

Gender Equality and the Governance of Long-term Care Policy: new models and paradigms

Kirstein Rummery, University of Stirling
Kirstein.Rummery@stir.ac.uk

Draft only

Abstract

There is a long established link between care policies and gender equality outcomes, but to date little research which has systematically and critically examined those links, and the governance of welfare in a comparative way. This paper draws on evidence from a recently completed comparative study looking at long-term care and gender equality. It used a CQA approach to identifying case studies and presents evidence which focuses on: the governance and design of policies that led to good gender equality outcomes; the level of policy making; the role of the state, the family, the community and the third sector in designing and delivering effective policies; and the transferability of policies across different state and sub-state policy arenas. New empirical data reveals the role of the state, public and private providers, and third sector organisations in developing and implementing care policies and examines the role different levels of governance (state, sub-state, federal and local) play in achieving policy design and outcomes. The paper also presents evidence showing that comparative welfare models are insufficient to account for gender equality outcomes, and proposes new models based on new empirical and theoretical insights derived from the data. The paper also draws on policy transfer theories and empirical data to examine key issues around policy transfer and the applicability of new policies and models across different welfare and governance contexts.

Background

Political, social, economic and demographic changes in developed welfare states have led to concerns about rising demands for services, particularly support services for older and disabled people (Pierson, 2001). On the 'demand' side, increased longevity, reduced morbidity and political pressure from citizens and service users has led to a growing realisation amongst policy makers and practitioners that present service levels, particularly in health and social care services, are inadequately funded and failing to respond effectively and efficiently to people's needs (Taylor-Gooby, 2005). On the 'supply' side, falling birth rates and changes in family structures, as well as neo-liberal changes to welfare provision which have stressed the importance of activation policies (for example, welfare-to-work programmes for women, lone parents, disabled people and the long-term unemployed), and changing relations and expectations within families and communities have meant that there are falling numbers of 'unpaid' and family carers available and there have been substantial changes to the "welfare mix" of contributions from the family, the state, the market and the third sector (Evers et al, 1994).

Care policy is an example of a social and structural issue that has profound effects on outcomes than can either exacerbate or reduce inequalities along social divisions, particularly gender, age and disability. Although this is changing, the evidence

suggests that in Scottish society, women bear the 'double burden' of being responsible for childcare, providing care and support for disabled and older family members, and taking part in paid employment: this contributes to the 'gender gap' in both public life (where women are substantially more less likely than men to occupy senior positions in work, politics and civic society) and private life (where women are significantly more likely than men to be at risk of poverty and to bear the effects of economic pressures and welfare restructuring). The evidence suggests that care policy (both in terms of childcare, and long-term care) in some types of welfare regimes achieves better outcomes than others (in terms of delivering equality, particularly gender equality) (Walby, 2004).

Scotland, as part of the UK, has responded to the challenge of how to manage welfare and long term care policies in such a way which caps the rising demand for resources, leading to a shifting of responsibilities across public sectors (for example from health to social care, and from national to localised provision), and across sectors (for example from state to private or third sector provision, or from state to family [or, indeed, family to state]) (Moffat et al, 2012). At the same time a variety of international, national and local political, social and economic factors have led to changes in the governance of welfare, including increasing commoditisation of services and deprofessionalisation of practitioners (Newman, 2005). Rising demand for support and services has also come not just from demographic changes but also from increasingly politicized 'user' movements (such a disability rights organisations in the UK and the Netherlands, and older people's organisations in the USA) who have rejected both family and informal care as exploitative (for both carers and cared-for) and state care as increasingly fragmented, unresponsive and dehumanising – indeed, rejecting the rhetoric of 'care' altogether and demanding social rights, empowerment and control over the type and level of support received instead (Morris, 2004). Increasing regulation of services in response to 'consumer' demand has only partially succeeded in responding effectively to these changes: new models of service delivery are being actively sought in response to these complex political, social and economic changes (Ungerson and Yeandle, 2007).

At present, care policy in Scotland since devolution has deviated in some respects from the rest of the UK: for example, in providing free personal nursing care for older people (Bowes and Bell, 2007). However, the substantive elements of care policy have not changed significantly. In governance terms this means that local authorities, rather than the Scottish Government, are responsible for providing long-term care for disabled and older adults, and for providing services to support informal carers. Local authorities are also responsible therefore for setting eligibility criteria for accessing services. In policy terms, this means there has been no deviation from the underlying principles and drivers of community care legislation: the marketisation of services, the targeting of services on those at most at risk, and the normative assumption that the family is responsible for providing care and support (Mason et al, 2006). Moreover, whilst there has been recognition of the role that childcare policy plays in tackling gender inequality, there is little emphasis in policy on the role that could potentially be played by long-term care policy. This is in stark contrast with welfare regimes that have been more successful at tackling gendered inequalities, who have explicitly recognised and attempted to tackle the structural inequalities caused by a reliance on family care in BOTH childcare and long-term care (Walby, 2004; Pascall, 2008, Pascall and Lewis, 2004). Care policy is also a site of conflicting normative, theoretical and empirical tensions (Rummary and Fine, 2012): for example, policy drivers which pull towards

employment for women, disabled people and older workers are in conflict with drivers which place the emphasis for the provision of care and support for children and adults on the family. However, the role that the *governance* of care policy plays in achieving egalitarian outcomes – particularly along gendered lines, but also those of age and disability - is not well documented or understood. What role do the various possible levels of policy setting (supra-national, national, regional and local) play in setting care policy? In those regimes with more egalitarian outcomes, what rights and responsibilities do individuals, families and communities have, as compared to the different levels of state intervention? What roles do ideas, actors and institutions play in the formulation and implementation of equitable care policies? And, given the 'window of opportunity' opened up by the referendum on independence and constitutional change in Scotland, if we applied the lessons from those welfare regimes with equitable outcomes, what role could ideas, actors and institutions play in Scotland? Which constitutional and governance options would achieve the most equitable care policies and outcomes?

A gendered perspective, and an explicit articulation of gender equality and gender justice have been largely absent from the current debates around constitutional futures in Scotland, in sharp contrast to their prominence in the run up to devolution in the 1990s. The issue of gendered inequality has been part of a distinctive Scottish policy platform: indeed, many of the campaigns around devolution and the need for a 'yes' vote in the referendum hinged around the need to develop 'Scottish solutions' to Scottish social divisions, with women's poverty and gender inequality becoming part of the Scottish policy 'problem' platform, with policy makers asserting in 2003 that:

"Inequality between women and men is both a widespread and persistent feature of contemporary Scottish society...in general women today still have less access to income and other material resources, less time that is their own, less political power and have a 1 in 5 chance of experiencing domestic abuse in their lives" (Strategic Group on Women, 2003: 6).

A potential new stream of 'policy entrepreneurs' came to power following the political and structural changes encapsulated in the devolution process. In 2003, 54% of Labour seats and 39% of seats overall in the Scottish parliament went to women (Durose and Gains, 2007), as compared to 18% of seats at Westminster (similar rises in women's representation in formal politics can be found in the Welsh Assembly, London Assembly and in other localised and regional assemblies. Indeed, the Welsh Assembly has arguably placed care policy at its heart in designing governance structures with the creation of an Older People's Commissioner and an absolute duty to pay regards to equality issues). Whilst women's increased political representation does not necessarily lead *per se* to an increased policy focus on women's issues, evidence from the Scottish parliament does suggest that women Scottish politicians do see themselves as 'feminising politics' (Lovenduski, 2005): that is, acting for women, taking on women's concerns, and making a difference to women's lives. McKay and Gillespie assert that "the new political structures and processes have established transparent mechanisms to ensure that women's voices across Scotland continue to be heard" (McKay and Gillespie, 2005; 115).

A 'window of opportunity' was been created both through the creation of the Scottish Parliament itself, and through pressure to implement 'gender mainstreaming' policy devices coming from a UK and European level. The establishment of the Scottish Women's Budget Group has led to a framework for the development of gender-sensitive policy initiatives, although to date has not yet provided concrete examples of

shifts in policy priorities that can be argued to be gender-aware (Breitenbach, 2003). Collective action by feminist 'policy entrepreneurs' both inside and outside the Scottish Parliament has led to the formation of new policy networks, including both the organisations included as case studies in this paper, has proved to be a 'useful example for the UK to follow', (McKay and Gillespie, 2005: 128) and feminist activists have certainly engaged with the new political structures in an attempt to instigate changes, for example through the work of the Scottish Women's Budget Group. However, the evidence that this had led to demonstrable policy gains or outcomes for women has not yet been forthcoming – equality considerations were evident in the 2004-5 budget, but there has yet to be convincing evidence that policy has been feminised using Lovenduski's (2001) definition of 'making a difference to women's lives'.

This lack of progress on gender equal outcomes is mirrored in the wider UK. At a national (UK) level, one 'window of opportunity' to instigate feminist policy change on the issue of women's poverty was the election in 1997 of a New Labour government in which a coalition of feminist campaigners both inside and outside the Labour party was successful in its attempt to create All Women Shortlists in the Labour Party prior to the 1997 election (Lovecy, 2007), which resulted in a historic 101 female Labour MPs entering the Westminster parliament in 1997. Russell (2005) has argued that this iconic feminisation of the image of the party has resulted in an association with progress on women's issues that is not necessarily matched in practice. The increased representation of women offers an opportunity to create a 'critical mass' within the context of an institutional framework which enables women to change the culture of a party or legislature (Dahlerup, 1988; Yoder, 1991).

Childs (2004) has found that female Labour MPs at Westminster do perceive themselves as 'acting for women' (echoing McKay's findings in the Scottish parliament), particularly in policy areas such as childcare and healthcare. Nevertheless, these potential new 'policy entrepreneurs' face significant constraints in engaging with the state, particularly if they see themselves as overtly feminist actors (Chappell, 2004). In the case of the UK and the Westminster parliament, the 'core executive' (i.e. those organisations and procedures which co-ordinate central government activity, cf Rhodes, 1997) remains male-dominated, despite the appointment of prominent feminist ministers. One analysis of attempts to translate feminist goals into policy points to the importance of women's 'policy machineries' (McBride Stetson and Mazur, 1995), particularly in overcoming male-dominated ideologies and policy structures. These could include women's ministries or women's policy units, which are particularly successful in achieving 'state feminism' in social democratic regimes and neo-liberal regimes where feminist organisations have a strong influence over a range of policy areas (Hafner and Pollack, 2002). At the Westminster level, the women's policy machinery was organised through organisations such as the Women's National Commission and the Equal Opportunities Commission, as well as within the newlyelected New Labour government the Women's Unit (which changed its name in 2001 to the 'Women and Equality Unit) – given the remit to scrutinise legislation to promote sexual equality and femalefriendly policies (Squires and Wickham-Jones, 2004). The Unit has disseminated guidance on equal pay, work-life balance and women in public life, but did not have a clear departmental 'home', and did not appear to have credibility amongst senior civil servants or ministers (Durose and Gains, 2007). Moreover, the Equal Opportunities Commission has now been subsumed at a national level to a wider Human Rights Commission,

incorporating a focus on wider equalities issues including race and disability, with a similar reorganisation at the Scottish level. There is therefore no powerful or cohesive women's policy machinery at a UK level to engage with an overtly feminist policy agenda.

The results of this lack of an overt feminist focus in ideology and structures on the part of the New Labour administration in Westminster is clear from an analysis of the policy outcomes of its first ten years in power (Annesley et al, 2007). The most significant achievements have been for working mothers: the full-time gender pay gap has narrowed to 83% from 73% in 1997, enhanced maternity leave provision has increased job security and tenure, and targeted tax relief and increased childcare places have made working full-time easier for many women, particularly well-paid women. A push towards activation policies that encourage lone parents to work rather than be dependent upon the state for their income have resulted in increasing numbers of women in full-time work. However, the UK still lags behind other European countries with regards to equal pay, and the pay-gap for low-paid parttime women has not closed significantly, remaining at around 62% of men's earnings (Grimshaw, 2007). Moreover, such gains as there have been for women have been achieved under the policy aims of tackling *child* poverty, not women's poverty, as a result of policy networks and coalitions such as the Child Poverty Action Group and national family interest groups (Lister, 2006). Coates and Oettinger (2007) argue that UK policies designed to increase mothers' participation in the labour market have been advocated on economic grounds, to increase the tax base and reduce social security spending, rather than addressing women's poverty and inequality on social justice or feminist grounds. Indeed, the policy outcomes for women outside the paid world of work have been notably poorer, with full-time mothers, carers and older women suffering from New Labour's focus on the 'worker-citizen' at the expense of the 'carer-citizen' (Rummary, 2007), including a refusal to raise non-working benefit levels significantly. Moreover, policy options favoured by the current UK Coalition government, focussing primarily on welfare retrenchment and the removal of benefits, are predicted to further exacerbate women's risks of poverty: particularly those with caring responsibilities (Macleavy, 2011).

Methods

The following methods were used:

1. A critical synthesis of the published literature on welfare regimes and the relationship between the governance of care policy and egalitarian outcomes (particularly along gendered lines but also taking into account areas that will affect other groups, e.g. care policies for older workers, long-term care policies etc);
2. Using the results of that synthesis to identify suitable case study countries for further analysis. They were chosen on the basis that they have a similar 'dependency ratio' to Scotland (i.e. similar levels of potential need, and similar socio-economic profiles, with developed welfare regimes), and have demonstrated high levels of gender equality (using indices developed by Pascall, 2008; and Sainsbury, 1996; and developed for use in Europe by Platenga et al, 2010, the work of the European Institute for Gender Equality (EIGE) on gender mainstreaming, and that of the UK Equalities and Human Rights commission on intersectional working on care policies). Five case studies were chosen and further research undertaken, comprising of an in-

depth critical review of the published literature describing care policies; the way in which they are governed (focussing particularly on the role of supranational, national, regional and local policies); the role of ideas, actors and institutions in developing and implementing the policies; and the duties and rights experienced by individuals, families, communities and the state in each case study;

3. Semi-structured interviews with a range of key informants, academics and stakeholders in Scotland and Wales with an interest in care policy and gender equality (up to 30), and focus groups with key stakeholders in Scotland (3). They included representatives from local authorities charged with commissioning care services, organisations of and for disabled and older people, organisations of carers, organisations representing the interests of care providers, trade union representatives, Members of the Scottish Parliament (MSPs) and of the Welsh Assembly from across different political parties, and policy makers in the Scottish Government (particularly in the Equalities and Budgetary Advisory Group and members of the Analytical Services Division) and Welsh Assembly. They were recruited using snowballing techniques. They focused on what elements of care policies the informants feel would lead to equitable outcomes, particularly for women but also for disabled and older people in Scotland and Wales, and what kind of 'gender architecture' and governance structures would be needed in Scotland to achieve these outcomes. These interviews provided the basis of the 'realist' element of the critical review and case study selection.
4. The appointment of five 'country experts' to check the reliability and validity of the findings (Hantrais, 2009). These experts would provide a country report giving a state of the art summary of care policies and equality outcomes in their country, and this would be used to check the results of the critical review of 2. above.
5. The checking of the reliability and validity of the findings will also take place through the presentation of the projects findings for peer review at two international conferences with a specialist focus on comparative social policy, public administration and gender, in the summer/autumn 2013 (the International Sociological Association's Research Committee on Poverty, Social Welfare and Social Policy; and the European Social Policy Analysis Network).
6. An 'Experts Seminar/Knowledge Exchange Event' on the topic of 'Equality, Care and Scotland's Constitutional Future' was facilitated by the PI (with research assistance) with invited experts from 4. and up to 15 invited non-academic stakeholders from communities of interest who did not take part in the interviews. Presentations from the panel of country experts were followed by roundtable discussion of the case studies and how the lessons might be applied in Scotland through the different constitutional options. These discussions were recorded and analysed as a final focus group to check the validity and reliability of the findings

Findings

The Universal Model

The Nordic states are commonly held up as an example of universal state provision of services leading to high levels of gender equality. This is slightly misleading: there is no one 'Nordic' model of welfare, and even those states with high levels of state control over welfare and long-term care services have introduced forms of market and individual involvement in the provision of services. Nevertheless the three case study examples discussed here all share common features that make them examples of 'good practice' in this field: they all have gender equality at the heart of their constitutional framework and policy values: they all score highly on the Gender Equality Index; they all have high levels of state involvement in the provision of (or commissioning of) childcare and long-term care services: they all adopt a universal 'social rights' approach to the provision of services.

Examples

Country	Population	EGEI score*	% of GDP spent on services (OECD data)
Denmark	5.614m	0.86 equal sharing of paid work 0.63 equal sharing of money 0.52 equal sharing of power 0.76 equal sharing of time	2.4% on long-term care
Iceland	0.323m	0.81 equal sharing of paid work 0.82 equal sharing of money 0.65 equal sharing of power 0.95 equal sharing of time	1.7% on long-term care
Sweden	9.593m	0.94 equal sharing of paid work 0.68 equal sharing of money 0.7 equal sharing of power 0.57 equal sharing of time	3.6% on long-term care
(UK)	64.1m	0.82 equal sharing of paid work 0.39 equal sharing of money 0.46 equal sharing of power 0.58 equal sharing of time	2% on long-term care
(Scotland)	5.295m	Not available	

Table 2 Universal model characteristics *based on Platenga et al (2009), using EU/OECD data

Long-term care and gender equality

Countries that fell into this model had normative policy frameworks that were heavily focused on gender equality. Aspirations towards gender equality informed the constitutions of the countries, and also underpinned the development of welfare services. All of the case studies fall into the 'social democratic/Nordic' welfare model (Esping-Anderson, 2009). This means they provide public services on a universal basis, without stigma or loss of status. The twin commitment to gender equality and universality means that long-term care services have always been part of state provision.

Comparative social policy experts have always questioned whether there really is one 'Nordic' model of welfare, and whether the difference between that and other models is as marked as is often claimed (Mahon et al, 2012). Although for the purposes of this project we were not using welfare state typology as a sampling frame, it is notable that all the 'Nordic' states met our sampling criteria of having good gender equality outcomes and state involvement in the funding and/or provision long-term care services. For this reason we chose to look at three countries in this group, who form our Universal model: Denmark, Iceland and Sweden.

Denmark

Around 1 in 6 of older people receive home care services in Denmark, which is provided free of charge. Recent changes include a re-ablement assessment and service before people are eligible for home care, and a very small direct payments scheme. Informal care is used but always considered to be supplemental to formal care.

As with all the countries in this model, Denmark scores relatively well on all gender equality indices. It works with a dual earner-carer model, whereby the assumption is that both paid work and unpaid care are equally shared between the genders, but this is more successful in long-term than in childcare policy: most parental leave is used by mothers, contributing in part to a gender pay gap of around 16%. Denmark, Finland and Iceland are commonly seen as the most 'marketised' or 'neo-liberal' of the Universal State Model countries, although the commitment to gender equality and universal social services remains strong.

Iceland

Until the early 1980s most state care for older and disabled people was provided through institutional care (ie residential and nursing homes), but since 1982 policy changes have led to the development of home care services which are provided by municipalities (local government). User fees are charged for the non-health parts of the services – these vary but are modest (and income-related), so only 9.4% of the total expenditure on home care services comes from these fees. Unpaid care by relatives plays a significant part in the provision of help and support for older people (Siguroardottir, 2013) with very small numbers receiving a working-age carer's allowance. The main caregiver is usually a spouse (roughly gender equal) but in 27% of cases this informal care is provided daughters (Siguroardottir et al, 2012). Iceland has one of the lower gender equality scores of the Universal State model countries, in part because of the segregated nature of the labour market, the 'care gap' of unpaid leave taken by mothers, and the reliance on unpaid care from daughters. The gender pay gap is 18% - slightly higher than the EU average – but still significantly lower than the UK. Moreover indices which combine different

elements of gender equality consistently put Iceland at or near the top of the league tables (European Commission, 2013).

Sweden

Gender equality policy since the 1970s has focused on improving women's access to work as paid carers (around 20% of employed women work in publically financed childcare and long-term care).

However, 14% of older people use home help services, and there has been a shift since the 1980s away from institutional towards home based services. At the same time there has been a rise in daughters – particularly low income daughters – providing unpaid care for their parents: higher income families are more able to pay for home based and institutional care.

Sweden has had a sustained policy focus on gender equality since the 1970s with the result that it scores highest amongst our Universal State model case studies on all the gender equality indices apart from equal sharing of leisure time. This is probably because it relies on mothers to provide at least 75% of the childcare of younger children, and on lower income women to provide unpaid care to disabled and older relatives.

Responsibilities of the state, the market, communities, families and individuals

The state plays the biggest role in the Universal State Model of all the models under discussion. It is the primary funder and provider of services at both a national and local level. Most services are funded through a mix of national and local taxation. The state also plays a significant role in the provision of training and quality assurance for workers and services, which offers protection to both those who provide and use the services. High levels of state involvement mean that the costs and risks of funding and providing services are shared equally across the population, whilst the benefits are also felt equally by all regardless of income.

The market plays a reduced role in the Universal State Model, but it is not absent altogether. Higher income parents and users of long-term care services are able to purchase additional help and services from a limited range of for-profit providers. There is some private sector involvement in the provision of long-term care services which are funded or commissioned by the state. There is also a limited 'internal market' of providers being developed whereby state providers are encouraged to use marketised means to compete for contracts to improve the quality of provision, and a limited use of direct payments for childcare and long-term care to enable individuals to exercise more choice in service provision. These are not popular: take up of direct payments is low, and marketization, particularly in long-term care, is met with discontent from both providers and service users – and there is no evidence that it substantially reduces costs or improves quality (Eydal and Rostgaard, 2011).

The community does play an informal role in providing and supporting childcare and long-term care, as it always has, but there is very little development of third sector providers or user-controlled services. It is not the case that where the state is heavily involved in the provision of services that civic involvement in the community is underdeveloped: levels of volunteering, civic organisation and individual participation in third sector organisations is as high if not higher in social democratic/Nordic countries as it is in other types of political and welfare regime (Immerfall and Therborn, 2010). However, community organisations are less involved in the direct provision of core long-term care services and more in the provision of additional,

special interest groups – for example self-help and self-care groups, sports and leisure groups, and training and advocacy.

Families tend to see themselves as working in partnership with the state, or as the providers of low level help and support, rather than the main providers of long-term care. There is some involvement of unpaid carers in inter-generational care of older parents, particularly in Iceland and Sweden (and Finland, another country which fits the Universal State Model), and this is gendered, with the burden falling disproportionately on daughters (particularly low-income daughters).

The primary responsibility for *individuals* in the Universal State Model is to take part in paid labour and share in the burden of paying, through taxation, for the provision of universal long-term care services. Services are universally available (although contributory fees are tailored to reflect income levels) and so there is no perceived difference between those paying for, and receiving the service: everyone pays into the pot, and everyone benefits (even those without children will benefit eventually from the provision of long-term care as they grow older). However there are gendered expectations on individual women to provide some kinds of care: to be at home with young children, and to provide unpaid care for older parents.

Advantages

- This model features case studies that are consistently high in gender equality indices, using a variety of measures.
- Gender equality is a given normative aim, regardless of the political, social or economic context of policy development.
- Services are available universally which adds to social cohesion.
- There is little or no stigma associated with accessing services.
- Services support women's employment both in the private and public sector.
- Public investment in the infrastructure (buildings) and the supply (staff) rather than demand means that the costs, risks and benefits of the services are equally shared, rather than the costs falling disproportionately on lower income families and the benefits being felt disproportionately by higher income families.
- Formal long-term care workers (the majority of whom are women) are highly trained and their labour is highly valued.
- Service provision is valued as one of the 'core' features of social policy (like health and education).
- Cultural and social expectations are geared towards equitable sharing of paid and unpaid work.
- Universal provision of high quality long-term care services reduces the burden on families, enabling them to participate in paid work for longer and reducing the risk of carer poverty.
- Less pressure on families to provide long-term care means better family relationships, and those that provide personal care do so out of choice rather than because of the lack of high quality alternatives.

Drawbacks

- Relatively high levels of state involvement and investment: high percentage of GDP spent on the infrastructure.
- Legal, social and cultural commitment to gender equality has been sustained over a substantial period: this is not easy to reproduce in a different context.

- A gendered policy machinery (eg women's equality ministers at cabinet level, gender mainstreaming of budgetary decisions and social policy) is required to sustain the normative commitment to gender equality that drives policy development.
- Universal provision can lead fewer opportunities to a heteronormative and homogenous approach to services which is not always responsive to individual needs and circumstances.
- Gendered expectations for who will step in when the state does not provide services (eg unpaid care of older parents, unpaid care of children when paid parental leave ends) persist, and the burden of providing unpaid care falls disproportionately on women (particularly mothers and daughters).

Key lessons and transferable features

1. **All of the case study countries in the Universal State Model have gender equality enshrined into their legislative and policy making structures.** Where countries have formal written constitutions, gender equality is one of the key values that underpin the aspirations of those constitutions. However, a written constitution is not the only place where a commitment to gender equality can be evidenced: key statutes and common laws can provide a similar level of commitment, particularly when backed up by gendered policy machinery to implement and police gender equality. Equalities ministers at Cabinet level in both the UK and devolved parliaments would be possible, as would a commitment to gender mainstreaming in budgetary processes, public commitment to European and UN objectives on gender equality, and power given to existing bodies such as human rights commissions to hold both national and local government to account for the provision of services which support gender equality.
2. **The Universal State Model provides universal, not targeted services.** This is crucial in tackling not just gender inequality but also inequality over the life course between those who work and those who are unable to work due to age (either being too young or too old) or impairment, illness and disability. Higher levels of workforce participation amongst women, particularly low income women, addresses child poverty as well as the poverty experienced by older women as a result of underemployment over the life course. Greater social cohesion and social solidarity results in societies that are more egalitarian and less divided. Long-term care services are treated in the same way as the NHS and education in the UK: as core parts of a universal, fair welfare state, with clear sharing of risks and benefits.
3. **Care, and thus women's work, is valued in the Universal State Model.** Formal carers are relatively highly skilled and well paid, there is investment in their skills and training, and they are a highly valued and respected sector of the workforce. Although these jobs remain highly gendered, (particularly unpaid care of older parents), the fact that care services are universally available and staff are respected means that women's labour, both paid and unpaid, is valued.
4. **Policies need, wherever possible, to 'join up' to be most effective.** The Universal State Model works effectively to support gender equality because it tackles it on many levels.

The lack of tax incentives or support for unpaid carers coupled with universal provision of high quality long-term care means there is reduced financial pressure on women to undertake high levels of unpaid long-term care. Moreover, investment in the provision of child care and long-term care means there are many jobs available for women that are highly valued and support their long-term career development. All of these 'joins' are possible if policy makers are willing to use gender equality as a

normative core for all policy development and implementation, and are willing to work with employers, the education sector, and the treasury – as well as across national and local government.

It should be noted that countries in the Universal State Model are not necessarily a feminist utopia. Investment in the universal provision of long-term care services reduces women's risk of poverty, and ensures that their paid and unpaid work is valued. However, levels of violence against women and domestic abuse are as high in this model as in others. Whilst political participation is high, there is still not gender parity in positions of power in national or local government. Occupational segregation and gender pay gaps persist, as do low levels of women in very senior positions in business and the judiciary. Universal child care and long-term care services can only address some elements of inequality.

Summary of the Universal model

- The Nordic States (Denmark, Finland, Iceland, Norway and Sweden) are often held up as a model of universal state provision of services but there is no single "Nordic Model":
 - the degree to which the State controls welfare varies from country to country; and
 - even where there is a high level of state control there are varying degrees of market or individual involvement in childcare and long-term-care services.
- The three states we have chosen to study (Denmark, Iceland and Sweden) are effective as examples of 'good practice' because:
 - all have gender equality at the heart of their constitutional frameworks;
 - policies are built around gender equality;
 - all score high on the gender equality index;
 - all have high levels of state involvement in the provision (or commissioning) of childcare or long-term care services;
 - all adopt a universal 'social rights' approach to the provision of services.
- While Denmark (along with Finland and Iceland) are seen as the Nordic countries with the greatest market involvement, the commitment to gender equality and universal social care is nevertheless high.
- Although scoring higher than the UK, Iceland has the lowest score on the gender equality index and highest gender pay gap. Reasons include:
 - high levels of gender divisions within the labour market;
 - unpaid leave taken by mothers to look after babies; and
 - reliance on unpaid long-term care by daughters.
- Sweden has the highest score on all indices on the gender equality index except for equal sharing of leisure time. This last is probably because:
 - 75% of childcare for younger children is provided by mothers; and
 - women on lower incomes provide most of the care for their elderly or disabled relatives.
- Despite the differences between the three 'Nordic models' we can still talk about a Universal State Model based on our findings.
- The state plays the biggest role as primary funder and provider of services at both a national and local level.
 - Most services are funded through a mix of national and local taxation.
 - The state also provides training and quality assurance for workers and services

- This offers protection to both those who provide and use the services.
- Costs and risks of funding and providing services are shared equally across the population.
- The benefits are shared by all regardless of income.
- The market plays a reduced role, but is not absent altogether.
 - Those who can afford it can buy extra help and services from a limited range of for-profit providers.
 - The state commissions some childcare and long-term care services from the independent sector
 - There is a limited 'internal market' being developed
 - There is limited use of direct payments but these are not popular and take up is low.
- The community plays an informal role as it always has but the voluntary sector and community self-help organisations are less involved in direct provision of care and more in advocacy.
- Families take primary responsibility for very young children but see themselves as working in partnership with the state.
- Individuals' roles are largely as paid carers and taxpayers and there is no stigma attached to receiving services which are universally available.

The Partnerships Model

Countries that fall into a Partnership Model do see gender equality as an important policy driver, but it is not necessarily the main, or even most important, factor underpinning the development of child care and long-term care policies. They have developed welfare states, but do not view the state as being necessarily the only or main provider of services. The state is seen more as a driver of policy: setting a legislative framework and in some cases providing funding and services, but doing so in partnership with the market, with communities and families, and with individuals. There is a greater role played by municipal authorities than in the Universal State Model, and thus sometimes a greater variation in the availability and quality of services. However, the state does play a strong regulatory role, and individuals do have important rights to access services.

Examples

Country	Population	EGEI score*	% of GDP spent on services (OECD data)
Germany	80.62m	0.79 equal sharing of paid work 0.47 equal sharing of money 0.51 equal sharing of power 0.58 equal sharing of time	1.25% on long-term care
The Netherlands	16.8m	0.8 equal sharing of paid work 0.56 equal sharing of money 0.53 equal sharing of power 0.7 equal sharing of time	3.7% on long-term care

(UK)	64.1m	0.82 equal sharing of paid work 0.39 equal sharing of money 0.46 equal sharing of power 0.58 equal sharing of time	2% on long-term care
(Scotland)	5.295m	Not available	

Table 3 Partnership model characteristics *based on Platenga et al (2009), using EU/OECD data

Long-term care and gender equality

The provision of long-term care has always been seen as the responsibility of the state to a certain extent in the Partnership Model, and the Netherlands in particular has seen relatively high spending in this area. Social rights to long-term care provided by municipalities has been a feature of this model since the mid 1980s, but in both of our case study countries underwent substantial revision in the 1990s and again in recent years, reflecting the growing demand for these services from an ageing population. In both child care and long-term care the state is seen as having an important role, but not being the sole provider of services and support. Instead support is seen as being funded and delivered in a partnership between the state, employers, the community, families and individuals.

Policy in the Partnership Model has the effect of recognising and valuing women's labour as carers: mothers and informal carers. It creates incentives for women, particularly low-income women, to provide care and rewards them for doing so: no mother or carer is left without an income because she is providing care and support. However, this is at the cost of women's labour market participation and equality in the public sphere, and there is little incentive towards a more equitable sharing of care labour across genders.

Germany

The most significant recent change to long-term care policy occurred with the introduction of long-term care insurance. This is a national scheme that offers benefits based on three levels of need with fixed lump-sum benefits, along with cash payments for carers which can be supplemented by means-tested benefits. The purpose is to enable those who need care and support to purchase their own services from a mix of formal and family carers, using insurance-based state benefits topped up either through their own means or additional benefits.

Unlike countries in the Universal State model, Germany has opted to support women's care labour in long-term care by reimbursing them through cash payments, rather than encouraging women into the labour market and providing universal formal care services. Although cash benefits to recompense mothers were heralded as supporting and valuing care work undertaken by women, they have been criticised for leading to greater gender inequality, particularly amongst low-paid, low-skilled women for whom the cash benefits incentivise remaining away from the formal labour market for longer periods. Moreover higher income women are more likely to make use of formal publically funded care services creating further social division. However this does mean that higher skilled women are less likely to take long career breaks meaning that employers are likely to benefit from their re-entry into the workforce, and income inequality across the genders in higher income families is

reduced. Lower income women are more likely to have a financial incentive to provide care to family members because they can receive payments through the long-term care insurance scheme and through cash benefits directed at them.

The Netherlands

Long-term care in the Netherlands has recently undergone substantial change, separating out those with medically-related chronic health problems (who are entitled to care within a health funded institution) from those with less severe needs (who are now eligible for support to help them stay in their own homes and participate in society). This is coupled with a reduction in eligibility for direct payments for disabled people, which enabled those living at home to employ their own carers (including family members). These changes are part of an ongoing policy drive to reduce costs by moving responsibility for the provision of long-term care from the public to the private purse (Grootegoed and Dijk, 2012).

Responsibilities of the state, the market, communities, families and individuals

In the Partnership Model *the state* acts more as a commissioner than a direct provider of services. It provides a regulatory framework for the quality of the delivery of care, including regulating who can provide the care and how payments to individuals to purchase care can be spent. It also plays some role in directly providing services at both a national and a municipal level. However, services are not simply provided through taxation, as in the Universal State Model, but through a combination of taxation, insurance, employer and employee contributions. Compared to the Universal State Model there is a greater role for local and municipal authorities in this model, both in directly providing services and regulating the quality of local market provision. However, eligibility for services and the level of cash benefits is set nationally, not locally, which provides an equitable and uniform level of subsidy regardless of location.

The market plays a significant role in providing formal care services in long-term care. Private day care for children is the only feasible option for parents that work full time in the Netherlands and makes up a significant portion of the supply because public provision cannot meet demand in Germany. Recent changes to long-term care policy in both Germany and the Netherlands have been specifically designed to allow greater choice for service users and to involve the market in the direct provision of services where appropriate. This is ostensibly a gender-neutral policy move: users are meant to be free to combine formal and informal care provided by the state, the market and family in ways which best meet their needs and circumstances, and in theory this could be from equal numbers of men and women in both the formal and informal sphere. However we know that women are hugely overrepresented as carers in both formal and informal long-term care. The reality of a large reliance on the market to provide care effectively means a continuing reliance on the paid and unpaid labour of women and does not address gender inequality in the provision of care. Moreover it creates a two tier care system between higher income women who can afford to supplement formal care through the market, and return to and remain in the labour market, and lower income women who cannot afford to supplement insufficient formal provision other than through their own labour, and thus are more likely to work part-time or withdraw from the labour market, increasing their risk of poverty.

Communities also play a more significant role in providing services and support in the Partnership Model than in the Universal State Model. Often the third sector is drawn into the market of providing formal services, and there is sometimes a great reliance on informal social networks to provide low levels of support (for example befriending services, housework and monitoring). Families, particularly women, who do not have access to these social networks are at a disadvantage in this model, as they are more likely to have to fill in the gaps themselves or to have to pay for formal support. However, social networks and social capital can be strengthened by community involvement in the provision of care, with carers who might otherwise be isolated building and sustaining emotional as well as functional support networks. *Families* are perhaps the most important partner in the Partnership Model, and it relies heavily on collaboration between individuals and wider families (particularly children in the case of long-term care) to take the responsibility both for providing care and support, and for arranging, co-ordinating and integrating with the formal delivery of services. Reliance on 'family' care usually hides the fact that such care is usually (but not always) provided by women. Cultural preferences for daughters over sons, coupled with a lack of family leave or other incentives to make increased participation in care work attractive financially to men, mean that care work remains gendered.

The responsibilities of *individuals* in the Partnership Model are firstly to participate in the paid labour market and contribute to the tax and insurance base which funds the formal provision of services. Secondly, individuals have a great responsibility to provide some or most of care themselves: in the low-level support of disabled and older relatives, and in the co-ordination (and sometimes provision) of higher level long-term care. The state acts more as a broker of support in partnership with individuals than a direct provider in this model.

Advantages

- The Partnership Model offers a great deal of flexibility and choice to people needing long-term care. It enables people to put together packages of care and support which reflect their own individual circumstances, and can be adapted to changes in those circumstances.
- The care work of women as family carers is valued and supported. Women (and some men) who chose to undertake long-term care have access to an income and are not necessarily reliant on their partners for access to resources.
- Access to benefits is tailored to individual circumstances but is also universal (nationally set) and fair. Whilst municipalities play a significant role in providing services, they do not set the level of cash benefits that parents and service users are entitled to.
- There is significant scope for municipalities to develop care services that are flexible and accommodate local need and circumstances. Because services are not homogenous there is the ability to deal with variations in demand for and supply of formal services, and to harness local community resources to provide support.
- There is the potential for community and kinship networks to be developed and strengthened. Because this model relies heavily on inter-generational care (children providing care for their parents) as well as intra-generational support (between spouses, siblings and friends) there is the potential for strengthened social networks and social capital. This can lead to emotional as well as practical support for carers,

reducing isolation and the mental and physical burden of providing child care and long-term care.

- This model is robust and able to deal with fluctuations in demand, particularly the rising demand for long-term care. Individuals have a significant responsibility to make arrangement for their own long-term care through insurance. Directing subsidies at parents rather than providers enables economic and social policy to be flexible to respond to changes in economic and political circumstance (it is far easier to make changes to subsidies and tax benefits than to withdraw funding from largescale publically funded capital infrastructure).
- The Partnership Model ensures that the risks and benefits of care provision are shared between the state, employers and individuals. Rather than the state being the main provider and commissioner of services, and therefore having the sole responsibility for protecting against social risks, employers and the market share the risks and benefits with the general population. There is therefore an incentive for employers to develop family-and-care friendly policies and to support a flexible and well trained workforce.

Drawbacks

- This model reinforces gendered patterns of labour. It provides little or no incentive for men (unless they are relatively low paid) to become more involved in the formal or informal provision of long-term care.
- The Partnership Model relies heavily on the family and this masks its reliance on women's labour. By presenting the policy frameworks as gender neutral and enabling choice, this model hides women's unpaid care and relies on cultural norms that expect women to provide care.
- This model offers significantly more choice and flexibility to higher income women. The use of the market to provide services, means that higher income women will be able to benefit from exercising choice and supplement state benefits with bought-in care. Lower income women are more likely to have financial incentives to withdraw from the labour market and provide care themselves, or to be trapped in low paid part-time work because of the need to combine paid and unpaid work. This reinforces inequality *between* different groups of women. It also means that lower income women are at far greater risk of poverty over the lifecourse due to their underemployment.
- Formal care is not necessarily highly valued or paid. Because the market plays a significant role in providing services in this model, there are strong incentives to compete on economic rather than quality grounds. This usually means that wages are kept low and workers are not highly skilled or valued. As the majority of these workers are women, this means that occupational segregation and low pay remain an enduring feature of women's working lives.

Key transferable features

- **Providing cash benefits directly to service users is fairly simple to do.** In fact, cash benefits, tax credits and child care benefits already form a significant part of social policy provision in most developed welfare states, including the UK.
- **This model could easily be adapted for different governance, legislative and political contexts.** Federal and devolved government and municipalities to develop their own versions if they have sufficient tax raising and social policy powers. A strong centralised social democratic state is not needed to deliver this model, and it can adapt to different political and ideological priorities.

- **Long-term care insurance is widely seen as one of the most important tools in preparing for the growing demand for services in developed welfare states.** Present systems of taxation and/or asset-based funding, or increasing reliance on unpaid informal care, are not tenable and will not deal with the growing crisis in long-term care funding and provision. Long-term care insurance.

Notes of caution

It is difficult to say how much of the Partnership Model's success is reliant on existing good relationships between the respective partners. Certainly employers have been willing to be engaged in tax breaks for working parents and in contributing to long-term care insurance schemes for a variety of reasons, including seeing the economic and social benefits of employee retention. However, workers in the Netherlands have always worked fewer hours and expected a good work-life balance than their UK counterparts, and health care in Germany is funded through insurance schemes which are partially funded by employer contributions, so long-term care insurance was not a significant departure or change in policy. Move towards more flexible working, shorter working hours, parental and carers' leave, and employer-funded care insurance may be more difficult in countries which do not have these as part of their social, economic, political and cultural contexts.