

Himmelweit, Sue; Land, Hilary

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Change, choice and cash in social care policies: Some lessons from comparing childcare and elder care

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Change, Choice and Cash in Social Care Policies: Some Lessons from Comparing Childcare and Elder Care

Professor Sue Himmelweit
and Professor Hilary Land

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Copies may be obtained from:

Economics Department
Faculty of Social Sciences
The Open University
Walton Hall Milton Keynes MK7 6AA
Telephone: 01908 654437
Email: economics@open.ac.uk
Fax: 01908 654488

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Change, Choice and Cash in Social Care Policies: Some Lessons from Comparing Childcare and Elder Care

Paper for the ESPANET conference in Vienna, Austria, September 20th-22nd 2007

by
Professor Sue Himmelweit and Professor Hilary Land

Across the EU, social care policies are being reformed in order to allow those needing care more 'choice' among care providers and flexibility with respect to how and where care is provided. Some argue this is the *key* factor underlying welfare state changes. Jenson and Sineau for example, concluded from their analysis of restructuring welfare states in the EU15 in the 1990s that "Maximising 'choice', implementing diversity of services and financing non-public provision are policy options frequently adopted in this neo-liberal era", (Jenson and Sineau, 2001,p.17). Their study was focussed in particular on childcare policies but the importance of increasing choice among policy objectives was noted in recent study of eldercare policies across twelve OECD countries (Lundsgaard, 2005).

Care policies lie at the crux of the relationship between public and private both in the sense of private meaning family and private meaning market. These relationships have changed over time and are manifest in the shifting and the blurring of the boundaries between formal and informal care as well as between paid and unpaid care. By the beginning of the 1980s feminist scholars in the Nordic countries were describing developments in childcare and eldercare policies as social reproduction 'going public' meaning that the state was providing more publicly funded care services and women's dependence on the public sector for employment as well as services was increasing (Hernes, 1984). However by the 1990s in several countries, and in particular Britain, social reproduction was "going commercial as marketisation and quasi-marketisation of services have been of growing importance of welfare provision" (Boje and Leira, 2000, p4) Thus 'private' in the policy debates in the 1970s usually meant informal family care. Twenty years later 'private' meant care services produced in the private market (Waerness, 2004, p96). The 'welfare mix' affecting care policies is changing. It is therefore important to understand under what conditions adequate care is forthcoming both within families as well as in the marketplace and in what ways the state can sustain and support this care in conditions which respect the well-being of both givers and receivers of care.

In this paper we will discuss how the value placed on increasing 'choice' is a major factor determining both childcare and elder care policies , focussing in particular on the increasing emphasis on using cash allowances and tax credits or reliefs to achieve greater diversity of provision and better 'value for money'. The use of cash means understanding how families and service providers in the market respond to incentives to provide more care and what choices are important both to those who need care and those who give it. However, as Nancy Folbre has pointed out: "In order to solve the care problems, we need to understand how markets work, but also how they *don't* work" (cited in Waerness, 2006 p76, emphasis added). We therefore begin by examining first, why the cost of care is increasing and second what happens when care is treated in the market as if it were a commodity like any other. Third, what evidence is there about how the capacity of and willingness to care within families is changing. Does it suggest growth or decline? Does state support for care, especially in the form of cash, substitute for or complement family care? Third, we will examine the circumstances in which 'cash for care' policies offer meaningful choices both to those giving care and those who need it. By comparing childcare and elder care policies and practices and analysing their differences, it is easier

to evaluate the consequences of treating care provision as a means to achieving other policy objectives rather than as a worthy end in itself.

The rising costs of care

The costs of policies to provide care are rising. There are a number of reasons for this, some of which are widely recognised, others less clearly so. The reason that is most often cited for such rising care costs is that there has been significant demographic change, with increasing life expectancy in all developed economies. However, the evidence suggests that improvements in morbidity have not kept up with those in mortality so that “disability-free life expectancy as a proportion of total life expectancy has decreased” (Wanless, 2006 p37). This means that, excluding the effects of migration, in most developed economies the proportion of the population needing care on grounds of disability can be expected to rise, even if birth rates were to remain constant. However, in the last thirty years most countries have also seen falls in their birth rates to a greater or lesser extent, (although there are signs that in some Nordic countries that the birth rate is now increasing). While falling birth-rates will cut the number of children needing maintenance and care, the net effect is that in future a smaller population of working age will be responsible for growing numbers of older people needing care as well as financial support.

There has been more recognition of the effects of this demographic shift on the costs to national budgets of old age pensions than on the implications for care. One response to the expenditure implications has been to try to increase revenue by raising the proportion of the working age population in employment (and in some countries raising retirement ages). ‘Active’ citizenship, to which all adults of working age should aspire, now means above all being active in the labour market (OECD,1999). For example, in Lisbon in 2000 EU countries adopted the European Employment Strategy (EES) giving target employment rates of 70% for the population of working age of all member countries by 2010, with the explicit purpose of helping counteract the increasing costs of pensions by increased revenue. Groups currently most likely to be out of the labour force because of unpaid caring responsibilities, women and older workers aged 55 years and over, were given specific somewhat lower targets (60% for women and 50% for older workers) reflecting a recognition of the fact that these are the only groups from which significant increases in employment rates can be expected and that among the obstacles to employment are their unpaid caring responsibilities (European Commission, 2005). Thus the EES, if it is successful, may solve the effects of changing demographics on the pension crisis by exacerbating their effects on the care crisis. More care will therefore have to be provided by means other than the unpaid work of women or older people of working age.

Other social changes have also tended to increase the amount of paid care needed by reducing the availability of unpaid care less or by increasing the total quantity of care needed. Increased mobility has reduced the proportion of adults needing care with family living nearby, although as discussed below this change can be both misinterpreted and

exaggerated. The perception of care needs has also changed. For example, in the absence of careful urban and transport planning in some countries increased traffic, reduced neighbourliness and greater perceived dangers of strangers in public spaces have resulted in children and frail elderly people being more frequently escorted than in earlier times. On the other hand, older people may be being expected to make do with less continuous care as state financed care packages become more finely tuned to specific physical needs and unpaid carers, both co-resident and non resident, try to combine care with employment. Young children, however, require the presence of others even if the care being provided is 'passive' rather than 'active'. As family size has fallen there are fewer older siblings to provide this care.

Finally, costs are increasing because not only is the amount of care needing to be paid for rising, so are the wage costs per unit of paid care. This, Baumol's well-known "cost disease", a result of productivity gains elsewhere in the economy, is arguably the most significant effect on rising care costs. It is also the least acknowledged politically. It occurs because, unlike for those commodities in which the output is separable from the producer, the time of a carer and the relationship developed with the person being care for is integral to her output. This limits how many people can be cared for at the same time. While this limit may be different for different caring relationships, after a certain point spreading care over more people becomes synonymous with reducing quality. Indeed, what in other industries would be seen as measures of high productivity are specifically taken as indices of low quality when it comes to care.

The forces of innovation and competition that increase productivity in most other industries can therefore do so to a much more limited extent in care. Increasing productivity causing wages to rise elsewhere in the economy raise the price of paid care at a similar rate, modified only to the extent that wage rises in caring differ from those in other industries. This rise in the cost of care is not caused by inefficiency (or rising standards) in the provision of care, nor by increasing numbers of people needing care, but is an inherent effect of the relational nature of care in economies in which productivity is rising in the production of other goods. It is an effect of getting richer not poorer.

Policy makers rarely acknowledge this, seeing rising costs as a problem rather than a symptom of increasing wealth that can easily be financed from the increasing productivity of the economy as a whole. More specially there is tendency to blame rising care costs on inefficiency, particularly in public sector provision where there is no market test of whether value for money is being delivered. This has fuelled a widespread policy shift across a number of countries away from public service provision towards market solutions to care needs, whether this is by direct payments to those needing care to employ their own carers or through demand side subsidies to the development of a market in care supplied by both for-profit and not-for-profit employers. Such policies have been enacted in varied ways in different countries reflecting differences in existing policies and the values behind them. Nevertheless there seems to be a common direction of change. Increasingly money is being provided instead of services.

Consumer choice and the market for care

One reason for this switch from care services to cash is a strong belief that the market provides consumers with the best opportunity of exercising choice (although in some countries care recipients' choices on how they spend any subsidies to which they are entitled may be restricted by employment or by excluding payments to certain relatives, for example). This is connected to the value for money argument because choice is not only supposed to be what care recipients want, where there is a market choice also has another social function. Consumer choice is required in order to make markets contestable so as to encourage best-value high-quality supply that meets demand. Through consumer sovereignty, that is purchasers being able to choose where to allocate their custom, more efficient providers will prosper and less efficient ones fail.

However, for consumer choice to be an efficient way to guarantee the quantity and quality supplied of a particular commodity, a number of conditions have to hold. These include that: consumers are able to assess the quality of what they are/would be purchasing, and have sufficient information to compare the prices which alternative suppliers would charge; the costs of changing from one supplier to another are low; suppliers face a reasonably competitive market. None of these conditions apply perfectly in the market for any commodity, but in the case of care they are particularly inapplicable. So, for reasons to do with the nature of care itself, consumer choice may be not be as effective a way to guarantee its quality as it is, at least in theory, for other commodities.

First, many people needing care are unable or unwilling to act as well informed consumers who can “shop around”. “Many people who use social care services are not in a position to make choices—indeed it may not even be their choice to receive social care.” (CSCI, 2005, pv) In practice then, the purchaser of care is often someone else, either a family member or a local authority, whose interests may not wholly coincide with that of the care recipient. But even where interests do not diverge, purchasers who are not consumers do not have the direct experience of the quality of the care received required to make informed choices. This is particularly true if the recipient has difficulty articulating their needs, as a child or some people with disabilities may have.

Second, quality of care is hard to assess and monitor not only for third party care purchasers, but also for care recipients themselves in trying to assess alternative providers. Care is a quintessentially “soft” product whose essential characteristics are not easily measured. It is possible to monitor certain physical or developmental standards in care provision, such as for example, the number of clients bathed for home helps, or developmental test scores for three year olds. Market driven provision in its drive for recognised efficiency will tend to meet these measurable outputs and economise on the less tangible aspects of good care. But these are of the very essence of good care, which in nearly all cases needs to include the development of a warm relationship between producer and consumer; such things are hard to monitor and necessarily tend to fall by the wayside in the pursuit of market-led “efficiency” (Gilbert, 2002 and Stone, 2000).

Third, providers in the private-for-profit sector will be failing in their duty to share holders if they do not take every opportunity to reduce costs. Lowering costs in ways that

affect the quality of care provided but does not show up in current monitoring procedures will be one way to do so. Monitoring standards can be changed in an attempt to prevent this, but they will always run behind existing practice seeking for further ways to reduce costs. (That after all is the argument for private provision being efficient.) Unless all aspects of quality can be monitored, the logic of the market leads to quality reduction in those aspects of quality that cannot. But these, as we have seen, may constitute the very essence of good care. Providing better information to consumers and those who make decisions for consumers about the measurable aspects of care quality may only exacerbate this tendency. Similarly, good information about prices in the absence of reliable information about quality, can lead to a pursuit of “value for money” that becomes a race to the bottom in terms of quality.

For example, reducing the amount of time home carers spend with a client (the care package) and giving a prescribed list of tasks to be done and recorded, practices that have been introduced in the pursuit of efficiency, have considerably reduced not only home carers’ ability to respond sensitively to their clients’ needs, which may vary from one visit to the next, but also the time to talk and listen as well as the opportunity to help the client do something for themselves in the manner which suits them. Reduced opportunities to develop relationships with their clients decrease satisfaction and increase turnover rates among care workers, as was found in the Netherlands, following increased dependence on the private-for-profit sector and the resulting ‘rationalisation’ or Taylorisation of working practices in the home care sector (Knijn 2000). In pursuit of cost savings, by destroying the job satisfaction and generous professionalism of a group of workers that came from developing relationships with their clients, increased turnover rates undermine not only those savings but also the quality of care.

Given the impossibility of monitoring the quality of all aspects of good care, the most reliable source of quality is for carers to have an intrinsic motivation to provide good care. In the right circumstances, such motivation can arise out of professional pride, notions of public service and/or emotional connection. These may be more difficult to harness for the private-for-profit sector than the not-for-profit and public sectors, with whose missions of public or charitable service, rather than maximising the profits of shareholders, carers might more easily identify

Fourth, assessment of quality is an inherent problem in any form of care provision, but particularly so in market provision which relies on consumers’ power to exit rather than on their voice. This is because exit is not costless in the case of care. Because good care involves the development of a relationship, continuity of care is important particularly, for older people and young children. Carers learn how to care for particular people and develop bonds of affection with them (Waerness, 1987). This tacit knowledge takes time to acquire and cannot instantly be replaced by a carer offering better value for money. This is one reason why given a free choice many older people choose to pay a carer who they *already* know, or a relative where that is allowed (Ungerson, 2004). However, this does not necessarily give care recipients the market power and flexibility providing cash rather than services is designed to promote, because the cost in terms of ruptured relationships of dismissing such a carer may be too hard to contemplate if care proves unsatisfactory or needs have changed. (Ungerson.2004)

For younger people with disabilities continuity of care may not matter so much. Ungerson's study of Direct Payments found that many younger people welcomed being given cash rather than services because they wanted an employer/ employee relationship which had no history and could be cleanly terminated if it became unsatisfactory (Ungerson 1999).

The move to cash rather than services has been supported by governments not only because they see it as giving care recipients flexibility and control over the care they receive and might thereby improve the quality of care provided, but also because costs may be reduced by so doing. The market should indeed be successful in reducing costs where unnecessary services have been provided and there may also be some scope cost containment through better management. However, for the reasons given above any productivity gains and therefore cost savings are likely to be small. In practice, costs savings from replacing state provision of services by cash payments are more likely to arise through the replacement of workers with public sector terms and conditions of employment by more vulnerable and less well remunerated private sector workers. With directly employed care workers, experience in the US shows that little or no regulation of may result in the state funded expansion of 'grey economy' of paid but unregistered care and domestic workers with heavy dependence on immigrant workers (See Gilbert, 2002). This provides greater savings still. Within many of the EU15 countries migrant workers had become an important source of care labour during the 1990s, the patterns of migration to a particular country depending on history, proximity and the porosity of borders. (Ungerson, 2004, Hillman, 2005). As a recent ILO report on care stated "The debate about care in the twenty first century should be linked to changes in the role and level of migration. There is a tendency for migrants to be used to fulfil the role of carer" (Daly and Standing, 2003, p5). The enlargement of the EU has increased the accessible pool of migrant care workers still further (Lister and Williams et al, 2007).

Finally, across all the sectors of the care market larger providers are becoming more dominant. This may increase efficiency, but it certainly reduces choice for residential care recipients, because most large providers in order to take advantage of some economies of scale run larger homes (CSCI, 2005, p184). It also means that those requiring specialist provision, for example, those with particular disabilities or older people from ethnic minority groups, will have increasing difficulty in finding a home of a type and in a locality which suits them. These same trends were observed in the US private market in the 1980s (Walker, 1995). Further as large providers come to dominate the sector and develop monopoly power, is no longer clear that costs savings will be passed on to consumers or to the public purse that finances their care.

For these reasons, it is not so clear that providing cash rather than services and relying on the market provision of care will, except in a few special cases, deliver consumer sovereignty. In so far as the market brings about "value for money", it will be difficult to ensure savings are not at the expense of the essential characteristics of good care. Further, a requirement for market provision to satisfy demand at lowest cost is that the market is competitive. If that is not the case, there is no reason to believe that private sector provision will be "efficient" even in that limited sense.

Choice and Care in families

“Socio-political assumptions on family life and relations between the sexes and the generations may have a stronger impact on financial support and care arrangements for the elderly, taxation and social security than economic developments” (Knijn and Komter, 2005, xiii)

A great deal more is known today about the care provided by family and friends. The second wave women's movement in the 1970s and 1980s did much to make women's unpaid work in the home more visible in the policy debates that care was essential to, but undervalued in the public world. Now, using the time-use studies that have been conducted across the EU, North America and Australia together with the development of Household Satellite Accounts, there is a means of calculating a monetary value for informal care.

The size of informal care provision dwarfs the size of public provision. Even in a country like Sweden with extensive formal adult care services, it has been estimated that the volume of unpaid informal eldercare is twice as large as the volume of formal care (Lundsgaard, 2005, p39). Daly and Rake have calculated that averaging across the EU15 and Norway, informal care of older people in 2000 was five times more prevalent than formal care (Daly and Rake 2004 p54). In Britain in 2000 the annual value of childcare and the care of elderly, sick or disabled adults was estimated to be more than a quarter of GDP calculated on an equivalent basis in the same year (National Statistics, 2002). In 2001 across the EU altogether 31% of women were involved in childcare and 18% in adult care. The proportions of men caring in these ways were 18% and 4% respectively (Daly and Rake 2004 p.55).

However, widespread beliefs that families care less than in the past co-exist with this evidence of considerable family solidarity in practice. These attitudes are not confined to politicians and policy makers. Attitude studies conducted in the 1990s found that the majority of the EU population agreed with the view that the willingness to care for family members had declined (Jacobs, 2003 p.414). These beliefs arise for a number of reasons, and not only inform both childcare and eldercare policies in individual nation states but also whether or not increased welfare state support is likely to decrease or increase the willingness of family members to support each other. Underpinning the recent growth of cash for care schemes are assumptions about why individuals 'choose' to care and whether welfare state provision in general 'crowds out', sustains or, better still *increases* the volume of informal care. This is particularly important in the case of eldercare because filial obligations are no longer underpinned by legal systems to the extent that parental care is. In addition there are different views about the desirability of introducing the payment of money into caring relationships.

At first glance the view that families care less than in the past may be supported by the growth in the number of old people living on their own and the decline in three generation households (Mabry, Giarrusso and Bengtson, 2004, p100). The decline in marriage and the growth in lone parent households may also contribute to the perception that family obligations are weaker than in the past. These trends are common across Europe but they have very different base lines so the distribution of household types still varies between countries. In particular, there are significant variations between countries with levels of solitary living among older people highest in north-western Europe and lowest in the south. However this focus on changing *households* gives only a partial picture of what is happening within *families*.

‘Family’, especially in official statistics is too often equated with household and confined to two parents and dependent children. In the latter half of the twentieth century this focus on the ‘nuclear family’ was influenced by American family sociologists such as Talcott Parsons (1943) who argued that the nuclear family form was better suited to a capitalist economy which needed mobile workers unencumbered by extended kin and parents who invested their time and money in their children-the next generation of workers. Family relationships and exchanges beyond the household were ignored until the recent growth of lone parent households. Tax and benefit systems in the past have acknowledged and facilitated the flow of money between the generations, but as many of these presumed and only benefited a married male tax payer they have disappeared with the introduction of independent taxation in many EU countries over the last thirty years. Obligations to maintain across the generations still vary between countries with southern European countries still retaining legal obligations between wider kin and in Germany between adult children and parents (Millar and Warman, 1996). Countries in northern Europe have the most narrowly defined family obligations with stronger claims on the state as individual citizens.

A more careful examination of family attitudes and behaviour reveals a more complex picture. First, the evaluation of these trends may be different across countries. For example, a recent study found that co-residence with adult children is considered more desirable in Italy (42%) than in Britain (30%). In Sweden institutional care or, better still, care in the old person’s home was preferable to co-residence (9%). These attitudes confirm Finch and Mason’s (1993) suggestion that family norms are *guidelines* rather than rules and that how these norms influence behaviour may change when circumstances including the availability, cost and quality of home care and institutional services alter (Tomassini et al, 2004 p31).

Further, research studies show that living alone should not necessarily be equated with loneliness, isolation or danger. A study of social exclusion in Britain in 1999 found that single pensioners are more likely than pensioner couples to have daily contact with friends and neighbours as well as more likely to have weekly contacts with family and friends (Patsios, 2006 p.448). Poverty as well as ill-

health and disability as much as absence of family were common reasons for not having or maintaining social contacts. Other research has shown that older people living with one of their children are less likely to see their friends often than those living in their own households. They are also more likely to feel lonely. Overall there is no evidence from British studies that older people are more lonely than they were in the past (Victor et al, 2005). Family relationships vary in their intensity over the life course and, depending on the history of a particular relationship may be positive or negative-sometimes violently so. Research on elder abuse shows that enforced co-residence can be dangerous to both givers and receivers of care. Family relationships are also unequal power relationships between young and old as well as between men and women. Ambivalence towards family relationships is not surprising.

Second, research on how family responsibilities are acknowledged and put into practice in daily life suggest that they are still strongly felt. A study conducted across Norway, England, Spain, Germany and Israel in 2000 found that: "It is increasingly apparent that solidarity, or felt obligations towards children *and parents*, are alive and well but that their manifestations have changed"(Daatland and Herlofson,2003,p540, emphasis added). This same study found that there were different views about whether it is the family or the welfare state which is primarily responsible for financial support, practical help and personal care, with respondents in Norway most likely to say the state and those in Spain and Germany, the family. However in all six countries a partnership between the welfare state and families was desired. They also found that when alternatives to family care were available, the young were *more* inclined to towards family care than the old. They therefore concluded that :''It could be that future changes in the sources of family care will be influenced more by what older parents prefer than by what their children are willing to offer'' (Idem. p551). In this context the question of who is given the *choice* about where eldercare takes place, who provides it and who receives money for care does not have a straightforward answer.

Welfare State Provision, Choice and the Motivation to Care

It is clear both on the grounds of cost and what the vast majority in every generation would choose that informal care, provided mainly by parents and close kin, is going to continue to be the main source of childcare and eldercare. The issue for policy makers is how to sustain and increase informal care in the light of the changes described in the first section of this paper. The policy solutions chosen depend on the assumptions made about what motivates family members to care and to continue to care. Governments convinced that 'familism' is being replaced by individualism (Giddens, 1992 and Beck, 1992) are more likely to be fearful of introducing policies which allow family members to choose *not* to care.

Across the EU15 until the later decades of the last century, public provision of care both for children and older people was concentrated on those for whom family had failed. Responsibility for these services usually rested with the lowest tier of government which had considerable discretion in whether or not they were free at the point of use and concentrated on poor families. This was in contrast to the development of universal education and health services in the post second world war years for which central government took the main responsibility. Public provision for 'normal' families who could be expected to care, were resisted until they were associated with the achievement of other policy objectives, as will be discussed in more detail below. These vary across countries, with greater variation found in the case of elder care than childcare. Moreover, childcare and eldercare provision has developed in some countries in divergent ways: generous development in one can be found alongside more cautious development in the other. (Pfau-Effinger, B and Geissler, B. 2005, Knijn, T and Komter, A. 2004, Daly, M and Rake, K 2003, Jenson, J. and Sineau, M., 2003 Boje, T and Leira, A (eds) 2000, Lewis, J. 1998,).

The pattern of payments for care can reveal the different assumptions policy makers believe affect the motivations to care. They also reveal how far governments are prepared move away from 'traditional' and highly gendered forms of family care. For example, in the case of support for childcare, payments for parents to stay at home to care for their children while they are young now mainly take the form of paid leaves from employment. All give longer leaves to mothers than fathers. In some countries in so far as there is a choice about how much leave a father can take, the choice depends on the willingness of mothers to give up 'their' leave to their partners. In Sweden, which introduced the possibility of leave for fathers in the 1970s, and there is a specified 'Daddy leave', there is concern that mothers' choices as well as fathers' will have to change if leave to look after young children is to be shared more equitably and gender equality achieved (OECD,2006). Within families one parent's choice may constrain the other's.

In some European countries, such as Germany, there are state payments made directly to parents who stay at home to look after children. In Norway, Finland and France, these are related to the fact that such parents are not making use of a publicly funded nursery place to which they are entitled either because there is insufficient provision in a particular locality or because that it is their choice. In practice it supports mothers with less education and lower earning capacity to stay out of the labour market. More highly educated mothers understand that the longer they 'choose' to stay out of the labour market, the greater the detrimental effect motherhood will have on their lifetime earnings. In these circumstances inequalities between women will grow. In Britain proposals (Conservative Party, July 2007) to give more support to mothers who stay at home until their youngest child is three currently take the form of a transferable tax allowance, which in effect is the re-introduction of the married man's tax allowance for single earner families. Like the Working Families Tax Credit, such a scheme would act as a

disincentive to the second earner (usually the mother) to return to work thus perpetuating the 'traditional' male breadwinner family with the dependent mother.

Cash payments to adult carers are more common and may take the form of social security payments to the carer in recognition of foregone earnings as is the case with the non contributory Carers' Allowance in the UK. Other allowances, such as Attendance Allowances are paid directly to the person with disabilities in recognition that they have additional needs. They are usually free to spend it as they choose. More recently, Austria, Germany, England and the Netherlands have introduced Direct Payments and/or Individual Budgets. These are replacing directly provided public services for children and adults with disabilities as well as older people needing care. As Ungerson noted the main difference between these schemes is whether or not they allow the payment of migrant care workers and co-resident relatives. England is unusual within the EU15 in only very exceptionally allowing Direct Payments to be used to pay co-resident relatives. Sweden and Austria do not allow payment of spouses, but all other co-resident relatives are acceptable as they are elsewhere in the EU.

In continental and northern Europe there is an understanding that payment for elder care not only sustains informal care but that it is very good value for money because relatives invariably provide far more care than they are paid for. Welfare state provision *complements* family care. The policy issue is how to avoid creating disincentives for carers to stay in or return to employment. In contrast, in England public provision is believed to *substitute* for family care so paying relatives is a deadweight cost. Worse, there is a belief which can be traced back to the early 19th century, that state support, whether in the form of cash or free services, *undermines* families' motivation to care. The UK government accepted the minority report to the 1999 Royal Commission on Long Term Care which argued against the majority which proposed free personal care for older people given on the same basis as health care. The authors were also against paying relatives for care because "most care without giving thought to the financial cost of caring, it somehow demeans them to reduce their dedication to cash amounts." (RC on Long Term Care, 1999, Note of Dissent, p133). The now devolved Scottish parliament introduced free personal care in 2002 and subsequently found that informal carers provided *more* not less care, though they did care differently. (Bell and Bowles, 2006).

Childcare and Eldercare: different agendas

Social policies on care are a manifestation of social solidarity between the generations both at the level of individual families and of wider society. For a society to survive, the adult generation must care, maintain and protect the younger generation until they are old enough to support themselves and contribute to the wider society. In return, they can expect to be supported when they become too frail to do so for themselves. Care can be seen as a public good in itself and to some extent all welfare states take such a view. However such a view is overlaid, in varying degrees in different countries, by other

agendas which differ for children and adults. As a result the common pressures on care policies outlined in the previous sections impact in differently on policies with respect to adult and child care.

Welfare states are required to spend more, because not only are the costs of care and numbers needing care rising, but also an ageing population means an increasing proportion with claims for income support from the state. This has led governments to look to the revenue sides of their budgets and in particular to attempt to increase revenues by ensuring high levels of employment among those of working age - thus the European Employment Strategy's target employment rates. Further, in a globalising world of increasing wage inequality and rapidly falling wages for the unskilled, education and training are seen, possibly over-optimistically, to provide the way in which western democracies can retain their higher standard of living while opening their borders to cheap imported goods. A corollary of this view is that the provisions of the welfare state can only be afforded if not only an increasing proportion of the working age population is in employment, but that working population has enhanced levels of human capital and the skills to function in increasingly individualised societies, where smaller numbers will be able to rely on less generous state support. This has generated increased interest in what happens to children in their early years, which recent research has shown to be particularly important for cognitive and behavioural development. In this way, the agenda on childcare encompasses an investment agenda too.

The provision of childcare is relevant to such investment in children in two ways. Both the quality of care received by pre-school children and the standard of living of their families have been shown to affect their future outcomes. Formal childcare can therefore be seen as a direct investment in the productivity of future workers both through ensuring the required inputs into their future productivity and by enabling both parents to stay attached to the labour market thereby improving family living standards. The language of "investment" is thus often used with respect to children and childcare¹.

Formal childcare is also explicitly recognised as necessary to boosting overall employment rates and the skill development of young mothers. That is why the EES includes specific targets for childcare as well as for the employment of women. Although the extent to which in many countries older people, particularly older women, are involved in the care of grandchildren is not explicitly recognised in the EES, in practice formal childcare may enable some older workers to take employment too. However, the situation here is more complicated because formal and informal care are not direct substitutes for each other; where formal childcare does not provide the flexibility that maternal care did, it is often grandmothers that step in, to the detriment of their own employment prospects. The British Government acknowledged in their latest Childcare Strategy document, "informal care is frequently the 'glue' that holds different childcare arrangements together" (DfES, 2004, p37).

¹ Although childcare is not categorised as investment by international fiscal rules which put spending on childcare under current expenditure rather than in the investment account, even though the rationale of the distinction is supposed to be between spending which benefits future tax payers versus spending whose benefits are short-term and direct (IFS 2007, p28/9).

Current discussions about the willingness and capacity of families to care often refer to a care 'crisis', 'deficit' or 'gap'. A more accurate and revealing term would be care 'reserves'. Some are now in danger of becoming depleted, not so much because of the growing economic activity rates of mothers or because families are less inclined to care but because significant numbers of *older* women, who in a number of countries (traditionally in the case of Britain (Roberts, 1986, Glucksmann, 2000) or as a response to the very recent entry of mothers in the labour market without adequate childcare services in place as in the case of Spain (Tobio, 2004)), are providing childcare for their grandchildren.

With respect to care of younger people with disabilities, there is also some interest in the disabled person's own potential productivity; in particular, that some types of care might enable employment more readily than other more standard less well thought-out forms of care. Thus one reason that direct payments (cash rather than services) have found support from governments is a belief that the flexible types of care they should facilitate would increase the potential productivity of younger people with disabilities.

For older people needing care, there is little if any interest in their own productivity and much less interest in the labour market potential of their carers, perhaps because the carers are on average older than the mothers whose employment is interrupted by the care of young children. Though this may be changing; the EES has a specific target for older workers as well as for women, but as yet no specific targets for replacement social care provision as there is for childcare. There is perhaps less consensus on what form that provision should take for the needs of older people are more diverse and unpredictable than those of children. In addition, unlike the mothers of pre-school children, there seems little interest in the training of older workers, who are considered to need jobs rather than careers. However, with rising retirement ages, the potential loss of productivity of 50 year olds may start to figure more, particularly as it involves men nearly as much as women. In addition, future cohorts of older carers may have different expectations and a stronger attachment to the labour market.

Nor is there much recognition of the consequences of increased numbers of older workers being in employment on the need for replacement care services. Just as it does for childcare but to a much greater extent, increasing the economic activity rates of older workers *decreases* the availability of informal social carers and so will *increase* the cost of elder care (unless prepared to see wellbeing of frail elderly people decline).

The impact of demographic changes may be different on families' capacity to provide elder care, however. While the patterns of marriage and childbearing of women across most of Western Europe who were born in the 1930s and 1940s, means women in their fifties and early sixties are currently the most likely members of the family to be caring for frail elderly parents, these same demographic patterns together with increased

longevity and a narrowing mortality gap between men and women means marriages are lasting well into old age. Already, elderly men are more involved in care-giving than their fathers were and, on the basis of a recent study of twelve OECD countries, it is anticipated that 'the role of spouses and other senior care givers may increase...' (Lundsgaard, 2005, p30).

In countries without the big imbalance between numbers of older men and women as a result of the Second World War, some demographers argue that as far as the current generation of elderly are concerned until 2030 the potential for informal care has never been greater (Pickard et al 2003). There are therefore proposals that formal care services to replace informal elder care should give priority to filial over spousal carers precisely because they are more likely to be in the labour market (Lundsgaard, 2005 and Wanless, 2006). In this context the decline of three generation households discussed earlier, may *not* result in an overall decline in intensive eldercare but a shift from filial care to spousal care thus reducing the problem of older workers combining employment with the care of elderly parents. The support which elderly spouses, especially husbands may need to care adequately is however rarely discussed, although research shows husbands and wives care for each other differently. (Rose and Bruce, 1995). It is likely that they will need more than some respite care from time to time as currently suggested (Lundsgaard, 2005, Wanless, 2006).

Nevertheless, because formal care does not substitute for informal childcare and eldercare in a simple way, the types of employment that are compatible with caring responsibilities will have to increase. Even in those countries with high levels of formal childcare and elder care services, informal care still outweighs formal provision, showing that to increase employment rates among carers employment policy as well as policy on care has to change. For example, there is evidence that grandmothers are being called on more than in the past to provide childcare even in those countries such as France where formal service provision is still high (Tobio, 2004). On the one hand, regulations requiring employers to become more flexible in their working hours in the interests of their employees, are beginning to be introduced even in the UK, which prides itself on having a very lightly regulated labour market. However, on the other hand, labour markets are changing in ways which are structuring patterns of care differently from the past. 'Atypical' work is increasing, albeit unevenly, across Europe, as it is argued that labour markets require ever more flexible workers in the name of greater efficiency and productivity.

The current debate about how to combine more flexible forms of work with minimum social rights for all workers (Commission of the European Communities, 2006) is highly contentious. It also has both strong gender and intergenerational dimensions since it is women, older and also younger workers who are engaged on non-standard contracts. (*ibid*, p8). Policies for reconciling family life and employment have therefore become more complex for the flexibility required by those with caring responsibilities may be very different from what employers and consumers want and expect.

The more significant other agenda driving policy with respect to the care of older people is concern with value for money. This agenda can dominate adult care, with the prime ways of saving money being providing choice. This can be seen both as a way to make market forces work to reduce costs; keeping people out of residential and hospital care as far as possible; or by allowing the choice of paying close relatives ensuring that a large proportion of care remains unpaid because they will always provide more care than they are paid for. Unlike other countries of the EU15, England favours the former approach. All these approaches can be successful, but also have inherent drawbacks that may render them ineffective or unsustainable in the long-run.

Market forces can reduce costs, but because of the inherent difficulties in raising productivity in care, tends to do so, as we have seen, by reducing wages, employment and training standards and consequently in many cases the standard of care. Such changes may not be sustainable in the long-term as recruitment and retention problems are magnified. Nor may they be politically sustainable if the quality of care descends below a level that the electorate find acceptable. Direct payments or the development of a regulated market in care do not have to function in this way. But if they are primarily seen as a way of saving money, they are more likely to do so.

Keeping people out of residential and hospital care as long as possible has been a long-standing cost containment measure, and a policy that largely accords with older people's own wishes. With decreasing co-residence with adult children who anyway are expected to be active in the labour market, such an approach requires home care services. But where social care budgets fail to keep up with rising costs, home care services come under increasing financial strain. One way to solve such problems in the short-term is to reduced eligibility to those with the most severe needs, hoping that family and friends will care in other cases. However family and friends may not be nearby and their willingness and ability to care varies. This is a high risk strategy that makes the person needing care vulnerable and removes the independence that policy in other respects is claiming to promote. It may also, of course, be incompatible with the policy of encouraging higher rates of employment among older workers. Such a policy of relying on informal unpaid care is certainly not costless, even from the point of view of governments, when that informal care comes at the expense of employment.

Finding ways to ensure that people pay for their own care can only be a long term strategy, one that governments are adopting to varying extent. Changing eligibility rules and distinguishing between personal and medical care may induce people to make provision for their own long-run needs if there have the resources to do so, but in the short-run it will not help with the rising cost of care. Moreover many of those most likely to need intensive long term care in their old age are often already in poor health with low earnings in their middle years (see Wanless,2006 for example). Further this does not answer the question of who should be doing the caring and on what terms. In any event, an increasing amount of care will be needed whether financed by the state, by individuals needing care themselves or the unpaid work of informal carers.

Thus the value for money agenda that dominates policy on care for older people is not one that is likely to be effective in reducing welfare bills, except at the expense of the quality of care received and the independence and autonomy of those needing care. For reasons explored in the previous sections more not fewer resources for care in general and older people in particular will be needed. This means that any particular set of policies that work to reduce costs in one policy area or to one group of people, simply increase costs somewhere else, if by costs we include the costs of unpaid care to the carers themselves and the costs of not receiving adequate care to the well-being of care recipients.

Some of these strategies for saving money have been applied to childcare too: for example, the use of subsidies to market provision in some countries and income dependent fees for state provision in others. However, because childcare is also seen as an investment in having “better” adults in the future, some of these contradictions in trying to save money are better recognised. Thus, for example, in the UK there is a clear division between universally provided free early years education, spending on which is justified in terms of benefit to the child, and childcare subsidies which are means-tested, limited to low to middle income families, and provided only for those children whose parents are in employment.

Further, childcare differs from elder care in that the range of costs of different childcare settings may not be so large, so the savings to be made in going for the cheapest are not so great. Nearly all children live with their parents and are cared for by them for most hours of the day². This means that the net gain to the economy from subsidising formal care for a child so that their parents can be employed can quite easily be calculated. This appears to have been done in calculating the childcare element of the UK’s WTC, where the level of subsidies to childcare does not increase after the second child. When a parent needs subsidised childcare for more than two children to be able to take employment, the government seems not to consider the net pay-off to the economy sufficient. Not surprisingly poverty rates among larger families in Britain are higher than among smaller families because amongst other things, they are more likely to depend on fathers’ earnings only (DWP, 2004)

Adults have much greater unpredictability and variety in their care needs, both in the length of time for which care will be needed and in the mix of care needs that are met or financed by the state, are met by informal care or financed by those needing care themselves. Further the responsibilities of family for the care of adults can be less automatically assumed. Practices vary in different countries, but the automatic assumption that in normal circumstances children will live with and be cared for by their parents, except when the parents are actually working, cannot reliably be made for adults needing care, except with respect to spouses.

Finally, these different agendas are reflected in different outcome measures for children, disabled and frail elderly. Childcare services are justified and evaluated using measures

² Parental care is partially funded by systems of paid leave from employment for parents, which are not available to anything like the same extent for other carers.

incorporating wellbeing and child development (that are more or less broadly defined in different countries) and in some countries measures of social inclusion (OECD,2006). In the case of older people, outcome measures are less likely to include the health and well-being of the person being cared for, but more likely to be length of time kept out of institutional care. The well being of carers attracts even less attention although there is substantial and growing evidence that their health is adversely affected by long periods of care (Lundesgaard,2005). Standards of the services which older people receive either in their own or residential homes are more often measured and monitored in terms of inputs rather than outcomes (see Wanless 2006 and CSCI, 2007).

Conclusion

Care which is adequate in quantity and quality will not be forthcoming unless societies are willing to spend a higher proportion of national budgets on care provision now and in the future. This is currently recognised more in the case of childcare than eldercare, not least because the consequences of inadequate childcare for children are taken more seriously than those arising from inadequate elder care and younger women's behaviour and prospects in the labour market are accorded more importance than those of older women. Replacing services with cash may appear to offer greater choice as well as containing costs to the public purse in the short run, only if the development of childcare and eldercare provision is considered in isolation from employment, health, education and broader taxation and benefit policies.

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