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Reducing gender inequalities to create a sustainable care system

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Introduction

Women mainly provide family care, but as women's economic opportunities increase they will not continue to bear the costs of providing care unaided. To create a sustainable care system, care and carers must be better supported and more highly valued in order to involve more men in caring and reduce gender inequalities

This paper will argue as long as most care is still provided through family obligations, unpaid but not free, since 'paid for' by reduced opportunities for carers, gender equality cannot be achieved. Family carers are mostly women, because of both gender norms and the gender pay gap, which makes it more costly for men to reduce their employment hours. As women move increasingly into employment, family carers' demand for employment will continue to rise, as will the need for paid care. The UK's long working hours make it difficult to combine caring with full-time employment, but part-time pay rates are often considerably lower. The care sector's poor pay is a large contributor to the gender pay gap and deters men from joining it. Privatisation of residential and domiciliary care has produced a labour market with insufficient opportunities for training and career development.

This situation will be unsustainable for meeting society's care needs unless: pay and conditions improve to retain more women and encourage men to enter the care sector. At the same time unpaid carers will need financial and other support. Cash payments to individuals must not be allowed to drive out funding for vital community services; Working hours need to be reduced for *all*, so that more people can combine family care with employment; Overall policies should be judged by the quality of care they support and how much they encourage a stable, less gender-divided workforce, as well as value for money. Any other solution would be unworkable, unfair and inconsistent with government commitments to reduce gender inequalities. Costs will continue to rise as the paid care sector grows, since to recruit and retain care workers, wages will have to keep up with those elsewhere. Because rising care costs are an effect of rising productivity elsewhere in the economy, paying for them will still let disposable incomes increase. Spending more on social care can be afforded.

Changing gender roles

Care in the twentieth century remained the responsibility of women *within* the family. This model of an 'independent' male breadwinner and a 'dependent' wife and mother providing unpaid care was embedded in economic and social policy. Childcare and social care services for older people were provided only for those whose families could not or would not look after them. Only in the 1990s did the care of children, and to a lesser extent older people, move more into the public realm.

As economic productivity rose so did wage levels, pushing up the opportunity costs of time out of the labour market caring for others. Women joined the expanding labour force in growing numbers. While only one in 20 employees in 1950 worked fewer than 30 hours per week, by 2000 this had risen to over one in four, mostly women, with two-thirds having caring responsibilities. Mothers were accommodated by the deliberate creation of part-time jobs. Women increasingly entered the labour force but they paid dearly for this method of reconciling paid work with family 'duties'. Part-time employment in Britain has always had lower pay, less security and fewer opportunities for training and promotion. Women working part-time earn on average just 64 per cent of full-time male wage rates, one of the EU's highest gender pay gaps (TUC, 2008). Britain's 'long hours culture' which has developed over the last 25 years disadvantages those who cannot work these hours (Manning and Petrongolo, 2005).

Twenty-first century policy has developed on the basis that women as well as men are expected to support themselves through paid work. However, less attention has been paid to the other side of the division of labour embodied in the male breadwinner/female carer model. Elevating financial 'independence' as an aspiration for all obscures the interdependence of *all* members of society, devalues care and imposes severe economic costs on the (mostly) women who provide it.

Encouraged by government policy to raise employment levels, more women have been moving into full-time employment (where the gender pay gap is smaller), producing a demand for alternative care services. Childcare subsidies and a national childcare strategy have been developed to enable mothers to take employment. However, perhaps because the carers of adults tend to be older women, little public policy has developed to provide substitute care services to enable them to take employment.

Men's roles have changed less. Although men increasingly provide unpaid care, this is primarily where no woman is available to do so (e.g. men caring for spouses). Gender differences in care-giving are decreasing among older people, but not to the same extent among those of working age. However recent policies adopted by many EU countries to raise as well as to equalise, pension ages will

have an impact on older men as well as women. The gender pay gap makes it less costly for the woman in a couple to reduce employment hours; men's long working hours limit what they can do outside of work. These factors reinforce gender norms in the division of caring responsibilities within the home.

Until recently, public policy focused on directly supporting unpaid family carers only where the male breadwinner/female housewife model did not apply. Only in the mid-1980s did married/cohabiting female carers become eligible for Carers Allowance, the benefit for carers not in employment. Expenditure on this benefit subsequently increased tenfold, reflecting carers' gender composition.

Care needs assessments are not carried out on a 'carer-blind' basis. So, irrespective of their wishes, some people – almost invariably women – have to care for relatives unsupported, because funding for alternative or complementary care is unavailable. They lose out on leisure, education and employment opportunities as well as risking damage to their health (Lundsgaard, 2005). It can also lead to substandard and possibly unsafe care, as good quality care has to be willingly given.

The quality of alternatives to family care is also an important issue for carers. Concern for the cared-for person's well-being is the motivation for providing care. Carers will not willingly substitute paid care of an inferior quality. Only if women can be sure that their relatives are well looked after in the paid care sector will they enter employment in the numbers that they, and the Government, would like.

Current spending fails to meet the demand for publicly financed care. Increasingly, only those with the greatest level of need receive any support. Inadequate public spending results in care that is 'paid for' in terms of lost opportunities by those who provide it. Losses in employment opportunities are nearly always borne by women. Crucially, this has consequences in their own old age, when women typically receive lower pensions (often below poverty levels) because they prioritised caring responsibilities over paid employment. Women's occupational pensions are on average nearly 40 per cent lower than men's (Department for Work and Pensions, 2007, p24).

Women are also the majority of care recipients: they live longer and their levels of disability are higher than men's at any given older age (Office for National Statistics, 2005). Women are less likely to receive spousal care; three in five women aged 75 and over live alone, compared with fewer than one in three men. As women are also poorer in old age, they comprise the great majority of those who need state funding for their care.

The other side of women's changing role is the growth of the paid care sector. Reflecting its 80 per cent female workforce, pay, training opportunities and career prospects in the paid care sector are particularly poor, and it is a large contributor

to the gender pay gap. As women's other opportunities improve, the sector is having increasing difficulties with recruitment and retention and is turning to other disadvantaged workers such as immigrants, often women again.

The level of public expenditure on care is therefore a gender issue, since women have greater care needs than men and fewer resources to meet them. Inadequate funding also affects women in the paid care workforce and, when paid care is not forthcoming, as those more likely to end up providing unpaid care. Thus, inadequate spending on care is effectively a transfer of resources (unpaid labour) from women to relieve taxpayers, disproportionately men, of their responsibilities to provide for the most vulnerable citizens.

As women's economic opportunities improve and they increasingly compete with men in the labour market, it is likely that women will not be willing to continue caring without increased contributions from both men and the state.

The increasing visibility of care

Social care and carers' needs have suddenly become more visible on the political agenda. The more immediate reasons include the following:

- As real wage levels have risen, the greater opportunity costs of being out of the labour force have led to increasing employment levels for women, and higher demand for alternatives to family care. Although families still provide most care, the number of full-time carers under retirement age is falling. An increasing number of people are paid to care, by the state or those needing care.
- Costs of care provision are rising, in a sector where labour is by far the largest component. As relationships in care are crucial, the scope for raising productivity without lowering quality is limited. Since women's employment opportunities have widened, rising care costs are an inevitable effect of having to pay wages that compete with those in other sectors.
- Increasing divergence in living standards in old age, between those who have built up a private pension and those who could not (often in women's cases because their employment history was reduced, interrupted or curtailed by caring), means that substantial numbers cannot afford the cost of their own care without state support.

While all major political parties resist raising taxes, demands on social care budgets have been further increased by shorter hospital stays and tighter healthcare budgets. 'Cost containment' has become a major driver for social care policy, resulting in further concerns:

- Social care budgets have not risen in line with increasing costs and demand; hence eligibility criteria for state support have been tightened and people with

social care needs 'who only five years ago qualified for council arranged help are today excluded by the system and left to fend for themselves' (Commission for Social Care Inspection (CSCI), 2008). Access to social care is increasingly seen as a 'postcode lottery'.

- Concern is growing for those ineligible for state support who are forced to rely on family and friends for care, or 'are simply left to cope with everyday life, while some are virtually trapped in their own home' (*ibid*). Most people in this situation, as well as most providing unpaid care for those lucky enough to receive any, are women.
- The quality of care provided is a concern, as staff time in residential homes is cut to the minimum and domiciliary care is provided in 'packages' (lists of tasks to be done in short, prescribed periods of time).
- Recruitment and retention difficulties in the care sector reinforce concerns about standards and reflect poor employment conditions and lack of training and career opportunities.

Two further concerns have also put care on the political agenda, though in opposite directions:

- Increasing life expectancy (combined with declining birth rates) has led to concern that there will be fewer younger people to meet growing demand for care.
- The Government (as in other European countries) is attempting to increase employment levels to pay for rising pension and social care costs. It is estimated that two million more workers will be needed in twenty-five years time (Department for Work and Pensions, 2008, p5). In particular, mothers of young children and carers of adults are being encouraged to take up employment. Of Britain's 4.5 million working-age people not in employment, over a third are carers (*ibid*). Women over 45, one in four of whom are carers, are joining the labour market in growing numbers; with appropriate support, many more would like to do so.

Whether new social care policies implemented over recent years can tackle these concerns in sustainable ways depends on whether they succeed in transforming gender divisions, so that both men and women can both contribute to care without paying too high a personal economic cost. Policies cannot succeed if those personal costs remain high: men will not take on these caring responsibilities and, with increasing outside opportunities, women will not continue to bear them on their own.

Social care provision

... the state should empower citizens to shape their own lives and the services they receive ... the best way of empowering users is to give them direct involvement in the commissioning of the services they receive.

(HM Government, Cabinet Office, 2007)

Choice and the market

Social care policies are being reformed to allow those needing care more *choice*, recognising that most people want support in their own homes. This is consistent with policy-makers' concerns to use alternatives to costly hospital and residential care. There is, therefore, consensus that flexibility in how and where to receive care should be an important policy objective.

In England, the development of markets in residential and then domiciliary care was chosen as the way to increase flexibility and choice. Whereas 25 years ago local authorities provided most social care services directly, today three-quarters are in the private for-profit sector. To increase flexibility and choice further, Direct Payments were introduced in 1997 for disabled adults under retirement age. Those needing care can use them to pay for support, including personal assistants (PAs). Introduced in response to the Independent Living Movement and other groups representing younger disabled adults (currently the majority of recipients), Direct Payments have been extended to older people. In 2006-07, they were used by 55,000 people to employ a PA, and their numbers are planned to increase substantially (Skills for Care, 2008, p5).

These changes are part of a larger shift towards a more market-oriented, consumer-focused approach within the welfare state. Underpinning this shift is a belief that market-style mechanisms are the most effective way to redress the balance of power between producers and consumers. Competition among producers should ensure value for money in meeting care needs. The motivation is to improve choice and quality, but also reduce costs.

In practice, the concern to reduce costs has limited the range of choices open to those needing care. For example:

- Older people dependent on local authority support cannot choose to enter residential care supported by their local authority until a social worker assesses them as incapable of living at home.
- To ensure that the state does not fund care which would otherwise be provided 'free', Direct Payments can only exceptionally (on a social worker's discretion) be used to employ co-resident relatives. It was thought that allowing payment of relatives would diminish the amount of unpaid care they would give. However, in many European countries without such restrictions, Direct Payments are popular *because* they can be used to pay co-resident family members, who usually do far *more* than they are paid for (Lundsgaard 2005, 2006; Ungerson 2004).
- Assessments are still not made on a 'carer-blind' basis (against the recommendation of the 1999 Royal Commission on Long Term Care). Those with an unpaid carer available do not have the choice of whether they wish to

rely on that person for their care; nor does the carer have a short-term choice whether to continue in that role.

Relatively minor public interventions enable people to maintain their lifestyle and social networks, and prevent 'isolation and loneliness ... major factors contributing to poor quality of life' (CSCI, 2008, p144). Individual cash payments cannot produce 'safe neighbourhoods, friendships and opportunities for learning and leisure, the ability to get out and about', nor can a Direct Payments system provide public transport for older people or mend the cracked pavements which cause so many falls and injuries (Audit Commission, 2004). One result of the attention to the market is that local authority spending on collective projects of specific benefit to those needing care is much curtailed.

The effects of privatisation on care quality

By 2007, 70 per cent of the social care workforce was employed in the private for-profit and voluntary sectors, and only 17 per cent directly by local authorities (CSCI, 2008, p81). What has this change meant for the quality of care, and the conditions under which people work in social care? Care quality depends on the relationship between care provider and receiver. High quality care requires working conditions in which good relationships can flourish.

Carers' intrinsic motivation and pride in their work is the most reliable source of high quality care. Such motivation can arise from the use of professional skills, notions of public service and/or emotional connection. In any sector, intrinsic motivation can be lost where workers feel under too much pressure, or are controlled in such a way that they cannot use their professional judgment. Greater public trust in the standards of not-for-profit and public sector care comes from a belief that employers are more likely to respect and generate such motivation in their workforce in sectors with charitable and/or public service aims, rather than making profits for shareholders. But is that greater trust justified?

The system of care packages – lists of tasks to be done in prescribed periods of time (sometimes as little as 15 minutes) – was introduced to reduce 'wasted' time, in pursuit of cost savings. It was introduced by local authorities, but intensified as private sector employers competed for contracts. Many home care workers regretted the change, because previously they took pride in their work, enjoyed a good relationship with their clients, and believed that what they did for them was valued and needed. Many also did far more than they were paid for (Social Services Inspectorate, 2002, p8). The UK is not alone in this; for example, a similar picture of reduced motivation was found in the Netherlands after privatisation of the home care service (Knijn, 2000).

Turnover rates in home care increased over the 1990s as the proportion of the workforce employed directly by local authorities fell from over 90 per cent to just over half. Since 'retaining staff is paramount for service users because the

relationship is one of the most important factors in service users' satisfaction' (Skills for Care, 2007), high turnover and staff vacancy rates reduce the quality of care provided. Turnover rates also reflect the extent to which social care is attractive to those seeking to develop their skills and careers. Making social care a good career is not only of concern to the women who make up most of today's workforce, but also vital if men are to be attracted to work in this area.

Wages comprise 80 per cent of care service costs, producing considerable pressure to hold down wages, particularly in the private for-profit sector dependent on local authority contracts. In 2007, basic wages in the private sector were only a few pence above the national minimum wage, there were few chances for career progression, and pay structures did not correlate with qualifications, length of service, employment status and clients' vulnerability (Skills for Care, 2007). In the voluntary sector, pay rates were higher, and earnings increased significantly with seniority, creating a meaningful career ladder. Research has shown that private care sector employers responded to introduction of the national minimum wage by cutting expenditure on supervision (Machin and Wilson, 2004, cited in Hall *et al.*, 2008, p32).

The voluntary sector has been more successful in recruiting and retaining staff, with turnover rates of 17 per cent compared with 28 per cent in the private for-profit sector (Skills for Care, 2007). High turnover rates militate against employers investing in their workers' skills. The Commission for Social Care Inspectorate (CSCI, merged in 2010 with the Health Care Commission to form the Care Quality Commission (CQC)) found that a higher proportion in the private for-profit sector than in the voluntary and public sectors did not meet the *minimum* standards for recruitment practices, supervision and training (CSCI, 2008, Appendix F). With little chance of career progression, workers have no incentive to invest in their own training, and even less incentive to stay if better jobs are available. Therefore, if training standards are to improve, government investment will be needed. Not making this investment would be a false economy in terms of the long-term effects on the quality of care and employment in the sector. With women's other employment opportunities increasing, the social care sector cannot rely on women continuing to accept such limited career prospects and poor employment conditions.

Personal assistants

The first study of the growing numbers of personal assistants employed through Direct Payments found that over 80 per cent of PAs and their employers were very satisfied (IFF Research, 2008). In light of the low pay and reduced job satisfaction now found in the formal social care sector, it is not surprising that people were attracted 'by the greater flexibility in working hours afforded by PA work, the higher rate of pay available and the fact that the PA would prefer to work continuously with one person and build up a better relationship with the employer' (*ibid*, p79). Their pay was also higher than that of the conventional social care workforce.

How far does using Direct Payments to employ PAs improve the prospects of developing social care as rewarding work leading to an attractive career? Most PAs (87 per cent) were women, many drawn from among informal unpaid carers as well as a fifth from the formal social and health care sectors (IFF Research, 2008). Consistent with experience in other European countries where Direct Payments are more established, half the PAs were already known to their employer. A third had already been caring for their employer (arranged by an agency), and two-fifths were a friend or relative. A quarter continued to work alongside their employment in the social care field, accounting for half of the 38 per cent who worked under eight hours a week as a PA. So this rapidly growing sector of the social care workforce straddles the formal and informal care sectors. Can it retain the best of both worlds? And if so, will it act as a route into social care for men and others who traditionally have not considered care work? Or are we recreating a form of domestic service?

Personalisation is designed to improve care quality for those needing care services. However, younger disabled people pressed more for this change than older people, many of whom find the responsibilities of being an employer burdensome. In practice, the cost of good employment practices (including providing training in some basic skills) has been shifted onto care recipients, who may not fully understand the legal obligations of being an employer and may not have family and friends to help them (Ungerson, 2004).

Some PAs had different views from their employers on doing unpaid overtime; the need for a written contract of employment, references or a Criminal Records Bureau check; being included in the planned registration of social care workers; and the lack of training opportunities (only 7 per cent of employers had paid for any external training) (IFF Research, 2008). This suggests that some Direct Payment recipients did not see their relationship with their PA as a straightforward one of employer/employee, perhaps because many chose someone already known to them. Also, many PAs expressed reluctance to insist on a contract: they already were, or had become, friends with their employer (*ibid*).

Although PAs are more satisfied and better paid than their counterparts in the corporate sector, their informal status may leave them in a particularly vulnerable position in the labour market, particularly the two-fifths who are friends or relatives of the person they care for. On the other hand, Direct Payments to employ PAs are bringing some previously unpaid carers into employment. Although this reduces the employment gap between men and women, it does so in a way that reinforces existing occupational segregation. Only if Direct Payments bring more men into care work will they have an effect on occupational segregation.

Not providing a supportive infrastructure might save public money in the short run, but in the longer term will undermine the objective of achieving and retaining a highly skilled social care workforce. Direct Payments may be at too low a level to cover training and normal employment entitlements such as holiday pay. Very few employers were opposed to training for their PAs if it were funded, but given the low level of payments would not pay for it themselves (IFF Research, 2008).

Significantly, half of the PAs did not expect to be doing the same work in five years' time (*ibid*). The most common reason was the lack of opportunity for career development, suggesting that by itself 'personalisation' will do little to address the major problems of recruitment and retention in the social care workforce. More needs to be done to value care and carers and strengthen the position of PAs in the labour market. Otherwise, social care work will not be seen as a good career choice, and particularly not for men. Male PAs were generally younger (a fifth were under 25), and only half as many as female PAs had previous experience of working in social care. Employment as a PA could be seen as a useful first step into a career in the formal social care or healthcare sectors, thus diminishing occupational segregation, but only with a more supportive training and career structure.

Use of the market: personalisation and choice

Where private sector providers reduce costs, it is often through paying lower wages or speeding up their employees' work. In recent years, much of the resistance to privatisation has come from the recognition that it may produce 'value for money' at the expense of the quality of provision or workers' pay and conditions (Gilbert 2002, Stone 2000). As women comprise the majority of the social care workforce as well as unpaid carers, and are also more dependent on formal domiciliary and residential care provision in their old age, these issues impact particularly on them.

But if quality can be maintained or improved by using private sector care or PAs, this will benefit recipients. Similarly, if people are enabled to remain in their own homes, this will benefit women in particular, as they constitute most elderly people living on their own – but not if this is achieved through reducing the quality of domiciliary or residential care.

Privatisation, although designed to increase choice, can at times reduce it. For example, if providers of larger residential homes come to dominate the market through cost advantages (as in the US private market) those needing care may have more difficulty in finding the smaller residential homes they prefer, the specialist care they need, or a place near enough for relatives to visit (Walker, 1995, World Health Organisation 2007).

Whether 'choice' in the form of increasing use of private solutions (through corporate providers or PAs) will increase or decrease gender inequalities depends on the extent to which the quality of care services and the conditions of

the care service workforce are improved or reduced. If care workers' conditions improve, one of the biggest sources of the gender pay gap will diminish; if more men enter care work, there will be an important reduction in occupational segregation.

However, the move to the market is also driven by a desire to reduce spending, which makes such improvements less likely. Public expenditure on care redistributes from taxpayers to those who are generally on lower incomes. An agenda for care based on improving quality reduces gender inequalities, while one based on reducing expenditure without regard for quality consolidates and exacerbates those inequalities. One challenge is whether the current focus on 'value for money' can work in the former direction rather than the latter.

Unpaid carers: combining care and paid employment

Government policy's other plank has been to encourage higher employment levels among carers. Interest in supporting carers in combining care with paid employment is very recent in the UK. It has arisen partly in pursuit of higher employment levels, to which all EU governments have committed themselves. Carers, along with mothers of young children, constitute one of the few remaining groups still incompletely integrated into the labour market.

Concern to enable carers to enter employment also arises from growing recognition of the huge contribution made by unpaid carers to meeting care needs that would otherwise fall on the taxpayer. The Government is therefore keen to find ways to sustain unpaid care. Increasing Carers Allowance, the lowest earnings replacement benefit in the social security system, to a level that would provide a meaningful replacement for lost earnings would be expensive. A cheaper alternative, and one in line with the wishes of many but not all carers, would be to enable carers to support themselves through employment.

Carers' rights to support from the state as care givers – and to participate in education, employment and leisure – were first acknowledged in principle in the Carers (Equal Opportunities) Act 2004. The government emphasises carers' rights to an assessment of *their* needs, the importance of respite care, better monitoring of the strains on their own health of long-term caring, and a very modest amount of training *as a carer* (HM Government 2008). However, its focus is often more on enabling carers to take employment.

In contrast to recognition of the need for childcare for mothers to enter the labour force, it is yet to be recognised in the UK (or at European level) that high quality social care services need to be available if older women carers' economic activity rates are to continue to increase. The lack of attention until recently to the carers of adults may be because most are older women, less visible and with fewer qualifications and shorter employment records than younger cohorts of women

as well as without a long future in the labour market. Thus proposed training opportunities (with access to free replacement care services) in preparation for returning to employment have been pitched only at basic skills level.

Similarly, carers' right to support from their employers in the form of *time for caring* is only just beginning to be recognised. There is still no statutory carers' leave, unlike paid and unpaid parental leave. However, some carers now have the right to request 'flexible working'. Employers are required to consider such requests seriously, although they can be refused. Current restrictions on using this right (only being able to apply annually, and any alteration constituting a permanent change of contract) may limit its usefulness to carers, given that the onset and duration of adult care needs are much less predictable than those of children. Finally, such requests cannot be made when applying for a job or within the first six months of employment, so this measure cannot help carers to re-enter the labour force.

Much more needs to be done to enable carers to participate more fully in society, including in paid employment. Carers need support in terms of *time, cash* and *services*. Being able to take paid leave to cope with intensive periods of caring would help. More effective would be to tackle the UK's long hours culture, by reducing the hours that make combining care with full-time employment nearly impossible. Most carers therefore have to accept the inferior employment opportunities of working part-time. Having long hours as standard also discourages carers from entering employment, and may disadvantage them in furthering a career. This is not just a matter of individual choice: many carers currently work part-time or not at all because others with whom they could share caring responsibilities work long full-time hours. More wholehearted implementation of the European Working Time Directive, in particular ending the UK's opt-out that allows individuals to agree to more than 48 hours a week, would be an important first step.

The gender pay gap means that in most families it makes sense for women to take any cut in employment hours necessary to cover care requirements. But this reinforces gender norms and attitudes, particularly those that consider women to be unreliable employees because their employment history is more likely to be interrupted by caring responsibilities. It would also be of great help to carers to both narrow the gender pay gap and improve the pay and conditions of part-time employment. More enthusiastic implementation of European legislation on part-time working would again make an important contribution. Other European countries do not have such a large gap (if any) between the pay and conditions of part-time and full-time workers.

If part-time working opportunities were to improve and carers were paid an allowance for part-time care, then many more might seek employment rather than subsisting on inadequate Carers Allowance. Similarly, high quality services enabling carers to take such employment would be of benefit. Tax credits finance

these measures for parents of young children, so why not for carers too? All these measures would cost money, but not spending enough on providing support services and cash to make up for earnings foregone is a false economy, given that providing paid care to substitute for unpaid care is far more expensive.

Supporting family carers to combine employment with caring responsibilities could diminish gender inequalities in several ways. By raising carers' incomes it would help to address the income gap between men and women, in particular the significant disparity in retirement incomes. Women are more likely than men to give up paid employment when they become carers, so a right to carers' leave (for example) would also help to reduce gender inequalities by assisting women to retain links with the labour market. Such measures could also encourage men to get more involved in providing care. On the other hand, if only women workers take them up, then such measures would increase gender inequalities and may even lead to discrimination against women as potentially more demanding employees. It appears that lengthening maternity leave has increased the level of pregnancy discrimination. It is important therefore to accompany efforts to help carers to enter employment by tough action against discrimination.

Finally, the Government needs to rethink its refusal of carer-blind assessment of the needs for which social services will take responsibility. It obviously saves money in the short run not to pay for such services when unpaid carers are available. But by refusing carers and cared-for people a choice, the quality of care may be compromised, for unwilling carers are unlikely to deliver good care. This may also have serious long-term effects if carers are discouraged from offering to care in the short run for fear of being trapped. Many women caring for relatives currently find themselves in this situation. As women's employment opportunities improve, they are likely to be far more cautious about being involuntarily excluded from the labour market.

The same applies to budgets that restrict help with care needs to the most needy. It may be a false economy to save money in this way if the result is a failure to prevent the growth of problems that eventually require more expensive solutions and/or drive away a carer who would otherwise provide useful back-up to formal services. Nurturing family carers by providing support services is more humane, and also makes good economic sense.

Containing costs without increasing gender inequalities?

Since labour constitutes 80 per cent of care costs, and the potential for increasing productivity without decreasing quality is severely limited, the cost of providing paid care must rise along with wages. This is modified only by the extent to which fewer people receive care *and/or* care standards are allowed to fall, *and/or* the pay of care workers is allowed to fall yet further behind that of other workers.

In practice, as budgets have not kept up with rising demand for paid care, all these 'savings' have been taking place. Many are not receiving the care they need, others are making do with less care, and care workers' pay and conditions have fallen behind those of other workers, leading to the current concerns over social care. The focus, however, has been more on the quantity and quality of care than on care workers' pay, conditions and training opportunities.

Greater choice, personalisation and use of market forces will not change the basic economics. Total costs will not be affected unless lower quality or less care is provided, lower paid workers are employed to provide care services, and/or there is greater reliance on unpaid care. None of these conditions are feasible (or acceptable) in the long run.

Less care may be one aim of personalisation and not objectionable where savings come from cutting out unwanted services. However, unless the public are prepared to accept considerably lower standards of care (which current concern suggests is not the case), the scope for this must be limited, especially given the already tight packaging of social care.

Greater reliance on family care is also unsustainable, beyond some scope in the short run where paid services can be better tailored around family care. But over the longer term, working-age family carers will – like everyone else – want to engage more in the paid economy, as the opportunity costs of being out of the labour market in terms of foregone wages rise. So although families will continue to provide the bulk of care, they will need greater support by paid care services.

Allowing care workers' pay to fall further behind those of other workers is not a sustainable long-term solution. The paid care sector already has recruitment and retention problems, and more workers will be needed in the future. One short-term 'solution' is to employ migrant workers if they will accept conditions the UK workforce would not. But already Polish workers are returning home as the gap between Polish and UK job opportunities narrows. The Government's proposed tougher restrictions on non-EU migrant workers have brought protests from the long-term care sector, which depends heavily on them. In 2007 a fifth of the social care workforce in England were born overseas (Cangiano et al, 2009). Migrant workers may have a future in the UK care sector, but their employment on inferior working conditions is not a solution to long-term funding problems or training failures. This is an issue which is not confined to the UK. As a recent ILO report stated: 'The debate about care in the 21st century should be linked to change in the role and level of migration' (Daly and Standing, 2001, p5)

Insofar as Direct Payments will achieve cost savings, it will be through employing people with little labour-market power. Personal assistants on individually negotiated pay and conditions may provide one such source of workers, especially where they are family members or friends. On average, PAs in

England are currently paid higher hourly rates than social care workers, but many have fewer employment rights. How will their pay rates compare in five years' time? Such 'informalisation' of the labour market for care workers may be an important cost-containment driver behind the personalisation agenda, but at the expense of generating high turnover rates, at least among younger people, who will move to better paid employment wherever they can. Experience elsewhere in Europe has also shown (Lundsgaard, 2006) that it is easier to let cash payments diminish in real terms by not increasing them regularly in line with prices than it is to cut services directly provided by the state.

Another way to reduce costs would be to change the balance between private and public funding, expecting a larger proportion of people to fund their own care. Scope for this is restricted by the overall level of inequality in the economy and the low level of older women's pensions. Those with low incomes will not be able to afford the rising cost of care. If they are to receive adequate care, state funding will need to increase at least in line with rising costs and needs. In the longer term, the need for state funding can only be reduced by greater equality in pensioners' incomes – including, crucially, greater gender equality. However, present tendencies are going in the opposite direction.

Although the rising costs of care to the public purse are a seemingly intractable problem, they can be afforded because they are an effect primarily of productivity increases in the rest of the economy. The economy's prosperity has been fuelled to a large extent by women moving into employment and the decline of the male breadwinner/female carer family. These productivity increases make the economy able to afford more spending on care without cutting living standards. In taxation terms, it requires governments not to give away all the gains of fiscal drag – the net gain in tax receipts when real incomes are rising, due to uprating tax thresholds in line with prices alone (Sutherland *et al.*, 2008). A higher proportion of GDP will need to be devoted to care, and within that to public support of care. The rising cost of care is an effect of getting richer, not poorer, as a society. Some of that increased prosperity can be spent on providing good care.

Conclusion: Our vision of the future

The current situation cannot continue. Many people, largely women, are not getting the care they need. Many carers, also largely women, are not getting the support they need and the opportunities they deserve to take part in society. The paid care sector is failing to plug the gap through lack of funding, leading to recruitment and retention problems. All this is producing an unsustainable situation that reinforces existing gender inequalities, which will continue unless:

- family carers receive more support to allow them to combine caring with good quality employment, including full-time;

- working hours are reduced so that more men can combine family care with employment;
- the care workforce's pay and conditions are improved to encourage men to enter the sector, and to retain men and women in it; and
- budgets are increased sufficiently to allow all those needing care to receive acceptable care, on a carer-blind basis, irrespective of ability to pay.

Any other solution would be unworkable and inconsistent with government commitments to reduce gender inequalities. It requires the removal of the economic disadvantages suffered by those who take on caring responsibilities, largely women.

We would like to see a society comprising worker/carer citizens which valued good quality care as much as economic gain. Everyone would be expected to participate in caring *and* paid employment over their life course. This requires a change in how care is seen: as a public good underlying the fabric of society, rather than a burden whose costs are to be minimised and shifted onto families in general and women in particular wherever possible. It also means that although family and friends would still provide most care they would be supported as necessary with time money and services .They would be respected and valued.

A new pact between families and the state is needed, recognising the interdependence between paid and unpaid care and that good care can only be provided in the context of a positive relationship. No-one would be forced to care for or accept care from a *particular* person. High quality, trustworthy, paid care services would be available to complement family care, with funding arrangements making them accessible to all. These services would have a well-rewarded, skilled care workforce consisting of both men and women.

Wider changes are needed, particularly in men's lives because they will not be persuaded to increase their contribution to care unless the costs of doing so are lowered,. The long hours' culture dominating British workplaces, which makes equal sharing of caring responsibilities and employment difficult would have to change; In particular the part-time wage penalty and gender pay gap, which make equal sharing of family care responsibilities expensive would have to end

The current situation is unsustainable. As women's employment opportunities increase, the paid care sector will not be able to recruit unless its pay and conditions improve, Leaving immigrant care workers and personal assistants on the margins of the labour market in order to contain the cost of care services only increases inequalities between women Women will not be prepared to bear the rising economic costs of providing family care unaided. These costs will need to be shared more equally between men and women, and between families and the taxpayer.

Sharing costs more equally between families and the taxpayer is affordable. A sustainable system in which those needing care are well looked after is possible. It is a political choice how much money to spend on social care. Women's entry into employment has brought increased prosperity but also increased the costs of care that have to be met collectively. Sharing the gains of increasing productivity with those needing care can be afforded and men could be enabled to take an equal role as full citizens of a more caring society.

About this paper

This paper was written by Susan Himmelweit, Professor of Economics at the Open University, and Hilary Land, Emeritus Professor of Family Policy at the University of Bristol. Their report, **Supporting Parents and Carers** (Equal Opportunities Commission, 2007) expands on some of the arguments presented here. See http://83.137.212.42/sitearchive/eoc/Docs/WP63_Supporting_parents_and_carers.rtf?page=20673

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