

## Care as a Good for Social Policy

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### *ABSTRACT*

Welfare states are highly innovative when it comes to dealing with care. The range of policies in place across nations is striking as is the degree to which making provision for care cuts across long-standing principles of social provision. This article focuses on care as a policy good, identifying care as an inherently social activity and linking it with different manifestations in and anticipated outcomes of public policy. Care is developed here as one of the key activities connecting state and society. Making provision for care, it is argued, affects a whole series of societal settlements. A consideration of a number of such settlements helps to identify factors which must be taken into account when we assay the relationship between public policy, care and society. The following are primary considerations: choices around receiving care, the choice to give care, gender equity, the legitimising of care, the welfare mix, public as against private expenditure, the demand for and supply of paid and unpaid labour. Having considered some of the main variations which are to be found in European welfare states' handling of care, the article goes on to conjecture about possible outcomes of a range of policy responses on the basis of the above considerations. All provisions have particular strengths and weaknesses but 'quality', understood in a broad sense, is elusive to any single measure.

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Care is nowadays a very popular subject of academic work. Scholarship has set about uncovering the characteristic features of care, as labour, set of relations and moral orientation, as well as how public policy has sought to handle it. Relevant work in the latter regard has had a marked empirical cast. While we know the main details about how care has been treated for social policy purposes, the relationship between care, public policy and the wider society has hardly been problematised. I hope to contribute to this by elaborating care as a complex social good and linking such an understanding to a range of policy approaches towards care.

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This is to be done in three stages. In the first instance I visit briefly the literature to draw attention to the defining features of care – as activity or labour, set of relations and exigency for public policy. In the second, a comparative approach is used to interrogate how the relationship between care and policy varies cross-nationally. The focus here is on the general trends in policy across Europe, underlying models or approaches and the linkages across policy domains. In the third step, care is placed in a broader societal context so as to identify a series of considerations which are associated with providing (for) it. Looked at from another angle these factors offer a set of parameters which can be employed to consider the wider implications of various policy approaches. An overview section draws the article to a close.

#### CARE CONCEPTUALISED

Care as I use it refers to looking after those who cannot take care of themselves. It can be defined as the activities and relations involved in caring for the ill, elderly and dependent young. Broadly speaking, care has had three currencies in the literature: as a concept utilised to interrogate and account for women's situation; as a moral orientation and particular type of relations; and as a framework for the management of the life course and economic and social relations more generally within the aegis of public policy.

#### *The development of care as a concept and field of study*

Care is one of the original feminist concepts. Initially focused on the defining features of women's life situation, the concept was used to depict the nature of the work involved in caring and how this and the allocation of responsibility for it served a gendered purpose. It was mainly what would now be called care giving which was focused on: how women's role as wife, mother, daughter required that they undertake unpaid domestic and personal services. Sociologically such roles were analysed in terms of the power relations of marriage and kinship; economically they were linked to the division of labour and the distribution of economic privilege and power. In this manner, the concept drew attention to the material and ideological processes which make up care and at the same time confirm women in the social role of carer. How women's lives revolve around care was explored in a scholarship that was informed by, in the first instance, women's oppression and, in the second, gender. While care was initially studied in the informal setting of the family, it was never treated in isolation from the role of the state (Finch and Groves, 1983; Waerness, 1984). Connections were made between the execution of a

particular set of tasks and functions, the position of women in society, the distribution of power and material goods and the role of public policy in shaping all three. Over time scholarship extended to take in paid care (Graham, 1991) and a more elaborated understanding of the role of public policy and the state (Ungerson, 1990).

A second focus, and one of the more recent veins of scholarship, has been the elaboration of the non-material basis of care. In this scholarship care is developed as an ethic or moral orientation, emphasising the welfare of the collectivity as much as that of individuals. Care is, one could say, a form of social capital. Rather than particularising care to one setting or one set of relations, this work seeks to identify the norms and values which are involved in care. The distinctiveness of care as a model of social relations is emphasised in a literature which elaborates care a social as well as ethical practice. In the latter regard, care is developed as a set of values to guide human agency in a variety of social fields (Sevenhuijsen, 2000). No longer limited to the family and kinship, care is seen to extend into society itself, invoking the networks and sets of relations of care in which people are embedded. Because it is these which make people social, individuals in their care relationships and the resultant collectivities are the proper units for policy and other purposes rather than individuals isolated from their care and other contexts. Care is a way of being in society as well as a way of making connections. In this literature care is defined very broadly, leading to a view of the world in which we live as including bodies, selves and environment (Fisher and Tronto, 1990: 40). Caring about is, therefore, as integral to it as is taking care of or being cared for.

A third currency of care in the literature has been its treatment in policy. Inclining towards the discipline of social policy, the main bulk of this literature focuses on how social policy has sought to manage the demand for and supply of care. Feminist insight is strong in this scholarship also. As women enter the labour market in ever larger numbers and family ties may no longer imply a readiness to care personally for one's children, parents or elderly relatives, this work has traced the agency of welfare states in providing either cash benefits or services for the young and old in need of care (Glendinning and McLaughlin, 1993; Ungerson, 1990). Care is revealed to have provided the impetus for a change in the objectives and in some cases the substance of family policy. In fact, one could go further and read this work to suggest that care policy may be a policy domain in its right, if not replacing family policy then certainly undermining its clear self-image. No longer can we separate financial support to families with the costs of children from policy measures designed to

influence how children and the elderly are cared for. As this scholarship has developed it has come to make a series of differentiations: between paid and unpaid care, between cash and services as responses to care, and between care for children as against that for adults. The differentiation between the provider and recipient of care is one of the most important landmarks in the entire field. There is in addition the setting of care, summarised, somewhat inadequately perhaps, as either formal or informal. This literature, following a trajectory which is to be observed in other areas of social policy as well, has acquired over the last decade a strong comparative focus. Provision for care is thereby treated as a source of variation among and a method whereby European welfare states can be compared (Evers, Pijl and Ungerson, 1994; Ungerson, 1995; Anttonen and Sipilä, 1996).

While they could not be said to have worked in isolation from one another, there has been a certain distance between these streams of scholarship. As a result we still have too little information about certain key questions. How are the more social if not sociological aspects of care handled by public policies? How does public policy on care speak to the wider societal settlement around the family and 'private' relations? What is the vision of care in society as it is embodied in public policies? At stake is the essence of care as a policy good.

#### POLICY PARAMETERS OF CARE

Care is a complex issue for public policy. Not alone do care-related provisions frame the boundaries between family, state and market but they seek to shape intimate human motivations and relations. Care is therefore quite unique as a concern for social policy which is more accustomed to meeting financial need and generally holds itself aloof from the relational implications of its own practice. In the following section I try and uncover the relationship between care and society as it is expressed in public policy across national settings. While I do not explicitly undertake a European-wide comparison here, the discussion is informed by a knowledge of patterns across European welfare states.<sup>1</sup>

#### *Provision for care*

Making provision for care involves welfare states in one of their most precarious balancing acts. The range of policy measures at the disposal of countries is large. These include cash payments, taxation allowances, different types of paid and unpaid leave, social security credits, and services. Table 1 outlines the universe of provision, organised according to the different measures and the policy domains in which they tend to be located.

Clearly, care policy denotes a wide diversity of policy measures. Not alone does care criss-cross a broad range of policy domains – social policy, health policy, education policy, labour market policy and incomes policy – but it may call forth a service, time-related and/or cash response (and sometimes all three). In other words, making provision for care can be interpreted as entailing the satisfaction of (one of) three needs: a need for services, for time, and for financial support.

For analytic purposes, such variation may be reduced by identifying general types of measures and searching for the common patterns in how countries across Europe have made provision for care.

#### *Classifying types of provision for care*

I suggest that the different policy responses basically draw upon four different types of measures:

1. *monetary and in-kind social security and taxation benefits* such as cash payments, credits for benefit purposes, tax allowances;
2. *employment-related provisions* such as paid and unpaid leave, career breaks, severance pay, flexi-time, reduction of working time;
3. *services* such as home helps and other community-based support services, child-care places, residential places for adults and children;
4. *incentives towards employment creation or provision in the market* such as vouchers, rearranged working hours, subsidies for private or market care.

Each type of measure assumes particular characteristics in the field of care.

While monetary benefits are the traditional stuff of social policy, they are unusual in a care context in a number of respects. First, they have the effect of calling forth (or retaining) certain amounts and types of labour. Cash payments for care either directly and/or indirectly affect labour supply and demand. Welfare states directly commission labour when they pay benefits to somebody to care for another person. In this case they are commodifying rather than, the more widely accepted welfare state activity of, decommodifying (Ungerson, 1995). Labour is indirectly commissioned by cash benefits paid to the care-receiver who can then decide how to expend the benefit. It will be obvious that benefits for care-receivers are paid only to adults (rather than children who form the majority of care-receivers). Payments for care involve a second type of departure from conventional cash payments as well. Welfare state support for families (especially those with children) has traditionally been of a direct

TABLE 1. *Universe of policy measures for care*

	Policy Domain			
	Social	Labour market	Education	Health
Leaves	paid and unpaid parental, paternity and care leaves	career breaks; time savings account; employment rights during leave	educational/training leave for caring	
Cash payments	means-tested or social insurance benefits paid to carer or care-receiver; child-care vouchers	severance pay for labour market withdrawal due to parenthood or motherhood		subsidies/subventions for residential care
Credits for social security	credits to carers for pension and other social sec. benefits			
Taxation				allowances for care-related expenses
Services	public childcare; home helps; meals on wheels	workplace childcare	creches; day care; schools; kindergarten	residential services
Incentives towards employment creation	vouchers for domestic employment	reduction of working time; part-time working		
Incentives for market services	subsidies towards the costs of care in private provision			tax allowances for the cost of care in market-run services

nature. Hence provisions such as child benefits and the forerunners of benefits for caring for the elderly sought to assist families with the direct costs of care. Now indirect or opportunity costs – the financial rewards which people are forfeiting by caring – are much more commonly a target of policy. The care scenario is even more complex still if we take account of the full spectrum of policy objectives. Cash benefits may aim to offset expenses incurred, to enable people to purchase outside help, to financially compensate carers for the services they provide or to affect labour demand and/or supply.

The second way in which care is ‘handled’ by policy is through employment-related provisions. Here family meets labour market policy with interesting results from a policy analysis perspective. Leave is a way of reducing the penalties which the market would otherwise impose on those who spend their time care-giving. Time can be as important as financial compensation in this regard. Given that this type of provision most often takes the form of leave from work or flexibility in working time, a main good which welfare states proffer in this regard is time. Sometimes this is paid time and in fact the over-riding trend in Europe is towards financially covered leave (especially for the care of children). Employment protection rights comprise a related good here – the legitimacy of care giving as a social activity is confirmed by the existence of legislation protecting one’s employment should one’s absence from the labour market conform to certain conditions. Regardless of whether time or employment-related rights are the substance of the provision, the rights’ holder is usually the employed provider of care (rather than the person requiring care or indeed non-employed providers of care).

Services are the third type of measure, the traditional means of assisting with the need for care. As a glance at Table 1 confirms, care-related services have the broadest reach of any measure, spanning the domains of social, labour market, education and health policy. Services are unusual in a care context in that they affect not only the setting of care but also the nature of the interaction involved. For example, services may have the effect of ‘professionalising’ the care relationship. The good being conferred also varies here. Sometimes it takes the form of professional or technical assistance, at other times it either assists with or substitutes for non-professional care.

The final type of measure, certain sets of incentives, is noteworthy in that the goal is not just to influence the location and hence form of care but also to promote one location over others. Most commonly such policies, which in a European context are at their most developed in France and Finland, seek to affect employment creation in the domestic sphere.

Varied means are used for this purpose: vouchers which can be exchanged either for cash, some benefit or service in kind or set against the social security contributions for the employed person, subsidies or tax allowances towards the costs of care in institutions.

Policy measures are never put into practice either in a pure form or in isolation. In the next section I outline some general trends in recent policy making around care in Europe. The purpose is to draw out some features of care as it is envisioned in and shaped by public policy across a range of national settings rather than, say, to identify national policy profiles or indeed typologies of care.<sup>2</sup>

*Some trends in providing for care in European welfare states*

Beginning with children, it seems as if their care has always been on the public agenda. However, the care of children is relatively new as a contingency for income support for European social security systems (apart perhaps from the Scandinavian states which have for longer tended towards collectivisation). Child benefit, for example, was never intended to be a payment for care. Its origins are different – to assist families with the costs of rearing children, in the process redistributing resources horizontally and to a period of the life cycle when families are most likely to be hard pressed financially (Bradshaw *et al.*, 1993: 1). There has been a change in the general climate around and indeed economics of caring for children, not least in that only relatively recently has caring for (as distinct from rearing) children come to be seen as a ‘cost’ to families. The priorities around childcare services have changed as a result. While in most countries public provision of services for the care of young children is rooted in education and pedagogy and is therefore to be regarded as a good for children, such services are now more and more regarded through the lens of parents’ labour market behaviour. As evidence, consider how the development of childcare is today framed quite widely in Europe in the context of a ‘reconciliation of work and family life’. There is, then, something qualitatively new about care as a public exigency in relation to families with children.

What are the patterns in European welfare states in regard to the redefinition of care of children? The faultline of development centres on the one hand on parental leave and on the other on childcare. When practices in Europe are examined over the last ten years, parental leave has dominated the field (Daly, 1997). In fact the trend towards paid parental leave is one of the strongest social policy moves in Europe. There is no single reading of this development though, other than that European welfare states are now having to compensate families for the costs (time



and money) involved in caring for children or to offer them inducements to provide care. A related, but less widespread, development pertains to the division of leave between parents. With practice indicating that leave is taken up almost exclusively by mothers, some countries (principally the Scandinavian states) have introduced father-specific provisions. This is truly an attempt at social engineering, not least in that social rather than economic motives underlie it. With regard to childcare, Schippers, Sieger and de Jong-Gierveld (1998: 191) suggest that across Europe there is a search for greater diversity and flexibility in regard to both services themselves and the identity of the providers. An expansion of subsidies paid directly to parents is to be observed as are greater efforts to increase both parental involvement and the volume of parent-run services. Taken together, the developments in relation to childcare reveal a set of continual contests around two main issues: whether care should be provided for through cash or services or a mixture of both, and the identity of the providers. While it is not clear that cash benefits are designed as a direct substitute for child-care services, there is a certain policy switch involved in the current trend in that with leave and other benefits welfare states are choosing to expend money on making payments directly to parents rather than investing in (public or private) child-care facilities.

Moving on to care for elderly and ill adults, care policies for older people in Europe today mainly aim to provide in-home services which allow them to remain in their own home, postponing institutional care for as long as possible (Rostgaard and Fridberg, 1998: 36). Against a background of rising costs of residential provision, European welfare states are increasingly willing to make a payment specifically for the activity of private 'care' for the disabled, ill and elderly. The UK was the first welfare state to pay for private care for ill and elderly adults with the introduction in 1976 of a categorical social security payment for the person providing care in the home of the elderly person. Finland, Iceland and Ireland all followed the UK's lead but other countries have chosen different routes – Austria, France and Germany also pay for this activity but they make the payment to the care-receiver. There are two striking points about provision for care for adults in contemporary European welfare states. First, when making this kind of payment welfare states almost universally interpret it as a dichotomous choice as to who should be the beneficiary of the payment. In other words, they make a payment to *either* the care giver *or* the care-receiver. A second noteworthy point is that for the purpose of caring for elderly and disabled or ill persons, time as distinct from money and services, is quite under-developed as a policy response in Europe.

An overview exercise such as this alerts us not just to the variations in policy but also to the links between these variations and the national social and cultural setting. Overall, what is striking is that care emerges as an issue under a particular rubric in different welfare states. This rubric is intimately related to the prevailing ideology around the family, the role of women and how public policy manages the relationships involved. Hence it is no great surprise that care as a paid activity within social policy should have first emerged in the UK where the ideology of family solidarity, especially as it pertains to intergenerational relations among adults, is relatively weak. In addition, while the range of measures at the disposal of welfare states in respect of care is relatively large, the package of measures put on offer is intimately linked to the labour market and the way it is conceptualised for public policy purposes. Hence, all policies on care can basically be thought of as oriented to the supply of either public or private services. Up to the recent past if welfare states had a policy on care, the public supply of caring-related services was the key focus but, in the last decade or so, policy attention in Europe has turned much more closely to the private, market and non-market, supply of services. It is more accurate to speak now of a 'care mix', for in all national settings the provision of care involves not just a mix of financial, time and services but also a mix of providers and settings.

INTERROGATING ALTERNATIVE MODES OF COMPENSATING FOR CARE  
 Looking at developments in social policy in Europe through the lens of care, one could say along with Evers (1993) that, whereas in the past states constructed welfare institutions on a large scale, contemporary developments have turned the emphasis towards the more small-scale solidarities of the family and community. There is a certain irony in the fact that welfare states are now required to call forth a form of solidarity which their own practice has helped to diminish. This is to be seen not just in developments around care but also in the contemporary currency of governance through partnership and networks. Problems of social integration and quality of life are therefore reframed in terms of inter-personal relations and the readiness to help, support and take responsibility on a small scale. Care plays a part in this for we are increasingly governed in terms of our particular relations (to families, communities and so forth) rather than our more general belongingness and relations to society as a whole.<sup>3</sup>

I suggest that the relationship between social policy and care be thought of in terms of a number of different levels. Starting with the inter-personal level, one has to consider the well-being and interests of

both the cared-for person and the care giver. But care is not limited to the relations between individuals and indeed as Tronto (1993: 103) points out we have to overcome a view of care as dyadic or a feature of personal relations only. It also has both an existence and a set of consequences at the macro level, in that it is shaped by and shaping of relations and balances among domains and sets of interests. Care is at the forefront of public–private relations. While it originates in the private world of love, intimacy, families and friendship, much of it is now carried out in the public world of work, organisations, markets and government (Stone, 2000: 89). To the extent that welfare states respond to the needs associated with care, they are altering the division of labour, cost and responsibility among and within the state, market, voluntary/non-profit sector and family. In addition, making provision for care involves welfare states in recasting what are or were heretofore in almost all national settings private forms of solidarity and exchange. Relations of gender and generation are especially affected as are matters of where the costs should lie, what kind of broader mix of provision and responsibility is desirable and the balance between paid and unpaid labour. In the next sections I want to develop these as dimensions of public policy on care and then to utilise them to take a reading of some of the implications of different policy approaches.

*The different features of care as a policy good*

It is instructive to enquire into what is the ‘good’ for policy purposes in relation to care. In this regard I venture to suggest that the good may be thought of as ‘high quality care’. Of course, it is not by any means self-evident what constitutes high quality care (Knijn and Kremer 1997). A number of considerations are involved.

The perspective and interests of the care-receiver constitute one starting point. The quality of care from this viewpoint may be taken to refer to the capabilities that are made available when one cannot any longer care for oneself (Feder Kittay, 1999: 132). This is usually interpreted, especially in a European context, in terms of the calibre of the forthcoming service and/or income compensation (the latter so as to adequately compensate for expenses incurred in meeting the costs associated with the need for care). But ‘quality’ has a much broader set of references, even if European countries have shown little explicit concern with the quality of life achieved by people with long-term care needs (Glendinning and McLaughlin, 1993; Nocon and Qureshi, 1996). Quality for the care-receiver fundamentally connotes choice (of carer and of care locus especially to allow people to remain in their own homes). Furthermore,

there is the matter of (the satisfaction of) emotional needs. If we understand care as embedded in a relationship, then emotional fulfilment is a major consideration. Power relations may intrude in this and other respects for, as Abel and Nelson (1990: 16) point out, caring can easily shade into social control.

The needs of the care provider, especially in terms of capabilities and wellbeing, are a further constituent of the quality of care scenario. One could say that the good in this instance is the opportunity to provide high-quality care. Those who are involved in providing care have a firm idea of the meaning of quality. Stone's (2000) research, for example, found that people in care-giving jobs derive their standard of good care from an image of the care given in good family relations. They emphasise the emotional over physical tasks, the moral value of the work rather than its technical quality.<sup>4</sup> This and other work confirms that emotional fulfilment, what one might term 'the intrinsic reward', is hugely important for the well-being of the carer. If one retains the understanding of quality used in relation to the care-receiver – as having material, choice and emotional components – then security for the provider relates not just to emotional or financial security but also to support and recognition (Barnes, 1997; Qureshi *et al.*, 1998). Furthermore, given that care is so often set within a culture of social obligation, choice for the potential provider about whether to get involved in providing care is critical. Another aspect of quality here pertains to what one might term 'the conditions of work', matters of security, payment, hours, support structures, and so forth.

But quality is even more complex still. Moving beyond the individual level, care policies in welfare states can be said to affect a number of broad societal relations. One such balance pertains to gender equity. Care is built into the fabric of unequal gender (and other) relations, fashioned by the gender division of labour in society which turns the responsibility for care over to women. Whereas men are viewed as choosing to care, there is an obligation on women in many societies to be the care-givers, even when this interferes with their own (income security and other) needs. The share of care work carried out by women and men is then critical and public policy on care has huge import for individual women and men and, writ large, serves to either alleviate or intensify gender inequalities. The matter is not exhausted by whether the work is paid or not. For we know that even if it is organised as employment, care work is often low paid and carried out under poor conditions. Paula England (1992) has suggested that there is a wage penalty on caring. It is her contention that a substantial part of the pay gap by gender can be explained

by the devaluation of work which involves nurturance. Gender equity and the valuing of care work are therefore very closely intertwined.

This brings us to societal values. Public policy serves a set of functions in relation to the societal value (to be) placed on care. What I am talking about here is the status of care in society. The role of public policy in this regard is tricky for a number of reasons. On the one hand, the line between valuing care and confirming it as a woman's domain is a fine one. On the other hand, paying money for work which has origins in personal relations may devalue caring. It seems to me that recognition is not enough, if only for the reason that recognition does not necessarily ensure valorisation (or respect). I suggest that quality in this regard centres on the legitimisation of care. This involves both recognition and valorising, whereby care is not just recognised as a good for society but policies are put in place to achieve its valorisation (Fraser, 1997).

Another important balance affected by care policy is that of the welfare mix<sup>5</sup> in society. This is rarely explicitly articulated in public policy and when it is it is usually framed in terms of economics. Hence the marketisation of care is represented as a desirable development from a welfare mix perspective. However, what I am getting at here is a matter not just of economics but of how society distributes care. Policies do not just affect intra-sectoral mixes though but are fundamentally about the distribution of costs and responsibilities across actors and sectors. Attention is drawn to the respective roles of the state, market, voluntary/non-profit and informal (family) sectors within the care mix. Hence mobilising a wider range of actors, especially voluntary or civic organisations and private firms, may be a value in itself and is certainly a consideration when conceiving of care as a social policy good.

An additional relevant consideration is the demand for and supply of paid and unpaid labour. We know that care policies are intimately related not just to labour but to labour market as well. Whether policies provide income, time or services, they are affecting the demand for and supply of labour. As outlined above, care provisions in Europe are coming increasingly to be viewed through the lens of their likely impact on labour and employment. Even more, care policy is actually being used as an instrument to affect the demand for paid labour. As evidence consider the increasing use of incentives for domestic employment. Such a strategy, pursued especially in Belgium, France and Finland, treats care or the increasing need for care as an opportunity for (particular types of) employment creation. Making provision for care can constitute, therefore, a form of labour and employment policy.

A further balance relates specifically to the distribution of costs. These

have never been widely dispersed for the family has long borne the lion's share of care. As families' preparedness to care becomes more conditional, care policies tend to be framed in terms of the costs of alternative ways of providing it to the public budget. We know that institutional care is more costly on the public purse than care in the community. We know also that market-based services are being developed in many national settings as a way of reducing public expenditure. The moves towards paying for care at home, which as we have seen have become so prevalent in western Europe in the last decade or so, are motivated as much if not more by expenditure considerations as the quality of care. The likely effect of policies on the distribution of costs is therefore a major consideration.

How then do the policy options set out in Table 1 above appear from the viewpoint of these different considerations?

*The implications of different policy measures*

Table 2 sets out in summary fashion how the main policy measures that are to be found in Europe might be compared in terms of their implications for care as a multidimensional policy good. I recognise that policy only rarely attends explicitly to one or more of these considerations. Therefore, it need hardly be pointed out I hope that what follows is undertaken in the spirit of a thought exercise. Much of it is speculative, the measures considered in broad strokes and by necessity on the basis of their generic features rather than their particularities or in terms of how they work in particular local and national settings.

A cash payment to the care provider has, at face value, considerable merit. It is estimated to affect most balances positively, except choice/quality for the care provider, gender equity and the creation of a welfare mix. In the latter regard its effect is likely to be negative since it constitutes no change in the *status quo*. The most likely outcome of this measure will be to encourage the provision of care in an informal or private setting, thereby either crowding out or exonerating of responsibility other sectors. When it comes to choice/quality for the care provider, there are questions about how well this kind of measure negotiates the difficult terrain between right and obligation. Payments to the care provider do not tend to be strongly rights-based. Rather, across Europe this kind of payment is usually low level and conditional. It therefore tends not to be endowed with many (social security or employment) rights. In Ungerson's words such payments run the risk of being 'symbolic' (1995: 48). Payments for the providers of care tend on balance to be negative for gender equity also. They are rarely generous enough to attract men and for this

TABLE 2. *How policy provisions rate in relation to different considerations*

	Choice/quality for care receiver	Choice/quality for care provider	Gender equity	Legitimation of care	Creation of a welfare mix	Alter labour supply/demand	Reduce public costs
Cash payment to carer	+	-	-	+	-	+	+
Cash payment to cared-for person	+	?	-	-	+/-	+/-	+
Public services	?	?	+	+	?	+	-
Leave	+/-	?	-	+	?	+	+
Incentives towards employment creation	-	-	?	?	?	+	+
Incentives towards market-based care	?	?	+	?	?	+	?

*Note:* + positive effect, - negative effect, +/- neutral ? effect could go either way

and other reasons tend to confirm women as the most appropriate care providers.

Making the payment to the person requiring care has more mixed implications. The only potential positive outcomes which I can identify here are that such a payment may improve the degree of choice available to the care-receiver (by empowering her/him to choose the preferred form of care) and also reduce the public costs of care. It is not clear that this policy response acts to improve choice/quality for the care provider since a payment to the care provider may act to alter the nature of the relation and in addition tie the carer in a relationship of dependence with the care-receiver (who is given financial control). There is nothing in this measure that promotes gender equity. Nor is this kind of policy approach likely to contribute much to legitimising care as a valuable social activity (again because it tends to undercompensate for the need or contribution involved). The effects of payments to care-receivers on the welfare mix and labour demand and supply are hypothesised to be neutral since the level of the payment is unlikely to be such as to bring about any major shifts.

Public services are potentially strong in a number of respects. They are, in theory anyway, likely to improve gender equity, to help to legitimise care work and to bring about a change in the demand for and supply of paid labour. These possible effects are associated with the tendency for care work in the public sector to be better paid than when it is undertaken privately by individuals and to open up job opportunities. However, there are some serious question marks about public services in relation to care as well. The extent to which they improve choice and quality for both the care-receiver and provider is open to question, the former because public services tend to be offered on an either/or basis and the latter because poor conditions in the public sector may mean that care providers are no better off when employed. Experience in some countries, especially the UK and Ireland, suggests that work in the public sector is no panacea either for the inferior conditions which plague care work or the general quality of care (Nocon and Qureshi, 1996). Other possible downsides are that public services are expensive and may act to stifle a broader welfare mix by, for example, crowding out the market and voluntary/non-profit sectors.

Leave from employment for the purposes of caring for adults and children also has some positive potential although this measure tends to be neutral in a number of key dimensions. Leave can play a positive role to the extent that it legitimises care as work and alters the demand for and supply of paid (and by implication unpaid) labour. It may also have the effect of reducing public costs (because it saves on institutional costs).



The impact of leave on quality, though, is likely to be either neutral (for the care-receiver) or unknown (in the case of the care provider). The latter is the case because while leave confers time to care it is in many countries remunerated at a low level and the norm of unpaid leave is still quite strong. There is also the possibility that employment leave is not relevant to many care providers since many carers of elderly people especially are likely to be outside the labour market anyway. To the extent that leave provides incentives to exit the labour market and encourages female rather than male exit, it can be conjectured to be negative from a gender equity perspective. However, there is some potential in this type of measure to improve gender equity if leave is targeted at men as well as women and if it contains incentives for a return to the labour market (for those of working age).

The fifth type of policy consists of incentives towards domestic employment creation. This is a policy with few likely positive effects – its advantages I regard as being confined to affecting the demand for and supply of labour and its relative ‘cheapness’ on public funds. Because the incentives are constructed in a fashion that makes for temporary insecure employment, they are unlikely to improve the level of choice and quality available to both the care-receiver and the care provider. In addition, the generally poor conditions of the jobs created render questionable the incentives’ implications for gender equity, the legitimisation of care work and the creation of a welfare mix.

Incentives towards market-based care are a further policy option (and the final one to be considered here). While there are different versions of this type of policy, here I concentrate on fully privatised care (rather than, say, marketised care in the form of quasi-markets). The possible effects of incentives towards fully privatised care are quite mixed and in general tend to be either unknown or negative. They may have the positive effect of increasing the demand for labour (and presumably also the supply because if caring is shifted to the market then more women are available for employment). Since they challenge the norm of home-based care, they may represent a move in the direction of gender equity. However there are serious question marks about the extent to which incentives towards market-based care improve quality and choice for both the care-receiver and the care provider. There is as yet no definitive statement on whether market-based care is superior to care provided privately in the family or through public services. As long as this information is lacking, no predictions about the effect of increasing incentives towards market-based care can be made. The cost to the public purse is also something of an unknown since in some national settings – such as the UK – subsidies have had to be very high.

*Overview*

Care must be understood and analysed as a social as well as a policy good. The former emphasises care as embedded in sets of norms and social relations which reach deep into the fabric of society whereas emphasising the policy dimensions draws attention to the fact that societies have settlements around care and that these are, to some extent anyway, both realised by and manifest in public policies. The range of measures available and the high degree of both policy activity and innovation in Europe suggest that the settlement around care is acquiring more of a public character. Not alone is there greater policy activity around care but the measures introduced range from payments (to either or both the care-receiver or the care provider), employment leave, public services, incentives towards domestic employment and incentives for market-based care. It seems accurate to claim as a Europe-wide trend the increasing willingness of welfare states to pay for private/family care – a good which was formerly generated free in the family.

Much of my attention in this piece has been about problematising the relationship between care, public policy and society. I suggest that this relationship be thought of in terms of a number of levels of complexity. Looked at from the lens of care as a social exigency, neither money nor services exhaust the array of needs. Time (to care) is also crucial. A further complicating aspect of care is that it is a policy good with two core sets of interests: those of the person experiencing the set of needs embodied in care and the actor(s) who seeks or is assigned to satisfy those needs. Apart from these a much broader set of relations is also associated with care. Making provision for care is precarious for welfare states because the issue of quality encompasses not just material and physical well-being but also emotional well-being and choice. Moreover, the needs which have to be met are not just those of the person requiring care. Quality for the (potential) care provider is even more exacting since its meaning has to be extended to include both the choice of whether to provide care or not and the conditions under which caring is carried out. In addition to these considerations, public policy on care connects in fundamental ways with values and norms and the organisation of society itself. Dimensions which I consider critical in this respect are gender equity, the appropriate welfare mix in society, the extent to which care is legitimised, the demand for and supply of labour and the balancing of the public finances.

When the likely implications of a range of provisions is looked at on the basis of these considerations, we can see that different policy options have particular strengths and weaknesses. Making a cash payment to the carer potentially improves choice/quality for the care-receiver and should

positively affect both the demand for paid labour and public finances (in that it saves on institutional care). Payments to the person requiring care should be beneficial in bestowing greater choice/quality for the care-receiver (by empowering that person to choose their preferred form of care) and in reducing costs to the public purse. Of the different measures considered, public services potentially have the widest range of positive effects. They tend, in theory anyway, to be good for gender equity and the legitimisation of care work and they should bring about a change in the demand for and supply of labour. Leave from employment is also potentially positive (especially as regards legitimising care work, altering the demand for and supply of labour and reducing public costs). The fifth measure – incentives towards domestic employment creation – has potentially few positive effects. Its advantages are likely to be confined to affecting the demand for and supply of labour and its relative ‘cheapness’ on public funds. The final policy measure considered was incentives towards privatised market-based care. Their effects are difficult to predict and are hypothesised to be quite mixed.

Overall this article serves to emphasise the complexities involved in care and in how welfare states respond to this growing social exigency. Care provides an excellent way of understanding contemporary social policy and the dilemmas which societies are resolving or creating when they shape the provision of care. While they may not always be intended or conscious choices, the care-related policies that are adopted have far-reaching ramifications. Economic matters, which are so often the lens through which public policy is framed, appear quite simple when juxtaposed with the moral and social aspects of care policy.

#### NOTES

- 1 For this purpose, I found the work of Bettio and Prechal (1998) and Lewis (1998) very helpful.
- 2 Helpful in this regard is the work of Ungerson (1995), Anttonen and Sipilä (1996) and Bettio and Prechal (1998).
- 3 Nikolas Rose (1996) regards this and other developments which represent a shift away from more general sets of societal relations as spelling the death of ‘the social’.
- 4 Stone’s research found that people involved in providing care experienced a series of tensions between their own ideals of how to provide quality care and the emphases and practices of their employing organisations. She identifies the following six tensions: talk versus tasks, love versus detachment, specialness versus fairness, patience versus schedules, family relations versus work relations, relationships versus rules.
- 5 For an elaboration of this concept see Evers and Wintersberger (1990).

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