

Claims and Frames in the Making of Care Policies in Europe: Recognition, Rights and Redistribution

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Please note: this paper replaces the one billed for the conference as I am unable to attend for family reasons.

INTRODUCTION

This paper is about the interpretation of care needs in Europe¹. It looks at this from two perspectives: first, in the sorts of claims for state support to emerge ‘from below’, that is, from movements and organisations of those with unpaid and paid caring responsibilities and those with needs for support; and second, in care policies ‘from above’ - from supranational organisations and national governments. It proposes that that these two perspectives represent two overlapping but competing frames for interpreting care needs: *social justice* (from below) and *social investment* (from above). The social justice frame encompasses discourses associated with equality, social rights, recognition of care needs, and redistribution of care responsibilities. On the other side, the social investment frame is concerned with the risks facing a globally competitive economy: child poverty, worklessness, increases in social expenditure due to an ageing population, increases in lone parents, and declining fertility. Its care policies are thus tied to the need to develop human capital and labour market activation. The paper argues that while the social investment frame has provided spaces to raise issues associated with the social justice claims, it has, at the same time, led to policies that have undermined those claims.

POLITICAL CONTEXT FOR CARE CLAIMS AND POLICIES

The political context for care policies has shifted over the last five decades. The dominant care regimes in many European post-war welfare states assumed, to lesser or greater degree, a male breadwinner–female carer system with institutionalized care for those unable to be cared for at home. With the rise of social movements in the 1970s that system came under attack from different quarters. For example, feminist writers and activists exposed the hidden, taken-for-granted, unpaid caring and domestic work women did in the home, especially with the

¹ The paper focuses more on Western, Southern and Northern Europe where there has been greater convergence in care policies than in Central and Eastern Europe.

movement towards 'community care' which was seen as formalising women's unpaid care in the home. Women's organisations called on the state to fund good quality residential and day care services for the care of older people and young children. The disability movement and radical practitioners challenged the 'warehousing' of disabled and older people in institutions and called for policies of participation and social inclusion.

There thus emerged by the 1980s different sorts of care claims around gender equality, against the social exclusion of disabled and old people, for the recognition of carers, as well as for young children's rights to good quality care. In addition, black people's movements and gay and lesbian movements exposed the underlying racist and homophobic assumptions in care policies – the high proportions of black children taken into care, or the dependence of the state on the low paid care workers many of whom came from minority ethnic groups, or the failure to respect the caring commitments and responsibilities of gay/lesbian partners (Williams 1999, 2001).

The rise in influence of neo-liberalism upon social and development policies from the 1980s displaced these voices arguing for social justice in care. Policies of cost-effectiveness, fiscal restraint and the development of the private sector in care provision meant that equality discourses became subsumed under policies for quality control and consumer choice. But they did not disappear. In some places, such as the EU (Lombardo and Meier 2008) and World Bank (Mayo 2007), gender mainstreaming became the focus of activity and women's mobilizations sustained by world women's conferences such as that in Beijing in 1995. Also, at this international level, in 1993 the Standard Rules on the Equalization of Opportunities for Persons with Disabilities were adopted by the United Nations General Assembly. These emphasized integration and civil and political rights for disabled people.

By the twenty-first century women's increased earning responsibilities weakened many European countries' attachments to the male breadwinner model. This placed the issue of care

more centrally on the political agenda, providing new political opportunities for social justice care claims-makers. In addition, the tempering of neo-liberal and structural adjustment policies of the 1980s and 90s led to a new convergence around a *social investment* approach whose manifestation found different inflections in different countries (Jenson 2008). This emphasizes the potential of human capital and labour market activation for *all* adults - women and men, disabled and able-bodied, young and old - as part of a strategy to enhance self-sufficiency, economic competition and social inclusion.

Furthermore, care policies began to incorporate many of the new measures and discourses associated with the modernisation of welfare provision. So, for example, new forms of financial support such as cash payments and tax credits/allowances that go direct to carers/parents or to care receivers represent a move away from state provision of services towards giving carers or care-receivers money to subsidise the purchase of their care or home-based assistance from the private and voluntary sectors. Such payments are also seen to encourage private market provision, to contain costs, to promote 'consumer choice', as well as to involve users of services as 'partners' in the provision and delivery of these services (Ungerson and Yeandle, 2007).

CARE CLAIMS FROM 'BELOW'

Contemporary claims-makers in care comprise many groups. Here we summarise five types of care claims: gender equality claims for work/care reconciliation policies, support for disabled people, recognition of unpaid carers, trade union support for flexible working, and advocacy for transnational care workers. While promoting different interests, they share a focus on equality, empowerment of service-users, universal access to financial support and collective services, time to care, independence and autonomy, social rights, quality and choice in care, and care-recognition (Williams 1999; Barnes 2006). Together their overarching frame is one of social

justice incorporating demands for care recognition, social rights and the redistribution of care responsibilities.

The development of new patterns of women's involvement in paid work has given rise to concerns by feminist scholars and activists about the threat to gender equality caused by mothers' care responsibilities placing them at risk of low paid, casual and part-time employment; the unequal gendered share of household and care work in the home; the decline in value of the male wage leading to a dual wage system that leaves increasing numbers of lone/ divorced parents/mothers and their children at risk of poverty. In addition, the combination of a long-hours work culture in many countries means that parents, especially mothers, face a 'time crunch' in trying to juggle earning and caring responsibilities. Children's well-being is also seen to be at risk because of inadequate child care or insufficient parental care when parents work full-time or poverty where they do not work at all (Fraser 1997; Crompton, 1999; Gornick and Meyers 2003, 2006; Cousins and Tang 2004; Scott, Dex and Joshi, 2008).

These issues and the claims that follow them are manifested differently in different countries, but are exemplified well by the blueprint developed by Gornick and Meyers originally in their book *Families That Work: Policies for Reconciling Parenthood and Employment*. (2003, see also 2006). They argue for a model which can encourage 'gender symmetry' in both earning and caring responsibilities through a *dual-earner/ dual-carer system*.² This would combine shorter and more flexible working hours with the possibility for mothers and fathers to share equally in unpaid parental care. Parents of young children would thus have the opportunity to be primary caregivers. It would encourage men to develop their caring potential and aim to render

² See also Nancy Fraser's arguments for a 'Universal Caregiver' model in her essay *After the Family Wage* (Fraser 1997)

men and women equal as workers and carers, thus giving a social value to care and gender equality at home and at work, and promoting children's well-being.

The role for public policy would be to encourage the dissolution of gender divisions in the home through the use of parental leaves; to transform the workplace away from its current androcentrism so that the hours of work were reduced and became more flexible to allow for better work/care balance; and to protect parents' rights for time to care and children's rights for quality care through provision of high-quality child care provided by well-trained and well-paid care workers (ibid: 40-59).

Thus, demands centre on care recognition, that is, making visible women's caring responsibilities. They re-interpret the need of care as a right of both parents to care and to earn and the rights of children to be cared for, as well as the political rights of parents to have some form of democratic control and choice over provision. These rights are framed in terms of the discourses of gender equality at home and work, time poverty, family economic well-being, and children's well-being. This involves a redistribution of responsibilities to care for children away from families and towards the state, and from mothers towards fathers. The demand for the regulation of working hours also invokes a redistribution of time from work to care responsibilities, and the concerns with affordable, accessible care points to the need to attend to redistribution in favour of poorer mothers (see table 1).

Trade union demands within the area of work/care reconciliation have been concerned, amongst other things, with ensuring that flexible working can be achieved without sacrificing job security. This involves the recognition of time as a value in collective bargaining (ETUC 2005). In a sense the attempt to save 'family time' has replaced the earlier trade union bargaining, within a male breadwinner system, over a 'family wage'. The recognition of time also involves its

redistribution to allow for care as well as work, for workers' as well as employers' control over time use, and rights to flexibility for working parents, working carers of older or frail relatives, and older workers seeking to reduce their hours before taking retirement (see table 1).

To many involved in disabled people's organisations the very concept of 'care' embodies an oppressive history in which the practices and discourses of paid (particularly professional) and unpaid carers have maintained disabled and older people in a position of unwanted dependency, at worst, abused, segregated and stripped of their dignity, at best, patronised and protected from exercising any agency over their lives. Instead care needs are reinterpreted as having choice and control as the strategies for the empowerment of disabled people (Finkelstein 1998). Thus recognition is seen as having voice and visibility both in society generally through challenging the discrimination in the social and cultural environment and taking disability up as a human rights issue³, and also in changing relationships with professionals by demanding greater self-determination through user voice and control ('professionals on tap not on top'). One example of this was the demand in the 1980s and 90s for 'direct payments' for independent living (Priestley 1999). These are cash benefits that go to disabled people to access the personal assistance and support they need. This type of provision implies a form of redistribution of power and control from service providers to service users (see table 1).

On the other side of this care relationship are unpaid carers who have also mobilised around their needs for support. Organisations now exist in a number of European countries including

³ The UN Convention on the Rights of Persons with Disabilities focuses on respect, autonomy and independence; on freedom from discrimination, on inclusion participation and equality. Disability has come to be recognised as a social development issue as well. According to the UN Development Programme 80% of disabled people live in developing countries, account for 15-20% of the world's poorest, and are often not included in rural poverty alleviation programmes (Action on Disability and Development 2009).

the UK, the Netherlands and Austria, and in 2006 Eurocarers was established to provide a collective voice in EU politics. The organisation Carers UK illustrates the way in which carers have challenged the assumed naturalisation of their caring role (Barnes 2001, 2006). By 2008 Carers UK had been successful in influencing the New Labour Government to produce a National Strategy for Carers which set out a ten-year vision of principles to be met through a partnership between central and local government, the NHS, third sector, families and communities. Their demands represent claims for both recognition of their dignity; their expertise as carers; rights to financial, health care and practical support; time to care for themselves as well as others; equal opportunities; the redistribution of responsibilities from family to state, and of power and authority from professionals to carers (Yeandle and Buckner, 2007; Carers UK, 2008) (see table 1).

A fifth group with specific claims around care are migrant care workers. In many areas of the world the increased demand for child care has been met by women migrants leaving their own families to care for the children and older relatives for families in richer countries. This has created the so-called global care chain (Parreñas, 2001) and has also led to the development of advocacy organisations and campaigns, for example, in the work done by the Black and Migrants Women's group for the European Women's Lobby in the 1990s (EWL 1995; Williams 2003), or the organisation Kalayaan in the UK (Oxfam and Kalayaan 2008). The risks these organisations identify are forms of exploitation, sexual and racial discrimination and marginalisation experienced by these workers resulting from a combination of migration rules, effects of deregulation of the labour market, and lack of the protection of employment law or welfare benefits.⁴ Claims for recognition have included making visible this hidden workforce and giving them rights to a collective voice, to economic, legal, social and civil rights, including, for

⁴ In Spain, for example, it is cheaper to hire a live-in newly-arrived migrant woman waiting for her settlement papers because employers can avoid paying social security, and her insecurity ties the worker more closely to her employer (Lister et al, 2007).

example, rights to residency, family reunion, to contracts, or to training. Redistribution claims have focused on shifting responsibilities to the state for the regularisation of care and domestic work. The reliance of richer countries on migrant care workers including doctors and nurses also raises wider questions about strategies of redistribution of care work capacity to withstand global inequalities in care chains and care drains (Kofman et al, 2005; Yeates, 2008 - see table 1). Table 1 below summarises the claims for recognition, rights and redistribution of care that have been discussed.

	Gender equality claimants	Trade unions	Disability Movements	Unpaid carers	Migrant care workers
Recognition	Visibility of women's caring Voice Valuing care as a social good	Collective bargaining over time	Visibility Voice Independence	Visibility, Respect, dignity	Visibility of hidden workforce Respect/dignity
Rights	To mothers and fathers as carers and earners – financial support, flexibility, good quality child care To democratic control and choice	Flexible working over life course	Human rights Civil rights Right to work Right to support and an enabling environment Control over support	Financial and practical support Right to work and care Rights to social inclusion Rights to improved health services	To collective organisation Residency Social protection Family reunion Training Contracted/regularized work
Redistribution	Of care responsibilities: From families to state From mothers to fathers Of services: towards poorer mothers Of time: from work to care	Of care responsibilities: From families to state and business/corporations	Of power: From providers to users	Of care responsibilities: From families to state	Of care resources: to poorer from richer countries

Table 1: Care claims of recognition, rights and redistribution

The paper now turns to look at how the discourse of social investment has influenced care policies across Europe and at the extent to which this and associated discourses have opened up or closed off opportunities to meet the sorts of claims described above.

CARE POLICIES FROM 'ABOVE'

By the first decade of the twenty first century some of these demands for care recognition and rights were met in many European states, influenced by policies created by the European Commission and reinforced by policy discourses from international organisations such as the OECD. The EU has been particularly influential in shaping policies for work/care reconciliation policies in its member states (Stratigaki 2004; Lewis 2006; Lombardo and Meier, 2008, Jenson 2008). The 1996 Directive on Parental Leave provided for a minimum of three months' parental leave for men and women. The 1997 Directive on Equal Treatment for Part-timers and the 1993 Directive on Working Time restricted employees' working time to an average of 48 hours a week and guaranteed a minimum of four weeks' annual leave. The 2002 Barcelona Council set targets for childcare services to reach 90% of children over the age of three and 33% under the age of three across all member states by 2010, and the 2000 Lisbon Council set a target of 60% labour market participation of women by 2010.

However, these policies were framed by a concern to encourage women's labour market activation and the contribution of their skills to productivity rather than the goal of gender equality. Proposals from the early 1990s to encourage the sharing of household work between women and men had slipped from the agenda and subsequent policies became much more focussed on ensuring the provision of child care services to facilitate women's labour market involvement. This meant gender equality became a minor frame in relation to the dominant

frame of employability. Thus for example, while the 1996 Directive on parental leave included non-transferable leave for men, it left it up to member states to decide whether such leave would be remunerated. Yet research shows that in those countries where there is no remuneration for men, they are less likely to take leave (Platenga and Remery 2005).

Employability and labour market activation are two of the central tenets of a social investment approach (Jenson and Saint Martin, 2006; Jenson, 2008). Lewis notes that the scaling down of gender equality policies in EU reconciliation policy was part of a development from the mid-90s of a model of a work-centred welfare state to resolve the problem of an ageing population and declining fertility by making work the basis through which pensions are earned and paid for (Lewis, 2006: 432). A similar development can be found in OECD policy where, by the turn of the twenty-first century, a new window opened for child care policy because of attempts by the OECD to temper neo-liberal social policy by yoking human potential not to justice but to investment by linking constrained social expenditure with efficient and effective services, and by pulling together labour market activation with self-responsible welfare subjects (Mahon, 2008; 2010). This saw child care as the instrument to allow women's labour market participation, to combat lone parent poverty and to insure against a falling birth rate (see *A Caring World*, OECD 1999, and *Babies and Bosses*, OECD 2003, 2004, 2005).

Although this approach to invest in human capital can provide the basis for meeting demands around child care, parental leaves, flexibility at work and for state recognition and support for parental care responsibilities, it can also imply that those who may have no productive capabilities – frail older people, severely disabled people – are mere objects of care. In fact, it is through two other discourses associated with the social investment approach that some of the demands of state support for carers and of disabled people have been met. The first is through the importance placed on the social inclusion of marginalised groups. Thus, labour market

activation has been intended for disabled and older people as well as women, indirectly meeting the demand for rights to work of disabled people noted above. The second is the welfare modernisation agenda through which cash payments to parents, carers and older and disabled people were introduced as a move to encourage a public/private/voluntary sector mix in welfare provisions, meeting demands for direct payments from disabled people and for choice in provision from parents, carers and disabled people's organisations. However, while these claims around rights and recognition to work, to care, to inclusion, and to choice may directly or indirectly have been met, the framing of policies has also had the effect of pegging back other social justice claims. We look at this dynamic now in terms of granting entitlements to groups as earners, as carers and as consumers.

Rights as earners

Europe has seen a significant convergence around early years' child care provision. By 2003 what was once the privilege of Denmark, Sweden, Belgium and France had begun to spread to many other European countries: the European Union's under 3s target (see above) had been met in addition by Iceland and the Netherlands, and Italy, Norway and Germany had met the target for over 3s. In countries such as Spain and the UK day-care has been expanding since 2005 (Lister et al. 2007). (However, Greece, Lithuania, Slovenia and Poland were particularly low on both counts - Platenga and Remery 2005: 17). The aim of this type of provision is to support parents as *earners*, although the form and take up of that provision varies across countries. State subsidies may still leave parents with pre-school children paying between 25-70% of the costs of child care, and, when childcare is provided by the private market, this can limit accessibility to the relatively well-off. On the one hand, it is possible to see a clear trend towards an acceptance of public responsibility for child care, no longer the assumed private responsibility of mothers. On the other hand, this does not necessarily mean that the trend is universally towards high quality, accessible and affordable day care. In other words, there is

more of a recognition of this as a social right than a reality, especially in those countries relying on the private market.

Policies for securing flexibility at work in ways which benefit workers with caring responsibilities have also developed across Europe. There now exist examples of innovative work-based measures, such as annualised hours, working time savings accounts, time-banking, and shorter working hours across public and private sector workplaces in Europe. In addition, the notion of *city time* has been applied in France, Luxembourg, the Netherlands and Italy where employers, trade unions and community organisations have worked together to align different timetables - services, personal time, travel time and family time - across the city (ETUC 2005: 26). However, as Lewis notes, combining flexibility and security at work has been promoted by EU policy as part of the productivity agenda rather than an equal opportunities issue (Lewis 2006:429-430). When these innovations take account of the disadvantages facing women workers and when workers through their unions have some degree of control over their implementation, they can benefit employees and give them greater control over the use of their time (Platenga and Remery 2005). The need to take more account of the specificity facing women workers can be seen in the Netherlands which instituted a life-course approach in 2006. Employees have the statutory right to save up to 12% of their annual wage to defer for a maximum of 2.1 years. In principle this means that parental leave, opportunities for career breaks, or for education courses are all treated in the same way. However, by 2007 take-up had been lower than expected, leading to speculation that it was too expensive for low paid or part-time workers and that it would take too long to save for parental leave (Lewis et al, 2008). In addition, EU policy can be translated in different ways on the ground. In the UK where flexibility has been interpreted as an 'individual choice' (and where the government exercised an opt-out in relation to EU directives on average working hours), this tends to lead to unequal gendered divisions in working and caring time being reinforced (Himmelweit 2008). Nevertheless, attempts to

reinterpret time in relation to people's work and care responsibilities are potentially radical in that they create opportunities to consider the range of care needs and responsibilities that women and men experience over a lifetime, not just restricting this to the child care as an investment in the future workforce. These experiments also signal the importance of local community involvement in new developments and extend a notion of citizenship beyond earning and caring to political participation. This, however, is not the dominant theme of policy.

In relation to disabled people, as mentioned above, the effect of the EU's anti-poverty inclusion agenda has been to extend labour market activation to marginalised groups (Annesley, 2007). However, the dominant framing of this has been more about reducing poverty through minimising dependence on welfare benefits and containing social expenditure rather than simply extending civil rights. Thus, in response to rising rates of incapacity at work, a number of countries have introduced more stringent medical criteria to test eligibility to social security, thus increasing bureaucratic and medicalised surveillance of disabled people (ISSA 2001).

Rights as carers

Where parental leave policies guarantee parents time off to care, and particularly where this leave is paid (which it is at least in part, in most European countries), it gives parents entitlements as *carers*. Where it is universal, it establishes the principle of a parental right to care for their child and it also provides for the right of a child to receive parental care in its early life (Lister et al, 2007).

Since 1996 EU member states have been obliged by EU directive to enable parents to care for their child full time for a minimum of three months. By 2006 maternity leave in the nine countries studied ranged from between 14 and 52 weeks (across Europe, particularly in some of the post-communist countries, this extends to three years). However, long maternity leaves, while

recognising mothers' rights as carers, do so at the risk of those mothers' disadvantage when they re-enter the labour force. In addition levels of payment vary. The UK provides for a total of 52 weeks' maternity leave, but much of it is unpaid or is covered by a flat-rate allowance. In many countries⁵ maternity leave has now a wage-related compensation for earnings, although often entitlement is restricted to the employed or those paying contributions. Thus, although the principle has been established widely, its effectiveness and its take up is influenced by factors such as eligibility, levels of payment, organisational culture, flexibility in work practices, and the labour market sector (the public sector tends to be a better provider) (Platenga and Remery 2005: 47-57).

What is particularly new is the development of paternity leave across most European member states, and, with that, the attempt to redistribute care responsibilities from women to men. Iceland, probably the best existing example, introduced in 2003 a parental leave of nine months in which three months are reserved for the mother, three for the father and three can be shared. Parents who have been in employment receive 80% of their wages. While this is also extended to same-sex parents, single parents are eligible for only 6 months. This introduces a tension between mothers' rights as earners (to re-enter the labour force without penalty) or equity amongst children to receive the same time in parental care (nine months) regardless of whether the parent is single or partnered. Sweden reserves sixty days' leave only for fathers at 80% replacement level. Other countries are, in different ways, following this model, including those which had until recently followed a male breadwinner model. Germany introduced in 2006 an earnings-related parental payment of 67% for fourteen months with a fatherhood quota of two months to a maximum of €1800 per month. In Spain paternity leave has been extended from two to ten days.

⁵ Denmark, Estonia, Italy, Lithuania, Finland, Sweden, Iceland, Norway and Romania

Where countries provide a separate paid paternity leave (that is to say, where the leave is not divided by choice but where some of it is designated to fathers on a 'use it or lose it' basis), fathers' take-up rates are relatively high. In 2007, 90% of fathers in Iceland took their allotted leave (Pillinger 2008). In 2000, 73% of Swedish fathers took the full 10 days of paternity leave. In Norway, in 2001, 81% of eligible fathers claimed their four-week non-transferable quota of parental leave, while 13% claimed over four weeks (Lister et al. 2007:124). However, whilst these policies mark out a recognition of men and women as *workers and carers*, (and probably come the nearest to institutionalizing a dual-earner/dual-carer system), it has yet to impact on the overall division of domestic and care labour in the home which is still undertaken to a large extent by women (Gershuny and Sullivan, 2003).

The other group whose claims have been met as carers are the unpaid carers of older, frail or disabled family members. The development since the 1990s in Europe has been towards 'cash-for-care' payments where the person receiving care has access to an allowance to be spent on services for her or his support. In a few countries (such as the Netherlands) this has included paying a relative for their care services. Part of the success of Carers UK in influencing the British government to produce a national strategy of support for carers was due to the way in which the movement drew on the discursive resources available to them. First, they positioned themselves as working *in partnership* with central and local government, the NHS, third sector, families and communities which found favour with the tenor of welfare service change which encourages partnerships between the different sectors. Second, they mobilised on the social inclusion discourse by presenting the barriers that prevent carers from working and evidence as to how much productivity is lost by carers having to leave employment in order to provide care for a spouse, partner or relative (Yeandle and Starr, 2007). This fits quite clearly within a social investment model of labour market activation. In addition, their claims dovetailed with the shift

from institutional care to a more cost effective community care. In some ways, then, their recognition and rights as carers were granted because of their potential as earners.

A similar conclusion was drawn in a study of care claims within the UK (Williams and Roseneil, 2004). This showed that NGOs and pressure groups held visions of how care needs could be met which did not fit with New Labour's particular social investment approach. They tended to focus on an ethos of care and interdependence, a holistic notion of well-being, and economic and cultural issues of social justice and equality. New Labour, however, kept tight control of the policy agenda such that issues of care and interdependence could be raised but were more acceptable in relation to child-centeredness, productivity, and equality of opportunity rather than gender, 'race' and class inequalities of outcome.

Rights as consumers

As already noted, a significant new policy instrument is the increased use of cash benefits, direct payments or tax credits that go to parents, disabled people and older people. These address citizens as *consumers* and they are also seen to promote *choice*. However, where this choice is exercised as a consumer in the private market of care provision, it can have repercussions on the pay and conditions of care workers as well as the quality of care and the affordability of that care.

For parents, there are three main forms of cash benefits: first are those paid to parents to purchase care services from for-profit or non-profit service providers (including private nannies/childminders). These are sometimes in the form of tax credits or vouchers. Second, there is financial support from local/central state for employing a child care worker in the home, in which case the parent becomes both an employer and a consumer. Both of these have become the main ways that working parents in Spain, UK and the Netherlands access child

care for children under three. Flat rate allowances to enable parents to buy in child care operate in Spain, Germany and Denmark.

The third type of cash benefit is a payment to encourage parental care of pre-school children at home. This is sometimes attached to parental leave as in Finland, Norway and France. In addition, there have been other motives behind the introduction of this type of cash-for-care. The German government in 2006 introduced *Elterngeld* (parent's money) as a way of reversing the declining birth rate. This provides mothers who take time off after childbirth with two-thirds of their take home pay (with a higher earnings cap) for up to 12 months, with an additional two months for fathers. However, some have seen the effect of this earnings-related element to create higher incentives for more educated, qualified and higher paid women to take it up, and to lower the value for low-paid parents (Henninger et al. 2008).

The effect of this last type of cash provision is to reinforce the gendered division of care and loosen women's attachment to the labour market as it is mainly mothers who take it up. In fact, few of these forms of cash provision work to encourage fathers into sharing responsibility for care. In addition, whilst tax credits or equivalent may offer choice if they operate in the context of the private market, they do so often at the expense of those who work in that market. On the one hand, they may create employment for women, but it may be low paid and precarious employment. Further, where private market care is expensive, care consumers will look for cheaper options, chasing cheaper and often exploited migrant labour.

Similarly, the forms of 'direct payments' which allow older people or disabled people to buy in support and assistance, for example, in the UK, Netherlands, Italy, France and Austria (Ungerson and Yeandle, 2007) encourage the development of a particular form of home-based, often low-paid commodified care or domestic help, generally accessed privately through the market. And this is where low cost migrant labour steps in. In Spain, Italy and Greece, this

strategy of employing migrant labour to meet care needs has become the major way for the state to resolve the care deficit. (Bettio et al, 2006).

Two discourses are in play here: one which emphasises the empowerment of disabled people by giving them choice and control, but another which repositions them as active consumers of welfare, reinforcing the commodification of welfare services, with the possible effect of worsening the affordability of care and the conditions of care workers. Empirical research has found that where direct payments have operated within the context of a collective local organisation committed to self-determination, flexibility, negotiation and equality (such as Centres for Independent/ Integrated Living), then relationships between disabled people and personal assistants are generally marked by mutual respect (Shakespeare 2000). External regulation can also mean improved conditions for care workers and personal assistants (Ungerson and Yeandle, 2007).

These developments also hit up against the rights of the fifth claims-makers, migrant care workers. Of all the groups, migrant care workers have the furthest to go in terms of winning visibility, respect, rights to collective organisation and training. They may be seen as the Achilles heel of the progress towards recognition of the needs of care-receivers and providers (Williams and Gavanas, 2008).

CONCLUSION

This paper has examined how the needs and claims of care givers and care receivers have been articulated and in what ways they have been recognized, interpreted and instituted by policy-makers and institutions of governance. It found two overarching frames are in play: on the one side are those movements whose claims are framed within a social justice discourse. They identify the risks of gender and class inequalities at home and at work, stress for working

mothers and carers, lack of flexibility at work, parents' time poverty, children's need for parental time and quality care, poor conditions of the care workforce, exploitation of migrant care workers, social exclusion of disabled, older people and their carers; and oppressive and stratified care services.

These concerns are not absent in the policies of national governments, the EU or international organisations such as the OECD or World Bank, but they tend to be subordinated within a frame in which care is an investment that can secure the employment of women in a more competitive economy and a welfare system that is based on labour market participation. This identifies risks as child poverty, worklessness and increases in social expenditure due to an ageing population, increases in lone parents and declining fertility. These discourses have provided opportunities to raise those issues which are crucial to gender equality – working time, flexibility, parental leave and child care – but have also led to policies that undermine equality aims. So, for example, the effect of EU policies has been to establish that child care is a social and not just a private responsibility, that mothers have a right to work and receive support for their care responsibilities and that fathers as well as mothers have a responsibility (and right) for time to care for their children. EU concern about social exclusion has also paved the way for disability issues and carers' concerns to be raised. In this way some of the key aspects of recognition and rights for parents, carers, trade unionists and disabled people have been met, and a start has been made on three of the claims for redistribution identified in the paper – on moving care responsibilities from families to the state, and from fathers to mothers and giving people more say over service provision.

On the other hand, the development of the private market in care provision, especially through the use of cash benefits to buy care support, has constructed parents and older and disabled people as consumers seeking value for their money in a low paid care sector. This reinforces

inequalities between families and individuals as well as jeopardising good quality care. Furthermore, it has encouraged (sometimes sanctioned by the state) migrant workers who are more vulnerable to exploitation into care work. While mothers' increased employment is in part an exercise of their right to work, the increase in areas of precarious employment not covered by social protection means that this is where women without qualifications find work. Similarly, the claims of disabled people for social inclusion in the labour market became reframed within a fiscal concern to make work-test criteria stricter for disabled people in their eligibility to invalidity benefits.

Similar difficulties exist in relation to innovations in working time. On the one hand, practices such as 'flexible working' and 'working time savings accounts' provide men and women with the opportunity to redistribute their working hours over time according to their caring responsibilities. However, without attention to the specificity of women's lives and their care responsibilities, such policies serve only to ease the status quo of gender share of care, rather than to challenge it. Also, when combined with insecure work environments or temporary or fixed term contracts, the financial cost of flexible working to enable mothers to fit work in with care and domestic responsibilities may be high. The tension here is between recognising the unequal care responsibilities of men and women while also attempting to redistribute them.

While there have been major developments to recognise care and to make care receivers and givers more visible, issues of redistribution and of voice still have some way to go. In analysing how gender equality discourses became subsumed in EU policies Lombardo and Meier (2008) argue that in the area of policy discussions about work/ family reconciliation feminist or gender expert voices were marginal. The main actors represented were the European Commission, Parliament and the social partners – employers and trade unions. This is in part because this policy was developed under the auspices of employment policy. In contrast, they show that in

other gender policy areas – domestic violence and gender equality in politics - women's organisations, such as the European Women's Lobby and the Parliamentary Committee on Women's Rights were involved and contributed to the framing of the issue in which gender equality (especially in domestic violence) was key. Groups need to have a voice to make their claims, to be partners in setting the policy agenda, and ultimately to have a say as citizens. In many areas of care policy the choices of citizens are exercised only as consumers. Where voices are heard, as the example of Carers UK showed, it is where they are prepared to work within the existing policy frame.

A still more challenging aim is to raise the social value of care (Williams, 2001). This involves the shifting of responsibility, power and control in the four main areas of redistribution of care identified in this paper: from families to the state, from mothers to fathers, from care providers to those receiving care and support, and from richer to poorer nations. Indeed, for care to be valued, all these forms of redistribution are needed. So far, the achievement of recognition and rights, even if on different terms, has been important in order to establish a foothold, to consolidate a voice, and to have the opportunity to articulate and pursue longer-term progressive scenarios.

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