

From the commodification to the corporatization of care

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Abstract

Recent developments in western Europe show that for-profit companies of different sizes, including large multinational firms, are increasingly investing in care and buying significant shares within the on-going privatization of the care and health national systems. Reflecting upon these developments this article argues that the current reconfiguration of care is driven not only by processes of commodification and marketization, but also by complex mechanisms of “corporatization.” To substantiate this argument we undertake an overview of the transformations investing elder and childcare in some European countries and provide a “typology of care” in order to clarify our concept of care corporatization.

Keywords: Corporate care, commodification of care, marketization of care, welfare state, Italy, UK, Sweden.

1. Introduction

Since the coinage by Clare Ungerson (Ungerson 1997) of the notion of “commodification of care” in an article for *Social Politics*, a number of migration, welfare and care scholars have analyzed the processes by which, in the European context, care provisions for the elderly, children, ill and disabled people have been

increasingly turned into marketable goods. Thus, they have highlighted the dynamics leading a number of European states to move to, or intensify already existing, cash-for-care models that put the responsibility for choosing care directly into the hands of care-seekers turned “care customers” (Pavolini and Ranci 2008; Picchi 2016; Simonazzi 2009). However, within this growing field of research, few studies have shed light on the ways in which states and households outsource care services to not-for-profit and, particularly, for-profit organizations, and the growing presence of corporate actors within the care sector. Recent developments in a number of western European countries show that for-profit companies of different sizes, including large multinational firms listed in the Stock Exchange, are increasingly investing in social care and childcare and buying significant shares within the on-going privatization of parts of their care and health national systems.

Reflecting upon these developments, this article argues that the current reconfiguration of care in western Europe is driven not only by processes of commodification and marketization, but also by more complex mechanisms of “corporatization.” Furthermore, we also argue that what we are witnessing today is an ongoing transformation of our understanding of care, which has been triggered by the application of corporatized logics to the management of care services. While notions such as commodification or marketization of care have been able to capture the processes by which care as unpaid labor and as a “use value” has been gradually turned into a commodity following market rules, the notion of “corporatization of care” designates the ways in which for-profit actors are increasingly entering the world of care as well as beginning to impose business rationalities and the corporate logic of profit-making and (labor) cost-cutting upon the whole sector.

In order to substantiate these claims, we undertake, first, a brief overview of the transformations that have occurred in the provision and organization of care for the elderly and children in contemporary Europe. It is an overview with a dual perspective. On the one hand, it describes sociological and historical transformations in care provision that have been comprehended in terms of the concepts of care commodification and marketization. On the other hand, it discusses how these concepts have been used in different scholarly debates.

Second, we turn to contemporary trends in the provision of care in western Europe that point to a growing importance of the for-profit sector in the care economy. By reconstructing the debate on the consolidated presence of corporate companies in the care sector in the Australian and US contexts, we suggest that a similar process of care corporatization might be taking place in western Europe as well. In order to support this argument, we provide a brief overview of care arrangements and particularly of growing corporate practices in the realm of care in three important national contexts – the United Kingdom (UK), Sweden and Italy.

Finally, we propose a “typology of care” in order to clarify our concept of the corporatization of care. The transformations we describe in the typology – from a commodified model of care to marketized and finally corporatized types – do not necessarily follow a linear evolution; nor are the forms of care provision captured by these concepts rigidly separated one from the other. Our typology instead aims to illustrate in a succinct and graphically effective manner different degrees through which the provision and organization of care are subject to market and profit-making rules and the ways in which our “imagery of care” might be transformed by these processes.

2. Transformations in care: commodified and marketized models

Discussions about the changes affecting the realm of care in the last twenty years have, in various ways, pointed out how care has been transformed from the unpaid “vocational” activity carried out mostly by women within private households, into paid labor and a commodity that is sold on the market (Folbre 2012; Triandafyllidou and Marchetti 2015; Ungerson 2003; Zelizer 2009). Unpaid female care labor in the family setting, in other words, has been used as the background against which to assess both the transformations affecting care provision as well as conceptions of care more broadly. Although this “familial” idea of care is still present today across Europe, insofar as female family members are still those mostly in charge of social reproductive tasks within households in unpaid form¹, since the mid 1990s scholars have observed important transformations affecting this model of care as well as a visible shift towards forms of care commodification and, more recently, marketization.

The commodification of care

As Clare Ungerson argued in a seminal article from 1997, instead of paying salaries to caregivers or further promoting in-kind forms of care, several European countries in the early 1990s had begun to introduce allowances for care users, which were “specifically intended to fund the purchase of services, especially personal care services, from an identified personal assistant” (Ungerson 1997, 364). Ungerson regarded this shift as the result of a particular combination between very different actors, rationalities and political agendas: first, the feminist claims throughout the 1980s that care could no longer be regarded as “unpaid labor,” particularly in a context of growing incorporation of women into the paid labor market; second,

demands by disabled people in the 1990s for the right to organize their own care needs; and third, neoliberal and anti-bureaucracy arguments coming from the new right that advocated the individualization and privatization of care in a context of welfare state cuts. The convergence of these demands (intentionally and unintentionally) created the conditions for the transformation of the care paradigm: from one in which the care user was seen as a recipient of welfare benefits, to one in which she was increasingly regarded as a consumer. The “presence of money” in the caring relationship, for Ungerson, represented a sea-change leading to processes of “marketization of intimacy” and “commodification of care.”

It was towards the end of the 1990s that the commodification of care thus became a central issue for scholarly debate, with the effects of a number of interconnected phenomena becoming increasingly visible. Firstly, in the last part of the twentieth century the ageing of the European population and the increasing costs of care provisions that have accompanied it prompted several western European states to reform their Long Term Care (LTC) services towards policies that support care in the home (Anderson 2012; Glendinning and Moran 2009; Pavolini and Ranci 2008; Simonazzi 2011). The ageing of the population has become particularly important in relation to the expansion of the morbidity time (Phillipson 2013), with a consequent need for residential care for elderly people who are chronically ill (Timonen 2008). Secondly, the participation of women in paid work and their reduced availability to provide care within their households has produced an increased demand for childcare, elderly care and other types of services now more readily available on the market (food, clothing, accessories, etc.). Finally, the intensification of the debate around the commodification of care also coincides with the increasing reduction of in-kind care services that, in some countries at least, had been provided predominantly by public

institutions or the state, and which have been increasingly reduced by the neoliberal restructuring of welfare regimes and social policies. From the early 2000s onwards, across Europe governments have introduced or intensified so-called “cash-for-care schemes,” which provide care-seekers with monetary benefits, or quasi-cash payments such as vouchers or tax credits, to allow them to purchase care services on the market. The widespread resort to cash-for-care schemes has not only affirmed a conception of care as a commodity that care-seekers turned consumers can freely purchase on the market. It has also privileged home-based care as a way to save on health and care costs, which tend to be far higher when care is provided in the form of services in-kind (Anderson 2012; Glendinning and Moran 2009).

The transition from a conception of care as a family-like relationship towards a conception of care as a commodity has posed several challenges both to sociologists and economists. For instance, through concepts such as “body-work” (Twigg et al. 2011; Wolkowitz 2006) and “intimate labor” (Hochschild 2012; Parreñas and Boris 2010) sociologists have tried to highlight the peculiarity of care work as “not just another work” – in Helma Lutz’s terms – but a “core activity of doing gender” (Lutz 2008, 1-48), which is imbued with “affect” (Gutiérrez-Rodríguez 2010). Similarly, feminist economists have drawn attention to the specific implications of the commodification of care tasks by speaking of a “care economy” (Folbre 2012; Zelizer 2009) and by emphasizing how this is characterized by the over-representation of a workforce with strong gender, race and class-based connotations (Anderson and Ruhs 2010; Cangiano and Shutes 2010; Cox 2006; Kofman and Raghuram 2015; Lan 2006; Sassen 2002). The intimate nature of the context in which commodified care services are performed (usually private homes) and the emotional character of the tasks involved in assisting children, elderly and sick people, have been considered as

obstacles to an exact quantification of the “costs” and “tasks” of this type of labor, which go well beyond a clear-cut relationship between assignments and outputs, and do not satisfy the principles of pricing based on customer-satisfactions (Folbre 2012, 3). Furthermore, as a type of human service that is labor-intensive and low in productivity, the care economy is said to suffer from the “Baumol costs disease” (Baumol 1967), which means that wages are independent of productivity and that profit margins are low (Simonazzi 2011; Yeates 2009). These distinctive features of care also explain why its commodification has been carried out both through the reconfiguration of the welfare state as a provider of monetary transfers rather than services, and increasingly through the outsourcing of care services to private (for-profit and not-for-profit) care providers, which tend to confront the low profit margins of the sector by cutting on labor costs and adopting business management models, as we discuss in more details below.

The marketization of care

As mentioned above, beginning in the mid 1990s, and increasingly in the 2000s, several western European countries reformed their welfare and LTC systems both by promoting home-based care as a way to save on social care costs, and through the outsourcing of care services to for-profit companies and not-for-profit organizations. The changing role of the state, from being a direct provider of services (at least in some contexts) to supporting the expansion of private care actors, has been described in terms of marketization. As Deborah Brennan et al. put it, marketization refers “to government measures that authorize, support or enforce the introduction of markets, the creation of relationships between buyers and sellers and the use of market

mechanisms to allocate care” (Brennan et al. 2012, 379). Accordingly, they see marketization as taking a variety of forms, from outsourcing care services to private providers to funding individual users to purchase services on the market. Along similar lines, Anneli Anttonen and Liisa Haikö (2011) use the term marketization to refer to the ways in which market-like mechanisms increasingly provide “services within the public and third sectors (or civil society)” (Anttonen and Haikö 2011, 71), thereby intensifying the construction of “both care as a commodity, and the individual in need of care as a consumer” (ibid.).

This approach thus emphasizes the role of the market in the realm of care not simply as one of the actors providing care alongside others – as in Eleonore Kofman and Parvati Raghuram’s (2009) metaphor of care as a “diamond” resulting from the intervention of the market, the household, the state and the not-for-profit sector – but as a key operator whose logic permeates the entire realm of care, causing a complete shift in the functioning and understanding of care provision. By using this concept, scholars have thus drawn attention to the new strategies adopted by several states in their privatization of care: if the commodification of care described the process by means of which various forms of cash-for-care are given directly to households in order to keep care services in the domestic sphere by allowing care-seekers to hire personal assistants, the marketization of care refers to the ways in which states promote the growth of private care-providers (both for-profit and not-for-profit) that compete on an increasingly crowded marketplace.

The process of marketization of care can be regarded as the intensification of dynamics that had been set in motion by care commodification: both spring from the neoliberal reconfiguration of the role of the state as one that ensures the functioning of markets, and the transformation of citizens into consumers individually responsible

for their care needs. While in-kind care services have been regarded as producer-focused, inflexible, paternalistic and inefficient, monetary transfers and private market-based providers have been increasingly framed as more consumer-focused, flexible and efficient (Clarke 2006). As Catherine Needham argues, the “personalization” of services has become the main narrative underwriting the public service reforms carried out from the 1990s onwards that aimed to outsource and privatize public provisions to non-state actors (Needham 2011). The political and theoretical approaches to the welfare state that underpin these changes emphasize the role of the agency of the individual and her capability to exercise her free choice within the market (Glendinning 2008; Shutes and Walsh 2012).

All in all, while the concepts of commodification and marketization of care describe both the epochal shifts that have taken place in the care sector since the mid 1990s as well as the emergence of new types of care, they do not entirely capture, in our view, some of the most contemporary developments affecting childcare and elderly care in particular. As the next section discusses in detail, such developments concern the increasingly aggressive presence of for-profit companies, including large firms, in the realm of care. These companies are not simply enriching the offer of care services options, but are fundamentally impacting upon the working conditions and quality levels of the sector, setting the terms for the emergence of a new type of care as well as transforming the broad conceptions people have about what care should be.

3. Towards the corporatization of care?

In recent years, healthcare and social care have become a very profitable business across Europe. According to the Healthcare Private Equity Association, private investments in healthcare, particularly in the provider and related services

section including LTC for elderly and dependant people, more than tripled between 2013 and 2014, and are set to grow rapidly in the next years (Global Healthcare Private Equity Report 2015). The healthcare and social care sector has been one of the few that registered considerable growth during and in the aftermath of the Global Economic Crisis of 2007-2011, thereby becoming an interesting site for private investors (Farris 2015a; Picchi and Simonazzi 2014). In 2014 alone, the value of new healthcare buyout investments hit a three-year high at \$29.6 billion, more than one-third of which was in Europe (Global Healthcare Private Equity Report 2015).

Across the continent since the early 2010s, press coverage and business literature in particular have reported that large companies are increasingly investing in elderly care and childcare, and buying significant shares within the ongoing marketization and privatization of parts of national care and health systems. While understudied in Europe, these trends have received more sustained scholarly attention in other regional contexts where authors have talked about the “corporatization” of the care sector. For instance, since the mid 2000s in Australia several scholars have identified a process of corporatization taking place while discussing the growing presence of large for-profit companies in childcare provision. By corporatization of care they refer to “the rapid expansion and escalating market share of childcare services owned and/or operated for profit by public companies listed on the Australian Stock Exchange” (Sumsion 2006, 100), as well as the ways in which the for-profit sector is “placing the provision of childcare in a different and unexpected commercial mainstream” (Press and Woodrow 2005, 278). Similarly, in an influential article discussing Hochschild’s concept of “global care chains,” Nicola Yeates (2004) discusses the private provision of various types of care work in terms of the emergence of a corporate care industry, with particular reference to the US. As she

puts it: “Care corporations provide a range of personal health and social care services in institutional (hospitals, nursing homes, nurseries) and domestic (households) settings; house care corporations provide private households with various ‘housewife’ services and maintenance, pest control and repairs. Corporations may specialize in one of these types of services or may combine different types of services (e.g. personal and house care)” (Yeates 2004, 382). Yeates sees “the corporate care industry [as] a major area of economic growth and employment generation” (ibid.) in many countries, even though public and informal providers remain a major source of less profitable and non-profitable care services. Unlike the scholars focusing on the Australian case, Yeates offers a more extensive concept of care corporatization, which would include a wide range of for-profit suppliers, from self-employed individuals to small enterprises, to agencies and multinationals. Accordingly, she charts the differences between various corporate care actors in terms of their size and the reach of their commercial activities, from the sub-national to the national and international scales (Yeates 2004, 382). In spite of their different conceptualizations, these studies emphasize how the growing presence of for-profit companies in the care industry in both Australia and the US was driven above all by the ideological dominance of neoliberalism and the idea that markets, rather than the state, enhance efficiency and a diversification of care options available to consumers.

As we discussed in the previous section, the notions of commodification and marketization of care have both served in the western European context to describe the progressive relinquishing by the state of its role as the direct provider of care as well as the emergence of privatized arrangements driven above all by various forms of cash-for-care schemes. Scholarly approaches utilizing these notions have in turn emphasized the changes affecting the care relationship, turning it from a relationship

between caregiver and cared-for, into one between care-provider and care-consumer. It seems to us, however, that important emerging trends in the field of care provision for children and older and/or disabled people in western Europe are also increasingly following in the footsteps of the Australian and North American examples.

In other words, we claim that in Europe as well we can observe the expansion of forms of marketization of care, giving rise to the growing presence of private for-profit care providers of various sizes and their adoption of corporate practices, including maximization of profits through economies of scale, profit-oriented business models and the adoption of corporate logics of cost-reductions in the management of the service provision and human resources. These emerging trends, it seems to us, are reconfiguring important parts of the European care sector in the direction of its corporatization.

By corporatization of care, therefore, we refer above all to the growing presence of for-profit companies of various sizes in the provision of care services. Furthermore, the adoption of corporate practices (cost-cutting, business management models, segmentation of the labor process) by public-private partnerships and not-for-profit organizations that provide care seem to us to suggest a general reconfiguration of care, even though not-for-profit actors strictly speaking do not belong to the type of care that we call “corporate.”

One of the driving forces behind the state’s reconfiguration of care as a business-organized activity and the increasing corporatization of care services in Europe has been the theory of New Public Management (NPM). As noted by Thanos Maroukis (2015), under its influence several European countries from the late 1990s onwards have applied to the care and healthcare sectors processes of decentralization of decision-making; managerialization (adoption of business-oriented management

methods, with a focus on accountability of results rather than process accountability); marketization (contract-based competition for service provision) and corporatization as, for example, in Private Financing Initiatives (PFI) which fund public infrastructure projects with private capital (Hood 1995; Hood and Dixon 2015; Pollitt and Bouckaert 2011). NPM has been pivotal for the LTC reforms in several European countries (on which more below).² Likewise, NPM helped to establish the demand-led approaches in childcare that contributed to the privatization of the provision of services for children in the UK and the Netherlands (Lloyd and Penn 2010). The application of the neoliberal doctrines of public expenditure cuttings, costs-benefits and business calculations, which is epitomized by NPM, has largely contributed to turn the care sector into contested territory for the operation of corporate actors and rationalities.

The corporatization of care in the UK, Sweden and Italy

In order to provide a preliminary roadmap of forms of corporatization of care in Europe, in the following section we discuss these emerging trends in three western European countries: the UK, Sweden and Italy. We chose to focus on these countries because they represent very different welfare models and care regimes as well as political traditions (liberal, social democratic and familistic in the well-known classification of Esping-Andersen (1989)). The discussion of an emerging corporatization of care in such diverse settings, therefore, can shed light on how the presence of corporate care actors is being promoted and the initial effects they produce, particularly in terms of labor conditions and care quality. Given the exploratory nature of our article, however, we should clarify from the outset that we

are not providing a comparison between diverse countries in terms of different degrees of corporatization, but rather employing them as exemplary case studies for the understanding of a phenomenon that is still in progress. Furthermore, we underline that the dynamics we describe in each country point not only to processes of corporatization, but also commodification and marketization. As we emphasized above, these processes are linked one to the other, and thus need to be discussed in conjunction in order to capture the true novelty represented by forms of care corporatization in Europe. As the examples below seek to highlight, the strength of the move to corporatization in the three contexts we discuss is very different, depending upon their welfare models and the trajectories undertaken by processes of care commodification and marketization in each of them.

UK

Like other liberal welfare regimes – in Esping-Andersen’s (1989) influential definition (e.g., Australia, Canada and the US) – the UK in the last thirty years has been at the forefront of reforms leading to the progressive marketization and corporatization of the care sector, thereby reconfiguring the country as the current leading example of care corporatization in Europe.

In the case of care provisions for elderly and dependant people, processes of marketization (and subsequent corporatization) began in the 1980s when a series of legislative acts were passed emphasizing the need to improve services for the elderly and dependant persons at the community level. These measures opened the path to the outsourcing of long-term-care to private companies and not-for-profit organizations (Tinker 1992). The Government’s decision in 2007 to roll-out individual budgets to be controlled directly by people eligible for publicly funded social care, even if not

taken in the form of cash, has fundamentally changed the logic of local authority provision, which “was thus superseded by a nationally mandated shift towards constituting service users as consumers exercising choice” (Brennan et al. 2012, 380). The extent of marketization and particularly corporatization processes in the UK is such that at the end of the 2000s, 81 per cent of places in residential care homes were in the private for-profit sector, compared with 13 per cent in not-for-profit and 6 per cent in care homes funded by local authorities (Land and Himmelweit 2010, 11; Shutes and Walsh 2012, 5). The case of Southern Cross Healthcare in the UK has become a paradigmatic example of corporate care and the ways it affects care quality as well as workers’ conditions in the sector. Taken over by Philip Scott in 2000 when it was still a small provider of care homes, in the space of a few years Southern Cross Healthcare became the largest provider of elderly care in the UK, mainly thanks to acquisitions. The company was bought in 2004 by the US based private equity firm Blackstone, which put Southern Cross on the London Stock Exchange, guaranteeing millions of GBP in shares for investors. In 2010, Southern Cross owned more than 750 care homes with more than 38,000 beds and employed around 44,000 staff. By the end of 2011, the business model established by Blackstone collapsed, leading to the closure of some of the care homes and redundancy packages for 3,000 staff (Tricker 2015, 142-4). Despite the failure of the corporate care model exemplified by the crisis of Southern Cross Healthcare, corporate companies have been encouraged to invest in the care sector. The 2012 Health and Social Care Act represents the latest and most advanced step towards the corporatization of elderly care, effectively allowing big companies to bid for the contracting out of care services. It is in this context, for example, that the Virgin corporation created Virgin Care. According to

the NHS Support Federation, since 2010 Virgin Care has won contracts for NHS work valued at around one billion GBP (which is likely to be an underestimate)³.

The introduction of market principles into the provision of childcare, on the other hand, is a relatively recent phenomenon. Until the end of the 1990s, the state did not invest in childcare, “with the exception of local authority nursery care for children deemed needy or vulnerable” (Brennan et al. 2012, p. 383), as it was considered mainly a family responsibility. Since the 2000s, however, investment in Early Child Education and Care (ECEC) grew dramatically mainly with the aim to increase the supply of provision. The Childcare Act of 2006 established that private providers should be prioritized, while forms of tax credits and tax breaks have been provided to low-income and middle class families in order to meet rising fees. The corporatization of childcare in the UK is the most advanced in Europe, with 97 per cent of all childcare provision for children under three years of age and 40 per cent for children over 3 years now firmly in the hands of private for-profit suppliers (Penn 2014). Furthermore, 8 per cent of all childcare facilities in the UK are run by corporate businesses (i.e., owners of more than five nurseries) (Penn 2014). Brennan and colleagues report that before the 2007-2011 global economic crisis, there was strong market consolidation “with a number of nursery chains listing on the stock market either as ‘stand-alone’ companies or elements of diversified corporations” (Brennan et al. 2012, 383). Helen Penn and Eva Lloyd discussed how, by 2007, nine out of the top ten providers of nursery places in the UK were listed on the Stock Exchange Market or were owned by private equity groups, while nursery workers were paid very poor salaries compared to the rising fees produced by the corporatization of childcare (Penn 2007). Furthermore, one of the effects of the privatization and corporatization of childcare has been “a rise in the fees charged by providers, a drop in the standards

in poorer areas, and an increase in inequalities of access” (Penn 2014, 453). Finally, processes of care corporatization can be seen in the UK context also in the growth of for-profit recruitment agencies, particularly for elder care and childcare. According to the Recruitment and Employment Confederation (REC), the growth of private agencies was particularly pronounced in the period between 2012 and 2015. Studies also show that private agencies put enormous pressure on workers to break down their labor into a clear number of tasks, each requiring no more than a certain, reproducible amount of time. However, workers experience the segmentation and quantification of their work not as a step towards more professionalization, but rather as a form of pressure and disregard for the actual time, complexity and efforts that care entails (Farris 2015b).⁴

Sweden

Despite its well-known association with a social democratic welfare model guaranteeing high levels of benefits and services in-kind provided by the state, Sweden began to move towards forms of care marketization already in the early 1990s. Arguments regarding improvement of quality were used in 1991 when the new Local Government Act permitted municipalities to outsource elderly care to private (for-profit and not-for-profit) actors. Initially very marginal in the landscape of non-state elderly care provision, throughout the 2000s the presence of for-profit companies in this sector grew at a dramatic pace. By the end of the 2000s they accounted for 17 per cent of Swedish elderly care, while the not-for-profit sector only constituted 2-3 per cent (Brennan et al. 2012). These proportions, however, present wide regional variations. For instance, while in and around Stockholm more than half of all elderly care is now provided by for-profit companies, in all other municipalities the not-for-

profit sector tends to dominate the supply of elderly care. Two corporations alone own half of Sweden's private elderly care market (Meagher and Szebehely 2010). In order to break this situation of oligopoly and multiply the range of private choices available to care seekers, the Swedish government in 2009 introduced the Act on Free Choice, urging municipalities to introduce more options for care-seekers and to implement a customer choice model (Brennan et al. 2012). However, according to Stig Montin, the policy framework on free choice continues to privilege large for-profit companies. As he puts it, "due to the fact that it is hard to provide any precise quality criteria, the price of the services becomes the most important criteria and smaller companies and non-profit organizations are not able to compete with the big ones, which have thus far turned a rather good profit in selling care to municipalities" (Montin 2015, 15).

Concerning childcare, in spite of its internationally renowned universalist and public system of education, Sweden was in fact one of the first countries in Europe to discuss the marketization of care provisions for pre-school children (Brennan et al. 2012). Already in the early 1980s the Swedish Employers Federation proposed to set up for-profit childcare centers in order to provide families with a wider range of choices. Although the proposal was rebuked by the then Social Democratic government, arguing that it would affect the quality of care delivery and produce forms of class-based segregation, it was re-launched and eventually implemented by the center-right government in the early 1990s, thereby allowing for-profit childcare providers to receive subsidies from local authorities. Thus, since the 1990s not only are for-profit childcare companies receiving tax-payer subsidies, but they also have been allowed to charge higher fees than public providers, in a clear break with the Swedish egalitarian tradition. Unlike in the case of elderly care, however, the presence of for-profit companies in childcare is more limited. In 2011, only 8 per cent

of childcare settings were for-profit, while 81 per cent of this provision was still offered by the state. Not-for-profit suppliers consist mainly of parental or staff cooperatives that operate according to the principle of co-production between the care users and the care receivers (Bergqvist and Njberg 2013; Brennan et al. 2012;). The few studies that have addressed workers' conditions in privatized, particularly for-profit, care settings in the country cite a report released by The Swedish National Audit Office. The report takes a critical stance towards the diverging regulations governing public and private elderly care providers. For instance, while care workers employed by public elderly care providers are guaranteed protection in cases of whistleblowing, workers in private companies are not. Furthermore, the latter are required to report abuse to their managers, while workers employed in public institutions report abuse to their local politician. In light of this, the Swedish National Audit Office concluded that "altogether there is a risk that bad conditions within privately provided elder care go undetected" (Meagher and Szebehely 2010, 27).

Italy

Like other Southern European countries, Italy has been historically affiliated with a familistic welfare regime and traditional model of care entailing strong reliance on family members – above all women – for the provision of care for both children and the elderly (Saraceno 2003). Accordingly, the Italian LTC system has been characterized by low levels of in-kind provision and, since the 1980s, by the establishment of a cash allowance [*indennità di accompagnamento*] for disabled and elderly people, which can be spent at the complete discretion of the beneficiary. However, from the 1990s onwards the growing participation of Italian women in the labor market outside the household and the rapid ageing of the population (which in

Italy is coupled with one of the lowest birth rates in Europe) has produced a rising demand by elderly people requiring care (Da Roit 2010). It is in this context that families with frail elderly members and children have begun to look increasingly at private solutions on the market (Da Roit and Sabatinelli 2013). The commodification of care in Italy has been shaped predominantly by the reliance of families on immigrant women hired as personal carers at home (commonly called *badanti*). This situation has not only received increasing media attention, but has also prompted sociologists, migration scholars and feminist economists to speak of a fundamental transition occurring in Italian society, from a “family model of care” to a “migrant in the family model of care” (Bettio et al. 2006). The “migrant in the family model” represents above all a cost-effective solution which allows Italian families to maintain a family model and a gendered division of tasks, as well as to save money, since migrants work long hours for very low salaries (Van Hooren 2012). As Marchetti and Scrinzi (2014) argue 2014, local authorities and not-for-profit organizations are also increasingly present in the care market. Social-cooperatives in particular are growing steadily, representing 14 per cent of the home-based care sector in Italy and employing an estimated 6 per cent of care workers. However, studies show that employment conditions within care cooperatives are not an improvement compared with those of (often illegal) migrant workers privately hired by households. Albeit still marginal in the care sector, for-profit care providers are also present and growing significantly, particularly since the end of the 2000s. For instance, the company *PrivatAssistenza* (private assistance), which operates through franchizing across the country and provides private home-based care services, is one of the fastest rising for-profit care operators in Italy, with revenues for over fifty million Euros in 2016. Between 2010 and 2015 the number of centers with the brand have doubled – from 80

to 180 – while the number of families resorting to *PrivatAssistenza* are now an estimated 40,000.⁵ The growth of a company like *PrivatAssistenza* testifies to the epochal shift occurring in the landscape of care in Italy, whereby the rising demand for care by an elderly population in steady growth is opening the space for a multiplicity of private initiatives including private companies with shares in the Stock Exchange, as has already occurred in other countries.

Concerning childcare, on the other hand, state-funded, low-fee nurseries are available only for children between three and six years of age. For younger children aged under three, the majority of crèches are provided by the private sector, often with state subsidies either to care providers or families. For instance, by 2010 state coverage of crèches was around only 11 per cent (ISTAT 2011). There are however important regional differences across the country, with richer municipalities in the Centre and the North providing the majority of places. As Da Roit and Sabatinelli report “in 2010, less than half (48.3 per cent) of municipalities provided public day-care places or monetary support to families using private ones, and the take-up rate ranged from 25 per cent in Emilia Romagna (in Northern Italy) to less than 2 per cent in Campania, in the South” (Da Roit and Sabatinelli 2013, 433). Families that do not have access to municipal crèches rely either on family members (particularly grandparents in the case of working mothers), or on private nurseries. Against this background, the rise of private facilities has been dramatic: between 1992 and 2005 private nurseries rose from 7 per cent to 39 per cent, providing over one third of available places (Da Roit and Sabatinelli 2013; Istituto degli Innocenti 2006).

As this brief overview has sought to show, the presence of corporate actors in the care sector differs from country to country. In the UK, the elderly care and

particularly childcare sectors are now dominated by for-profit actors, thereby bringing the country closer to other liberal welfare states such as Australia and the US where care has been subjected to processes of corporatization for longer. In Sweden, on the other hand, forms of corporatization of care have invested almost exclusively in the elderly care sector particularly in the Stockholm metropolitan area where private oligopolies prevail, while the childcare sector is still run mostly by the state or outsourced to not-for-profit actors. Finally, in Italy the presence of for-profit companies in the care sector is still very limited, both in the case of elderly care and childcare where the not-for-profit sector or commodified forms of home-based care prevail. Even in a context such as Italy, however, for-profit actors have become particularly dynamic since the early 2010s and registered dramatic growth.

The differences between the strength and development of moves towards corporatization in these countries are likely linked to the characteristics and histories of their respective welfare regimes as well as to the ways in which they have responded to calls to reform their LTC systems (Pavolini and Ranci 2008). These differences notwithstanding, it is important to note that in all these countries the number of for-profit care providers has grown at a dramatic pace, particularly since the last decade. In other words, even though the presence of for-profit companies is still very limited in a country like Italy, or confined to the elderly care sector in Sweden, their exceptional expansion in the space of only a few years speaks of significant developments regarding investing in the care sector, which are worth registering and analyzing vis-à-vis contexts such as the UK where analogous processes are more advanced.

The growth of the for-profit sector is certainly due to the rising demand for both elderly care – in a context in which those over-80 years of age are projected to treble

by 2060 (European Commission 2011, Graph 1.6.8) – and childcare, given the rising presence of women in the labor market. However, it is also the result of state policies that increasingly outsource care to private actors or promote their proliferation in order to contain the public costs associated with the rising demand for care.

5. A typology of care: from commodified to corporatized

In the previous sections we have sketched out an overview of the changes that have invested the organization and conceptions of care from the 1990s to the present in western Europe. First, we have focused upon the concepts of commodification and marketization of care as the most important and fruitful scholarly attempts to grasp such changes and, second, we have put forward the concept of corporatization of care as one that enables us to make sense of the dramatic growth of for-profit actors in the care sector in some significant western European countries. This overview, however, should not be conceived as a sequence of historical developments in which each concept describes a specific change and stage that supersedes the previous one. In other words, we do not argue that the process of the corporatization of care is taking the place of its commodification and marketization. On the contrary, we regard these concepts as describing processes that are intertwined one to the other, that co-exist at the same time (albeit with different “intensities” in each national or regional context), and that put more or less emphasis upon different but inextricably related dynamics. These include the presence of cash-for-care schemes to hire personal caregivers (as in the type we call commodified care); the importance of the market as the key factor in the multiplication of private care-providers (as in the type we call marketized care); or

the growing significance of for-profit actors in the care sector (as in the type that we call corporatized care).

In order to clarify the conceptual tenets of our discussion and the concrete mechanisms through which processes of commodification, marketization and corporatization of care occur, this concluding section offers a typology of care (see Table 1) as a useful tool to navigate and to put order into these processes. The typology we propose is neither an exhaustive reconstruction of all the possible ways in which care is organized, nor establishes rigid boundaries between the various types and dimensions. It is conceived instead as a framework that succinctly captures the most important dimensions that scholars consider when they conceptualize the changes affecting the care sector and the differences between different types of care provision. Accordingly, each of the care types in our typology – commodified, marketized and corporatized – results from the combination between different dimensions of care.

The first dimension in our table distinguishes between different types of *care-providers*, i.e. the individual, the institution, the organization or the company delivering care. In some instances, care-provider and caregiver overlap, as in the case of individual caregivers employed directly by private households, while in all others the care-provider is usually an institution, an organization or a company of different sizes hiring caregivers for different caring needs. As the previous sections discussed, corporate care arrangements, for instance, are characterized by the fact that care-providers tend to be small or bigger for-profit companies, while discussions on the commodification of care emphasized the renewed importance of individual caregivers hired by private households thanks to the various forms of cash transfers made available through cash-for-care schemes.

The second dimension in our table – following the columns from left to right – describes the *employment* relationship, which refers to the actors mostly involved in setting contractual rules. The types of care we identify – commodified, marketized and corporatized – are defined by the main contractual partners involved in the care “transaction.” Thus, caregivers can either be employed directly by the care-receivers (sometimes through an agency), or by a public institution, an organization or a company that allocates its workforce into private homes, nursing homes or kindergartens. As the table shows, different care types can share very similar ways of regulating the work agreement between care-provider or caregiver, and care-receiver. For instance, in the case of corporate care actors like for-profit agencies placing care services in private households, as in the UK, they can either operate as introductory intermediates who are paid a fee, in which the contractual relationship binds the care-receiver and the caregiver alone, or they can hire caregivers directly and offer them a contract, particularly in the case of short-term, highly specialized services (e.g., emergency nannies, temporary carers for the elderly and so forth).

The third dimension relates to *funding* and draws attention to where the money for the payment of care originates. Almost all (paid) care-providers listed in Table 1 are paid by the care-receiver or their household. In our typology, this situation also includes cases in which households receive refunds, tax-exemptions or subsidies for these payments (through cash-for-care schemes), as long as they use them to pay for care. A different case is the one in which care-providers are fully funded by the state and/or local governments, as in the case of public nursing homes and kindergartens, or public institutions providing domiciliary care services (see note 2 in the Table). Public care institutions are commonly associated with models of full welfare provision, where households are relieved of their care commitments, and the service is

fully sponsored by state authorities that are also politically and economically accountable for the standards and the forms of care provision. Such institutional care providers are increasingly rare in Europe although they still play an important role in countries like Sweden and Italy, especially in the case of childcare. Much more common today are, instead, not-for-profit organizations and for-profit companies that are partly subsidized by public funding bodies (e.g., municipalities or the state) in order to support their activities (cf. notes 3 and 4 in the Table). These actors can be public-private partnerships, associations, municipal corporations, associations, cooperatives, or employment agencies and so forth. Public funds are usually directed to services for low-income care-receivers, or for care needs that are considered a priority for state intervention.

The fourth dimension looks at the *workforce management* that different types of care-providers employ to organize, monitor and assess workers' care tasks, and the delivery of care more generally. The cases in which the caregiver is hired directly by the household present a "personalized" form of workforce management. This means that the individual/household that hires the caregiver exercises control, supervision, and assessment of the caregiver work performance in very personal and discretionary ways. On the other hand, when care is funded wholly or partly by public institutions or the state, care work and delivery are subjected to more or less rigid forms of control. For this reason we refer to this type of workforce management as "bureaucratized." Bureaucratic mechanisms of management are used by state authorities or public institutions in order to control how public monies are spent and to comply with the duty of financial and political accountability they have before citizens and other authorities. In these contexts, the relationship between caregivers and care-receivers tends to be more impersonal. An example of bureaucratized

management is provided by Scrinzi and Marchetti (2014) for the Italian case. Finally, what we call “liberalized” workforce management is adopted by private for-profit (large or small) companies, which might or might not receive public funds, but are nonetheless freer to organize the provision of their services in more flexible ways, as shown in the Swedish case. The level of flexibility and discretion the company adopts in the management of the caring workforce and care delivery depends upon specific legislations in each country, for instance, in terms of the presence of certification and monitoring of services that apply to the delivery of childcare and elderly care. Beside quality constraints, for-profit private care providers are not required to justify their business strategies before political or civic authorities, as in the case of organizations partly or fully funded by public monies.

Finally, our typology includes the dimension that we call “*imageries of care*”. This concept aims to grasp care not necessarily as a specific service or an activity, but as the understanding of care needs, and the ideas about how and who should respond to them in our everyday life (Weicht 2015). In other words, “imageries of care” can be thought of as the broad conceptions of care held by a group of people (or population) in a specific context. They can vary from, for instance, imageries according to which care is a “public good” that should be provided for free by the state, to imageries that see care as an intimate and highly personalized arrangement involving care-receiver and individual caregiver within private households, whether in paid or unpaid form. The latter imagery is found in its purest form in unpaid, family-based care settings. This “familial” model of care does not involve rigid limitations in the modality, duration or content of the assistance provided and is ideally expressed in a one-to-one relationship between children or elders and typically a female carer. Even though our typology does not consider forms of care in unpaid form, the familial

imagery of care still permeates even those commodified arrangements in which an individual caregiver is hired by a household (forms 1a and 1b), as long as the caring relationship resembles that between the family member and the cared-for person, as in the case of the figure of the *badante* (private caregiver) in Italy.

While such a familial imagery of care in western Europe prevailed widely between the 1950s and 1970s, insofar as care was mostly provided by female family members within the household, and it is still present even in monetized care settings that reproduce forms of personalized, home-based care, processes of commodification, marketization and more recently corporatization are, in our view, leading to the emergence of a new imagery that we call “corporate care”. The corporate imagery of care is one in which care is understood as a very structured activity, articulated in tasks clearly defined on the basis of their content, duration and the modality of their provision. When care is corporatized, as in the case of care services provided by for-profit residential homes, the one-to-one caring relationship no longer prevails, but is often replaced by a relationship between the cared-for and multiple caregivers who rotate in shifts, each of them with a different specialization and therefore a different task. This is the case also when private for-profit recruitment agencies (as in the UK) provide care according to rigid schedules and forms of control.

When care moves towards its corporatization, caregivers might not be the ones assessing the care needs; instead, they are only those implementing services designed by upper-level authorities (usually managers who might know very little about care – Farris 2015b). The expertise of caregivers is based on previous training and formal education, a system of references and CVs, which need to be in line with the guiding principles of the specific company or organization. In terms of workforce management, corporate care is oriented to efficiency and costs-reduction, which might

be achieved through a Toyotist-like organization of tasks and work-flow – as in the case of the biggest private cooperatives in Italy or for-profit agencies in the UK – and especially through the diminution of salaries and rights for the workforce.

Table 1 attempts to convey the blurriness of the transition from the imagery of familial care to that of corporate care by means of the shadow-effect produced by the intensification of the grey color when moving from the top to the bottom of the column. We suggest that the corporate imagery of care begins to emerge when the commodification of care is consolidated into forms of care marketization and intensifies in corporatized care settings. Even though we see the corporatization of care as an emerging and recent phenomenon in the western European context, we suggest that the likely deepening of this process in the future will influence the ways in which people will think about, and organize, care in general. In other words, once corporate care practices become more consolidated, the idea of care as a commodity to be sold for-profit might take hold and change the predominant imagery associated with care within our societies.

In conclusion, by establishing business-oriented models of organization of care services, the corporatization of care is magnifying those processes that were initiated by its commodification and marketization, as well as introducing a number of changes which challenge the idea of care as a special type of practice. By turning it into an activity that is ever more codified, less personalized, poorly paid and less sensitive to the changing needs of the people towards whom it is oriented (children, disabled, ill or elderly persons), care work is becoming the contested territory for the penetration of new forms of capitalist restructuring. In light of the speed of the diffusion of these new corporate forms of care, scholars are faced with new dilemmas and the challenge to investigate them in all their dimensions.

Table 1.

A TYPOLOGY OF CARE: FROM COMMODIFIED TO CORPORATE						
CARE TYPE	Care-provider	Employment	Funding	Workforce management	Caregivers	Image-ries
Commodified	1A. Individual caregiver hired by household	Contract between household and caregiver	From care-receiver	Personalized	Low and medium-skilled workers	Familial Imagery of Care 
	1B. Individual caregiver hired by household via agency	Contract between household and caregiver (via agency)				
	2. Not-for-profit public institutions	Contract between institutions and caregiver	From public authorities	Bureaucratized	Medium-skilled workers	
Marketized	3. Not-for-profit private organizations partially publicly funded	Contract between caregiver and care provider or care-receiver	From public authorities + from care-receiver			
	4. For-profit private companies when partially publicly funded					
Corporatized	5. For profit private companies			Liberalized	Low, medium and highly-skilled workers (including transnational nurses)	
	6. Large companies in the stock market					

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² . See Schwiter et al. 2015 for the Swiss case.

³ Source: <http://www.nhscampaign.org/> (Last accessed 22 October 2016).

⁴ Similar findings were reported for the Swiss case by Schwiter et al. 2015.

⁵ Source: <https://www.disabili.com/home/ultimora/privatassistenza-il-franchising-dell-assistenza-domiciliare-da-50-milioni-di-euro> (Last accessed 7 March 2017).