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Explaining contradictory developments in child and elderly care policies in the Netherlands

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ABSTRACT

After World War II, public involvement in the provision of elderly care services increased rapidly in the Netherlands. On the contrary, child care remained a family affair well into the 1980s. Recently these trends have been reversed. Public investments in child care have grown exponentially after 1990, while subsequent governments have attempted to cut expenses on elderly care services. This paper compares and explains these highly contrasting processes. They are placed in the context of general Dutch welfare state developments as well as in an international perspective. The relative explanatory relevance of political parties, institutions, demographic and economic developments and cultural norms is assessed. It is argued that the, at least until very recently, passive nature of Dutch welfare state politics in conjunction with the prevailing cultural norms regarding appropriate forms of care can explain the large initial differences between the two policy fields. Once these differences were institutionalised, they shaped developments for the following decades. Only since the 1990s, when the Dutch welfare state became more 'active', a consensus emerged on the necessity of providing child care services in order to enable female labour market participation. It is the very different rationales behind child and elderly care policies that explain the variation in responses to the contemporary economic and demographic challenges.

1 INTRODUCTION

Child care and elderly care are not at the heart of comparative welfare state research, but they are of eminent importance because they relate to demographic problems in western societies, to the participation of mothers on the labour market and, indirectly, challenges of international economic competition. For competent women staying at home for child care cannot optimally contribute to an economy’s competitiveness. Both child and elderly care also involve huge costs, of course. The Dutch welfare state has turned out to be an interesting case because it is a very special hybrid of strong Christian-paternalist, social democratic and liberal influences each of which has had their strongest impact at different times. We will see whether or not this specific, and changing, mixture has also been present in the structure of child and elderly care and how important factors such as the labour market and costs have been in their development.

In the context of the outspokenly Christian Dutch society of the late 1940s/early 1950s the welfare state was built upon a conservative conception of the appropriate role of women within the private sphere and a subsidiary and residual role of the state vis-à-vis the family. Consequently, female labour market participation was strongly discouraged and among the lowest in Europe. ‘Women were, so to speak, insured through the wage labour of their husbands and, in exchange for this income guarantee, women were assumed to perform their family ca-

ring tasks' (van Kersbergen 2009: ?). In those years and until the 1960s /1970s the near absence of child care facilities as an alternative for caring in the family were understood as 'blessing for the welfare state' (Bussemaker and Van Kersbergen 1994: 23). In the 1960s, the ideological orientation started to change but until the 1990s public child care provision remained on a very low level. As can be seen in table 1, by 1987 only 2 percent of all children aged 0 to 2 made use of formal childcare facilities. Until 1990 the Netherlands was, together with the United Kingdom, the biggest laggard of Europe in terms of use of child care services. This in contrast with for example Denmark, Sweden, Belgium and France, where formal child are services were developed much earlier (cf. Kamerman and Kahn 1991)

Table 1: Percentage of young children attending formal child care facilities.

	Children aged 0-2			3-5/compulsory schooling	
	1987	1993	2004	1970	2004
Denmark	48	50	62	20	90
Sweden	…	33	40	22	87
Belgium	20	30	34	95	100
France	22	23	28	87	100
Germany	2 [1]	4 [1]	9	33	80
Italy	5	6	6	58	100
Spain	5	5	21	42	99
Netherlands	2	8	30	60	70
UK	2	1-2	26	16	81

Source: data for 1987 and 1993 (Tietze and Cryer 1999: 181); 2004 (OECD 2007)
1970, 1987 and 1993 figures refer to partly or fully publicly funded services.
[1] Refers to West-Germany, coverage rates in East Germany were much higher

While child care was initially considered to be only a family affair, public involvement in elderly care was considerable already in the immediate post-war decades. Older people were encouraged to move into residential care homes, which were largely financed by the state. As can be seen in table 2, by the early 1990s the Netherlands was the country with the highest percentage of elderly in institutional care facilities among the European countries for which data was available. The coverage rate of formal home care services in the Netherlands was 8 percent, lower only then Sweden and the United Kingdom.

Starting in the 1980s but more notable since the 1990s the trend in Dutch child care provision has reversed. After an unprecedented expansion caused by generous public subsidies, by 2004 30 percent of all children between 0 and 2 years old attended some kind of

formal day care facility. Although it should be remarked that most Dutch children attend day care services only part-time, the Netherlands has undoubtedly transformed itself from a laggard to more than the average when it comes to child care provision.

Table 2: Use of formal long-term care services. Care recipients as percentage of population aged over 65

	In institutions		At home		Total
	Early 1990s	2006	Early 1990s	2006	2006
Netherlands	9	6.9	8	13.1	20.7
Denmark [1]	…	5.4	…	12.9	18.3
Sweden	8	6.8	13	9.8	16.7
UK [2]	5	4.2	9	6.9	11.1
Belgium [3]	…	5.0	…	5.8	10.8
Germany [2]	5	3.7	2	6.6	10.4
France [3]	5	6.3	7	3.5	9.8
Spain	…	2.1	…	6.0	8.1
Italy	2	3	1	3	6

Source: 2006 data (OECD 2009); 1990s data + all data Italy (Ranci and Pavolini 2008)
Definitions:
Long-term care institution is a place of collective living where care and accommodation is provided as a package for people with moderate to severe functional restrictions.
Long-term care at home is provided to people with functional restrictions who mainly reside at their own home.
[1] Data do not refer to a specific day of the year, resulting in overestimation
[2] Data include privately funded care recipients
[3] All data for Belgium and data for home care recipients for France refer to recipients aged over 60 years old.

In elderly care, a shift from residential care to home care services that had already begun in the 1970s, came to blossom in the 1990s. As a consequence, by 2006, home care services were used by more elderly (13.1 percent) in the Netherlands than in any other European country. However, regardless of this high coverage rate, retrenchment measures are now an important element of Dutch policy.

The description and explanation of the opposing developments in child and elderly care are the subject of this paper. Why could elderly care expand so early in a welfare state in which the caring role of the family has been prioritised until very recently? And why is child care currently at the centre of attention and quickly expanding, while elderly care is subject to retrenchment? The aim of this paper is to supplement research on the Dutch welfare state, as well as to enhance our understanding of explanations for the development of care policies.

Research on social care – here understood as ‘the provision of daily social, psychological, emotional, and physical attention for [dependent] people’ (Knijn and Kremer 1997: 330) – has made considerable progress in describing different social care systems (cf. for example the edited volumes of Anttonen et al. 2003; Lewis 1998). The same authors, however, have been less successful in explaining specific policy developments. Looking for appropriate explanations we will address the relevance of political parties, institutions, demographic and economic developments and cultural norms and discuss functional, political, institutional and cultural approaches.

The comparative dimension will be present in regular references to the developments in other European countries. Do other countries reveal similar developments; what are the main differences? What we do can best be characterized in terms of Charles Tilly’s classification of comparative research and called an ‘individualizing’ study (Tilly 1984: 87ff) in the context of some ‘variation finding’ (ibid: 116ff). Whereas the bulk of the work is on the Netherlands the comparative, variation-finding, excursions have the intention to provide some overview but notably to carve out the peculiarities of the Dutch development.

2 UNDERSTANDING DUTCH SOCIAL CARE IN A CONTEXT OF WELFARE REGIMES

For welfare state theory the Dutch case has always been somewhat enigmatic. As a consequence, some confusion seems to exist in the literature. Alternatively it has been treated as a social democratic, a conservative, a specifically Christian democratic, or as a hybrid case (van Kersbergen and Becker 1988). To a certain degree, the Dutch welfare state’s position as an outlier or exception in (almost) all theories stems from the difficulty to place it properly in the mainstream typological frameworks proposed for classification. Most mainstream typologies are varieties of Esping-Andersen’s distinction between liberal, conservative and social democratic types. The problem with these typologies is that they do not strictly distinguish between ideal types and empirical cases and that the conservative type is a very broad one. Cases such as the Dutch one have been a reason to rethink the typology of welfare systems into a direction that distinguishes ideal types from empirical cases and makes change explainable (see, also for the subsequent paragraphs, Becker 2000).

Welfare systems can be differentiated and classified in a variety of ways. It matters for the findings if one focuses, for example, on the level of social security provisions, the way the system is financed, the degree to which policies aim at preventing unemployment or on a

bunch of criteria that also might include social care. We want to propose an encompassing method of distinction that identifies the regulating or guiding assumptions underlying the ways in which countries deal with market risks and market (and family) failures. We take several issues into account, such as the relationship between politics and the market, the make-up of society (hierarchical, socially-egalitarian or individualist), the locus of responsibility for welfare (elites, society, families or individuals), the centrality of freedom, gender equality, equality of opportunity, and equality of condition. Based on these criteria, we propose a typology of welfare systems where Esping-Andersen's conservative category is split into a paternalist and a communitarian one (both might be conservative, but are very distinctive).

Before outlining this typology we want to emphasise that typologies simplify reality and help bringing order in the differences between the many (possible) worlds of welfare. We understand the types we propose explicitly as *ideal types* in Max Weber's sense, as 'pure' (yet not normative) constructions that are nearly never met in reality. Commonly, comparative social science confuses ideal types and classifications, and ideal types and empirical cases. Working with classifications, one may decide to classify a welfare system as liberal, social democratic, and so forth. Classifications, however, conceal sometimes considerable differences between cases – for example between the 'liberal' US and Canada – and do not leave space for change other than the radical jump from one type to another. Working with ideal-typical typologies, cases never *represent* the ideal types, however; they only *approximate* them. Typologies as sets of ideal types can be reformulated, but in principle they are fixed constructions. Cases, by contrast, are historical entities and over time they change their location on the axes (Dogan and Pelassy 1990: 174) in the field between different ideal types, for example from a position approximating the social democratic ideal type to a position approximating the liberal type. Taking the criteria mentioned above we propose a four-type typology of welfare systems. How exactly social care forms part of this typology will be discussed in detail below.

- In the first *paternalist* type, components of which have been approximated on the European continent, social inequalities – both socio-economic and gender-based – are considered as given facts, but 'the strong' are expected to care for the 'weak' or disadvantaged through charity or state action. Markets should be regulated, while poverty and excessive material inequality have to be fought against in the general interest of a harmonious society.
- The second type is the *liberal* one – most approximated in the Anglo-Saxon countries - where a positive-optimist view of the market dominates, where individual responsibility is central and public provisions are residual, and where the idea of equality of opportunity prevails.

- The third, *social-democratic,* type – approximated by Scandinavian countries – is characterized by a critical view of the market, emphasizing that market risks are both a collective and individual responsibility. The ideas of social citizenship and equality of condition are central and welfare benefits as well as employment stimulation are high.
- In the fourth, *meso-communitarian* type – Japan resembles it – 'the whole' and the group are the dominant reference frame of society. Companies, villages or neighbourhood communities provide for social security, and group norms restrict individualist market inequality whilst the welfare state only plays a complementary role.[1]

Because of its high benefits in case of unemployment, relatively low poverty as well as inequality rates and, as a consequence, a high level of labour 'decommodification', the Netherlands has often been labelled social democratic. And indeed, in these terms the country has always scored high and still does as Table 1 illustrates. Table 1 moreover shows that nowadays the employment rate, which until the early 1980s was at a level of just above 50 percent, is also high – even if one has to take into account the very high rate of, particularly female, part-time work.

Table 1: Socio-economic data for selected countries

	Employment rate overall		Employment rate women		Percentage of women working part-time	Standardized unemployment rate	Income percentile ratio 90/10	Poverty rate [2]
	1983	2007	1983	2007	2007	2007	Early-2000s	Mid-2000s
Belgium	54.6	61.6	44.5	54.9	32.9	7.5	3.3	8.8
Denmark	71.7	77.3	72.8	73.3	23.9	3.8	2.8	5.3
France	60.8	64.4	55.6	59.8	23.1	8.3	3.4	7.1
Germany	62.2	68.9	52.5	62.9	39.2	8.4	3.4	11.0
Italy	54.5	58.7	40.1	46.6	29.9	6.1	4.5	11.4
Netherlands	52.1	74.1	40.2	68.1	60.0	3.2	2.8	7.7
Spain	50.2 [1]	66.6	31.1 [1]	55.5	20.9	8.3	4.7	14.1
Sweden	78.5	75.7	78.3	73.2	19.7	6.1	2.8	5.3
Switzerland	73.8	78.6	66.4 [1]	71.6	45.6	3.6	3.4	8.7
UK	64.3	72.3	62.5	66.3	38.6	5.3	4.5	8.3
US	66.2	71.8	63.5	65.9	17.9	4.6	5.5	17.1

Sources: OECD 1995, Statistical Annex; OECD 2008, Statistical Annex; OECD 2008c: 127, database ; Lis Key Figures.
[1] Data refer to 1990
[2] Poverty rate refers to the percentage of households earning less than 50 percent of the median income.

Apart from confusing ideal types and hybrid cases the characterization of the Dutch case as social democratic is misleading, however. Social democracy is not a necessary requirement of

[1] One could add a *rudimentary* category (Leibfried 1993). Such a 'type' has no specific profile but contains family help, some poor relief by state and church as well as voluntary insurances. It refers to earlier stages of capitalist development and is not relevant for discussing the Dutch case. Furthermore, a welfare system has *clientelist traits* when social provisions are part of political exchanges of personal privileges and favours. Clientelist traits, strong in southern Europe and outside western society, do not constitute a clientelist *type* (Ferrera 1996), however, because in modern society requiring universal rules clientelist relations can only be effective parasitically.

high benefits and low poverty/inequality and its influence at the cradle of the Dutch welfare system was rather modest. In the 1940s and 1950s, this system had strong paternalist features with a Christian democratic background. Social life was largely structured by hierarchical principles and public life and politics were dominated by Christian-conservative organizations and parties which (including the small, fundamentalist ones) were good for more than 55 percent of the vote and the backbone for 'pillarization'. 'The strong' had to care for 'the weak' and for the sake of social harmony benefits had to be generous. So, it is no accident that the Dutch welfare state is called 'caring state' (*verzorgingsstaat*).

In the 1960s and 1970s, in the context of rapid secularization annex 'depillarization' and as a part of a general trend in Western societies the Christian-conservative order was replaced by the permissive society. In and with respect to the welfare system citizens rights became stressed and some social-democratization took place. In politics it was the time that will be remembered as that of the Labour Party-led Red-Christian coalition of the Den Uyl administration from 1973 to 1977. Ideologically, the 1960s and the Den Uyl years marked a shift from the traditional Dutch family bias to the rise of individual welfare claims as the point of reference for social policy. For the first time, women were seen as individuals with the same rights as men. Yet even in this period, when the stance of politics against the market was relatively critical, the Dutch welfare system remained largely passive, unlike the Scandinavian, particularly Swedish, systems of actively creating employment in the public sector. Though dressed in the vocabulary of citizenship, the stress on the right to be assisted or to be cared for by the democratic state was rather an expression of a leftist variety of paternalism than genuinely social democratic. So, up to the early 1980s the development of the regulative assumptions of the Dutch welfare system could be described as a change from predominantly elitist paternalism towards a social democratized or progressive paternalism.

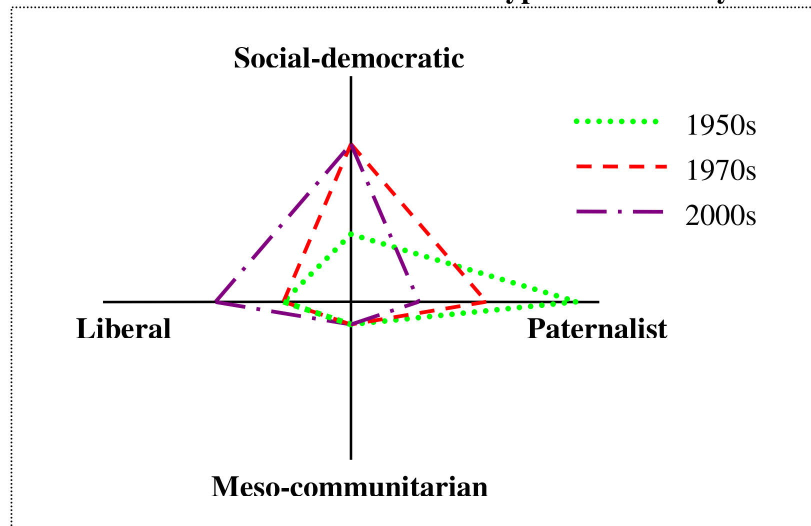
With the recession of the late 1970s the system went into financial problems that propelled a period of reorientation. At that time the term 'Dutch disease' was coined: a very generous welfare system combined with high unemployment in an economy losing competitiveness. The latter was the starting point for attacking the welfare state and for blaming the Social Democrats for rising welfare costs. The Christian-Liberal coalition taking office in 1982 – at the time of Thatcher, Reagan and Kohl – under the slogan of 'no nonsense policy' shared in this liberal atmosphere of departure. Its main goals were to improve the competitiveness of the Dutch economy and to bring down the budget deficit. All welfare and |Keynesian 'nonsense' had to be stopped and individual responsibility to be emphasized. The difference to notably the US and Britain remained, however. For the Christian Democratic notion of subsidia-

rity (social and political responsibility of lower societal units such as companies and the family) was put forward even more strongly than the liberal values.

At least equally important as any welfare philosophy or ideology at that time have been austerity arguments. Therefore domestic politics in the entire 1980s were determined and (modest) benefit cuts were justified by a financial discourse – a discourse perfectly fitting into the cliché of the Netherlands being ‘a country of preachers and shopkeepers’. It took a second ‘no-nonsense’ term, starting in 1986, and a new Christian–Labour coalition in 1989 before the politics of austerity really succeeded in the attempt to reduce the budget deficit (Schick, 1993: 216). During the time of renewed economic prosperity in the 1990s the Netherlands then (in 1994) got its first entirely secular government, four years later followed up by a second one. In terms of socio-economic policy this period has particularly been characterized by privatization, the tightening of eligibility criteria and some flexibilization of the labour market. Though the Dutch socio-economic system became internationally discussed as an alternative ‘model’ in those years, its development was one of slow liberalization. In the 2000s, with the Christian democrats back at the centre of administrative power, this process continued and brought about a move towards more privatization of the health care system and the introduction of market criteria into social care. The relatively generous level of welfare and social security benefits and arrangements has largely been maintained, however.

Figure 1 provides a crude impression of the change the Dutch welfare system has undergone from a strongly paternalist coloured hybrid in the mid-1950s via a period of social democratization to a hybrid with a considerable liberal impact. The spider web illustrates the distinction between ideal types and cases and the three lines indicate the specific hybrid character of the Dutch system in the mid-1950s, the late 1970s and the 2000s respectively.

Figure 1: A sketch of Dutch welfare state development according to the four-directional typology of liberal, paternalist, social democratic and meso-communitarian types of welfare systems.



So far the overall development of the Dutch welfare system. Central welfare components must reflect this development, but this is not necessarily true for all separate components. So social care might have different characteristics and have had particular development trajectories. Before addressing these particular trajectories, we have to take a closer look at the ideal typical configurations of social care arrangements. Several scholars have proposed to look at the degree of 'defamilialisation', which can be understood as the extent to which household members can obtain an acceptable standard of living independent from their family (Lister 1997: 137). As Esping-Andersen has emphasised, defamilialisation in the area of social care can essentially be obtained in two ways. Either care services can be purchased on the market, or they can be provided by the state (Esping-Andersen 1999: 45). Although in practice social care provision is usually a mixture of public, market, and family provision, we can distinguish ideal-typical configurations in line with the ideal types earlier described.

- In the *paternalist* type, the traditional family, consisting of a male breadwinner and a housewife, is expected to take care of vulnerable family members. The state plays only a subsidiary role where families fail. Eligibility criteria contain an assessment of family's capacity to care or to pay for care. Services are often provided by charity organisations – usually linked to a church – which receive state funding.
- In the *liberal* type individuals are responsible for their own care provision. Care services should be purchased on the market. Residual public services are available. They are strongly means-tested, but contrary to the paternalist type, these means-tests are based on the individual and not on his or her extended family.

- In the *social-democratic* type, citizens have the right to receive care. Care services are publicly provided and universal. Needs are assessed on an individual basis and means-tests are absent.
- In the area of social care the meso-communitarian type is very similar to the paternalist type. The companies, villages or neighbourhood communities that provide for social security leave care issues to the traditional family (Peng 2002). This type will hereafter not be considered separately.

To distinguish between the different configurations we have to take into consideration both policies and outcomes, because both the liberal and the paternalist type are characterised by limited public provision of social care services. However, in the liberal type we will find a much higher market provision of care services, while these are almost entirely absent in the conservative type.

In the next section we will consider to what extent Dutch social care has approached these three ideal types. In addition to describing the developments of child and elderly care policies and practice, we also attempt to explain these developments. In welfare state research there are a number of factors commonly identified as explanations for the direction of change. Some of the classics point at a functional logic, in which social and economic change would directly cause changes in welfare state policies (e.g. Wilensky 1975). Such explanations are problematic because they lack a causal link between structure and policy (Myles and Quadagno 2002: 36).

Power resource theory (Esping-Andersen 1990; Korpi 1983) provides such a link. This theory predicts that where left-wing political parties and trade unions were dominant, a a social democratic welfare regime emerged. On the other hand, where Christian parties were important, a paternalist (or conservative) welfare regime emerged. The question is whether this also applies to social care regimes. Morgan, for example, has pointed out that not all social-democratic parties and trade unions were in favour of defamilialising care (Morgan 2009: 61), while indeed religious parties and groups have played an important role in maintaining a paternalistic family model (Morgan 2006: 20).

The influence of religious groups is related to the role of culture. Kremer, for example, argued that different 'cultures of care' shape care policies. Unfortunately such 'cultures of care' are hard to operationalise, and it is difficult to exclude endogeneity problems: policies may also cause cultural change. Finally, we should take into account a range of institutional effects. If policy making depends on coalition governments or a large number of actors that can veto policy choices, it might become more difficult to enact new policies, both when these policies are expansive and retrenching. Policy legacies also create feedback mechanisms. As Pierson

has convincingly shown, once a certain policy is in place, this creates beneficiaries with an interest in preserving the status quo (Pierson 1996). In addition, when policies stay the same while society changes, this might create an increasing burden on the state (Morel 2006: 244).

Earlier research on the Dutch welfare state has shown that its general development can be explained by overall politico-ideological changes, which are a combination of changing power resources and general ideological changes in society (Becker 2000; van Kersbergen and Becker 1989). Whether the same combination can explain developments in Dutch social care will be addressed below.

3 DEVELOPMENTS IN CHILD AND ELDERLY CARE

3. 1 Social care in a paternalist welfare state, 1945 - 1977

Elderly care: expansion of residential care with support from the state

Institutional care was not invented in the 20th century. In the Netherlands – as well as in other Western European countries – such care facilities had existed already for centuries (Bijsterveld 1995: 161). While the well-off relied on servants or private homes, the less well-off had to turn to poor homes or old people's homes run by churches and local (WRR 1988: 14).

The situation changed in several ways after World War II. First of all, the number of elderly people living in some kind of residential home increased strongly, as can be seen in the table below. While an estimated 3.8 percent of all those aged over 65 lived in old people's homes in 1950 (cf. table 4), this gradually increased to 6 percent in 1965 and almost 9 percent in 1975. Second, the composition of residents of care homes changed. From poor houses they developed into a general provision for all older people. Third, as will be shown below, the role of the state in the regulation and financing of elderly care services increased strongly.

Table 4: Percentage of people aged >65 living in residential or nursing homes

Year	In old people's/ care homes [1]	In nursing homes	Total
1950	3.8	…	…
1955	(4.3)	…	…
1960	(5.3)	…	…
1965	6.0	…	…
1970	7.8	…	10
1975	8.9	…	…
1980	8.1	…	11
1985	8.8	2.5	11.3
1990	6.8	2.4	9.2
1995	5.7	2.5	8.2
1999	4.9	2.4	7.3
2004	4.3	2.5	6.8

Source: residential homes 1950-1980: (Bijsterveld 1995: 208). Figures between brackets are for various reasons less reliable.
Totals 1970, 1980: Rapportage ouderen 1996
Data 1985 - 1995: Rapportage ouderen 1998: 138
Data 1999, 2004: (CBS 2006: 104)
[1] Initially "Bejaardenoorden", later "Verzorgingshuizen"

How can we explain these post-war developments in residential care? Many scholars have pointed to the role of a context of enormous housing shortage. As a solution to this problem, old people would have been encouraged to leave their houses in order to make place for young families (Kremer 2000: 34; WRR 1988: 14; WRR 2006: 116). Although housing shortage did indeed play a role as justification of the building of old people's homes, this was not the only reason. As Blijsterveld shows in her historical study of residential care in the Netherlands, the state was also committed to providing specialised accommodation for people who were in need due to their age and validity (Bijsterveld 1995: 177). There was a conviction that older people wanted to live independent from their children. An older people's home would provide them with both independence and the necessary care facilities. Such homes had to be available for people from all classes.

The state contributed to this aim by subsidising the building of care homes, which continued to be built and administered mostly by voluntary organisations which were linked to the different Catholic, Protestant, and secular pillars. Inhabitants were expected to pay for their own living costs, but could receive some contributions towards these costs when they had a low income. After repeated requests from Parliament, the new Social Assistance Act –

adopted in 1965 – required the state to contribute towards the costs of residential care in as far as the older person in question could not pay for it. At the same time the state, again at the instigation of Parliamentarians, started to regulate quality requirements in the 1963 'Law on old people's homes' (Wet of de Bejaardenoorden).

The pillarised nature of Dutch society initially contributed to the growth of the residential care sector, because every pillar wanted to provide its own care facilities in each neighbourhood (Baars and Knipscheer in Bijsterveld 1995: 189). De-pillarisation, subsequently, led to increased state involvement. Where pillarised organisations got into trouble, the state stepped in by providing ever higher subsidies (Alber 1995: 141). Gradually and silently, public responsibility expanded from 'reserve role to central position' (WRR 1988: 13)

With the Social Assistance Act of 1965 expenditures on social care had become an explicit burden for the state. In the same period, a national long-term care insurance (the AWBZ, Algemene Wet Bijzondere Ziektekosten) was introduced in 1968, to cover the costs of nursing homes and long stays in hospitals. As with the expansion of public responsibility for residential care, the main reason for the introduction of the AWBZ was the idea of solidarity and care for the weaker in society (SER 2008: 139). The social insurance covered long-term care costs for all Dutch citizens. A social insurance was deemed necessary because anyone could at a certain point be in need of such care, while the risks could hardly be insured privately.

With the silent expansion of public responsibility for both residential care and nursing homes, the government also got a stronger interest in containing the rapidly rising costs. It is in this context that we should understand why the state started to intervene with accession criteria. Initially older people's homes were mostly seen as alternative living arrangements, which did not provide many care services (WRR 2006: 116). The homes were open for all older people, need for care was not an important accession criteria (Kremer 2000: 35). In the late 1960s politicians and civil servants started to plead for reserving care home places for those who were really in need of care. In the 1970s – in a context of oil-crisis and economic constraints - the government therefore started to tighten admission criteria for residential homes, accepting only those people in need of long-term care (Kremer 2000: 35).

As a consequence, the need for home help and home care services started to grow. Home care providers could count on governmental subsidies because they would allow old people to stay at home longer. However, home care costs grew so rapidly that these, too, became a problem. One of the responses to these rising costs was the aim to de-professionalise

the sector by recruiting married housewives into the job. In 1977 the ‘alpha-help’ construction was introduced (Tweede Kamer, zitting 1976-1977, 14396, nr. 1). Alpha-help is a carer who enters into a direct contract with the client. When she worked less than 2 days or 12 hours a week, she was exempted from paying taxes and social insurance premiums as well as from being paid the minimum wage and unemployment benefits, illness benefits and pensions.

Child care: the primacy of maternal care

Historically daycare facilities for young children (e.g. ‘bewaarhuizen’) were, just as the homes for the elderly, available only for the poor. Contrary to elderly care, this situation did not change much after World War II (Zwier 1989: 14-18). As table 5 shows, in the post war decades day care centres (‘kinderdagverblijven’) remained rare. In 1960 there were only 30 day care centres in the whole of the Netherlands. The male breadwinner model, in which mothers were expected to stay home with their children, dominated Dutch society. Women’s labour market participation was among the lowest in Europe and the absence of public child care facilities was ‘understood as an important blessing for the welfare state’. (Bussemaker and Van Kersbergen 1994: 23).

In the 1960s' context of tight labour markets, some companies started to provide child care facilities for their employees. But: ‘public opinion was against the working mother and against daycare, so firms never openly advertised their daycare centres’ (Gustafsson 1994: 53). After the oil crisis of 1973 the centres disappeared again, and the total number of daycare centres in the Netherlands decreased from 150 in 1972 to 126 in 1980 (table 5).

Table 5: Child care in the Netherlands, number of playrooms, day care centres and other (such as guest parent) facilities, 1965-1980

	1965	1972	1980
Day-care centres	30	150	126
Playgroups	100	-	2933

Source: Tijdens and Houweling 1993: 15, 23

The only child care services that were developed for young children were linked to education. In the 1960s parents and women’s organisations initiated playgroups for parents, which were soon financed by the government and became very popular. As the table above shows, the number of playgroups increased from only 100 in 1965 to 2933 in 1980. These

playgroups provided services for only a few hours per day and aimed to give mothers some time of and to contribute to children's development. At the same time, pre-schools were opened for 4 and 5 year olds. These were seen as part of the educational system. Their growth could partly be attributed to the legal obligation of the state to open pre-primary and primary schools if parents requested it (Morgan 2006: 85).

How is it possible that in a time in which many other European countries - Sweden, Denmark, Belgium, France – developed provisions for young children that allowed their parents to participate in the labour market, nothing like that happened in the Netherlands? Many authors have pointed at the strength of Christian political parties in the Netherlands. The post-war Roman-Red coalition aimed at the 'restoration of the family' (Morgan 2006: 83), where the family should be seen as the male breadwinner model. The catholic principle of subsidiarity and the Protestant idea of 'sovereignty in one's circle' both prescribed that welfare should be provided at the lowest possible level of society, i.e. the family. The state should not interfere with family life. Although these ideas were common in many continental European societies, the Netherlands stood out because the country's prosperity allowed families to really live these ideals.

In fact, not only Christian democrats opposed publicly provided child care facilities. Social democrats that were active proponents of public daycare provision in other countries, remained silent or even opposed in the Netherlands. There was a broad consensus on the issue well into the '70s: 'Roman Catholics, Protestants, social democrats, and liberals […] all agreed that a stable and tranquil family life was the best guarantee for social prosperity' (Bussemaker 1998: 71). While women's interests in the child care debate were increasingly emphasised by feminist groups such as MVM ('Men, Woman, Society') and Dolle Mina ('Crazy Mina'), this hardly resonated in mainstream public or political discussions (Bussemaker 1998: 79). Even the Labour Party-led Red-Christian coalition of the Den Uyl did not favour child care expansion (Morgan 2006: 83). As a consequence, the Netherlands stayed among the laggards in Europe in terms of the availability of child care services well into the 1980s (see table in introduction).

3.2 Social care in times of austerity and liberalisation, 1977-2009

Elderly care: containing costs, expanding care

In the 1980s the concerns of growing costs of especially intramural care services continued to play an important role in the development of elderly care policy. The Christian-Liberal

government tried to increase control over residential homes by both centralising control and further tightening the needs and means test for social assistance payments. For example, from 1984 inhabitants of care homes had to pay their contributions no longer to the homes, but instead to local governments, which in turn subsidised the care homes. This way local governments would have better control of spending as well as of the means-testing of clients (WRR 1988: 18, 29). The attempts to discourage intramuralisation became successful in the late 1980s. As can be seen in table 4, the total number of those aged over 65 living in nursing or care homes decreased from 11.3 percent in 1985 to 6.8 percent in 2004. Extramuralisation increased demand for home help and home care services. Consequently, the state started to set national eligibility criteria for home help services and out of pocket payments in the same way (WRR 1988: 34).

The above described measures were about more than just cost containment. The Christian Democrat – Liberal coalition of the 1980s aimed to recreate a 'caring society in which individual responsibility would replace state dependency' (Rostgaard and Fridberg 1998: 291). Only when informal help (from family members) was not available, should public services be invoked (Kremer 2000: 42). This point proved to be a contentious issue, because allowing older people to live independently was found to be equally important, nor should the state prescribe what appropriate private care would consist of (WRR 2006: 131). In line with the ideology of private responsibility of the Christian – Liberal coalitions it was also attempted to encourage competition with private for profit providers. Some profit-making organisations were established, but after extensive protests from the non-profit organisations the number of profit-making organisations was frozen (Knijn 1998: 100).

The aim to control expenditures pushed the state gradually into tightening its control over more and more aspects of long-term care services. As a consequence, home care, home help and residential homes were all brought under the umbrella of the long-term care insurance (AWBZ)[2]. Therefore, the 1980s and early '90s in which individual responsibility and subsidiarity revived, also saw increasingly centralised control over elderly care services.
In the early 1990s, in a context of economic downturn, expenditures through the AWBZ were capped. The AWBZ functioned as a fixed budget, meaning that when all money was spent, people had to wait until the following year. Since demand for care services continued to increase, long waiting lists emerged for both home care and institutional care. Already in 1998 the second purple government committed itself to combating waiting lists, both in the

[2] Home care ('kruiswerk') was brought into the AWBZ already in 1980, followed by home help ('gezinsverzorging') in 1990 and care homes ('verzorgingshuizen') gradually between 1996 and 2001.

"cure" and in the "care" sector, for which it set aside substantial sums of money[3]. Later that year, in series of court rulings judges ruled that all AWBZ-insured citizens (i.e. all Dutch citizens) had the right to receive appropriate long term care[4] (Pijl and Ramakers 2007: 85). These rulings reinforced and intensified the efforts to combat waiting lists. The initiatives were quite successful, waiting lists decreased[5] and the volume of provided care services increased. The percentage of people aged over 65 receiving home care services increased from 17 percent in 1999 to 20 percent in 2005. Besides, on average clients received 163 hours of care in 2005, which is 34 hours more than six years earlier. This makes the coverage of home care services amongst the highest of Europe (see table ? in introduction).

The two purple governments were also committed towards developing a long-term care system that was more tailored towards the needs of individuals and that was demand-led instead of supply side oriented[6]. One of the things that fitted well with these ideas - and that was strongly promoted by the Disability Council ('Gehandicapten Raad') – was the introduction of Personal Budgets ('Persoonsgebonden Budget'). Such a budget consists of cash payments to the person in need of care, enabling the care recipient to choose what kind of care service he or she wants to purchase. After some first the Personal Budget was introduced for a selected group of AWBZ users in 1995. In 1997, due to pressure from 'clients and informal carers', it became allowed to employ spouses (Kremer 2006: 389). Until 2001 there was a fixed maximum state budget for Personal Budgets, which resulted in waiting lists (Kremer 2006: 389). In 2001 – in a context of combating waiting lists and encouraging demand led care - this restriction was lifted (Pijl and Ramakers 2007: 85).

The expansion of elderly care services enacted by the purple coalition in the late 1990s came at substantial costs. These costs were subsequently translated into higher social security contributions for the AWBZ, which rose from 9.6 percent of gross wages in 1998 to an astounding 13 percent in 2004[7]. In 2003 the new Christian-Democratic/Liberal government announced in its coalition agreement that measures had to be taken in order to prevent uncontrollable growth of the AWBZ. These measures included the tightening of eligibility criteria, higher out of pocket contributions, and 'in the most extreme case also the

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[3] VWS, Brief aan de Tweede Kamer der Staten Generaal, 'Meerjarenafspraken zorgsector', 1998, FEZ-U-981147, VWS, Persbericht, '1,6 Miljard voor aanpak wachtlijsten verpleging en verzorging en werkdruk; 6-7-1999

[4] See also the following newspaper articles: NRC, De Volkskrant, 'Werk wachtlijsten zorg weg met verhoging AWBZ-premie', 2-11-1999; 'Zorg afdwingen via een gerechtelijke procedure, 9-12-1999.

[5] VWS, Persbericht, 'Wachtlijsten verpleging en verzorging met 20% gedaald', 23-4-2001

[6] VWS, Persbericht, 'Kabinet volgt de vraag bij de AWBZ, 28-6-2000; VWS, Kamerstuk, 'Investeringen in de wachtlijstaanpak, 4-12-2000, PBO/2135028

[7] VWS, Brief aan de Tweede Kamer der Staten-Generaal, 2003, DBO-U-2412236

reintroduction of a budgetary ceiling for (parts of) the AWBZ' (Regering 2003: 8-9). The new government would indeed follow a different course. It reemphasised that: 'In principal, state responsibility ends literally at the front door'[8]. A problem with the existing system would be that informal help was too often and too easily replaced by an appeal to the public system. The share of responsibilities between state and citizen had to be redefined.

In 2004 co-payments for services were increased and eligibility criteria were tightened. Criteria were developed to assess which caring tasks could be expected to be provided by household members, so called 'common care' ('gebruikelijke zorg'). Professional help should only be provided for those care tasks that exceeded 'common care' (Morée 2006). In the same year, a budgetary cap on the AWBZ was re-introduced.[9]

Simultaneously, plans were made to remove home help services from the AWBZ and make it part of a social assistance programme administered by local governments. After a series of debates and amendments by both governing and opposition parties, the proposed reform became effective in the Social Support Act (WMO, Wet Maatschappelijke Ondersteuning). In the final parliamentary vote in 2006, the act received widespread support (140 out of 150 MPs).

Under the new WMO the responsibility for the provision of home help services is decentralised to local governments. People no longer have the right to receive domestic help. Instead governments have a 'compensation duty', which means that local governments have the duty to assist citizens who are not able to 'run a household' by themselves. What exactly this compensation duty contains, however, is not specified and can be interpreted by local governments. The WMO has increased marketisation and competition in the home care sector, because local governments have to organise tenders for home care providers according to European competition regulations. Local home care organisations compete against each other for the order. In the first round of tenders many providers offered services below their cost price. As a direct result many home care providers fired their personnel and then let them work as 'alpha-helpers', which essentially lack job-protection and social insurances.

[8] VWS, Brief aan de Tweede Kamer der Staten-Generaal, 2003, DBO-U-2412236
[9] VWS, Brief aan de Tweede Kamer der Staten-Generaal, Beheersing groei AWBZ/voorhang aanwijzing ex WTG, 2004, Z/P-2472134

Child care: sudden change

Although the demand for child care services increased, and daycare centres were increasingly initiated privately, the neo-conservative Christian-Liberal governments of the 1980s had initially no intention of expanding public care provision (Heite and Reinders 1996: 1465). The appropriate place to raise a child was and should remain the family. The Christian-Liberals, however, tended towards a social-liberal position in the second part of the 1980s. Within the view, child care was seen as a potential economic gain, because it could increase women's labour market participation (Bussemaker 1998: 86). This view made public contributions towards care services acceptable.

The final turnaround occurred in 1990 when the WRR published a report in which child care as precondition of women's labour market participation was recognised. (Bussemaker 1998: 87). In 1990 the Christian-social democratic government introduced a temporary stimulation measure for child care and funds were made available for child care expansion. The national budget for child care tripled. Municipalities were responsible for setting up and subsidizing day-care centres, while companies were stimulated, through subsidies and tax relief, to provide child care for their employees. It was the aim of the government to let employers, parents and the state each equally contribute to the costs of child care (Gustafsson 1994: 56). Employers were free to decide whether they wanted to contribute or not until 2007 when it finally became mandatory. The stimulation measure became a success and was extended several times. As can be seen in table 6, the number of young children attending day care centres increased from 5.7 percent in 1990 to 25.9 percent in 2006.

Table 6: Percentage of children 0-3 years old in formal day care

	1990	1996	2000	2004	2006
Day care centres (kinderdagverblijven)	5,7	13,1	20,2	24,9	25,9
Guest parents	0,1	0,7	0,9	0,9	1,4

Source: (SCP 2009: 131-2)

Until 2005 the only legal regulations governing child care were part of the Social Assistance Act (Welzijnswet). In the coalition agreement of 1998 the Dutch government declaimed its intention to come to a new comprehensive law on child care (Regering 1998: 10, 24). There

was a strong consensus among the coalition partners (PvdA, VVD, D66) that there was the need for a (new) law, but there was disagreement about the exact terms and conditions, especially about how child care should be regulated and financed. While the Labour Party favoured some kind of basic provision for all children, financed through collective means and organised by local governments, the other coalition partners as well as important actors in the sector[10] favoured a demand led-system, in which parents would receive subsidies directly and were free to choose which form of (market-provided) child care they preferred. Eventually, agreement was reached on a demand-led system, but just before the law could be passed, the government fell. Therefore, the final decision was postponed and had to be taken by a Christian Democrats / Liberals government. This brought the Christian Democrats – traditionally critical of public child care provision – in the position to change or even reject the Child care Law, but this never happened, because the party was in favour of the demand-led system and generally agreed that a new law on child care was necessary.

The law radically reformed the Dutch child care system. Subsidies no longer go through local governments to day care centres, but are transferred directly to the parents, who can choose between a daycare setting or a guest parent. Initially, employers were expected to contribute to the costs of child care on a voluntary base. Although most employers contributed to their employees' child care arrangements, the government nevertheless made these contributions mandatory in 2007. They are now paid through taxation to the government. Making employers' contributions mandatory was a political choice motivated by a will to simplify the system for parents.

In the same years state subsidies were also increased meaning that parents on average had to pay for only 19 percent of real child care costs. The additional 81 percent of costs was refunded by the state. The actual amount of the costs parents can get refunded depends on their income, but even high-income families can count on a substantial subsidy (33 percent of the costs for the first child and 90 percent of the costs for the second). The use of child care has increased substantially as a consequence of the new arrangements. The number of children in daycare centres increased from 250,000 to almost 300,000 in just a year time. Even more explosive was the growth of the use of registered 'guestparent', which were eligible for the same amount of funding as daycare centres, making them an attractive alternative for many parents. These very quick developments made coverage rates in Dutch child care suddenly among the highest in Europe (see table in introduction). It should be

[10] The parents' organisation BOINK as well as all big providers of child care services

remarked, however, that contrary to many other countries, Dutch children mostly attend daycare on a part-time basis.

The success of the new child care arrangements was so big, that in 2008 concerns were raised about the costs and effectiveness of the law. In spring 2008 Prime-minister Balkenende announced that it was ‘doubted whether more people will start to work when more money is invested in child care’[11]. Soon after that Finance Minister Bos, announced that restrictions of the child care subsidy were necessary. Consequently, in autumn 2008 public child care subsidies were lowered, but only marginally.

The main concern about the child care law regarded the massive increase in usage of guest parent subsidies. It was found that the system was abused to pay grandmothers (the ‘op-pas oma’) who would have looked after their grandchildren anyway, with or without a subsidy. In 2009 it was decided to end public subsidies for informal guest parents. Only ‘mini-crèches’, in which a childminder takes care of several children, is still eligible for public subsidies, but only if they fulfil certain quality criteria.

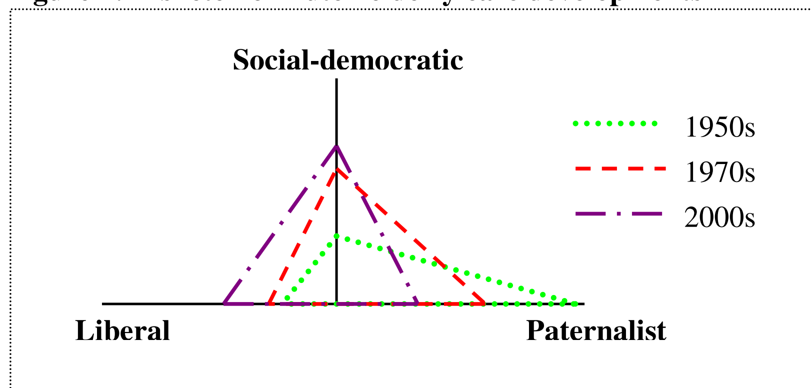
4 COMPARING DEVELOPMENTS IN CHILD AND ELDERLY CARE: EXPLANATORY FACTORS

Figure 2 and 3 sketch the development of child and elderly care regimes in the Netherlands. As follows from the great similarities between figure 1 displaying the development of the Dutch welfare state in general and figure 2 showing elderly care specifically, developments in elderly care strongly resemble general developments. In the 1950s, elderly care was still organized according to paternalistic principles. The different pillars took responsibility for the provision of elderly care services, the state only played a residual – financial – role. By the 1970s, state involvement had increased substantially. A social insurance for long term care (AWBZ) had been established and would be gradually expanded in subsequent years. The state increased its control over financing and eligibility criteria for residential and home care. Paternalism remained visible in the importance of voluntary organisations administering care homes and home care providers and in recurrent discussions about the appropriate role of the family. In the 2000s the long term care insurance covered most areas of long-term care and a high percentage of the Dutch elderly population used publicly financed long-term care servi-

[11] De Volkskrant, Kabinet snijdt in kinderopvang, 26 april 2008

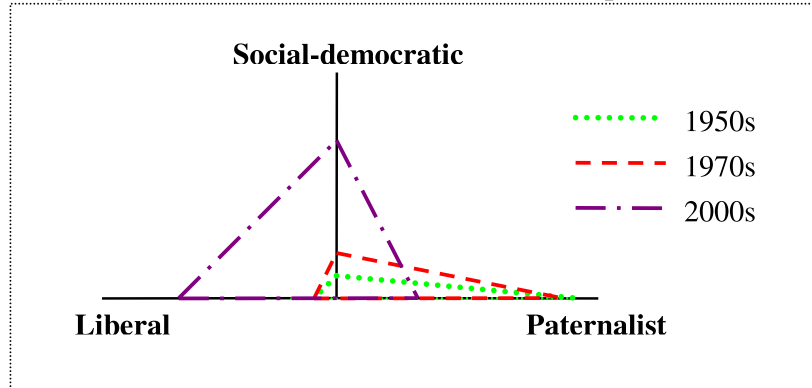
ces. At the same time, the market had started to play a more important role, especially after the introduction of the WMO.

Figure 2: A sketch of Dutch elderly care developments



As figure 3 shows, developments in child care have differed from elderly care and more general welfare state developments. It remained based on paternalist principles for much longer. While the Dutch welfare state became more social democratic in the 1970s, this was not the case for child care. The paternalist idea of a breadwinner-housewife family, in which the mother had to take care of her children, continued to dominate policy making well into the '80s. It was only in the 1990s that state responsibility suddenly surged, in combination with a strongly marketized mode of service provision. As a consequence by the late 2000s, the organization of child care had changed radically, making it more similar to the situation in the Dutch welfare state in general. Characteristics of the social-democratic type were present in generous public subsidies for social services, while the market logic underlying care provision approached the liberal ideal type. Paternalism remained present in the subsidiarity of childcare services, which continued to be only available for the families that needed it because both parents were working or studying.

Figure 3: A sketch of Dutch child care developments



How can we explain the developments in child and elderly care, and why were they so different? The first important puzzle to be solved is why public responsibility for elderly care services developed so quickly in the post-war decade while the state kept is hands far from child care provision. As discussed in section 3.1, the functional logic that scholars proposed as explanation of the quick growth of elderly care homes is only part of the story. It was also an explicit political goal to provide services for older people. It was a broadly shared idea that older people should be enabled to live independently (Bijsterveld 1995), just as they deserved a minimum income. While Social Democrats and Catholics laid the basis for these welfare provisions, Protestants and Liberals did little to oppose them (Becker 2000: 223). At the same time, there was an equally widely shared idea that children should be looked after by their mothers at home (Bussemaker 1998). An explanation for the difference between child care and elderly care can therefore not primarily be found in political preferences and power relations, but is related to different ideas regarding the appropriate form of care for children and the elderly – ideas possibly related to culture understood as patterns of interaction considered 'normal'.

In the post-war decades, residential care services were expanded rapidly also in the United Kingdom (Baldock 2003; Means and Smith 1998), Denmark and Sweden (Rostgaard and Fridberg 1998). In Germany attention for elderly care was less (Evers and Sachsse 2003: 69). In Italy and the other Mediterranean countries elderly care would remain confined to the family for a much longer time (Fargion 2000; Naldini 2003). This cross country variation is not entirely surprising. Historical research (Reher 1998; Smith 1984) has shown that the elderly in North-western Europe (UK, Netherlands, Denmark, Sweden) have for centuries lived more independent from their children than the elderly in Southern Europe (Spain, Portugal, Italy). Poor laws and denominational organisations have contributed to older people's well be-

ing much more in these northern European societies that, obviously, earlier started to individualize. It is therefore not unlikely that these pre-existing cultural patterns have affected post-war policy making. In a country such as the Netherlands where the welfare state was mostly paternalist and passively maintained existing social stratifications, such prior patterns became easily entrenched in social policies.

In the post-war decades elderly care developed in line with general welfare state developments. Expansion continued well into the '70s, facilitated by economic growth and gas-reserves. In the 1980s, when there was a general neo-liberal backlash against welfare state expansion, it was attempted to limit expenses on elderly care. This consisted primarily of discouraging residential care and offering home care services instead. By that time, however, the right to receive care was already firmly established, and retrenchment was marginal. This right to receive care services led to a series of court rulings in the late 1990s which forced the government to expand investments in elderly care further. Once institutionalised, it proved to be difficult to retrench public involvement in elderly care.

Child care, on the contrary, continued to be hardly developed well into the 1980s. Then, around 1990, a turnaround occurred and the availability of formal child care services grew exponentially in the subsequent decade, more rapidly than in any other European country. This brings us to the second important puzzle to be resolved. Why could childcare expand so suddenly in a society in which until that time there was hardly any political support for formal child care services? The only reason why child care could expand so rapidly was the expected correlation between child care services and women's employment. It was argued that investments in child care services would be beneficial for employment levels and would therefore lead to economic growth. This idea resonated with general concerns about European welfare states being to passive, encouraging people to stay at home. Child care was presented as an activation measure and as such it gained the political support that feminists could previously never find. Not only Social Democrats, but also Liberals became strong proponents of expansion of publicly provided child care. Although Christian Democrats remained sceptical, they did never oppose the expansion.

Because of their different origins, in the Netherlands elderly care is seen as a costly social service for dependent people, while child care is perceived to be an economically beneficial social investment. This difference has consequences for current policy developments. In the debate surrounding increasingly expansive elderly care, family care ('mantelzorg') is encouraged as a potential solution. That such family care will mostly be provided by women who might have to quit their paid job is hardly recognised. No attention goes to the apparent

contradiction between pulling women out of the labour force to care for their older family members, while encouraging them to stay in the labour force when they have young children. This contradiction is a direct consequence of the different policy legacies in the two fields, which legitimate retrenchment in the field of elderly care, while it encourages expansion of child care services.

5 CONCLUSION

The comparison of developments in child and elderly care policies presented in this paper has shown that child care rather than elderly care has been the outlier in comparison with general developments of the Dutch welfare state. Power resources played a role only at the margins of policy making in the two fields. When the Social Democrats were in power, public provision was usually expanded, while Christian Democrats reemphasised family responsibility and Liberals encouraged marketization of care services. Because these different political parties were always united in a variety of coalition governments, they never managed to simply push through their preferences and as a consequence reforms have been modest.

The big differences between child and elderly care cannot be explained by changes in political alliances. Instead, the reason why elderly care could develop after WWII and child care could not is cultural. It is related to pre-existing societal patterns, which were simply incorporated by the passive Dutch welfare state. The very strong ideal of a breadwinner-housewife family inhibited any public investment in child care, while this never regarded elderly care. Only when the Dutch welfare state became more geared to activation, and when child care was cleverly linked to this economic discourse, could childcare expand.

REFERENCES

Alber, Jens. 1995. "A framework for the comparative study of social services." *Journal of European Social Policy* 5: 131-149.

Anttonen, A., J. Baldock, and J. Sipilä, eds. 2003. *The Young, the Old and the State. Social Care Systems in Five Industrial Nations*. Cheltenham: Edward Elgar Publishing Ltd.

Baldock, John. 2003. "Social care in the United Kingdom: A pattern of discretionary social administration." in *The Young, the Old and the State. Social Care Systems in Five Industrial Nations*, edited by Anneli Anttonen, John Baldock and Jorma Sipilä. Cheltenham: Edward Elgar.

Becker, Uwe. 2000. "Welfare state developments in the Netherlands in comparative perspective." *Journal of European Social Policy* 10: 219-239.

Bijsterveld, Karin. 1995. *Geen kwestie van leeftijd.Verzorgingsstaat, wetenschap en discussies rond ouderen in Nederland, 1945-1982.* Amsterdam: Van Gennep.

Bussemaker, Jet. 1998. "Rationales of care in contemporary welfare stated: The case of childcare in the Netherlands." *Social Politics* Spring: 70-96.

Bussemaker, Jet, and Kees Van Kersbergen. 1994. "Gender and welfare states: some theoretical reflections." in *Gendering Welfare States*, edited by Diane Sainsbury. London: Sage publications.

CBS. 2006. "Gezondheid en zorg in cijfers 2006." Voorburg: Centraal Bureau voor de Statistiek.

Dogan, Mattei, and Dominique Pelassy. 1990. *How to Compare Nations: Strategies in Comparative Politics.* Chatham: Chatham House.

Esping-Andersen, Gøsta. 1990. *The three worlds of welfare capitalism*. Cambridge: Polity Press.

—. 1999. *Social foundations of postindustrial economies*. Oxford: Oxford University Press.

Evers, Adalbert, and Christoph Sachsse. 2003. "Social care services for children and older people in Germany: Distinct and separate histories." in *The Young, the Old and the State. Social Care Systems in Five Industrial Nations*, edited by Anneli Anttonen, John Baldock and Jorma Sipilä. Cheltenham: Edward Elgar.

Fargion, Valeria. 2000. "Timing and the development of social care services in Europe." *West European Politics* 32: 59-88.

Gustafsson, Siv. 1994. "Childcare and types of welfare states." in *Gendering welfare states*, edited by Diane Sainsbury. London: Sage publications.

Heite, D, and T Reinders. 1996. "Beleid inzake kinderopvang geordend." *PS* 23.

Kamerman, Sheila B., and Alfred J. Kahn, eds. 1991. *Childcare, Parental Leave and the Under 3s: Policy Innovation in Europe*. New York: Greenwood Publishing Group.

Knijn, Trudie. 1998. "Social care in the Netherlands." Pp. 85-110 in *Gender, Social Care and Welfare State Restructuring*, edited by Jane Lewis. Aldershot: Ashgate.

Knijn, Trudie, and Monique Kremer. 1997. "Gender and the caring dimension of welfare states: toward inclusive citizenship." *Social Politics: International Studies in Gender, State and Society*: 328-361.

Korpi, Walter. 1983. *The Democratic Class Struggle*. London: Routledge.

Kremer, Monique. 2000. *Geven en Claimen. Burgerschap en informele zorg in Europees perspectief.* Utrecht: NIZW.

—. 2006. "Consumers in charge of care: the Dutch personal budget and its impact on the market, professionals and the family." *European Societies* 8: 385-401.

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

Lister, Ruth. 1997. *Citizenship: Feminist Perspectives*. Macmillan: New York.

Means, R, and R Smith. 1998. *From Poor Law to Community Care: The Development of Services for Elderly People*. Bristol: Policy Press.

Morée, Marjolein. 2006. "Combining work and long-term care in the Netherlands." in *International Federation on Ageing, 8th Global Conference*. Copenhagen, 30 May - 2 June.

Morel, Nathalie. 2006. "Providing coverage against new social risks in Bismarckian welfare states. The case of long term care." Pp. 227-247 in *The politics of Post-Industrial Welfare States*, edited by Klaus Armingeon and Giuliano Bonoli. London and New York: Routledge.

Morgan, Kimberly. 2006. *Working Mothers and the Welfare State. Religion and the politics of work-family policies in western Europe and the United States*. Stanford: Stanford University Press.

Myles, John, and Jill Quadagno. 2002. "Political theories of the welfare state." *Social Service Review* 76: 34-57.

Naldini, Manuela. 2003. *The family in the Mediterranean welfare states / Manuela Naldini*. London ; Portland,: Frank Cass.

OECD. 2007. "Babies and Bosses, Reconciling Work and Family Life: A synthesis fo findings for OECD Countries." Paris: Organisation for Economic Cooperation and Development.

—. 2009. "Society at a Glance 2009." edited by OECD Social Indicators. Paris: Organisation for Economic Cooperation and Development.

Peng, Ito. 2002. "Social care in crisis: Gender, demography, and welfare state restructuring in Japan." *Social Politics* 2002: 411- 443.

Pierson, Paul. 1996. "The new politics of the welfare state." *World Politics* 48: 143-179.

Pijl, Marja, and Clarie Ramakers. 2007. "Contracting one's family members: the Dutch care allowance." in *Cash for Care in Developed Welfare States*, edited by Clare Ungerson and Sue Yeandle. Houndsmill: Palgrave Macmillan.

Ranci, Costanzo, and Emmanuele Pavolini. 2008. "Crisis and transformation of the Italian care model: beyond familialism?" in *Conference: Transforming care*. Copenhagen, 26-28 June.

Regering. 1998. "Regeerakkoord." Den Haag.

—. 2003. "Meedoen, meer werk, minder regels. Hoofdlijnenakkoord voor het Kabinet CDA, VVD, D66." Den Haag.

Reher, David Sven. 1998. "Family ties in Western Europe: Persistent contrasts." *Population and Development Review* 24: 203-234.

Rostgaard, Tine, and Torben Fridberg. 1998. "Caring for Children and Older People - A Comparison of European policies and practices." in *Social Security in Europe*. Kopenhagen: The Danish National Institute of Social Research.

SCP. 2009. "Emancipatiemonitor 2008." Den Haag: Sociaal en Cultureel Planbureau.

SER. 2008. "Advies. Langdurige zorg verzekerd: Over de toekomst van de AWBZ." Den Haag: Sociaal-Economischie Raad.

Smith, Richard M. 1984. "The structured dependence of the elderly as a recent development: Some sceptical thoughts." *Ageing and Society* 4: 409-428.

Tietze, Wolfgang, and Debby Cryer. 1999. "Current trends in European early child care and education." *ANNALS, AAPSS* 563: 175-193.

Tilly, Charles. 1984. *Big Structures, Large Processes, Huge Comparisons*: Russell Sage Foundation.

van Kersbergen, Kees. 2009. "Religion and the welfare state in the Netherlands." Pp. 119-145 in *Religion, Class Coalitions, and Welfare States*, edited by Kees van Kersbergen and Philip Manow. Cambridge: Cambridge University Press.

van Kersbergen, Kees, and Uwe Becker. 1988. "Social Democratic Welfare State in a Christian Democratic Ruled Society." *Journal of Social Policy* 17: 477-499.

—. 1989. "?" *?*

Wilensky, Harold. 1975. *The welfare state and equality. Structural and ideological roots of public expenditures*. Berkeley: University of California Press.

WRR. 1988. "Ordening en sturing in de ouderenzorg." 's-Gravenhagen: Staatsuitgeverij.

—. 2006. *De verzorgingsstaat herwogen. Over verzorgen, verzekeren, verheffen en verbinden.* Amsterdam: Amsterdam University Press.

Zwier, B. 1989. "Schets van de ontwikkeling van de kinderopvang in Nederland." in *Kinderopvang*, edited by B Zwier and E Mostert. 's-Gravenhagen: VUGA Uitgeverij.