

The future of the welfare state: paths of social policy innovation between constraints and opportunities

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**A comparative discussion of the gendered implications of
cash-for-care schemes: markets, independence and social
citizenship in crisis?**

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Abstract

There are moves across many countries away from state-led provision of services for disabled people towards cash-based systems, which have been welcomed by disabled people as increasing choice and control over services and support, and increasing independence and social participation. However, feminist scholars have long warned about the implications of commodifying care for women, and the implications of substituting cash for services for social citizenship have remained underexplored, for both disabled people generally, disabled women and mothers more particularly, and for personal assistants/care workers. This paper will attempt to address that gap by carrying out a comparative literature review and policy analysis of the role of policy development and outcomes in cash-for-care schemes, looking comparatively across policy developments in several European countries* as well as developed welfare states beyond Europe to examine:

- a) the impact of the tensions between various governance levels, particularly local and national government, in the development and implementation of cash-for-care policies and
- b) the gendered impact of such policies on (for example) gendered divisions of paid and unpaid work, citizenship and social participation
- c) the impact such policies have, or are likely to have, on different groups of men and women across the lifecourse and across different social and economic groups
- d) how such policies can contribute to the wellbeing and/or detriment of different groups of women (and men) within different social, political, economic and historical contexts

The paper will conclude with a critical discussion of the usefulness and complexity of carrying out a comparative analysis of policy developments across various governance schemes, and particularly the role that tensions between local and national government play in developing and implementing policies that have direct and indirect impacts on social citizenship outcomes for different groups of disabled people, and the intended and unintended gendered outcomes of such policies.

* countries to be included are UK, Netherlands, Italy, France, Austria and the USA

Keywords: care, commodification, cash, gender, comparative, policy analysis

Introduction

Political, social, economic and demographic changes in developed welfare states have led to concerns about rising demands for services, particularly support services for older and disabled people (Pierson, 2001). On the 'demand' side, increased longevity, reduced morbidity and political pressure from citizens and service users has led to a growing realisation amongst policy makers and practitioners that present service levels, particularly in health and social care services, are inadequately funded and failing to respond effectively and efficiently to people's needs (Taylor-Gooby, 2005). On the 'supply' side, falling birth rates and changes in family structures, as well as neo-liberal changes to welfare provision which have stressed the importance of activation policies (for example, welfare-to-work programmes for women, lone parents, disabled people and the long-term unemployed), and changing relations and expectations within families and communities have meant that there are falling numbers of 'unpaid' and family carers available and there have been substantial changes to the "welfare mix" of contributions from the family, the state, the market and the third sector (Evers et al, 1994).

There have been long-standing concerns within developed welfare states as to how to manage welfare and care policies in such a way which caps the rising demand for resources, leading to a shifting of responsibilities across public sectors (for example from health to social care, and from national to localised provision), and across sectors (for example from state to private or third sector provision, or from state to family [or, indeed, family to state]). At the same time a variety of international, national and local political, social and economic factors have led to changes in the governance of welfare, including increasing commodification of services and deprofessionalisation of practitioners (Newman, 2005). Rising demand for support and services has also come not just from demographic changes but also from increasingly politicized 'user' movements (such as disability rights organisations in the UK and the Netherlands, and older people's organisations in the USA) who have rejected both family and informal care as exploitative (for both carers and cared-for) and state care as increasingly fragmented, unresponsive and dehumanising – indeed, rejecting the rhetoric of 'care' altogether and demanding social rights, empowerment and control over the type and level of support received instead (Morris, 2004). Increasing regulation of services in response to 'consumer' demand has only partially succeeded in responding effectively to these changes: new models of service

delivery are being actively sought in response to these complex political, social and economic changes (Ungerson and Yeandle, 2007).

These pressures have led to the development of 'cash-for-care' schemes across a range of developed welfare states. Although these vary considerably in their intentions, scope and the way they function, they are essentially mechanisms whereby a disabled or older person receives a cash benefit in order to purchase help or services themselves, in lieu of receiving services or support directly. They can be seen as a way of 'commodifying' care (Ungerson, 1997) and several different models have emerged: tightly controlled personal care budgets allowing direct employment of formal care workers; care allowances paid directly to disabled and older people but not directly governed; income maintenance approaches (whereby allowances are paid directly to carers to acknowledge or compensate for the loss earned income, usually only available to low-income carers); and directly paying informal carers to replace publicly funded formal care. In some forms, particularly those paid directly to disabled and older people, their popularity amongst disabled and older people is well-documented: they have been hailed as an important victory for social rights by campaigners in the UK, because of the way in which they have allowed disabled and older people to exert choice and control over the type of assistance and support they receive (Rummery, 2006), and the way in which they have enabled disabled people to combine different types of support (health and social care, formal and informal) in ways which have led to greater independence and social participation, without the 'burden of gratitude' experienced by people receiving informal care from family members or voluntary or paid workers not directly employed by the disabled or older person themselves (Galvin, 2004).

A gendered analysis of care work and its relationship to women's oppression has been the subject of feminist attention since Mary Wollstonecraft articulated the dilemma of whether to pursue equality by feminising the public, male sphere or by masculinising the private, female sphere (Pateman, 1989; Lister, 2003). Much attention has been paid to citizenship and care policies, with commentators pointing out that welfare states often accord women a second-class citizenship because of their involvement in caring for both children and disabled and older adults, whilst at the same time relying on care work being carried out in a way which does not undermine the working of a capitalist economy (Fraser, 1994). A long running debate within feminist social policy has been taking place between writers such as Dalley (1988) and others on the one hand, who, building on the understanding of the way in which care work is gendered and leads to gender-based oppression have pointed out that 'policy is personal' (Ungerson,

1996) and have argued for greater state involvement in the provision of care and support for disabled and older people, and Morris (2004) and others who, building on the understanding of the way in which lack of control over the care and support they receive leads to disabled people's oppression, point out that disabled (and older) women receiving care are subject to patriarchal AND 'ablist' oppression. What has been missing from that debate is an understanding of the complex nature of women's lives and the way in which 'care' and support are often reciprocal, and that the quest for independence and control over their lives is one shared by carers and disabled and older people alike (Rummery, 2007; Lloyd, 2000).

Cash-for-care policies have not been traditionally seen as examples of gender mainstreaming or of feminist social policy, but, like any other policy development they have 'deep normative cores' (Sabatier, 1999) that dictate both why and how the policies have been developed and implemented, and these 'deep normative cores' have been implicitly gendered, resting on sometimes unarticulated but nonetheless powerful normative assumptions about the acceptable role and value of care work as 'feminised' (and hence legitimately undervalued in market terms) and 'private' (and hence legitimately underpoliced by the state) (Lewis, 2002). This has the result that both the aims and outcomes of the policies have gendered impacts in both covert and overt ways, but because the policies themselves have not been overtly articulated as gendered these have been underexplored. It is the purpose of this paper to address that gap. The next section will give a brief overview of cash-for-care policy developments in six developed welfare states, before going on to discuss: how 'gender aware' or 'gender blind' the development of cash-for-care policies has been; the governance issues raised the development and implementation of cash-for-care policies and the gendered implications of these; the gendered impact of such policies of the division of paid and unpaid work, citizenship and social participation; the impact such policies have, or are likely to have, on different groups of women across the lifecourse and across different social and economic groups; and how such policies can contribute to the wellbeing and/or detriment of different groups of women within different social, political, and economic contexts. Finally the paper will conclude with some reflections on how the successful commodification/marketisation of independence for disabled people can be reconciled with the concerns about gender equity in social citizenship.

Examples of cash-for-care policies

There are many ways of comparatively classifying welfare regimes, but the most commonly used are those developed from Esping-Andersen's 'Three Worlds of Welfare' thesis (Esping-

Anderson, 1990), which divided welfare states into ‘liberal’ (in which means-tested assistance and modest universal or insurance transfers take place, and the free market is seen as the best way for distributing resources, with the state supporting it – such as UK and USA), ‘conservative’ (in which state-led social policy development reflected invested interests that are neither purely social democratic nor market driven, such as the Netherlands, Italy, France and Austria), and ‘universal’ (where a commitment to universalism and decommodification involves the state working outside the market, such as the Nordic welfare states). Bettio and Plantenga (2004) have extended and nuanced this analysis with respect to European care regimes and found five typologies: countries that rely on the family for all care (Italy, Greece, Spain); countries that rely on informal care (but more so for childcare than adult care) (UK, Netherlands); countries with state facilitated private care (Austria, Germany); countries with highly developed formal care (France); and those with moderate to high levels of formal care (Denmark, Finland, Sweden).

Country	Welfare typology	Percentage of people over 65 receiving formal help at home*
UK	Liberal ¹ informal care ²	5.5
Netherlands	Conservative ¹ informal care ²	12
Italy	Conservative ¹ family care ²	2.8
France	Conservative ¹ formal care ²	6.1
Austria	Conservative ¹ public/private care	24
USA	Liberal ¹	16

Fig 1, *source Casey et al (2003) ¹ Esping Andersen (1990) ² Bettio and Plantenga (2004)

It is perhaps worth noting at this point that no case study examples of cash-for-care schemes have been included from either Esping-Andersen’s ‘universal’ nor Bettio and Platenga’s ‘moderate/high informal care’ regimes, as schemes in these countries have either been relatively underdeveloped, or have not followed the marketised route of enabling direct employment of carers.

United Kingdom

In the United Kingdom a system of direct payments was introduced in 1996 which replaced previous ad-hoc schemes. Disabled and older people are now able to apply for payments in lieu of directly provided services (the level of which are set according to a needs assessment) and these payments are usually used to directly employ formal care workers, or purchase care from not-for-profit care agencies. It is not possible to directly pay family members, as, unlike other schemes, it is intended to replace formal rather than informal care and support, and there

is relatively low take-up amongst older people. A regulatory system is in place, although there is little formal employment protection for directly-employed workers, and lack of formal assistance in recruitment of care workers is a problem for both users and employees. It is implemented locally, with the result that there is considerable regional variation in criteria, eligibility and access, although policy developments are in place to support more systematic take-up and to enable users to purchase a wider range of services (at present the scheme is limited to 'social care') (Rummary, 2006).

The Netherlands

The Netherlands has seen the introduction in 1991 of a personal care allowance scheme that was extended in 1995 to become part of the national long-term care insurance scheme (Pijl and Ramakers, 2007), allowing recipients to choose to receive direct payments in lieu of directly provided services. This scheme is relatively strictly regulated, providing a degree of protection for directly-employed care workers and making it impossible to directly pay workers on the 'black' or unregulated market. However, it can be used to purchase care from family members and thus enables recipients to combine formal and informal care arrangements flexibly. It is also relatively generously funded, leading to political concerns about rising demand, although, in common with other cash-for-care schemes it is still cheaper than directly providing state-funded services (Weekers and Pijl, 1998).

Italy

Italy has historically seen very little development of formal residential or community based care services, explained in part by very decentralised state provision of services generally (leading to substantial regional variations), and a reliance on family and informal care (Gori, 2003), accompanied by a reluctance to develop formal, central-state driven responses to the rising demand for long-term care and support (Pavolini and Ranci, 2006). The 'Indennità di accompagnamento' is a non-means tested benefit available to disabled and older people who are certified as 'dependent'. It is not tempered according to need, and no restrictions are placed upon its use. This comparative lack of regulation means that it is most often used to employ care workers, often on the black (unregulated) labour market (Ranci, 2007; Gori and Da Roit, 2007). Local means-tested care allowances, which are subject to local variations in terms of eligibility and access, are also available, and are also used primarily to purchase care from individual workers and family members, reinforcing gendered divisions of labour – or sometimes as a supplement to the family income and not paid out directly for care (Gori and Da Roit, 2007).

France

France is usually viewed as a 'familialist' welfare state, with insurance-based health and social care payments couple with a strong ethos of family-based care (Martin and Le Bihan, 2007). In 1997 the 'Prestation Specifique Dependance' (PSD) was introduced, which was replaced in 2002 by the 'Allocation Personnalisée a l'Autonomie' (APA). This is a payment made directly to older people (which can be supplemented by other means-tested benefits) which enables them to directly purchase their own care, either from a professional or a relative (but not from a spouse). It is most commonly used to purchase services from formal, not-for-profit social care organisations, rather than directly employing individuals. It has been argued that this formalised element to the payment is an important part of France's strategy of protecting the employment rights of care workers, as well as reinforcing gendered divisions of low paid formal and informal labour (Martin, 2000). The more formalised APA system has led to more employment protection for professional carers (Bresse, 2004), but it has not altered the gendered division of formal and informal care (Le Bihan and Martin, 2000).

Austria

Austria has traditionally been viewed as a strong social-democratic state with an emphasis on a gendered division of labour and the 'male breadwinner' model of welfare provision, resulting in low levels of provision of formal care services (Bettio and Plantenga, 2004). In 1993 the long term care allowance ('Pflegegeld') system was introduced, a tax-financed non-means tested benefit paid directly to the disabled or older person (Oesterle et al, 2001). It is generally used to purchase care from either organisations, individuals, or to reimburse family members (Hammer and Oesterle, 2003). They have tended to be used to fund informal care or migrant/'grey' labour market workers (often from neighbouring accession states), reinforcing traditions of lowpaid workers (often women) with very little employment protection whilst also reinforcing gendered divisions of labour within the familial sphere (Kreimer and Schiffbaenker 2005; Oesterle et al 2001).

USA

A high degree of policy decentralisation has led to considerable federal-level variation in American social care provision. Since 1981 Medicaid programmes in the USA have been allowed a greater discretion in providing services and support for older and disabled people, leading to a proliferation of 'consumer-choice' programmes allowing people to directly hire their own care workers, particularly through schemes such as the Cash and Counseling Demonstration pilots in Arkansas, Florida and New Jersey (Mahoney et al, 2000). These

schemes usually allow disabled and older people to directly employ workers with whom they have an ongoing relationship (through kinship or long-term care relationships), and have proved popular and successful, with the result that such 'private market solutions' are becoming part of mainstream social care policy (Keigher, 2007).

Gendered policy outcomes

Gender mainstreaming, broadly conceived, is the process by which gender equality becomes part of public policy strategy (Daly, 2005). Despite the fact that, as Lewis points out, the question of who undertakes or pays for care is crucial in addressing women's oppression (Lewis, 2006), developments towards gender mainstreaming social policies in care have focussed more extensively on the issue of activation and childcare policies than on care and support for disabled and older people. It is clear, in looking across the different types of cash-for-care developments described above, that several normative cores or themes emerge: but none of them appear to be about addressing gender inequalities. Indeed, as will be seen below, some of the consequences of such policies will be to reinforce gender inequalities.

On the one hand cash-for-care appears, in some cases, to be attempting to address neo-liberal concerns with reducing the role of the state in providing formal support (often accompanied by concerns about suppressing costs, particularly in cases where the policy is explicitly designed to support moves away from costly residential support, such as in the UK and the Netherlands). Certainly, advocates of state feminism would point out that when the state aims to reduce its role it usually expects the family to step in (Stetson and Mazur, 1995) – and this will, overwhelmingly (but not exclusively) mean reinforcing gender inequalities through a reliance on family care. On the other hand, cash-for-care schemes can also be shown to be responding to demands from users for more responsive care and support, and more control over that care and support (the political campaigns from user groups in the UK, Netherlands and USA are evidence of this) (Donnellan, 2001). Whilst not overtly or exclusively about tackling gender-related oppression, part of that political argument has been about the exploitative nature of informal care for both carers and cared-for, as it both reinforces dependency and powerlessness for both parties (Morris, 2004). The other political argument that has had an overtly gendered dimension in cash-for-care scheme development has been around campaigns to recognise and recompense women's informal care work as part of a citizenship agenda (Lister 2002) – working towards carer-parity in welfare regimes (Fraser, 1994). In the cases where cash-for-care is about replacing, or commodifying, *informal* care (such as Italy and Austria) it would appear that twin aims can be discerned that do show an awareness of gender-

based inequality: firstly, by freeing up 'unpaid' carers to participate in the labour market, and secondly by recompensing previously 'unpaid' carers for their care work. In the case where cash-for-care development was driven by a desire to protect the employment rights and status of formal care workers (France), given that these are overwhelmingly women, it could also be argued that this was a policy objective intended to address gender inequalities.

However, there is arguably a limit to how far an analysis of these policy developments can show them to be 'gender mainstreaming'. At best, an awareness of the gendered dimensions of care work can be said to have informed policy development: that is not the same as asserting that these policy developments were aiming to address gender inequalities. Other, more powerful, overarching policy drivers can be argued to be in play: specifically, the neo-liberal drive to reduce state involvement and expenditure on social care and, correspondingly, all the schemes under scrutiny can be shown to be justifying their existence on cost-benefit terms, with various mechanisms for cost containment (such as shifting overhead and employment costs, and the associated risks, onto users) being an important part of their *raison d'être*. Other, also more powerful, overarching policy drivers can be seen in the consumerist response to political pressure from users to promote autonomy, independence and user-controlled support. Neither of these policy drivers is mainstreaming gender issues: however, this does not mean that they do not have overtly gendered outcomes, as will be seen below.

Governance and cash-for-care schemes

Two issues pertinent to the governance of cash-for-care schemes emerge from an analysis of the six schemes under discussion. Firstly, there is the issue of national versus regional/local governance. Where schemes have been developed which allow for a degree of localised discretion in their implementation (eg UK, USA and, to a certain degree Italy) there is considerable scope for inequalities and inequities inherent in the system to have a gendered impact: (for example in the different types of employment protection available to workers, and the differential impact commodifying care can have on family relationships). Secondly, there is the issue of the governance of the schemes themselves: how they are operated, how users are made to account for the ways in which they spend money, and the level of policing and surveillance that gives the state over individual's lives. Some schemes (eg UK, the Netherlands, France) are highly regulated, which, on the one hand, offers a degree of protection both to potentially vulnerable users and workers (and, particularly in the case of France, offers valuable employment protection to potentially exploited groups of care workers who are overwhelmingly women), but which, on the other hand also gives the state a

considerable degree of power to scrutinise and police intimate caring relationships, and limits the degree to which these relationships can be user-controlled or reflect complex, reciprocal obligations. Other schemes (for example Austria and Italy) are explicitly and deliberately unregulated, allowing on the one hand a high degree of personal flexibility and control on the part of users and carers (reducing the state's role in policing care and regulating women's lives), but on the other hand sustaining an unregulated and unprotected employment market that has the potential to be exploitative to vulnerable groups of workers (overwhelmingly, but not exclusively, women), whilst at the same time reinforcing gendered divisions of labour that are potentially aggravating structural social and economic inequalities.

Gendered divisions of work

Given the considerable variations in political, social and economic aims, and governance arrangements, of the schemes under scrutiny, a remarkable consistency across all of them is that they have not made any significant impact on the gendered division of labour. Care work, whether paid or unpaid, is still overwhelmingly the responsibility of women in all six schemes. Perhaps because of the overarching policy objective of cost containment, in all schemes the actual value of payments to users have deliberately set low (even in the comparatively expensive Netherlands scheme), which has had the result of reinforcing gendered inequalities: if routed as 'wages' to previously unpaid carers, they have the result of 'trapping' women into gendered expectations of delivering care whilst at the same time not adequately compensating them for the value of that care; if routed as actual wages to formal carers, they still have the result of 'trapping' women into underpaid and underregulated employment, with poor prospects for formalised skills and training development or employment protection.

Divergent policy goals have led to differential policy outcomes regarding the gendered division of labour. Where cash-for-care schemes have incorporated a specific element designed to formalise and protect the status of employed carers (for example through routing payments to recognised care agencies, such as in France and the Netherlands, or through governance mechanisms designed to scrutinise the level and quality of the care received, such as in the UK and USA) this is likely to have the effect of 'polarizing' the care market (Ungerson and Yeandle, 2007) – creating ever increasing gaps between paid workers with structured career paths working in the non-profit and statutory sectors, and family or casual labour carers without the benefit of such regulation and protection. It is likely, as in other traditionally feminised caring professions that have become regulated and professionalised (such as education and nursing) that men will be attracted into the former, particularly into managerial roles, in much greater

numbers than into the latter. This polarization of the care market is therefore likely to lead to greater gender inequalities in both the public, formal, regulated sphere and the private, informal, unregulated sphere of care provision.

Lifecourse and social divisions

In some respects, the introduction of a marketised, consumerist mechanism such as cash-for-care schemes into an area that was previously the domain of either the private, familial sphere or the public, statutory sphere is likely to create and exacerbate social divisions already apparent between different social groups. For example, the evidence on takeup of such schemes in the UK suggests that it is generally articulate, younger, well-educated disabled people who are disproportionately represented amongst those who chose to use them (Spandler, 2004). Take-up amongst older people, ethnic minorities and learning disabled adults remains comparatively low. These findings echo concerns across other areas of welfare provision that consumerist-driven reforms will tend to favour those best-placed to benefit from the market by exercising choice, voice and exit (6, 2003). In other words, the gulf between middle class and poorer disabled and older people is likely to be made greater by the introduction of cash-for-care schemes, as is the gulf between middle class and poorer carers, with the former being more able to exercise choice about the level and type of care work they undertake than the latter. As discussed above, cash-for-care schemes are also likely to lead to a widening gulf between carers working in regulated, professionalised and protected formal care employment and those working in private, unregulated employment, whether this be for a family member, direct employer or through the grey/black labour market. They are likely to further disenfranchise low-skilled, poorly paid women in comparison to their wealthier, better-educated sisters and to widen social division within and across genders.

Furthermore, the impact of cash-for-care schemes on power relationships within the family sphere across the lifecourse and across generations remains unexplored, but there are reasons to voice concern about several aspects. Firstly, in low-income families where the use of the cash payment is fairly unregulated (for example in Italy) it is likely, based on what we already know about the distribution and use of money in low-income households, that gender differentials will emerge, with women more likely to use the payments to purchase care and men being more likely to use the payments as part of the general household income (Vogler and Pahl, 1993), leading to a reinforcement of gendered power differences within families. Secondly, where cash-for-care schemes are used to route money to informal family carers this can have the effect of creating, or reinforcing dependency relationships both intergenerationally

(for example between learning disabled adult children and parent/carers; or between daughters/daughters-in-law and parents) and intragenerationally (for example between spouses). Finally, the use of unregulated and unsupervised cash-for-care payments, both to pay family carers and directly employ unskilled care workers, has the result of commodifying intimate and sometimes unarticulated relationships and expectations, with the possibility of exploitation and abuse of vulnerable parties on both sides (Ungerson, 2004). Money, after all, in a highly consumer-oriented capitalist society, is power, and the person controlling the money in a care relationship is in a position to be able to exert power and influence over the person who does not: and any relationship involving the exertion of power and control over another person is open to the possibility of the abuse of that power and control. Again, better-educated, better-skilled and better-paid women are likely to be in a better position to avoid the potential abuse and exploitation suffered by lower-education, lower-skilled and lower-paid women in these situations, leading to greater inequalities between different groups of women (and sometimes men).

Wellbeing and citizenship

Notwithstanding the issues and concerns raised above, the evidence across all the schemes, particularly in comparative and qualitative studies (see for example Ungerson and Yeandle, 2007; Glendinning and Kemp, 2006) suggests that such schemes do appeal to both users and formal and informal carers, and it is worth exploring some of the gendered dimensions of why this is the case. Firstly, cash-for-care schemes are a way of recognising the complexity and reciprocity that characterise many caring relationships. One thing that both feminist and disability rights researchers and campaigners have pointed out is that people's identities within the social world are not easily divided into binary distinctions: public versus private, user versus carer, worker versus non-worker. It is possible – indeed, usual – for disabled and older people to simultaneously be employers (for example of personal care workers), carers (for example of spouses, children, or grandchildren), workers (whether full or part-time, paid or unpaid, voluntary or involuntary, or a combination of all of these) and to be exercising citizenship rights and duties in other complex ways (Rummary, 2007; Lloyd, 2000). The advantage of cash-for-care schemes over the alternatives (ie formal state provision or informal family provision of care and support) is that giving choice and control to disabled and older people enables them to purchase care and support that fits in with both statutory and informal networks, and enables them to carry out their own caring and other duties (Rummary, 2006).

Secondly, cash-for-care schemes are a very effective way of filling in gaps between service provision that are not easily addressed by formal provision – for example, by enabling users to employ workers who cross the ‘health/social’ care divide, or by allowing users to purchase support for themselves in a caring role (eg as a parent) – which can have the result of ameliorating the effects of power dependencies within families. The effects of freeing people up (to be parents, spouses and children, rather than carers and/or cared-for) can have a significantly positive effect on the wellbeing and relationships of all concerned. Exercising choice and control is empowering not only for users but also for carers: being able to choose when and how to care and being able to choose *not* to care can reduce the disempowering effects of having to provide care because no other options are available. As women are still the primary carers in families their concerns are with the wellbeing of all their families, and a policy development that has the effect of increasing the wellbeing of all members of the family is one to be welcomed.

Finally, if we move away from a neoliberal economic analysis of cash-for-care schemes as being a way of trapping women into low-paid, unskilled care work towards a more nuanced understanding of the *value* of care work and an ‘ethic of care’ (Sevenhuijsen, 1998), both for carers and cared-for, we can conceivably argue that giving women the opportunity to engage in that work for payment, even if that payment is low, is possibly opening up citizenship opportunities in a way that is preferable to some of the alternatives available. For example, engaging in care work, particularly if freely chosen, is arguably less dangerous and exploitative to low-paid migrant workers than other black-market alternatives: any gendered analysis would have difficulty asserting that contributing to the wellbeing of disabled and older people is of less importance than contributing to the wellbeing of the purchasers of sexual services, for example.

Conclusions: cash-for-care schemes, empowerment and choice

A gendered analysis of cash-for-care schemes therefore throws up some interesting challenges and contradictions. On the one hand, there are some very real concerns for gender equality heralded by the development and extension of these schemes. The overarching policy objective of cost-containment means both that the risks (such as covering for gaps in provision, and employing and managing care workers) are devolved to users and absorbed by them and their families, and that the level of payments has been set so low that carers employed by such schemes (whether they are agency workers, privately employed workers or previously unpaid family members) are having to work long hours for low pay with often little employment protection or direct scrutiny of their labour, and are therefore vulnerable to exploitation, abuse,

and being trapped into low-paid work with little prospect of improving their skills or career development. The potential for social divisions (for example between well-educated and poorly-skilled workers, and between well-supported and more vulnerable users) to be created and exacerbated by cash-for-care schemes is significant, as is the potential for the reinforcement of gendered-divisions in labour. The governance of cash-for-care schemes also highlights potential problems, with issues of concern arising both from over-governance (the limitations placed on how money can be used, the opening up of women's lives to further state scrutiny and policing) and under-governance (the potential for exploitation and abuse, particularly of grey/black labour market workers and family members).

On the other hand, there are some very real potential gains in terms of gender equity, if not equality, in terms of wellbeing and citizenship that arise from cash-for-care schemes that cannot be ignored. These appear to derive mainly from the introduction of choice and control into relationships that may have previously been characterised by disempowering obligations, burdens of gratitude and inflexible formal services. Allowing disabled and older people to freely choose who supports them, how, and when enables them to exercise control in their lives, combine giving and receiving care and support in ways which frees them up to exercise their duties and choices as independent citizens. This can have a significant impact on their wellbeing and on their ability to work, care and contribute to the wellbeing of their families, communities and society as a whole. Correspondingly, allowing carers to freely choose whether to engage in paid and/or unpaid care (because cash-for-care schemes can work to either free unpaid carers to be engaged in other paid work, or, in cases where cash is routed to pay previously unpaid family members to reimburse them and alleviate the constrictions caused by poverty) can free them from disempowering obligations, having a significant impact on their wellbeing and their ability to work, care and contribute to the wellbeing of their families, communities and society as a whole.

Of course, engaging in a gendered analysis of the policy impacts of cash-for-care schemes is problematic, because they are not explicitly gendered policy developments. However, as this analysis has shown, even gender-neutral or gender-blind policies can have significantly gendered outcomes (Rummery et al, 2007). The six cash-for-care schemes under scrutiny in this paper appear to fall into three groups: schemes whereby the some protection of the potential negative gender-effects of the policy is offered by the relatively high degree of formalisation (France and the Netherlands); schemes whereby some degree of protection against abuse is offered by a degree of scrutiny and limits on paying family members but the

high degree of discretion and variability in operation offer the potential for some negative gendered impacts (the UK and USA); and schemes whereby existing significant gender inequalities are likely to be exacerbated by the low levels of state governance (Austria and Italy). Interestingly, the most positive outcomes for disabled people and older people would appear to be in the most formalised schemes (France and the Netherlands), which would lead us to conclude that what is good for gender equality and equity is good for other groups of society too, and that a benign-but-powerful welfare state has an important role to play in protecting the citizenship rights of women, disabled people and older people.

However, as the pressures of rising demand, increased longevity and social and economic changes leading to higher labour market participation generally for women are global and affect developed welfare states of all political constituencies, it will be interesting to observe whether the type of commodification characterised by cash-for-care schemes will be adopted across different welfare regimes, and what the gendered impacts of those will be. It is clear that marketised solutions involving the commodification of care can offer gains in social citizenship for users AND carers if the state is prepared to have a strong influence over the governance of such solutions whilst still enabling both groups to exercise choice and control: it is also clear that marketised solutions involving the commodification of care can offer potentially worrying effects on the social citizenship of users and carers if the market is left unchecked.

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