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The Production and Consumption of Long-Term Care: Does Gender Matter?

CLARE UNGERSON

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Ungerson: *The Production and Consumption of Long-Term Care: Does Gender Matter?*

This Working Paper has been written in the context of the 1998-1999 European Forum programme on **Recasting the European Welfare State: Options, Constraints, Actors,** directed by Professors Maurizio Ferrera (Universities of Pavia and Bocconi, Milano) and Martin Rhodes (Robert Schuman Centre).

Adopting a broad, long-term and comparative perspective, the Forum will aim to:
· scrutinize the complex web of social, economic and political challenges to contemporary European welfare states;
· identify the various options for, and constraints on institutional reform;
· discuss the role of the various actors in promoting or hindering this reform at the national, sub-national and supra-national level;
· and, more generally, outline the broad trajectories and scenarios of change.

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The Production and Consumption of Long-Term Care: Does Gender Matter?

CLARE UNGERSON

University of Southampton

BADIA FIESOLANA, SAN DOMENICO (FI)

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European University Institute
Badia Fiesolana
I – 50016 San Domenico (FI)
Italy

INTRODUCTION*

The question as to whether or not 'gender matters' in the issue of the delivery of care may seem a very odd one, given the enormous literature that has developed within a number of social science disciplines that takes gender relations as the primary perspective in the analysis of care. However, this paper will argue that, certainly in the British literature, the emphasis on gender has recently been diluted and altered such that the gendered perspective on care has tended to disappear. But that literature has taken the *unpaid* nature of informal care delivered within households and kin network as its starting point. In this paper I want to argue that gender does indeed still matter if one considers the changes that are taking place in the organisation of *paid* care as a result of the marketisation and privatisation of care that has occurred in Britain (and elsewhere) since the early 1990s. I will suggest that 'gender matters' in the production of care and that, in turn, this has gendered effects in the consumption of long-term care in old age. However, it should also become clear that 'gender' is not an altogether satisfactory way of understanding social divisions and care - income inequalities and the opportunity to acquire social rights during a working life are equally important and point to ways in which 'gender' is increasingly cross-cut by income and labour market inequality, both between women and men, and between women.

When we look backwards over the last fifty years, from the millenium to the great welfare state settlements of post-1945 Europe, we can see that major shifts have taken place in the organisation and conceptual underpinnings of welfare in most of the welfare states, particularly those designated as 'social democratic'. We have moved from an ideology - if not a practice - of universalism delivered by the bureacracies of state institutions to, more recently, a fragmented notion of the appropriate role of the state in the delivery of welfare and an increasingly selective or targetted allocation of social protection and service . The most obvious changes have occurred in the 'service state' where there has been a shift away from the idea of the passive user of services towards an idea of an active consumer seeking out an optimum package of services from a mix of privatised, marketised and state delivered services. However, in the field of social care, and especially long-term care of the elderly,

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there have in effect been *two* great shifts especially in the United Kingdom: the first was the switch from institutional care to 'community care' or what I shall call the policies of 'decarceration'; while the second - the shift towards marketisation, privatisation, targetting and consumerism - succeeded that shift and was connected to it. The gendered critique of decarceration , which was heavily influenced by the second wave of feminism's focus on domestic labour in the early 1970s and developed into a full blown commentary on care in the 1980s, has had very considerable impacts on the gendering of social policy analysis in general. In contrast the second great shift in social care has so far attracted little in the way of gendered analysis. This paper constitutes an attempt to redress that balance.

GENDER, CARE AND DECARCERATION

The policies to promote 'community care' and drastically reduce the numbers of people cared for in residential institutions was first introduced in the late 1950s in the UK. At that time, the policy was largely restricted to the care of the mentally ill and mentally handicapped, but in the 1960s and more particularly in the 1970s, the policy of decarceration was extended to the older population. A consultative document called, significantly, *A Happier Old Age* was published in 1978 and a white paper introducing the policy changes called *Growing Older* appeared in 1981. The intention was that elderly people would increasingly be cared for in their own homes and that public monies would be switched from residential provision to domiciliary services. In one very important way this policy was a complete failure: between 1980 and 1990 the number of elderly people living in residential care *increased* by 52% and exceeded the growth in population aged 75+. However,during the same period, the number of places provided by local authorities had decreased by 12%, while the number of places provided by the private, for-profit , sector had increased by 477% (Tinker et al, 1994:20). Thus a government policy designed to reduce institutional long-term care had had some impact on those providers - the local authorities - largely within the remit of central government control. The expansion of the private for-profit residential care sector had clearly taken up some of the consequent unmet demand.

The area in which the policy of switching from residential care to 'community care' was rather more successful was in the reduction of so-called 'geriatric beds' in National Health Service hospitals. For example, between the three years 1987 - 1991 alone the number of such beds declined by 10%. One way of dealing with this reduction was to ensure that old people admitted to hospital spent less and less time there so that more elderly people *in toto* could

be treated - the average length of stay in a geriatric bed declined from nearly 80 days in 1979 to just under 40 days in 1988 (Tinker et al, 1994: 17). The implication is that in 1988 old people were leaving hospital at a much earlier stage of their rehabilitation than they had done only ten years earlier - and that, as Tinker et al put it, 'has obvious implications for community care services'.

Thus the decarceration story as far as British elders is concerned was complicated and certainly more effective in the health care sector than in the social care sector as a whole. A clear policy devised in the 1970s had an unexpected impact due to the way in which demand for residential care among the very poor had been rendered effective through the social security system, and the way in which the private sector was particularly well equipped, in a rising property market which reduced the risk of capital loss, to respond. It was also clear that elderly people, especially those aged 85+ and with the resources to do so (whether these came from the social security system, their own income and wealth, or the incomes and wealth of their kin carers) were opting to enter residential care in very large numbers, such that in 1991, 23.7% of the 85+ were in residential care (Joseph Rowntree Foundation Inquiry, 1996).

Nevertheless, a strong feminist critique of the *policy* for decarceration began as soon as the policies were put in place. This was partially an accident of timing: the second wave of feminism really took a hold of British politics in the 1970s, as demonstrated by legislation which made sex discrimination in employment and in the school curriculum illegal in 1975. Just as the rhetoric of 'community care' was finding its place high on the social policy agenda in the 1970s, so the British women's movement with its particular focus on the family and the oppressions contained within it (for example, Barrett and Macintosh, 1982) and a feminist critique of the way in which the welfare state exploited women (Wilson, 1977) was also developing fast. The move away from collective provision in the form of local authority funded and administered residential care towards care by individual women working within their families held, for marxist feminists in particular, a resonance with general marxist analysis of the nature of the capitalist state. It was inevitable that the gender blindness of the policies for community care would be unpicked by feminist critics, and the early literature from British feminists constituted a pioneering breakthrough (Finch and Groves, 1980; Land and Rose, 1985; Finch and Groves, 1983).

The core of these criticisms was that policies for 'community care' were based on the assumption of the availability of women's unpaid labour within the home: as the first piece of published feminist criticism put it: 'care by the community equals care by the family equals care by women' (Finch and Groves,

1980). Almost all of this early literature was concerned with the care of the frail elderly. This was probably because the analysis drew on the feminist perspective that valued personal experience and the assumption made by most of these women authors (most of whom were still in their twenties and early thirties) was that they would be called upon to care for their own parents, or, if they married, for their in-laws. There was much discussion of the role of daughters and daughters-in-law in contributing to the care of the older generation (Ungerson, 1987; Lewis and Meredith, 1988; Qureshi and Walker, 1989). The focus was on women who were acting as surrogate 'parents' for their own parents or in-laws, or on mothers who had particular problems of mothering for children with special needs (Glendinning, 1986). Thus the emphasis was on the *inter* generational care rather than *intra* generational care. At this stage there were only rare mentions of the possibility and actuality of caring by spouses (see Ungerson, 1983 and Ungerson, 1987 for some early work). It was the later focus on 'spouse care' which began to disperse the primary notion that 'care' was a particular domain of women as opposed to men - a point we turn to in later discussion.

Since that early British literature which focused on the practice of and motivation to care for people with disabilities, the salience of gender to questions of 'care' has become much more general in its application and moved into broad brush discussion of the relationship between welfare states and their citizens. As the work triggered by policies for decarceration demonstrated, the assumptions embedded in social policies could easily be presented as essentially patriarchal (Pateman, 1988). A north american and northern european literature developed which took Carole Gilligan's work on sex differences in moral development to argue for an 'ethic of care' as opposed to an 'ethic of justice' within political theory and political practice (Tronto, 1993; Sevenhuijsen, 1998). Others responded by arguing that justice still played a central part in the activities and allocation of care (Bubeck, 1995). In the literature on citizenship it was argued that in order to 'de-gender' the welfare state the idea of citizenship had to include a concept of care, and value care as a responsibility of citizenship as much as paid work (Lister, 1997; Leira, 1992; Knijn and Kremer, 1997). A feminist economics literature developed in the 1990s which identified and analysed 'unpaid work' largely carried out by women in relation to 'paid work' (Himmelweit, 1995). In wider sociological debates, the literature which had looked at the motivations of women to care was extended into a more general discussion of the way in which obligations and responsibilities within families and kin networks were structured or negotiated and how far gender played its part (Finch, 1989; Finch and Mason, 1993). In this way, the original analysis that had taken decarceration and the practice of 'care' for people with long-term disabilities as the focus for feminist analysis grew into a much wider

gendered perspective on the operations of the state and led to a development of gendered work within a range of social science disciplines.

At the same time, the question of care in practice moved on to the political agenda and as it moved into the mainstream of politics the feminist perspective tended to get diluted, or even lost altogether. In Britain pressure groups such as the Carers National Association were founded in the 1980s and a 'National Carers' Week' is now an annual media event. Neither makes reference to feminist origins because they see their work as supporting practicing carers engaged in long-term care, many of whom are men. The new Labour government is presently engaged in devising a 'National Carers' Strategy' which will consider the best ways to support carers. While it is recognised that care impacts considerably on women's labour market participation, background papers and consultative meetings around the National Carers' Strategy have equally stressed other factors that determine the structure and impact of caring, most notably the feature of 'race' and ethnicity. In the mid 1980s Government began to fund surveys of carers in order to discover how many they are and what they do. As a result large databases have been developed from questions asked in three General Household Surveys (1985, 1990, 1995) and an annual Family Resources Survey since 1996. Much of the research on care that has ensued has consisted of secondary analysis of the data generated (see, for example, Arber and Ginn, 1991; 1992a; 1992b) and a great deal of it, as we shall see below, has been used to argue that men care too, thus shifting the way in which the analysis of care is gendered. The term 'informal care', used to denote the provision of care within households by unpaid kin, has moved into the vernacular of the English language such that these surveys now refer to 'informal care' during the interview in full confidence that the respondents will understand the issue that is being addressed (ONS, 1998).

Within this context of the mainstreaming of the issue of care and the consequent dilution of its gendering, there has nevertheless been some continuity of feminist ideas. The government reports that use the data generated by these large-scale surveys always foreground gender as a variable of analysis and this has become not only a lasting memorial to second wave feminism, but also a rich source of data for continued gendered analysis. Among feminist scholars, work has concentrated on the effect the activities of care have on women's life chances, career opportunities and life time earnings (Joshi, 1992; 1995), on the differentials in receipt of support services between men and women carers (Parker, 1990), and on the importance of gender in relation to old age generally (Arber and Ginn, 1991). Much of the work on lost opportunities and lost earnings has widened the notion of 'care' to include the care of normal children - a practice which has brought the British literature in line with the

work on care being developed in other parts of northern Europe (Ungerson, 1990) but which thereby slightly dilutes the peculiarly British focus on the particular exigencies arising out of long-term care especially of the elderly. However, this emphasis on the impact of care on carers' economic participation has had some significant policy impacts. For example, a social security benefit (Invalid Care Allowance) was put in place in 1977 and extended to married women in 1988; this compensates full-time carers of working age for absence from the labour market. State pensions entitlement now contains a twenty year 'home responsibilities payment' which compensates those unable to participate fully in the labour market because they have had caring responsibilities either for children or for others in need of care.

In the British scholarly literature on care the gendered analysis has, in the 1990s, taken three paths. Each of these paths has used gender as its starting point but then taken off in its own particular direction such that the primary variable of gender has tended to be displaced. The first path, and the one that has probably had the greatest impact, is that taken by disabled writers such as Jenny Morris and Lois Keith. In their work, dating from the early 1990s, they have been critical of the feminist literature's assumption that the care relationship consists of 'carer' and 'dependant' and that disabled people are without agency. Keith (1992) particularly argued that if disabled women are mothers then it is wrong to assume that they are not carers too, and more recently she and Jenny Morris have developed this argument into work that is strongly critical of those who argue for the identification of and support for child carers (Keith and Morris, 1996). Morris, in a much cited article entitled ''Us' and 'Them': feminist research and community care' castigates feminists - notably Ungerson - for assuming an invisibility of disabled people such that their autonomy and agency are completely written out of the caring literature (Morris, 1991). In that sense these commentators have used the original ideas of second wave feminism to make claims for visibility in social analysis in exactly the same way as feminists in the 1960s and 1970s did (Morris, 1996). This critique has been very successful in shifting the gendered analysis of care away from a dichotomous discussion of 'carer' and 'dependant' towards a commentary that recognises the value of *independent living* for all disabled people. Disabled people in general argue that in order to achieve independent living they should be given the resources to employ their own personal assistants rather than rely on the bureaucratically managed and professionalised care services, or rely on their informal carers.

The second path that scholarly literature has taken is to shift the gendered discussion away from the position of *women* as carers towards discussion of *men* as carers. The impulse for this move - which of course remains a gendered

analysis but with a change of emphasis - came from the publication of data from the first national quantitative survey which sought out carers. The 1985 General Household Survey established that 12% of men were carers compared with 15% of women - a mere 3% difference which hardly justified the emphasis of the feminist literature on women as carers! Since then secondary analysis has indicated that men carers were 'significantly more likely to be involved in looking after their spouses and parents-in-law and less likely to be looking after friends and neighbours than are women' (Parker and Lawton,1991:12). In other words, the discovery of such high numbers of men carers constituted part of the impetus to rename a part of informal care as 'spouse care'. The ages of men carers also indicated that large numbers of them were caring for their elderly wives - a higher proportion of men carers than women carers were aged over 65. Secondary analysis also indicated that where men carers were caring for someone other than their wives they were less likely than women carers to be involved with personal care tasks (Parker and Lawton, 1991:15). Thus the analysis of large data sets indicated that the gendered features of care were much more complex than at first thought: women *and* men were almost as likely to be carers but their routes into care were somewhat different and the tasks they commonly undertook also differed. Moreover, it was clear that the early feminist literature had overemphasised the intergenerational aspects of care at the cost of ignoring care between spouses. The omission of men from gendered analysis has now been put right by a number of male commentators (Fisher, 1994; Bytheway,1987).

The third path of the literature on care built on the issue of diversity and difference as it has emerged in general feminist analysis, and also as it has developed within the caring literature itself. Hilary Graham, in a series of articles (1991; 1993; 1997) has argued that feminist perspectives on care 'have become fixed in the form in which they developed in the early 1980s' (Graham, 1997:124) and has pleaded for a more 'fluid and open-ended framework' that can take class and race as well as gender into account in the caring literature. Since she began to write in this vein, there has been a growth of literature on care which has looked at care and 'race', notably Askham et al (1995) who consider the allocation of social service resources to black elders and Ahmad and Atkin (1996) who have collected together a number of wide ranging essays concerning general issues embedded in 'race' and community care. Class and care has been investigated by Arber and Ginn (1992) who use the General Household Survey data set to argue that resources are an important determinant of informal care since those with higher incomes are less likely to be involved in co-resident care and are more able through the use of a car and through employment of others to maintain 'intimacy at a distance'. Disability, as we have seen, has been an important impetus behind a separate pathway in long-

term studies, but sexuality, apart from some very limited work on lesbians and care and on 'buddy' systems for HIV/AIDs sufferers, has yet to develop properly.

What all this means is that in the recent British literature on informal care, gender as a variable of analysis has been somewhat overtaken by other equally important variables. However, as I have suggested, the first great shift in long-term care towards decarceration provoked the pioneering of gendered analysis of community care which itself formed the basis for further analysis of difference and diversity in relation to care. For the remain der of this paper I will look at the second great shift of privatisation and marketisation and interrogate how far gender can be used to understand the impact of these current changes.

GENDER AND THE MIXED ECONOMY OF CARE

I have suggested that there have been two paradigm shifts in the organisation of welfare services since the post-war settlements. But these changes have not been totally disparate; indeed it is arguable that marketisation and privatisation are a logical development of the ideas embedded in decarceration. For among the ideas that led to the notion that care is always better delivered in the home is that it is assumed that the individual with his or her preferences can still flourish at home, whereas in residential care services become routinised and the individuality , identity and autonomy of the residents rapidly disappear (Goffman, 1961; Jones and Fowles, 1984). Very similar ideas are used to justify the ideas of marketisation and privatisation of social care. One step further down the line from decarceration it turns out that the domiciliary services delivered within the British policy of 'community care' are also standardised and routinised such that they do not effectively serve the needs or preferences of those in receipt of them (Davies and Challis, 1986). Individuality is not so much extinguished, as it is in residential care, but beyond recognising the individual within the home, it does go unregarded. One of the important ideas behind the 'new' community care system in Britain is that it should be 'needs led' and that individuals should be able to express and implement their preferences for the type, timing and deliverer of social care services. 'Choice' it is suggested is ultimately best served by the market, brokered by a local authority care manager if necessary, but nevertheless consisting of alternatives between which the care 'consumer' can choose. Thus through consumerism individuality is maintained and previously standardised services diverge through an active market seeking out niche commodities for sale.

However, the market, in combination with domiciliary services, cannot resolve all problems without some radical inventiveness. Despite the strong critique of the destructive elements of residential care, the outstanding advantage of such care is that it stretches over twenty four hours. In that sense it provides continuous surveillance and hence management of risk. Residential care can also respond to urgent and unpredicted need. (These points assume of course that there are no risks that arise directly out of residential care, such as abuse by staff and by other inmates, and that residential care staff will effectively respond as needs arise). If home care is to replicate this important feature of so-called 'round the clock' care but on an individual basis, then methods have to be found which produce domiciliary services which in some way copy but do not exactly reproduce the features of twenty four hour care, and do so within carefully costed limits. Obviously informal care, which is traditionally unpaid, is the primary method of replication of twenty four care, especially when it is provided by co-resident informal carers. As one would expect, all the documentation surrounding the introduction of marketised and privatised community care in Britain stressed the importance of informal care as the 'lynch pin' of the new system (Griffiths, 1988). If, in this paper, I were to concentrate on the production of informal care as part of the 'new' British community care system, there is little I could add to what has already been said:the advent of the new system of domiciliary care appears so far to have made little difference to gender differentials in informal care (Parker, 1998). More fruitful is a consideration of the impact of these reorganisations on the production of *paid* care. I will concentrate here on the how the state and the market has developed inventive ways of marshalling paid and volunteer carers, able to deliver care at all hours of the day and night, and willing to do so at a price both state and individual consumers are able to pay. It is here that the nub of the argument of this paper lies. I will argue that the way in which these inventive replications have worked in combination with the introduction of marketisation and privatisation means that the system that is emerging is profoundly gendered and is, in both the long and the short run, disadvantageous to many women.

The three features of replicated twenty four hour care which particularly affect women are as follows: the reconfiguration of the tasks of care and their consequent deskilling and - paradoxically - reskilling; the construction of the tasks of 'care' as a hybrid of love and instrumentality that persuades people to work beyond contract; and, in a contracting out system where private agencies are involved in marshalling labour, a source of employment particularly suited to women who are paid very low wages and who wish to fit employment around their own domestic lives but which, at the same time, allows very limited

opportunities for the acquisition of social rights. I shall tackle each of these aspects in turn.

The reconfiguration of tasks follows from two aspects of the attempt to replicate twenty four hour care without actually providing it. First, it is essential that people who are living in their own homes are able to get the advantage of being at home in the sense that they can move around within it and even beyond it, and can generally survive without total care. After all, if they are not able to move beyond their beds then the additional expense of caring for each individual *at* home rather than *in* a home is hardly justified. Thus care tasks must involve ensuring that individuals are out of bed in the morning, in bed at night, regularly fed, bathed etc. Second, it is also essential that, in a 'needs led' system which is also supposed to reflect personal preferences, users of services are not got out of bed or put back in bed before or after they want, and that, above all, they receive reliably punctual services. As a result of these two features of home care, the tasks of care get fragmented into smaller and smaller units so that they can be delivered at speed. This in turn alters the content of the occupation of caring. If there are fifteen people in a neighbourhood who need to be got out of bed punctually within a period of two hours then the emotional content of care, which generally takes time, has to be withdrawn - only the instrumentality of the task remains. The same is obviously true of meal delivery, bathing, shopping, and putting someone back to bed. In a recent study of the impact of domiciliary care developments on demand for caring labour, Ford et al (1998) found that workers were unhappy with the deskilled nature of their new style jobs and were themselves inventing ways of reintroducing more labour intensive methods of work.

> "The growing trend of reducing the period for the delivery of certain kinds of services (sometimes to as little as 15 minutes) created less favourable employment conditions for workers. The more fleeting pattern of contact could in itself be unrewarding and unsatisfactory and this was a development that both contractors and providers also acknowledged as a potentially exploitative one as care workers might then provide additional services in their own time." (Ford, Quilgars and Rugg, 1998: 28 - 29)

The times at which many of these services have to be delivered are outside 'normal' working hours. Hence, if the labour that provides these fragmented tasks has to be cheap despite being at the 'expensive' ends of the day, the tasks have to be construed as essentially unskilled and easily undertaken by the untrained, uncredentialised and unlucky. Moreover, they are tasks that can easily be allied to the experience of the instrumental tasks of mothering. Thus women's labour seems 'natural' for these deskilled and fragmented activities. In the study by Ford et al, which included a survey of care workers, 96% of their

respondents were women reflecting the more than 80% female predominance of care work at national level (Ford et al, 1998: 30).

Paradoxically, at the same time as tasks are being fragmented, deskilled and delivered, due to competitive pressures, at an increasing rate, there are also pressures to 're-skill'. This counter trend arises out of the aspect of the shift of the mixed economy of care that involves targetting of domiciliary services on those who in previous decades would, through their frailty, have been obvious candidates for residential or hospital care. The withdrawal of minimal maintenance services from those with lesser needs in order to concentrate services on those with the greatest need has been an objective of the new community care system put in place in Britain since 1993. (Part of the reason to develop private sector services is to ensure that those who wish to can purchase their own services rather than rely on state organised and funded services. It is after all essential that, in a heavily targetted system which only provides for those with very high needs, that those with low and medium needs are, in theory at least, able to access private services and provide for themselves.) The result is that domiciliary care-work delivered by or purchased by the state sector involves dealing with very sick people, many of whom will be mentally infirm as well as have physical problems. For them, the rapid delivery of fragmented tasks is inappropriate. It is noticeable therefore that the conventional amount of time spent with individual households by home helps and home carers is moving rapidly upwards - from an average of 3.2 hours per week in 1992 to 5.1 hours per week in 1996 (Department of Health, 1997). Another way of indicating this is that over the same period, the number of households in England receiving home help and home care services *dropped* by 19% but the number of hours delivered *increased* by 50%. The study by Ford et al indicates how these changes were influencing the nature of the occupation of home carer:

> "Some of those previously providing the home help service were not really up to the new job. In particular, people had to be able to make decisions, liaise with other agencies and handle a more dependent set of clients. *The authority was trying to professionalise the service more and more* ."(Ford, Quilgars and Rugg, 1998: 42) (My emphasis).

Ford et al are clear as to what is happening to the labour markets for domiciliary care as a result. Two segmented markets are developing: one that contains women workers on very low wages with poor working conditions, producing standardised services on a care production line, and most often employed by a private sector company or finding work through a private agency. The other market is located within local authorities and a few specialist voluntary organisations. They are delivering more complex care services for which the workers are increasingly specially and comprehensively trained and where both

wages, which are still low, and working conditions are considerably better than in the private and agency sector. Thus the replication of the twenty four hour feature of residential care is developing into a bifurcated domiciliary care labour market where *both* fragmentation and consolidation are taking place. Both labour markets are heavily dominated by women workers, and it remains to be seen whether this leads to an overall increase in the job opportunities and career advancement for women, or whether it is likely to lead to increasing divisions between women workers - a point we consider in more detail later in this paper.

The second method that is used to replicate but not reproduce twenty four hour care is to recruit workers who can easily be persuaded to work beyond contract - so long as they have the time to do so. There are ways of presenting the work of care so that it particularly appeals to those who seek out intimacy at work. If the care work can be organised so that there is an opportunity to develop a relationship over a long period of time with a particular individual and where the caregiver can act relatively autonomously, then the work can rapidly acquire non-pecuniary benefits for the worker and the relationship between the two people can expand so that the problem of fragmented care resolves itself into continuous care. In Britain, 'community care helpers' have been recruited to care for single individuals within their neighbourhoods and paid symbolically - per 'visit' - to do so. Schemes of this kind, which essentially present the work of care as a 'labour of love', have been remarkably successful both in recruiting workers who have time on their hands and no great desire to earn conventionally sized wages, and in satisfying the needs of very frail elderly people (Qureshi et al, 1989). It has also been argued that part of the purpose of these schemes, and part of their success, is to introduce *feeling* into the relationship such that the workers behave increasingly like informal carers and involve their own families in the provision of total care (Davies and Challis, 1986). What these schemes essentially do is profile the 'nurturing' aspect of motherhood (as opposed to the instrumentality of mothering referred to above). It is not surprising, therefore, that the huge majority of individuals recruited to such schemes are women. The exception are 'buddy' schemes for the largely male sufferers of HIV/AIDS where a shared identity and a shared sense of minority oppression serves to recruit men to the nurturant role embedded in care - and hence to work beyond contract.

The third method of replicating but not reproducing the merits of residential care is to find methods of recruiting labour which do not entail high administrative costs or the possibility of unionisation and which reduce the wages of the workers involved. The contracting out culture which has come through marketisation has proved, in the British context, to be a very successful means of encouraging both the growth of private firms and voluntary

organisations which provide caring labour on a casual and task orientated basis, and also of reducing the costs of caring labour. As Table 1 demonstrates, over a third of home help and home care is now provided by the private sector and this is on an upward trajectory. The means by which this has happened is through so-called 'compulsory competitive tendering' (CCT) which, since 1988 has been applicable to various forms of manual work, such as building cleaning, school catering and refuse collection, generally found in local authority services. Since 1993 community care, in the form of residential care and home care, has been subject to a very similar system known as 'market testing' but many local authorities had already introduced a form of tendering before 1993. Both types of privatisation have been the subject of a study of 39 local authorities by the Equal Opportunities Commission between September 1993 and March 1994 (EOC,1995). This research demonstrated that the total number of jobs were reduced particularly in the occupations dominated by women and particularly in part-time jobs. For example, there was a 13% drop in employment in community care in the case study local authorities, an increased use of temporary staff, and 'overtime opportunities and unsocial hours payments for evening and weekend work have also been severely restricted under contract' (EOC, 1995:16). The private sector paid considerably less than the local authorities, very rarely had maternity leave and sick pay schemes, and some private contractors had also managed to avoid paying towards contributory benefits by 'a combination of employing people on low hours and paying lower wage rates' (EOC, 1995:19). All these points have been confirmed by the more qualitative and recent work of Ford et al carried out in 1997(1998). Thus the work involved in the delivery of care has literally been cheapened. As the provision of care switches from local authority employed workers to private sector workers so it is to be expected that for many workers, wages and working conditions will take a turn for the worse. It is this point, and its implications, that provides the context for the later discussion of the gendering of care consumption.

Table 1: Contact hours of home helps and home care per 10,000 households, by sector of provider, 1994-1996

ENGLAND

	1994: number	**1994**: index	**1995**: number	**1995**: index	**1996**: number	**1996**: index
All sectors	1,180	100	1,277	108	1,451	123
Local authority	952	100	900	95	924	97
Voluntary	33	100	42	127	56	167
Private	195	100	335	172	471	242

1994= 100

Source: Department of Health, *Community Care Statistics*, England 1996, Table 1.7.

PAID CARE WORK AND RESOURCES IN OLD AGE

In the previous section the changes that have taken place in the organisation of long-term care were explored in terms of their impact on the labour market for care, and the prospects for care workers. What is happening here is that the tasks of 'front-line' care are being reconfigured so that new fractions of task are emerging such that some are moving towards 'core' parts of the labour market, and others are moving further towards the periphery. On the one hand, a 'core' labour market is emerging, particularly for care workers who manage to retain their jobs with local authorities, where the shift to domiciliary care means that front-line care work is developing in complexity and is likely therefore to lead to increasing credentialism and career ladders. Although much of this work will remain part-time, the particular 'flexibility' that will be demanded will be 'adaptive flexibility' whereby well-trained and trusted workers will be allowed to acquire relative autonomy to practice a variety of skills in relation to the varied needs of care recipients with high and complex needs. At the same time, opportunities are developing for individuals, which will obviously include women, to enter self-employment in the care sector and, assuming that they are successful in winning competitive tenders for contracted out care, lay the basis for growth into the world of for-profit enterprise. In contrast, some care tasks will be increasingly routinised and standardised such that they can be undertaken by untrained and classically flexible labour working at 'unsocial hours' and for short shifts and casual contracts. The overall gendered impact of these trends may mean that some women will succeed whereas others (the majority?) will remain impoverished both in terms of money and of time. (One

of the features of the 'junk jobs' labour market is that many workers - possibly up to and beyond 20% and growing - are holders of multiple jobs which pay badly but which nevertheless use up their time (EOC., 1995; Ford et al, 1998).) What we are seeing here are the embryonic beginnings of divisions between women engaged in front line social care work, parallel to the growing inequalities between women already visible in the British labour market as a whole. These divisions will manifest themselves both in terms of income and in term s of status as some occupations within domiciliary care which are currently regarded as unskilled become credentialised, and as opportunities for profit in care develop.

The knock-on effects into old age are obvious. The low-waged and the 'atypically' employed are profoundly disadvantaged when it comes to the accumulation of social security rights both to cover exigencies such as sickness and unemployment during the working lifetime, and, more particularly, to provide pensions on retirement. This disadvantage is a particular feature of the British social security system which means that those on very low wages do not participate in the otherwise compulsory national insurance scheme (McKnight et al, 1998). Similar features appear in other contribution based social security systems. Moreover, earnings-related benefits, which are common particularly in the Scandinavian systems, replicate inequalities of earnings - usually to the considerable disadvantage of women. This is the argument of this section - namely, that the provision of *paid* care during a working life generally entails poverty in old age and that that poverty will in turn impact on the consumption of care. Such an argument is a variant of the usual argument linking women's working lives with their subsequent poverty in old age (Joshi, 1992; Walker, 1992; Groves, 1992). Those arguments are commonly couched within the framework of the impact of *unpaid* care, particularly for normal children, on the labour market opportunities of British women. What I am suggesting here is that the way in which the new systems of care are being developed, with their core search for cheap but exhaustive methods of care service delivery, means that *intrinsic* and *internal* to the system itself is a basic element of gendered exclusion. Many of the workers within the system will become impoverished consumers within it - unless methods are adopted, both endogenous and exogenous to the community care system, which attempt to ameliorate the impact of paid care provision on ultimate care consumption. This is an argument about the way in which policy has to take account of its impacts as a whole. This is particularly the case in considerations of policies for long-term care, since the ability to become consumers of care depends so heavily on the accumulation of assets and the establishment of legitimate claims during a relatively healthy working life.

GENDER AND THE COSTS OF CARE CONSUMPTION

Before considering the implications of gendered poverty on the consumption of marketised and privatised care, it is important to outline the gendered differences in the need for care. It is a much remarked - though little understood - phenomenon that women's relative longevity compared to men's combines with higher morbidity, such that women are more likely than men to live long but unhealthy lives. The impact on the need for care and the costs thereby entailed is considerable. Glennerster has calculated the comparative costs of health and social care for men and women over 60 years of age.

Table 2: Expected Lifetime Public Spending on Selected Long Term Care Services by Age and Gender in the UK

	Life expectancy (years)	Total expected cost excl. NHS (£)	Total expected cost incl. NHS (£)
Man aged 60	17.6	3,913	4,765
Woman aged 60	21.7	11,099	12,560
Man aged 70	11.0	5,397	6,368
Woman aged 70	14.2	12,909	14,470
Man aged 80	6.4	7,383	8,307
Woman aged 80	8.1	19,298	21,266

Note:1993/4 prices
Source: Glennerster, H (1996), page 14.

As can be seen from his calculations, which take into account life expectancy and expected morbidity, the anticipated costs of care for women are roughly three times those of men of the same age. Another way of presenting such data is to calculate the actuarial premiums that would be necessary to generate an annual insurance benefit that would pay for long term care. Burchardt has estimated, using models of incapacity based on the British Household Panel Survey, and assuming that an insurance benefit of £15000 per annum becomes payable on failure of three 'activities of daily living', that the lump sum premium payable by men at age 65 would be £19,000 compared to £37,200 for women of the same age. These huge differences (and costs) are maintained throughout the elderly age ranges, up to £31,600 for men aged 80 compared with £58,300 for women of the same age (Burchardt, 1997:47).

The conundrum that emerges from these figures is as follows: that the poorer members of the population - namely women - have the most expensive long-term care needs. As a result of their poverty, they would have very

considerable difficulty in providing for their own care needs, even at very low cost for a minimal service. In terms of income, 23% of all pensioner households are dependent on State Retirement Pension plus Income Support only, with a somewhat higher proportion (38%) of those aged 85 or over, who are likely to be the most frail, similarly reliant on the very low British pension arrangement (Department of Social Security, 1997). (Comparative pension data calculated by Evans and Falkingham (1997) indicates that both men and women pensioners modelled in a variety of 'typical' paid and unpaid work histories are considerably worse off in the UK relative to average earnings than pensioners in Italy, Sweden, and Poland). While the above data is not presented by gender, work by Dulcie Groves, using data from various surveys in the late 1980s and early 1990s, indicates that on all counts - state pensions, occupational pensions, earnings and investment income - women of pensionable age are considerably worse off than male pensioners (Groves, 1995). As Groves points out,

> "It is patently clear that only a very small minority of elderly people could fund an indefinite stay in residential or nursing home care out of income." (Groves,1995:154).

Given the low levels of income represented by the state pension plus income support on which nearly 40% of very elderly pensioners depend, it is also the case that they will have very limited resources to pay for small amounts of domiciliary care even at the low rates of pay that prevail in that sector (over 56% of female 'care assistants and attendants' earned less than £4-70p per hour in 1997 (New Earnings Survey, 1998: Table D10)). Chetwynd and Ritchie (1996), in a study of local authority charging policies found that pensioners, some of whose incomes were considerably above the state pension level, were having to make considerable sacrifices in their 'normal' consumption in order to pay even very low charges in the region of £15 -00 a week for their 'care packages'. In terms of capital assets (apart from their accommodation) it is also the case that few pensioners have any form of cushioning such that they could afford, for example, to purchase long term care insurance with a lump sum premium. According to the British Family Resources Survey - an annual national sample survey - 20% of pensioner couples and 34% of single pensioners have *no savings*. Altogether 41% of pensioner couples and 60% of single pensioners have total savings of less than £3000 (Family Resources Survey, 1997: Table 5:10). They clearly cannot possibly afford the kinds of premiums that Burchardt suggests are necessary, especially for women.

There are two ways in which this very bleak picture of a mass of impoverished elderly women in need of care but facing a targetted and very carefully rationed social care sector may improve - exogenously to changes within the care system itself. The first concerns the impact of the expansion of

owner-occupation, and the second concerns trends in the labour market as far as 'women's work' is concerned. Owner-occupation has been widely regarded as the means by which ownership of capital assets would become widespread across social classes, and there is no doubt that its impact has been to equalise wealth holding a little - although it is still the case that only 6% of all wealth is held by the bottom 50% of wealth holders (Hamnett, 1995: 165). The gendered impact of this redistribution is not clear, but it is safe to assume that women will have lower access to owner-occupation in their own right during their working lives but, if they have been fortunate enough to remain married to a male owner-occupier until he dies, then they are likely to become independent owner-occupiers at the ends of their lives. In 1988-89, Hamnett's data indicates that the total value of property left by dead married people to their spouses was £3.66 billion, of which £3 billion was left by married men to their widows (Hamnett, 1995:171). Such acquisitions may well represent problems, in the form of expensive maintenance and repair bills, but it also represents a very considerable capital asset made available to generally elderly women. Moreover the expansion of owner-occupation will have considerable effects on the assets of old age well into the next century: over 50% of people aged 80 years or more are now owner-occupiers, and this group will increase as lower cohorts with even higher rates (up to 77% for those presently in their forties) move into old age (Family Resources Survey, 1997: Table 4:3)). Such ownership represents a possible route into the purchase of care which has considerable potential. Hamnett (1995) has estimated that approximately 36,000 owner occupiers a year sell their homes in order to pay for residential care which, according to Hamnett's figures, represents about one fifth of the annual new recruitment to residential care. A further 2,000 homes are sold into 'equity extraction schemes' which allow owner-occupiers to derive some additional income from the value of their homes and hence purchase domiciliary care if they wish, rather than move permanently into residential care. Such figures do not of course take account of equity extraction arising from moving to less valuable accommodation, which may be common among elderly people, or through increasing a mortgage or remortgaging, which will be considerably less common. They also demonstrate that when it comes to realising the capital value of one's home in order to fund long-term care the most likely route taken is to sell one's home in order to fund a move into residential care rather than extract a part of the equity to fund privately purchased domiciliary care. This is a stark choice which many elderly people will be reluctant to take. It remains to be seen whether new schemes widely advertised at the moment in the financial press which allow for partial equity withdrawal will be more successful than similar schemes which went badly wrong in the early 1990s when house prices fell. However, there will remain some one quarter of the population to whom such additional resources will never be available and for whom no cushioning

of any kind, whether from their accommodation or from other savings, will be of assistance. For them it will be entirely a matter of serendipity as to whether other members of their kin network - their adult children for example - are in a position to help them financially and it will be a matter of personal psychology and of culture as to whether such assistance is welcomed by elderly parents. Moreover, some elderly people will deliberately divest themselves of their property in order to safeguard the inheritance of their descendants and prevent its value being eroded by the depradations of local authorities seeking contributions to the costs of otherwise subsidised residential care. These are indications of the development of a 'family welfare system' by which I mean systems of exchange whereby family networks beyond the immediate household of an elderly person seek to optimise the care resources and the capital assets of a kinship grouping - a point I return to in the discussion section of this paper.

The second factor which may ameliorate the bleakness of poverty in old age, particularly for women, concerns changes in the labour market especially in 'women's occupations'. As we have already seen, the care labour market is showing distinct signs of bi-polarising, whereby there is simultaneous growth in casualised and very low paid 'junk jobs' at the periphery on the one hand, and on the other, a trend towards a recognition of the skills of care in relation to users with intense long-term frailty . A concomitant trend towards training, credentialism and - eventually - higher pay and stronger social rights for care workers follows. Whatever happens in care-work , it will have considerable impacts on women's work overall: nearly two million women work in the sector of 'personal service occupations' which includes care-work, most of them part-time. Similar bi-polarisation is taking place in the labour market for women as a whole with some women, particularly those with high levels of qualification, beginning to generate working histories and working conditions that look much more like those traditionally located in men's occupations (Sly et al, 1998). These inequalities that are developing between women are likely to generate a politics of care provision and pensioner protection which does not have gender at its heart, but rather social class. It is interesting to note that alongside the mass of elderly poor there is also a significant minority of elderly people, particularly those who are still married, who are relatively well off. For example, 31% of pensioner couples have savings of £20,000 or more, and 15% of single pensioners are that affluent (Family Resources Survey, 1997: Table 5:10). But if attention drifts towards the affluence of what remains a minority of British pensioners, and the polity is mesmerised by the potential of owner-occupation to act as a resource for up to three quarters of the populace, the eye can move away from the fundamental point: that there will, as a result of labour market trends, remain a significant minority of elderly pensioners, most of

whom are women, whose work histories - many of them, ironically, one time paid care workers - will guarantee an old age characterised by ill health and financial dependency and a complete inability to enter the world of care consumerism.

DISCUSSION

Thus it can be argued that gender remains at the heart of the new care system. Women are caught in a vicious circle: as carers of their own children, (arising out of the very underdeveloped child care services available in the UK - a factor which may change as a result of government policy to encourage the growth of and use of public and private child care facilities), they are very seriously disadvantaged in the labour market. In addition, 'care' jobs assume a lack of skill in care tasks because they bear such a close resemblance to the practices based on the experience of mothering and hence are construed as 'natural' aptitudes of women. For these reasons employers of caring labour, whether they are individuals or private or public sector organisations, are likely to continue to seek out women as care workers. Despite the low pay prevailing in the care sector, it is also likely that care occupations will remain attractive to women with few qualifications but who also seek intimacy at work and the particular satisfactions that arise out of the delivery of nurturing service. In material terms too, the fragmentation of care and the attempt to replicate features of twenty four hour care by extending the working day renders such paid work particularly flexible and amenable to delivery over short shifts which can be fitted around other domestically based responsibilities. Yet in the long run such occupations offer little in terms of acquisition of savings or pension rights and hence underwrite an insecure old age.

Nevertheless, it is also the case that this stark story is complicated, particularly by the phenomenon of growing inequalities between women. One way of considering the implications is to use the framework of the well-established 'welfare triangle' of state, family and market (Evers and Wintersberger, 1990). As far as the *family* is concerned, there are serendipitous possibilities that members of an extended network will be able and willing to fund both privately purchased domiciliary care and residential care for low income elderly and frail female relatives. But for many families such options will not be available, dependent as they are on social and economic mobility between generations. As a substitute for the material resource of purchased care, family networks are, of course, the primary source of informal care and it is to be expected that very considerable pressure will continue to be exerted, especially on women in a younger generation, to take on the work of informal

care. Again, however, there are certain aspects of serendipity here, depending on the availability of suitably located kin, or the possibility of migration of the elderly person towards her relatives or movement of her relatives towards the person in need of care. The context for decision-making of this kind lies in the interaction of the affective and material base of family and kin network relations. A combination of income poverty with ownership of a capital asset in the form of the accommodation occupied by the elderly person means that there may be contradictory pressures both to use up the current capital resource to fund care and, at the same time, to preserve it for future generations. In family networks where, given lack of social mobility the marginal utility of even a low value house is high, it is likely that there will be considerable pressure from those expecting to inherit on individuals within the network to provide informal care rather than use housing equity to purchase care. These kinds of pressure will be particularly heavy within poorer family networks and in this sense gender and social class cross-cut and interact. Such systems of calculative strategies for resource expenditure and containment can be characterised as a 'family welfare system'. Unless there are other forms of intervention, particularly from the state, and very cheap forms of purchasable care develop within the market, the family welfare system especially amongst the poor will have to grow. Once more, the likely involvement of female kin in the younger generation in the provision of informal care will store up problems for those women once they reach their own old age.

One means whereby the impact of providing unpaid informal care for members of the older generation may be obviated is through *state* intervention, particularly in the organisation of pension rights. If informal care is recognised - as it is in the British national insurance system through 'home responsibilities payments' - as a form of work which can legitimately lay claim to pension contributions, then the impact of absence from the formal labour market on incomes in old age will be ameliorated to some extent. Similarly, pension rights can be organised in such a way that those with chequered work histories or those who have worked 'atypically' in low-paid part-time occupations (for example, in paid care work) are not plunged into considerable poverty on retirement from paid work. Current British proposals to introduce subsidised 'stakeholder' pensions even for those on as wages as low as £9000 per annum should make poverty in old age, especially for women, somewhat less inevitable. Similarly, the introduction of a minimum wage may lead to higher wages within the paid care sector which in turn may mean that care-workers have an opportunity to save for the exigencies of retirement. Such contextual factors help determine the effective demand for privatised and marketised care, but they are exogenous to the care system as a whole.

There are also ways in which the state can intervene to break the impact of low-paid work on the purchase of long-term care which are endogenous to the care system. The most obvious, in the British system, is the rapid development of means tested charges for care services which in turn are heavily targetted, particularly to those living on their own and those assessed by care managers as having 'high' needs. If women recipients of care packages are relatively poor and, as is likely given their longevity, living alone, then the combination of means testing and targetting will mean that they will, in the short run, be immediate beneficiaries of subsidised services. Indeed, one can argue that means tested and targetted service delivery is likely to constitute institutionalised gendering of the long-term care system since so many of those in need who are on low incomes will be women rather than men. In this way one can argue that in a social and economic structure such as that currently prevailing in Britain, where there are growing inequalities between rich and poor and growing divisions, in paid work, between core and periphery, then selectivity and targetting towards the very poor is the obvious ameliorative policy solution to the consumption problems entailed by women's poverty in old age. However, this leads to the classic question about selectivity. While selectivity may resolve problems in the short - run (assuming that means-testing does not immediately depress take-up of services) the long-run problems surrounding selectivity involve loss of political support for state funded services, with subsequent tightening of resources and increasing emphasis on the merits of self-provisioning. The fact that poor, elderly women would be the major consumers of selectively allocated and subsidised services may add to the residualisation process.

Alternatives to such drift towards residualisation of state organised and funded services involve the long established concept of the 'pooling of risk' but they also involve some pressing choices. On the one hand it is possible to envisage promotion of market - based consumption through, for example, state organised and subsidised long-term care insurance as is currently part of the German welfare system; on the other, it is possible to envisage social care which is free at the point of consumption (in the same way that British health care is) where funding is based on taxation revenues. In both cases, gender remains problematic. Long-term care insurance will have similar problems to social security insurance based schemes in that it is particularly difficult to see how an adequate system of benefits for all can include those who, due to low and irregular income, are only able to make very low contributions during their working lives. Social care free at the point of consumption has been argued for by Glennerster (1996) and he suggests that a such a system could be rationed by medical professionals operating within cash limited budgets. While there is a certain logic to this similarity to a well-tried and tested health care allocation

system, rationing of free social care services would almost certainly take account of the availability of informal care. In other words, rationing would have at its heart a subsidiarity principle which would, inevitably, be gendered.

As far as the *market* is concerned, there are a number of issues both at the consumption and production ends. One factor that is likely to be of importance is the extent to which different types of market for care services will develop across space. For example,the development of private sector care, particularly of residential care, has had very clear spatial elements to it, with heavy concentrations of for-profit residential care homes in the south of Britain and in towns and cities, such as at the seaside, where there already existed a housing stock that was both cheap and suitable for conversion into multiple occupation (Audit Commission, 1986). As far as markets for domiciliary care are concerned the structure of the British community care system is such that the spatial concentration of markets for care may be less heavily skewed. All local authorities are obliged to contract out up to 85% of their domiciliarycare services which means that one would expect that there would be tendencies towards less spatial concentration of for-profit enterprise. However, private sector domiciliary care firms cannot rely on a continuous flow of contracts for care from local authorities and will need to be reassured that there is, in the areas where they operate, sufficient effective demand from private consumers to support their services. Thus one might expect the skewed development of well-organised and quality audited domiciliary care enterprise in areas where there are concentrations of middle class, middle and upper income elderly owner-occupiers. (To my knowledge no research has been done on this important question although the basic data is probably available). In contrast, where there are concentrations of poor elderly people (for example, on social housing estates or inner cities) one would expect there to be little in the way of an organised market for domiciliary care. This is despite the fact, given what has been already been said about the way in which the labour market for care is developing, that there will be many residents of such areas who, if they are of working age and female, are likely to be employed as care-workers both in the core and, more likely, at the periphery of that labour market. In these areas, the market for domiciliary care will exist but it may have a very different feel to it - it may constitute part of the largely invisible system of informal economic activity whereby neighbours provide each other with services at very low cost (for examples, see Baldock and Ungerson, 1994) or payments for care develop within families and kin networks (Ungerson, 1997).

These speculative comments about differential development of domiciliary care markets across space reflect not so much gendered differences in effective demand but socio-economic differences. However, given what we

know about the differential care needs of men and women, it is likely that the consumers active in these care markets are more likely to be women than men. While it is a relatively easy matter for better off women to access the for-profit care market (there are, for example, over 40 such organisations currently listed in my local Yellow Pages) it is a more complicated matter to access and manage the informal care market, depending as it does on local knowledge and an ability to control the low and illegally paid such that they provide a reliable service. Policies to deal with these differences are difficult and controversial. Some may argue that a system of informally employed caring labour which provides services to poor elderly people who live at home is an inventive and satisfactory way of dealing with the effects of state withdrawal from provision for those with only low and medium needs. Others may argue that such differentiated markets merely exacerbate already profound inequalities in the quality of life between elderly people of different socio-economic status, and that the labour providing such work is criminalised. They would argue that the state should intervene to ensure that those in poorer areas who do not qualify for heavily targetted services can access well organised and quality audited private sector services in the same way as the more affluent can. If this is to happen, then only positive discrimination in the allocation of care management and subsidised services on an area basis, or a national policy to reduce income and wealth inequality in old age, are likely to be policies wide reaching enough to be effective.

As far as the production of care within the private sector is concerned, there are countervailing pressures both to push the price of caring labour upwards and to push it downwards. One of the pressures that may lead to increasing wages of care workers is the introduction of quality audit by the contracting state agencies. (Indeed the development of the domiciliary care market is generally orchestrated and managed by local authorities, such that a concept of a *free* market hardly applies.) Such pressures are part of the reconfiguration of paid care work that has already been discussed, with its countervailing tendencies both towards 'core' and 'periphery'. Where quality audit really bites, then one would expect there to be pressure on for-profit enterprise to retain their experienced workers through training and higher wages, and, in order to ensure quality monitoring, to introduce layers of management which might provide career ladders for paid care workers. In this way, the tendency towards development of a core of trained and credentialised workers, just as within the public sector, is likely to be reinforced within the for-profit sector. At the same time, however, the for-profit sector is likely to diversify. As I have argued above, there will be spatial differences in effective demand, and where there are concentrations of relatively poor elderly people with low and medium level needs who do not qualify for large 'care packages'

on a subsidised basis from their local social service departments, then some labour markets in paid care work will retain and develop further features of informal and 'grey' labour. Such workers will necessarily have to be very cheap and, by definition, will acquire no social security rights. Indeed their work will be illegal and hence invisible and there will, as has been argued, be considerable knock on effects in the workers' own old age.

CONCLUSION

I have argued that an important feature of the reorganisation of care, from residential to domiciliary care, and from conventional public sector funding and delivery to a 'mixed economy of care', is that of gender. It is clear that changes in the production of care will generate new forms of gendered inequality which in turn will impact on gendered patterns and exigencies of consumption of care. In short, the reorganisation of care work entails the reproduction of a minority of very poor elderly women who will be unable to enter a private market for care, and will have considerable difficulty in accessing even quite heavily subsidised but nevertheless charged for care.

The long-term implication of these trends is that if hardship and inequality of access are to be avoided, then there will have to be some form of state intervention. One form of such intervention could be endogenous to the care system, and rely on targetting that positively discriminates in favour of the very poor such that even those with low or medium needs but on low income qualify for subsidised 'care packages'. But such a system bears with it considerable risks of stigma and residualisation. Alternatives include systems that are universal and point to social care free at the point of consumption, or the acquisition of rights to consume in the private market for care. Exogenous factors would be concerned with the way in which the care labour market is developing, and would involve upgrading the incomes of those who work within it, for example through the introduction of a minimum wage (which has only just - in April 1999 - been introduced) and radical changes in the aquisition of social rights such that those in 'atypical' work (which is of course increasingly typical) are able to enjoy a rather less poverty stricken old age. Policy changes in the delivery and organisation of long-term care are themselves having profound knock-on effects. We are at the cusp of decision-making where, unless other policies are introduced to deal with those effects, we will make no progress whatsoever in resolving gendered inequality amongst the elderly.

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Professor Clare Ungerson
Department of Sociology and Social Policy
University of Southampton
Southampton SO17 1BJ
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