

Gender, Care, and the Welfare State



Clare Ungerson

This chapter outlines the way in which feminist debates surrounding care have developed, particularly in the latter half of the twentieth century. Much of this debate has been concerned with unpaid 'informal' care which takes place within households, and where it was initially assumed women very much predominated as household carers. The chapter suggests that this assumption was in certain respects oversimplified, and that succeeding debates have taken into account that men care, too, that disabled people feel demeaned by the whole notion of 'care', and that a gendered perspective on care has also to take account of a perspective informed by 'race' and ethnicity. This last perspective has encouraged widening the concept of care to include work carried out within households by non-kin and eventually to a discussion of paid as well as unpaid care. The chapter then goes on to consider various social policies for care as they have recently developed in welfare states and uses a cross-national perspective to discuss the various ways in which different social policies impact on gender and care.

DEVELOPING AN UNDERSTANDING OF CARE IN THE TWENTIETH CENTURY

Western feminism, both first and second waves, has always problematized 'care'. The first wave, around the time of the First World War, was very largely concerned with women's right to vote. But once suffrage had been granted, suffragists, certainly in Britain, turned their attention to the meaning of 'equal citizenship' and, in particular, how mothers both as workers and as carers should be guaranteed equality with men. In debates that continued to the period immediately after the Second World War, they discussed whether or not the care activities encapsulated in the word 'motherhood' should be provided by the state in the form of nurseries for children, or whether mothers should be compensated for the care work they undertook through

payment by the state of benefits related to the number of children they cared for. Those who argued for cash support, named by its supporters the 'endowment of motherhood', argued that the receipt of family allowances or child benefits would, at one and the same time, alleviate family poverty, provide mothers with an independent income, and undermine the concept of the 'family wage' which men trade unionists used to boost the wages of men workers (Rathbone, 1917; 1924). Those who argued for state services suggested that cash payments related to care treated women like 'domestic tabby cats' because they relied on the assumption that women were natural carers and homemakers (Nield Chew, 1982). Thus, from the start of the twentieth century onwards, care, particularly the care of children, divided feminists and raised the question as to how care should be provided while at the same time admitting women to full citizenship.

In the second wave of feminism in the late 1960s and 1970s, feminists again took up the question as to how 'care' should be analysed and compensated. At this point, the meaning of the word 'care' expanded to include, quite explicitly, the care of adults with dependencies arising out of what were then called 'handicaps', both mental and physical, and the frailties associated with old age. This expansion reflected two contextual changes which had occurred since the period of suffragist feminism: the ageing of the population and the rapid increase in life expectancy that had occurred across all social classes (but differentially) throughout the twentieth century, and the reversal of long-standing policies (at least two centuries old) that until the 1950s had removed individuals with special needs from their communities and families of origin and sent them to institutions well away from centres of population. The new policies of 'community care' had been fuelled by the discovery of drug therapy for mental illness in the 1950s and by the highly critical analysis, by Erving Goffman and others, of institutional life (Goffman, 1961; Townsend, 1962). Feminist scholarship, by expanding the term 'care' to include, as its objects, *both* adults with special needs *and* children, was simply reflecting a social reality driven by demographic and policy changes. But it was the strength of the analysis brought to bear by feminists on the meaning of 'care' that was to have highly significant impacts on both continuing feminist scholarship into the twenty-first century and, slowly but surely, on the development of policy for people with special needs, and *for their carers*, in the developed welfare states of Western and Northern Europe.

The analysis of 'care' in second-wave feminism, in its early stages and certainly within the British context, emphasized the care of people, both adults and children, with 'special needs' arising out of learning and physical disabilities, mental illness, and the frailty of old age and chronic illness (Finch and Groves, 1980). At the same time, other scholars pursued an analysis of policies for child care and the compatibility of responsibility for child care with participation in paid work (Moss and Fonda, 1980; Sharpe, 1984). This bifurcation of the analysis of care into, on the one hand, the care of people with disabilities and, on the other, the care of 'normal' children was common in the influential British literature. In more recent writing, the influence of feminist

analysis, coming particularly from the Nordic countries, has taken the concept of care into the more aggregated phenomenon of care for children as well as care for people with other dependencies (Hobson, Lewis, and Siim, 2002). This chapter will take 'care' to mean, largely, the care of adults with special needs.

The initial impetus for the feminist critique was based on the analysis of the policy-makers' implicit assumption of the availability of women in the home to undertake the care of people with special needs. From the beginning, the analysis was informed by the strands that were then emerging in second-wave feminism. For example, liberal feminists argued from a perspective of equal rights between men and women that even where there were shifting policy recognitions of the role of carers in the provision of welfare, such as the British Invalid Care Allowance,¹ the fact that this social security benefit was not available for married women was a clear infringement of the principle of equal treatment of men and women (Groves and Finch, 1983). It was also a clear demonstration of the gendered construction of family life embedded in social policy. Radical feminists were principally concerned with relations between men and women within the household and the way in which both tasks and resources were allocated between them in the private domain. Care was yet another set of activities where women were organized and driven, within a patriarchal structure, to provide the primary resource for care, to the benefit of men and their kin (Delphy and Leonard, 1992). Socialist feminists, while not rejecting either of these perspectives on care, developed an analysis which emphasized the way in which the paid labour market impacted on the availability of women, rather than men, to care, and how, within specific modes of production and particular welfare states, different forms of care relations emerged, some with more 'woman-friendly' aspects than others (Ungerson, 1990).

Clearly absent from these early forms of second-wave feminist analysis was any strong recognition of difference and diversity, particularly along lines of 'race' and ethnicity, social class, and age. Similarly, there was, as yet, little development of the ideas, prominent now in the North American literature, of an essentialist argument that women learn, from an early age, a distinct moral framework of care (Gilligan, 1982).² Without an analysis that incorporated differences among women, once British feminists working at the forefront of this field had identified what they called informal care and the role of women in its provision, they concentrated on identifying why (all) women, rather than (all) men, were the providers of informal care. Much of their analysis was constructed within an argument about culture and what Janet Finch (1989) called 'normative guidelines' prevalent within society that formed the basis for the emergence of carers. Her work, as with many others, tended to take existing literature and small samples as the foundation for their case. Using gender and kin relations as the two main variables, many writers in the early 1980s found evidence of clear 'rules' or 'guidelines' as to who was an appropriate carer. For example, Hazel Qureshi and Alan Walker

(1989) suggested a 'hierarchy of obligation' which identified spouses as first port of call, and then daughters and daughters-in-law.

The strong feature of this early work on motivation was an assumption of a relatively homogeneous contextual culture and very little recognition of how hierarchies of obligation might vary across the many subnational and transnational communities then emerging in multiethnic Western societies with developed welfare states. Moreover, there was a marked absence in the early analysis of men as carers, despite, in the work of Qureshi and Walker, the top 'spot' in their hierarchy of obligation being taken by 'spouses' – of either gender. Scholarship rooted in feminism continued, quite understandably, to put women centre stage. In my small study of carers of elderly people undertaken in the mid 1980s, I had identified men who were carers, in this case, as one might expect, of their wives (Ungerson, 1987). I developed a gendered analysis of motivation to care, suggesting that men did it out of love for and a sense of reciprocity towards their particular wives, while women did it out of a mix of motivations. These were largely founded on a more general sense of duty based on a set of culturally determined norms of what 'women' are expected to do in relation to people with special needs within their kin networks.

The emergence of men as carers became a major issue in the literature, certainly in Britain, in the late 1980s and early 1990s. The shift in focus was largely due to the quantitative data set on informal care that was developed from questions included in 1985 in the government-sponsored national annual survey in Britain known as the General Household Survey. There have since been two repeats of these questions in 1990 and 1995, so that there is now very good longitudinal quantitative data available on informal care activities in Britain. The first report of this data, published in 1988, indicated, to the astonishment of those who had developed the feminist analysis of informal care, that proportionately almost as many men as women were carers – or at least claimed to provide services for someone 'with special needs' in the same household or beyond it (Green, 1988). What was more surprising was that there was even less difference in the proportions of men and women who provided care that consumed a lot of time (over twenty hours a week). Secondary analysis of the GHS data demonstrated that men tended to be concentrated among the carers aged 65 and over who were caring for their wives. Women, on the other hand, while also carers of their husbands, were more likely than men to be caring in their own middle age, and for people with special needs of an older or younger generation. When the particular tasks of care were analysed, it became clear that women were proportionately more than men involved with personal tasks that involved intimate bodily contact.

While these findings accorded with the earlier feminist scholarship that identified women as predominant among carers, it nevertheless became clear, and has been accepted in the literature on gender and informal care, that men care, too (Arber, 1989; Fisher, 1994). The early feminist literature had its origins in the workings of the family and the household. In recognizing the

170

role of men in caregiving, feminist analysts have developed the literature on care such that gender and differences between men and women carers are examined within a framework of work, both paid and unpaid, as well as within a framework of the underpinnings of citizenship for those who care.

The second debate that overtook the early feminist analysis of informal care arose out of a strong critique from disabled feminists writing from a perspective of 'independence' or 'independent living'. They took strong objection to a number of aspects of the early feminist literature (Morris, 1991). First, they objected to the way in which care was construed as necessarily a burden, and complained that the person being cared for was treated as an object of care with no agency, let alone autonomy. The frequent use of the terms 'dependants', 'dependency', 'people with dependencies', 'the cared for', in the early literature was, to disabled people in general and disabled feminists in particular, offensive and inaccurate, describing a passive and dependent state that they were fighting to be free of. Second, they objected to the way in which some feminists, in particular Finch (1984) and Gillian Dalley (1988), had suggested that the solution to the problem of informal care and women's apparent predominance within it lay in the re-establishment of residential care – or, in the case of Dalley, collective and communitarian care – whereby dependent people would be cared for within communal rather than familial settings. Again, such a recommendation was antithetical to the way in which disabled people were developing their analysis of disability. They were campaigning to leave residential care and were promoting 'independent living' whereby they could live independently of both formal and informal care through the use of paid personal assistants employed directly by themselves (Morris, 1993). Finally, as some of these disabled feminists pointed out, they were, as mothers, carers themselves (Keith and Morris, 1996). In effect, what their critique pointed out was that just as feminist scholarship had claimed that women had been treated as objects with no autonomy, so feminist scholars who were analysts of care had proceeded to do exactly the same to disabled people.

This argument, along with the recognition that men were carers too, brought into focus the way in which early feminist scholarship had over-generalized the way gender impacted on the emergence and practice of care, and, similarly, had over-emphasized cultural homogeneity in determining motivations and obligations to care. Much of the early literature had failed to recognize difference and diversity across class, racial and ethnic groups, age, and disability. These additional variables have to be taken into account if we are to understand fully the way in which care is constructed, how it emerges within particular configurations of expressed need, and how the practice of informal care is structured within particular welfare states.

Two further strands of scholarship informed the development of a more nuanced analysis. First, the emergence of Black feminism, with its critique of the ethnocentricity of the early second wave, opened up the analysis of care to

include care delivered within the private domain by non-kin. (Historically, such care had been the work of Black slaves in ante-bellum North America.) Once home care by non-kin was recognized, it was a small step to include paid care delivered to people who continued to live in their own homes (Graham, 1991).

The second strand of scholarship that fed into the developing analysis of care was the increasing amount of cross-national research and data available, particularly on an EU basis. This data allowed for and encouraged an increasingly sophisticated study of social policy across national boundaries. It steadily became more and more possible to demonstrate that the configuration of care, how it was practised, and who undertook these activities, was at least partially determined by the nature of the particular welfare state in which those activities took place. In this respect, the Scandinavian countries, particularly Sweden and Denmark, rapidly came to be seen as welfare states that were arguably 'woman-friendly' (Hernes, 1987). In these countries, and to a slightly lesser extent in Norway and Finland, the work of care for both elderly and disabled people and for 'normal' children was understood to be an important activity of the state, but where families, and both men and women within them, were recognized as vital deliverers of care. The assumption was that family members worked alongside the state but that the state was on the whole responsible for providing, through paid home and residential care, the practical tasks of care (caring for), thus freeing kin to provide the affective relations of care (caring about) that underpin high-quality care. Moreover, in all the Scandinavian countries, paid employment and a system of care leaves embedded within it was organized in such a way that both men and women could relatively easily combine full-time paid work with the unpaid work of child care and adult care. Using cross-national analysis, scholars were able to develop a more complete understanding of how different welfare states, at a macro level, can profoundly influence, at a micro level, the nature of the informal care relationship, and how and in what way it is gendered (Ungerson, 1990).

THE WELFARE STATE, GENDER, AND CARE

Cross-national research on gender and care has fed into the literature on gendered citizenship. The central difficulty has been that it is very difficult to see how, in welfare states that commonly stress paid work as the preferred route in the acquisition of social rights, care for both 'normal' children and people with special needs can be integrated into a support system where the activity of paid work is treated as morally, symbolically, and practically superior to the activities of unpaid care. Various policy configurations that deal with the conundrum of care and citizenship present themselves, and each has different gendered implications.

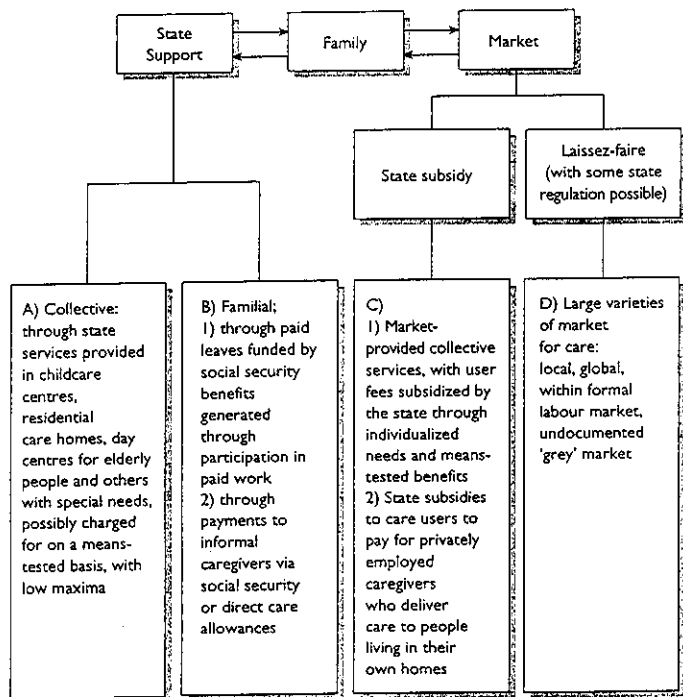


Figure 15.1 Different types of care policy and provision: state and market

In Figure 15.1, a number of the options for state support of care are laid out schematically. The basic distinction is between support from the state for families and households that find themselves faced with the tasks of care, and policy that basically leaves support for people with special needs (and often support for children) to the market and provision to private enterprise. Straddling both state and market in the sense that it has a relation with both is the family or families. First, families pay taxes and individuals within them pay social security contributions. Second, individuals within them are, notionally anyway, the final arbiters of government policy through the democratic process, as well as being consumers of state- and market-provided services. Third, in many welfare state systems, particularly those of Western continental Europe, families are the basis on which needs for services and the charges for them are assessed. Delivery of cash and services to support care is organized in various complex ways in many developed welfare states. Each of these arrangements has profoundly different implications for women, both as paid workers within formally organized care services and as unpaid

carers within their families and kin networks. The next section of this chapter outlines some of the gendered impacts and the politics of these different arrangements for care.

The state can and does support care in a wide variety of ways: it can provide care services for both children and people with special needs directly, it can subsidize those who use market-based services, and it can regulate markets. In Figure 15.1, the traditional way in which welfare states support care is outlined in box A. Here, the state directly provides care services which are funded largely through taxation, although there may be some (usually) very low and generally means-tested charges. The front-line care delivery workers within these services are predominantly women state employees. As state employees, they may be privileged compared with care workers employed in for-profit care enterprises, but they are still likely to be low paid. The low pay follows from the assumption that the occupation of care is unskilled and can be competently delivered by any woman, especially if she has gained experience through motherhood. Nevertheless, this type of delivery of care is probably the best situation for paid women care workers to find themselves in. They can organize collectively into trade unions and occupational associations, they may have access to career progression into management, and, increasingly, as welfare states modernize and respond to consumerism, they are likely to have access to training and generally recognized qualifications.

As consumers of care in these types of settings, women may well find themselves in difficulties. If the services are of high quality – as they are in the Scandinavian countries – they will almost certainly be heavily rationed, possibly through targeting only to those in very great need, or through long waiting times. Such services may also become stigmatized since, even if they are of high quality, but available only, for example, to children with special needs or at risk of abuse, then mothers and other carers may prefer to find their own solutions. If the services are of low quality – as in the previous command and control economies of the one-time Soviet bloc – then users may prefer, at high personal costs, to stay away from them, and, if they are in need of care, use their kin networks as their support system.

These collective service-based solutions to the problem of care hark back to the old debates, in the early part of the twentieth century, as to whether care is best supported through services or through cash and which form of support underwrites women's citizenship the best. The collective-based service solution tends to be associated with the politics of the left; it is not surprising, therefore, in a period where collectivism is in decline relative to individualism to find that individualistic arrangements via both state and market are now in the ascendancy in most developed welfare states.

The first of these kinds of individualized arrangements is suggested in box B. These are systems which are funded by the state and which provide income maintenance for those who care for their own children or adults with special needs within their kin networks in their own homes. The system

172

under B1 is based on generous rights to paid leave to care for a sick or very young child or someone elderly or terminally ill, rights generated by participation in paid work. Individual citizens in these welfare states are treated as *both workers and carers*: the expectation is that all citizens will engage in paid work, and it is through that primary activity that they accumulate generous social rights. Again, the Scandinavian countries are at the forefront of developing paid leave as the means whereby care of many different kinds can be best supported. The amount of payment is highly earnings related, and individuals have rights to return to their previous occupations at the end of the leave.

Some systems, notably in Norway and Sweden, have developed incentives within the leave system itself so that the gendered division of labour, whereby mothers rather than fathers take time off to care for newborns, begins to break down (see Leira, 1998, for an analysis of the Norwegian 'Daddy leave'). These individualized solutions to the problem of care have embedded within them an idea that the best and most preferred form of care is that provided by kin in a domestic and intimate setting. In the case of care of elderly people, the provision of care leaves for workers means that, in effect, support is being given for intragenerational care, rather than intergenerational care.

It is a small step from this form of state-supported care to systems which, rather than using social rights to income maintenance during periods of care leave, instead actually pay carers to stay at home to care for their children or adults with special needs. An example is the system of Finnish Home Care Allowances, which pay parents and other caregivers who stay at home to care for their children and adults with special needs at rates similar to those generated in the paid labour market for care work. These kinds of payment could be construed as constituting what early second-wave feminists called 'wages for housework'. While they clearly constitute a form of compensation and recognition of formerly unpaid care work, it is more difficult to build in gender-bending incentives, since the levels of the allowances tend to be relatively low and therefore unattractive to high earners.

The home care allowances may compensate and recognize care, but they tend to embed a highly gendered division of labour. In 2004, the British Conservative Party discussed the Finnish Home Care Allowance as a possible basis for the development of an allowance (£150 a week) which they considered would be enough to encourage British mothers of pre-school children to stay at home to care for their children. They have since abandoned these ideas in favour of benefits which encourage mothers to enter paid work as well as care but would allow them to pay their children's grandparents (for 'grandparent' read 'grandmother') with childcare benefits. Such cash-based solutions to the problem of care are therefore, potentially, a policy of the right. If allowances are paid only to mothers, they embed a gendered division of labour and reintroduce a traditional model of family life, based on the breadwinner husband/carer wife model.

Increasingly, welfare states are pursuing a mix of individualized solutions to the problem of care, including support for the development of private markets for its provision. Some of this support comes in the form of means-tested supplemental benefits for care users who enter private for-profit residential and nursing care (if they are frail and elderly, for example) or employ carers to work in their homes. These kinds of market solutions to the problem of care are outlined in box C in Figure 15.1.

The gender implications of each of these types of state-subsidized market activities are complex. In the first place, any means testing for consumers of care who are themselves elderly is highly likely to mean that the chief beneficiaries of lower or subsidized fees for service will be women, since, given their biographies of low pay and unpaid work, women are much more likely to be poor in old age than men are. So, if a means-testing system works properly, at least those on very low levels of income should benefit. But they will be buying a service provided for them by other women who are *currently* low paid and working for profit-making care enterprises determined to extract maximum labour for the least cost. Many of these women paid caregivers will be part of the global care market sucked into the vortex of highly developed welfare states which seek care labour wherever they can find it (Anderson, 2000; Ehrenreich and Hochschild, 2002). Much of that care labour will consist of documented women migrants from the poorer nations of transitional Europe and the very poor nations of the Second and Third Worlds.³ Not all the paid care workers will be migrants; there will also be local labour, again predominantly women, providing care in people's homes and in residential care facilities. Most of them will be low paid and lacking in qualifications.⁴ In sum, it is a feature of the private sector care market that it draws on both local and global labour, of whom the huge majority are women.

Other types of state support for the private market come in the form of subsidizing care users' effective demand so that they are able to employ their own labour to deliver care for them in their own homes. The names for these types of payment in different countries – 'direct payments in Britain,' 'consumer-directed care' in the United States, 'personal budgets' in the Netherlands, 'companion payments' in Italy – indicate that care users are free to spend the money as they wish. The assumption in most of these schemes is that they will use it to employ their own caring labour directly. There are large variations among these systems, but the two most important are whether or not the cash can be used to employ and pay relatives, and whether or not there are any regulations to ensure that those who are employed are covered for social security and other employment rights (Ungerson, 2004).

The gendered implications of these schemes, which are rapidly growing in importance, are considerable. In those schemes which allow care users to pay their relatives, we have a very clear example of the commodification of intimate caring relationships – wages are being paid for informal care which was, until the scheme was introduced, wageless. Once again, this has echoes

of the old 'wages for housework' debate and whether the payment of wages for work in the domestic domain carried out by family members is a form of recognition of the importance of domestic labour or whether, in practice, it is demeaning for women (and men who care for their wives) and likely to trap them into the demanding and isolating tasks of care delivered at home.

The question of regulation also raises issues of gender, since, in the systems where regulation is strict, it can ensure that care workers are properly covered for social security and related rights and thus escape the common fate of unpaid carers who usually lose full social security and pension entitlements. In the Dutch 'personal budget' scheme, for example, relatives including spouses can be paid and are elaborately contracted to do so, and at the same time they are included in formal labour market regulation, fully integrated into social security and taxation systems, and entitled to holiday rights and other work-related benefits. Not surprisingly, paid caregivers (and the great majority of them are women) in this kind of system report high levels of satisfaction and a sense of full citizenship (Ungerson, 2003). There are also gendered implications for the schemes that are not regulated, for it is here that care labour can be most easily recruited from undocumented migrants and from local labour seeking, illegally, to supplement low social security benefits. Given the highly feminized nature of care work, it is most likely that these entirely unprotected workers will be women, but given the invisibility of this type of 'grey' labour located within the domestic domain, it is impossible to quantify gender breakdowns. Such labour is easily exploited, especially if the workers are co-resident with the people they care for. Many such workers, with no rights of residence, seek out live-in work to resolve their own housing needs. Of course, that means they lose their own living space and control over their own time (Ungerson and Yeandle, 2005).

Box D in Figure 15.1 depicts the situation where the state takes little interest in the way people satisfy their care needs and largely ignores the care market, on both the demand and supply sides. There may be some attempt to regulate the market through incentives encouraging the registration of workers for tax and social security,⁵ but on the whole, this market and the workers in it are left to their own devices. Typically, such markets exist alongside residual state services which are heavily targeted towards those in highest need and/or to those on lowest incomes. Such free markets cater to those who are not eligible for the more regulated state services or for subsidies for collectively provided private sector services. The workers will again almost certainly be women, many of them migrants without documents, and so in the most vulnerable position in terms of their social and employment protection.

Thus, the debates about the future of care, in particular long-term care of elderly people, and the way in which it is gendered are closely tied to the way in which welfare states are developing. In particular, the trends towards individualism, consumerism, and privatization are moving the site of care, except for the very frail elderly, into the home and into the control, through cash injection, of care users. This market-based care is a highly gendered world – of

elderly women in need of care and of younger low-paid women, some of them deeply vulnerable to exploitation, who provide it for them through paid labour markets. Where care users cannot afford to employ their own carers or cannot afford, despite some subsidy, to access private sector residential care, they must seek out unwaged, informal care in their kin networks, where, paradoxically, the gender division of care is not so pronounced since, informally, men care, too. The alternative to this type of policy solution, which is a feature of liberal and corporatist welfare states, is that pursued in the social democratic welfare states of Scandinavia, where workers are entitled to care leaves. Within a system of care leaves, some incentives can be built in to break down the gendered division of care, but so far such incentives have been developed only in relation to the care of very young children.

INTO THE FUTURE

The traditional choice between family, state, and market as far as care is concerned is no longer straightforward, and the way in which these three institutions interact within particular policy and welfare state contexts is complex. When gender is taken into account, the possible policy choices and debates become even more difficult to untangle.

The long-standing discussion among feminists about whether motherhood in particular, or care in general, should be supported by collective services or by cash supplements, and whether care is best carried out by kin whose work is recognized and compensated for, is still unresolved. Moreover, it is impossible to ignore the impact of care policy on both the care user and the caregiver, both of whom, particularly when it comes to the care of the elderly, are likely to be women (except where elderly men are caring for their wives). The care issue is additionally complicated by the development of a globalized care labour market where those in the developed world import women workers, some undocumented.

At the core of the care issue is the question of how high-quality care can best be delivered, and whether this can be done informally by kin who are compensated and recognized as caregivers, or by paid workers who are fully protected. Welfare states are increasingly concerned with the quality of care, and in many countries, training for care and care qualifications are proliferating which, it is argued, provide the basis for high-quality care. The early assumptions made by policy-makers that 'community care' could be based on the untrained, unwaged labour of women caregivers are now giving way to an argument that high-quality care should not be based on experience but rather on expertise. In other words, high-quality care is now regarded as a *skill*. As a result, credentialism and its concomitant, occupational hierarchy, are beginning to proliferate in the field of hands-on care delivery. Slowly but surely, the kinds of occupational and organizational structures put into place

in nursing in the nineteenth and early twentieth centuries are developing in the formal care delivery sector. The outcome for women care workers working within the better organized care delivery sector, whether public or private, is likely to be considerable improvement in their working conditions and the development of a clear career structure.

But there are two profound paradoxes embedded here. First, the development of a care profession will entail higher wages and therefore higher care costs. Such labour will be too expensive for many welfare states to provide extensively or for many care users to afford to purchase. Hence, the growth of a care profession will also drive an added dependence on the caring labour of close kin – many of whom will be women caregivers who are unwaged and without social protection – and a dependence on the much cheaper grey labour of undocumented and illegal women care workers in the global/local care market. The second paradox is that even as welfare states try to improve the quality of care by introducing compulsory qualifications for formally employed care workers, so they are also seeking to maintain the informal care sector, sometimes through direct cash support to caregivers, but also by providing them with support services such as respite from care duties. Clearly, there is an ambivalence here – either high-quality care is based on training and qualification or it is not. And yet we have the spectacle of welfare states currently trying to ride two horses, arguing that care delivered by women who are not the kin of the people they care for has to be carried out by skilled professionals, whereas kin care, especially if delivered by untrained women caregivers, is 'good enough' care.

Future feminist scholarship in the area of gender and care will inevitably be concerned with these issues, many of which are very long-standing. How can care users and caregivers and workers best be protected, and what is the best configuration of family, state, or market in relation to care delivery and its gendered implications? Is 'care' a skill, and, if so, what are the implications of the professionalization of care? And how can caring labour be found that will provide for the ageing populations of the First World that does not pull out of the Third World their mothers and nurturers? There are no easy solutions to these issues, but their careful analysis will continue to demand feminist attention, since the rights and biographies of women across the globe lie at their core.

NOTES

¹ This social security benefit, introduced in 1977, compensated carers of working age who were not working in paid labour but were providing care in the home for someone with dependencies for at least thirty-five hours a week. All men between 16 and 65 years old were eligible; all women, except married women, between 16 and 60 were eligible. The law was only changed to include married women after a test case on grounds of gender discrimination was taken to the European Court of Justice in 1987.

² Carol Gilligan's moral framework was later developed by Joan Tronto (1993) and Selma Sevenhuijsen (1998) into their feminist conceptualization of an 'ethic of care'.

³ Typically, these workers are Mexicans for California, Latin Americans for Italy, North Africans for France, Filipinas, Malaysians, West and East Africans, and Afro-Caribbeans for Britain, Turks and Central and Southern Europeans for Germany and Austria.

⁴ In Britain, there are now considerable efforts, under the *Care Standards Act, 2000* to ensure that at least 50 per cent of such care workers have a minimum care qualification by 2008.

⁵ In France, for example, there are voucher schemes for care users which are contingent on the employment of documented workers.

REFERENCES

- Anderson, Bridget (2000) *Doing the dirty work? The global politics of domestic labour*. London: Zed Books.
- Arber, Sara (1989) 'Men, the forgotten carers', *Sociology*, vol. 23, no. 1, pp. 111–118.
- Dalley, Gillian (1988) *Ideologies of caring: rethinking community and collectivism*. Basingstoke: Macmillan Education.
- Delphy, Christine and Diana Leonard (1992) *Familial exploitation: a new analysis of marriage in contemporary Western societies*. Cambridge: Polity Press.
- Ehrenreich, Barbara and Arlie Russell Hochschild (eds) (2002) *Global woman: nannies, maids and sex workers in the new economy*. London: Granta Books.
- Finch, Janet (1984) 'Community care: developing non-sexist alternatives', *Critical Social Policy*, Issue 9, Spring.
- Finch, Janet (1989) *Family obligations and social change*. Cambridge: Polity Press.
- Finch, Janet and Dulcie Groves (1980) 'Community care and the family: a case for equal opportunities?', *Journal of Social Policy*, vol. 9, no. 4, pp. 487–511.
- Fisher, Mike (1994) 'Man-made Care: Community Care and Older Male Carers', *British Journal of Social Work*, vol. 24, pp. 59–80.
- Gilligan, Carol (1982) *In a different voice: psychological theory and women's development*. Cambridge, MA and London: Harvard University Press.
- Goffman, Erving (1961) *Asylums: essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor Books.
- Graham, Hilary (1991) 'The Concept of Caring in Feminist Research: the case of domestic service', *Sociology*, vol. 25, no. 1, pp. 61–79.
- Green, Hazel (1988) *Informal carers: a study carried out on behalf of the Department of Health and Social Security as part of the 1985 General Household Survey*. London: HMSO.
- Groves, Dulcie and Janet Finch (1983) 'Natural selection: perspectives on entitlement to the Invalid Care Allowance', in Janet Finch and Dulcie Groves (eds), *A labour of love: women, work and caring*. London: Routledge and Kegan Paul.
- Hernes, Helga Maria (1987) *Welfare state and woman power: essays in state feminism*. Oslo: Norwegian University Press.
- Hobson, Barbara, Jane Lewis, and Birte Siim (eds) (2002) *Contested concepts in gender and social politics*. Cheltenham: Edward Elgar.
- Keith, Lois and Jenny Morris (1996) 'Easy Targets: a disability rights perspective on the "children as carers" debate', in Jenny Morris (ed.), *Encounters with Strangers: feminism and disability*. London: Women's Press.
- Leira, Arnlaug (1998) 'Caring as Social Right: Cash for Child Care and Daddy Leave', *Social Politics*, Fall.
- Morris, Jenny (1991) *Pride against prejudice: a personal politics of disability*. London: Women's Press.
- Morris, Jenny (1993) *Independent lives? Community care and disabled people*. Houndmills: Macmillan.
- Moss, Peter and Nickie Fonda (eds) (1980) *Work and the family*. London: Temple Smith.

- Nield Chew, Doris (1982) *Ada Nield Chew: the life and writings of a working woman*, London: Virago Press.
- Qureshi, Hazel and Alan Walker (1989) *The caring relationship: elderly people and their families*, Basingstoke: Macmillan.
- Rathbone, Eleanor (1917) 'The remuneration of women's service', *Economic journal*, vol. 27, pp. 55–68.
- Rathbone, Eleanor (1924) *The disinherited family: a plea for the endowment of the family*, London: Arnold.
- Sevenhuijsen, Selma (1998) *Citizenship and the ethics of care: feminist considerations on justice, morality and politics*, London: Routledge.
- Sharpe, Sue (1984) *Double identity: the lives of working mothers*, Harmondsworth: Penguin.
- Townsend, Peter (1962) *The last refuge: a survey of residential institutions and homes for the aged in England and Wales*, London: Routledge & Kegan Paul.
- Tronto, Joan (1993) *Moral boundaries: a political argument for an ethic of care*, New York and London: Routledge.
- Ungerson, Clare (1987) *Policy is personal: sex, gender and informal care*, London: Tavistock.
- Ungerson, Clare (ed.) (1990) *Gender and caring: work and welfare in Britain and Scandinavia*, New York and London: Harvester Wheatsheaf.
- Ungerson, Clare (2003) 'Commodified Care Work in European Labour Markets', *European Societies*, vol. 5, no. 4, pp. 377–396.
- Ungerson, Clare (2004) 'Whose empowerment and independence? A cross-national perspective on "cash for care" schemes', *Ageing & Society*, vol. 24, no. 2, pp. 189–212.
- Ungerson, Clare and Sue Yeandle (2005) 'Care Workers and Work-Life Balance: the Example of Domiciliary Workers', in Diane Houston (ed.), *Work-Life Balance in the 21st Century*, London: Palgrave.

Blending into Equality

Family Diversity and Gender Convergence

Molly Monahan Lang and Barbara J. Risman

Two major trends occurred in gender and families in the last half of the twentieth century in Western post-industrial societies: an increasing diversity of family structures and a trend toward what we call gender convergence between women's and men's life patterns, both inside families and outside of them. Economic and cultural revolutions, including deindustrialization and feminist social movements, have led to an increasing assortment and acceptability of family forms, as well as a weakening of previously rigid gender expectations. The trend toward gender convergence can be seen in families headed by two parents or one, gay or straight. It has also been encouraged – and discouraged – by governmental family policies. While these trends are not occurring without controversy, they are expected to continue well into the twenty-first century.

INTRODUCTION

As families change, so does gender. As gender changes, so do families. Two major trends occurred in gender and families in the last half of the twentieth century in Western post-industrial societies. First, there was clearly a trend toward a diversity of family structures. Families now come in a variety of shapes and forms and include married couples with and without children, cohabiting couples with children, single mothers, childless lesbian and gay couples and many with children, grandparents raising their grandchildren, remarried parents with their biological and stepchildren, and many other configurations. Second, there is a trend toward what we call *gender convergence* between women and men in terms of their life patterns, both inside families and outside of them. Men's and women's lives are becoming more like one another as they are less likely to be forced into social roles because of rigid gender expectations.

176