

CONSUMERS IN CHARGE OF CARE: THE DUTCH PERSONAL BUDGET AND ITS IMPACT ON THE MARKET, PROFESSIONALS AND THE FAMILY

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ABSTRACT: One of the icons of the Dutch welfare state reforms is the Personal Budget. With the introduction of this budget, care patients now have become consumers. They can manage their own budget and employ a care worker who cares according to the cared-for's wishes. The Personal Budget intends to create a market of care, as well as a shift of balance of power from professionals to care receivers. In practice, the market has not come yet. Instead, the majority of budget holders employ a family member. This is important as it gives recognition to informal carers. On the other hand, this may hamper the employment career of people with care responsibilities as they are likely to be constrained in their care relationship. Another caveat is that the Personal Budget undermines the professionalisation process of care workers. When consumers are in charge, care workers are no longer the custodians of their professional development. This may have unwelcome consequences for the quality of care in the long term.

Key words: care; professionalism; consumerism; informal care; market; family

1. The empowerment of consumers: the Dutch Personal Budget

All over Europe, patients have entered the driver's seat. Rather than services, patients can now opt for cash and spend that money on the direct employment of carers who deliver this care in their own home. In Britain, this system is called Direct Payments, in France, *Prestation Specifique Dependance* (PSD), *Pflegegeld* in Austria and Germany, and in the Netherlands it is called *Persoonsgebonden Budget* (PGB), Personal Budget. In place since 1995, the Dutch scheme is not only very regulated compared with other European schemes – strict rules apply – but also

allows care users to employ family members. A daughter who cares for her frail father can now receive a wage paid to her bank account and a pay slip from the national Social Insurance Bank (SVB). Patients are generally very content with the budget and the number of ‘budget holders’, as they are called, increases every year. While in 1996 only 5400 clients managed their own budget, this increased more than tenfold to 65,000 in 2003 (SVB 2004).

The Personal Budget can be considered as one of the major innovations of the Dutch welfare state. Initiated by the patients’ movement, and strongly supported by both the political left and right, the Personal Budget aims to strengthen patients as *consumers*. The Personal Budget gives them autonomy – especially in relation to professionals. With their own budget in their pockets, they ‘own’ the definition of good care. The Personal Budget recognises that clients – rather than professionals – should have the last word on how, when and under what conditions care should be given. In addition to autonomy and empowerment, the Personal Budget should also increase competition between providers, increase efficiency and improve the quality of care. As patients are now given the possibility to exit, they have a crowbar to break through and open up what is seen as highly bureaucratic, impersonal and supply-side-oriented care services.

This article questions what the Personal Budget has brought us so far. Did it really stir the welfare diamond of markets, professionals, state and clients? Did it really introduce the market of care? And what are the consequences for caregivers – professionals as well as family members? Have caregivers indeed lost power? What are the consequences of this policy change for the quality of care? Before moving to the consequences of the Personal Budget for the market, professionals and informal carers, I discuss the background to the Dutch Personal Budget. I finish by presenting the trilemma of consumer power.

2. The answer is free choice: a short history of the Personal Budget

The concept of free choice has become a powerful concept in Dutch care politics and policies. Part of its success lies in bringing together the patients’ movement and the Liberal left on the one hand, and neo-liberalism on the other hand. The Personal Budget originated in the disability movement. Inspired by the American Independent Living Movement, the Dutch Council for Handicapped People (*Gehandicapten-raad*) published a report in 1988 in which it proposed the introduction of a ‘client budget’. It signalled many organisational problems within the care system, such as the lack of transparency, high turnover of care workers, no flexibility in working times, the impersonal character of care and the lack

of time. By granting disabled people their own budget they could shop in the care market and buy the services they wanted (Ramakers 1998; Munk 2002). This appeal of the Council for Handicapped People is part of a larger democratisation movement, pleading for more client autonomy and a stronger voice. In the Netherlands, more than in other European countries, patients' movements – which include the disability movement – have grown substantially from the 1980s onwards, and with more than one million members it is very large and well organised (SCP 2002). The underlying idea is that patients should – at the very least – have the same rights as everyone else, including the able bodies. Patients should be able to decide about their own lives too.

The Personal Budget should be seen as part of the informed decision-making model rather than the Parsonian model (1964, 1968) in which professionals and patients have separate roles: the client listens to the all-knowing expert. In the informed model, in contrast, patients not only have the moral right to decide the services they need but as well-informed people they are also capable of making choices about care. In that sense, the Personal Budget was not only the answer to the discontent with bureaucracy but also rejected the dominance of care professionals (Ramakers 1998). Anti-professional sentiments were widespread in Europe at the end of the 1970s and 1980s. Foucault and Illich pointed to the disciplinary power of professionals, and the Netherlands also had its own critics. The philosopher Hans Achterhuis (1980), for instance, argued that welfare professionals were not solving or diminishing social problems but were creating a new market: 'The Market of Welfare and Happiness' was the title of his book. According to Achterhuis, professionals were more interested in keeping their jobs than sorting out patients' problems. This assault received unexpected support from the workers in the field, because they were themselves dissatisfied with the anti-democratic care and welfare practices. This self-criticism undermined their own position (Duyvendak 1997). The history of the Personal Budget should thus also be seen in this context: care professionals are thought to exercise too much control. They have too much power to decide how care is given. Indeed, when the Personal Budget was introduced in 1995 the right-wing Liberal Secretary of State, Erica Terpstra, said: 'A personal budget makes handicapped people less dependent on professionals' (in Munk 2002: 11).

Democratisation, empowerment and autonomy of patients have been the keywords since the 1970s. What is new is that these wishes are now believed to be fulfilled in a market of care. Patients should therefore become not only citizens but also consumers. As citizens, patients get a stronger voice in both care politics and the organisation of care: they are stimulated to use – in Hirschman's (1970) terms – their voice. As

consumers, patients receive money to be able to have an exit option: they are stimulated to leave the existing care services (Tonkens 2003; Kremer and Tonkens 2006). The Personal Budget system is fully coloured by the language of the market, which was very dominant in the Netherlands in the 1990s. One explanation is that until the beginning of the 1980, the Dutch welfare state was based on a system of pillarisation in which denominational parties – Liberals, Social Democrats, Protestants and Catholics – tried to reach consensus. The pillars were the organisational principle of society. The health care system as well as the media and welfare organisations were organised along these lines. From the 1970s onwards these pillars were instrumental in their own demise in that they became completely dependent on large state subsidies. The welfare *society* became a welfare *state* (van Doorn 1978). In addition, owing to processes of democratisation and secularisation, this social and political system of pillarisation underwent erosion, leaving only an ideological vacuum. To fill this political gap the Netherlands borrowed the neo-liberal language which was popular under Reagan in the United States and Thatcher in Britain. Citizens thus became consumers and faith in God became faith in the market (Duyvendak 1997).

In the domain of care, the market discourse was introduced in 1987 in the report of the Commission that Dekker entitled '*Bereidheid tot verandering*' (Willing to Change). This Commission, led by the president of Philips – the Dutch multinational – was appointed by the Dutch government and made an authoritative plea for cost control and efficiency. More competition between providers and insurance companies would lead to tailor-made services which would increase both efficiency and the quality of care. The Dekker report stresses the importance of consumers. Firstly, consumers should be stimulated to substitute expensive care for less expensive care – if people have insight into the costs of care perhaps they would be more careful with using professional care. But consumers should also be an important pressure group, pressing insurances and providers to offer what they need. The possibility of the Personal Budget was also mentioned, again in order to increase competition between insurance companies (Ramakers 1998; Munk 2002).

In 1991, the first experiments took place in which a limited number of chronically ill or handicapped patients were allowed to manage their own care budget. The evaluation was very positive: clients were very content with the care they could buy and the financial benefits were significant, especially through the loss of overheads. In 1995, the Personal Budget was institutionalised – at least for those in need of care for three months or more. The first budgets were granted to specific categories of clients, such as those needing home help and nursing (VV) and mentally retarded clients (VG). Later, budgets could also be used by other categories of

clients, such as for handicapped children. In 1997, as a result of pressure from clients and informal carers, it became possible to employ one's own husband or wife, which has had rather unintended consequences for family care. At its introduction, the Personal Budget was never intended to pay for family care, but, as we will see below, this has become standard practice.

Until 2001 a set maximum of money was spent every year on the budgets. When the yearly maximum was reached, no more clients could opt for it, resulting in huge waiting lists. But from 2001 onwards, investments in home care took place. Under pressure of public opinion, the second Purple coalition (Liberals and Social Democrats) focused on waiting list reduction and invested substantially in elderly care (VWS 2002). Consequently, the spending ceiling was removed and in 2003 the bureaucratic procedures for budget holders were changed, resulting in less bureaucratic control. Patients can decide themselves whether they opt for a Personal Budget or use regular care. Table 1 shows how the number of budget holders expanded over the years. While in 1996 more than 5000 clients had their own budget, this increased to nearly 70,000 in 2004. This is more than 10 times as many as in the mid-1990s. Strikingly, there are few educational or other differences between the users of the budget and those who receive regular services. Budget users only tend to be slightly younger (but still 67 years on average for care and nursing) (Ramakers 1998; TK 2004–2005)

The Dutch Personal Budget is thus the icon of turbulent shifts in care policy; it is part of a 'regime change'. The Personal Budget is intended to transform the relations and positions of the market, the state, professionals, the family and care users. In the following sections I will analyse how far these changes go. Are clients really empowered as consumers? And what are the consequences for professionals and informal carers? Have they lost power and, if so, is that a problem?

TABLE 1. Number of budget holders, 1996–2003

	1996	1998	2000	2002	2003	2004
VV/care	4000	7118	16,282	34,544		
VG/mentally retarded	1400	3101	6195	11,197		
GG/psychologically retarded	1	125	141	2203		
LG/physically disabled	0	0	0	95		
Total	5401	10,410	22,618	48,039	65,015	69,500 ^a

^aEstimation (TK 2004–2005).

Source: Ministerie van VWS, *Persoonsgebonden Budgetten*, Tweede Kamer, vergaderjaar 2002–2003 25657 (2).

3. Free choice in a market that did not come

Can Dutch clients really act as consumers in the care market? Firstly, the impact of the Personal Budget should be put into perspective. The money spent on all Personal Budgets is much less than on all public services, as shown in Table 2. If we look at the most used type of budget – for nursing and home help – this absorbed only 3 per cent of the total budget for this kind of care in 1999 and 8 per cent in 2002 (van den Berg and Schut 2003). In 2004, the number of all budget holders was about 10 per cent of all care users while the budget was only about 4.5 per cent (TK 2004–2005). In other words, compared to the massive flows of money that go into the regular care system, the PGB seems to be a needle prick rather than a crowbar. Most patients opt for the regular system. Having said that, the symbolic significance of the Personal Budget is much greater than the financial picture suggests. Since client organisations, politicians, managers and bureaucrats believe that the Personal Budget has far-reaching consequences for the welfare mix of family, market and state, the impact is real in its consequences.

Indeed, when people opt for the Personal Budget, regular home care organisations are likely to lose patients. Research shows that only 30 per cent of budget holders buy nursing in regular organisations and 20 per cent buy regular home help. This means a significant loss of clientele for the regular services (Ramakers 1998). However, it should be noted that there is a difference between nursing and home care. Less professionalised help such as home care is more likely to be bought in the market. For nursing, budget holders tend to turn to regular organisations. It seems that patients in need of specialised care trust regular care much more, and professional nurses are more difficult to find outside the regular scheme.

It is by no means easy to find the right help, as the care market is not extensive. One indication is that at the end of the 1990s, 30 per cent of the allocated budgets had not been used, although this percentage has decreased by half more recently (TK 2004–2005). Sometimes the under-spending occurs because the budget holder has been admitted to

TABLE 2. State expenditure on care, 2002–2007 (€ million)

	2002	2003	2007 (est.)
Nursing homes	4190.7	4291.5	4605.9
Residential homes	3180.7	3211.2	3211.7
Home care	2076.0	2082.2	2096.4
Personal budget (care and nursing)	212.2	212.2	212.2

Source: VWS, *Zorgnota* 2003.

hospital or temporarily needs less help, but some of the clients of the personal budget have problems finding help (Ramakers *et al.* 1999), especially with finding help which is cheap enough for them to afford, although the average PGB in 2001/2002 was €1308 a month for 65.5 hours per month (van den Berg and Schut 2003), which is quite substantial in a European context (see Ungerson 2004). Budget holders are waiting for a market that has not come yet. Most home care organisations still have monopolies in the regions and small providers hardly exist. Ironically, since the introduction of market incentives, providers have undertaken many mergers, thereby reducing choice for consumers (RVZ 2003). Consequently, budget holders are dependent on individual professionals who have left the regular system. In some regions, budget holders are not even allowed to buy home help in provider organisations as it is too complicated and they have to invest too much in the budget holder and cannot come to the right care agreement (Ramakers *et al.* 1999).

Another reason why the market has not come yet is that the system is very bureaucratic, although things changed slightly in 2003. Successive Dutch governments have been afraid to introduce a real market of care. Parliamentary debates often centred on the accountability of clients: they would either misuse the system or would be incapable of behaving as rational consumers. Moreover, principles of fairness and equality were still dominant in the Dutch welfare state debate. Therefore, the Personal Budget is granted to clients only under strict conditions, especially in the sphere of accountability. About 10 organisations are involved in providing the PGB – among them the Regional Assessment Commission (RIO), which decides how many hours of which type of care are necessary, the Social Insurance Office (SVB), which organises the money flows, the Care Offices, the Treasury, etc. An organisation for budget holders has been set up – Per Saldo – which has become a huge success with 15,000 members. It helps budget holders with questions they may have. In addition, the bureaucracy is so complex that a completely new profession has come into being: care consultants (*zorgconsulenten*). They are paid by the state to guide the budget holder. Recent research shows that one-third of the budget holders have outsourced all bureaucratic procedures, such as paying the caregiver, keeping in touch with the tax office and informing the National Insurance Office (van den Wijngaart and Ramakers 2004).

While the Personal Budget was intended to increase the independence of patients from professionals, consumers are now dependent on a new type of professional. In addition, installing such bureaucratic logic in what

is supposed to be a market has put many clients off: they do not want such a bureaucratic Personal Budget (Ramakers *et al.* 1999). These are the consequences of a state that wanted a market of care but at the same time introduced control. Besides, care providers did not behave in a market-like manner, so few alternatives for care arose. Consumers have little to choose from.

4. Empowerment of the client, disempowerment of the professional?

Another important motive behind the introduction of the Personal Budget was to change the power relationship between the client and the professional. With money in their pockets, patients would gain autonomy. The hope was that the market would bring them what the democratisation of the 1970s did not: the right to shape their own lives (Tonkens 2003). Clients who chose the Personal Budget were indeed very dissatisfied with regular home care. They complained about the continuous turnover of personnel and the inflexibility of working hours. Managing their own budget would grant them independence.

Indeed, budget holders are generally very content with the care they receive. Recent statistics even note that 95 per cent of budget holders say that the care they buy is of (very) good quality (van den Wijngaart and Ramakers 2004). At the same time, the recipients of regular public care are also very content with the quality of care. The main difference between budget holders and regular care recipients is that the former feel they have a real voice in what kind of help is given, who comes to help, and at what time (Ramakers 1998). For budget holders this is the main improvement. In that sense, patients 'won'. The question now is whether caregivers have 'lost'. In other words, does the empowerment of clients lead to the disempowerment of formal caregivers? If so, why would that be a problem?

Eliot Freidson (2001) – one of the first scholars to criticise professional power in the 1970s – has more recently expressed worries about how professional logic has been undermined by bureaucratic logic and market logic. He describes professional logic as a secular calling; professionals do not work for money *per se* but want to do all they can for the client, but based on their own vision, standards and education. Professionals distinguish themselves from managers and laypeople (now: consumers) because of their specialised knowledge, training, inter-professional regulation and their need or urge for a continuous development of knowledge. Professionals need freedom of judgement or discretion in performing their work, but they are increasingly undermined by

bureaucracy and the market of consumers. Professional logic has lost because of market logic and bureaucratic logic.

Freidson is less worried about the status of professionals or their working conditions – he does not have to worry, as his main points of reference are doctors and lawyers. Freidson's main concern is the erosion of morality, or in other words the reduction of the institutional ethics of professionalism. 'What is at risk today, and likely to be a greater risk tomorrow, is the independence of professions to choose the direction of the development of their knowledge and the uses to which it is put', he writes (Freidson 2001: 14). Professionals have a claim of licence to balance the public good against the needs and demands of the immediate clients or employers. Transcendent values add moral substance to the technical content of disciplines. In his book 'Professionalism: The Third Logic' he concludes the following about professionals: 'While they should have no right to be the proprietors of the knowledge and technique of their disciplines, they are obliged to be their moral custodians' (Freidson 2001: 222).

Home helps, especially, are hardly ever seen as professionals. At best, they are considered as semi-professionals, also according to Freidson's criteria. One of the reasons is that these care jobs are viewed historically as women's jobs and caring is considered as a natural quality most women have. Consequently, the formal educational level is low, although in the Netherlands specific tasks need specific educational levels. Home helps are also not subject to the observance of special laws, unlike nurses. But home helps do have an organisation – Sting – which tries to take small steps towards the professionalisation of home help, something encouraged by the Dutch government. The strategy is to stress some of the conditions as mentioned by Freidson: to increase the level of education, to stress the importance of learning from each other and intra-professional control. Sting is concerned about the consequences of the Personal Budget in that it has most impact on this kind of home care. As stated above, more budget holders buy home help via the market in which no a priori conditions are demanded in relation to the education of the caregiver. So far, they can hardly be called professionals. Will the Personal Budget undo this project? With the Personal Budget, anyone can be employed as a home help if a client wishes to do so.

Strikingly, a survey among Sting's members who worked for budget holders (which included the experiences of 400 people) shows that these care workers are very satisfied. They say that the quality of care they can give now is much higher than when employed by a care organisation: they have more time to spend and are able to do what the client wants. They also like the freedom and independence which goes with the job; they can develop their own views about what needs to be done (Sting 2004). Care

workers employed by budget holders appear to have found what they had lost in regular care: more time with a client, a more personal relationship, and fulfilling the needs of the client. They feel that they are better professionals now than when they were part of the regular home care scheme. However, this seems to be a negative choice since they are disappointed that the regular system of care is not what they expect it to be.

In a comparative study on cash for care schemes, which included the Netherlands as well as Austria, Italy, France and Britain, Clare Ungerson (2004: 203–4) found similar results for the British case of Direct Payments. Some of the professionals she talked to wanted to work on a one-to-one basis because it allowed them to work according to the standards they preferred. One of them told her: ‘When I have the chance to go and work with one lady – I can then make sure that lady gets all the attention that she needs. Whereas when I was in the Nursing home I couldn’t do anything about it. Some days it was like a conveyor belt.’ The discourse, Ungerson writes, was often couched in family terms: ‘Here it is sometimes like I am part of the family.’

But the downside of being treated as ‘one family’ is that expectations grow, and the care users’ needs always have priority, stresses Ungerson. The difficulty is that, because so many care workers lived close to the people they helped, they were frequently called to assist them outside their contracted hours. Ungerson (2004: 204) notes:

For these workers, it was often a matter of luck whether they had a ‘good employer’ or not. The fact that they were frequently working alone with no colleagues, and operating in a segment of the labour market which credentialism has barely touched, meant that they were vulnerable to exploitation based on emotional blackmail. Their independence was hardly enhanced, and their power was minimal.

Personal assistants employed via Direct Payments sometimes feel obliged, like family carers, to undertake certain tasks or duties which may be beyond their skills or which may go against their professional standards (Pickard *et al.* 2003).

Sting’s spokeswoman, Ineke Bakx, also notes that it is difficult for home helpers because the client has the monopoly on the quality of care and clients do not always understand their role as employers. She illustrates this by telling the story of an older man who had difficulty standing. He refused to buy a chair for showering. He did not change his mind, not even when the carer told him that, without the support of a chair, she was afraid that she would drop him during bathing and would injure her back. This professional has to give care which goes against her professional norms.

Moreover, she cannot resign from her post as she is dependent on the income. Bakx says that the PGB holder has become an employer but may not be able to cope with the responsibilities which go along with being a budget holder. Indeed, many problems which come to light in Sting's (2004) survey relate to labour market conditions, payments and, again, bureaucracy. Nearly one-third of the budget holders also express problems with the 'employment' relationship (TK 2004–2005).

Most problems for home helpers relate to the fact that the Personal Budget undermines the professionalisation strategy. A client can employ simply anyone and home help is not a legally protected profession. In addition, home helpers employed by clients have less back up than other home help since their work is not based on inter-professional regulation and the client has the last word on the quality of care. The survey of home helps shows that professionals themselves are concerned about their professional development. They not only miss the direct contact with other professionals but also complain about the lack of space for development of knowledge and education. Some of them would like to improve the quality of care but lack the opportunities to do so: they cannot consult other professionals or train and educate themselves (Sting 2004). They have no control over the development of professional knowledge. The difficulty is that with the introduction of the Personal Budget the Dutch state is no longer in charge of professional impetus, and neither are home helps ready to regulate themselves as professionals: it is left to the all-knowing clients. But with tight budgets, individual clients will not pay for professional innovation. The definition of the quality of care is in the hands of consumers instead of in the hands of the home helpers.

To conclude: as a result of the Personal Budget, home help is still not seen as a real *job*, let alone as a *profession*. It is even further removed from Freidson's definition of a professional: the boundaries between lay knowledge and skills and professionals are not always recognised and labour market entry is little regulated. Eventually the lack of inter-professional consultancy and educational opportunities will erode the content of the job. It is, however, an ironic paradox that care workers employed by a budget holder feel they can work more according to professional standards than when they worked for a regular care organisation. So, while regular care falls short in recognising that professional care is about intensive, one-to-one time with the client, the Personal Budget falls short in providing the necessary conditions to further develop care work as a profession and secure working conditions.

5. The commodification of family care

Interviewer: Has it affected the way in which you get on together?

Husband: Not at all.

Wife: He hasn't fired me yet! (Ungerson 2003: 391)

What has further undermined the professionalisation of home care is the fact that many budget holders employ a family member as a home help. Freidson rightly blames bureaucratic logic as well as market logic as the source of the erosion of professional logic. But care workers also compete with informal carers, who are often women. In the Netherlands, formal care work has always struggled with the idea that 'if a woman can care, and she generally does, she can also become a home help'. When a budget holder can employ his own wife this refutes the notion that care is a profession.

When the personal budget was first introduced, married people were not allowed to have a labour contract. However, the law changed in 1997. Pressure from organisations as LOT – the organisation for informal carers – saw the PGB as a way of compensating care giving (Kremer 2000). In the Netherlands, approximately one million people (10 per cent of the population) care for others (Timmermans 2003). A recent study has shown that more than half of the budget holders employ an informal carer (van den Berg *et al.* 2003). Research presented by the Secretary of State shows that 64 per cent of budget holders buy care from people they know or informal carers, and 65 per cent of all expenditure on the personal budget goes on informal care (TK 2004–2005). Most of the informal carers paid via the budget are partners (37 per cent), followed by children (22 per cent) or parents (17 per cent) (van den Berg *et al.* 2003).

A monetarisation of informal care has taken place as a result of the introduction of the Personal Budget, and family care has become commodified. Or, according to Trudie Knijn (2000, 2004), market logic intrudes into family logic. Care users seem very content with this solution. They appreciate the quality of care and they like the fact that their daughter is paid and contracted, although others have difficulties understanding why their long-standing care relationship should have money attached to it (Ungerson 2004).

What is in the interests of the care receiver is not necessarily in the interests of the caregiver. But, generally, informal caregivers feel valued and recognised (Ungerson 2004). Several problems may potentially arise. Firstly, and more so than for professionals, these carers will be even more reluctant to exercise the social rights they have – such as three weeks' holiday per year. Informal caregivers will have even more difficulties rejecting 'their job' than formal care givers in that it will have emotional

and economic costs. Thus, more rights to exit on the part of the care user go hand in hand with fewer rights to exit on the part of the care giver. They feel even more responsible because of the formalised contract. In other words, moral obligations feel stronger when they are formalised (Ungerson 2004). At the same time, family obligations are strengthened. As a result of the Personal Budget, 're-familialisation' takes place.

Informal carers may therefore care too much and become overburdened. This is the second problem. Informal carers paid via the Personal Budget care on average for a period of seven years, five hours a day, often seven days a week. Sixty per cent live in the same house. One-third of 'family workers' say they are heavily burdened, and, according to a more objective standard, 50 per cent seem overburdened (van den Berg *et al.* 2003). The Personal Budget may thus give carers recognition and relieve the client, but family carers may become even more dedicated and committed, and spend more time with the clients, even though the labour-like contracts should offer them some protection. But the perverse consequences of formalisation may be that the rights of informal carers are loosened rather than strengthened. This may eventually overburden the family carer.

Further problems are the loss of income and labour market prospects. Starting with the latter: although half of the informal carers employed by a budget holder are still in paid employment, 30 per cent put in fewer work hours because of the informal care. More than 20 per cent provide an extra 10 hours a week more in informal care because of the PGB (van den Berg *et al.* 2003). Thus, to some extent, the PGB can push people out of the labour market. The problem is that informal care does not contribute to recognised human and social capital, as Ungerson (2003) points out. Or as an informal carer put it: 'Informal care still does not score on your CV!' (van den Berg *et al.* 2002: 4).

In the Netherlands, paying for informal care has always been seen as out of place and inappropriate. Such a pure thing like caring should not have money attached to it. In that sense the Personal Budget is a breakthrough: it compensates caregivers who would otherwise earn their income in the labour market. The financial problems of informal carers are significant and have been recognised only recently (SCP 2002). In half of all cases income was lost compared to the previous income when the caregiver still worked. On average, informal caregivers employed via a Personal Budget now receive €550 a month. This is a substantial amount of money in a European context, and can also be seen as the financial recognition of caregivers.

The fact that the state pays informal carers, although this was never intended, is also the dominant political issue at the moment. Indeed, all political parties, movements and actors in the field of care agree that

patients should have the possibility of buying the care they need. But the Dutch government (Christian-Democrats and Liberals) has been specifically critical about the monetarisation of informal care. They are afraid of what economists label ‘dead weight loss’: people are paid although they would also care if this were not the case. According to the government, this has a huge budgetary impact. This has given rise to an ongoing debate about limiting the Personal Budget by excluding payments to informal carers. Recent research (Ramakers and van den Wijngaart 2005), however, shows that it is only partly true that some people would not ask for a Personal Budget if they could not pay their daughter or partner. Besides, many clients would then move to formal care, which is much more costly for the state. In addition, many informal carers provide care for many more hours than they are paid for. The fact that ‘altruism’ still exists has softened the criticism of paying family members to care, at least for the time being.

6. Conclusion: the trilemma of the Personal Budget

The Personal Budget offers us a difficult trilemma. The first part of it concerns the market. With a Personal Budget, the patients’ movement hoped that empowerment would come via the market. Patients could shape their own lives as consumers. But the market has not come (yet). As a real free market with a conflict between the principles of justice and equality, and the belief that clients cannot be fully trusted as rational consumers, the Personal Budget is built on a strong bureaucratic logic. Another problem, however, is that care providers did not behave as risk-taking producers; they merged, and only few entrepreneurs started a care business. Thus, should the welfare state include more and better incentives to develop a care market? Perhaps we have to admit that a care market does not fit other moral notions – such as holding consumers accountable for public money payments – so marketisation is unrealistic in modern welfare states such as that possessed by the Dutch.

Secondly, the Personal Budget aims at empowering consumers at the expense of the professionalisation strategy of home helps. But, ironically, care workers employed by a budget holder seem very satisfied. Much more than in regular home care, they feel they can work according to *professional* standards. Fulfilling the needs of clients is seen as one of the basic departure points of a home helper. Good home helps are concerned about the wishes of clients. At the same time, the conditions for being and acting as a professional are absent: home helps employed via the Personal Budget more than those employed in regular care provision lack the continuous development of knowledge and inter-professional control. Although home

helps are not professionals in Freidson's (2001) sense, they will never become professionals under the Personal Budget scheme. This may also be harmful in relation to the future of care. There are no custodians of the moral and professional dilemmas of care, as Freidson (2001) puts it.

Finally, the Personal Budget offers informal carers – often family members – recognition via wages. For the first time in Dutch history, informal carers are directly paid for. Although both caregivers and care receivers seem very content, this may nevertheless reinforce the image that anyone, especially a woman, can be a carer. Care workers are thus not only undermined by the market and bureaucratic logic but also by the gendered family logic. Besides, it may also trap family carers in a situation in which they are more dependent on the care receiver than vice versa. In fact, the right to exit for the care user reduces the right to exit for the family carer. The formalisation of the care contract may even be more binding for the family carer than was previously the case. And although the PGB offers payments which are quite substantial in a European context, these are still less than market wages. In the long term, family work reduces labour market prospects.

The Personal Budget has indeed increased patients' control, power, and autonomy. Via consumerism they have gained a stronger voice. This is a major improvement of the Dutch welfare state. But when – especially in the long run – family carers and professionals become trapped in market-like, short-term care contracts, consumers may also eventually lose. The problem is that the quality of care is not only a matter of consumer choice but is also heavily dependent on the qualities of the caregivers – both now and in the future.

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