been regularly updated since 1987, they allow for a valuable intermunicipal comparison over time of the costs and performance of each of the Swedish municipalities (Kuhlmann and Wollmann 2019, p.283).

In the late 1990s, some municipalities formed a “comparing quality network” that later became a national project, including almost 200 municipalities working together in 30 different local networks (Montin et al. 2016, p.102). Based on the experience of this horizontal networking, in 2009 the Swedish Association of Local Authorities and Regions (SALAR) developed a strategy for “open comparisons” (*Öppna jämförelser*). Based on the voluntary participation of the local authorities, this covers all fields of social care, including eldercare. About 80 per cent of the Swedish municipalities participate in the social services network. Consequently, its underlying 40 performance indicators have practically become a national standard for eldercare service quality (Montin et al. 2016, p.102). In its voluntary, “bottom up”, horizontal, inter-municipal comparative and open-access form, the benchmarking strategies mirror typical features of Sweden’s political culture.

However, somewhat contrasting with (and complementing) this essentially decentralized “bottom-up” approach to local level performance measurement, Sweden has developed institutions that are prone to exercise some “top-down” supervision. This seems to be particularly strong in the field of local level eldercare that is at the heart of Sweden’s welfare state (see Montin et al. 2016, p.101). Thus, a great number of public agencies and quasi-public organisations are involved in the scrutiny of eldercare performance. In general, supervision consists of various forms of

inspections to ensure compliance with the law. Recently, supervision has been given a wider definition, which means that the integrated health and social care (IHSC) system bases also its performance assessment of local social services on national indicators of quality, statistics and measures (Montin et al. 2016, p.102). It is worth highlighting that in Sweden, as suggested by the recently enhanced scrutinising mandate of IHSC, the “top down” supervision of local level social service provision has been tightened and somewhat centralized in the very period when, in the UK, the “centralist” Audit Commission was abolished and the performance scrutiny of local level providers has been decentralized and attenuated (Montin et al. 2016, p.106).

<c>Germany

Since 1999, evaluations regularly compiled by the German Federal Statistical Office (*Statistisches Bundesamt*) have been expanded to include data on long-term care (*Pflegestatistik*). This is to monitor and evaluate the implementation of the 1994 federal legislation that opened the eldercare market to all providers. Data on the use and type of providers of domiciliary and residential services are available for the national/federal, the individual Länder, as well as the county (Kreise) levels. These lend themselves to comparisons over time (since 1999), across Länder and counties (see e.g. Bönker et al. 2016, table 6.1.). However, they do not address the quality of services (Wollmann and Bönker 2018, p.69).

In 2009, a country-wide performance assessment scheme was undertaken (*Pflegenoten*), hinging on care “grades” (slightly reminiscent of school grades) (see Wollmann and Bönker 2018, p.70ff). In view of mounting criticism about its

conclusiveness and validity, in 2019 the “Plegenoten” approach was replaced with a new system. This is based on a combination of internal indicator-based quality monitoring, carried out twice a year by the care-providing facilities, and external indicator-based quality checks, periodically carried out by staff of the medical service of the health insurance funds (*Medizinischer Dienst der Krankenversicherung*).

The instruments of benchmarking-type performance comparison have been introduced into administrative modernization since the 1990s, when NPM made its entrance into Germany. This was a modified version which, under the label “New Steering Model” (NSM), accentuated its managerialist stance (Kuhlmann and Wollmann 2019, p.234ff). The logic of combining “self-evaluation” with cross-municipal performance comparison underlies the formation of intermunicipal benchmarking networks (“*Vergleichsringe*”, “comparison circles”). Since the 1990s, some 150 of such benchmarking networks emerged on a voluntary basis, focusing on different functions and services, including social services (see Wollmann and Bönker 2018, p.72).

In Germany, the expansion of local level benchmarking networks essentially occurred, as in Sweden, through a process of inter-municipal, horizontal, voluntary, “bottom up” development. However, unlike Sweden and its characteristic “freedom of information” culture, the information and assessments obtained in Germany through benchmarking has remained mostly inaccessible beyond the local authority concerned.

<c>France

In France, mechanisms to check administrative performance (*contrôle de gestion*) were introduced, particularly in big cities, in the first wave of decentralisation in the 1980s, without explicit reference to and link with NPM maxims. Interestingly, they were not imposed or prompted by central government (see Kuhlmann 2009, 201ff; 2010, p.6). Crucial elements of administrative reforms were the ‘performance tables’ (*tableaux de bord*), which measure and monitor selected performance indicators of various administrative services. Throughout the 1990s, performance measurement (*contrôle de gestion*) and quality assessments (*démarches de qualité*) continued to gain importance in local service delivery. Moreover, French local governments have increasingly used self-evaluation tools in social service delivery. However, systematic inter-municipal comparisons through benchmarking networks have not yet been undertaken (see Kuhlmann and Wollmann 2019, 287ff).

<c>Italy

As discussed above, Italy’s political system was beset by a profound crisis during the late 1990s and early 2000’s. The country’s administration underwent significant reforms that were inspired and explicitly committed to NPM maxims (Lippi 2003, p.143ff, Kuhlmann and Wollmann 2019, p.280ff). In 1995, the so-called “management plan” (*piano esecutivo di gestione*) was introduced to promote the diffusion of new controlling practices (*controllo di gestione*) in setting local managers with targets, programme performance objectives and defining indicators of efficiency. In the meantime, most municipalities have introduced management control systems. The performance indicators defined and applied have varied widely and are different for

each sector of welfare provision (residential care homes, other social services etc.). Hence, performance management still 'is often somewhat improvised, without systematic and uniform implementation' (Lippi 2003, p.158).

Impact of COVID-19 on LTC and implications for neo-liberal policy and NPM

The COVID-19 pandemic, raging globally since the beginning of 2020, has had disastrous consequences, primarily for older people – especially those receiving LTC in residential homes or home care. At the same time, the personnel engaged in residential homes and home care have also been severely affected. According to available data on 26 countries, by September 2020, residential home residents have accounted for an average of 47 per cent of the total of recorded coronavirus deaths (see Comas-Herrera et al. 2020, p. 22; Rothgang et al. 2020; IPP Universität Bremen 2020a, 2020b on Germany). During the pandemic, deficiencies and shortcomings have been laid bare in the technical equipment (e.g. personal protective equipment, PPE, testing, tracing etc.) of many residential homes. Moreover, the glaring understaffing of care and medical personnel has patently come to light.

Evaluative monitoring and assessments have been embarked upon by multiple international and national agencies and institutions to take account of these shortcomings and prepare counter measures. For example, the United Nations published a data-based "Policy Brief" on "the impact of COVID-19 on older persons" (see United Nations 2020). The *International Long-Term Care Network*, a consortium of

academics and policymakers, undertook a data-collection, comprising 26 countries, on the 'mortality associated with COVID-19 in care homes' (see Comas-Herrera et al. 2020). In Germany, university-based evaluative studies focused on 'care homes and COVID-19' (Rothgang et al. 2020, IPP Universität Bremen 2020b) and 'home care during the Corona-pandemic' (IPP Universität Bremen 2020a).

In the public debate about how and why these infrastructural and personnel deficiencies have occurred in the LTC facilities, it has been pointed out that, to a significant degree, they result from neo-liberal policy and NPM-inspired retrenchment to which the care-provision sector has been exposed. In a similar vein critical reference has been made to the neo-liberal policy-promoted marketization and privatization drive that ushered in the expansion of private care providers, whose entrepreneurial logic is directed at containing the operational and personnel costs.

Conclusions

This chapter has been guided by the question as to whether, how and why the provision of eldercare/long-term care (LTC) has unfolded in the wake of neo-liberal policy and NPM postulates. Our analysis of five European countries (UK, Germany, Sweden, France and Italy) has identified macro trends, whilst also showing variations in the respective countries' starting conditions, shifting political constellations and other country-specific givens. First, in a convergent development, all five countries have

abandoned the primacy of public/municipal sector-centred provision of social services and care and embraced outsourcing and market-like strategies.

Second, since the 1990s, another common trend has been the belief that persons in need of care, essentially LTC, are better off when receiving home care rendered by family members, peers (e.g. friends and neighbours), informal care-givers or by domiciliary care providers.

Third, since the 2000s, in another common trend, “cash-for-care”/care allowance schemes have been introduced. Such cash allowances aim at enabling the persons in need of care to make their own decisions as to which kind of care, and which care provider, to choose. Whilst inspired by the neo-liberal mantra of the “freedom of consumer/client choice”, “cash-for-care” schemes also reflects reformist ideas of empowering people to make their own decisions. In the meantime, cash allowances have entailed the further expansion of informal caregivers (see Zigante 2018, p.7).

To sum up, notwithstanding cross-country variations, the five European countries discussed in this chapter show a significant degree of convergence in service provision, as illustrated by the LTC case. With regard to the drivers that have influenced this development, the cross-country account points at a mix of factors, amongst which neo-liberal policy and NPM maxims have loomed large, whilst other reform discourses have also come to bear.

Concerning the position and function of local government in the provision of personal social services, including LTC, it should be recalled that, for most of the countries discussed in this chapter, the provision of personal social services was

historically a key responsibility and task of local government. This was epitomised by the UK where, prior to 1979, local authorities held a quasi-monopoly in the provision of personal social services, including LTC. Similarly, in Sweden, the provision of personal social services by local government, be it in-house or through municipal companies, was part and parcel of Sweden's (essentially local) welfare state. In Germany, the non-public, not-for-profit organizations which traditionally possessed of a quasi-monopoly of the personal social services were, through cooperative ties, closely linked to local authorities, which gave them a quasi-municipal status. In sum, until the 1980s, local authorities were involved directly in the operation of the services (through the "in-house" model or through municipal companies), or indirectly through local cooperative ties and networks.

In the decades that have followed, following the rise of neo-liberal policies and NPM, the involvement of local government in the provision of personal social services, particularly of LTC, has undergone profound changes. In line with the neo-liberal call for making the public sector leaner, local authorities have significantly withdrawn from direct social service provision and have outsourced and marketized service provision, primarily to private sector providers. Thus, local governments' direct link with service provision has been severed and replaced with a commissioning (purchaser-provider) relation; consequently, social service provision has been de-localised (Evers and Sachße 2003, see also Wollmann 2016b, p.318).

Further, care-providing organizations and companies have commonly adopted an entrepreneurial logic, comprising a cost containment orientation. This also applies to the still remaining municipal care-providing facilities which, in the face of market

competition, have moved to adopt an entrepreneurial stance. In a similar vein, the not-for-profit organizations, traditionally guided by charitable, rather than profit-seeking motives, turned entrepreneurial. Finally, this entrepreneurial logic was at the core of private sector commercial/for-profit organizations, which increasingly dominated the market of residential homes as well domiciliary care providing facilities. Hence, the entrepreneurial logic and its innate cost-containing rationale have increasingly come to impinge on the provision of personal social services, in particular of LTC, not only by private sector commercial, but also by public/municipal and non-for-profit providers. This resulted, most noticeably, in all but chronic and systemic deficiencies in lacking technical equipment and understaffing in caring and medical personnel.

The often-gaping deficiencies in technical equipment and personnel have been glaringly laid bare by the onslaught of the COVID-19 pandemic, as the LTC sector has proven woefully unprepared to react effectively and in due time. Whilst the unprecedented thrust and dimension of the pandemic were beyond any outside possibility of sufficient preparedness, there can be no doubt that the fatal toll that the pandemic has taken on the residents and on the personnel of the LTC facilities is, to a significant degree, due to the technical and personnel deficiencies the care sector has “inherited” from its cost-containment-driven past. The latter also prevented, not least, the formation of any (technical or personnel) “slack” in resources, which could have been mobilized fast in the case of emergency.

In looking ahead, it seems advisable for local government to resume its historically rooted involvement in the sector of LTC. This should and could be done by

enhancing its operative presence in this field by establishing new municipal residential homes and domiciliary care-providing facilities. This would fall in line with the “re-municipalisation” moves observable also in other fields of public and social services provision, such as, depending on country-specific givens, water and energy (see Wollmann 2016b). Moreover, and perhaps even more important, the trend of “de-localising” (Evers and Sachße 2003) care provision should and could be reverted, and its re-localisation should be embarked upon by making LTC a prime concern again amongst the genuine local self-government tasks in the best interest of the local community. Such re-localized poise and influence of local government in and on the local care market might rectify the entrepreneurial logic that has detrimentally impinged on care provision.

References

Bönker F., M. Hill and A. Marzanati (2010), ‘Towards marketization and centralization? The changing role of local government in long-term care in England, France, Germany and Italy’, in H. Wollmann and G. Marcou (eds.) (2010), *The Provision of Public Services in Europe. Between State, Local Government and Market*, Cheltenham: Edward Elgar, pp. 97-118.

Bönker, F., J. Libbe and H. Wollmann (2016), ‘Re-Municipalisation Revisited: Long-Term Trends in the Provision of Local Public Services in Germany’, in H. Wollmann, I. Kopric and G. Marcou (eds.), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan, pp. 71-86.

Borgetto, M. and R. Lafore (2004), *Droit de l'aide et de l'action sociale*, 5th edition, Paris: Montchrestien.

Citroni, G., A. Lippi and S. Profeti (2016), 'Local public services in Italy: still fragmentation', in H. Wollmann, I. Kopric and G. Marcou (eds.), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan, pp.103-118.

Comas-Herrera, A., J. Zalakaín, E. Lemmon, D. Henderson, C. Litwin, A. T. Hsu, A. E. Schmidt, G. Arling and J.-L. Fernández (2020), 'Mortality associated with Covid 19 in care homes: International evidence', October2020, accessed 26 January 2021 at <https://ltccovid.org/wp-content/uploads/2020/10/Mortality-associated-with-COVID-among-people-living-in-care-homes-14-October-2020-3.pdf>.

Esping-Andersen, G. (1990), *The three worlds of welfare capitalism*, Princeton: Princeton University Press.

Evers, A. and C. Sachße (2003), 'Social care services for children and older people in Germany. Distinct and separate histories', in A. Anttonen, J. Baldock and J. Sipilä (eds.), *The young, the old and the state. Social care systems in five industrial countries*, Cheltenham: Edward Elgar, pp. 55-79.

Hill, M. (2000), 'Trends in the marketization of British social services', in H. Wollmann and E. Schröter (eds.), *Comparing Public Sector Reforms in Britain and Germany*, Aldershot, pp. 304-326.

Hill, M. (2003), *Understanding Social Policy*, 7th edition, Oxford: Blackwell.

IPP Universität Bremen (2020a), ‚Zur Situation der Langzeitpflege in Deutschland während der Corona-Pandemie‘, accessed 25 January 2021 at https://www.socium.uni-bremen.de/uploads/Ergebnisbericht_Coronabefragung_Uni-Bremen_24062020.pdf.

IPP Universität Bremen (2020b), ‚Zur Situation der häuslichen Pflege in Deutschland während der Corona – Pandemie‘, accessed 25 January 2021 at <https://www.dak.de/dak/download/studie-2372026.pdf>.

King-Dejardin, A. (2017), ‘The Social Construction of Migrant Care Work. At the intersection of care, migration and gender’, Report, Geneva: International Labor Office, ILO.

Kopric, I. and H. Wollmann (2018), ‘Evaluating Reform of Local Public and Social Services in Europe’, in I. Kopric, H. Wollmann and M. Marcou (eds.), *Evaluating Reforms of Local Public and Social Services in Europe*, Basingstoke: Palgrave Macmillan, pp. 1-18.

Kopric, I., H. Wollmann, M. Marcou (eds.) (2018), *Evaluating Reforms of Local Public and Social Services in Europe*, Basingstoke: Palgrave Macmillan,

Kuhlmann, S. and H. Wollmann (2011), ‘The evaluation of institutional reforms at subnational government levels, a still neglected research agenda?’, *Local Government Studies*, **37** (5), 479-494.

Kuhlmann, S. and H. Wollmann (2019), *Introduction to comparative public administration*, 2d edition, Cheltenham: Edward Elgar.

Laffin, M. (2016), 'The Politics of Evaluation in Performance Management Regimes in English Local Government', in I. Kopric, H. Wollmann, G. Marcou (eds.), *Evaluating Reforms of Local Public and Social Services in Europe*, Basingstoke: Palgrave Macmillan, pp. 49-64.

Lippi, A. (2003), "'As a voluntary choice or a legal obligation". Assessing New Public Management policy in Italy', in H. Wollmann. (ed.), *Evaluating in Public-Sector Reform. Concepts and Practice in International Perspective*, Cheltenham: Edward Elgar, pp. 140-169.

Lutz, H. and E. Palenga-Möllennebeck (2011), 'Care, gender and migration: Towards a theory of transnational domestic work migration in Europe', *Journal of Contemporary European Studies*, **19** (3), 349-364

Montin, S. (2016), 'Local government and the market. The case of public services and care for the elderly in Sweden', in H. Wollmann, I. Kopric and G. Marcou (eds.), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan, pp. 87-102.

Montin, S., V. Johansson, L. Lindgren (2016), 'The Institutionalisation of Performance Scrutiny Regimes and Beyond. The Case of Education and Eldercare in Sweden', in Kopric, I., H. Wollmann and G. Marcou (eds.), *Evaluating Reforms of Local Public and Social Services in Europe*, Basingstoke: Palgrave Macmillan, pp. 97-115.

Norton, A. (1994), *International Handbook of Local and Regional Government*, Aldershot: Edward Elgar.

Peters, B. G. (2011), *Institutional Theory in Political Science. The 'New Institutionalism'*, 3rd edition, London: Bloomsbury.

Pierson, P. (2000), 'Increasing returns. Path dependence and the study of politics', *American Political Science Review*, **94**, 251-267.

Pollitt, C. and G. Bouckaert (2017), *Public Management Reform*, 4th edition, Oxford: Oxford University Press.

Rothgang, H., K. Wolf-Ostermann, D. Domhoff, A. C. Friedrich, F. Heinze, B. Preuss, A. Schmidt, K. Seibert and C. Stolle (2020), *Care Homes and COVID-19: Results of an Online Survey in Germany*, Report, accessed 26 January 2021 at <https://ltccovid.org/wp-content/uploads/2020/07/Care-homes-and-Covid19-survey-of-care-homes-in-Germany-16-July-2020.pdf>.

Scharpf F. W. (1997), *Games Real Actors Play: Actor-centred Institutionalism in Policy Research*, Boulder: Westview Press.

Schmidt, V. A. (2008), 'Discursive Institutionalism. The explanatory power of ideas and discourses', *Annual Review of Political Science*, **11**, 303-326.

Triantafillou, J., M. Naiditch, K. Repkova, K. Stiehr, S. Carretero, T. Emilsson, P. Di Santo, R. Bednarik, L. Brichtova, F. Ceruzzi, L. Cordero, T. Mastroiannakis, M. Ferrando, K. Mingot, J. Ritter and D. Vlantoni (2010), 'Informal care in the long-term care system. A European overview', paper, accessed 26 January 2021 at <https://www.euro.centre.org/downloads/detail/768>.

United Nations (2020), 'Policy Brief: The Impact of COVID-19 on older persons', accessed 26 January 2021 at <https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf>.

Van Hooren, F. J. (2011), 'Caring migrants in European welfare regimes', European University Institute, accessed 26 January 2021 at https://cadmus.eui.eu/bitstream/handle/1814/17735/2011_VanHooren.pdf?sequence=2.

Williams, F. (2012), 'Converging variations in migrant work in Europe', *Journal of European Social Policy*, **22** (4), 363-376.

Wilson, D. and C. Game (2011), *Local Government in the United Kingdom*, 5th edition, Basingstoke: Palgrave Macmillan.

Wollmann, H. (2003), 'Evaluation in public sector reform: towards a 'third wave' of evaluation?', in H. Wollmann (ed.), *Evaluation in Public-Sector Reform. Concepts and Practice in International Perspective*, Cheltenham: Edward Elgar, pp 1-11.

Wollmann, H. (2007), 'Policy Evaluation and Evaluation Research', in F. Fischer, G. J. Miller and M. S. Sidney (eds.), *Handbook of Public Policy Analysis*, Boca Raton: CRC Press, pp.. 393-402.

Wollmann. H. (2016a), 'Comparative Study of Public and Social Services Provision. Definitions, Concepts and Methodologies', in H. Wollmann, I. Kopric and M. Marcou (eds.), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan, pp. 1-12.

Wollmann, H. (2016b), 'Public and Social Services in Europe. From Public and Municipal to Private Provision – and Reverse?', in H. Wollmann, I. Koprivic and M. Marcou (eds.), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan, pp. 313-334.

Wollmann, H., I. Koprivic and M. Marcou (eds.) (2016), *Public and Social Services in Europe. From Public and Municipal to Private Sector Provision*, Basingstoke: Palgrave Macmillan.

Wollmann, H. and F. Bönker (2018), 'Evaluating Personal Social Services in Germany', in I. Koprivic, H. Wollmann and G. Marcou (eds.), *Evaluating Reforms of Local Public and Social Services in Europe*, Basingstoke: Palgrave Macmillan, pp. 65-80.

Zigante, V. (2018), 'Informal care in Europe Exploring Formalisation, Availability and Quality', European Commission, accessed 26 January 2021 at <https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8106&furtherPubs=yes>.