Whose empowerment and independence? A cross-national perspective on ‘cash for care’ schemes

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ABSTRACT
This paper uses qualitative data from a cross-national study of ‘cash for care’ schemes in five European countries (Austria, France, Italy, The Netherlands and the United Kingdom) to consider the concepts of empowerment and independence in relation to both care-users and care-givers. The paper locates the schemes along two axes, one of regulation/non-regulation, the other whether relatives can be paid or not. Each of the schemes has a different impact both on the care relationship and on the labour market for care. In The Netherlands where relatives can be paid, for example, a fully commodified form of informal care emerges; but in Austria and Italy with low regulation, a mix of informal and formal care-givers/workers has emerged with many international migrant workers. In the UK, direct payments allow care-users to employ local care-workers who deliver care for various lengths of time; while in France a credentialised system means that care-work is delivered by qualified workers but for very short intervals. The main conclusion is that none of these schemes have a simple outcome or advantage, and that the contexts in which they occur and the nature of their regulation has to be understood before drawing conclusions about their impact on empowerment and independence on both sides of the care relationship.

KEY WORDS – Care-users, care-givers, care-work, social care, direct payments, cash for care, migrant labour, comparative social policy.

Introduction
Recent work on paid and unpaid work has suggested that the dichotomy between them is breaking down, particularly in the field of domiciliary care. Increasingly, the forms of unpaid work known as ‘informal care’ are having cash attached to them through state subsidy, a process which the author has named the ‘commodification’ of care (Ungerson 1997a). The effect has been that hybrid forms of ‘work’ and ‘care’ are developing, whereby

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the cash nexus enters the care relationship in the domestic domain, and the
nexus of affect enters and permeates the work relationship (Ungerson 1999). These systems have taken various forms in Europe and the United
States, as their various names indicate: ‘independent living’, ‘consumer-
directed care’, ‘direct payments’, ‘dependence subsidy’, ‘personal budget
schemes’ and ‘companion payments’. But all have the same basic intent –
to allow the users of social-care support to receive cash instead of services
and spend that money on the direct employment of carers who deliver care
to them in their own homes. In effect, frail elderly and disabled people are
being given the means to enter the labour market and to contract caring
labour. The specific form of commodification that these systems dem-
strate has been named ‘routed wages’ (Ungerson 1997a).

The arrangements of these systems vary; some are highly regulated and
designed to ensure, for example, that ‘employees’ are properly covered
for their social rights, receive holiday entitlement and holiday pay,
and work regular and contracted hours. Other schemes allow a complete
free-for-all: care-users who receive these payments are not monitored to
see how or on whom they spend the money. Indeed, if they wish, they can
put the money under the proverbial mattress. The use of illegal and/or
undocumented labour is not explicitly forbidden or sanctioned. Thus
there is a major difference between these schemes along the axis of regu-
lation/non-regulation. But cross-cutting this axis is a further distinction,
whether care-users can use the cash to ‘pay’ their relatives. The regulated
British scheme of ‘direct payments’, for example, expressly forbids the
payment of relatives (the list of who is vetoed reads very like the list at the
end of the Anglican Book of Common Prayer of whom one cannot marry),
while the even more highly regulated ‘personal budget’ scheme of
The Netherlands allows care-users to pay their relatives (who actually
receive their wages from the Social Insurance Bank). In the unregulated
schemes, the payment of relatives may be part of the prevailing culture
of the scheme.

Until recently, the literature on these developments has focused on the
way in which the funding of care-users to employ their own labour has
underwritten their control of the quality, timing and responsiveness of the
social support they receive. Much of the literature has contributed to the
empowerment discourse, and argues that through direct employment,
care-users can control the care relationship and act independently of the
professional social services system (Morris 1993). A focus on care-workers
is relatively recent, has tended to take a more critical stance, and suggests
that the schemes and their vocal supporters, coming from the disabled and
pensioner lobbies, have been relatively insouciant about the impact on
care-workers and on the labour market for care (Ungerson 1997b). The
more critical argument is that these schemes are likely to foster the development of a care-labour market that is ‘grey’, marginalising the workers and locking them into peripheral, low-paid and transient employment, while at the same time denying them social rights such as employment-related benefits, and excusing them social responsibilities such as the payment of employment-related taxes. On the other hand, it may also be the case that these schemes, by allowing for the payment of relatives who previously have been ‘classic’ unpaid and formally unrecognised informal carers, actually provide a means whereby the work of care-givers is recognised and recompensed, such that they become more and more like care-workers.

This paper draws upon empirical data from a cross-national study in five European Union countries to investigate how far care- ‘workers’ and care- ‘givers’ are, or are not, rendered independent or empowered by these different schemes. The countries selected (Austria, France, Italy, The Netherlands and the United Kingdom) were chosen because each represents a different type of scheme. The model that the paper investigates is based on two cross-cutting axes: one of regulation/non-regulation; the other of ‘care’ and ‘work’. This model is named the ‘cross of routed wages’.

Figure 1 represents commodified care schemes, and its vertical axis describes the policy context and the way in which schemes are or are not regulated in their implementation. The regulation of care can take two forms. The first is that care is construed as work and falls within the generic regulations governing work as a whole – earnings from care are taxed, social rights are derived from employment in care, and hours of work are regulated. The second draws on the principle that the activities
of care should be subject to specific regulations – that certain standards can be imposed (generally through a care qualification), credentials are visible and checkable, and authorisation – for example, in the form of police checks – is imposed. Non-regulation is less easily categorised; it covers many different kinds of care relationship and ‘contract’, but none publicly accountable. In a non-regulated setting, the cash payment is contingent on the demonstration of need on the part of the care-user, not on the existence of a commodified care relationship. Its impact on the type of person who comes forward to care may vary, from members of the care-user’s household recruited through affect, to informally-employed workers operating in a ‘grey’ labour market. The horizontal axis describes the type of care relationship in commodified care. In those schemes which allow relatives to be paid, the relationship, and the work of care, may most resemble that of informal care – a relationship based on kinship and affect rather than contract, and one that provides holistic care. In those schemes which most strongly promote the activity of care as paid work, its organisation most resembles conventional employment: it is subject to contract; the employer has the right (and legitimacy) to hire and fire; and the employee the right (and legitimacy) to exit employment.

Developing the model

Before reporting the data analysis, it is important both to define terms and to elaborate the model used to identify different types of commodified domiciliary care arrangements and different types of care-giver/worker. Figure 2 presents different types of carer along the two axes of regulation/non-regulation and care/work. In the lower-left quadrant are the ‘classic’ informal carers – wholly unregulated and recruited through affective relations. In contrast, in the upper-right quadrant are the care-workers recruited through the labour market and subject to contractual relations. Some carers straddle the quadrants, for example, the ‘remunerated’ carers who are paid a wage to care for their relatives and are subject to both affective and contractual relations. They could also be high on the ‘regulation’ axis and in the upper quadrants, depending on how far their income is subject to taxation, their hours contracted and their social rights guaranteed. Similarly, ‘agency’ workers could be workers who are heavily regulated through, for example, the Care Standards Act 2000, which imposes minimum training and quality assurance procedures on domiciliary care agencies, but they could also be self-employed and beyond the frameworks of employment law. The figure is schematic, partly because the policy and labour market contexts influence the precise position of particular groups.
of carers, and as both policy shifts and labour markets change, groups of carers will move around the ‘map’.

Figure 3 uses data from the empirical studies described later in the paper to locate different ways of organising ‘commodified’ care, that is the ‘routed wages’ type (Ungerson 1997a). It also introduces the time spent in the delivery of care. The spectrum from ‘care’ to ‘work’ contains implicit distinctions about time commitments. The time of a ‘carer’ is available flexibly and for long periods. For this reason, despite the commodification of the care relationship and the payment, in some sense, of the care-giver, the care is similar to that of ‘classic’ informal care – one carer is solely responsible and provides care in a holistic way and some are available 24 hours a day, seven days a week (24/7 care). On the other hand, the time of a ‘worker’ is often very carefully organised and subject to contractual arrangements. Care-giving is likely to be distributed in very short bursts to multiple clients. As we shall see, however, in the unregulated quadrant at the ‘work’ end of the spectrum, very cheap ‘grey market’ labour is flexible, available for long periods and can provide 24/7 care.

All these different types of arrangement exist. For example, the Dutch system (A on Figure 3), which is highly regulated by quasi-government agencies – in this case, the Social Insurance Bank – falls into the upper left quadrant. It is highly regulated and its overall impact, by allowing for kin, friends and neighbours to be paid, is to commodify ‘classic’ informal care.

The French system (B), as depicted in the qualitative data from Rennes
and its hinterland, is a regulated system that is dependent on paper trails for monitoring and audit of expenditure and which forbids the employment of spouses but not other relatives. Its scale and culture encourages the employment of care-workers recruited and managed through agencies. Many of them are qualified with a basic care-work diploma. It therefore falls in the upper-right-hand quadrant. The United Kingdom system (C), known as ‘direct payments’, is also a regulated system, forbids the employment of close relatives or co-residents (unless they are employed specifically as personal assistants), and insists on a paper trail of expenditure and the payment of national insurance contributions for the care workers. Recruitment of care-workers is difficult, however, and our data suggests that it mixes very local networks (which may well mean the actual employment of people long known to the care-users) and mainstream care agencies and job centres. This mixture means that it is located near the centre of the regulation half of the diagram. The Austrian and Italian systems are placed low on the regulation axis. These systems simply provide monies for the care-users, and do not regulate at all. One result can be that the payments simply enter the household economy of the care-user, raising the household income but not that of the individual care-giver (they may be a spouse or other co-resident). Another possibility is that the money is used to pay for care-work from the ‘grey’ labour market. It is only with such an unregulated form of disbursement that this possibility

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arises, and it is not surprising that, particularly in countries where such labour is easily available, these monies are used to recruit it. Commonly in these systems, both (D) and (E) occur concurrently.

The five country study

The analysis that follows is based on a study recently undertaken by the author, Professor Sue Yeandle of Sheffield Hallam University and four research teams working in four European Union nations. The five countries under scrutiny are Austria, France, Italy, The Netherlands and the United Kingdom. The objective was to investigate the employer–employee relationship in depth, and to develop an understanding of how and whether the presence of the cash nexus alters the care relationship, such that it emerges as a hybrid of work and care (Ungerson 1999). In addition, the cross-national framework facilitated the examination of both the differential impact of the five funding regimes, and the impact on contrasting labour markets. The adopted methods were appropriate to these aims and contexts. In each of the five countries, the research teams interviewed to elderly care-users who received monies through a ‘cash-for-care’ scheme. In three of the countries – Austria, The Netherlands and the UK – the sample was found through the agency or agencies that either allocated the monies or supported the care-users. In France the sample was found through an agency that provides care-workers, and in Italy through church organisations which directed the researchers to frail elderly care-users.

In no sense are the samples representative, but the qualitative data provided considerable insight into the meaning of the cash-for-care schemes for the care-users. Once contacted and interviewed, the elderly care-users were invited to provide the names and contact addresses of their caregivers, and the majority of interviews with care-givers/ workers were from these caring dyads. It became clear during the studies in Italy and Austria that the study had revealed interesting migratory and global features of the care-labour market, and both used purposive ‘snowball’ sampling to contact additional migrant care-workers. In each of the five countries, approximately 20 care-giver/workers were interviewed. The research teams collaboratively devised the interview schedules for both elderly care-users and care-giver/workers, and the interviewers, who all spoke excellent English, actively participated in these meetings.

At the development stage of the project, it had been decided to translate the interview material into English. This countered the view (previously argued by the author) that translation in cross-national research inevitably
loses nuance and culturally determined meaning (Ungerson 1996). On reflection, and in practice, some compromise is needed. For this project it was thought that the gains in fluency from translation by qualified translators would be greater than the losses of cultural sensitivity and meaning. Moreover, in order to maintain an overall understanding of all the qualitative material, it was thought that the analysis was best undertaken by the English-speaking directors of the project. Once the interview material had been collected, the research teams reconvened to discuss the emerging key issues. A consensus was reached on what should be selected from the interviews for translation (up to a maximum of 3,000 words per interview).

This project therefore approached cross-national data collection and analysis in a centrally managed and selective manner. Strong elements of trust and consensus meant however that the research teams worked within an agreed framework at both the data collection and data selection stages. The richness of the data available in English is very considerable. A further issue arose over the nature of the qualitative samples. There is a great deal of ‘noise in the system’ for it was not possible to hold the variables constant. For example, in Austria, Italy and the UK, the samples of elderly care-users were in the large cities of Vienna, Salzburg, Milan and Sheffield. But, even so, these cities differ markedly, with Vienna and Milan having many incoming international migrants, while Sheffield has a stable population with little in-migration, particularly from abroad. Both the studies in The Netherlands and in France were conducted in the largely rural hinterlands of urban regions, which probably means that the labour markets in these areas are much less diverse, and the local networks more solidaristic than those of urban areas. The differences among the areas of origin of our sample populations continue to be uncovered, but it is known that if we had attempted to hold the variables constant, for example by using a triangulated method, the entire project would have been prohibitively expensive. In short, the project has produced data from qualitative interviews carried out in defined areas of five European countries (and in five languages), and the data have been selectively translated into English.

The analysis assesses how far each category identified in Figure 3 supports the ‘empowerment’ and ‘independence’ of both care-user and care-giver/worker. A broad definition of ‘empowerment’ was adopted, that care-users receive the care that they want – at the right time, of appropriate quality and delivered by the person or people they prefer. Similarly, a broad definition of the ‘empowerment’ and ‘independence’ of the caregivers/workers is taken to mean that their position is broadly as they would prefer, and that they perceive themselves as recognised and/or adequately remunerated for the work they do. Another issue is the extent to which the
social and employment rights of the care-givers/workers are protected – and this, as we shall see, is a major differentiator of the systems.

The five variants of commodified care

A. Fully commodified ‘informal’ care

In this study, there were two examples of fully commodified ‘informal’ care: the Dutch system organised by the Social Insurance Bank and framed by welfare state legislation; and an arrangement in Austria organised by Caritas, the Roman Catholic charity, which pays informal carers to care. The Dutch system pays cash according to the amount of care-work time that is judged to be necessary, in conjunction with an assessment as to how much ‘domestic’, ‘personal’ and ‘nursing’ care is required. The sums provided to the respondents therefore varied considerably. In the Dutch sample, a paraplegic man was assessed as needing 19 hours of nursing care per week, and 3 hours of domestic help, and for this care his wife received £21,828 a year. Smaller payments, in the region of £300 a month, were more usual.

In Austria, on payment of a fee from the care-user, Caritas acts as the employer of a care-giver, who may be a relative. The care-giver receives pay for the tasks undertaken (which is often more money than the cash benefit the care-user receives in benefit), and is fully covered for social security rights and holiday pay. For example, Mrs S, aged 39 years, cared for her 80-year-old mother with whom she lives. Her mother received £266 a month in care allowance, and paid Caritas a fee of £290 a month.3 In return for her care-work, Mrs S received a monthly wage of £562, plus cover for social security contributions, holiday rights and holiday and sickness pay.

There was general satisfaction with these schemes on both sides. As an example, an elderly Dutch couple, both of whom had had strokes, were cared for by their daughter on five mornings a week, for which she received £4,591 per year, plus her social rights. As the mother said:

Things are excellent the way they are now. And I am happy if she receives some money. I and my husband receive help and that is the main thing for us. I don’t know how we would manage otherwise. And he will not have anyone else. He doesn’t want a nurse, which is why our daughter does it.

This couple are secure in the knowledge that their daughter is paid and contracted: ‘I think it’s great. Bad weather or fine weather, in the winter in frost and snow, she is always here.’ These typified the comments from the Dutch ‘employers’ about their informal carers, and most of the care-givers/workers also said that they were satisfied with the scheme.
Interestingly, while many were aware of their employment and social rights under the scheme, they were also reluctant to exercise them, particularly if to do so meant that they would have to spend time away from caring:

In principle I could take a summer holiday … I can have three weeks’ holiday like anyone else, but I do not do that. But if there is a day when I cannot come, then I arrange for someone else to peel the potatoes, like my sister for example. It’s all about caring.

These relationships are therefore a hybrid of work and care. The payments and the contracts to care promote both the reliability of the care and the care-users’ satisfaction. The care-users both ‘employ’ the carers they prefer and they have the comfort of knowing that their care-givers are recompensed. The Austrian Caritas scheme also evoked positive comments from both sides of the care relationship. All the paid kin working within the Caritas scheme were satisfied with it. Mrs M, an 86 year old who was being helped by her daughter, said: ‘We’re very satisfied. Yes, very. We’ve never had a single complaint. We’ve always sent in the money that had to be paid.’ Later in the interview, Mrs M said it would be ‘dreadful’ to be cared for by a stranger. A typical care-giver in the Caritas scheme said: ‘It’s marvellous. To be at home, do the housework and get paid for it’. Not only do these schemes increase the income of care-givers and their co-resident care recipients and create social security entitlements, they also provide care-givers with a sense of self-esteem. One carer, who had previously cared for her father-in-law outside the Caritas scheme, described how she felt when she discovered she would be paid for caring for her mother-in-law:

You can only say that I simply felt as if I had been promoted. Society also saw it totally differently then. Suddenly it was, ‘Aha, you’re doing a job’. Although I didn’t do anything differently from before, it was suddenly seen as self-evident. But if you then say that you’re working for Caritas, people say to you, ‘Wow, you’re working now’ … As soon as you’re in employment and can say to the doctor that you have your own health insurance, it appears you are a better type of person. From the point of view of society, this type of employment is very good for women.

At least some of those engaged by these fully commodified informal care schemes had therefore begun to regard themselves and came to be regarded as ‘workers’ rather than ‘carers’. Others resisted this recategorisation. In The Netherlands, for example, two respondents found it difficult to understand why their long-standing friendship should suddenly have money attached to it:

I found it strange, but the one who came here to offer the allowance said that you could get help with it. Then I thought I would find out if my friend wanted it. But
it was difficult, because she said that was not necessary, not necessary at all. But I said that I had the allowance because it was already being paid. And now everything’s fine ... the money comes by post and I don’t have to do anything myself. I find it very easy. She tells me, ‘I have had the money’; and that is all. I don’t have to open my purse; I would find it more difficult.

When asked how she felt about being paid, the care-giver said:

I don’t think it’s necessary. And Ger put pressure on me, because the scheme people came to see me and asked why I wouldn’t do it. I told them there was no need, no need, but it happened anyway. But it’s not necessary for me. That isn’t why I started it. I do things just as well if I get nothing for it.

These systems are clearly setting up new types of social relationships in the presence of a cash nexus, and individuals are having to work out new ways of relating to each other in this framework. This is for most a relatively minor problem, particularly if handing over money to friends and relatives is undertaken by a third party. In general, the high level of satisfaction on both sides of the care relationship indicates that elderly care-users were comfortable with payments to their informal carers and received care from the people (their familiar kin) whom they most preferred. Care-giver/workers also felt valued and recognised, and their incomes had on the whole increased (some received a higher wage from this work than they had previously in a conventional job). Their social rights were intact, although their ability to exercise those that took them away from the caring tasks were attenuated. This positive picture has two caveats. First, it is unlikely that this occupation of ‘commodified informal carer’ will be recognised as valid ‘experience’ if and when these care-givers re-enter the conventional labour market. In that sense, while remunerated and recognised in the present, their human capital may be eroded, and their future employability jeopardised. Second, in this type of ‘job’ it is particularly difficult to exit – should these care-givers or care-users decide that they would prefer an alternative form of care (e.g. residential care or a different care-giver), then these relationships are now even more difficult to leave, since to do so would incur direct economic costs as well as emotional costs.

B. Regulation plus credentialism

One of the advantages of fully commodified ‘informal’ care is that, like informal care, where needed the care-giver/worker commonly gives 24/7 care. In another form of regulated care, which is combined with credentialism and quality control, there are few opportunities for 24/7 domiciliary care because of the very high cost of fully qualified care-workers.
The result is that ‘regulation plus credentialism’ is likely to proliferate care over very short episodes at crucial times of the day or night, e.g. getting up and dressing in the morning, bed time at night and at meals during the day. From the five country study, the closest approximation to this system and outcome is the means-tested Prestation Spécifique Dependance [Dependency Benefit] (PSD) in France. This pays around £350 a month, insufficient to employ someone full-time or for many hours. As a result, many care-workers are employed through agencies and engaged with multiple clients. It was found that French care-workers worked for up to 13 people whom they visited at least once a day. Most of these workers had received training and acquired the basic care qualification, the Certificat d’aptitude fonction d’aide a domicile [Certificate of Aptitude for Domiciliary Care Tasks]. The fact that these care-workers were engaged with numerous ‘employers’ meant a constant battle with time and location. Many of them complained about the problem of dealing with so many employers at once, and how difficult they found it to combine holistic care (see below) with the exigencies of having to deliver care-work at speed:

I asked the question, ‘Until what time are we to work in the evening?’ I was told, ‘Usually you should be home by 7.30 at the latest’. Yes, but when I have both clients ... Like this evening, I have Mr Morin first. Friday is griddle-cake night, the night on which he eats best ... so the griddle cakes have to be heated up, the egg has to be placed on top and everything ... I don’t know where he puts it all! He eats three of them! But it makes him happy. On Friday he treats himself. You cannot do it in five minutes! Afterwards there is the washing up, and then he has to be undressed. As I have shopping to do this evening I will take a quarter-of-an-hour to go to the nearest grocer’s, it’s more expensive but what can you do? On Fridays, instead of half-an-hour it takes a good three-quarters-of-an-hour, plus a quarter-of-an-hour for shopping, that makes one hour.

These workers are engaged, as we can see from the above quote, in diverse tasks including cooking and shopping. They repeatedly move from client to client, and deliver their services and care in ‘short bursts’. Their bureaucratically determined diurnal programme frequently clashes with the physiological rhythms and preferences of their elderly ‘employers’. At the same time, this group of care-workers have training, a qualification and are highly reflexive about the contradictions of and boundaries between the tasks they undertake. ‘The profession is not recognised. You’re really a cleaner, a housekeeper. Of course we do all that! But when you allow yourself to wash somebody, do the shopping, fill in papers ... you deviate a little from the profession of a cleaner. Nobody understands’. This sense of not being properly understood was something of a continuous refrain in these interviews. Another care-worker said: ‘It is true that the work of the carer is not understood very clearly. Frankly, we are not recognised’. Like
many others in the French sample, this worker identified a holistic approach as the distinguishing feature of her care:

We cannot, when the person asks us, takes us by the arm and says ‘come and see my granddaughter’ … you drop everything and go to see her. The relationship is important. Touch … it must not go to extremes but I think that a slight caress or a pat on the back is important. If you do not have that instinct to feel things, there is no point, you should find another job.

Such reflexive commentary on the nature of the work was typical of this group of workers, and it was also clear that as a group they are engaged in a boundary dispute with the neighbouring (and better paid) occupational category of ‘care assistant’: ‘we are not permitted to do dressings, or anything like that. We do not have a Care Assistant Diploma. If we give any assistance, it is at the request of the doctor and we can refuse to do it’. Later this same care-worker argued that the fact that she was not supposed to wash her ‘employers’ was contrary to the holistic approach she wanted to adopt:

I am not against washing, on the contrary, I find that a relationship is created during washing that perhaps you do not have while the person is eating or I am making the bed. It’s a different relationship when you wash them. She says to me, ‘You are hurting me, you are rubbing too hard’. There is a whole exchange. I think washing is very important. But it seems we do not have the right to do it.

Thus these care-workers are in an interesting relation to the issues of empowerment and independence. In terms of independence, they are operating in the conventional labour market and their social and employment rights are fully intact. But in the job itself they encounter frustrations: working within a strict division of labour, they are not allowed to act autonomously and to provide the service they judge best. Moreover, the need to move from client to client according to bureaucratic rather than their elderly clients’ body times, means that they experience dissonance between their desire to provide holistic care untrammelled by the need to ration time and the imperative to provide task-orientated care. This dissonance appears to be made worse by their training, which has stressed holism rather than fragmentation in the delivery of care. It is not surprising therefore that in important respects they feel themselves disempowered in their job. One major advantage of their situation remains – they have a position in an occupational hierarchy which means that, for those with the ambition and the skill, career progression is available.

The care-users in this system were generally satisfied. But, interestingly, the language that they used to describe their relations to their care-givers was full of distancing terms. It was words like ‘kind’ and ‘competent’ rather than ‘loving’ and ‘sensitive’ that recurred in the interviews. ‘I
myself, and my wife as well, have a certain consideration, esteem, I cannot say affection. You get used to these people and in particular she is very kind, very competent. She enjoys her work’. When they found the quality of care inadequate, they felt able to complain or to terminate the relationship: ‘You can always say that you are not happy. You pay a lot of money and want to receive a good service. We do not ask too much, our assistant does not complain. She is kind to us. Otherwise we would say, “That is enough, it is not working”. We would get a cleaner and that would be cheaper.’ One French care-user had actually managed to change his wife’s carer: ‘The person in question came and did nothing but housework. She was above all a cleaner. Her manner left something to be desired. One day I said “I have had enough”. The person did not come again and afterwards I was sent someone else who gets on well with my wife.’ The care-users in this system are therefore supported in their desire to maintain their independence and feel empowered to voice complaints and exit relationships if they wish. Using an employment and service-related discourse, they are empowered to enact as consumers of task-orientated care. They can come and go in the relationships and create different configurations of care-giving. These are distanced relationships based on contract. The roles are clear, and the emotional content concomitantly reduced.

C. Direct payments

It is suggested in Figure 3 that the direct payments type of ‘routed wage’ system falls near the centre of the ‘care/work’ spectrum and low on the regulation axis. This positioning is based on the finding of our research on the UK Direct Payments scheme, that some care-users searched for labour by using close local networks, and that some of the people eventually recruited had been known for long periods (although by the rules they could not be kin). Moreover, it was also found that among this group were both care-users with only one carer who worked for many hours, and care-workers who only worked for one employer. The scheme therefore generates rather different types of care relationship from those of the regulated credentialised system. With a direct payments system, care-users and care-workers operate in a labour market characterised by low wages and few skills and qualifications, and in which the organisation of care work (as through agencies) may be rudimentary or non-existent.

The situation that emerges is very complicated. Among our sample, we found care-users who had recruited their care-workers through word-of-mouth, and others who had used impersonal forms such as newspaper advertisements and notices at the Job Centre. Some care-users had only
one care-worker, who provided care over long periods during the
day, while others through huge supplementation from their own resources
employed many care-workers who, working in shifts, provided 24/7
care. In this regulated care system, care-users and care-workers are left
to their own devices as to how they recruit and organise the care.
These features are overt and promoted, for they are consistent with the
ethos and discourse of consumerism and empowerment. The result is a
wide variety of care ‘solutions’ and relationships, which may or may not
increase the independence and empowerment of both care-users and care-
workers.

‘Direct Payments’ in Britain have evolved from a policy designed ini-
tially for disabled people of working age, and only since 2000 have been
extended to elderly care-users. The use of the ‘Direct Payments option’
by older care-users has yet to become widespread, and although all our
sample of care-users were of pensionable age, most had come to Direct
Payments through disability rather than age. Many had therefore ab-
sorbed the empowerment discourse which the disability lobby articu-
lated to support the development of Direct Payments. Thus care-users
were well aware of the reason why they had taken the option of Direct
Payments:

I mean, we have to have these carers and it’s better than having social services
that come in at a certain time and treat you like you’re robots – you get up at a
certain time, go to bed at a certain time and you function at a certain time.
Whereas [with] your own carers, to a certain extent you have got control of what
time you want to get up, what time you go to bed, things like that. You see people
say to us, ‘Whatever do you get up at six o’clock for in the morning?’ Well we say
when we’ve been put to bed at say half-past-ten the night before, we can’t move
about at all in bed, we can’t go to the loo and things like this, so we’re ready to get
up and move about at that time, you see.

Another respondent had taken advantage of the Direct Payments scheme
to employ two carers from the Caribbean, from where she came. By doing
so she had brought to an end the anxieties that she felt when attended by
‘English’ carers – whom she thought were racist and dishonest. There is
some evidence, therefore, from our small sample that the Direct Payments
scheme gives individual care-users the ability to control both the type of
care-worker who assisted them, and the timing and type of care they
received. In that sense both their independence and their control of the
care relationship were enhanced. The picture from the care-workers’
perspective was more mixed. Some of them were very positive, and re-
ported that they preferred to work in the domiciliary setting on a one-to-
one basis because it allowed them to work to the standards they preferred:
‘When I had the chance to go and work with one lady – I can then make

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sure that lady gets all the attention that she needs. Whereas when I was in the nursing home I couldn’t do anything about it. Some days it was just like a conveyor belt.’ Moreover, the discourse of the relationship was often couched in ‘family’ terms:

Here it is sometimes like I am part of the family. They went away a couple of weeks ago and brought me back slippers and a bar of chocolate, it was really sweet. And so it is quite like I am part of the family.

Here – being on a one-to-one – it gets more personal because you know they are relying on you to come in every day. When they were in hospital, you know, friends would ring me up and find out how I feel, what’s happening and stuff like that, so you become more like an extended part of the family.

These care-workers had constructed an occupation for themselves that they found congenial. Whether this constitutes an enhancement of their independence or empowers them is more difficult to judge, since the downside of being treated as ‘one of the family’ is that expectations grow, and the care-users’ needs always have priority. This was particularly clear in the frequent mentions during the interviews of disputes about time. The difficulty was that, because so many care-workers lived close to the people they helped, they were frequently called to assist them outside their contracted hours:

**Interviewer:** What about the looking after X at the moment – do you find that fits in with your life at the moment? At the moment it’s just 5 minutes’ walk from home.

**Care-worker:** Yeah, I did, at first, but then it’s too handy – it’s just across the road, and he rings me up a lot. You know: ‘Oh, can you just do this and that’, like, out of my time.

**Interviewer:** Does he call you up, then, outside your working hours?

**Care-worker:** He does at night-time, yes.

**Interviewer:** And how do you find that?

**Care-worker:** Not bad, but when he does it all the time, it gets a bit much.

**Interviewer:** Does he do it daily, every week or … ?

**Care-worker:** About three times a week or something, sometimes it’s at weekends as well. ’Gos he expects you to be there at his beck and call, all the time.

**Interviewer:** Would he pay you additionally for the extra time?

**Care-worker:** No.

For these workers, it was often a matter of luck whether they had a ‘good’ employer or not. The fact that they were frequently working alone with no colleagues, and operating in a segment of the labour market which credentialism has barely touched, meant that they were vulnerable to exploitation based on emotional blackmail. Their independence was
hardly enhanced, and their power was minimal (as demonstrated by one employer who appeared to sack employees on a whim).

**D. Additional income flows into the household**

As has been suggested, in the systems which are entirely unregulated, the payment of cash supplements which are intended for the purchase of caring labour can in practice be spent on anything, not spent at all, saved or even given away. In the five country study, the systems in Austria and Italy were entirely unregulated, and we encountered several households whose members regarded our questions about the transfer of money to the care-giver as entirely absurd. This was most likely when spouses were the carers. As an 82-year-old disabled Italian woman being cared for by her husband put it, ‘When two people are married, they’re married. Previously we existed on his pension and mine. Now we exist on this money as well’. And a very angry disabled 61-year-old Viennese man being cared for by his wife said:

> How can I be recognisable as a genuine human being to the person who cares for me – and in this case there is now only my wife. To talk about money in this context is meaningless. She brings it home and I should give it back to her? That doesn’t make for a completely healthy relationship. Put yourself in my situation: if I want to give her a present – because it is Easter or Christmas – she has to get it herself. Even if I want to give her a mere daisy, she has to pick it herself. I can’t even go to the florist any more. I am stuck here on the 18th floor. I can spit over the balcony – at least I can still manage that.

In both these cases, it would be possible in the Dutch system for the caring spouses to be paid. But once the allocation of funds is devolved to the household itself it is understandably impossible, given the customary allocation of resources in a marriage between spouses, to unpack these monies such that the carer directly benefits, especially where that carer is a co-resident or a close relative such as a spouse. Not only were there strong cultural reasons embedded in these decisions not to use the monies to ‘pay’ carers. In most cases these households reported that, as a result of receipt of these cash benefits, they were now able to make financial ends meet. A typical Italian respondent said:

> I put it together with my pension, and with this money I try to arrive in some way at the end of the month. … I use it also to pay the rent, the electricity, the gas, the telephone, medicines, household shopping, everything in fact. … I could not live without the money.

Thus there were strong material reasons for the subsidies to be used to supplement the household income. Nevertheless, there were several examples, particularly amongst the Italian sample, of using these monies to
lubricate social relationships so that they acquired caring dimensions. For example, in the case of the respondent quoted above, she also used the money to pay a neighbour, whom she had known for 40 years, to do regular cleaning. As she put it:

I have not employed him in the strict sense of the word ... he simply does me a favour, gives me a hand, and I pay him for this favour ... sometimes I also give him a little present, so that he thinks I am fair, and does the cleaning better.

This use of the word ‘favour’ or ‘tips’ was common among the Italian older people to describe the symbolic payments they gave to people with whom they had shared long biographies—such as friends, neighbours and adult children—in return for defined caring tasks provided over short periods. Among the Austrian sample, there was less evidence of this kind of ‘favour’ giving, although it may happen and could be common. Hence the payment of these monies in an entirely unregulated context, by supplementing the household incomes of disabled older people, had allowed them to continue to live independently with reduced financial anxiety. At the same time, it had enabled them to shift social relationships into small-scale care relationships and to reciprocate in a small way for these limited services. In both these senses, their independence had been maintained and even enhanced. Similarly, they had gained control over some aspects of their lives, had reduced their sense of indebtedness to kindly neighbours and loving kin, and hence been moderately empowered. On the other hand, the position of the informal carers who cared for many of these individuals had hardly altered at all—they remained ‘classic’ unpaid informal carers. The only substantial difference, as a few respondents noted, was that they had additional income with which to purchase very small amounts of surrogate care, again largely recruited through the social networks used by the elderly care-users themselves. Those who gave the modest services and were recompensed through small payments were satisfied, but since they spent little time in caring, their lives had hardly altered.

E. Undocumented ‘grey market’ carers

The non-regulated forms of routed wages make it possible to pay labour which is itself unregulated and operates within the ‘grey’ labour market. This labour is relatively cheap since the ‘on costs’ of taxation and social security contributions are avoided, which makes it attractive to those who need intensive and continuous care but are unable to pay the wages demanded by regular and regulated care-workers. Not surprisingly, in the two countries where ‘routed wages’ are unregulated, namely Austria and Italy, our study found extensive (and in Austria organised) use of undocumented care-workers, almost all of whom were foreign migrants. Amongst
the Italian sample, the needs-tested cash subvention that older care-users received was commonly around €700 to €1,000 a month. It became clear during the interviews that a full-time non-resident carer from the ‘grey’ market could earn about €750, although live-in paid carers in Milan were paid somewhat less. Hence the amount that is available to care-users through this cash payment is enough to employ 24/7 help. It is not surprising therefore that among those who had decided to use a paid carer from outside the immediate kin network, only ‘grey’ labour was employed. Three of these workers were immediate neighbours who provided small amounts of care – for example, one hour in the afternoon while a carer husband did the daily shopping – and were paid in cash and with small presents. All of the five paid carers who lived in the same dwelling as the care-user and provided 24 hour care, in some instances for seven days a week, were non-European Union member-state nationals. Care-workers of the following nationalities were either mentioned in the care-users’ interviews, or were subsequently interviewed: Peru (3), Ecuador (2), Romania (1), the Philippines (1), Mauritius (1) and Sri Lanka (1). It is clear from the interview material that only one of these non-EU nationals had residence rights in Italy.

In Milan there is a culture of, as one respondent put it, ‘taking a foreigner’ to provide care. The general understanding of and acceptance of this practice is so widespread that the respondent had been advised by the consultant neurologist in charge of her 90-year-old mother that she should ‘absolutely not take a non-European, because it does not go down well with people like this’. It was also clear that local recruitment networks worked very well for the care-users: workers were passed from neighbour to neighbour, from sister to sister, and some were found by concierges. None of the recipients of this cheap 24/7 care reported difficulties, and all were satisfied with the quality of the care provided (despite the strictures of the consultant neurologist). Their independence had been maintained, and they were absolutely in control of their care-workers, especially if they were co-resident. For most of the workers, however, it was a different story, for many were unwilling care-workers. A typical comment came from a Peruvian woman working in Milan:

Even if I don’t like it, what can I do? It is a stressful job, not easy work. Here the only work that one can do is to care for old people. What I did in my own country (nurse training) is not recognised here.

An Ecuadorian woman echoed these remarks: ‘It doesn’t please me at all. I do it only because I haven’t managed to find any other sort of work. I’ve looked everywhere, especially in the co-operatives that clean offices’. One of the main difficulties that these care-workers experienced
was the organisation of their personal time. A Romanian woman described her day:

I wake up between six and seven in the morning. She calls me because she is very hungry (then describes the series of caring tasks which fill her day). At six in the evening I am free for an hour – my husband comes home and we chat together for a bit. Then it’s suppertime, and after supper she goes to bed. But she calls for me even in the night.

One Italian respondent who had worked for her employer for 26 years reported that although she was deeply fond of the elderly woman (she regarded her as her sister), the relationship between them had recently broken down because she had tried to protect her personal time. The care-worker was Spanish but had acquired Italian citizenship and was not co-resident. The arrangement was that she would be paid for two hours a day, but would be continuously available:

Certainly it was a job with no fixed timetable – let’s say that for a fixed payment I was obliged to stay with her for two hours a day, but that this could be more or less according to the situation. ... In practice she called for me only when she needed me; and called me also from one moment to another, sometimes in the morning, sometimes in the afternoon, and I had to keep myself free to go to her immediately ... sometimes I went every day, six hours or more a day; or I might go for a week or even a month without seeing her, because she went away, to her holiday home, and did not need me.

Finally, this flexible arrangement had broken down, in a dispute about personal time: ‘One time I said that I could not come to her house for a week because I had to take care of my grandson, and she got very angry – perhaps she felt herself a little neglected, as if she had been “put aside” ... so we quarrelled and I decided to go: but I’m sure we will manage to make peace before long’.

The Austrian sample similarly had engagements with undocumented, foreign labour but with crucial differences. First, the recruitment pathways of foreign labour were entirely different, because the Viennese care labour market is organised by agencies that recruit carers in the neighbouring transition economies of Hungary and Slovakia. They cross the permeable borders freely, allowing for temporary and brief periods of care-work. This contrasts with the Milanese grey care-labour market, which draws on inter-continental ‘third world’ labour migrants. Another difference is that the Austrian foreign labour market is dedicated to finding care-workers for elderly care-users, whereas in Italy care-work is one of a very limited range of occupations available to illegal immigrants, and may be the most acceptable, especially to women with a need for housing. The cash supplement payable to Austrian care-users depended on the level of their disability, and was typically £400 or £543 a month. The characteristic
wage paid to a foreign worker was between £281 and £300 for two weeks in every month. For this cash payment (it was always cash), the Hungarian and Slovakian workers provided 24-hour care while they lived in the same accommodation as their elderly employer. At the end of their fortnight ‘on’, they returned to their home country, while another worker, usually from the same country, replaced them during their fortnight ‘off’. The state benefit payment that the older employers received was therefore almost enough to cover 24/7 care by illegal, undocumented care-workers. Typically the care-workers involved were very young – all those who lived with their employers for their fortnight ‘on’ were in their late teens to mid-twenties.

In contrast to the migrant care-workers in Italy, their equivalents in Austria were highly satisfied with their work. It enabled them to work part-time, earn a reasonable income, and lead a transitional life between two economies and two homes. As one of them put it, ‘Well, it’s good pay for me and he gains as well – it isn’t too much for him either. He would have to pay more for an Austrian woman. It’s quite a good deal’. Most of the employers of such labour were also satisfied with the round-the-clock care that they received at relatively low cost, but not all reported total satisfaction. As the employer of the young woman quoted above said:

It’s like this: a person who needs someone round-the-clock can’t manage. I have to take on a foreigner, because otherwise I can’t manage financially. I just couldn’t manage. That’s sad. I have to employ someone from abroad because those in our country are so expensive, ... These people can hardly speak any German; they have to learn it with a great deal of effort when they come here and if everything goes well, then they’re off after one or two years – so there’s a change in carers.4

The overall picture that forms from our research is that the position of the care-users is generally enhanced when they employ undocumented care-workers. They can afford to employ care-workers for sufficient hours to provide them with good enough and continuous care. But for the care-workers themselves, the position is less positive. Wages are very low; their social and employment rights are non-existent; their housing, especially if they are co-resident, is likely to be poor; and their future is unpromising -- all because their ‘race’ (in the case of third world migrants) and perceived ‘foreignness’ are likely to trap them in the work they do. East European care-workers, as in Austria, were in a less constrained position and take advantage of the permeable national frontiers to enter care-work as a means of acquiring human capital (in the form of a first world language) and comparatively high ‘Western’ wages to fund a reasonable standard of living in their countries of origin.
Conclusions

This paper has demonstrated that the outcomes of cash-for-care systems vary considerably, largely because of two major variants in the rules and regulatory framework — whether or not it regulates the type of worker employed by care-users and enforces the social rights of care-workers, and whether or not the payment of relatives is permitted. It is also clear, however, that the geographical, social and economic contexts influence the attributes of the care-givers or workers that care-users employ, in terms of ethnic origin, their locality and proximity to the care-user, the methods of recruitment and the care hours available to the care-user. The availability of migrant workers is partly determined by location — they are present in a metropolis that taps into global labour markets, or near the permeable frontier between Western-capitalist and Eastern-transitional Europe. And the availability of migrant labour in turn determines the ability of care-users to employ labour for long hours, even 24/7 time, and has important impacts on the way in which migrant care-workers perceive the work they do. This paper has examined the relationships between these variations and the independence and empowerment of all those involved in the care relationship. It is clear that all the variant systems whether regulated or not entail advantages and disadvantages and costs and benefits.

The paper has left unanswered several questions which will be explored in further papers and which deserve further research. For example, while it was not the purpose of the project to assess the quality of care that emerges from commodified care relationships, the findings about the variations in care hours, and the narratives from the care-givers about the impact on them of the need to deliver care at speed or for very long periods of the day and night, have provided fascinating insights into the way in which the duration and quality of care inter-relate. Nor has this paper considered the difficult question of whether routed wages increase the supply of care. There is some evidence from the Dutch and Austrian data that the impact of payments on the supply of informal care is neutral: in other words, informal carers behave exactly as they did before they were paid while appreciating the increase in their incomes and recognition. Finally, the paper says nothing about the relative cost of these schemes compared to conventional formal services, nor does it address the politics and economics of their retention and expansion. These are very important issues, particularly in Britain at the present time, for a priority of policy-makers is the promotion of direct payments in the delivery of social care and carer support. The most important conclusion of the paper, however, is that policy-makers should proceed with caution. These
policies or systems do not create unqualified benefits or utility. It is important to understand how their initial construction impacts on the empowerment and independence of both users and carers, and also to recognise that the location of care-users and the type of labour market they are able to access will influence the way in which the care relationship develops and its quality. Such caution is essential; this paper demonstrates that one cannot simply conclude that ‘routed wages’ are well suited to the management of social care.

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NOTES

1 The research teams were: in Austria, August Oesterle and Elisabeth Hammer; in France, Claude Martin and Blanche Le Bihan; in Italy, Cristiano Gori, Barbara da Roit and Michela Barbot; in The Netherlands, Marja Pijl, Clarie Ramakers and Fransje Baarveld; and in the UK, Sue Yeandle and Bernadette Stiell.

2 The research teams have full intellectual rights to all the data they collected and are publishing papers using the data in the original language of the interviews. Papers from each of the research teams using the full material are being edited by the directors of the project, for publication as a collection in English.

3 All the care receivers in our sample paid Caritas a little more than their care allowance – thus they supplemented their expenditure on care from their other income, especially from their pension. Two paid kin care-givers reported that they themselves contributed to the Caritas fee from their own income from Caritas.

4 Despite the language problems referred to by this older man, all the interviews with the care-workers were conducted in German, and the (translated) data indicates that there was no problem of communication between these respondents and the interviewer.

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