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The involvement of the non-profit sector in Flemish child care and elderly care: a comparative exploration of its share in service delivery at the local level

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INTRODUCTION

This paper presents an empirical investigation into the relative prevalence of non-profit service delivery in the fields of residential elderly care and child care for children aged between 0 and 3 years in Flanders. Traditionally, welfare services in Flanders are provided by either local government, by private not-for-profit organizations (often embedded in religious or ideological networks), or by private for-profit organizations (commercial initiatives). The welfare sector in Flanders is a typical example of co-production of public service delivery between different sectors (public, private nonprofit and commercial). Each of these three ‘sectors’ can establish and manage organisations, such as residential homes, serviceflats and home-care in elderly care provision and day care centres or family day care in child care. These organisations operate on the local level, as close as possible to the clients, but are to a large extent regulated and financed by the central government (both federal and regional government). Over time, this has resulted in a dense network of service providers from different sectors (public and private) in both policy areas in the 308 Flemish communities. As organisations of three sectors deliver services in both policy areas, studying prevalences seems promising for theorizing about the circumstances in which one or another sector prevails. In particular, the paper will look for possible explanations for the over- or underrepresentation of the non-profit sector in local service delivery.

The paper has a descriptive and a theoretical explanatory component. Firstly, we will sketch the service delivery landscape in both policy fields at the Flemish level to facilitate further reading. Prevalence patterns in both sectors will be compared and discussed. Secondly, we will try to describe the extent to which organisations of three different sectors deliver residential elderly and child care at the local community level: (a) public organisations (organized by the local government), (b) private nonprofit organisations (mostly organized by ideological groups or religious congregations), and (c) private for profit or commercial organizations (organised by profit-seeking entrepreneurs). Thirdly, we will try to explain the descriptive findings. In this part we will address the question why a certain sectoral pattern (distribution of places in public versus private non-profit versus private for-profit sector) can be observed in a certain local community. Hypothetical explanations for the observed patterns can be derived from a large literature that has been eloquently described by Anheier (2006, see also Gronbjerg & Paarlberg 2001, and Corbin 1999). By comparing prevalences in two policy areas, our design clearly has an added value in the testing of theory-based hypotheses. As one or more hypotheses can be confirmed in both areas, the validity of theoretical assumptions will be strengthened. Fourthly, in the

conclusion we will relate our empirical findings to the theoretical frameworks, and we try to add to some of the policy-relevant discussions that are currently taking place concerning welfare service provision in general and elderly and child care provision in specific. To date, we do not know how the future sectoral pattern in Flemish elderly and child care will look like. Some prefer and advocate for a marketization of care and foster a growing private commercial sector, while other consider elderly and child care as a public responsibility that needs to be financed and organized by public means. These prefer a growing nonprofit sector. Hence, a fierce ideological debate is currently taking place about the future of welfare service provision in Flanders.

1. SERVICE DELIVERY IN FLEMISH ELDERLY AND CHILD CARE: THE COMPLEXITY DISENTANGLED

As both policy areas count a lot of organisations and are characterised by a rather complex institutional design over the Belgian governmental levels, we start the paper with a short description of both policy areas in which we will sketch their institutional design, their service delivery organisations and their size (compared to demand indicators).

Welfare policy in Belgium

Flanders is a Dutch-speaking region in the federal state of Belgium.¹ Belgian regions have their own parliament and government with extensive autonomous regional competences in (amongst other) the policy field of welfare services. These competences have been devolved from the federal to the regional level over time, as the result of some consecutive steps in the Belgian state reform process. This means that Flanders has law-making competences in the welfare area, although some (parts of) competences are still regulated and subsidised by the federal state.

The local level -308 local communities, governed by their own elected local government- has some additional competencies with regards to welfare policy-making and is also responsible for the coordination of social policy at the local level. Its main role however consists of the delivery of welfare services, either directed and subsidised by the federal or Flemish government, or delivered on their own initiative, financed by their own means.

Why elderly and child care?

¹ The other regions are the Walloon region (French-speaking, 262 local communities) and the Brussels Capital region (bilingual, 19 local communities).

As mentioned above, we chose two policy areas to strengthen the testing of theory-based hypotheses about the prevalence of the public, non-profit and commercial sector in welfare service delivery. Analysing the Flemish welfare landscape, child care and elderly care turned out to be the best areas to study for four reasons:

1. The amount of places available in both policy areas is approximately equal.
2. In the policy areas of child care and elderly care, all three sectors are to a large extent delivering services.
3. Both areas are characterised by a strong central steering (regulation and subsidies), but service delivery happens at the local level in rather small care organisations.
4. The target group of both areas can be neatly demarcated and the care needs are rather homogenous in each group. This is for instance less the case in a policy area dealing with disabled persons.

Moreover, both policy areas share the characteristic that they became highly relevant last decade as increasing demands pressed the governments to expand the care capacity in both areas. Demographical trends², but also societal evolutions (such as the higher amount of single parents, the decrease of informal family care and a higher labour market participation of women) will keep the expansion of both areas without a doubt on the political and policy agenda for the next decade.

Residential elderly care in Flanders

Professional elderly care in Flanders can be residential care or home care. Home care means that people live in their own house, and receive professional assistance³ for some hours per week, or even daily. Residential care is about people moving permanently out of their house. These people can go to a residential home for elderly care (a so-called resthouse), or a serviceflat. A serviceflat offers less specialistic care than a residential home does, and is a care facility that attracts people that are able to live autonomously and independent. Residents can make use of facilities such as

² In Flanders the population is growing older at increasing speed. In 1996 there were approx. 940000 people older than 85, in 2020 there will be 167000 people older than 85 years (more than 6% of the total population). Although the birth rate decreased for several years, it raised again since 2003, exponentially resulting in a growing demand for child care. In 2007 there were 8137 births more than in 2002 (67.862 versus 58.460).

³ This assistance can be nursery, for example some basic medical care, or bathing, or the assistance can be for basic tasks of a normal household (cleaning, cooking, shopping etc.).

meals, leisure, etc. if they want to.⁴ People with special needs of a medical or nursery nature can go to a residential home where these care facilities are offered, besides common household facilities such as meals and leisure. The official definition (Decree 5-3-1985) of a residential home is “*one or more buildings which altogether form a facility for collective and permanent residence, where housing-facilities as well as facilities of household care and nursery care are offered to the residents*”. Table 1 offers an overview of the demand for and supply of elderly care.

Demand		Supply	<i>Residential homes</i>	<i>Service flats</i>	<i>Total</i>
Number of people 65+	1.089.307	Number of residences	746	374	1120
Number of people 80+	277.514	Number of places	63.382	12.872	76.254

Table 1: Demand and supply elderly care in Flanders (2005)

There are approximately 76.000 places in residential homes and service flats. Most places (83%) are situated in residential homes. These places are meant for all elderly people in Flanders. In 2007, there were more than 1 million people older than 65 and 277.500 people older than 80 years. However, the demand for residential elderly care is naturally less high, as a lot of old people manage to live autonomously or supported by informal care. Residential homes are then mainly services for older people with rather high caring needs. 20% of all people that are older than 80, and 35% of all people older than 95 live in residential homes. The average age of the resident is 84 years, and 75% of residents is female (Mostinckx & Deven 2008). Relatively spoken, there are 5,85 places in residential homes per 100 people older than 65 and 22 places per 100 people older than 80 year. As residential homes are the dominant care service in elderly care, because the target groups of both elderly care services differ a lot and as the demand for service flats is of a different degree as the demand for residential care, we decided to focus only on the supply of elderly care in residential homes in this study.

Residential elderly care in Flanders has a free *admission*, which means that people that want to make use of residential elderly care need to sign in with the provider of care they prefer. Often, there are long waiting lists, because many residences have reached their maximum-capacity. In some cases, care providers set criteria for admission (e.g. being older than 75). The Flemish government *regulates* the residential elderly care sector, and has an oversight on whether the quality norms are reached. If the norms about e.g. admission-policy, respect for ideological and

⁴ The official definition (Decree 5-3-1985) of a serviceflat-building is “*a complex of facilities that altogether form a functional entity of individual flats where elderly people live self-reliant and can make use of common facilities of service delivery on an optional basis*”.

religious belief of the resident, quality of services delivered, hygiene, etc. are reached, then Flemish government can recognize and concede the residential home, which is a necessary condition for establishing and managing an elderly care facility. Elderly care facilities that have received the Flemish governmental recognition, are subsidized both by the federal government and the Flemish government. Federal government subsidizes residential homes for medical and nursery care (via the health insurance system). The more people with special medical and nursery care needs in the residential home, the higher the subsidy. Flemish government subsidizes for investments in infrastructure and buildings for up to 60%, but this only applies to public and private nonprofit homes (Decree 18-12-1991, art.5§1). Similarly, only public and nonprofit homes receive subsidies by the Flemish government for the employment of animators in the residential home (1/2 FTE per 30 residents). Residents pay for the so-called hotel cost (food, drinks, newspapers, hygienic products, ...) which is (on average) between 35 and 50 euros (daily).

Child care in Flanders

The child care delivery landscape is more complex than the elderly care sector, as it covers more different organisation types and labels, and as the demarcation between the sectors is not that clearly defined. The first characteristic of the delivery field is the difference between recognised and subsidised organisations on the one hand, and supervised but not subsidised organisations on the other hand. Organisations with a certificate of supervision ('attest van toezicht') are less heavily regulated with regards to personnel and infrastructural requirements, and can determine their own fees and admission criteria. Recognised and subsidised care providers are characterised by a large focus on quality and accessibility, and are obliged to ask parents a fee that depends on the taxable income and the familiar situation (number and kind of children), varying from 0 to 25 euro a day. The parental fees are complemented by governmental subsidies to finance staff and running costs.⁵

The recognised and subsidised sector has a public or non profit character, but not all organisations with a certificate of supervision are commercial. As recognition is coupled to subsidies and as the

⁵ Some organizations with a certificate of supervision can also get a subsidy per place if they fulfill some preconditions on competencies and opening hours. This kind of subsidy however can hardly be compared with the subsidies that subsidized care centers receive. The subsidy per place for day centers with a certificate of supervision is approximately 550 euro, the subsidy for its recognized equivalent is approximately 9000 euro per place.

budget for enlargement of the sector is scarce⁶, a lot of public and non-profit organisations that want to be recognised or could be recognised, set up their own care organisations, without Flemish subsidies. The second aspect that should be mentioned is the difference between residential care at the one hand and familiar type care in the house of the care provider at the other hand and that this difference exists as well in the subsidised (public or not for profit) as in the private forprofit sector. In the recognised and subsidised sector, familiar child care is organised by a family day care service who selects the baby minders and introduces them to parents.⁷ The third aspect worth mentioning has to do with the scale of the care providers. Every care provider has to respect the minimum or maximum capacity that is legally fixed by the Flemish Government:

- Subsidised day care centres have to count at least 23 places, non-subsidised day care centres have to count at least 8 places.
- A private family day care provider may take care for up to 7 children at the same time, family day care providers related to a family day care service may take care for up to 8 children at the same time, but on average they may only care for 4 children per quarter. A family day care service is subsidized based on its capacity in places. In order to keep its subsidies, the service has to attract and maintain sufficient baby minders to provide its places in a fixed working area, mostly –but not always- limited by the borders of a local community. The capacities of family day care services differ tremendously as the smallest one has 49 places and the largest one has a capacity of 607 places.

Table 2 gives an overview of the sizes of the different types of child care providers.

⁶ The recognition of new places depends on the availability of resources. It is the Flemish Government and the Minister of Welfare in particular who decides if and how many places can be subsidized. The recognition occurs by an enlargement operation in which public and non-profit care providers can apply for a number of places. The available places are spread out over the provinces based on parameters that try to estimate the need for child care, related to the existing supply of care facilities. Within every province, a ranking of communities is set up to allocate the places first in those communities with the highest needs. The ranking is made based on the combination of several demand and supply parameters, such as the number of young children with a working mother. The last enlargement period took place in 2005, at the moment a new enlargement is being held in which more than 1000 subsidized places will be allocated.

⁷ However, the people who take care of the children in their houses are not tied to the family day care service with an employment contract as they got a specific statute in the Belgian social security system.

Sector/ Places	Subsidised		Non-subsidised		TOTAL
	<i>Subsidised day centres</i>	<i>Subsidised family care services</i>	<i>Non-Subsidised day centres</i>	<i>Non-subsidised family care</i>	
<i>Number of care providers</i>	291	193 ⁸	977	1144	2567
<i>Number of places</i>	13.439	30.679	18.456	6.859	69.433
	44.118 (64%)		25.315 (36%)		

Table 2: Number and size of the different child care providers

At the end of 2007 there were 69.433 places in Flemish preschool⁹ child care.¹⁰ Approximately two-third (64%) of the places are subsidised. 54% of the places are of familiar care type, 46% are group care like. We know that early 2007, 83.600 children attended pre-school child care. A child care place thus is used on average by 1,2 children¹¹. As we know that there were 195.000 children younger then 3 years, approximately 43% of Flemish young children make use of formal child care services. Although the use of formal care is rather high, informal child care (e.g. grandparents) thus maintains to be the dominant care type for young children. The Flemish Government delegates the competency of child care to a public agency named Kind en Gezin (Child and Family). Kind en Gezin is responsible for organising and monitoring formal pre-school and out-of-school care.¹² Kind en Gezin does not deliver any care service itself, it only regulates, subsidizes and controls. All formal child care must be registered to Kind en Gezin. A recognition or certificate of supervision is important for the working parents as only costs for recognised or supervised child care can generate fiscal benefits.

Sectoral prevalences in child and elderly care at the Flemish level

After having sketched the demand and supply side in both policy areas, we will now compare the sectoral prevalences in both areas. We only look at the prevalences in terms of places and will not look at prevalences in terms of residences or organisations, as the minimal size of care providers differs a lot between both policy areas.¹³

⁸ More then 5000 baby minders are affiliated to these 193 services. If we would count them like private family care providers, the total number of care providers would exceed 7000 providers.

⁹ An unknown amount of places will be taken by children older than 3, as private day care providers may also take care of children up to 6 years.

¹⁰ Per 100 children under 3 year there are approximately 35,3 places, which is more than the European target figure of 33 places per 100 children under 3 years.

¹¹ Not every child has a continuously need for formal child care, as some parents or grand parents can take care for one or more days a week.

¹² Besides its child care competencies, Kind en Gezin is also responsible for the preventive medical and educational support for families with young children.

¹³ Child care providers can be a lot smaller then elderly care residences.

Table 3 contains comparative data on the sectoral prevalences in both policy areas.

Supply capacity (in places)	ELDERLY CARE		CHILD CARE					
	Residential home	%	Subsidised day centres	Subsidised family care	Non- Subsidised day centres	Non- subsidised family care	Total	%
Public	23.923	38%	8.958	21.766	3.913		34.637	21%
Non-profit	34.423	54%	4.481	8.913	1.153		14.547	50%
Profit (Commercial)	7.036	11%			13.390	6.859	20.249	29%
Total	63.382		13.439	30.679	18.456	6.859	69.433	

Table 3: Sectoral prevalence in both policy areas

Table 3 confirms the assumption that all three sectors are important actors in delivering care facilities. In the area of elderly care, there is one sector that is rather small, as the profit sector represents only 11% of the total amount of places. In child care all three sectors represent more than 20% of the total capacity. In both policy areas, the non-profit sector has the largest share in total capacity. The Flemish welfare policy, and more specific elderly care and child care, is thus a typical example of co-production of service delivery between different sectors (nonprofit, public, and to a lesser extent commercial). In child care, the nonprofit sector represents half of the places, in elderly care it even exceeds 50%. Remarkable is the observation that in elderly care the public sector is more important than the commercial sector. In child care the opposite can be concluded, but the size differences are not as large as in the elderly sector. This could be explained by two facts. First of all, starting a commercial initiative may be easier in child care than in elderly care.¹⁴ Secondly, the fact that there exist some subsidies for commercial day centres may attract entrepreneurs to invest more in child care than in elderly care. Table 3 also shows that most of the non-profit capacity is subsidized¹⁵, implying that the Flemish welfare field is a typical example of a governmentally subsidized field in which the non-profit sector is mainly a government-dominant funded sector, in a rather corporatist society characterized by large governmental social spending and a large nonprofit sector (Anheier 2006, Salamon & Anheier 1998). As the amount of places in both policy areas is large enough and as all sectors take an important share of the total capacity in both fields, we now are capable to make a reliable analysis of sectoral prevalences at the local level.

¹⁴ The requirements with regards to personnel and infrastructure seem to be less heavy in child care than in elderly care. Moreover, the minimal capacity to start a profitable initiative is smaller in child care than in elderly care.

¹⁵ In child care only 11% of the non-profit places is not subsidized. In the public sector only 8% of the places are not subsidized.

2. SERVICE DELIVERY IN ELDERLY AND CHILD CARE AT THE LOCAL LEVEL

Absolute figures about (variation in) elderly and child care service delivery

In Flanders, there are 308 local communities, which are the units of analysis in this paper.¹⁶ Table 4 describes the existing variation between these communities with regard to the number of residences/child care providers and the number of places in each sector. We distinguish between public, private nonprofit and private forprofit (commercial) care facilities per local community.

ELDERLY CARE				CHILD CARE			
	<i>Mean</i>	<i>Min</i>	<i>Max</i>		<i>Mean</i>	<i>Min</i>	<i>Max</i>
Total residences 2005	2,42	0	49	Total providers 2007	8,45	0	177
Public residences	0,78	0	18	Public providers	0,7	0	37
Nonprofit residences	1,18	0	24	Non-profit	1,54	0	40
Commercial residences	,46	0	7	Commercial	6,2	0	100
Total places residences 2005	199,45	0	5251	Total places 2007	225	0	4494
Places in public sector	77,65	0	2806	Places in public sector	47,19	0	1535
Places in non-profit sector	98,46	0	1988	Places in non-profit sector	112,46	0	2065
Places in commercial sector	23,34	0	706	Places in commercial sector	65,79	0	1137

Table 4: Supply of elderly and child care in Flemish local communities (N=308)

With regard to the number of care providers, both policy areas differ a lot due to scale differences in minimal capacities. On average, a Flemish community counts 2,42¹⁷ residential homes and 8,45 child care providers. This variability difference between both areas is confirmed by differences in the maximum number of care providers, as the maximum number in child care (N=177) exceeds largely the maximum in elderly care (N=49), mainly caused by a large number of small commercial familiar care initiatives in child care. Looking at the minima in table 4, we can conclude that that the coverage of welfare services in Flanders is not perfectly, as in both policy areas the minimum in care providers is 0, what means that there is at least 1 community without elderly and/or child care services. The sectoral minima indicate moreover that no sector is present in all 308 local communities. In the following paragraph, we will describe this sectoral variability in depth.

¹⁶ For a good understanding of this paragraph it is useful to keep in mind that there exist huge differences between these units of analysis as big cities as Antwerp or Ghent are compared to smaller cities or very small local communities.

¹⁷ Most of the communities however have only 1 (40%) or 2 residences (27%).

The total number of places in residential homes varies from 0 to 5251 (in Antwerp). On average, in Flemish local communities, there are 199 places in residential homes. In child care, the maximum number of places is 4494, but on average there are 225 places in a community.

Relative distribution of public, private nonprofit and private for profit supply

Table 5 contains information about the extent whether service provision is absent in a local community, whether there is ‘hegemonic’ service delivery, or whether there is ‘co-production’ between sectors in local communities. By the label hegemonic we refer to the situation in which all service delivery in a local community is delivered by only one sector. By the label co-production we refer to those local communities in which more than one sector supplies services.

	ELDERLY CARE (N of local communities)	CHILD CARE (N of local communities)
<i>No supply at all</i>	20	18
<i>Hegemonic supply</i>	162 - 51 (public hegemony) - 91 (nonprofit hegemony) - 20 (commercial hegemony)	90 - 1 (public hegemony) - 14 (nonprofit hegemony) - 75 (commercial hegemony)
<i>Co-production</i>	126	200
Total	308	308

Table 5: Relative distribution of places in elderly and child care organizations in the three sectors

In 20 local communities (5,5%) there are no residential homes, while 18 communities have to deal with a lack of child care services. In elderly care, the public sector is hegemonic in 51 local communities, the nonprofit sector is hegemonic in 91 local communities and the commercial sector is the only service provider in 20 local communities. In child care, we observe hegemonic situations in 1 (public sector), 14 (nonprofit sector) and 75 (commercial sector) local communities.

The data thus show that there are more ‘hegemonic’ situations in elderly care than in child care (162 versus 90), which is mainly caused by the fact that the scale of a residential home often leaves few space left for residences of other sectors in that local community. This implies that there are far more situations of co-production in child care than in elderly care. In 200 communities at least two sectors are present in child care¹⁸, in elderly care this occurs in 131

¹⁸ There are even 63 communities in which all three sectors are active. In the 137 other communities with child care facilities, there was always one sector missing, mostly the public one (92 communities without public supply, 38 communities without non-profit, 7 communities without profit supply).

communities. In these local communities, we have a situation of so-called co-production of welfare services between two or three sectors. Also, we can observe that the dominance patterns do not correspond between the policy areas. Although the non-profit sector was the largest sector in both policy areas, in elderly care a lot more non-profit hegemonies can be observed than in child care (91 versus 14). In child care most hegemonic situations are commercial (75). The difference in public hegemonies is even larger. While there is only one community where all child care supply is public, there are 51 public hegemonic cases in elderly care. These numbers show that there is a large variation in the prevalence of the three sector's service delivery among the 308 Flemish local communities. This observation brings us to the next part of the paper, in which we will try to explain this variation of the sectoral prevalence. However, the observed differences in sectoral prevalence (largely caused by differences in the size of care initiatives) should be kept in mind as they may interfere with our ambition to test cross-validate theory based assumptions in two policy areas. Explaining non-profit prevalence in elderly care seems to be a matter of explaining non profit hegemony or non-profit absence, while the explaining of non-profit prevalence in child care is more a relative matter.

3. EXPLAINING THE PREVALENCE OF SECTORS IN ELDERLY AND CHILD CARE

In search for theoretical explanations

Three sets of hypothetical explanations for the extent to which public and private organizations (non-profit, for-profit) are engaged in welfare service delivery can be derived from a large literature on theorizing the nonprofit sector, that has been eloquently described by Anheier (2006, see also Anheier and Ben-Ner 2003, Grönbjerg & Paarlberg 2001). These hypothetical explanations can be linked to (a) demand-side factors, (b) supply-side factors and (c) the specific situation in a local community.

a) Demand-side explanations

The first theoretical direction looks at the demand for welfare provision. According to this line of reasoning, supply of elderly and child care will be organized in those local communities where there is a demand that is large enough. It seems obvious to claim that in local communities where there are relatively more elderly people or little children, there will also be more care supply.

However, this assumption cannot explain which sector (public, nonprofit, forprofit) will supply the services in case of large demand. Therefore, we need other demand-side factors in a theoretical model. The concept of demand heterogeneity may be a valuable starting point (Weisbrod 1988, Anheier 2006). Demand heterogeneity is the extent to which the demand for quality and quantity of service delivery in a society is heterogenous or not. Public goods theory assumes that the public goods and services provided by the public sector will always have the quality and quantity as demanded/desired by the largest segment in the population (the so-called “median-voter”), because serving this largest segment of the population is electorally spoken most valuable for public officials. The marginal (electoral) gains of delivering services to minority groups outside the median-voter segment are too small for public officials. This means that some segments of the population are left unserved or insufficiently served, because these segments demand other levels of quality and/or quantity than the services provided by the public authority. In societies that are characterized by a large demand heterogeneity, these unserved demands will be large. Hence, in a heterogenous society, private supply will be larger, compared to public supply (private sector fills large gaps that are left by public sector supply). *Ceteris paribus*, in a society that is characterized by homogeneity, public supply will be larger, compared to private supply (public sector can address large groups of the electorate with a supply that will satisfy the demands of this large group). Whether private sector supply will be nonprofit or forprofit, will depend on the nature of the demander. We can argue that market failure mechanisms will prevent forprofit providers to deliver services to those demanders that are rather distressed or less well-off, because there is few profit-making chances in this segment of the population. Forprofit suppliers tend to invest in markets where the chances for profit-making or growing are larger. Hence, we could hypothesize that private for profit initiatives will prevail in communities with elderly people or young families that are relatively spoken better off (financially). Related to the demand-heterogeneity thesis, we could argue that the forprofit sector will tend to supply those segments of the society that demand for higher levels of supply than provided by the public sector (e.g. in terms of quantity and quality). On the other hand, nonprofit providers can be assumed to fill the gaps at the other end of the societal spectrum, by addressing demands of people that are left unserved by private forprofit suppliers (market failure) and by public sector suppliers. If this assumption is correct, we will observe more private nonprofit initiatives in local communities with a population that is relatively spoken more distressed or less well-off.

b) Supply-side explanations

The second theoretical direction looks at the supply of welfare services. Demand alone is not enough as an explanation, one also needs suppliers, or people or sectors that are willing to invest in providing welfare services. A lot of literature has been published already on the social entrepreneur, explaining why people or what kind of people start nonprofit initiatives. Corbin (1999), Booth et al (1989) and Ben-Ner & Van Hoomissen (1991) all found that in communities that are relatively wealthy, there is a large private non-profit (and in some cases also profit) sector. Also the existence of human resources in a local community (e.g. socio-economic status, education-levels, or age) may contribute positively to the size of the nonprofit sector (Galper 1999, Lincoln 1977, Guterbock & Fries 1997). These features point at a potential existence of entrepreneurs, which may be a prerequisite for a strong private sector (James 1987, Rose-Ackerman 1996, Young 1983). So we can argue that in a local community that is characterized by an averagely wealthy, well-educated and middle-aged population, there will be a large private welfare sector, because conditions for entrepreneurship are good. The question whether this entrepreneurship will be rather 'social' or 'economical', can be linked to some of the demand-side factors discussed above. We can distinguish between social and economic entrepreneurs. Concerning social entrepreneurs, Wolch & Geiger (1983) hypothesized that in a local community, affluent community members may have the incentive to invest (resources, talent, ...) in nonprofit initiative that serve particular target groups that are in need for services. Thus one can assume that in communities with a lot of economic distress, social entrepreneurs that are driven by altruistic motives will tend to invest their resources and talents in private nonprofit initiatives. A variation on the theme of the social entrepreneur, that mainly explains the existence of private nonprofit organisations from a social motive, is the economic entrepreneur. One can argue that also entrepreneurs driven by an economic motive may be attracted to deliver some welfare services in order to make some (monetary) profit. Economic entrepreneurs will take action when the conditions for profit making action are good. This may be the case in the situation where the demand by people that are relatively well-off is large (e.g. large number of elderly people that are relatively wealthy). Next to human resources as crucial supply factor, there are also financial resources. Firstly, there is already evidence that in wealthier communities there is a larger nonprofit and forprofit sector (Ben-Ner & Van Hoomissen 1992). This could be explained (cf. supra) by the fact that in these communities private funding and donations may be higher. But, in the case of elderly care in Flanders most of the funds of service providers are governmental subsidies (to a lesser extent this applies to private for profits in elderly care in Flanders, cf. supra).

According to the so-called interdependence theory (Salamon 1987) a (financial) partnership between government and nonprofit sector grows, in which governmental weaknesses are compensated by nonprofit strengths and vice versa. In such partnerships, nonprofits perform public tasks on behalf of government, and receive governmental funding in turn. This is also the case in Flanders, where dense public and nonprofit sectoral activity in elderly care can be explained by the fact that central government provides many financial resources to both sectors. This central governmental funding does not suffice for explaining differences in prevalence of sectors between local communities. Therefore, we can look at local governmental spending for social and welfare purposes (local government is the governmental tier on which services in elderly care are delivered). In the case where there is a lot of local governmental welfare funding, we might expect a larger public sector in providing elderly care services, compared to the private sector. This may potentially lead to a crowding out effect, by which a lot of welfare service supply by the public sector hardly leaves space for supply by other sectors (because the demand for services to a large extent is already supplied by the public sector). Hence, a strong public sector crowds out other (private) sectors.

c) 'Social origins' explanations

A third set of explanations is less instrumental than the demand- and supply-explanations. Social origins theory (Salamon & Anheier 1998, Anheier 2006) explains the prevalence of different sectors in public service delivery as the result of economic, social and political factors that shape the sector and what the sector looks like. Relying largely on the concept of path-dependence, some factors are identified that explain the size and composition of the nonprofit sector. Although the theory was initially developed by Salamon and Anheier for explaining size and composition of the nonprofit sector cross-nationally, it might also be useful to test some of the social origins arguments in the case of elderly and child care supply on the local governmental level in Flanders. As Flanders is a prototype of a pillarized society in which ideological organisations were/are strongly tied to specific political parties, electoral success of political parties at the local level in particular may be an important factor for explaining sectoral prevalences. Ideologically, we could link the non-profit sector to the christian-democrat party (historically supporting private initiatives by religious congregations), the public sector can be linked to the socialist party (supporting public collectivistic service delivery), while the commercial sector is tied to the liberal party (supporting market solutions and private initiative for welfare service delivery). Hence, according to a social origins explanation, we may assume that the strength of a certain

sector (public, nonprofit, commercial) in a local community may depend on the dominant political ideology in that local community.

Overview of hypotheses

The theoretical discussion we described above results in following hypotheses:

Hypothesis 1: In local communities with a heterogenous population, heterogenous demand will be addressed predominantly by private sector suppliers (*governmental failure argument*). In local communities with a homogenous population, homogenous demand will be addressed by public sector supply (*median-voter argument*).

Hypothesis 2: In local communities with a population that is relatively spoken well-off in financial terms, we will observe a large forprofit sector. In local communities with a population that is characterized by higher levels of social distress, we will observe a larger private nonprofit sector (*market-failure argument*).

Hypothesis 3: In local communities with a population that is wealthy, well-educated and has a large segment of middle-aged people, there will be fertile conditions for entrepreneurship, from which a large private sector can emerge (*entrepreneurship argument*).

Hypothesis 4: In local communities with a lot of local governmental welfare and social spending, there will be a larger public sector in elderly and child care provision, compared to the private sector (*financial supply argument*).

Hypothesis 5: The prevalence of different sectors in welfare service delivery depends on the dominant political ideology in a local community (*social origins argument*). In local communities in which the christian-democrat party has a relative large share of seats in the municipality council, the non-profit sector will be larger. In local communities with a strong social-democrat party, the public sector will be dominant. In local communities with a strong liberal party, the commercial sector will be stronger.

Method

For testing the hypotheses formulated above, we will perform linear regression analysis with care facilities (in terms of places) as dependent variables, and demand-, supply-, and social origins factors as independent variables. The data we rely on for measuring the dependent and independent variables are taken from various databases (see annex 1). For all analyses, cases (local communities) in which elderly care residences or child care providers are absent, are omitted. These cases are omitted, because we want to test the relative prevalence of the three sectors in welfare service delivery, rather than the absolute prevalence. This results in an N of 288 local communities (residential homes) and 290 local communities (in child care).

Measurement of the dependent variables

The relative number of places in residential elderly care and child care facilities per local community are the dependent variables. This is the number of places in (a) public, (b) private nonprofit and (c) private commercial residential homes or child care initiatives, divided by the total number of places in residential homes or child care initiatives in the local community. Each local community thus receives a score for the relative prevalence of places in elderly and child care facilities for three sectors (public/nonprofit/commercial). This score ranges from 0 to 1.¹⁹

Measurement of the independent variables

The ***demand heterogeneity*** is measured by looking at the span of income. This is a measure of income heterogeneity and represents the difference (in euros) between the third and the first quartile (interquartile difference). A large interquartile difference suggest a large span of income, hence large income heterogeneity. A second demand variable is the number of ***distressed people***. This variable is operationalised differently in both policy areas. In elderly care, it can be measured by looking at the number of elderly people that receives the minimal guaranteed income²⁰ per 1000 people of 65+. In child care, it can be measured by looking at the number of births in underprivileged families²¹ related to the total number of births. As to supply-side variables, we look at some measures that give an indication of the ***potential entrepreneurship*** in

¹⁹ For example, if for a local community with in total 12 places in residential homes 6 places are public, 4 places are nonprofit, and 2 places are commercial, then the relative scores are: places in public residential homes .50 (6/12), places in nonprofit residential homes .33 (4/12), and places in commercial residential homes .16 (2/12).

²⁰ This is the lowest income possible not to be officially in poverty.

²¹ This figure depends on subjective interpretations of family situations by nurses working for Kind en Gezin. Every family is being judged on 6 criteria (income, educational level of parents, working situation, living conditions, health care and level of educational stimulation). When a family gets a negative score on three of these criteria, the child is being considered as underprivileged.

the local community. First, the mean income that was declared to the fiscal authorities in a local community. Second, the percentage of people in the age category of 40-59 years. Third, the number of low educated people that are unemployed (per 1000 inhabitants). These measures are used, as previous research has shown that (social) entrepreneurship is more likely to be observed with middle-aged people that are relatively well-off (financially) and have had a higher education (e.g. Galper 1999). As a final supply indicator, we look at *local governmental spending* for social and welfare funding, by measuring the number of euros the local government spends per capita to the public centre of social welfare (the public local institute for welfare). For the social origins indicators, we use the *political ideology* of a local community as an independent variable. Therefore we use the electoral success of three political parties (christian-democrat CD&V, social-democrat SP.a, and liberal VLD) in the elections for the local council in 1976 and 2000. We have constructed an index that reflects the mean electoral score of these parties for both election-years. By using an index that covers electoral scores over 25 years, we hope to be able to capture some aspects of dominant and persistent political ideologies in local communities, rather than election-results (that are no more than a snapshot at one moment in time).

Empirical results

Before we present the results of the linear regression analysis, we first take a look at the correlation analysis of the dependent variables (table 6).

	<i>Nonprofit supply child care (relative)</i>	<i>Public supply child care (relative)</i>	<i>Commercial supply child care (relative)</i>	<i>Nonprofit supply elderly care (relative)</i>	<i>Public supply elderly care (relative)</i>	<i>Commercial supply elderly care (relative)</i>
<i>Nonprofit supply child care (relative)</i>	1	-,333(**)	-,592(**)	-,028	,091	-,083
<i>Public supply child care (relative)</i>		1	-,311(**)	-,064	,015	,073
<i>Commercial supply child care (relative)</i>			1	,087	-,028	-,089
<i>Nonprofit supply elderly care (relative)</i>				1	-,753(**)	-,436(**)
<i>Public supply elderly care (relative)</i>					1	-,264(**)
<i>Commercial supply elderly care (relative)</i>						1

Table 6: Correlation-analysis (Pearson) between the dependent variables (Sig: ** 0.01 level).

Two important observations can be made. Firstly, there is no significant correlation between child care supply and elderly care supply (correlation coefficients in bold). This suggests that sectoral

prevalences in both elderly and child care are not necessarily the same in Flemish local communities. For example, a local community with a large relative nonprofit supply in elderly care, not necessarily also has a strong nonprofit supply in child care. Secondly, we observe significant negative correlations between sectoral supply in elderly care and in child care (correlation coefficients in italic). This means that within both policy areas of elderly and child care, there seems to be a kind of crowding-out effect between sectors. In other words, in local communities where one sector is dominant (e.g. the public sector), the other two sectors (e.g. nonprofit and commercial) are less involved in the service delivery in that local community.

<i>Independents</i>	<i>Prediction</i>	<i>Public Supply (relative)</i>		<i>Nonprofit supply (relative)</i>		<i>Commercial supply (relative)</i>	
		Elderly care	Child care	Elderly care	Child care	Elderly care	Child care
<u>DEMAND</u>							
Span of income (2004)	- (public) + (private)	-.12**	.05	.06	-.01	.08	.03
Distressed +65 / 1000 people of +65 (2006)	+ (nonprofit) - (profit)	.01		.09		-.14**	
Distressed children			.04		.21***		-.24***
<i>R</i> ²		.02	.00	.01	.05	.03	.05
<i>F</i>		2.28	.35	1.17	6.92	4.72	8.19
<i>Sig.</i>		.10	.70	.31	.00	.01	.00
<u>SUPPLY</u>							
Mean income (2003)	+ (private)	-.04	.08	-.06	-.03	.14*	-.03
Percent age 40-59 (2005)	+ (private)	-.09	.10	.02	.09	.09	-.16***
Low educated unemployed / 1000 inh. (2006)	- (private)	.04	.07	-.07	.20**	.05	-.26***
Local govt. welfare spending per 1 inh. (2005)	+ (public) - (private)	.37***	.17***	-.31***	.09	-.05	-.21***
<i>R</i> ²		.17	.05	.11	.07	.03	.15
<i>F</i>		14,029	3,77	8.83	4.99	2.42	12,29
<i>Sig.</i>		.000	.00	.00	.00	.05	.00
<u>SOCIAL ORIGINS</u>							
SP	+ (public)	.15	-.04	-.10	.08	-.07	-.07
CVP	+ (nonprofit)	.06	-.17	-.04	.12	-.02	-.03
VLD	+ (commercial)	-.11	-.10	.14	-.20	-.05	-.36***
<i>R</i> ²		.04	.02	.04	.07	.00	.14
<i>F</i>		1.17	.64	.990	2,06	.11	4,27
<i>Sig.</i>		.33	.59	.40	.11	.96	.01

Table 7: Summary of the linear regression analysis, standardized Beta-coefficients (Sig.: *** .01 / ** .05 / * .10)

In the table 7 the results of the linear regressions are presented. Three theoretical models for explaining the sectoral prevalence in elderly care and child care are tested. The **demand-side** model seems to be a weak explanation for the sectoral differences in supplying welfare services. For the dependent variables (supply in child and elderly care) the R^2 is low, ranging from .00 to .05. Some variables do have some explanatory power however. The level of *distress* in the local community (distressed children and distressed 65+) is related negatively to the level of commercial elderly care and child care provision, suggesting that this sector is less prevalent in supplying welfare services in local communities that are characterized by a relatively large level of distress (as it was assumed theoretically). This is an important observation, with potentially important policy-relevant implications. We could question, with extreme caution, whether in a marketized welfare sector dominated by commercial supply, all socio-economic segments of society will be reached. Secondly, in local communities with a relatively large number of distressed children, the supply of nonprofit child care provision is relatively larger. An explanation for this observation is that the number of distressed children is one parameter for distributing central governmental subsidies in child care. It could thus be the case that nonprofit providers in local communities with a lot of distressed children have better chances to receive governmental subsidies (and that explains their larger prevalence in those communities). Social distress is, however, not related to nonprofit elderly care supply. One explanation could be that the public sector also focuses on the group of (relatively) distressed elderly people. Thirdly, also in line with our theoretical assumptions, we observe that the lower the *span of income*, the higher the level of public sector supply (but only for elderly care).

The **supply-side** model offers a better explanation for the sectoral differences in supplying elderly care services. 17% of the variance in public supply of elderly care ($R^2=.17$), 11% of the variance in private non profit elderly care supply ($R^2=.11$), and 15% of the variation in commercial child care supply can be explained by the supply-side variables. Especially the extent to which *local governments spend* resources to welfare programs is a strong predictor. As hypothesized, there is a positive and significant relationship between local governmental welfare spending and public supply (both in child and elderly care). Next to that, also in line with our hypotheses, there is a negative and significant relationship between local governmental welfare spending on the one hand, and private non profit elderly care supply and commercial child care supply on the other hand. Of course this finding is quite obvious, as local public welfare services are managed by the local public authorities. Hence, in local authorities with a lot of public supply, and subsequent poor private supply of welfare services, we may observe the so-called crowding-

out effect (cf. supra) by which one sector (in this case the public sector) dominates the field at the expense of the other sectors. The variables of *entrepreneurship* yield some contradictory results however. We hypothesized that in local communities with a population that are rather wealthy, have a lot of people in their middle-ages, and have a population with higher levels of education, private sector welfare services supply may be higher. The empirical results show that mean income is positively related to commercial elderly care provision, and that in local communities with fewer low educated unemployed people the commercial child care provision is relatively higher (as hypothesized). This observation might be explained by the fact that establishing and managing a child care facility requires a lot of managerial skills (pricing, HR management, quality management etc). On the other hand, and contrary to what we have hypothesized, the fewer people in their middle ages, the more commercial child care provision exists, and the more people that are unemployed and poorly educated, the more nonprofit child care provision we observe. The latter observation may be the result of the potential dominance of demand-related factors: in local communities where a lot of unemployed and poorly educated people live, the demand for income-related child care (the amount of the fee for care depends on one's income) may be higher, hence the positive relationship between the level of unemployment with nonprofit child care supply.

Thirdly, the **social origins** model also offers a poor explanation for the sectoral differences in supplying welfare services. Only for explaining the commercial child care provision, this model is significant (.00, $R^2=.14$). It is however contrary to what we have hypothesized, as we observe a negative relationship between local communities with a strong liberal political ideology and commercial child care provision. No significant relationships between welfare provision and christian-democrat and social-democrat ideologies can be found. Perhaps, this empirically unexisting relationship can be explained as the result of the difficulty for local governments to provide welfare services themselves, especially in a sector that is characterized by strong central governmental steering and control. For example, in elderly care there is the so-called 'programmation-norm'. According to this norm, in a local community only a certain number of places in residences are subsidized by the central government (1 place per 100 people between 60-74, 4 places per 100 people between 75-79, 12 places per 100 people 80-84, etc.). This policy results in a situation that only in those local communities where current elderly care supply not meets the norm, there is still room for new initiatives. Potential (public or private) suppliers are

thus dependent on the local situation to be able to invest in supply or not.²² A second kind of policy is that central governmental issues very strict quality norms (care, kitchen, safety, ...). This means that the starting-up costs for new residences are very high because of necessary investments to meet these norms. To a certain extent, these policies by central government lead to a more or less stable public-private distribution: new initiatives are only possible in local communities where the norm is not reached yet, and it is easier to adapt existing infrastructure to the (ever increasing) quality norms, than to invest in new and very expensive infrastructure. Hence, factors like central governmental policy (programmation- and quality-norms) may determine the supply of welfare services at the local level, rather than the local political (ideological) constellation.

CONCLUSION & DISCUSSION

Elderly care and child care in Flanders are provided at the level of the local community in Flanders. Care facilities may be organized by three sectors: public, private nonprofit and commercial. Hence, we can say that in both policy areas, a typical situation of co-production of welfare services between different sectors may exist. The figures in table 3 (supra) show that the three sectors have a share in service provision. Public facilities account for 38% of the elderly care and for 21% of the child care in Flanders. Nonprofit facilities account for 54% of the elderly care and 50% of the child care in Flanders. And commercial facilities account for 11% of the elderly, and 29% of the child care in Flanders. The large share of the subsidized nonprofit sector in both policy areas is exemplary for the fact that Flanders (Belgium) is a country that has a corporatist society with a large governmental social spending and a large nonprofit sector. We also observed large differences between local communities as to sectoral prevalence in both policy areas. Table 5 (supra) shows that in elderly care, in 162 local communities only one of the three sectors supplies services. In child care, there are 90 hegemonic local communities, where service supply is offered by only one sector (public *or* nonprofit *or* commercial). In the rest of the local communities with elderly care and child care provision, two or three sectors are present in the provision of welfare services (public *and/or* nonprofit *and/or* commercial). In these local communities, we have a situation of co-production of welfare services between sectors at the

²² In child care there does not exist a formal kind of programmation norm, but the fact that scarce Flemish child care subsidies are allocated based on rankings of communities within every province, it is clear that communities beneath the ranking hardly make any chance to get subsidies.

local governmental level (200 local communities in child care, 131 local communities in elderly care). Only few local communities have no child care supply (18) or elderly care supply (15).

In search for an explanation of these differences in sectoral prevalence between local communities, we developed hypotheses that are linked to three different theoretical models (demand, supply and social origins). Statistical analysis shows that these models at best can only be partially supported. The supply-side model offers the strongest explanation for variation in sectoral prevalence in elderly and child care. Still, some variables have some significant explanatory power. We found for example that the span of income in a local community is negatively related to the public sector welfare service provision. This is in line with our hypothesis that assumed that in local communities with a homogeneous demand, the public service delivery will prevail over private sector service delivery (median voter argument, see hypotheses). The level of social distress is also a strong explanatory variable. In line with our hypotheses, we found that commercial service delivery will be stronger in local community that are rather distressed. In local communities with a population that is relatively more distressed, nonprofit supply will prevail (market failure argument). This observation may have some important policy-relevant implications. Also the level of potential entrepreneurship in a local community may explain sectoral prevalences in welfare service provision. The higher the average income in the local community, the more commercial welfare service delivery. The lower the percentage of low educated unemployed people, the more commercial initiatives. The higher the percentage of low educated unemployed people, the more private nonprofit initiatives. These findings, however, seem to be in line with the demand-side theoretical arguments, rather than with the supply-side theoretical arguments. Variables such as mean income, and low educated unemployed people may tell us more about the demand for services, than about the supply of services. If we consider these variables as demand-side variables instead of supply-side variables, the theoretical model of demand may gain in strength.

One final important variable for explaining sectoral prevalence is the extent to which the local government spends for welfare service delivery. This variable is positively related to public supply, and negatively related to nonprofit and commercial supply. As already said supra, this may be one explanation for the observed crowding-out effect (see table 6 supra). The more the local government spends for delivering public welfare services, the less room for other (private) initiatives to deliver services in that local community, because a large part of the demand for welfare services is already addressed by the local government. This crowding-out effect may even

be strengthened by central governmental policies. In elderly care for example, there exist programming-norms and quality norms. These norms prevent extra supply in local communities where the programming-norm is already reached (the maximum number of places that can be subsidized by the central government is reached already). This decreases the opportunities for other suppliers to enter the local market. Central government policy may thus be a stronger predictor for sectoral prevalence than more instrumental explanations. In countries like Flanders, that are characterized by a large nonprofit sector besides a large public sector, and where nonprofits are heavily subsidized by government, we may need other explanations for nonprofit sector prevalence compared to countries where the nonprofit sector is mainly funded by fees and donations (fee-dominant countries, Anheier 2006). In Flanders, both public sector and nonprofit sector serve the same target group with the same (governmental) means. In other countries that are more fee-oriented in nature, demand heterogeneity theory may be more relevant (nonprofits as complementary gap-fillers for delivering services to target groups that are not served by public sector service supply). In government-dominant countries where nonprofits receive a lot of public money, explanations for whether the public or the nonprofit sector will prevail, will thus depend on some specific (local) contextual characteristics (e.g. relationship between local governmental welfare spending and the prevalence of public and nonprofit welfare service suppliers).

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Annex 1: variables, measurement and data-source

<i>VARIABLE</i>	<i>MEASUREMENT</i>	<i>SOURCE</i>
<i>Dependent elderly care</i>		
Public supply (relative)	Places in public residential homes per total number of places(2005)	www.wvc.vlaanderen.be/ouderenzorg/
Private non-profit supply (relative)	Places in private nonprofit residential homes per total number of places(2005)	www.wvc.vlaanderen.be/ouderenzorg/
Private for profit supply (relative)	Places in private forprofit residential homes per total number of places (2005)	www.wvc.vlaanderen.be/ouderenzorg/
<i>Dependent child care</i>		
Public supply (relative)	Places in public recognised day centres / family care services and public day centres with a certificate of supervision (2007)	Data file offered by Kind en Gezin
Private non-profit supply (relative)	Places in non-profit recognised day centres / family care services and non profit day centres with a certificate of supervision (2007))	Data file offered by Kind en Gezin
Private for profit supply (relative)	Places in private forprofit day centres or private family care providers (2007)	Data file offered by Kind en Gezin
<i>Independent</i>		
Span of income	Interquartile difference income (difference between first and third quartile) (2004)	APS – lokale statistieken
Distressed +65 / 1000 people +65	Number of people older than 65 that receive minimum income/pension (2006)	APS – lokale statistieken
Distressed children	Number of births in underprivileged families / total number of births (average of 3 years: 2004-2006)	APS – Lokale statistieken
Mean income	Mean income (2003)	APS – lokale statistieken
Percent age 40-59	Percent of people in age category 40-59 (2005)	APS – lokale statistieken
Low educated unemployed / 1000 inh.	Number of unemployed people with low education per 1000 inhabitants (2006)	APS – lokale statistieken
Local govt. welfare spending per 1 inh.	Number of euros per inhabitant local government spends to public centre for social welfare (2005)	ABA jaarbeeld 2005
Political ideology Christian-democrat	Mean election-results local elections 1976 and 2000	Database from VUB
Political ideology social-democrat	Mean election-results local elections 1976 and 2000	Database from VUB
Political ideology liberal	Mean election-results local elections 1976 and 2000	Database from VUB

ANNEX 2: Descriptive statistics

	<i>Independent variables</i>	<i>N</i>	<i>Mean</i>	<i>Min</i>	<i>Max</i>	<i>Std.Dev.</i>
DEMAND-MODEL	Span of income (2004)	308	21068	12880	33049	3436
	Distressed +65 / total number of +65	308	,05	,01	,12	,02
	N births in underprivileged families / total N births	308	0,06	0,00	0,21	0,03
SUPPLY-MODEL	Mean income (2003)	308	25725	19509	37602	3122
	Percent age 40-59 (2005)	308	28,80	23,68	38,37	1,67
	Low educated unemployed / 1000 inh. (2006)	308	14,77	4,11	39,24	6,04
	Local govt. welfare spending per 1 inh. (2005)	308	83,87	,000	218,76	36,92
SOCIAL ORIGINS-MODEL	SP.a (social-democrat)	196	,17	,00	,53	,12
	CD&V (Christian-democrat)	236	,45	,18	,85	,13
	VLD (liberal)	119	,22	,02	,62	,11
	<i>Dependent variables</i>	<i>N</i>	<i>Mean</i>	<i>Min</i>	<i>Max</i>	<i>Std.Dev.</i>
	Places child care non-profit sector (relative)	290	,34	,00	1,00	,36
	Places child care public sector (relative)	290	,18	,00	1,00	,28
	Places child care commercial (relative)	290	,48	,00	1,00	,36
	Places elderly care nonprofit (relative)	288	,50	,00	1,00	,42
	Places elderly care public (relative)	288	,36	,00	1,00	,39
	Places elderly care commercial (relative)	288	,14	,00	1,00	,29