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Gender and the Caring Dimension of Welfare States: Toward Inclusive Citizenship

Abstract

This article brings care to the center of analysis of welfare states. We argue that modern welfare states have shaped needs and rights of caregivers and care receivers and have done so in ways that contribute to gender inequality in citizenship rights. This idea is explored through a comparative analysis of Britain, Denmark, and the Netherlands and reveals different patterns of organizing care. Due to the focus on care as an integral part of citizenship, the Danish welfare state has come closest to gender equality. After presenting this analysis, four dilemmas of care are discussed: care as public or private responsibility, care as paid and unpaid work, care as a form of dependence or independence, and care as the right of caregivers or of care receivers. These dilemmas lie at the heart of the welfare state and illuminate how care policies can contribute to the ideal of inclusive and ungendered citizenship.

In the last decade of the twentieth century, a topic that dominated the turn of the century has reappeared on the public agenda: the provision of care for people who are not able to take care of themselves. The care of young children, frail elderly people, and people who are chronically ill or handicapped has once again become of

great concern. This is not to say that nothing has changed. At the end of the nineteenth and the beginning of the twentieth century, mothers were granted the opportunity (and concomitantly the moral obligation) to take care of their children as a result of a combined struggle of trade unions and (parts of) the feminist movement.¹ The introduction of breadwinner wages, pensions for single mothers and widows, maternity leave, and far-reaching labor protection for women were expressions of a certain recognition of the need to liberate people from the obligation to work so that they could care. Of course, “people” actually meant “mothers” (Lewis 1990; Koven and Michel 1993; Bock 1993). The outcome of these state interventions was the “modern family” in which women were not only enabled to take care, but were also condemned to do so. This new care regime made women largely dependent on their husbands.²

Despite differences between welfare states, the general picture of the infrastructure of care in the postwar period can be characterized as a two-track care system. On the one hand women took care within the family; this was made possible through a variety of financial arrangements such as taxes, pensions, premiums, and social assistance, which were mostly paid to the husband. These care arrangements are part of what Anttonen has typified as the “insurance state” (Anttonen 1990). On the other hand, for those kinds of care that were assumed to go beyond the resources available within the family, a professional care domain was developed. These care provisions are closely related to what Anttonen calls the “service state” (Anttonen, manuscript). Through a combination of various financial arrangements offering women time for care and specific forms of professional and subsidized care, welfare states achieved their national and unique character. Within this two-tier care state, welfare state bureaucracies classify groups and categories of the population to define and determine their specific needs (Fraser 1990).

This process of defining specific care needs of specific groups of citizens contains striking differences between welfare states. While in France, for instance, extended maternity leave was provided on the basis of familial and pronatalist notions, in some Nordic countries similar kinds of leave were assured grounded on labor market policies and the assumption that citizens are individuals with care responsibilities. However, in the Netherlands such leave was not established until 1991 (and even then it was unpaid) on the grounds that mothers should not participate in the labor market at all. Striking differences can also be found with respect to professional care. State-organized child care, for instance, is well developed in countries such as Belgium, France, Denmark, and Sweden, whereas it is hardly available in Britain, the Netherlands and Germany (Moss 1990; Leira 1990; Borchorst

1990; Pfau-Effinger, 1996; European Commission Network 1996). Despite a variety of care arrangements among welfare states, a common characteristic in the postwar period is that care was acknowledged as an important factor in citizens' well-being, and accordingly, an important factor in social stability.

Because of current transformations in welfare states, however, this statement is less valid: the infrastructure of care is under pressure. On the one hand, social benefits that supported caregiving within the family, social assistance for single mothers, or maternity leave have been cut back. Also, state-organized care provisions such as residential care and home care for the elderly have been subject to similar trends (Jamieson 1991). On the other hand, new kinds of care leaves, for example parental leaves, and new forms of caregiving, for instance, privatized care services and (client) budget systems, have been introduced. This cross-national tendency for the transformation of welfare states particularly applies to state-organized care provision, although not to the same degree in all countries.

In this article we bring "care" (caregiving and care receiving) to the center of analysis of welfare states. Care includes the provision of daily social, psychological, emotional, and physical attention for people. This can be provided by paid or unpaid work, on the basis of an agreement or voluntarily, and it can also be given professionally or on the basis of moral obligation. Such a broad definition of care certainly has disadvantages: it might be too diffuse a definition for analytical goals, but there are also advantages. The most important advantage is that a broad definition of care enables us to analyze the often arbitrary and politically determined differences in the provision of care in specific welfare states. Care of children, the frail elderly, husbands, the handicapped, and the sick is not by definition paid or unpaid. Care is paid or unpaid as a consequence of political choices, shared cultural beliefs, and gender structures. Moreover, this broad definition of care offers the tools to understand and analyze connections between developments in different areas of care. Often care within the family is analyzed separately from developments in paid formal care: family sociologists deal with the former and welfare state analysts study the latter.

We argue here that modern welfare states have shaped needs and rights of caregivers and care receivers and have done so in ways that contribute to gender inequality in citizenship rights. This thesis will be explored through a comparative analysis of Britain, Denmark, and the Netherlands and reveals different patterns of organizing care. Due to the focus on care as an integral part of citizenship, the Danish welfare state has come closest to gender equality. After presenting this comparative analysis, four dilemmas of care will be discussed:

care as public or private responsibility, care as paid or unpaid work, care as a form of dependence or independence, and care as the right of caregivers or of care receivers. These dilemmas lie at the heart of the welfare state and illuminate how care policies can contribute to the ideal of inclusive and ungended citizenship.

Care and Gendered Citizenship in a Comparative Welfare State Perspective

Although the importance of caregiving and care receiving for individual and social well-being was recognized by postwar welfare states, this seldom led to the view that caregiving as well as care receiving is part of the basic needs of citizens. Moreover, in T.H. Marshall's influential conceptualization of citizenship, care was only recognized insofar as it concerned medical care (Marshall 1948/1976). His third "right of citizens," that is, social citizenship (besides civil and political citizenship), includes many human rights, such as the right to housing, education, employment, and income, but it left aside the right to give or receive care. In Marshall's day, care was viewed as part of the communitarian duty to care and was supposed to be provided by family and social networks. This view is not surprising, as at that time strong sex segregation was taken for granted. This domestication of care, however, forms the basis for its exclusion from citizenship rights (Fraser 1990). The individualization of men was the starting point for the claim to rights of citizenship in relationship to the state. Women's caregiving work, and herewith their deindividualization, engendered this male individualization. As care belonged to the domain of the deindividualized citizen, it was not necessary to lay down the rights of care dependents because women were supposed to take care of them (Vogel 1994; Fraser and Gordon 1994). The Norwegian sociologist Arnlaug Leira concludes: "What is lacking is a concept of citizenship which recognizes the importance of care to society" (1990, 208).

Such a concept of citizenship should go beyond the gendered character of care: it should be based on the assumption that every citizen, whether male or female, could claim the right to give care to people in his or her immediate context when circumstances demand it. The notion of citizenship should contain the idea that every citizen at some time or another has to take care of people they care about. At some point within a citizen's life, people have to care for young children, and at other times close friends or elderly parents need personal care. Such demands of "significant others" can nowadays only be fulfilled at the cost of what is perceived as the most vital aspect of social citizenship: labor participation. Hence, caregiving leads to a reduction

of citizenship status. Rather than focusing on labor-participation alone, we argue for a conceptualization of citizenship which acknowledges that every citizen will be a caregiver sometime in their life: all human beings were dependent on care when they were young and will need care when they are ill, handicapped, or frail and old. Care is thus not a women's issue but a citizenship issue.

The term "inclusive citizenship" should be used to describe the social citizenship we argue for. In this conceptualization of citizenship, which contains civil, political, and social rights, citizens (women and men) still have the right and the obligation to participate in the labor market, but this conceptualization also recognizes citizen's involvement in caregiving or care receiving. Paid work remains important, but care is just as important. Only when care becomes a vital dimension of citizenship can both care (giving and receiving) and citizenship be degendered.

How is care organized in modern welfare states and how does it structure gendered citizenship? These questions have been touched on in the political domain of the welfare state but seldom by welfare state analysts; in their studies the questions surrounding care and citizenship are conspicuously absent. Although recently valuable contributions have been made by Ungerson (1990a), Taylor Gooby (1991), Langan and Osner (1991) and Alber (1995), the influential power resource analysts such as Korpi (1983) and Esping-Andersen (1991, 1993) hardly incorporate the organization and provision of care. Mirroring the male interpretation of care, namely the provision of financial resources, these latter analysts primarily focus on social security in relation to labor participation. Care has primarily been acknowledged as the fabric of both society and the welfare state by female researchers. This is no coincidence as it is women who contribute through their caregiving work to welfare (see also Graham 1983; Balbo 1987; Pateman 1989).

Modern welfare states have shaped the needs and rights of caregivers and care receivers and by this have produced gendered citizenship. This is particularly clear when we use two empirical and theoretical concepts: the right to time for care and the right to receive care. The first right contains the option to take care oneself of people whom one cares about, whereas the latter refers to the right to be cared for, whether formally or informally. A clear and increasingly popular example of the right to time for care are labor-market-related parental or care leaves. This enables citizens to continue labor market participation while caring. Also the exemption from the obligation to work for parents and caregivers on social security should be considered as a citizenship right to time for care, just as are other payments for care. In this case the right to care full-time enables citizens temporarily

to give priority to care responsibilities instead of paid work. Part-time work, which enables citizens to synchronize work and care responsibilities, is another translation of the citizenship right to time to care. Just as with unpaid care leave, statutory regulation of part-time work and provisions with respect to social security are favorable toward time for care and therefore contribute to the caring dimension of citizenship. On the other hand, in this case, citizens (mainly women) have to resolve the dilemma of care and work at their own cost; they do not receive financial compensation and their careers may be hampered by working part time. This right to time for care, however, acknowledges that care is an aspect of interdependency: it recognizes the needs and rights of the citizen as caregiver. The right to time for care is an important condition of informal caregiving at least when it is not perceived as a moral claim and when it does not frustrate a caregiver's right to make an autonomous choice not to provide care.

The right to receive care is not mutually dependent on the right to give care. Of course, to receive informal care from a relative, significant other, or a volunteer who has the right to time for care is often a good solution for both the person in need of care and the caregiver. But the person in need of care can never enforce this right, as this type of care is conditional upon the character of the relationship with the potential caregiver. Nor can the market grant citizens the right to care, as it is inherent in market logic that citizens in need of care but who are unable to purchase care services will not be granted them. The only possibility left is good institutional care, where the costs are covered by the state, the collectivity. The right to receive care thus implies accessible and qualitatively good institutional care to meet the demands of different groups of citizens who are in need. Home care, nursing homes, and child care are part of this dimension, but so too are social services such as social work and day centers for the elderly. The right to receive professional care is only enforceable when the services are good and affordable, so all citizens can and want to use their rights.

So ungendered and inclusive citizenship contains two dimensions of care. Only when both the right to give and the right to receive care are assured can citizens (caregivers as well as care receivers) have a real choice about how they want to integrate care in their lives. Only then are people able to choose, at specific times within their life course, whether they need time to care, time to be cared for, or whether they need professional care.

Within the financial and legal regulations of the welfare state and the provision of care, the two dimensions of care can be analyzed. How these two dimensions have been developed in modern welfare states, the quality and quantity of these dimensions, how they relate

to each other, their historical contexts, and the concomitant political discourse are important questions within welfare state analyses. We will start the analysis of care by focusing on empirical cross-national comparisons of the caring dimension of the British, Danish, and Dutch welfare states (see Table 1). The specific countries have been chosen as they can add to and modify Esping-Andersen's liberal, social-democratic and corporatist model, respectively (Esping-Andersen 1991). Care for children and the frail elderly will be used as the exemplar because these categories of citizens have uncontested needs to receive care.

The Right to Time for Care

Exemptions from the Obligation to Work and Payments for Care

In Denmark, the right to time for care by means of the exemption from the obligation to work was abandoned in the 1970s when women started participating in the labor market. According to current Danish social assistance regulations, caregiving work is no justification for being unavailable for paid work. Both lone parents, who have always been confronted most with the dilemma of work and care, and caregivers for the elderly and disabled have to be available for work. The citizen-caregiver therefore does not exist in Denmark: preference is always given to paid work. In contrast to Denmark, both in Britain and the Netherlands caregivers can achieve citizenship rights on the basis of caregiving work (Kremer 1994). Lone mothers in particular have been exempted from the obligation to work and received the right to social assistance instead. Although these rights are less generous and dignified than those that can be achieved through labor market participation, they show that the right to time for care has been recognized as a citizenship right. Since January 1996, however, in the Netherlands this right has been eroded significantly. Whereas in Britain lone mothers are still exempted from the obligation to work till their youngest child reaches the age of 16, in the Netherlands women should have to give preference to paid employment, unless their children are under the age of 5. These new availability rules indicate a vital change in Dutch policy toward care and citizenship: women's participation in paid employment is valued more than mothers' full-time attention for children, unless they are very young (see also Knijn 1994a; Bussemaker et al. 1997).

In Britain caregivers for the severely disabled can achieve limited citizenship rights. Caregivers who can comply with strict rules that entitle them to Invalid Care Allowance do not have to be available

Table 1. The Caring Dimension of the Danish, Dutch, and British Welfare States

Country	The Right to Receive Care		The Right to Time for Care ^a	
	Children	Elderly	Children	Elderly
Denmark	High State/municipal responsibility for right to childcare; 47 percent of children under 3 provided with care; extensive child care for children 3–16; no market role	High State/municipal responsibility for the right to elderly care; homecare is primary carer; high percentage of care receivers, ~18 percent; no market role	1) High Extensive/full-time and paid child care leave; paid leave for children ill for more than 25 days 2) Low Mothers or lone mothers not exempted from the obligation to work, yet one can take leave; no credits for care in social security 3) Low Substantial part-time jobs are possible, but part-time work gives fewer social security rights; not possible to be available for part-time work while on social assistance	1) Medium Paid terminally ill allowance; possible to pay family as a home help; no general care leave 2) Low Caregivers are not exempted from the obligation to work; no credits for care in social security 3) Low (see column to left)

(continued)

Table 1. Continued

Country	The Right to Receive Care		The Right to Time for Care ^a	
	Children	Elderly	Children	Elderly
Netherlands	Low Mother is most important caregiver, 8 percent of children 0–3 are provided with care; little child care for older children; market forces and nannies are of growing importance	Medium/high Provision of care only when the family is unable to care; family and not home help is primary caregiver; extended residential services	1) Low Parental leave part-time and not paid; no rights to care for ill children 2) Medium Lone mothers on social assistance have to be available for paid work when the children reach the age of 5 (was 12/16); medium credits for caring for children within social security provision 3) High Part-time work is well integrated in social security; part-time work gives the right to social insurance; possible to be available for part-time work	1) Low No care leave 2) Low No formal exemption from obligation; no credits in social security 3) High (see column to left)

Britain	Low State intervenes only when there are social problems; 2 percent of children 0–3 cared for by state-subsidized child care; market is extremely important for child care	Low Family and not the state is responsible for care; family is the primary caregiver for elderly, not the home help; growing importance of market	1) Low Extensive maternity leave, but poorly paid; no parental leave 2) High Lone mothers are exempted from work till their children reach the age of 16; home responsibility credits for social security 3) Low Unemployed on benefit have to be available for full-time employment; people working part-time have few social security rights	1) Low No care leave 2) Medium Payments for care/ICA; a strictly defined small category of caregivers is exempted from the obligation to work; care credits in social security 3) Low (See column to left)
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a. Time for care categories: 1) leave; 2) exemption from obligation to work and other payments for care; 3) possibilities for part-time work.

for work, as ICA is a compensation for not working. Their care has thus been recognized as work. However, payment is very low, so caregivers are not financially independent (Glendinning 1990; McLaughlin 1991; Baldock and Ungerson 1991; McLaughlin and Glendinning 1994). The price that caregivers pay for British citizenship rights is a strict division between citizen-workers and citizen-caregivers. When a citizen is defined as a worker, care responsibilities are not allowed for. Every worker has to live up to male standards of ever-harshening obligations in social security. When a citizen does not fit into the narrow category of caregiver (as in the ICA) and they cannot meet the demands of a full-time worker, benefit, Job Seeker's Allowance, is withdrawn. The right to time for care in social security is thus only institutionalized for a narrowly defined category of citizens. In Denmark, social security legislation offers family members and close friends the possibility to be paid as a home helper when the municipality has insufficient means to provide the necessary care and both caregivers and care recipients favor this option (Kremer 1994; Evers et al. 1994).

Credits for care, which could be given in social insurance, such as pensions and unemployment insurance, to grant caregivers (almost) the same record as workers are not available in Denmark; paid employment is the only route to social insurance. In Britain and the Netherlands, however, credits can be given on the basis of caregiving work, so this increases the opportunity for caregivers to receive insurance benefits. Whereas in the Netherlands full credits are given only to parents who care for a child under the age of 6, and half of the credits for caring for a child between 6 and 12, the British home responsibility protection is more efficient. Caring for children under the age of 16 and for severely disabled people is recognized in full for social security purposes (Kremer 1994).

Care Leave

Due to the financial problems of many welfare states and the critique of bureaucracy and distant state services, care leave, rather than the extension of care services, is becoming increasingly important. Besides the fact that care leave acknowledges the fundamental interdependence of citizens, it also enables women (and men) to continue their participation in paid work. This, however, also means that most care leaves are work related. Particularly in Denmark, leave schemes are well developed. They are thought to improve the quality of care but also to combat unemployment, as leave can also redistribute labor. Since January 1994, Danish parents can take up a maximum of one year of parental leave and are compensated 70 percent of an unemploy-

ment benefit. A large number of parents (80,000 in 1994) applied for this paid parental leave (Arbejdsministeriet 1995). Children above the age of three still have the right to receive part-time child care. This seems to be a compromise between assuring that parents who take leave indeed care for their children and emphasizing the necessity of child care for the rearing of children. Moreover, Danish social security regulations contain a well-paid terminally ill allowance. This leave has been introduced for those who are in paid employment but want to care for a dying spouse, relative, or close friend. An important condition is that it should be neither helpful nor necessary to receive residual medical care, although it is still possible to receive home help assistance. Finally, paid leave of one year maximum has been made possible for parents with a sick child. If a child under the age of 14 is ill for more than 25 days, one of the parents can receive sickness pay. However, only public employees have the statutory right to take up this sick leave, and the terminally ill allowance can only be paid when the employee agrees (Evers et. al. 1994; Kremer 1995).

Until now Dutch social policy contains only a rather limited parental leave. Since the introduction of parental leave in 1991, a parent has the right to work reduced hours, with a minimum of 20 hours a week, for a period of 26 weeks. Except for civil servants, who receive 75 percent of their wage, no compensation for loss of income is granted. In 1993 21,000 parents—9,000 fathers and 12,000 mothers—took such a leave. Not surprisingly, fathers mainly took paid leave while mothers took unpaid as well as paid leave (Spaans and Veldhoen 1995). Because the Dutch government is also interested in keeping women in the labor market and redistributing paid employment through a leave scheme, new rules have developed. The obligation to remain in paid work for at least 20 hours a week has disappeared because many mothers find this too high a barrier, and there are not many mothers working this many hours. The government has also proposed a leave scheme people can use to care for children and elderly people or to enter education. The employees on leave receive a modest amount of money on the condition that an unemployed person temporarily replaces them.

In Britain, care leave is hardly developed, as it is expected that care dilemmas are resolved privately. Neither for frail elderly, ill, or disabled people, nor for children has care leave developed. Maternity leave, however, covers a relatively long period of 40 weeks, although the last 22 weeks are unpaid (Moss 1990). This means that only mothers can take up this leave, which demonstrates a highly gendered approach to the right to time for care.

Combining Work and Care Through Part-Time Employment

The right to part-time work can also make the extent to which citizens can synchronize work and care visible. One indicator of the extent welfare states enable and are favorable toward citizens working part time is to see how this has been integrated into social security: is it possible to receive unemployment benefits when one has worked part time, and if unemployed, is it possible to be available part-time for work? Is there a right to part-time work? In other words, is there a right to time for care without losing one's citizenship rights?

In Denmark, citizens can hardly harmonize care and paid employment at the same time; they can indeed realize a certain sequence of work and care (by parental and care leaves), but have no rights to combine both activities simultaneously. Social security rules indicate that full-time employment is the norm: only when a person has part-time insurance, rather than full-time unemployment insurance, is part-time employment possible. However, the conditions for this insurance are less favorable and the rates of pay are relatively low. The outcome is that only a few people, most of them women, have this second-class insurance. When unemployed, it is impossible to be available part time for work. Citizens on social assistance are not allowed to refuse a full-time job, even when they have care responsibilities (Kremer 1994). Despite the fact that welfare state policies hamper part-time employment, approximately 35 percent of all working women are employed part-time, but most of them work 32 hours per week (OECD 1994).

In Britain, many mothers and informal caregivers work part time: more than 40 percent of women work part time (OECD 1994). According to social security law, however, part-time employment is no real choice; it will not only lead to comparatively few social rights, but unemployed persons are also not allowed to apply for part-time employment only. When on Job Seeker's Allowance, citizens, in practice, have to be available for a full-time job, even when care responsibilities might demand part-time employment. On the other hand, many lone mothers who work part-time receive Family Credit. This benefit, which is only payable to people working 16 hours or more, enables lone mothers in particular to combine part-time work and care. However, when receiving this benefit one still has to be available for a full-time job. Also in Britain, full-time employment is the norm (Kremer 1994).

In the Netherlands part-time employment is an even more common practice: more than 60 percent of all working women work part time, and also a substantial number of men are employed part time (OECD 1994). In this country part-time employment is a valid option, but

rather more for women than for men. This dominance of part-time work can partially be explained by the fact that the Dutch economy is still based on a one-breadwinner wage, but it is also determined by welfare state policies that are more favorable toward citizens working part time in the Netherlands than elsewhere. Not only is it comparatively easy to receive unemployment benefits on the basis of part-time work, part-time availability when one receives benefits is also possible. At the moment the Senate is even discussing the right to work part time, an increasingly important feature of Dutch citizenship rights. In the Netherlands using part-time work as a way of harmonizing work and care is a popular and viable option for women, although the outcome is that many women remain financially dependent on breadwinners and have broken careers.

Looking at aspects of the right to time for care cross-nationally, we find that Britain has a strictly defined category of less dignified full-time citizen-caregivers who have a very elaborated right to time for care, but work-related time for care hardly exists. Although this recognizes care as an important aspect of the welfare state, it does not contribute to the harmonization of paid employment and care responsibilities. In the Netherlands citizens' right to time for care exists, but only at the expense of women's financial independence. Nevertheless, it is the most common strategy of Dutch women, who, until now, have had hardly any rights to work-related leaves. Because the financially independent full-time worker is the norm, the Danish welfare state only has a limited option for combining paid work and care synchronously. There are, however, more opportunities in Denmark than in the Netherlands and Britain for work-related paid care leaves, and this implies a sustainable right to care for citizen-workers.

The Citizenship Right to Receive Care

The Right of the Elderly to Receive Care

Another citizenship dimension of care is the right to receive care. Because in all three welfare states the elderly make up a considerable percentage of the total population, the right to receive care for elderly people is becoming of paramount importance. The objective of policies for the elderly in all three welfare states has been the same: to enable them to stay in their own homes for as long as possible. Although primarily introduced because institutional care is considered to be more expensive, this shift in policy has also been introduced to improve the quality of life for the elderly (Jamieson 1991). But despite similar objectives, both the amount of care given through the welfare

state and the mix of care (residential or home help) still differs substantially in the welfare states concerned. As a result, in some welfare states elderly people are largely dependent on the sense of moral obligation of their family members, whereas other welfare states grant the elderly the citizenship right to receive care.

The Danish welfare state embodies the latter welfare state. The state has taken explicit responsibility for care; it is not a private matter: citizens have the right to receive care. This has even been laid down in the 1976 Social Act. The municipality has to offer "sufficient" care for the elderly. However, an indicator of the need to receive home care is based on the existence of a (female) spouse: elderly people living alone and married women are more likely to receive care. Nevertheless, a demand for home help is hardly ever turned down (Holstein et al. 1991; Platz and Freiberg Petersen 1992). Though some market experiments have been set up, home care for the elderly remains the responsibility of the municipality. Many elderly people use the services of the municipality, particularly home care. While the number of elderly people in residential care has been estimated at around 8 percent, at least 17 percent of the frail elderly receive home help. The number of hours of home help received is also comparatively high (Jamieson 1991; Commission of the European Communities 1993; Sundström 1994).³ As a result, the family is not the primary caregiver for elderly people, as the recent OECD report "Caring for Frail Elderly" demonstrates. And if the family does take care of the elderly, then the work devolves on the partner rather than on the children (Sundström 1994). Thus, although in Denmark informal care has not vanished, the state takes a large responsibility in the provision of care.

In Britain, there is no national advice on entitlements in terms of amount and type of care. Although the needs of caregivers are now formally recognized in the Caregivers (Recognition and Services) Act 1995, which gives caregivers a right to be assessed for their needs, it does not give a right to services as such. Rather than universal care rights, the recent tendency has been to target help to those in greatest need. The numbers of elderly people in residential homes and of those receiving home care are low: 5 percent live in residential care and 9 percent over 65 receive home help. This is comparatively low, especially when taking into account the fact that the number of elderly people living on their own is high. Although the quality of care varies from local authority to local authority, the number of hours of home help provided is, in general, low. As a logical consequence, the elderly are mainly cared for by their families; in only 13 percent of cases the home help is the primary caregiver, whereas 64 percent of the frail elderly receive help from someone in their household. Often these

caregivers are their children as a comparatively large percentage of the elderly live with their children, particularly compared to the Dutch and even more so to the Danish (Sundström 1994). In contrast to a country such as Denmark, British elderly people are thus primarily dependent on the goodwill of their families, particularly their spouses and daughters. In Britain the right to receive care is not very developed. This also means that a growing number of (rich) elderly have to turn to the market to satisfy their need for care, which leads to important class differences in receipt of care.

In the Netherlands citizens have the right to the necessary nursing, care, guidance, and information in their home environment in connection with illness, convalescence, invalidity, age, and chronic sickness. However, to receive state-funded help, the household must be able to demonstrate that they cannot provide adequate care themselves. This not only means that workers in the field determine who receives help, as no clear guidelines are given, but also that the individual right to care does not exist: one first has to look to other members of the household for care. Nevertheless, care for the elderly is relatively well developed, particularly residential care. According to Jamieson (1991), 12 percent of the Dutch elderly receive residential care and another 12 percent receive home care, though other figures show a much lower (6 or 8) percentage for home help. In addition, the number of hours of home help received is rather low. As a result of this care policy, some elderly people turn to the (semi) market for services, but most elderly have to turn to their families. For only 11 percent of the elderly is the home help the primary caregiver, whereas 44 percent are cared for by someone from the household (De Boer et al. 1994; Sundström 1994). It has been estimated that informal care is given eight times as much as institutional care. Women are the main caregivers, though husbands of frail women also participate in informal caregiving (Emancipatieraad 1993; De Boer et al., 1994). It seems that the Dutch welfare state provision can be placed in between: the right to care for the elderly is less developed than in Denmark, though more than in Britain, where despite an increased recognition of caregivers' needs, care is still no more than a safety net provision.

The Right to Child Care

Child care also differs significantly in the countries concerned. A report from the European Commission Network on Childcare shows that in Britain and the Netherlands there is little publicly funded child care for children from birth to three years. Whereas the Dutch rates have risen from 2 percent in 1988 to approximately 8 percent in 1994, the British rates are still only 2 percent. Denmark, in contrast, has a coverage rate of 48 percent (ECNC 1996). The same pattern is

visible for the care of older children. While this is hardly developed in the Netherlands and Britain, in Denmark children of all ages have the right to child care facilities. Nor is child care limited to preschool children in Denmark: when the children are older there is a spectrum of services ranging from after-school centers to clubs for adolescents (Ministry of Social Affairs 1992). Denmark is thus unique, even compared to the other Nordic countries, because more money, more people, and more children are involved in public state-organized child care (Nordic Social-Statistical Committee 1993).

Since 1964, in Denmark, child care has been regarded as a responsibility of the public sector rather than as a private responsibility of women. The state in general, but municipalities in particular, are legally bound “to supervise the conditions under which children live and to support their parents in the upbringing and care for them” and to supply sufficient child care services (Social Act of 1976). This state commitment has indeed enabled mothers to go to work—child care has also been developed to cater for the labor force—but at the same time, child care provisions have been extended to protect the welfare of children. From the start, pedagogical objectives were strongly emphasized, and play and social contacts were regarded as the cornerstones in child care provision (Borchorst 1990). Since 1981 there has been only a moderate increase of child care, but due to the rise in the birthrate at the beginning of the 1980s, demand has increased. As a result of this stagnation, long waiting lists for municipal child care existed, and child care became a problem (Jensen 1993). But more recently, since 1993, the government re-emphasized child care as an important part of Danish welfare and stressed that every child aged one to six should be offered a place for child care, but based on an understanding that parents can take parental leave in the first year of a child’s life. Since then a large number of child care centers have been developed and waiting lists have fallen (see ECNC 1996). Danish children genuinely seem to have the right to child care.

In Britain, child care is not a responsibility of the welfare state. Bowlby’s maternal deprivation thesis is still much alive and fear for a generation of “crèche children”—a lost generation—hinders the development of good-quality child care. Although local authority nurseries have been set up for children at risk, child care facilities are not an integral part of the welfare state. The conservative government’s principle that the state should not intervene in family matters reduced child care to a private problem, that is to say a woman’s problem (Brannen and Moss 1991, Gregson and Lowe 1994). Unless there are special needs, daycare is considered to be a matter for private arrangement between parents and private and voluntary sources

(Cohen 1990). Therefore, the state keeps its distance from financing and organizing child care, although local authorities do monitor and register the provision of care. The private market, however, should increase supply. Yet child care facilities are both scarce and costly, and many parents have to depend on relatives and friends to care for their children when they are working. Employers and the voluntary sector also provide, to a small extent, child care facilities, but, in Britain, private child care (both registered and unregistered) is by far the most common form of care arranged for children under three (Holterman and Clarke 1992). This type of care, which has become an important source of low-paid employment for working-class women, has expanded by 60 percent since the mid-1970s (Cohen 1990; Ginsburg 1992).

In the Netherlands, both paid and unpaid informal arrangements are the most common child care practices for children whose mothers are unemployed. Yet at the same time, due to the rise in labor market participation, formal child care facilities are expanding rapidly, resulting in a chaotic mix of state, market and employer-funded organized child care. Many newly created child care centers are organized by municipalities and every child care center is obliged to reserve 70 percent of their spaces for employers who can buy them (with discount) for their employees (Hooghiemstra and Niphuis-Nell 1993). As a consequence, empty spaces exist alongside long waiting lists. Existing child care facilities by no means meet demand, and against the background of retrenchment of the welfare state, politicians are hesitant to extend the welfare state with new care provisions. In fact, policy toward child care has been decentralized and since 1996 municipalities are no longer obliged to invest in or improve child care facilities. Historically, the absence of child care as an integral part of the welfare state has been seen as an advantage. Mothers were supposed to care full-time for their children (Knijn 1994b); institutional child care was viewed as a moral hazard, an indicator of social degeneration, and regarded as a final solution to protect the welfare of children in need (Rijswijk-Clerkx 1978; Singer 1989). More recently, in the light of an aging population and the financial crisis of the welfare state, women's economic potential has been recognized, and this has eventually transformed the view on child care. The moral debates, though still present, have been overtaken by discussion of whether the development of child care can contribute to the economic crisis through women's labor market participation (Bussemaker 1993). It is in the context of improving welfare mothers' labor participation that additional budgets for child care (85 million Dutch guilders) are available to the municipalities. In the Netherlands, child care has become an economic and labor force issue.

Thus the Dutch welfare state might be more directed to the provision of child care than the British, but in both welfare states, child care is only guaranteed as a last resort. This seems in sharp contrast to Danish child care policy, where child care is guaranteed.

The Caring Dimension of the Dutch, British, and Danish Welfare State

In the Danish welfare state model, in contrast to the other two welfare states, children's and older people's right to receive care is extensive. The organization and quality of care has been regarded as a responsibility of the state and defined as a right. Danish women are freed from the (moral) duty to care. Moreover, due to extensive care services much paid employment in care work for women has been created. Care in Denmark is seen as work, and therefore it has been paid as such (see also Borchorst and Siim 1987; Esping-Andersen 1991). This has produced more financial independence for women, and men are no longer dependent on their wives to take care of their children or frail parents. This objective of individual independence rather than family independence (see also Esping-Andersen 1991) has created comparatively less inequality in social security (see also Kremer 1994).

On the other hand, this also means that rather than a duty to care, Danish women have a duty to work. The right to time for care is limited. Only few rights to give care have been integrated. The lack of exemptions from the obligation to work shows that Danish citizens are citizen-workers first. However, more and more work-related leave schemes have become part of Danish citizenship, though the right to care for children seems to be recognized rather more than it is for elderly people. Thus in the Danish welfare state, the sequence, instead of the combination, of work and care and the gendered stratification of care-inclusive and care-exclusive professions are hindering inclusive citizenship. Yet an important transition seems to be taking place in which the right to time for care and the right to professional care are more balanced and might become equal and valid options. This also means that for the first time since the 1970s citizens are allowed to be (partly) dependent on a family member. The relief of private care responsibilities is no longer seen as a good strategy for individual (financial) independence. For the first time not only the needs of care receivers have been placed centrally, but also the rights of the caregiver.

In the Dutch welfare states, care and work are not only highly gendered, they are also constructed as opposites. In contrast to the Danish welfare state, care is hardly regarded as work and through

indirect compensation, paid to the husband, women organize caregiving privately. Although in the Dutch welfare state the right to receive care for the elderly is more established (but only as a last resort), the organization of care for children is almost completely regarded as part of the private domain. Yet when the family is no longer able to give care, the state takes responsibility. Care is thus, in contrast to the Danish model, a safety net provision and not considered as a need that should be transformed into a right. Women, who have low labor participation rates because they are supposed to give unpaid care in the private sphere, are therefore financially dependent on their partners. In line with this practice, men became care dependent on their wives.

More recently, in the Netherlands, there is a growing tendency in the welfare state to value women's paid work rather more than their care. Due to the fact that the right to time for care has become stricter (though it always was with respect to the elderly) and the right to receive care has not been strengthened, ungendered, inclusive citizenship is becoming even more unattainable. Citizens have to solve the societal care dilemma in their private life. This means that Dutch women who have been made responsible for unpaid care in the welfare state can hardly choose how they want to live their lives; nor can men. Yet one way to solve the care dilemma is part-time employment. Although based on the interdependence of citizens, the part-time strategy shows that Dutch men and women have to solve social dilemmas themselves. This is often at the expense of women's citizenship status, yet rights on the basis of part-time work are better arranged than in many other welfare states.

In the British welfare state the dilemma of work and care has resulted in the polarization between workers with and without care responsibilities, between men and women, and also between women. Work-related rights, such as care leave, are not perceived to be necessary in Britain. At the same time, the right to receive care is barely present, and persons with care responsibilities only have the option of becoming a full-time caregiver. But for limited cases, care has been seen as work and replaces the state responsibility for care. It seems that the British welfare state takes relatively more responsibility for financial compensation for caregivers who work at home, which is atypical for a welfare state seen as representative of the liberal regime type. This, however, does not give financial independence. With the exemptions for work and payments for care with respect to motherhood and care for the elderly, respectively, the importance of care has been recognized, but in an exclusive way. Most of the time it is women who opt for this low but citizenship status. At the same time, more and more women participate in the labor market, particularly

when their children are of school age. As the state neither supplies work-related time for care such as care leave nor provides sufficient care services, women, but only when they have sufficient resources, are driven to the market for care.

The British organization of care means that many women (but also men) are trapped between becoming full-time caregivers and having limited financial resources or being workers not allowed to have any care responsibilities or not recognizing the moral obligation to care. The latter is only possible for citizens who have good jobs and can buy care in the market. Caregivers now have the right to needs assessment, but care is still targeted to those with the greatest needs. Only for the frail elderly are services available. The organization of care, that is in Britain the lack of the universal right to care, works out to the disadvantage of citizens with care responsibilities. This perpetuates the strong division between citizens, men and women, and workers and caregivers. The British welfare state neither recognizes nor values the fundamental interdependence of citizens nor contributes to the harmonization of paid work and care.

Dilemmas of Care in the Welfare State

The empirical cross-national comparison of the caring dimension of the British, Danish, and Dutch welfare state shows that none of the analyzed welfare states solve care in terms of ungendered and inclusive citizenship. In some countries, as we have seen, some of the rights to receive and to give care are in the process of development, but more often the care rights of citizenship are far from being established. The way in which welfare states can strive for inclusive and ungendered citizenship relates closely to how they resolve the four interrelated dilemmas of care with which welfare states are confronted. These dilemmas are (1) care as a private and public responsibility, (2) care as paid and unpaid work, (3) care as a form of (in)dependence, and (4) the rights of caregivers and care receivers. Here, we first explain each of those dilemmas and refer to the results of the empirical cross-national study from the perspective of each.

Care as Public or Private Responsibility

All welfare states have taken public responsibility for care, although they maintain different care arrangements. During the heyday of welfare states, much financial effort was made to ensure that housewives remained at home to care; breadwinner wages, tax advantages for single wage-earners, mothers' and widows' pensions, and social assistance were different kinds of financial compensation for mothers' caretaking. At the same time, many welfare states invested in public

care for the elderly, children, and other care dependents. Therefore the pivotal question is not whether the state has to take public responsibility for care and whether the state has to guarantee citizens the right to give or receive care; the question is to what extent, at what costs, and on the basis of what assumptions and conditions is this responsibility undertaken. Who organizes publicly funded care—the welfare state, for instance, through the municipalities, the family, or neighborhood networks?

The conditions under which care is given and performed are decisive for its quality: do care receivers get the care they need, in the environment they choose, given by people who have enough time to pay attention to them? Do caregivers have enough time to care without becoming second-class citizens, are they well paid for caring, and do they have adequate resources for their work? Ultimately the welfare state is the only institution in society which has the political, financial, and legal instruments to guarantee the conditions necessary for good-quality care. That is why the dilemma of public or private responsibility for care is in the end a welfare state's dilemma: what are the limits of the market and the family in providing good care, and what are the state's responsibilities in protecting categories of citizens with special needs, caregivers as well as care receivers?

Currently welfare states in this era of retrenchment are trying to reform their care policy. The essential issue in these care reforms is whether welfare states recognize explicitly the citizen's right to receive or give care. Or are care rights under attack? In Denmark the state still takes responsibility for the right to receive care; the (paid) right to time for care is an important development, and both the municipally organized child care services and home care services are extended, although, of course, they are never fully sufficient. In Denmark marketization of care does not constitute a real danger for citizenship rights, as some experiments are set up, but within the context of overall welfare state responsibility. It seems that the Dutch government has more problems in working out whether care is a private or public responsibility. In the Netherlands market forces are of growing importance in the provision of care, and this constitutes an important barrier to the right to receive care. But at the same time, the government is trying to stimulate the provision of care, especially child care, and steps are also being taken to develop a paid leave scheme so that workers have time to care. While care is considered to be a private problem, at the same time the government feels it must take responsibility to ensure adequate provision and time to care. The British welfare state seems to be less torn apart by this care dilemma. Care remains part of the private responsibility of citizens and only in limited cases can caregivers and care receivers turn to the state for time to

care or professional provision of care. Mostly these citizens have to pay the price of second-class citizenship.

Care as Paid and Unpaid Work

In welfare states, full-time informal caregivers are labeled as inactive, and the care they give is viewed as an unproductive activity; in no welfare state has this activity been counted toward the GDP, and in all welfare states activity rates exclude informal care participation. This can be explained by the strong association of social citizenship with paid employment. The way to achieve autonomy—to become a full citizen—is narrowed down to earning one's own income, that is, to become financially independent. This concept of citizenship is almost completely internalized by men, but for women, this conceptualization leads to a unresolvable dilemma. Because in contemporary welfare states work and care have been constructed as mutually exclusive and as opposites, women are dealing with what Lister calls "the contemporary variant of the Wollstonecraft dilemma":

We are torn between wanting to validate and support, through some form of income maintenance provision, the caring work for which women still take the responsibility in the 'private' sphere and to liberate them from this responsibility so that they can achieve economic and political autonomy in the public sphere. (Lister 1994, 19)

It should, therefore, be taken into account that the recognition of the importance of care, and the conclusion that formal and informal care can both be beneficial (Ungerson 1990), should not lead to gendered care with its well-known consequences: the dependency of women on private relationships, their relative poverty, and exclusion from the public domain.

The complexity of and the potential disagreements about the public or private character of care in relationship to the question of how and to what extent care should be paid for can be illustrated by two international reports by organizations that have been mainly concerned with economic targets. In the OECD report "Shaping Structural Change" (1991) as well as in a report of the European Parliament (1992), the importance of care for the development of a well-functioning labor market has been stressed. The reports, however, differ in their opinion as to how to provide good care. The European Parliament report is a clear example of supporting privately organized care. It recommends recognition of informal caregivers by giving them a kind of salary and granting pensions and other social rights on the

basis of their caregiving work. An entrance ticket to the labor market after finishing caregiving should be one of these social rights. The OECD report, in contrast, partly follows the Scandinavian route. It argues for incentives to keep caregivers employed and to give them labor-related rights to time for care, such as parental leave, sick leave, and temporary, part-time jobs. The OECD also recommends pension schemes that give credits for care breaks during careers.

It is remarkable, however, that despite different views on how to guarantee good care, both reports are based on three assumptions that are important for the idea of inclusive citizenship: first, the recognition of care as a potentially degendered activity; men as well as women can be assured to take care; second, the acknowledgment of the need to finance care and to improve conditions for caregiving in terms of social security and labor market perspectives; and third, the states' responsibility for creating a good infrastructure of care which includes the notion that care and work should not be two poles but could be considered simultaneously.

Analogous to the first dilemma of care, care as a public or private responsibility, the second dilemma of care, whether care is regarded as paid or unpaid work, is less dichotomous than it seems at first. The question again is not whether care should be paid for, but how it is paid and what are the consequences for caregivers and care receivers. In the three welfare states we studied, three routes to pay for care are perceivable: direct financial compensation of care, indirect financial compensation of care, and the professional provision of care. The first route includes paid care leave, payments for care and exemption from the obligation to work (for instance, for solo mothers). These are forms of guaranteeing citizens' rights to give care. In Britain the latter forms of direct financial compensation are developed well, though the payments are rather low. In Denmark these types of financial compensation do not exist: here the right to time for care is only shaped in well-paid work-related care leave. In the Netherlands, direct compensation of care has been cut back—especially for lone mothers—but seems to be extended more through work-related care compensation, such as care credits in unemployment benefit and the recently proposed care leave.

The second route lies in the indirect compensation for care. Tax benefits for single wage-earners, family-based minimum wages, and family-based benefits which try to discourage women from entering the labor market are examples of indirect compensation for care. This indirect financial compensation is particularly visible in Britain and the Netherlands: these welfare states still contain regulations that give families financial incentives for the woman to remain at home to

care. In contrast to direct compensation, this care policy cannot be considered as a citizenship right to time for care, since it is not a citizenship right but a family right, so it is no right at all.

The third route is to provide care, organized (often indirectly) and paid for by the state, often through taxation and premiums. Rather than a compensation for care, in this route the state takes over daily care. This is particularly visible in Denmark where both the care of elderly and of children is taken over. In both Britain and the Netherlands this is hardly the case, although elder care in the Netherlands is much more developed than child care. Each of these three avenues leads to a specific form of financing and organizing care, but with very divergent and gendered consequences for citizenship and the relationships between caregivers and care receivers, in particular their interdependence (see also Glendenning and McLaughlin 1993).

Care as a Form of (In)dependence

Within the framework of citizenship, care is easily associated with dependence. People who depend on professional care as well as on informal caregivers, including women who care for their families, who are dependent on the welfare state or their husbands, seldom meet the standards for autonomy, independence, or self-development that have been defined within the concept of citizenship. Why is it so difficult to accept that dependence is the ultimate characteristic of every individual human being? The answer probably lies in the fact that the fundamental discourse on citizenship is connected to the “male” discourse of the autonomous individual without involvements and ties—a virtual, nonexistent human being. This discourse also underlies the feminist perspective on autonomy: only the liberation from ties of dependence and caregiving work can give women autonomy and citizenship status. Because this approach is not only invalid (autonomy and citizenship should also be possible through care-giving and care-receiving), it is also impossible to strive for complete independence: every citizen is dependent on someone else in one way or another. Therefore it is more fruitful to use an alternative perspective: all citizens are interdependent, but not always in an equal way.

Women’s financial dependence on their husbands or on the welfare state, for instance, is regarded as a manifestation of inequality. These financial relations are approached negatively, and, accordingly, women are often labeled with the pejorative term “dependent.” Men who are, in turn, often dependent on women’s caregiving work are considered as powerful: their dependence on women does not seem to be burdensome. Some dependence relations are not only more visible than others but some are valued less highly than others. These dependence relations, which are an integral part of a citizen’s life, are

often hierarchical and constructed in a subjective and gendered way. Gender inequality and power are embedded within specific types of care relations: each type of care denotes a different kind of inequality.

Waerness (1984) distinguishes three kinds of care relationships: in *personal services* the cared-for person is of superior status to the caregiver. This involves the kind of care which the care receiver could provide for themselves. This kind of care is given to healthy adults, adolescents, to husbands, high-income families, to managers and bosses—that is, to people who, because of their status, “earn” their care. Such care is provided on the basis of moral obligation (by mothers and housewives, for instance) or on employment basis (by domestic servants or secretaries), but always the status of the care receiver (often male) dominates the status of the caregiver (often female). A second type of care Waerness distinguishes is *caregiving work*. Here the care receiver is not able to take care for him- or herself because of age, disability or illness. Although the care receiver could be male or female, due to the fact that women are living longer than men, more and more women need care. In this kind of care relationship the care receiver heavily depends on the caregiver and the status of the latter is dominant. Caregivers are in the position to make decisions about the needs of care dependents and about the quality of care given. This kind of care takes place within the public domain (child care, nurseries) as well as in the private domain (care by mothers for young children, elderly parents) and can be paid or unpaid. Women are likely to perform the caregiving work.

A final category of care is *spontaneous care* in which caregivers and care receivers can see each other as equals. This is care provided by friends, colleagues, and neighbors in case of emergency or because of reciprocity. Although Waerness stresses the spontaneous character of this type of care, it is preferable to emphasize the reciprocal character of caregiving among equals. Reciprocal care balances caregiving and care receiving among and between citizens, whether they form a married or cohabiting couple, are parent and child, or are friends, relatives, or neighbors.

Reciprocal care might be a fruitful concept for “inclusive citizenship,” as it stresses the fundamental interdependence of citizens as well as the simultaneousness of being a citizen-worker and citizen-caregiver (Sarvasy 1992). It is the recognition of care as a form of mutual dependence which can contribute to women’s citizenship, rather than the neglect of care as an issue.

One way to acknowledge interdependence is to incorporate the right to time for care or provide direct compensation for care. Different types of care leaves, such as the Danish, which should be well paid and less gendered than they are currently, are examples of an emphasis

on dependence and on the reciprocal character of care. Another viable route is to develop part-time work so that caring for children, elderly people, and sick friends can become an integral part of a citizen's life. Only when citizens are allowed to feel dependent and when caregiving is made possible and highly valued, such as financially, can the caring dimension of citizenship become a reality.

Citizens' Right to Give and Receive Care

Rethinking interdependence implies rethinking conditions for commitment among citizens along gendered and generational lines from a political perspective. In line with Tronto (1987), as well as Fraser and Gordon (1994), we stress that interdependence among citizens is a matter of interpreting the rights and needs of caregivers as well as care receivers. Such an approach goes beyond individualized moral claims on caregivers and recognizes the variety and diversity of the needs of care receivers. This approach also goes beyond the polarization of the advantages and disadvantages of private or public care.

To modify existing theoretical dilemmas two theoretical and empirical themes are important: the citizenship right to time for care and the right to professional care. It is by the combination of these rights that citizens' right to receive care can be guaranteed.

The rights and needs of caregivers are multiple and are linked to the provision of resources: time, money, rest, respite, and being involved in a (formal and informal) support network. These are the main conditions under which caregivers (professionals as well as informal caregivers) can decide to say "yes" or "no" to the needs of care receivers, whether to be attentive and supportive, whether to deal with stress and burnout, and whether to view caregiving as a satisfying relational activity instead of a favor on gendered moral grounds.

The idea that most caregivers (formal and informal) are women who are supposed to give care unselfishly postponed the realization that this kind of interdependent work needs its resources too. Many studies (Jamieson 1991; Qureshi 1990; Ungerson 1995; Herik, Been, and Vulto, 1995) show that burnout and stress among professional as well as informal caregivers result from the fact that they have to do their work in a hurry, they cannot share it with others, and they are the only providers of care for an excessive period, and, as a result, they experience a loss of motivation (in the case of informal caregivers). Many formal caregivers have too many clients and therefore find that they cannot provide the good-quality care their clients need (in the case of professional caregivers). If they are paid at all, their payments are exceptionally low, and they have to either combine informal care with a full-time job or end up in poverty. And if they have rights at all, it is important that the welfare state enforces these

rights (see, for instance, the low take up of home help and ICA; Twigg and Atkin 1995, McLaughlin 1991); caregivers often do not regard themselves as such, let alone consider that they might have rights.

And limited rights have developed. Well-paid time for care improves the conditions under which caregivers work, and in a country such as Denmark payments for both informal care workers on leave and professional workers are relatively good (see also Kremer 1995). Also in Britain, in the area of informal care, payments for care might improve the conditions under which caregivers work, though the rights, the content of the job, and the working conditions of informal and formal care workers is a research area that needs further exploration.

The same story is true with respect to the rights and needs of care receivers; obtaining good-quality care is strongly connected to the conditions under which their caregivers work, but there is more. It also implies accessible and qualitatively good care to meet the demands of different groups of citizens who are in need of care. Receiving care as a favor can result in an intersubjective relationship confused by all the possible strains connected to an unequal dependence. This is primarily the case in the Netherlands and Britain. On the other hand, being dependent on institutionalized, bureaucratically organized professional care, such as in Denmark, can lead to a lack of control, passivity, and inefficiency (Adriaansens and Zijderveld 1981). This is why having a legitimate choice of one form of care or another, or of combinations of care, is of crucial importance for care receivers. There are, however, some limitations to the choices of care receivers. First, they cannot demand care from one individual in particular, since no one can be obliged to give care (this would contradict the rights of caregivers). Second, some specific categories of care receivers are not able to make rational choices for one kind of care or another; people with serious psychiatric problems, elderly people suffering Alzheimer's disease, and alcohol and drug addicts cannot be expected to make rational choices. Also other groups of care dependents cannot always foresee the pros and cons of different kinds of care (Knijn 1997). Despite these limitations, the acknowledgment of interdependence needs a political discourse on care in terms of the rights and needs of care receivers as well as caregivers.

Beyond the Delicate Construction of Gender and Care: Toward Inclusive Citizenship

Due to simultaneous social, demographic, and economic changes, such as the graying of society and the fact that in many welfare states, women, who were made responsible for care-giving, increasingly par-

ticipate in the labor force, the fragility of the organization of care in current welfare states becomes highly visible. Currently, all welfare states are dealing with the transformation of their infrastructure of care, and while in some welfare states this tends to result in a decline in standards and in the quantity of good, formal care, often in liberal welfare states care has been extended and improved, such as in some Scandinavian countries.

This vulnerability of the infrastructure of care can be explained by two of its main characteristics: the gendered character of caregiving (and accordingly care-givers' vulnerable social position) and the weak social position of care receivers. Caregiving is a highly gendered activity and vice versa; it is by care that the gender identity of women is constructed. A woman's position in the family, her opportunities in the labor market, her relationship with relatives is defined in terms of her potential caregiving and the realization of her capacity to care—because it goes without saying that she can care. Moreover, women's identity, their self-esteem and self-image, the way women are valued and/or criticized is related to their caring capacities. Care and femininity are regarded as two sides of the same coin: they are mutually related (Pateman 1989, Sevenhuijsen 1993; Lister 1994). Even the increasing labor participation of women, which started in most western countries, has not resulted in the degendering of care. And if women's labor participation has led to an increase in state-organized care, such as in Scandinavia but also in France and Belgium, the care provided remains gendered; paid caregivers are, almost without exception, women. Sex segregation in care work has also found its way into the public domain.

The second reason for the vulnerability of the organization of care is related to the vulnerable social position of care receivers. People dependent on care are sometimes well equipped to assure that they receive the care they need. Male breadwinners are good at making certain they are taken care of by their wives, and affluent people can pay for insurance that guarantees good-quality care or buy services from the market. Nevertheless, in many countries a care gap is visible. The withdrawal of the welfare state, in relation to an aging society, women's increasing labor market participation, and the declining birth rate, has meant that care dependents cannot get the daily care they need. Young children, the frail elderly, and disabled people dependent on the state and/or their relatives for care increasingly discover that they are not expected to make claims. Although some consumer groups manage to gain influence, most care dependents do not have the power or the resources to influence or alter current welfare state praxis. Care dependents more and more fall between the two stools: they can no longer rely on (women's) informal care nor on the state's formal care.

Because the welfare state as well as the position of care receivers as caregivers (read women) is always at issue in times of economic recession, it is necessary to degender caregiving and revalue care and go beyond the delicate construction of gender and care. It is therefore necessary to include care in the definition of citizenship, so the rights to time for care and to receive care are protected. Although this conceptualization of citizenship seems a long way off, some dimensions of the Dutch, Danish, and British welfare states already shed light on how welfare states can aim for inclusive, degendered citizenship.

NOTES

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1. Parts of the enlightened bourgeoisie and the churches also supported a certain protection of female familial care. This can be explained by the recognition of the importance of caretaking for the social and physical well-being of the population in order to assure a situation of social stability (de Swaan 1988).

2. In addition to care within the family, which eventually became the dominant way of caretaking in most welfare states until the 1960s, new forms of care were developed by local communities, (religious-inspired) organizations of volunteers, and professional organizations. It was on the basis of an already existing, broad, well-developed, semiprofessionalized field of medical, social, and psychological care that postwar welfare states could complete their "infrastructure of care."

3. Denmark spent 0.7 percent of the GDP (gross domestic product) on home care for elderly and handicapped people in 1990 (Nosoosco 1993). In the Netherlands, the percentage spent on home care is comparatively less, 0.3 percent of the GNP in 1987, while in England and Wales a percentage has been reported of 0.14 percent of the GDP in 1985 (Jamieson 1991).

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