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The limits of social investment and the resilience of long-term care

Franca van Hooren
Political Science Department, University of Amsterdam, Netherlands

Clémence Ledoux
Laboratoire Droit et Changement Social, Université de Nantes, France

Abstract

This article investigates the extent to which a social investment paradigm has guided policy reforms in long-term care for the elderly in France and the Netherlands and how this relates to the resilience of the sector during the Covid-19 pandemic. It conceptualizes the theoretical impact of social investment on long-term care policy and analyzes its use to justify reforms since the early 2000s. It concludes that social investment has not played any role in Dutch long-term care reforms and a moderate role in France. Meanwhile, in both countries a neoliberal emphasis on the efficiency of the market has contributed to a rise in for-profit service provision and fragmentation of the long-term care sector. While long-term care provision in both countries proved relatively resilient in the first phase of the pandemic, at a later stage its resilience was undermined by fragmentation and marketization, limiting the government's ability to respond adequately to new challenges and, crucially, to improve working conditions in the sector. The article concludes that a social investment approach cannot resolve these problems and that there is a need for a new paradigm that acknowledges the inherent value of care work and prioritizes the long-term sustainability of care provision.

Keywords

Elderly care, social investment, resilience, Covid-19, long-term care policy

Corresponding author:
Franca van Hooren, Political Science Department, University of Amsterdam, Nieuwe Achtergracht, 166, Amsterdam 1012 DL, Netherlands.
Email: f.j.vanhooren@uva.nl

Introduction

The Covid-19 pandemic brought ample attention to the importance of care as a critical infrastructure. While the initial focus was on hospitals and their overwhelmed intensive care facilities, in its wake followed accounts of the hardships experienced in long-term care facilities. Amidst reports of the huge death toll of the pandemic in nursing homes, long-term care workers were praised as heroes and were listed as key workers. In the aftermath of the pandemic, many of these same care workers left the sector, sick or frustrated with the poor working conditions, leading to mounting staff shortages across Europe.[1]

The Covid-19 pandemic could be seen as a magnifying glass, exposing the strengths and weaknesses of existing care systems. In this article we assess what this magnifying glass can tell us about the resilience of long-term care for the elderly[2] in Europe and how this relates to the social investment paradigm that has guided both European Union (EU) discourse and welfare state reforms across Europe in the past two decades (Bouget et al., 2015; Guillén et al., 2022; Hemerijck, 2017; Morel et al., 2012). We compare developments in France and the Netherlands, two continental European welfare states that have been influenced by the social investment paradigm, while having a legacy of rather different long-term care systems.

Paradigms are a mix of political ideas, norms – defining how a problem is seen, which policy objectives are set – and instruments chosen to reach these objectives (Hall, 1993; Hemerijck, 2015). The social investment paradigm prioritizes investment in human capital and capabilities, 'rather than "repair[ing]" damage after moments of economic and personal crisis' (Hemerijck, 2015). Thus, social policies should contribute to higher employment levels and 'future improvements in productivity, growth and prosperity' (Hemerijck, 2015). Contrary to traditional welfare state policies which view social policy as a means of social protection, stabilizing income across the life course, the social investment paradigm understands social policy as a means of supporting life course transitions and aims to avoid 'people being "trapped" outside the labour market' (Saraceno, 2015: 260).

The social investment paradigm first emerged during the Dutch presidency of the EU in 1997, and then permeated the EU's Agenda 2000, leading it to adopt a package on Social Investment for Growth and Social Cohesion in 2013 (Hemerijck, 2015). During the Covid-19 crisis, the EU adopted recommendations on the National Recovery and Resilience Plans that were not only influenced by the European Green Deal and the objective of digital transformation, but also by the idea of a social investment welfare state, showing the persistence of this paradigm on the European agenda (Guillén et al., 2022). While in 2012, Morel et al. considered this paradigm as 'emerging', not fully established and only beginning to replace the neo-liberal approach (Morel et al., 2012), this set of ideas seems now to have begun to firmly shape EU and national policies: the policy initiatives supported by the EU in Greece and Spain, and in post-communist countries, are illustrations of this, as are the Netherlands' social activation measures and France's minimum income protection for labour market outsiders (Bouget et al., 2015).

1. See e.g.: https://www.socialeurope.eu/health-and-social-care-staff-shortages-critical (accessed 25/03/2023).
2. By long-term care for the elderly, we understand *the activities and relations involved in meeting the physical and emotional requirements of dependent adults* (inspired by Daly and Lewis, 2000: 286). Care for elderly people makes up a large share of long-term care and includes care provided at people's homes and care provided in institutional facilities such as nursing homes.

The first aim of this article is to understand to what extent the social investment paradigm has guided policy reforms in long-term care in the Netherlands and France in the 21st century. The key ambition of social investment as a normative paradigm is that welfare state benefits and services should support the economy and citizens' capabilities to engage in paid employment. Feminist and other critical scholars (Bothfeld and Rouault, 2015; Jenson, 2009; Saraceno, 2015) have argued for years that the social investment paradigm risks favouring 'productive' citizens, at the cost of vulnerable and care-reliant citizens. We conceptualize how the social investment paradigm could nevertheless shape elderly care policy and empirically assess to what extent it has done so.

Second, we assess the resilience of long-term care for the elderly in France and the Netherlands during the Covid-19 pandemic and its aftermath and ask how this relates to (the absence of) a social investment paradigm. Following Klenk and Reiter (2023), we maintain that a focus on resilience underlines the critical importance of implementation in terms of (institutional) structures (public, private, non-profit or mixed) and the extent to which this implementation guarantees continuity of care provision in challenging circumstances.

In the first part, hereafter, we critically discuss the concepts of social investment and resilience in relation to long-term care, developing an operationalization of both concepts. We then present the study's research design. Subsequently, the article describes developments in long-term care for the elderly in both countries, followed by an empirical analysis of the use of the social investment discourse in policy documents and of the resilience of long-term care since the pandemic. We find that the influence of a social investment paradigm on long-term care policy has been moderate in France and nearly absent in the Netherlands. Moreover, any resilience shown by the long-term care systems in both countries was not, we see, related to the presence of social investment policies. We conclude that a resilient long-term care system requires a new policy paradigm that prioritizes care and sustainability over economic productivity.

Social investment as the new welfare state paradigm in a critical perspective

Feminist scholars have criticized the social investment perspective because of its focus on productivity. The paradigm prioritizes participation in the labour market and considers paid work as a basis for citizenship. As a consequence, rather than valuing care as an important activity in itself, it is instrumentalized for the purpose of productivity gains (Saraceno, 2015: 259–260). For example, early childhood education and care is considered to be a cornerstone of the social investment welfare state, because it prepares children to become productive citizens in later life, while at the same time enabling parents (i.e. mothers) to participate in paid employment. From this perspective, families are only considered in terms of human capital formation and labour market participation. Meanwhile, the rights to family life and time are ignored, leaving the gendered and unequal distribution of work and care unchallenged, and failing to value unpaid as well as paid care work (Saraceno, 2023).

There is a potential tension between social investment's focus on productivity and the care needs of the elderly. After all, the latter often cannot be cured and most probably will not return to the labour market (Saraceno, 2023). Indeed, Hemerijck's (2017) substantial volume *The uses of social investment* does not contain a single chapter on long-term care (Hemerijck, 2017). However, some attention to long-term care policy in the context of social investment has emerged in recent years, for example in the 2019 EU directive on work-life balance for carers. Here, 'the targets of social investment are not the frail elderly, but the (mostly female)

family caregivers, whose attachment to the labour market the directive aims to support' (Saraceno, 2023: 312). The availability and accessibility of elderly care services may 'free' family carers to engage in paid labour while also creating employment opportunities in the care sector (De Deken, 2017: 186). Indeed, in their assessment of the main social investment policy trends in national reforms, Bouget et al. also recognized this, stating that 'the more extended is long-term care (LTC), the more middle-aged and older women work' (Bouget et al., 2015: 31).

Next to its focus on productivity, social investment also focuses on outcomes, rather than the process of service provision (see also Klenk and Reiter, 2023). The social investment paradigm states *that* the state should contribute to the availability of care services but does not give details on *how* these should be provided. Consequently, it accords little attention to working conditions in the care sector. Moreover, the social investment paradigm is fully compatible with the marketization of care. Throughout Europe, care markets have emerged, for example through the subsidizing of private for-profit providers and organization of competition among care providers (Brennan et al., 2012; Ledoux et al., 2021b). Such marketization may challenge the resilience of care services in times of economic downturn (Van Hooren, 2021).

Conceptualizing social investment and resilience in relation to elderly care

To guide our study of the extent to which a social investment paradigm has influenced policy development in long-term care in the Netherlands and France, we compare its implications with those of three other policy paradigms. In addition to the conventional neoliberal and conservative policy paradigms,[3] we consider an 'inclusive citizenship' paradigm, which we borrow from Knijn and Kremer and which is also inspired by Saraceno's critique of social investment (Knijn and Kremer, 1997; Saraceno, 2015, 2023). It is an ideal model that places care at the centre of citizenship, including both the right to care and the right to receive care. Table 1 presents how the ideal types of social investment and competing policy paradigms manifest – in theory – on four different dimensions. These dimensions are derived from the critiques presented in the preceding paragraph, which imply that a focus on service recipients is insufficient. Instead, implications for paid and unpaid care work need to be studied as well as the organization and implementation of care provision.

The Covid-19 pandemic has had devastating consequences for long-term care recipients and providers across the globe (Bahn et al., 2020). It has also made care and care work more visible everywhere, and care has frequently been presented as a critical infrastructure. In this article we aim to understand what the Covid-19 pandemic has taught us about the resilience of long-term care systems and how this relates to the previously discussed paradigms.

The term 'resilience' features in different types of literature, especially in ecology and psychology (Cyrulnik, 2001; Folke, 2006; Hall and Lamont, 2013: 12–13). Drawing on these branches

3. Other scholars have compared social investment with neoliberalism and Keynesianism (e.g. Jenson, 2009, 2011). While a comparison with neoliberalism is fruitful for our purposes, Keynesianism has historically been associated with varying ideas about care and care work, ranging from an ideal of reliance on unpaid family care in conservative continental European welfare states to significant state investments in care provision in social democratic welfare states in Scandinavia, which could be seen as a form of social investment before the concept as such existed. Therefore, we have opted to juxtapose social investment with a conservative welfare paradigm, in which care is largely relegated to the family and is mostly unpaid.

Table 1. Paradigms in long-term care reforms.

	Social investment	Neoliberalism	Conservatism	Inclusive citizenship
Long-term care recipients / dependents:	Can rely on publicly funded services that aim to promote rehabilitation and enable productive societal participation	Are consumers of marketized care services, public funding only available as last resort	Have to rely on care provided by family members or non-profit organisations	Have the right to receive publicly funded care, which is an inherently valued public good
Unpaid long-term caregivers (family members, volunteers):	Have to reconcile their unpaid care work with paid employment, which is enabled by reconciliation services	Have to provide for their own income and are not entitled to public support	Are the norm and ought to be supported by family members or the state	Have a right – but not a duty – to provide unpaid care, while receiving income protection from the state
Paid caregivers:	Are important to allow others to also engage in paid employment, but are not inherently valued	Receive low wages due to low economic productivity	Receive low wages, because they replace (unpaid) family care	Need to be recognized, financially valued and protected (Saraceno, 2015)
Organization of care provision:	The state acts as an entrepreneur, investing in a network of public / private / non-profit care services (Jenson, 2011; Morel et al., 2012)	Care is organized through the market, by for-profit providers	Care is provided by family or non-profit organizations	Mix of public / non-profit / family care, access to be guaranteed by the state

Table 2. Resilience in challenging times in long-term care for the elderly.

Long-term care recipients / dependents:	Continue to receive adequate care which supports their physical and emotional wellbeing
Unpaid long-term caregivers (family members, volunteers):	Can continue to provide unpaid care without loss of income or wellbeing
Paid caregivers:	Can continue to provide paid care without loss of employment, income or wellbeing
Organization of care provision / systemic resilience:	System can respond and adapt swiftly and effectively to new challenges

of literature, Hall and Lamont define social resilience as an 'outcome in which the members of a group sustain their well-being in the face of challenges to it' (Hall and Lamont, 2013: 13). While some approaches to resilience have been accused of only placing further responsibilities

on individuals, Hall and Lamont emphasize that the capability to be resilient despite social change largely depends on collective resources, such as state policies and institutions. This article studies the extent to which French and Dutch long-term care policies and systems seem to have supported the wellbeing of elderly care recipients, family members and paid care workers despite challenging circumstances (see Table 2). The resilience assessment is based on governmental and non-governmental reports and indicators of death tolls, the continuation of care provision, the (over)burdening of family caregivers, sick leave and turnover rates of paid caregivers, and political responses throughout the pandemic. Drawing on the literature on the organization of care (Brennan et al., 2012; Knijn and Kremer, 1997), we expect the inclusive citizenship paradigm to produce more resilient outcomes.

Research design

The Netherlands and France were selected for comparison because both of these historically rather conservative welfare regimes have been influenced by the social investment paradigm in recent years (Bouget et al., 2015). France and the Netherlands are therefore both 'likely cases' for discerning an influence of the social investment paradigm in elderly care. At the same time, the Dutch and French elderly care systems have been organized very differently, with publicly financed care being developed earlier and more comprehensively in the Netherlands than in France (Morel, 2007). This difference allows us to study how the social investment paradigm and elderly care resilience have interacted with different policy legacies since the beginning of the 21st century.

To assess empirically the influence of social investment and other paradigms on policy making, we must trace the definitions of policy objectives and norms, by analyzing the intentions and meanings of chosen policy instruments (De Deken, 2017), over time and in various national reforms. We study policy reforms in elderly care as of the early 2000s, when the social investment paradigm emerged on the European agenda.

The policy analysis presented below is based on a study of key policy documents, including new laws and regulations, coalition agreements, policy proposals and selected parliamentary debates. We traced the extent to which motivations and objectives expressed in policies or debates around policies displayed characteristics of either the social investment paradigm or any of the other paradigms outlined in Table 1 above. To assess resilience we used descriptive statistics, reports, newspaper accounts and secondary sources to assess how both countries performed in relation to the continuity of care provision, the wellbeing of care providers and the adaptability of the care system (see Table 2 above).

Key developments in long-term care for the elderly

This section starts with an outline of broad trends in the development of long-term care for the elderly in the Netherlands and France, followed by an analysis of how social investment and other paradigms have informed policy reforms in the two countries.

The Netherlands

In the decades after World War II, Dutch social policy was firmly based on a conservative male breadwinner model. However, already in this period, governments were committed to facilitating

Table 3. Long-term care for people aged 65+ in the Netherlands and France, as a percentage of the total population aged 65+.

		1995	2000	2005	2010	2015	2020
Beds in residential long-term care facilities	NL	9.1	7.8	7.5	6.8	8.2 (B)	7.1
	France	4.8	4.7	4.7	5.4	5.3	4.8
Recipients of long-term care at home	NL	–		13.4	12.9	8.7 (B)	7.5*
	France	–		5.3	6.6	6.1	5.7

Source: OECD (2023). Beds in long-term care facilities include beds in nursing care homes and other types of residential facilities that provide long-term care. Recipients of long-term care at home include APA recipients in France and recipients of cash or in kind AWBZ (before 2015) or WLZ / Zvw (from 2015, hence excluding WMO) care in the Netherlands. Notes: (B) indicates a statistical break. New modes of calculation for the Netherlands meant a downward adjustment in the number of home care recipients and an upward adjustment in the number of beds in residential care; * data for 2019.

older people's independent living in care homes (Van Hooren and Becker, 2012). A long-term care insurance (AWBZ, Algemene Wet Bijzondere Ziektekosten) was enacted in 1968 and was subsequently expanded. By 1975, 8.9% of Dutch people aged over 65 lived in a care home (Van Hooren and Becker, 2012: 91). Subsequent policy encouraged more elderly people to stay at home, supported by broad entitlements to publicly financed home care services. Hence, by 2005 the share of elderly living in a care or nursing home had fallen to 7.5% (see Table 3 above), while some 13% of people aged over 65 received publicly funded support at home. In sum, in terms of the availability of and entitlements to receive elderly care, the Netherlands came close to an 'inclusive citizenship' model, very similar to that of Scandinavian countries. Unlike the Scandinavian countries, however, the Dutch state acted only as a regulator and funder (Da Roit, 2018: 61), while non-profit providers organized the provision of long-term care services.

Policy reforms were initiated in the 1990s, but only really became effective in 2007 (Da Roit, 2018). These reforms entailed both conservative and neoliberal elements. In 2007, home help services (such as house cleaning) were taken out of the long-term care insurance and instead became part of a newly created decentralized social support act (WMO, Wet Maatschappelijke Ondersteuning), which encouraged private, for-profit provision and competition for tenders, while eligibility for services became conditional on the absence of unpaid family care.

In 2015, further decentralization and retrenchment followed, abolishing the existing long-term care insurance (AWBZ) altogether and delegating the services that it covered to other schemes. All home help and support services and some forms of cash for care payments went to the decentralized and marketized WMO. Home care services were transferred to the existing health care insurance act (Zvw, Zorgverzekeringswet). The category of care homes ('verzorgingshuizen'), in which people with moderate care needs could live in an institutional facility was abolished, and replaced by arrangements in which clients are still entitled to care services, but need to pay for their own accommodation. Nursing homes ('verpleeghuizen'), i.e. institutional care facilities for people with severe care needs, as well as other cash for care options, were included in a new, narrower long-term care act (WLZ, Wet Langdurige Zorg). All three acts also offer options for respite care for family carers.

Both the 2007 and 2015 reforms implied substantial budget cuts. In 2017 some of these budget cuts were overturned and funding for institutional care (nursing homes) was even increased. The reasons for this reversal are discussed below.

The decentralizing and cost-cutting reforms of home care led to a drop in the share of elderly receiving publicly financed services at home, from 13.4% in 2004 to 7.5% in 2019 (Table 3).[4] The number of beds available in residential care facilities decreased from 8.2% in 2015 to 7.1% in 2020.[5] Publicly funded long-term care is increasingly targeted at those with the most severe care needs, accompanied by additional reliance on unpaid family care (SCP, 2020).

In terms of the organization of care, reforms have led to growing fragmentation and increased for-profit provision. The social support act (WMO) – the law that regulates decentralized provision of home help and support services – has explicitly allowed for-profit provision since 2007. The other two laws on home care (Zvw) and institutional care (WLZ) do not allow profit making through in-kind care provision, but for-profit provision is possible through the use of cash for care. Consequently, there is a growth in residential facilities that offer non-profit care, while making profits through housing arrangements (SCP, 2019). In 2022 there were 1425 providers of home help and support, 4298 providers of home care and 2355 providers of institutional/ nursing home care.[6] Providers range from very large – employing tens of thousands of employees –to very small.

At around the time of the 2007 and 2015 reforms, budget cuts combined with enhanced competition between providers brought home help and care providers into financial trouble, leading to a series of bankruptcies and the loss of 50,000 jobs between 2012 and 2016 (Van Hooren, 2021: 7). By 2019, the financial situation had improved and substantial profits were reported instead (CBS, 2022). Since 2020, employment in the long-term care sector as a whole is at an all-time high with over 450,000 employees (CBS, 2023), which is around 5% of total employment in the Netherlands. By 2020, due to recent financial investments in nursing homes, the number of workers per resident had increased to 104 full-time equivalent (FTE) for every 100 residents (Actiz, 2021). Women form the great majority of workers in long-term care and, contrary to many other European countries, migrant workers are underrepresented.[7]

Most workers in the sector – with the notable exception of those that are self-employed or directly employed by households through cash for care benefits (Van Hooren, 2021) – are covered by a collective agreement that regulates wages and working conditions. Statutory monthly wages for full-time employment are relatively high in comparison to other European countries, including France (Eurofound, 2020). They range from a starting salary at minimum wage level (€1950 per month) for untrained home helps, to around €2600 for trained care assistants, with a maximum salary of €4000 for nurses.[8] However, an average long-term care job is only 0.6 FTE, which brings the real monthly wage of an average untrained home help down to €1170 per month and that of a trained care worker to €1560. In practice, many care workers are not financially independent, meaning that they do not earn enough to support themselves (RVS, 2020). Meanwhile, workers experience high work pressure and too little autonomy (ACVZ, 2022).

4. This drop is overestimated because of a break in statistical data collection (see Table 1).
5. This is part of a long-term trend which is underestimated by the data in table 1 due to a break in measurement.
6. As found on www.zorgkaartnederland.nl/ on 1 September 2022.
7. 81% of long-term care workers are native Dutch (both parents born in the Netherlands), which is higher than average in the Dutch economy.
8. CAO Verpleging, Verzorging, Thuiszorg en Jeugdgezondheidszorg 2022–2023, https://www.actiz.nl/sites/default/files/2022-05/CAO-VVT-2022-2023.pdf, accessed 24 March 2023.

France

Unlike the Netherlands, until the 1990s the French long-term care system was similar to a conservative model (Morel, 2007). Elderly people were partially included in disability policy: the main social policy applicable to elderly people at home was the *Allocation Compensatrice Tierce Personne*, for people with disabilities (Capuano, 2019). For institutional care, elderly people were hosted in dedicated institutions partially financed by social assistance and/or covered by the health insurance. This system was far from sufficient to cover care needs, and emphasized the caring function of the family (Le Bihan and Martin, 2010; Morel, 2007).

In 1997 a means-tested allowance for elderly dependent people, the *Prestation Spécifique Dépendance* (PSD), was introduced. The PSD could be used to pay for home care or for care in nursing homes, where residents still had to pay for their accommodation. Meanwhile, standardized price setting rules aimed to encourage convergence and a kind of competition between providers. For home care, the PSD allowance required the use of formal services or a declared worker with an employment contract.

In the home and in institutions, the PSD was distributed and monitored by local authorities (the *départements*). Notably, after the beneficiary of the PSD had passed away, local authorities could reclaim the allowance as a part of the elderly person's estate. It was because of this that the PSD was heavily criticized and in 2001 it was replaced by the APA (*Allocation Personnalisée d'Autonomie*-elder care allowance[9]); this retained characteristics of the PSD, but the local authorities could no longer reclaim the allowance and the means-test was reduced. Since the PSD and APA did not cover all needs, means-tested social assistance allowances still existed in parallel to the PSD and APA, at home or in institutions.

A 2015 reform of the APA (the *Loi d'Adaptation de la Société au Vieillissement - ASV Law*[10]) changed the way in which users' fees were calculated and made them more progressive, increased the amount of APA allowances especially for people with severe loss of autonomy, and recognized a right to respite (*droit au répit*) for family helpers, creating the possibility for them to be replaced by temporary institutional or home care. It also changed the authorization regime for home care and expanded financing of home care providers through tenders.

In parallel to the PSD/APA, tax break policy instruments were developed. These had existed since the 1950s, but they were made available to all households only in 1991. Tax reductions could be received for the costs of purchasing care/household services or for employing a care/domestic worker (Ledoux et al., 2021a, 2021b). The amount of these tax breaks was increased incrementally. In 2017, for people without paid employment the tax deduction was replaced by a tax credit, which benefits people on low incomes who are not paying (a high level of) income tax. Tax breaks were gradually increased to finance care demand, positioning recipients as consumers employing a growing paid workforce in a welfare market organized by the state, much in accordance with the social investment paradigm.

In terms of the availability of services, the number of care recipients more than doubled after the PSD was replaced by the APA.[11] Due to simultaneous population ageing, the percentage of the

9. Loi no 2001-647 du 20 juillet 2001 relative à la prise en charge de la perte d'autonomie des personnes âgées et à l'allocation personnalisée d'autonomie.
10. Loi no 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement.
11. From 130,000 beneficiaries of the PSD in 2000 (Kerjosse, 2000) to 596,000 receiving the APA in 2002, 867,600 in 2004 (DREES, 2021) and 1,338,000 in 2019 (DREES, 2022: 92).

population aged over 65 receiving home care services increased from only 5.3 to 5.7% between 2005 and 2020 (see Table 1). In recent decades, the absolute number of places available in French nursing homes has also grown[12] but the relative share has stayed fairly stable, with 4.8% of elderly people residing in institutional care in 2020. Meanwhile, various studies insist that the population in care homes suffer from more polypathologies and are less autonomous than in the past, so support needs have increased (Reynaud, 2020).

The introduction of the APA together with the tax breaks led to the emergence and rapid growth of private for-profit home care providers, employing 26.7% of home care workers in 2018 (Ledoux et al., 2021a, 2021b), while the share of public and non-profit providers fell to under 45%. In institutional care homes, the same process of marketization took place. The number of places in private for-profit nursing homes increased from 87,900 in 2003 to 132,430 in 2015 (DREES, 2021; Gratieux, 2016).

The total number of workers employed in home care (for the elderly, families and disabled people[13]) has grown from 356,000 in 2004 to 518,000 in 2018. Of these workers, 95% are women, 72% work part time and 19% are immigrants (twice the proportion of immigrant women in the whole population of employed women) (CESE, 2020). Contrary to many other European countries, there are huge incentives to declare workers and all declared workers are covered by collective agreements (Van Hooren et al., 2021). In 2018, home care workers earned, on average, €893 net per month. In practice, even if they work part time, the time they dedicate to their work often exceeds 35 hours a week because of unpaid breaks between clients.

In institutional care, too, employment has grown and all workers are covered by collective agreements. Staff to client ratios have increased in both care and nursing homes,[14] with better staffing ratios in public nursing homes than in non-profit nursing homes and better in non-profit private nursing homes than in for-profit nursing homes.[15]

Despite the inclusiveness of the collective agreements, several reports (e.g. El Khomri, 2019; Kulanthaivelu and Thiérus, 2018) written before the Covid crisis mentioned the difficult employment and working conditions of care workers, in the home or in institutional care, with a heavy physical and mental workload and poor wages. In 2019 the minimum wage for care workers, in both care homes and home care, was at or just above the level of the national minimum wage (€1521 / month for a full-time job) (CGT Archives, 2018 for the public services; El Khomri, 2019). Unlike in the Netherlands, most jobs in long-term care require little formal training, and skills are hardly recognized through higher wages. The sector has faced high turnover and recruitment difficulties: in the home-based non-profit sector, the annual turnover was one-fifth of workers, and 81% of the homes for dependent seniors had job vacancies in 2019 (El Khomri, 2019: 36).

Social investment and the justification of long-term care reforms

In this section we describe how social investment as well as other paradigms have influenced and been used to justify reforms in elderly care in the Netherlands and France since the 2000s. As we will show, the two countries have followed quite different paths.

12. From 668,500 places in 2003 to 717,953 in 2011 and 769,489 in 2019 (DREES, 2021: 109).
13. Listed as '*Aides à domicile, aides ménagères, techniciens de l'intervention sociale et familiale* (TISF)'.
14. From 43.7 to 57.4 FTE for 100 beds in care homes between 2003 and 2019 (DREES, 2022) and from 60.9 to 65.3 in nursing homes (EHPAD) between 2011 and 2019 (DREES, 2022: 123).
15. https://drees.solidarites-sante.gouv.fr/sources-outils-et-enquetes/lenquete-aide-sociale-aupres-des-conseils-departementaux (accessed 25 March 2023).

Social investment not used to justify care reforms in the Netherlands

The conservative/neoliberal turn of 2007. The 2007 and 2015 reforms led the Dutch long-term care system away from an 'inclusive citizenship' towards a more conservative and neoliberal model. The Christian/Liberal coalition government that initiated the 2007 reform justified the necessity of change by placing a strong emphasis on the need for cost containment. It highlighted citizens' 'personal-responsibility' for 'finding their own solution' to their care needs rather than turning to the state, which should only be called upon when it is 'really necessary'.[16] Instead, care should be provided by 'family carers' or 'informal or private help'[17], much in line with a conservative paradigm. The policy documents that the government published in this period[18]overlook the consequences these policy reforms might have for unpaid caregivers – the majority of whom are women – and their employment participation. It is therefore distinctly *not* a social investment-based approach. This contradicts the guiding logic in other policy areas at the time. For example, the same government was preparing a considerable expansion of public investment in childcare services explicitly to encourage women's participation in the labour force (Goijaerts, 2022). There was a more consistent government emphasis across these various sectors on the 'primacy of private provision'[19] as opposed to any form of direct public involvement, resembling the neoliberal paradigm. This issue was barely raised in parliament, nor was there a focus on the employment position or remuneration of people employed in long-term care[20] (or childcare). Instead, workers in long-term care remained completely invisible.

2015 reform: more of the same. Although a different (Liberal/Labour) coalition spearheaded the next major long-term care reform in 2015, the continuities are striking. Again, there was a strong emphasis on the problem of cost hikes[21] and on the 'personal responsibility' of those in need of care, as well as a focus on people's own financial contribution.[22] Care would preferably be provided by a family member, neighbour or volunteer. Again there was no consideration at all of the impact of increased demand for family care on the paid employment of unpaid family caregivers. Those employed *in* long-term care were mentioned, because they were the 'social capital' of the care sector,[23] but job losses were presented as inevitable (Da Roit, 2018). While client and providers' organizations were extensively consulted throughout the reform trajectory, employees and trade unions were left out.

2015–2019: movements contesting conservative reforms. The reforms of 2007 and 2015 had far-reaching consequences, as described above, including job losses and reduced availability of care services. In response, in 2015 the trade unions FNV and CNV initiated a campaign called 'Save the care sector', including a large demonstration[24] and a petition that was signed by almost one

16. Tweede Kamer, 2003-2004, 29538–1, https://zoek.officielebekendmakingen.nl/kst-29538-1.html
17. Tweede Kamer, 2003-2004, 29538–1, https://zoek.officielebekendmakingen.nl/kst-29538-1.html
18. For example: Tweede Kamer, 2004-2005, 30131–3.
19. Tweede Kamer, 2003-2004, 29538–1, https://zoek.officielebekendmakingen.nl/kst-29538-1.html
20. For example, Tweede Kamer, 2004-2005, 30131–27.
21. Interestingly, frequent comparisons were made with other countries, but only to point out that Dutch long-term care is more expensive. The fact that it might also be better was completely ignored.
22. Tweede Kamer, 2012-2013, 30597–296, https://zoek.officielebekendmakingen.nl/kst-30597-296.html.
23. Tweede Kamer, 2012-2013, 30597–296, bijlage, https://zoek.officielebekendmakingen.nl/blg-224333.pdf
24. https://nos.nl/artikel/2057275-duizenden-bij-demonstratie-red-de-zorg-in-amsterdam, (accessed 25/03/2023).

million people.[25] Simultaneously, between 2014 and 2016, there was public outcry over a few highly mediatized examples of poor-quality care in nursing homes.[26] Together, these two developments put the quality and organization of care as well as employment *in* care high on the political agenda. Job losses and deskilling in home care, as well as the importance and lack of professional staff in nursing homes, were widely discussed.[27] This led to the reversal of planned budget cuts in home care in 2015[28] and a new 'Nursing home care quality framework' (*Kwaliteitskader verpleeghuiszorg),* accompanied, in 2017, by additional structural investment of €2.1 billion to improve the quality of care in nursing homes.[29]

Policy documents in this period were characterized by a clear return to the 'inclusive citizenship' paradigm, with plenty of references to the responsibility of the state to guarantee the quality of care and care work.[30] However, although trade unions and some political parties on the left contested the marketization of the sector, this aspect was never fundamentally discussed by the government. Instead, the government referred to the need for standards for 'responsible market mechanisms'.[31] As in the previous periods, there was little focus on reconciling family care and paid work, and no social investment logic could be discerned.

The growing use of social investment to justify care reforms in France

Social investment as such in the tax breaks policy path. When the French government encouraged the development of a household services sector through tax breaks, these services were seen as responding to unmet 'new needs' within families, but also as a means to employ women considered as unskilled, therefore reducing unemployment rates (Ledoux et al., 2021a). Household services, including care services, were expected to free up the working time and mental space of wealthier, skilled women (Morel, 2015). This approach emphasizing enhanced labour market participation could be seen as the use of a social investment paradigm before this existed as such. By financing the demand for care/domestic services and positioning recipients as consumers, the policy was also clearly inspired by neoliberal ideas.

The 2015 reform of the APA: a late onset of social investment. When the APA was first adopted, social investment objectives were not mentioned, as the new allowance was seen as a means to help elderly people have a decent life, and to respond to their needs. However, a social investment logic emerged later when the APA was reformed through the ASV Law in 2015. The *Délégation aux Droits des Femmes* in the National Assembly wrote a report on the bill before it

25. https://www.fnv.nl/over-de-fnv/wat-we-doen/successen, (accessed 25 March 2023).
26. These examples involved the mother of the junior minister responsible for long-term care in 2014 (https://www.ad.nl/gezond/radeloze-joop-81-soms-loopt-urine-langs-haar-enkels~af8145d5/) and the mother of sports journalist Hugo Borst. The latter, Hugo Borst, wrote a book about his mother's situation and subsequently launched a petition for better care.
27. See e.g. Tweede Kamer, 2014-2015, Handelingen 108–4 https://zoek.officielebekendmakingen.nl/h-tk-20142015-108-4.html; Tweede Kamer, 2015-2016, 29538–202 https://zoek.officielebekendmakingen.nl/kst-29538-202.html; Tweede Kamer 2016-2017, 31765 - 252 https://zoek.officielebekendmakingen.nl/kst-31765-258.html.
28. Tweede Kamer, 2015-2016, 29282–238, https://zoek.officielebekendmakingen.nl/kst-29282-238.html
29. Tweede Kamer, 2016-2017, 31765–273, https://zoek.officielebekendmakingen.nl/kst-31765-273.html
30. Tweede Kamer, 2015-2016, 29282–238, https://zoek.officielebekendmakingen.nl/kst-29282-238.html; Tweede Kamer, 2016-2017, 31765–273, https://zoek.officielebekendmakingen.nl/kst-31765-273.html.
31. Tweede Kamer, 2014-2015, Handelingen 108–4, https://zoek.officielebekendmakingen.nl/h-tk-20142015-108-4.html

was adopted, emphasizing the workload of female carers. In the ex-ante statistical evaluation of the reform,[32] one of the objectives assessed was the possibility to improve the living conditions of carers, but also to ensure that they could continue to provide care if they were also working. These concerns corresponded to the social investment paradigm, which sees care as a means to enable the participation of all adult family members in paid employment.

2018: a social movement challenging neoliberal instruments. In 2018, as in the Netherlands, a social movement appeared around nursing home care. A number of trade unions and employers' organizations denounced the neoliberal policy on funding of nursing homes and the related lack of personnel in these homes. According to the actors involved, these policies were one reason why workers were spending less and less time with the people they were caring for, and a factor in worker burnout and increased risk for their elderly charges.[33] The employment situations of care workers in institutional care, resulting in staff shortages, as well as the feminized characteristics of the workforce, were also highlighted. From a perspective fitting the 'inclusive citizenship' paradigm, they underlined that care was undervalued. A national strike day and demonstrations were organized on 30 January 2018. These actions put nursing home care on the political agenda, with the launch of various commissions and reports: immediate one-off extra budgets and nursing staff were provided, but no real transformative change took place. While President Macron, like his predecessors Nicolas Sarkozy and François Hollande, promised to reform the elderly care sector, he did not implement any structural reforms.

Covid-19 and resilience

The Covid-19 pandemic had devastating consequences especially for elderly people across the globe. In this section we discuss how resilient the French and Dutch long-term elderly care systems have been during the Covid-19 pandemic and its aftermath, looking at the wellbeing of care recipients, unpaid care providers and paid care providers, as well as at the ability of the system as a whole to adapt to new challenges.

The Netherlands

The Covid-19 pandemic clearly had profound negative consequences for the wellbeing of *care recipients*. According to a comparative report (Comas-Herrera et al., 2021), by January 2021, 51% of all Covid-19 related deaths in the Netherlands occurred in care or nursing homes, which corresponds to approximately 5% of all care and nursing home residents. This high percentage is surpassed only by the United States, the United Kingdom and a few other countries and seems directly correlated with the overall death toll in each of these countries. In addition to immediate health risks, elderly people residing in long-term care institutions were also reported to experience loneliness and depression as a consequence of a months-long ban on visitors (Van der Roest et al., 2020).

32. Projet de loi relatif à l'adaptation de la société au vieillissement, étude d'impact, June 2014, p.93-95
33. https://www.lemonde.fr/sante/article/2018/01/30/le-personnel-des-ehpad-se-mobilise-pour-denoncer-ses-conditions-de-travail_5249003_1651302.html (accessed 25 March 2023).

Unpaid (family) caregivers reported an increased care burden as a result of the pandemic.[34] This was due to general stress as well as to the interruption of some formal care provision, including respite care. Many of these unpaid caregivers had to combine an increased care burden with paid work. They could use an existing entitlement of two weeks of paid leave for emergency care per year. Otherwise, no special arrangements were made for this group, which has continued to receive little political attention.

Meanwhile, *paid care provision* largely continued throughout the pandemic. The Netherlands did not experience the kind of major disruptions that occurred in nearby countries which relied heavily on rotating migrant care workers, such as Austria and Germany (Leichsenring et al., 2021; Van Hooren, 2020). In the Netherlands, workers in long-term care were listed as ‘essential workers’, meaning that they were expected to continue working and could, for example, continue to use childcare services which were closed for other workers’ children. Even where care service provision was interrupted – for example daytime activities or respite care – the formal status of care workers protected them from dismissal or loss of income. Consequently, few jobs were lost among long-term care workers employed by care agencies.[35]

However, paid care workers were negatively affected by the pandemic in other ways. In the first months of the pandemic, workers in long-term care worked without adequate testing and personal protective equipment, which were allocated to workers in the ‘cure’ sector first. In the longer run, the pandemic has contributed to exhaustion[36] and rising levels of sick leave (from 6.8% on average in 2019 to 9.2% in 2022, CBS, 2023) combined with a high turnover rate. In 2022, 15% of long-term care workers left the sector (CBS, 2023). These trends have contributed to mounting staff shortages (RVS, 2022). The sector’s vacancy rate nearly doubled, from 11,000 vacancies in early 2021 to 22,000 in summer 2022 (CBS, 2023).

Turning to the *organization of care provision*, various studies have identified systemic weaknesses that have undermined the sector’s ability to adapt swiftly and effectively to new challenges. A report on the government’s response to the first wave of Covid-19 notes that government attention was initially focused on the ‘cure’ sector (hospitals and doctors) much more than the ‘care’ sector, which therefore received little protective equipment. The report explains this by the fact that long-term care is highly fragmented, with many different rules and different providers which are not jointly organized (Onderzoeksraad voor Veiligheid, 2022). Another study concludes that the subsidiary role of the state in a largely decentralized and marketized care sector ‘resulted in a “soft” crisis management: characterized by shifting strategy, untransparent decision making, and absence of strong leadership’ (Bruquetas-Callejo and Böcker, 2021: 25) Even the payment of bonuses to ‘frontline’ care workers in 2020 and 2021 proved complex and vulnerable to fraud.[37]

The pandemic did lead to greater societal and political awareness of wages and working conditions in the (long-term) care sector (RVS, 2020). The 2021 coalition agreement stated that:

34. https://www.binnenlandsbestuur.nl/sociaal/mantelzorg-het-gedrang-door-corona (accessed 25 March 2023).
35. Formal employment in long-term care grew by 19,000 between early 2020 and early 2021 (« Werknemers seizoensgecorrigeerd », CBS, 2023). It should be noted that workers who were self-employed or directly employed by households were probably more financially affected by the pandemic, because they lack social and employment protection and may have lost their income in periods of lockdown (https://www.oneworld.nl/lezen/discriminatie/sociaal-onrecht/jij-zit-betaald-thuis-je-schoonmaker-ook/)
36. https://www.groene.nl/artikel/wij-zijn-slijtende-werkpaarden (accessed 25/03/2023).
37. https://www.rtlnieuws.nl/onderzoek/artikel/5272824/zorgbonus-fraude-zorgfraude-coronabonus-zorgmedewerkers (accessed 25 March 2023).

> 'The corona crisis has demanded the utmost of the care sector and continues to do so. The workload, absenteeism and staff shortages have increased even further as a result of the crisis. Working in care must become more attractive.' (Coalition agreement, December 2021)

However, the decentralized, marketized and fragmented nature of the long-term care sector makes government intervention in wages and working conditions more difficult, and at the time of writing, no steps have been taken to fundamentally improve care workers' welfare.

Meanwhile, in spring 2022, in the context of an economy that had quickly deteriorated due to the war in Ukraine, the government partly returned to the cost containment discourse that was so prevalent in the 2000s and 2010s. While opposition parties on the left have continued to raise the issue of poor working conditions in long-term care,[38] in its most recent plans the government's priority has returned to limiting the demand for care,[39] thereby aiming to guarantee its future sustainability (WRR, 2021). Unlike during the preceding decades, 'quality' and 'government control' are now also presented as cornerstones of future policy change. This possibly suggests that some lessons were learned from the challenges posed by fragmentation during the Covid-19 pandemic, but how this will be translated into actual policy reforms remains to be seen.

In sum, while Dutch elderly care seems to have been resilient in terms of continued provision of care throughout the pandemic, the sector's resilience was also hampered by its fragmentation, which limited coordination in times of crisis and restricted an efficient response to labour shortages.

France

As in the Netherlands, the Covid-19 pandemic clearly had profound negative consequences for the wellbeing of *care recipients*: 43% of Covid-19 related deaths in France occurred in care or nursing homes, which corresponds to approximately 5% of all care and nursing home residents (Comas-Herrera et al., 2021). For the first time, the number of APA beneficiaries decreased in 2020 (−1.5% between 2019 and 2020, DREES, 2022: 93), due to Covid-19 related deaths. In care homes, the central government prohibited families of residents from visiting them and collective activities were interrupted. Solutions were sometimes found to maintain links with family members outside, and some caregivers, portrayed as heroes, decided to move into the nursing homes and live there to minimize the risk of virus circulation. Nevertheless, this could not compensate for the reduction in activities for the elderly, and many elderly people began to suffer from psychological problems (Balard et al., 2021).

Prevented from visiting their elderly family members in institutional care, *unpaid (family) caregivers* could theoretically continue to visit them at home. They were excluded from the very strict lockdown rules that prevented other citizens from leaving their place of residence,[40] but not all family members could visit their elderly relatives, especially when they did not live in the same town. Therefore, the relations between families and elderly residents were sometimes interrupted, entailing more difficulties for care service providers.

38. See, for example, Tweede Kamer 2021-2022, 34104–356, https://zoek.officielebekendmakingen.nl/kst-34104-356.html.
39. Tweede Kamer 2021-2022: 31765-638, https://zoek.officielebekendmakingen.nl/kst-31765-638.html.
40. During the first wave of the pandemic, French residents were forbidden to leave home for more than one hour or to go further than 1 km from their home. They had to fill out an authorisation paper which included, as an exception, visits to dependent relatives.

Paid care provision concentrating on vital tasks largely continued throughout the first wave of the pandemic, and financial schemes were deployed to support the workers who could not work. This showed an apparent resilience of the system (Balard et al., 2021). In March 2020, staff in home care and nursing homes were theoretically designated as a priority group for receiving protective equipment, but its availability was very limited (Caillaud et al., 2022). It was in autumn 2020 that *care provision* began to become more and more disorganized because of the absence of workers who had been in contact with someone with Covid-19, who had contracted the virus or who had decided to leave the sector because of bad working conditions and lack of recognition. Although labour shortages existed before the pandemic, they began to intensify after the first wave. The situation became even more difficult after the summer of 2021, when care workers were required to be vaccinated.[41] In sum, the resilience the system had shown during the first wave was not sustained.

In terms of *systemic resilience*, the necessity to recognize essential workers was quickly declared by President Macron:

> 'Our country today relies entirely on the women and men that our economies so poorly recognize and reward. "Social distinctions can only be based on common utility." The French wrote these words over 200 years ago. Today we must pick up the torch and give full force to this principle.' (Speech by Emmanuel Macron, 13 April 2020)

'First line', 'second line' and 'essential workers' were identified in a more warlike discourse than in the Netherlands. Workers in nursing homes and in some segments of the home care sector were identified as essential workers, and care was recognized as possessing an inherent value, showing a symbolic shift towards the 'inclusive citizenship model'.

In nursing homes, the workers were given bonuses and, in 2021, were included in a large-scale reform of the health sector (the *'Ségur de la Santé'*), which resulted in wage increases (€183 net/month). In the home care sector, employers' organizations fought for more resources, comparing their sector to the health and nursing home sector. Home care workers employed by providers were finally entitled to specific bonuses (which were nonetheless lower than those granted to nursing home workers) and the state extended the collective agreement covering non-profit organizations in the home care sector, with associated wage increases.[42] In autumn 2021, action by for-profit home care providers, who also wanted to benefit from more resources, led to an increase in the level of the APA for home care, to an hourly tariff of €22 for all providers, but without the obligation to transform this into wage increases. Home care workers employed by households were excluded from these changes, despite lobbying by the organization representing households as employers. The 2021 National Recovery and Resilience Plan mentioned an intended significant reform of elderly care, presenting investment in care as corresponding to a 'resilience' objective.[43] This reform was finally abandoned in the summer of 2022, showing the incapacity for a real shift to an 'inclusive citizenship model'.

41. For workers employed by households, vaccination was made compulsory, but there were no checks and no sanctions applied by the state, unlike in nursing homes and home care provider organisations, where employers were obliged only to employ vaccinated workers and could be fined if they failed to do so.
42. Negotiation of codicil 43 to the collective agreement covering non-profit care providers.
43. *Plan national de relance et de resilience*, Gouvernement français, 2021, p. 700 https://www.economie.gouv.fr/files/files/directions_services/plan-de-relance/PNRR%20Francais.pdf (accessed 19/02/2023).

It was only as a consequence of a scandal associated with a multinational care provider that significant changes were made in some care homes. After a journalist's investigation had shown that the multinational home care firm Orpea was mistreating its clients by rationing food, protective layers and also staff (Castanet, 2022), the group fell into debt, its stock market value collapsed, leading to quasi-nationalization in February 2023.[44]

In sum, the relative resilience of the French long-term care system during the first wave can be explained by formal employment relations and the symbolic heightened status of care workers, who sometimes showed sacrificial commitment. For the first time, care workers were highly visible in and valued by the media (Caillaud et al., 2022). This resilience, however, did not last. On the contrary, the French case shows how overly precarious employment conditions and a lack of material recognition helped to weaken the system following the first wave of the pandemic, the very fragmented response to the crisis and how difficult it has been to transform rhetoric into real measures.

Conclusion

The social investment paradigm has not guided long-term care policy reforms in the Netherlands. On the contrary, this approach was conspicuously absent from discussions about increasing reliance on unpaid family care. By contrast, a social investment logic could be identified in some of the French policies and reforms, including the emphasis on job creation in its household tax breaks and the attention paid to work-life balance in the 2015 APA reform.

In both countries, a neoliberal emphasis on the supposed efficiency of the market has contributed to a rise of for-profit service provision and competition among providers. The comprehensive coverage of collective agreements has somewhat shielded care workers in both countries from the consequences of marketization. However, marketization has resulted in a highly fragmented system lacking direct government control.

At the start of the Covid-19 pandemic, the long-term care sectors in both countries were fairly resilient, due to the relatively high levels of formal employment in the sector and the strong personal commitment of the workers, who ensured relative continuity of service provision. At a later stage, however, the pandemic showed the incapacity of governments to transform the symbolic valuing of care workers into a material valuing, and revealed massive problems in labour supply, hampering the quality and availability of care services. These challenges exposed the vulnerability of a highly fragmented, decentralized and marketized sector.

In line with Klenk and Reiter (2023), we argue that resilience requires a far greater focus on the organization and implementation of services, and the extent to which this enables adequate and coordinated responses to challenges such as the Covid-19 pandemic. However, where Klenk and Reiter conclude that the provision of social services needs to be taken more seriously within the social investment paradigm, we are less optimistic about the paradigm's overall promise. This article has shown that the social investment paradigm has not only underestimated the importance of the organization of care services, but has also ignored the inherent value of care work, paid or unpaid. The labour shortages that emerged after the onset of the Covid-19 pandemic in the long-term care sector in France, the Netherlands and many other countries are a consequence of this undervaluation and demonstrate the limitations of a focus on investment in economic productivity. Concurring with scholars

44. https://www.reuters.com/business/frances-scandal-hit-orpea-reaches-restructuring-agreement-2023-02-01/ (accessed 19 February 2023).

who advocate eco-social policies as a response to the environmental emergency, we believe that there is a need for a radical alternative to social investment, in the form of a welfare state paradigm that no longer focuses on 'including people in the labour market', but rather on promoting their 'capability to take care of the world' (Bonvin and Laruffa, 2022: 490), a paradigm that prioritizes long-term sustainable care for people as well as for the planet (Williams, 2021).

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ORCID iD

Franca van Hooren https://orcid.org/0000-0001-7270-7302

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