** please do not cite this very preliminary and incomplete draft. The contents of this draft will be a part of my PhD thesis.*

[Transforming Care Conference, Marketisation of Care]

Third sector in Policy Network of Home Care Policy for Older People in Finland, England and South Korea

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INTRODUCTION

The aim of this paper is to explore how the characteristics of actor involvement results in types of policy networks in the home care policy of Finland, the United Kingdom and South Korea, and to interpret the similarities and differences in country context. In this draft, I only report very preliminary result of QCA analysis. As the result of this analysis is very first attempt and has considered limited sources of date, biases especially confirmation bias was not thoroughly controlled. Please do not cite this draft until it is published after completing study. Any kindly given comments, impressions, questions, advices and suggestion should be greatly appreciated.

The global scale care-dependent demographic change requires the reform of care system toward easy access and adequacy of care service; increased quality of care; maintaining financial sustainability; care mix (deinstitutionalisation by increasing demand of informal care); the mode of care preferred by clients from traditional hospital care and living in long-term care institution (Genet *et al.*, 2011; Ilinca, Leichsenring and Rodrigues, 2015; Spasova *et al.*, 2018).

To increase accessibility of care, many countries draw different sources of care from market and grey market area (Zechner and Valokivi, 2012). Mathew Puthenparambil, Kröger and Van Aerschot (2017) diagnose this issue that the restricted and insufficient access to public care leads the growth of private services. Knibb (2006) regards it as political promotion to meet user's expectations and to improve care service provision (p. 4).

Regulation issue to secure service quality level in delivering services from private and informal service providers (especially in home care) (Genet *et al.*, 2011), and care (provider) mix between public and private sector including third sector care service provider is another strand consisted of transformation of care and care policy to be shown that the expansion of actors (Kendall, 2000; Hogg and Baines, 2011; Mathew Puthenparambil, Kröger and Van Aerschot, 2017). Client-centred care

service is discussed in a boundary of care mix in terms of expansion of care actors as well (Visvanathan *et al.*, 2003; Genet *et al.*, 2011).

With those trends, it is recognisable that the care provider has widened to private and third sector from public sector exclusive care provision. This background is well fit to my research interest on third sector involvement in care provision for older people. As the second part of my doctoral thesis, the hidden aim of this project is to identify policy actors in home care policy and to figure out network attributes, and shapes in three different countries.

I obtained three lessons from my previous research: the review of the roles of third sector in delivering care service for older people in Finland, the United Kingdom and South Korea. First, the roles of third sector in care for older people are getting prominent. Second, I found the most area where the third sector providers involved in is home care (including similar concepts such as home-based and community-based care, residential care, domiciliary care and care or nursing home in a broader sense. Although the boundary between the concept of similar concepts is not clear, the room for third sector provider is higher in home care provision. Third, there are less significant differences on the role of third sector as a care service provider for older people in three selected countries. Third sector providers respond to dramatic population changes (ageing) and care crises by economic downturns, being dependent upon the public policy provisions, working in both inside and outside of institutional boundary of care policy.

These findings allow me to decide to deeply look at home care policy. And several studies about home care in European countries convinced me to focus on home care with the driving factors of home care such as demographic trend, changes in the epidemiological landscape of disease, the increased focus on user-centred services, the availability of new support technologies and the pressing need to reconfigure health systems to improve responsiveness, continuity, efficiency and equity as well as recent trend of care preference in care recipients' home and government care provision focusing on home care (Tarricone and Tsouros, 2006, p. vi; Ilinca, Leichsenring and Rodrigues, 2015; Spasova *et al.*, 2018). Promoted market of care home becomes a momentum to undertake this study as well.

On the other hand, existing research finding to support interrelationship between policy actors are less obvious and less suitable to answer the question: how do the characteristics of policy actor involvement act in conjunction to formulate particular type of policy networks? To fill the gap between the theory of policy process (networks) and practice, and to discover the different pattern of policy networks in home care policy in sample country, I begin by presenting the theoretical and analytic background of policy studies, introduce methodology. I then identify actor and organisation-based condition.

UNDERSTANDING POLICY PROCESS AND POLICY NETWORKS

The Concept of Policy Process and Policy Networks

The concept of home care has characteristics closer to public affair. This led the study to approach the objective through policy analysis. Policy process is used not only broad analytic boundary of this research but also key term to address research objectives. Policy process is a concept encompassing policy analysis in every step of policy progress: decision-making, policy implementation, policy management. And the concept also includes the actors (or participants) who involve in every policy process as well. Policy process refers to as theoretical framework, analytical outlines in macro, micro and meso level (Sutton, 1999; Sabatier, 2007; Hudson and Lowe, 2009).

This study adopt policy process in several reasons of which Heikkila and Cairney (2017) suggested. Firstly, this concept is particularly useful to comparative study in terms of that the theory covers the basic elements of policy theory, developing indicator and introducing detailed guideline of policy analysis in multiple case study (p. 302). Secondly, policy process includes the concept of policy networks as a tool of analysis by examining the interaction between actors (p. 303).

Policy network is a tool to analyse policy process. This concept is discussed in decision-making process and policy implementation and management process of policy. Policy network presumes that policy actors mutually dependent each other, and seeks to explore the resource interchange, power distributions, relationship arrangements (e.g. bureaucratic), and the intervention of decision making process from the core of the network actor (Atkinson *et al.*, 1989; Klijn, 1996). Further, the concept also enables to identify the types of state-industry relations by actor linkage pattern: politicians, bureaucrats and interest representatives (Waarden, 1992, p. 31). In his research, policy networks used for the concept to describe state-industry relation in a view of corporatism.

This research draws policy process as a main and detailed conceptual tool for analysis of home care policy for older people with following facts (1) most policies are consisted of the interrelationship of the actors and agents operating them; (2) policy process can be described by the dependency of a group of organisations that is connected with government; (3) policy outcome can be differed by the type of network, are considered as fit for this actor relationship research (Kenis and Schneider, 1991; Marsh and Smith, 2000; Verweij *et al.*, 2013). This approach will also be a touchstone to illustrate current marketisation of eldercare trend in detail.

The Involvement of Third sector in Policy Process and Policy Networks

The term third sector in this paper encompasses various range of organisations providing care services for older people without revenue redistribution to stakeholders and staffs. Civil society organisations (CSO), voluntary sector organisations (VSO), charitable organisations, social enterprises are all inclusive in this paper.

The role of third sector has been remarkable in the hardship period of government in many countries. A time or political and economic upheavals such as war, famine, economic crises were good opportunities to the third sector to both support public service delivery and develop innovative solution to the public service reform. Accumulated experiences of working together with third sector and public authorities formulate recent model of networks consequently.

Key features of this transformed care system are as follows. First, third sector involvement drives the modernisation of public services (Martin, 2011). Third sector, in some views, regards as social economy organisation (Di Domenico, Tracey and Haugh, 2009). In this premise, third sector consolidates their roles through the network with components of trust, community-based activity and the quality of service delivery through ensuring accountability (Di Domenico, Tracey and Haugh, 2009; Connelly, Markey and Roseland, 2011). It captures that enhancing the effectiveness, efficiency of the public service provision and incorporate complex set of care policy into the new system, the third sector

Secondly, the care provision changed to user-centred model. Since the third sector began to participate policy process of care services through reflecting users demand in policy process, this change takes place in state-centred public service delivery system. Martin (2011) designates it to ‘personalisation of public service’ to meet the individual needs of care flexibly (p. 909). This model

aims to develop and deliver more direct and customised services to the care recipients through the third sector involvement under the contract from the state (Martin, 2011, p. 909)

Thirdly, 'co-' theories support this care transformation. Pestoff and Brandsen (2006) introduce concepts to illustrate third sector involvement in care policy process: co-production, co-operation, co-governance, co-management. These concepts are terms to illustrate the relationship between the sectors of supplier and user. Amongst the concept, co-governance and co-management seem to fit the objectives of this research in terms of third sector participation in the policy planning and service delivery in collaboration with other sector (Pestoff and Brandsen, 2006).

In addition, a political ideology the 'Third Way' including neoliberalism and social democracy is also a description to explain the relationship between public sector and the public through alternative mechanism for public service delivery (Tritter *et al.*, 2003). This explanation suggests the mobilisation of third sector as an alternative mechanism for public service delivery with emphasising the user involvement

Fourth, the relationship between the state and third sector has developed toward the way of informal and encouraging participation by creating appropriate environment (Di Domenico, Tracey and Haugh, 2009). Although traditional fiscal support is still lasting, the contract-based public service outsourcing, coordinating policy with third sector, and public procurement is also widely considered and implemented recently (Grimshaw, Vincent and Willmott, 2002; Lamothe and Lamothe, 2008; Allen, Wade and Dickinson, 2009; Di Domenico, Tracey and Haugh, 2009).

On the other hand, third sector involvement in policy process also has drawbacks according to Martin (2011, p. 909).

- Resulted in less distinctive: losing a distinctiveness of third sector in the space of governance
- Rising tensions of third sector from contradictory demands of public service
- The risk of co-optation, deradicalization
- A closing down of diversity and autonomy: conflicting interests that result from opportunities to increase influence for both third sector organisations and involved service users

Summarising the third sector involvement in policy process, it brings the change of the supplying pattern of care service into network-based system including users as well as the change of service aims from state-centred to personalisation with the risk of increasing isomorphism associated with public endorsement.

METHODOLOGY

Method and data collection

A method to address complex research questions in home care policy process is qualitative comparative analysis (QCA). This method allows me to take account (1) a set of explanatory factors and connections between conditions; (2) systematic analysis of similarity and differences across cases; (3) to cope with complexity and the influence of context which may be difficult to examine through other methodological approaches (Masue, Swai and Anasel, 2013; Simister and Scholz, 2017). It represents the method best fit to policy analysis of actor-centric structures and to understand complex policy problems (Scharpf, 1997; Blackman, Wistow and Byrne, 2013). It is also specialised to explain elements of policy process, policy outputs and outcomes that lie in complex causal relationship (Scharpf, 1997; Fischer and Maggetti, 2017).

QCA is a methodology that enables the analysis of multiple cases in complex situations, and can help explain why change happens in some cases but not others (Simister and Scholz, 2017). In terms of technical aspect, QCA refers to as an analytic technique which combines case-based qualitative and variable-oriented quantitative approaches (Masue, Swai and Anasel, 2013; Roig-Tierno, Gonzalez-Cruz and Llopis-Martinez, 2017). It also has distinctive feature that moves back and forth across inductive and deductive logics in the process of analysis, research result is drawn through this dialogue between theory and evidence based on cases (Fischer and Maggetti, 2017). Through this technique, QCA derives understanding how the interventions of conditions interact with the outcomes by combination of causes and multiple causal pathways (Blackman, Wistow and Byrne, 2013). Thus, underlying assumption of this method is as follows (Simister and Scholz, 2017).

1. Outcomes can be causally explained by combination of necessary and sufficient conditions.
2. Change is often the result of different combinations of factors, rather than on any one individual factor
3. Different combinations of factors can produce similar changes

There are three types of QCA methods: crisp-set QCA (csQCA), multi-value QCA (mvQCA), and fuzzy-set QCA (fsQCA). The model sequentially developed to respond to the size of study and improve criticisms. This study selects first model of QCA (which is csQCS), since this study is only to compare three countries. As QCS developed to cope with increasing sample size medium to large -n study, later model is not suitable for this small-n study.

csQCS has several distinctive features as a methodology. It aims to simplify and discover configuration of models of multiple causal configuration by using Boolean logic (Roig-Tierno, Gonzalez-Cruz and Llopis-Martinez, 2017, p. 17). In addition, it focuses more on identifying qualitative differences, calibrating breakpoints that assign membership of cases as being either in or out of the relevant sets (Greckhamer *et al.*, 2007, p. 700). The number of configurations are equal to 2^k, where K is the number of conditions (variables) included in the study (Roig-Tierno, Gonzalez-Cruz and Llopis-Martinez, 2017, p. 17). In the process of analysis, csQCA dichotomises both conditions and outcomes. 'Present or true' is coded as 1 (full-membership) and 'absent or false' is coded as 0 (full non-membership). Although this methodology is good enough to explain complex causality between conditions and outcomes, dichotomisation technique implies the problem of discrepancy with the clear threshold of choice (De Meur, Rihoux and Yamasaki, 2009, p. 6). To overcome this criticism, it requires clear theoretical backup, strong criteria for variable indicator and iterated process (De Meur, Rihoux and Yamasaki, 2009).

According to the instruction of csQCA, the research process progresses as figure below.

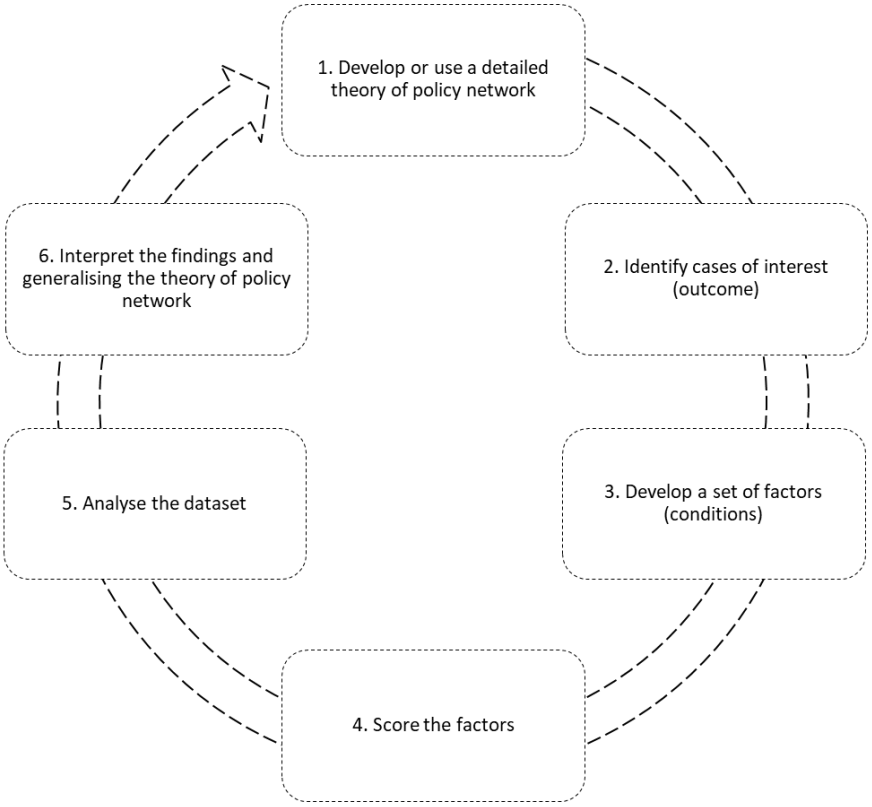


Figure 1 Research Process of csQCA

Source: Author modified from Simister and Scholz (2017)

Data is collected from various sources: policy documents, document produced by policy actors, secondary data extracted from existing studies, and statistical database. Dichotomised dataset is coded to the software TOSMANA 1.6 for the analysis.

Source of data is as list below.

Data for Finland:

- Burau, V., & Kröger, T. (2004). The local and the national in community care: Exploring policy and politics in Finland and Britain
- Hyvinvointiala. (2015). Sosiaali- ja terveyspalveluntuottajien määrä ja laajuus
- Anttonen, A., & Karsio, O. (2016). Eldercare Service Redesign in Finland: Deinstitutionalization of Long-Term Care
- Zechner, M., & Valokivi, H. (2012). Negotiating care in the context of Finnish and Italian elder care policies
- Teperi, J., Porter, M. E., Vuorenkoski, L., Baron, J. F., & Reports, S. (2009). The Finnish Health Care System: A Value-Based Perspective
- Johansson, E. (2010). Long-term Care in Finland
- Anttonen, A., & Häikiö, L. (2017). Care 'going market': Finnish elderly-care policies in transition.
- Mun, M. (2017). Autonomy in long-term elderly care. Laurea University of Applied Sciences
- Yeandle, S., Kröger, T., & Cass, B. (2012). Voice and choice for users and carers?
- Suhonen, R., Valimaki, M., & Katajisto, J. (2000). Individualized care in a Finnish healthcare organization

- Määttänen, N., & Salminen, T. (2017). Informal vs . Formal Care in Finland: Monetary Incentives and Fiscal Implications

Data for England:

- CQC. (2019). Service in your home
- Francis, J. (2012). An overview of the UK Domiciliary Care Sector
- Macdonald, A., & Cooper, B. (2007). Long-term care and dementia services: An impending crisis
- Young, N. (2011). The Third Sector is Vital to the Care of the Elderly
- Way, R., & Sm, W. (2019). UK domiciliary care market : an overview
- Charles, A., Ham, C., Baird, B., Alderwick, H., & Bennet, L. (2018). Reimagining community services
- Age UK. (n.d.). Integrated Care Services: Bringing together leaders to transform services and outcomes for people living with long-term conditions
- Jarrett, T. (2018). Social care : care home market – structure, issues, and cross-subsidisation.
- NHS. (2018). National Homecare Providers
- Bennett, L., Honeyman, M., & Bottery, S. (2018). New models of home care
- Rushton, R. (2018). Demand for adult social care across counties and unitary authorities in England
- Bottery, S., Jefferson, L., Bennett, L., Hall, P., Cream, J., Dale, V., … Murray, R. (2018). Home care in England: Views from commissioners and providers
- Humphries, R., Thorlby, R., Holder, H., Hall, P., & Charles, A. (2016). Social care for older people: Home truths

Data for South Korea:

- 석재은, 임정기, 전용호, 김욱, 최선희, 이기주, & 장은. (2015). 장기요양보험의 공공성 강화 방안. 보건복지부
- 석재은, 박소정, 권현정, 최선희, 이기주, 장은진, & 김명숙. (2016). 장기요양 재가서비스 개편방안 연구.
- MOHW. 2018 노인복지시설 현황. , (2018)
- MOHW. 노인주거복지시설 현황. , (2018)

Analytical Framework

This paper follows general procedure of QCA. Firstly theorising the policy network of care provisions for older people, then executing the analysis process based on the evidences collected from each cases. Lastly, it reports and interprets the result.

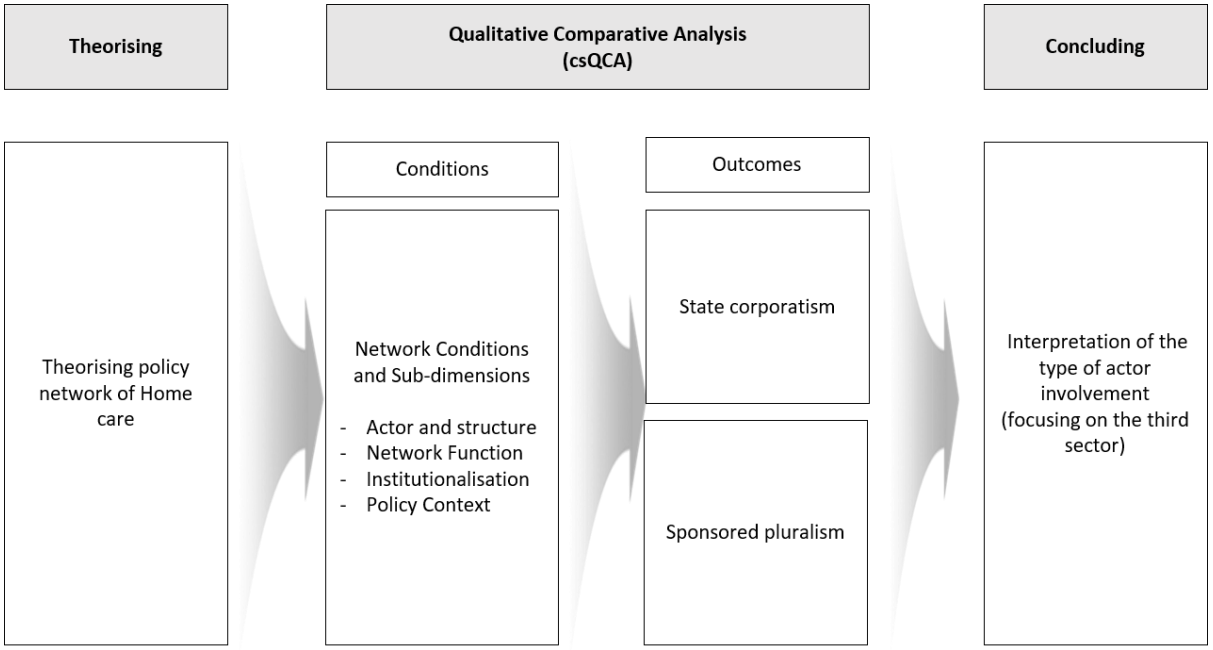


Figure 2 Analytic Framework

THE SELECTION OF CASE OF INTEREST AND CONDITIONS

Outcome selection

In existing literature on home care, the ultimate goal of the policy is described in twofold: cost effectiveness and ageing in place (Carpenter *et al.*, 2004; Genet *et al.*, 2012). These goals allude the increasing care service out of hospital and giving more space for private and societal actors to mobilise resources from various sources. This study started from this point to see whether the private participation in home care policy has turned to the outcomes in practice.

However, outcomes of policy network of care policy are often difficult to define with a reflection of the complex context such as formal and informal care, long-term and short-term care, and term selection between community, home and domiciliary care. In other word, this diversity becomes unique feature of the policy process.

Cost effectiveness often refers to as maximising actor and resource mobilisation from diverse range of sector for the purpose of decreasing public spending. It can thus be measured by characteristics of actor participation and how wider range of actor participated in the policy network (Waarden, 1992; Börzel, 1997; Klijn and Koppenjan, 2000; Court *et al.*, 2006; Robertson, Gregory and Jabbal, 2014).

To identify the outcome of policy networks, several types of policy network model were considered. First model of policy networks is the classification of 'policy community' and 'issue networks'. This model was developed by Rhodes and Marsh (1992) with four dimension: membership, integration, distribution of resources, and power (accessibility, presence of dominated actor, equality of resource share) (p. 187). It is useful to explore the extent to which it is becoming more or less integrated.

Second model of policy networks is suggested by Waarden (1992). He presents eleven different types of policy networks. His spectrum of policy network divided, (1) statism & pantouflage, (2) captured statism, (3) clientism, (4) pressure pluralism, (5) sectoral corporatism, (6) macro corporatism, (7) state

corporatism, (8) Sponsored pluralism, (9) parental relations, (10) iron triangles, and (11) issue networks (see Table 1A-C, Waarden, 1992, pp. 39-41).

Amidst these types of policy networks, this research initially selects 'sponsored pluralism' and 'state corporatism' as an ideal regime type of policy network in terms of the concept of co-production of care service for older people. First criteria to select outcomes was the fact that home care policy aims to draw as many actors and much resources as possible. Thus, the type which has various range of actor estimated as an outcome of policy network in home care policy. The network types which contain one or two or very limited number of actors are removed from the list. Rhodes' issue networks met the requirement of variety, but the type only includes individual (personal) network in the explanation of Waarden (1992). Encompassing individual, organisations including association was second criteria of selection.

In addition to avoid excessive limitation in QCA process, I select two outcomes initially. One can be eliminated in the process of analysis or both can survive as outcomes in a case. Specific feature of outcome is illustrated in the table below.

The case selected amongst the actors in supply-side due to examine the interaction of policy actors in policy process. It is surely possible that ultimate service consumers (older people) participate in several policy process. However, policy consumer's aspect was not worth to be considered according to the purpose of this research to simplify the complex network of home care policy.

Identifying conditions of policy networks

The policy network indicator is also developed by Rhodes and Marsh (1992) and Waarden (1992). Rhodes and Marsh (1992) suggest four dimensions of network: membership, integration, distribution of resources, and Waarden (1992) proposes seven dimensions: actors, function, structure, institutionalisation, conventions of interaction, distribution of power, strategies of public administration. I decide to use Waarden's (1992) model because this model contains more variety indicators being able to use and cover almost of Rhodes and Marsh (1992)'s indicators. The more indicators the better in this stage due to leave as many variables as possible after the QCA's simplification process.

The composition 'membership' and 'actors' have similar subset with the size of participants, types of actor (individual, association or organisation), actor-properties (needs and interest, degree of professionalisation, role conception [e.g. public servant]). The term 'actors' is picked up for the analysis to avoid confusion of membership in QCA process.

In the policy network, function means the bridge between the structure and actor encompassing whole policy process (Waarden, 1992, p. 33). The main aims of the function of policy network is to increase intensity of relationship through indicators described as follows (Waarden, 1992, pp. 33–34).

1. Channelling access to decision-making processes;
2. Consultation, or exchange of information;
3. Negotiation, that is, exchange of resources and/or performances, or, seen from a different perspective, resource mobilization;
4. Coordination of otherwise independent action;
5. Cooperation in policy formation, implementation and legitimation;
6. Broadness of policy issues.

The network condition of structure refers to the pattern of relation between actors (Waarden, 1992, p. 34). Integration category of Rhodes and Marsh's model (1992) is duplicated with this condition. Detailed indicators are in table 1 below. Through this condition, we can measure the size, boundary, type, pattern, intensity/strength, density/multiplexity, symmetry or reciprocity of connections, cluster/differentiation, type of coordination, and stability of network (Waarden, 1992). As all the indicators are interrelated, this condition can formulate a specific type of network itself (Waarden, 1992).

Institutionalisation is and indicator to monitor the degree of institutionalisation to estimate stability of networks by the feature of institution (e.g. closed networks, compulsory membership, ordered link so on) (Waarden, 1992). The condition 'conventions of interaction' is about the property of actors, it provides background of the network property (Waarden, 1992). 'Distribution of power' indicates the resource dependency and network structure according to the organisational characteristics (Waarden, 1992). The last category of condition is strategies of actors being able to estimate network property by the interdependency with satisfaction of needs, interests and goals (Waarden, 1992).

The referenced analytic model of policy network in home care policy developed by Waaden (1992) is as table 1 below.

Table 1 Referencing source to develop policy network conditions

Condition	Policy network type (outcomes) Indicators	State corporatism	Sponsored pluralism
Actors	**Number**	Several	Many
	Type	State-created interest associations	Associations
	Representative monopolies	Y	N
Function	**Channelling access**	Y	Y
	Consultation	N	Y
	Negotiation	N	Y
	Coordination	Y	Y
	Cooperation in policy formulation	Y	Y
	Cooperation in policy implementation + delegation of public authority	Limited	N
	Broadness of policy issues	Narrow-medium	Narrow
Structure	**Boundary**	Closed	Relatively open
	Type of membership	Formally compulsory	Voluntary
	Ordered relations?	High	Medium
	Intensity	Medium	Medium
	Multiplexity	Medium	Low
	Symmetry	Low	Low
	Subclustering	Likely	Possible
	Linking pattern	Interlocking leadership	Horizontal
	Centrality	High	Low
	Stability	High	
	Nature of relations	Forced cooperative	Conflictual/ cooperative

Institutionalisation		High	Medium
Conventions of interaction	**Adversarialism/consensus-search**	Forced consensus	Adversarialism/ consensus
	Idea of serving public interest	Y (forced)	N
	Formal or informal contacts	Formal	Formal/informal
	Secrecy	Y	N
	Attempts at depoliticization	Y	N
	Ideological dispute	Not allowed	Possible
Distribution of power	**Autonomy of state re society**	High	Somewhat
	State dominant	Y	N
	Societal interests dominant (capture)	N	N
	Balance, symbiosis	N	Possible
Strategies of public administration	**Being accessible**	Y	Y
	Recognition	Y	Y
	Active support of interest association	Y	Y
	Creation/changing interest associations	Y	Y
	Delegation of state authority	Y	Possible
	Attempts at destroying interest associations	Y	Possible

Source: Author edited from Waarden (1992), p. 40

CONDITION OPERATIONALISING FOR QCA DESIGN

Although given network conditions is widely used form for network analysis, indicators are too many and some are not available to measure. To generate network model to fit more on QCA design, the study needs to merge and rearrange indicators in four sections based on the combinations of indicators from Table 1 and network theories.

Hermans and Thissen's (2009) study is considered to organise the category of conditions with their categorisation: stability, characteristics, motivations, and objectives of network (p. 809). In addition Snijders, Steglich and Schweinberger's (2017) determinants to analyse actor relations through pattern of homophily, attractiveness, actor's characteristics, behavioural tendencies is also considered to design network condition for the research.

Actor Characteristics and Network Structure

The first condition is actor characteristics and network structure. This category is designed to explore the properties of policy network. In this condition, the size, initiative, composition, interdependency, and tension of networks.

It is possible to set up five assumptions: network structure which has (1) Larger number of participants, (2) Societal-led network initiative, (3) Network consisted of heterogeneous boundary, (4) Chaotic interdependency, (5) conflict and competitive relationship, the more chances that it will be more closer to ideal type of network effectiveness

Table 2 Condition of Actor Characteristics and Network Structure

Sub-dimension	Measurement	Example	Modification
Number of participants	Size of the network	1, 2 (at least 2), limited (very limited), many	Less than case: 0 More than case: 1
Type of actor membership	Initiative of networks	State agency, state-created interest association, political party, interest group, individual expert	State-led: 0 Societal-led: 1
Boundaries	Composition of network	Organisation (for or non-profit), individual actors	Homogeneous: 0 Heterogeneous: 1
Pattern of linkage	Interdependency, hybridity	Economic and/or professional interests, wider range of interests	Ordered: 0 Chaotic: 1
Nature of relations	Tension of networks	Conflictual, competitive, cooperative	Cooperative: 0 Conflict, competitive: 1

Network Function

Amongst network properties, the function of network is a process to identify in which function is emphasised in the policy network of care for older people.

Function of policy network is a condition to estimate the relationship between 'structure' and 'actor' in policy networks (Waarden, 1992, p. 33). Main strands of this condition in increasing intensity are divided in lobbying and policy participation which contains concertation (consultation and coordination) and cooperation. Lobbying influences on various stage of policy process accessing, understanding network position and decision making process in an unidirectional way, whereas policy participation only affects to decision-making process in multidirectional way (Waarden, 1992).

Assumptions in network function are the combination of network property (1) more involving in policy process, (2) sharing common goals, (3) having complexly connected interest is closer to the ideal type of network effectiveness.

Table 3 Condition of Network Function

Sub-dimension	Measurement	Example	Modification
Network Intensity	Type of involvement in policy	Decision made by state: consultation and coordination, partaking in decision making itself: cooperation	Lobbying: 0 Policy participation: 1
Sharing goal	Consistency of networks	Conflicting, consensus, accommodation, appeasement	Consensus: 0 Conflicting: 1

Share of interests	Density of network	-	Secrecy: 0 Openness: 1

Institutionalisation (Power Relations)

The condition of institutional level is to look at structural property of policy networks (Waarden, 1992, p. 33). In his explanation, this condition measures formality of relationship in state-industry relationship with the length and formality.

In this part of condition, it can be assumed that (1) temporary length of relationship, (2) informal relationship, (3) marketised relations, and (4) fragmented autonomy is more likely to effective network.

Table 4 Condition for Institutionalisation (Power Relations)

Sub-dimension	Measurement	Example	Modification
Length of relationship	Durability of relation in policy process	-	Permanent coalition: 0 Temporary: 1
Formality of relationship	Network compulsion	Contract based-formal, informal	Formal: 0 Informal: 1
Colonisation	Dominated level by private actor	Degree of marketisation	Low: 0 High: 1
Autonomy	Possibility of independent decision making and service providing	Centralised, fragmented	Low: 0 High: 1

Policy Context

In this condition, I examine the affect of contextual variables to the type of policy networks. As it is preliminary and experimental research design, there is less theoretical backup to support this context. This part will be improved continuously.

Table 5 Condition of Policy Context

Sub-dimension	Measurement	Example	Modification
Decentralisation	Level of localisation of policy	Centralised, localised, community-based	Low: 0 High: 1
Service clients	Number of home care clients	-	More than case: 0 Less than case: 1
Policy willingness	Public spending for home care	-	More than % of case Less than % of case

UNDERSTANDING CASES AND DATA CODING

Actor Background and Structure

The number of home care service providers are less than 6,147 in Finland (2017), 10,429 in England (2019), and 12,902 (2015) in South Korea (Sotkanet; Seok *et al.*, 2015; CQC, 2019). Since Finnish data counts total number of private care providers, it is only possible to estimate number less than 3.512 when it considers the portion of home care service providers and adds public sector (mainly municipality) providers. This data has to be updated later, but now only used for comparison. Regarding to England, twenty three care providers are engaged in public sector[1] (NHS, 2018). However, it is difficult to distinguish providers between third sector and private sector because both categorised in independent sector in English home care provision.

To identify the network initiatives, it requires to explore the policy history and changes of sample countries. In Finland, home care service was triggered by legal reform in the 1990s (Anttonen and Häikiö, 2017). Economic recession led the social service reform to be closer to market mechanism, participation of third sector and private firms in care service provision started to be proliferated. This transformation has accelerated marketisation of home care and the rising demands of care clearly appeared in development of home care policy, it is not possible to decide societal-led participation with several reasons. (1) Both providers and users rely on public finances either subsidies such as reimbursement or vouchers, (2) Finnish government still retains the policy aims of universalism, the care system (e.g. quality) is controlled by public sector: mainly by municipalities.

In England, Yeandle, Kröger and Cass (2012) highlight that "increasing numbers of older people contribute to the cost of care from their private resources" while pointing out of the lack of tax rebates on purchasing home care services (p. 436). It means that it is impossible to purchase home care services from single sources of funding, and providers rely more on market economy than public support (Macdonald and Cooper, 2007). Moreover, Bennett, Honeyman and Bottery (2018) report increasing proportion of privately funded home care in England directly. In addition, home care market has transfigured to ensure proper market competency through self-quality improvement for survive in the market.

In South Korea, brief system of home care service is as Table 6. The most key thing to be considered to decide the condition is that the authority to choose service providers is on the government (Seok *et al.*, 2015).

Table 6 The System of Home Care Service in South Korea

Provider mobilisation	Provider support	Explanation
Financing	- State financing - State + Private financing - Private financing	- Mixture of state-private financing - Socialisation of long-term care insurance
Service providers	- Private - Non-profits - Profit-private	- Mixture of public and private service providers - Formulation of service

[1] Able Community Care LTD, Agincare, Allied Healthcare, Almond Care, Ark Home Healthcare, Bupa Home Healthcare, Care UK, Christies Care, Consultus Care, Healthcare at Home, Helping Hands Home Care, HomeCare Direct Limited, HomeTouch Care Limited, MiHomecare, Origin Recruitment, Promedica24, Pulse Healthcare Limited, Saga Healthcare, Sevacare, Spinal Homecare Services, Team 24 Limited, The Complete Group, The Good Care Group: 23 public sector providers in total.

	- Informal provider	- Privatisation of service
Payment of Service	- Reimbursement - Cash benefit	- Financial path ▪ Reimbursement: state -> service providers ▪ Cash benefit: state -> service user -> service providers - State responsibility: ▪ reimbursement > cash benefit - Public expenditure: ▪ reimbursement > cash benefit

Source: Author translated and edited from Seok *et al. (*2015, p. 61)

Sector boundary in network is shown that heterogeneous in all selected countries. Anttonen and Häikiö (2017) shows welfare-mix of Finland through the percentage of service usage by sectors using the data 2008. The most home care services for older people is provided by municipalities, for-profit service was the least than public and non-profit services. On the other hand, the services provided by private sector was the greatest (see Figure 2 in Anttonen and Häikiö (2017), p. 82). This implies that mixed actors from around the sectors come together to provide home care services.

In England, Bennett, Honeyman and Bottery (2018) demonstrate current proportion of publicly funded and privately funded service provider for home care services 49% and 51% respectively. Although there are not exact percentage shown the portion between third sector and private firm, it can be assessed that various actors are involved in the network to provide home care services. In South Korea, has also various actors across the sector as table below. One difference is that public agency cannot be found in South Korea in the data by Seok *et al.* (2015). Data contains the number of private and individual service providers.

The nature of relationship in Finland is rather co-operative. According to Yeandle, Kröger and Cass (2012), this cooperative relationship between informal carer and care professions and partnership of formal care worker and professional group in municipal care system. The service system led by strong groups of social and healthcare profession and other providers acquire the information and way of service details within the integrated system by municipality (Yeandle, Kröger and Cass, 2012, p. 439). In England, some tensions and competition are discovered within and between the sectors (Bottery *et al.*, 2018). It appears between government and private sector care organisation (including third sector) while co-ordinating services between the sectors. However, overall trend of in sector relationship in England is rather cooperative (Francis, 2012; Charles *et al.*, 2018). Korean home care system is originally designed for market competition, and it is recently coming down to the lack of publicity of home care services (Seok *et al.*, 2015).

Table 7 Rationale for Allocating a Dichotomous State of Actor Characteristics and Network Structure

Sub-dimension	**Case**		
	Finland	**England**	**South Korea**
Number of participants	6,147	10,429	12,902
Type of actor membership	• Publicly funded • Universalism	• Mixed publicly funded and privately funded	• Participants selected by govt

	• Controlled by municipality	• Compete-based quality control	
Boundaries	• Municipalities (5,361) 87% • Non-profit and For-profit (786) 13%	• Publicly funded : 49% • Privately funded: 51% • Monitored by CQC	• For-profit: 669 (6%) • Non-profit: 1,723 (13%) • Individual (private): 10,510 (81%)
Pattern of linkage	• Chaotic	• Chaotic	• Ordered
Nature of relations	• Partnership	• Integrated	• Market competition

Network Function

According to Yeandle, Kröger and Cass (2012), home care providers in both Finland and England intervene political decision-making process and extends carers' and care user's needs to the policy makers. It is pointed as one advantage of privatisation of care in their study. In other sources, there are some cases detected in Finland, taking part in the decision-making process in health care sector is strongly recommended and implemented in care service for older people through the form of policy participation, Tampere's homemarket project for instance (Suhonen, Valimaki and Katajisto, 2000; Anttonen and Karsio, 2016; Anttonen and Häikiö, 2017). However, for England, it seems impossible for policy actor to directly influence to decision-making process (Charles *et al.*, 2018). In South Korea, home care policy is strongly based on interventionist principle, there are less room for policy network to participate in decision making process (Seok *et al.*, 2015).

In terms of providing better care service effectively is common goal of policy network in home care provision in every selected country. However, some conflicted aspect between the sector is discovered in England and South Korea.

Finnish third sector access the network to access the channel of information and referral to different sources of care (Zechner and Valokivi, 2012, p. 135). This is clear in health care sector sharing patient information with carers and care organisations (Suhonen, Valimaki and Katajisto, 2000). They also suggest this openness of information becomes a foundation of individualised care (p. 226). England introduces integrated model between health care sector and social care sector and build a partnership trust encompassing public and private care provider to avoid fragmented and duplicated services (Charles *et al.*, 2018). In addition, co-owned model has shown in establishing CIC (community interest company) by purchasing the CIC with the member of community (Charles *et al.*, 2018). With these models, information of care and care recipients is shared between the providers and enabling to provide integrated services. In South Korea, it becomes possible to access social welfare facility information system as a home care service provider.

The differences between the share of interest is that the home care information in Finland and Korea is managed by public sector such as municipality and central government, it is shared between the providers by partnership model in England.

Table 8 Rationale for Allocating a Dichotomous State of Network Function

Sub-dimension	Case		
	Finland	**England**	**South Korea**
Increasing Intensity	• Influencing policy decision making process • Homemarket project in Tampere	• Delivering carer and user's voice	• Focusing more on the role of service providers • Mostly controlled by the policy provision
Sharing goal	• consensus	• conflict	• conflict
Share of interests	• Channel of information	• Integrated model • Co-owned model	• Social welfare facility information system

Institutionalisation (Power Relations)

Table 9 Rationale for Allocating a Dichotomous State of Institutionalisation

Sub-dimension	Case		
	Finland	**England**	**South Korea**
Length of relationship	Permanent	Permanent	Temporary (5-year)
Formality of relationship	Informal based	Registered	Registered
Colonisation	Public	Market based public	Market based policy design
Autonomy	Professional autonomy	Admitting wide range of autonomy	Activity in the boundary of registration

Policy Context

Table 10 Rationale for Allocating a Dichotomous State of Policy Context

Sub-dimension	Case		
	Finland	**England**	**South Korea**
Decentralisation	Localised	Localised (centrally controlled)	Centralised
Service clients	73,563	Later	Later
Policy willingness	Later	Later	Later

ANALYSIS AND RESULT

Dichotomisation Result

Table 11 Dichotomised Condition and Sub-Dimensions

Condition	Sub-dimension	Finland	England	South Korea
Actor Characteristics and Network Structure	Number of participants (NOP)	0	1	1
	Type of actor membership (TYMEM)	0	1	0
	Boundaries (BNDS)	1	1	1
	Pattern of linkage (PTLK)	1	1	0
	Nature of relations (NARES)	0	0	1
Network Function	Network intensity (NETITS)	1	0	0
	Shared goal (GLSHNG)	0	1	1
	Share of interest (INTSHNG)	1	1	1
Institutionalisation (Power relation)	Length of relationship (LNGRES)	0	0	1
	Network formality (NETFORTY)	1	0	0
	Colonisation (CLNST)	0	1	1
	Autonomy (AUTMI)	1	1	0
Policy context	Decentralisation (DECNT)	1	1	0
	Service clients (NUSC)			
	Policy willingness (PLWL)			
Outcomes	State corporatism (OUTCOME 1)	1	0	1
	Sponsored pluralism (OUTCOME 2)	0	1	1

Truth Table and Findings

State corporatism

(1) Actor Characteristics and Network Structure

The cases correspond to the type of policy network in 'state corporatism, were Finland and South Korea. However, in a boundary of actor characteristics and network structure, only South Korean home care policy shows state corporatism network property with state-led network initiatives.

Table 12 Truth table of State Corporatism in Actor Characteristics and Network Structure

CASEID	NOP	TYMEM	BNDS	PTLK	NARES	OUTCOME
FIN	0	0	1	1	0	1
KOR	1	0	1	0	1	1
ENG	1	1	1	1	0	0

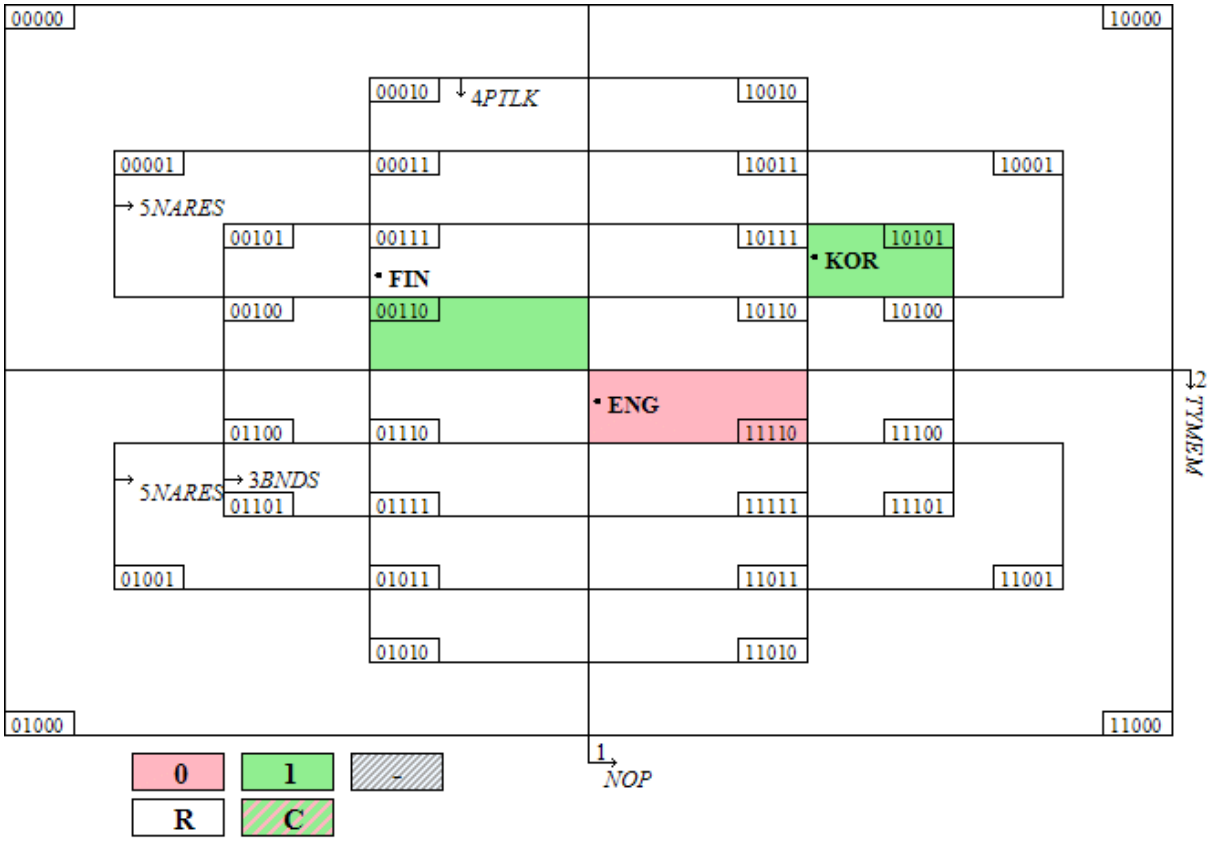


Figure 3 Venn Diagram Output of Actor Characteristics and Network Structure (Outcome: State corporatism)

(2) Network Function

Analysis with sub-dimension of network function, only Finland shows the property of state corporatism under the condition with 'network intensity'. This means that the availability of actor (network) participation to policy process in Finland corresponds to the type of state corporatism.

Table 13 Truth table of State Corporatism in Network Function

CASEID	NETITS	GLSHNG	INTSHNG	OUTCOME
ENG (0), KOR (1)	0	1	1	C
FIN	1	0	1	1

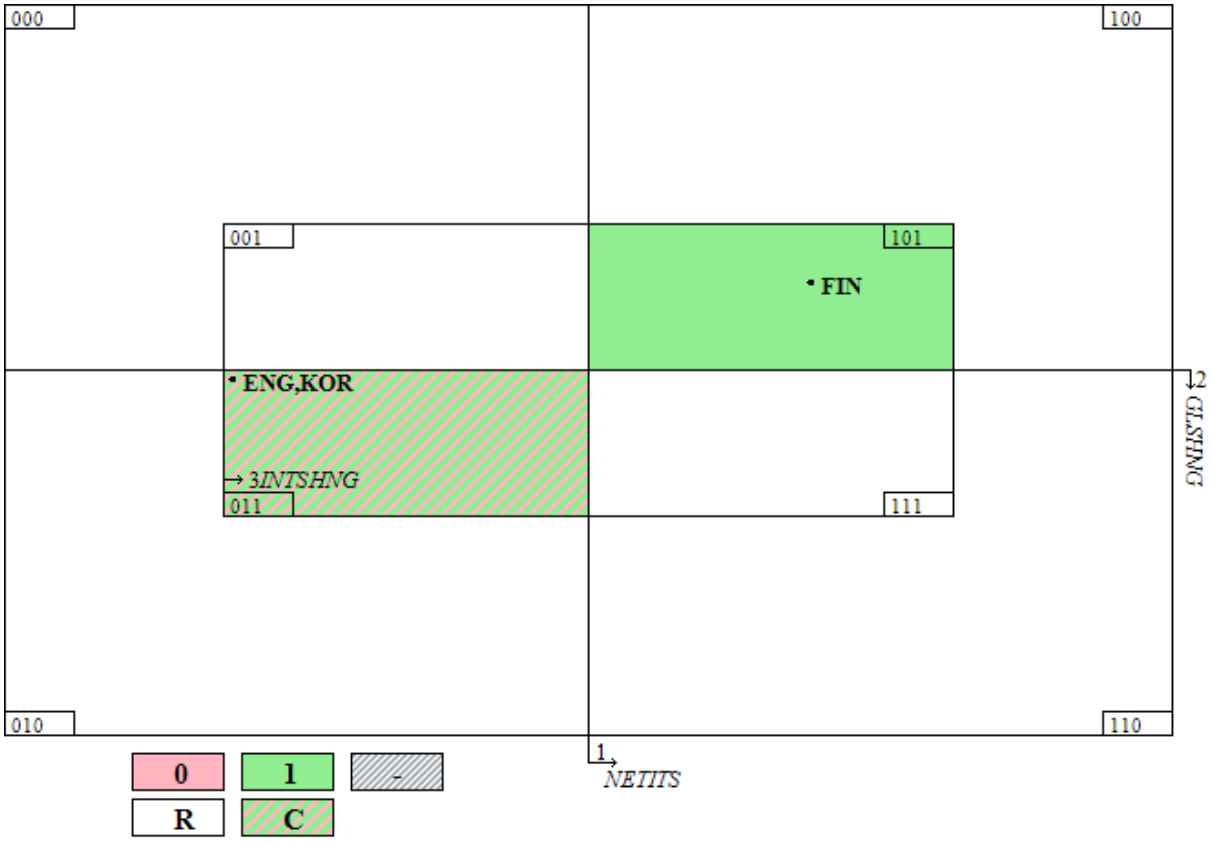


Figure 4 Venn Diagram Output of Network Function (Outcome: State corporatism)

(3) Institutionalisation

Under the condition of institutionalisation, Finland and South Korea reveals the characteristics of state corporatism network. However, configurations of sub-dimensions to fit the state corporatism are significantly different between two countries. Analysis constitutes 4 combinations (see Table 12).

Table 14 Truth table of State Corporatism in Institutionalisation

CASEID	LNGRES	NETFORTY	CLNST	AUTMI	OUTCOME
ENG	0	0	1	1	0
FIN	0	1	0	1	1
KOR	1	0	1	0	1

Table 15 Typology of State Corporatism by Institutionalisation of policy network

Type of configuration	Case	Note	Outcome
LGNRES + NETFORTY	KOR, FIN	Temporary participation OR informal network	State corporatism [1]
LNGRES + clnst	KOR, FIN	Temporary participation OR highly marketized	State corporatism [1]

NETFORTY + autmi	FIN, KOR	Informal network OR less autonomy	State corporatism [1]
clnst + autmi	FIN, KOR	Marketised OR less autonomy	Not state corporatism [0]

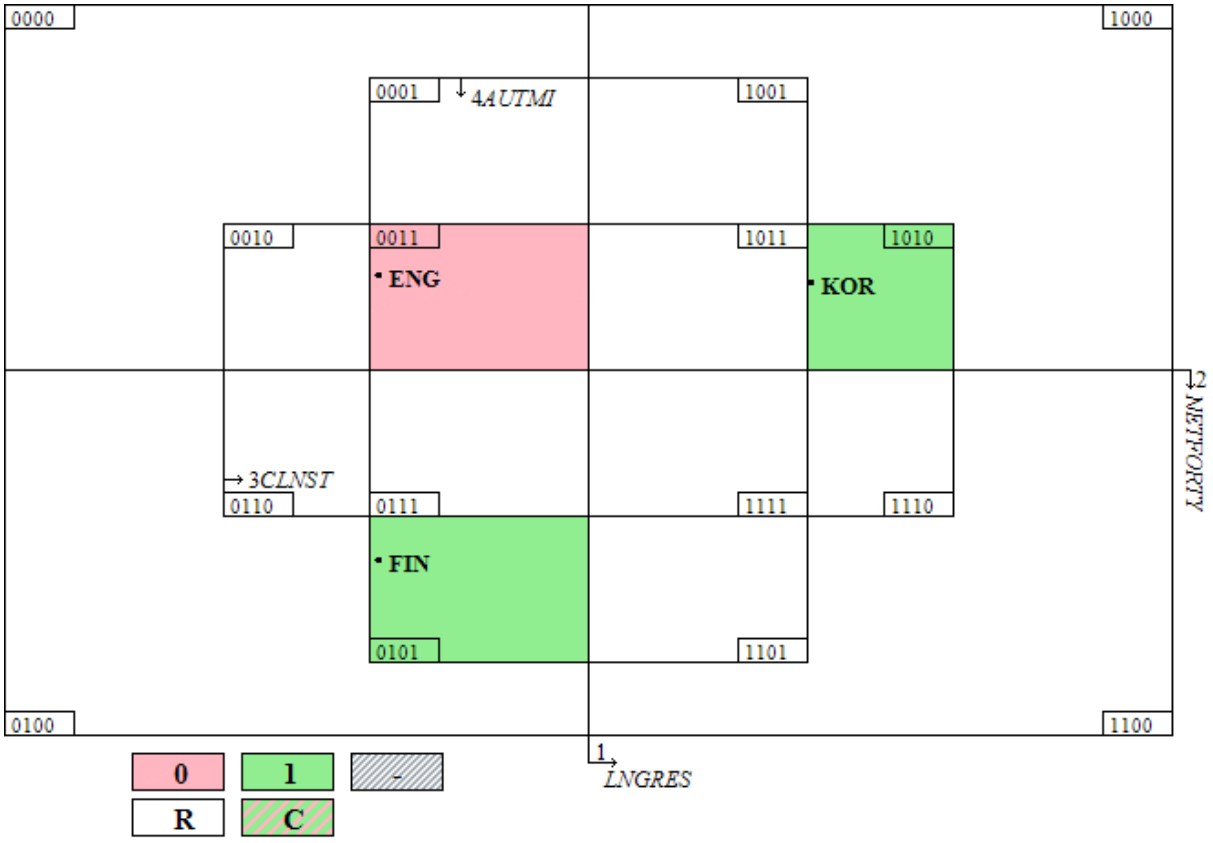


Figure 5 Venn Diagram Output of Institutionalisation (Outcome: State corporatism)

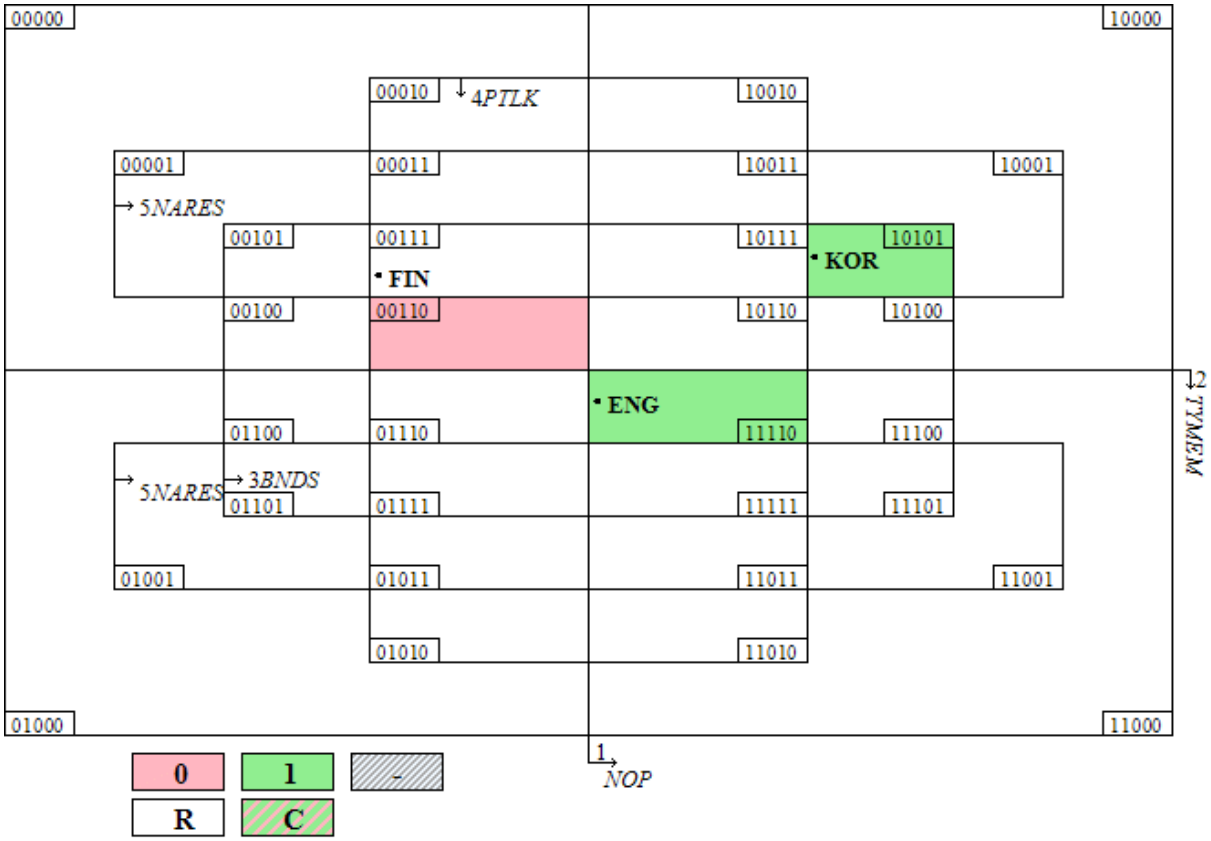
Sponsored pluralism

(1) Actor Characteristics and Network Structure

Home care policy network in England and South Korea is shaped in sponsored pluralism under the condition of the over 10,000 policy participants.

Table 16 Truth table of Sponsored Pluralism in Actor Characteristics and Network Structure

CASEID	NOP	TYMEM	BNDS	PTLK	NARES	OUTCOME
FIN	0	0	1	1	0	0
KOR	1	0	1	0	1	1
ENG	1	1	1	1	0	1

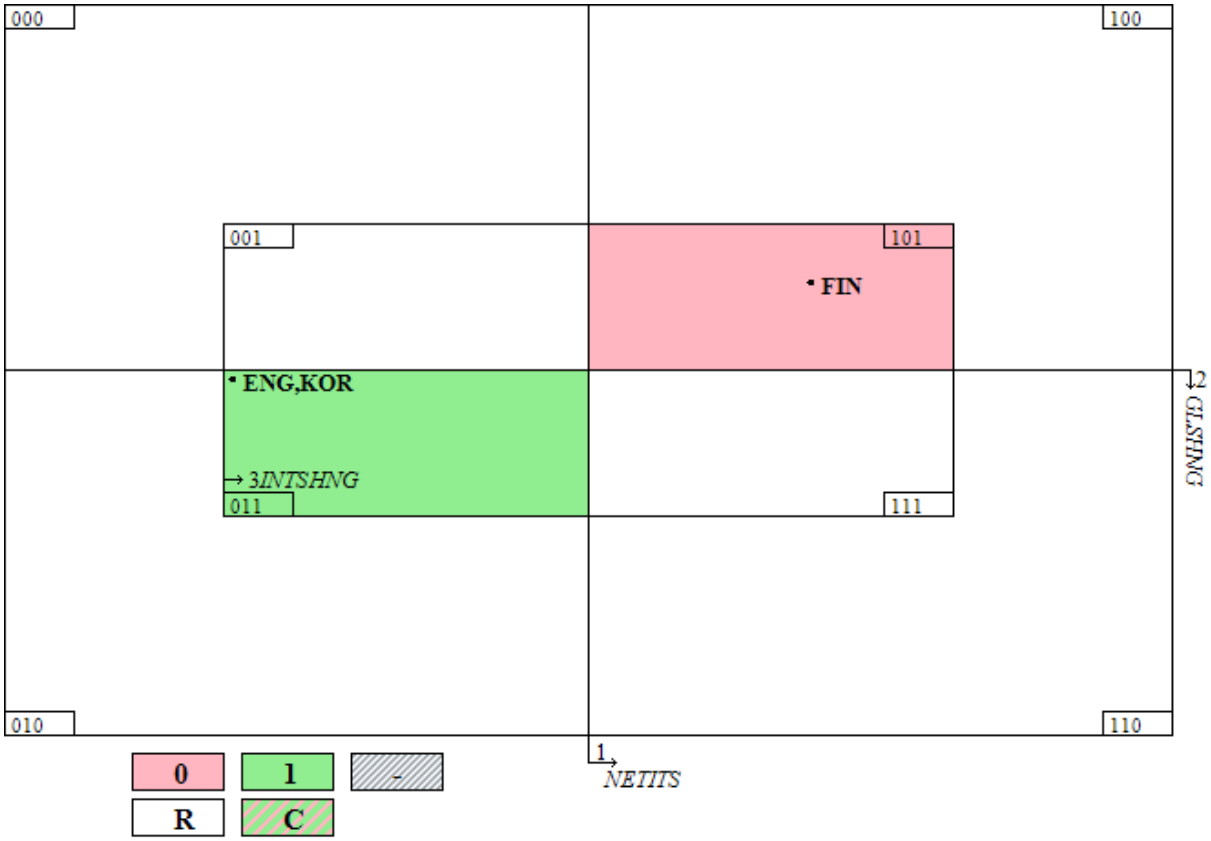


(2) Network Function

Network function in England and South Korea is classified as sponsored pluralism. Lobbying function and conflict of shared goal is identified to the factor of sponsored pluralism.

Table 17 Truth table of Sponsored Pluralism in Network Function

CASEID	NETITS	GLSHNG	INTSHNG	OUTCOME
ENG, KOR	0	1	1	1
FIN	1	0	1	0

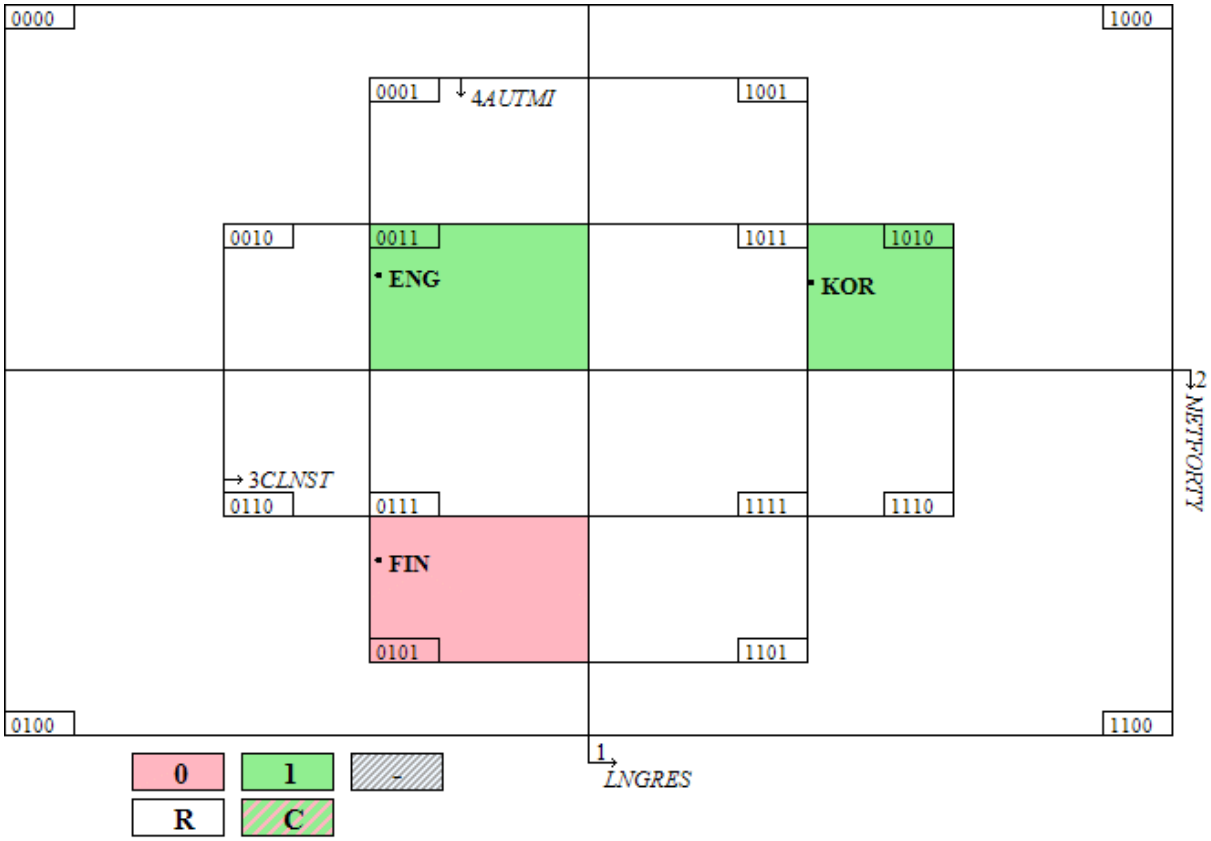


(3) Institutionalisation

England and South Korea are also included in sponsored pluralism in institutional condition. Formal network in England or South Korea and high degree of marketisation in either country detected as components to consist of sponsored pluralism.

Table 18 Truth table of Sponsored Pluralism in Institutionalisation

CASEID	LNGRES	NETFORTY	CLNST	AUTMI	OUTCOME
ENG	0	0	1	1	1
FIN	0	1	0	1	0
KOR	1	0	1	0	1



SYNTHESISING VERY PRELIMINARY RESULT AND CONCLUSION

Type of Home Care Policy Network

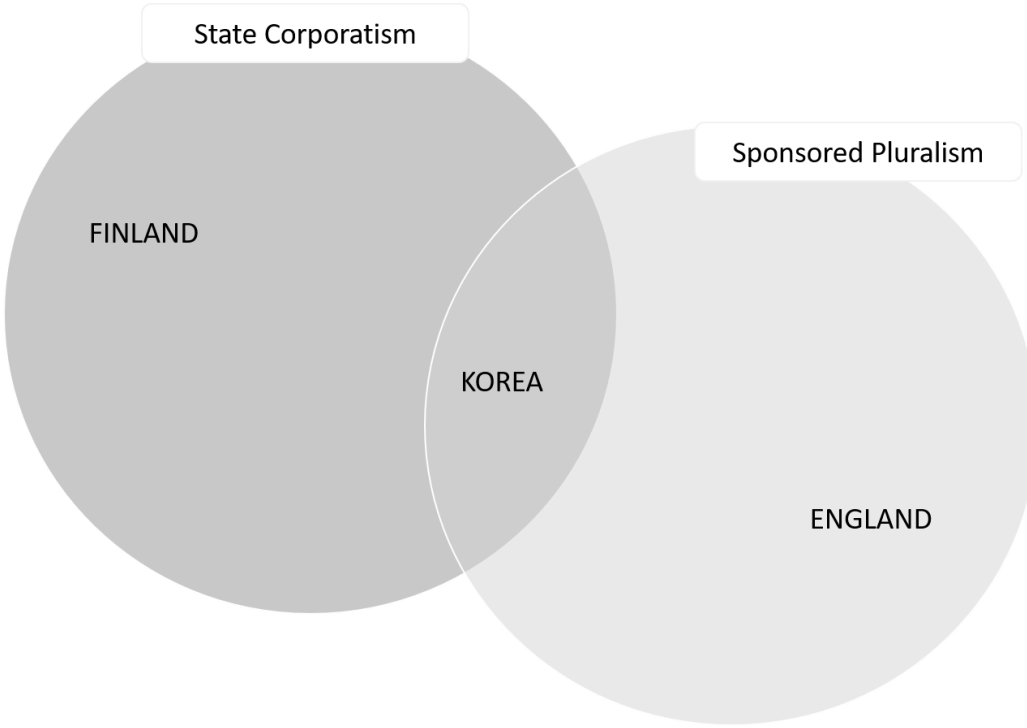


Figure 6 Type of Home Care Policy Networks by Countries

Configuration of Network Conditions

- Case Finland and South Korea

State-led network initiative + Lobbying AND policy participation + Temporary participation OR informal network + Temporary participation OR highly marketized + Informal network OR less autonomy = State Corporatism

- Case England and South Korea

Vast of policy participant + network function of lobbying + conflicted goals in network + Formal network + high degree of marketisation = Sponsored Pluralism

LIMITATION TO DATE

1. Omitted variables : this research cannot reflect all possible network conditions, and it is impossible why some are included and some are not.
2. Have not concerned the separation of policy process: network in policy provision and policy implementation
3. Separation of home care and care home (nursing home) issue

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