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In and beyond New Labour: towards a new political ethics of care

Abstract

This article argues for a political ethics of care to balance New Labour's current preoccupation with the ethic of paid work. However, care as a practice invokes different experiences, meanings, contexts and multiple relations of power. With this in mind, the article traces the development of the concept of care taking up, in particular, challenges and differences raised by disability, 'race' and migration. These offer important insights for a new political ethics of care whose key dimensions are spelled out in the final part of the article.

Key words: care, disability, New Labour, 'race', work/life balance

Introduction

The bottom line for reforming the welfare state could be said to be the following: to reverse the misery of those in poverty, to provide sound protection and security from social and economic risks, and to promote citizenship. The crucial questions for New Labour, given the legacy of the New Right, are, not only how to do this, but also what *values* and *principles* should underpin a new welfare strategy, and how it can be defended.

New Labour's first term was mixed. Between 1997 and 2001 New Labour had initiated a number of important reform measures, including the pledge to end child poverty; increases in income support rates for children; a national minimum wage; the commitment to neighbourhood renewal and to reducing health inequalities; setting up a National Childcare Strategy, a Care Commission, a Disability Rights Commission and a National Carers Strategy; support for working parents; and naming and acknowledging institutional racism and

social exclusion. At the same time, other measures seemed to undermine and contradict these moves: the demonisation of asylum seekers; cutting of lone parent benefits; the negative representation of people on benefits, especially disabled people on incapacity benefits, and of people with mental health problems; and miserable increases for pensioners (until challenged). The redistributive measures that were introduced were brought in through the back door, rather than defended and argued for so as to win and maintain support for them. Principles of equal worth and mutual respect have been enunciated, but those values that found more elaboration in policy documents and implementation are those that foster opportunities for individual self-sufficiency, especially the work ethic.

It is the narrowness of the ethic of paid work underpinning New Labour's welfare reforms with which this article is concerned. I argue that an ethic of *paid work* has to be balanced by an ethics of *care*. But care as a practice invokes different experiences, different meanings, different contexts and multiple relations of power, of which a political argument around care needs to take account. It is with this in mind that this article develops a political ethics of care, taking up, in particular, challenges and differences raised by disability, 'race' and migration. I have argued elsewhere for four key principles of recognition to underpin reforms in the organisation and delivery of welfare (Williams, 2000). These are *mutualism*, *autonomy*, *inclusive diversity* and *voice*. The following discussion around a political ethics of care is, in particular, an elaboration of an aspect of the principle of mutualism, but I use it also to demonstrate that issues of autonomy, inclusive diversity and voice are essential in developing an ethics of care.

The article begins by setting out the reasons for the issue of 'care' to take political and intellectual centre stage in the study and making of social policy. It then briefly traces the development of the concept of care, noting that its most recent manifestations follow different trajectories:

- the *universalising* orientation of work around care and citizenship;
- the *particularising* challenges to care from the disability movement;
- the *transnationalising* direction taken in the pursuit of the connections between 'race', ethnicity, migration and care.

These three different directions all offer important insights for a new political ethics of care whose key dimensions are spelled out in the final part of the article.

Why care? Why now?

There are compelling reasons why care should be recognised as a central political and intellectual issue for social policy. They are concerned with what it reveals about both the changing social formations and changing welfare states, about the exigencies of current social and political change, and about the spaces that afford political intervention in care's name.

Mary Daly and Jane Lewis have recently argued for care to become a central analytical concept in the comparative study of welfare regimes (Daly and Lewis, 2000). This is because current policies associated with the giving and receiving of care provide a unique lens to view so much that is changing in the unfolding of new welfare settlements in European welfare states. These include the following:

- the shifting relations between state, family, market and voluntary/community sectors as providers of care;
- the shifting relations between cash and services as the mode of provision;
- the shifting relations between carer and cared-for as the recipient of whichever provision;
- shifting gender relations through the increase of women in paid work;
- shifting demographic relations through which care of both young and old has become a central welfare concern.

Without an understanding of the ways in which different countries' welfare states are responding to these changing boundaries of welfare provision, they argue, the picture of changing welfare trajectories is incomplete. Accordingly, they develop a multidimensional concept of 'social care' that provides the basis for developing the indicators for a cross-national comparison of these changing welfare regimes. They identify three key dimensions to the concept: care as labour, whether paid, unpaid, formal or informal; care as part of a normative framework of obligations and responsibilities; and care as an activity that carries financial and emotional costs that are borne, in different degrees in different welfare regimes, by individuals, families and public institutions/domains.

Daly and Lewis's argument for the centrality of care in welfare state analysis is an important one, and below I reinforce this with reference to the importance and timeliness for developing the political capacity of 'care' arguments. Their conceptualisation of social care

could be extended to further shifting relations and changing boundaries in care practices and provision. First, Daly and Lewis acknowledge that one of the important new variations in care policies in different countries is in the relationship of cash to services, and within this a further variation, in terms of cash payments, in who receives that payment—carer or cared-for (ibid.: 292–3). They further identify the ‘deep ramifications’ of such a choice between carer and cared-for since in ‘making the payment to the person requiring care . . . welfare states are in effect distancing themselves from how the care needs are satisfied’ and that ‘we could be seeing the emergence of a new kind of welfare citizenship’ (ibid.: 294). I would suggest that, in so far as this move to direct payments has also been, in part, and in some places, the consequence of demands from the disability movement, then it indicates not simply a ‘distancing’, but also a challenge to the assumed, all-encompassing dependency of the ‘cared-for’ in care relations and practices.

Second, unpaid and paid-care practices and provision are also the subject of a further changing boundary not identified by Daly and Lewis, that of the nation, and this has two aspects to it. First, there is the question of the nation-imaginary, and how this influences the (multi) cultural frame through which care practices and provision are constituted. Who and what are ‘families’?, and who and what are ‘the nation’?, are interlocking questions that reveal historical variations in different countries, as well as significant contemporary changes and challenges. These have emerged not only from changes in ethnic and national identities, but from demands for the recognition of different sexual and familial identities. Second are the transnational issues of ‘diasporas of care’ where families care across continents, and the ‘global care chain’ where (usually female) migrant workers move from poorer countries to provide domestic service for individuals and families in richer countries. This suggests that the ‘costs of care’ are not just a question of the changing relationship between the state, market, family and community, but of geopolitical inequalities between states affecting individuals in gendered and racialised ways. These two issues of shifting relations and changing boundaries are developed later, but the point here is to think through the ways in which the contemporary social processes of care are multi-relational, and what that might mean for a political ethics of care.

These points add weight to the argument that care is a central analytic referent in social policy: a point at which social and cultural

transformations meet with changing relations of welfare. In political terms, too, care has become increasingly significant in a number of different policy-relevant discourses, for example, in the move to a 'mixed economy of care', in community care, in the treatment of children in care, in debates about what constitutes good parenting, in long-term care for older people, and in claims for the recognition of care responsibilities in employment-based 'work-life balance' policies. All focus, in one way or another, on what care means, its uses and abuses, what it costs, how it is supported, how it is delivered, and by whom. For example, the move towards community care in the 1980s and the development of a mixed economy of care with a purchaser/provider split, and the marketisation of services have added, in different ways, to the politicisation of care. To begin with, these moves have been accompanied by the growth of more clearly defined constituencies of 'care users', for example, in the development of a Carers National Association and local groups of carers organisations, as well as in the organisation of disabled people's groups, through, for example, the British Council of Disabled People, and the National as well as regional Centres for Independent/Integrated Living, through organisations of people with learning difficulties, self-help support groups for parents of disabled children, users of mental health services, as well as the growth of self-help and support groups for people living with different health conditions, such as AIDS, different cancers, anorexia, addictions, and so on. The demands these groups have made in terms of greater access to information, challenging the medicalisation of life, challenging assumptions of dependency, wanting a greater say in the organisation and delivery of services, and demanding recognition and respect for difference, have raised important questions about the social relations of the organisation and delivery of care services (Williams, 1999; 2000).

At the same time, the mixed economy of care is intensifying long-term disadvantages for particular groups, especially women. Clare Ungerson has shown how the reorganisation of care work has drawn women to work in care jobs where the hours and skills that are demanded fit particularly with women who have existing domestic responsibilities (Ungerson, 2000). However, most of these jobs do not offer women the necessary benefits to provide for security in their own future old age, or the wherewithal to pay for their own future care needs. In this way, the mixed economy of care locks its lower paid employees, most of whom are women, into a marginalised and

exploited form of dependency as both care producers and care consumers.

The drive to fuller employment is also having consequences in terms of care and time. Fathers in the UK work the longest hours in Europe and complain that they do not have enough time with their children (National Family and Parenting Institute, 2000). This hits working mothers the hardest, as they tend to take most responsibility for care. More than three-quarters of working mothers say they feel stressed through lack of time from juggling between paid work and care responsibilities (Good Housekeeping, 2000).¹ This is because without good quality, universal, affordable and flexible forms of day care, the various employment strategies open to parents entail difficulties. A dual full-time employment strategy where both parents are in full-time work tends to be more feasible where women's wages can cover the costs of private childcare, that is, partnered women in professional or managerial jobs. But even here, without shared care responsibilities at home, it makes women's lives particularly stressful. In those situations where women work part time and take on most of the care responsibilities, men/partners often take on overtime to compensate for lowered household income and women find their career development and job opportunities limited. This strategy does not meet men's or women's aspirations for quality time for themselves or for their children; it ignores women's skills and employment capacity, especially given the insecure and low paid nature of part-time work; and it renders women very vulnerable on divorce (Gardiner, 2000). Again, without good quality, affordable childcare, these difficulties of time, costs of care and career development are compounded for working lone parents unless they have childcare help from their own mothers or friends.

The emergence of a new discourse which is not just about 'family friendly' policies, but about *work/life balance*, that has emerged in discussions among voluntary organisations and think-tanks, trade unions and some government departments (Bryson et al., 2000; Department of Trade and Industry, 2000), is a response to these issues of care and time. It provides, I believe, an important political space in which to start to argue for a political ethics of care. For example, the currency which *time* has acquired is particularly important not only in how working parents negotiate their day-to-day relationships but, increasingly, in how trade unions negotiate with employers. In the case of the latter, a number of pressures have given time this premium in

employment. Employer demands for flexibility often run counter to employee security and work satisfaction and have given rise to demands for greater employee control over flexibility. In addition, as Jane Pillinger explains, in Europe the greater scope for bargaining around time is a consequence of the link between pay and productivity being broken in the private sector (because companies can relocate elsewhere), and in the public sector because shrinking public expenditure budgets provide limited opportunities for advantageous pay bargaining (Pillinger, 2000). In a sense, there has been a shift from the demands for a 'family wage' to 'family time'. This focus on time has provided the opportunities for women (particularly in The Netherlands and Sweden) to demand a restructuring of work in ways that redistribute working and care time between men and women. Pillinger argues that new forms of time flexibility that *benefit* women, rather than those that reinforce job insecurity and care/work incompatibility, appear to work best when developed as part and parcel of local strategies, which integrate issues of work, time, care, space and welfare services, such as the 'Time in the City' projects in Italy, where they are 'rooted in the decentralisation of services, the articulation of user demands and imaginative responses to improved delivery of services and the very operation of cities' (Pillinger, 2000: 334). Similarly, experiments around annualised hours, time banking and lifetime working hours can give parents, and women in particular, more choices in negotiating work and care.

These examples suggest that policies associated with care have the potential to be innovative, yet are often operating in ways that reinforce inequalities. My argument is that if care policies are going to fulfil that innovative potential in ways that secure greater and not less equality, then the political values that support such policies have to be clear. There have, to date, been some important commitments by New Labour around care: the setting up of a National Childcare Strategy and a National Carers Strategy; a promise of one million childcare places by 2003; a range of measures to help working parents from the Treasury, the Departments of Trade and Industry, Social Security (now Work and Pensions), Education and Employment, and Health (including extended maternity leave and pay, and paid paternity leave, and unpaid time off for dependants), a *Better Government for Older People* initiative, Commissions on Long-term Care and on Disability Rights. However, policies for maternity leave and pay are redressing thirty years of neglect. Britain lags behind the rest of

Europe in terms of provisions for working parents; it was the EU rather than New Labour that was behind the part-time and parental leave directives. There has been a reluctance to confront employers about implementation, which is patchy across the employment sectors. More importantly, perhaps, no clear political justification has emerged for these measures other than those associated with the work ethic, productivity and competitiveness. Some measures have been introduced to help get single mothers into work, to help business retain women workers with skills, to avoid absenteeism, to encourage women into the new economy and to develop private sector initiatives. There exists a fundamental tension between the practical acknowledgement of care and the political privileging of the work ethic.

The principle of paid work has been central to New Labour's welfare reforms, providing the financial imperative to get people 'off welfare and into work', and the moral imperative to turn people into better citizens. Paid work is presented as the:

- first responsibility of citizenship;
- route out of dependency into independence and economic self-sufficiency;
- solution to poverty;
- point of connection that individuals have to the wider society;
- role model to offer children (both for mothers and for fathers);
- glue that binds society together.

Paid work is also the condition of eligibility to a new range of benefits such as the working families tax credit. On the other hand, it is possible to read this emphasis on paid work as the recognition of education and training needs, and, particularly, the recognition of the rights of those whose access to paid work was historically marginalised, such as women or disabled people. On the other hand, without an equal commitment to, and recognition of, needs for care and support, we could find ourselves moving away from a male breadwinner regime to one that is still premised upon the model of the male worker—a relatively mythical self-sufficient being whose care needs and responsibilities are rendered invisible because they are carried out somewhere else, by someone else. No political principle about care equivalent to that of paid work exists that can begin to link together, argue for, and defend these disparate measures that have been taken, and those that need to be developed, for those who care and those requiring care and support.

The final reason for asserting the importance of care as a political issue is that to talk about an 'ethics of care' may provide us with a more robust discussion of the values that are important to people in their relationships of care and intimacy than that which is allowed by the phrase 'family values'.² New Labour policies and politicians often talk the talk of family diversity, of a greater awareness of the realities of intimacy, while also walking the walk of 'family values'—invoking the superiority of the two-parent heterosexual family as the site of care (Home Office, 1998). A new discourse linking the diverse practices of care and intimacy to the positive values attached to them is urgently required.

Paradigms of care

Over the last 30 years academic research on care has developed around a series of overlapping paradigms. These have never been far from the politics of care. From the 1970s, research on 'informal care' came from two different quarters: from those concerned with recognising the 'informal sector' of welfare in order to give it, and the new mixed economy of welfare of which it was part, a greater role in the development of social policies; and from feminist writing, which sought to reveal the sexual division of labour between men and women, the exploitation of women's unpaid labour as carers and the role of state in maintaining this. What developed was a powerful critique of community care policies. Central to this was the concept of care as (oppressed) labour and the political demand for the recognition and reward of carers.

By the 1980s this paradigm shifted as feminism moved against the notion of women simply as victims and into the celebration of women's difference and a woman-centred culture. The focus of care shifted similarly to an investigation of the meanings of care for women, for their identity, and for their view of the world. Thus, caring was not simply unwanted labour foisted upon women but 'the medium through which women are accepted into and feel they belong in the social world' (Graham, 1983: 30). One of the most developed sets of ideas within this new turn was Carol Gilligan's *In a Different Voice* (Gilligan, 1982) where she suggested that there are gender differences in the moral frameworks within which men and women operate. Whereas men's moral frameworks guiding their actions

are underpinned by a notion of rights that are subject to public and rational assessment, women's are underpinned by a notion of *responsibility*, which are assessed in relation to individual circumstances. She therefore posed a female ethics of care against a male ethics of justice. In doing this she placed care within a new *ethical*, or *moral*, paradigm. More sociologically, Janet Finch's work (Finch, 1989) moved away from the exploitation paradigm into the territory of social obligations to study the *normative* structures that influence people's caring activities.

These studies made important strides, but also had limitations: they were almost entirely gender-focused and tending, with some exceptions, towards an undifferentiated category of womanhood. Gilligan's work was underpinned by an essentialism around gender differences. There was also an assumption that the site of care was the heterosexual 'normal' family, and the focus on the carer and care as either work or ethic ignored care as a set of relations involving power and featuring both carers and cared-for. Indeed, the carer-centred critique of community care policies often overlooked the fact that these policies were, in part, the result of campaigns against institutionalised care by, among others, disabled people's organisations. In response to these limitations, work which followed in the 1990s went in two directions. Some emphasised different perspectives from the point of view of disability (see particularly Morris, 1991; 1993, for a disabled feminist critique); 'race' and ethnicity (see Gunaratnam, 1990, and Ahmad and Atkin, 1996), sexuality, in terms of non-heterosexual 'families of choice' as the site of care relationships (Weeks et al., 1996) or friendship as the basis of care (Pahl, 2000). This 'paradigm of difference' came largely from those whose experiences had been marginalised in the policies for informal and formal care. They pointed to the need for analyses and strategies to take account of differences of *power* in care relations, especially between care giver (paid or unpaid) and care receiver; the different *sites of care* outside the conventional nuclear family; the different *contexts of care*, including the racialised context; and, consequently, different *strategies* around care.

Some of these elements of difference were acknowledged in a second development that attempted to resolve the tensions between an ethics of care and an ethic of justice, rather than to understand them as a gendered binary, as Gilligan's work had implied (Tronto, 1993; Sevenhuijsen, 1998). This moved the debate into an exploration of how the ethics of care may influence public democratic practices

and our understandings of citizenship. Tronto, for example, considers care not as just a moral concept but as a political concept through which we can make judgements about the public world (in a US context):

Care helps us rethink humans as interdependent beings. It can serve as a political concept to prescribe an ideal for a more democratic, more pluralistic politics in the United States in which power is more evenly distributed . . . care can serve as a strategic concept to involve the relatively disenfranchised in the political world. (Tronto, 1993: 21)

Care, in these terms, recognises power and encourages a democratic pluralistic politics. The practices of care also provide the basis for considering its moral qualities. Tronto suggests these are fourfold:

- *attentiveness*—caring about, that is, noticing the needs of others in the first place;
- *responsibility*—taking care of, and through that assuming responsibility to care;
- *competence*—care-giving and the activity of caring involved in this;
- *responsiveness*—care-receiving, which involves an awareness of one's own vulnerabilities as well as an appreciation of the different positionings of the care giver and care receiver (ibid.: 127–134).

Furthermore, she argues, care is central to all our lives, so, for example, care receiving makes one aware of one's vulnerability, and vulnerability is not simply an attribute of, say, children or old people, but is something we all experience.

Care is not a parochial concern of women, a type of secondary moral question, or the work of the least well off in society. Care is a central concern of human life. It is time we began to change our political and social institutions to reflect this truth. (Tronto, 1993: 180)

This *universalist* paradigm is taken up by Sevenhuijsen, who advocates an ethics of care as an important element of citizenship. Rather than simply being counterposed to justice, we should see care as a social process engendering important elements of citizenship. The processes of caring for or being cared for make one aware of diversity, of interdependence, of the need for acceptance of difference, which form an important basis to citizenship (and are as likely, or more likely to be learned through care as through paid work practices). Thus, the moral qualities that Tronto describes—attentiveness, responsibility, competence and responsiveness—should be seen as

civic virtues. Furthermore, care provides an important *lens* through which to make situated judgements about collective commitments and individual responsibilities. In this way it is different from liberal notions of justice, which are based upon legalistic principles that assume individuals are independent and atomistic beings. Instead it recognises us all as interdependent and as having the potential and responsibility to be caring and cared for.

This new universalist paradigm seems to offer much by way of argument for balancing the current preoccupation with the ethic of work. However, if we go back to the paradigm of difference, we can find refutations of some basic concepts and premises of the ethics of care argument that have been questioned by writers from disability critiques. The next section considers these and goes on to ask how we might apply the ethics of care to the racialised context.

'Care' as disabling?

The most powerful and searching critique of the social relations of power between the providers and receivers of welfare services has come from the disability movement (Oliver, 1990; Finkelstein, 1991; Oliver and Barnes, 1991; Morris, 1993). A number of arguments for a social model of disability and for civil rights for disabled people would appear to challenge some of the key concepts of the arguments for 'an ethics of care'. So, for many, the very concept of 'care' embodies an oppressive history in which the practices and discourses of paid (particularly professional) and unpaid carers have maintained disabled and older people in a position of, at worst, unwanted dependency, abused and stripped of their dignity, and at best, patronised and protected from exercising any agency over their lives:

Disabled people have never demanded or asked for care! We have sought independent living which means being able to achieve maximum independence and control over our own lives. The concept of care seems to many disabled people a tool through which others are able to dominate and manage our lives. (Wood, 1991, 199–200)

Instead Wood talks of *choice* and *control* as the key concepts of empowerment for disabled people, and Finkelstein (1998) argues for *support* to replace the laden notion of care. Second, where the ethics of care

argument emphasises *interdependency* as the practical reality of people's lives, organisations of disabled people have emphasised *independence*. Sevenhuijsen argues against the reification of the autonomous, atomistic individual in liberal thought and the denigration of dependency that goes with it:

An ethics of care would replace the idea that dependency forms an obstacle to autonomy with the concept of interdependency and recognition of the ways in which good care can contribute to behaviours and choices which enhance people's feelings of self-respect. (Sevenhuijsen, 1998: 140)

In contrast, disabled people have argued for the strategic centrality of *independence*, tying it to the practical demand for independent living in which autonomy and control over one's life is key. It is as part of this that the provision of direct payments and personal assistance schemes has emerged. Direct payment to the people requiring care (rather than the carers) enables them to buy in their own form of assistance.

This argument against recognition of dependency and vulnerability as universal human traits is also taken up by Silvers (1995) in her critique of the ethics of care. She argues that dependency and vulnerability as experienced by disabled people are constituted historically through their marginalisation and oppression and cannot, therefore, be taken to provide the basis for an alternative morality or an acceptable moral personhood. Furthermore, to argue that the mutual exchange and practices of close caring relationships become the basis for social life, and are recognised as 'virtues', fails to fully appreciate the power inherent in extra-familial care relationships where the tenderness of intimacy is absent. In turning oppression into a virtue, it also places a moral onus upon the cared-for person. Without the structures and conditions for equality, it becomes incumbent upon the cared-for person to ensure that the carer behaves virtuously (Silvers, 1995: 42). Silvers' argument is reminiscent of similar arguments against the assumptions that women should feel responsible for dealing with men's violence, or minoritised groups feel responsible for putting white or straight people at their ease. Ultimately what Silvers argues is that the ethics of care deflects from the paradigm of equality, and it is this that can both contain the demands for civil rights for disabled people, as well as connect to the struggles of other marginalised groups.

These are important arguments. However, there are also points of commonality in the ethics of care arguments of Tronto and Sevenhuijsen and those from disabled activists, and thus good reason for exchange and synthesis. Such an ambition is not possible within this article, but the aim is to encourage the dialogue begun by Tom Shakespeare, who says that both perspectives share a critique of the way care is organised but 'neither perspective has engaged with the other, despite opportunities this might offer for a more holistic programme of reform' (Shakespeare, 2000: 73).

What commonalities exist? Both Tronto and Sevenhuijsen operate within an equality paradigm and against the historical inequalities in care relationships. Tronto argues that 'how we think about care is deeply implicated in existing structures of power and inequality' and argues against the inequalities in current care practices of 'otherness', 'paternalism' and 'privileged irresponsibility' (this being the ignoring of the needs of others). Sevenhuijsen also stresses the application of principles of equality and an accommodation to the ethics of justice:

We need to reframe norms of equality and access to public provisions in such a way that they meet basic standards of social justice. This is also important in order to counter the deeply entrenched tendency towards thinking in terms of an opposition between an ethics of care and an ethics of justice. (Sevenhuijsen, 1998: 142)

Similarly there is some agreement, in spite of different emphases, between the way autonomy/independence is understood in their works and that of Jenny Morris. Morris makes a distinction between independence as self-sufficiency, which she, in common with Tronto and Sevenhuijsen, rejects, and independence as having the capacity to have choice and control over one's life, as is implied in the independent living movement (Morris, 1993: 22–3).

But there are tensions too. Silvers' argument about relationships of care being structured around domination and subordination is important, but it may be that she overstates the fixity of such relations. After all, even though there is a constructed unequal binary between able-bodied and disabled, we can in practice be carers or cared-for in different situations and do not always occupy one single position in this binary. Disabled people may be active carers even though their structural position may render this invisible. Indeed, disabled parents' struggle is to have their role as carers of their

children made legitimate (Wates, 1997).³ Able-bodied people experience physical and emotional dependency upon others. The capacity for understanding the other's position is important in breaking down its abusive elements. Nevertheless, Silvers' and others' emphasis upon disability as a set of socially and historically constructed power relations and as a civil rights movement as significant as those around gender, 'race' or sexuality, is one that deserves more acknowledgement in the ethics of care literature. This literature does not ignore the power relationship between care giver and care receiver, but neither does it attach a great deal of analytic power to the social relations of disability, nor to those strategies or innovative practices that the social movements of disability have generated. So, for example, the concept of interdependency needs to take account of the fact that collective struggles around care have placed a premium on independence. Thus, whereas it is possible to argue that, in the longer term, disabled people's (and older people's and children's) interests would be better served by a society that valued interdependence and acknowledged the vulnerability of all, the immediate strategy for disabled people is for rights to secure the conditions for independence. The task then becomes less one of arguing against autonomy as a liberal concept than one of redefining the concept of autonomy to fit with a notion of interdependence.

At the same time, strategies for disabled people's independence need also to be seen in the context of other discourses or practices of inequality. Thus, some of the arguments for direct payments and personal assistants *could* be seen as complementing those moves within welfare work to marketise and privatise care work, and to strip it of any skills it may require. For whilst it empowers disabled people by giving them choice and control, it does so by repositioning them as active consumers of welfare, reinforcing the commodification of welfare services. In fact, in practice, as Tom Shakespeare (2000) points out, relationships between disabled people and personal assistants are generally marked by mutual respect and shared negotiation. This may be precisely because they take place within the context of a movement that values equality, and with reference to local organisations of Centres for Independent/Integrated Living (CILs), which emphasise the quality of the relationship between disabled person and assistant. This point is supported by Ungerson's research based upon interviews with personal assistants:

I've worked out that it's a people thing and you've really got to like the people. And with the CIL, when I get a name to go and visit, you may not like them so that's fine—we don't work. So they have the choice. With the lady at the Nursing Agency, she has no choice, whether she likes me or not, I'm there. (Female personal assistant quoted in Ungerson, 1999: 589)

It is this, the 'power to exit' and the flexibility of the work, which Ungerson found were valued by personal assistants. Flexibility, choice and control are the requirements of service users, as Mark Priestley's study of the Derbyshire Centre for Integrated Living demonstrates. While personal assistant and direct payment schemes may fit closely with an individualist, privatised model of welfare, he argues, they are also part of a collective response to the social relations of welfare and have, as such, more in common with socialist and communitarian traditions (Priestley, 1999: 119). Nevertheless, differences of class, age, 'race', sexuality and gender among disabled people suggest that when choice, flexibility and control are present in other arrangements, such as freely chosen familial, partnered or collective living, these could also be preferable to some (Shakespeare, 2000: 68–70).

The argument that *untrained* personal assistants demonstrate better the attributes necessary for good support, because they have not been inculcated with professional attitudes of paternalism, is important.⁴ But it overlaps dangerously with arguments that have kept women workers low paid for generations—that they bring with them skills which are 'natural' and need not be valued (an issue more than exemplified by the relationship between care and migration, discussed below). It is here that Tronto's four elements of care (attentiveness, responsibility, competence and responsiveness) may be a useful contribution to a discussion about what is necessary for good personal support. It could be argued that these skills/attributes/qualities are precisely those that need to be *claimed for* rather than disclaimed in the practices of care and support, and that the issue is how to develop training so that the knowledge and experience of disabled people and other service users influence work practices.

In recognition of some of the difficulties around the concept of care and the way it lurches between oppressive family care and oppressive professional care, Shakespeare proposes the concept of 'help' in order to draw attention to the significance of alternative forms of support to emerge from non-professional, informal, grass-roots net-

works and practices. Help, he suggests, is underpinned by altruism and he sees this as an important value to be recognised (Shakespeare, 2000: 71). Given that help is what friends do for each other and care is what families and professionals do, this concept may have some mileage; it may be that the friendship paradigm is beginning to provide more possibilities than the family paradigm. However, there is an element of voluntarism about help and altruism. One consciously enters into a helping relationship, whereas care is there, and for many people caring for others and being cared for is part of our lives, whether we like it or not.

Finally, writers on the ethics of care, on independent living and disability, point to the need to link their strategies to a participatory democracy—of giving people a voice. It is here that much more work needs to be done to document how this can happen, and how, given their different perspectives and positionings, those involved in care practices may begin to voice their claims. In other words, as a practical politics, the ethics of care must drive our democratic practices deeper: it has to involve dialogues between unpaid carers, paid carers, those who receive care and support and trade unionists representing paid carers. The ideas behind the practices of ‘transversal politics’ may be helpful here. This has emerged from feminist and black feminist politics. It is neither only universalist nor simply based upon diversity, but it recognises different perspectives and identities, and aims towards a common vocabulary of values. Nira Yuval-Davis has identified the following elements that its practice involves: from each positioning the world is seen differently; a wider view involves dialogue; differences are seen as important, but not in hierarchical terms; they should encompass rather than replace equality; there is a recognition of the differences in identity and values. One may share an identity with another but this is transected by different, say, class positionings. One may have a different identity and positioning from another, but share the same values (Yuval Davis, 1999).

‘Race’ and care: local and global contexts

I referred above to one of the changing boundaries of care which receives little attention in the care literature, and that is the changing internal and external boundaries of the ‘nation’. These refer both to the multicultural and racialised contexts of formal and informal

practices of care, and the transnational and global context affecting what might be called an international political economy of care. My aim here is to signal briefly the issues for care to which these point (see Williams, 2001).

In terms of the racialised context, an ethics of care would have to take account of the effects that the minoritising of ethnicity, culture and religion have upon the experience of caring and receiving care. So, for example, Tracey Reynolds' study of Caribbean mothering practices in Britain shows that these are constituted through 'race' and ethnicity effects in a number of significant ways. An understanding of what it means to grow up black in a relatively hostile white world where there is racial violence on the streets and in schools involves both protecting one's child and teaching her or him how to negotiate this. Similarly, the 'proper way to behave' that one teaches one's children is informed not simply by a view of 'not letting the family down', but also 'not letting the (black) community down'. That is to say, good behaviour is not simply what a child owes her or his mother, but her or his ethnic community. In addition, the construction of a Caribbean female ethnic identity as strong and independent provides normative guidelines for mothering, employment and parenting practices such that it has become the norm to combine breadwinning with mothering (Reynolds, 1998).

The racialised context of care not only means that the organisation and delivery of those services need to take account of culturally specific needs, accessibility and entitlement differences, but also of the ways in which changing regimes of care provision reconstitute, for better or for worse, existing racial divisions of labour. Although these issues have been part of academic and practice discussion for some 20 years, research suggests that minority ethnic groups continue to be less well served by care services than white users. For example, a study of minority ethnic families caring for a disabled child found that levels of unmet need in relation to access to benefits, services, support and counselling were twice as high as among white families in a similar situation (Chamba et al., 1999). Second, the history of the post-war welfare state as employer is one in which attempts to cut labour costs down were borne particularly by those women and minority ethnic workers on the lower grades, and by the recruitment of migrant workers (especially in health care) (Williams, 1989). There is evidence that these practices are continuing (see Glover et al., 2001). In recent government campaigns to recruit international nurs-

ing staff, private agencies and nursing homes have recruited nurses from India and the Philippines to jobs with appalling conditions. 'Hundreds of vulnerable overseas nurses are being trapped into what unions and royal colleges denounce as a "modern form of slavery"' (Browne, 2001: 5). In the voluntary sector of the mixed economy of care, there is also concern that the contracting out of services is bypassing smaller, minority ethnic providers (McLeod et al., 2001).

The place of migration in care relations points to a further set of issues. First, the increases in women working outside the home have been worldwide, creating demands for help with care and domestic service (Anderson, 2000). Second, in many countries these demands are neither being met by the existing welfare services, nor by changes in the gendered division of domestic work in the home. Third, the deregulation of public services for day care has led to an increase in women employed as nannies, carers of older people and cleaners in private homes or low paid workers in private care institutions, particularly in southern Europe, but also in France, Britain and Germany (Anderson, 2000; Kofman et al., 2000). Fourth, the increasing feminisation of migration leads migrant women into those less protected jobs, such as private nannies and domestic workers. This is because the increasing constraints on the rights of refugees and migrant workers, combined with assumptions of migrant women's economic dependency, means that these are the easiest ways into employment, it also makes these women vulnerable to exploitation (Williams, 2001). New tracks of migration may be emerging that are meeting the needs of professionally employed women workers in conditions of dwindling public services. In the US context, this set of processes is what Arlie Hochschild has called the global care chain. The care chain starts with a mother in a developing country needing to work to care for her own children, but also needing to support the mother or sister who is caring for her own children as she works. Working as a nanny in a western country provides her with work, a place to stay, and the possibility of sending remittances home. (According to the IMF, at the beginning of the 1990s, the value of remittances sent home by migrant workers was US\$65 billion, some US\$20 billion more than official overseas global aid programmes—Travis, 2000.) At the same time her employer, also a mother, is likely to be working in an area of employment—teaching, health care, social work, human resources—which requires another, socialised form of care or emotional labour. The chain is therefore not simply one

involving migrant labour, but one in which caring emotions are displaced from a mother's own child(ren) to other peoples' and other people (Hochschild, 2000).

A further, and historically long-standing, process in this international political economy of care is the existence of 'diasporas of care'. With greater migration, and with permanently settled and second and third generation migrants, families extend across continents, and patterns of familial and non-familial obligations are transnational (Chamberlain, 1998), an issue rarely considered when appeals to 'community care' or to 'family duties' are made by governments.

Finally, the globalisation of migration and globalisation of capital are also reshaping the new international mixed economy of care: increasingly the organisations setting up residential institutions are internationally based, and multinational companies operate in the area of domestic cleaning (Yeandle, 1999). EU directives on, for example, working time or migration policies are also important in how they influence the conditions under which both paid and unpaid care is carried out. This, and the developments noted above, suggest that, as the practices and values of care are becoming internationalised, arguments for a political ethics of care are as important among international policy-making bodies as they are among nation states. In addition, the process of devolution in Britain means that there are possibilities for new influences upon Westminster on social issues. One example is the Scottish Parliament's decision to implement the recommendations from the Royal Commission on the Long-term Care of the Elderly that the residential costs of older people should be met by the state, in contrast to Westminster who decided against this.

Towards a new political ethics of care

What, then, do these interpretations of care mean for policy? Below I suggest the issues and arguments that have been raised by the preceding discussion. This is followed by strategies that might, in practical ways, instate an ethics of care alongside an ethic of work as the basis of welfare citizenship.

Issues for an ethics of care

- A recognition that care of both the self and care of others are meaningful activities in their own right; they involve us all, men and women, old

and young, able bodied and disabled. We are all, after all, neither just givers nor receivers, but at some level, the givers and receivers of care to and from others. Care is an activity that binds us all.

- In receiving and giving care we can, in the right conditions of mutual respect and material support, learn the civic virtues of responsibility, trust, tolerance for human limitations and frailties, acceptance of diversity. Care is part of citizenship.
- An ethics of care demands that interdependence be seen as the basis of human interaction; in these terms, autonomy and independence are about the capacity for self-determination rather than the expectation of individual self-sufficiency. It recognises that vulnerability is a human condition and that some people are constituted as more or less vulnerable than others, at different times and in different places.
- It attributes moral worth to key positive dimensions of caring relationships such as dignity and the quality of human interaction, whether based upon blood, kinship, sexual intimacy, friendship, collegiality, contract or service. And it recognises and respects diversity and plurality in the social process of care.
- It asks who is benefiting and who not from existing care policies. It argues against inequalities in care giving and care receiving; it recognises that these inequalities may be constituted through different relations, particularly gender, but also disability, age, ethnicity, 'race', nationality, class and occupational status, sexuality, religion and marital status. Care requires time, financial and practical support and the recognition of choices. The meeting of such needs extends beyond income maintenance benefits and social services provision to equal access to public space and transport, and to anti-discriminatory and anti-poverty policies.
- It challenges the false dichotomy of carer and cared for, and the relations of power inherent in this. It asserts the fundamental importance of an inclusive citizenship where all those involved in the social processes of care have a voice, particularly those whose voice has historically been marginalised—disabled people, older people, children and unpaid carers.
- Quality, affordability, accessibility, flexibility, choice and control are the key to service provision. This involves a re-evaluation of the value of paid and unpaid care, as well as the principles that govern the recruitment, pay, conditions and training of care workers.
- Care is not only personal; it is an issue of public and political concern whose social dynamics operate at local, national and transnational levels.

The reprivatisation of care services, in conditions of women's increased participation in paid work, has intensified national and international forms of gendered exploitation constituted especially through class, 'race'/ethnicity and migrant status.

Strategies to balance the ethic of work with the ethics of care

Earlier I pointed to the importance of the new political discourse of *work/life balance* in providing a space in which to argue for an ethics of care. Bearing in mind these points made above, we can think about time and space differently. Rather than care needs being fitted in to the traditional requirements of work, we can map people's work/life needs within three different but connected areas of their lives.⁵ First, there is *personal time and space*: what do we need for the care of self and maintenance of body, mind and soul (e.g. mobility/relationships/relaxation/life-long learning/spirituality)? Second, *care time and space*: what do we need to care properly for others? This would include, for example, child care and adult care provision; home care services; cleaning, laundry and food services; domiciliary services; kite marking for services; raising standards and reward for paid carers; direct payments for people receiving care/support; carer credits to protect pensions; state support for residential care costs. These would be underpinned by principles of accessibility, affordability, variety, choice, quality, flexibility and user control; they would be complemented by the removal of disabling barriers around space, time, organisations and the environment and a commitment to a caring, enabling environment—e.g. safe and accessible public spaces; safe, accessible, affordable transport. Third, there is *work time and space*: what do we need to enable us to gain economic self-sufficiency and balance these other areas? Included here are paid maternity and paternity leave; paid carers' leave for women and men; job-sharing; annualised hours/lifetime hours; work-based nurseries/breakfast clubs/holiday clubs; sabbaticals; part-time/flexible hours; shorter full-time hours; decent universal pensions with added protection for poorer and older pensioners. A 'care' culture in work organisations and in social and political organisations, such as Parliament, the trade unions and welfare services, would move away from male breadwinning times and cultures and prioritise the relational in people's lives.

All these areas are interlinked—for some people quality time with their children provides them with the regenerative qualities of personal

time. For others, relationships at work are a key to their personal well-being. In addition, thinking across these areas allows us to prioritise the opportunities to give and receive care and to normalise responsibilities for giving care and support and needs for receiving care and support. In this way, direct payments and domiciliary services can be seen as important for providing personal time and space, care time and space *and* opportunities to work.

At a more general strategic level, the setting up in Britain of a National Childcare Strategy and a National Carers Strategy is to be welcomed. There is a case, however, for making policies for care broader and less fragmented. This is an issue that would benefit from 'joined-up' thinking and 'joined-up' government. A National Care Strategy could mobilise such an approach. It could bring together strategies for childcare, for the care and support of older people and disabled people, for income support, for family policies and family law, for employment and education policy, for anti-poverty and anti-discrimination measures, and for the environment. It would provide the basis to develop the values attached to care and intimacy, such as trust, dignity, mutual respect and bodily integrity, and use these as guidelines for informal, social and professional practices of care. This could be the practical way forward for developing an ethics of care, which could begin to balance the past century's fixation with the ethic of work.

Notes

1. There is evidence that paid working mothers spend *more* time with their children now than non-paid working mothers did in the 1970s (Gershuny, 2000).
2. This is the aim of Care, Values and the Future of Welfare, the ESRC Research Group at the University of Leeds (M564281001).
3. The most vivid illustration of this is the emphasis by the Department of Health in providing support for young carers (the children of disabled parents) without developing services for disabled parents, such that, as a recent report has shown, disabled parents may have to make claims for support through their children's needs as carers rather than their own (SSI, 2000; Wates, 2000).
4. In buying in this assistance, disabled people have also opted, on the whole, to go for the attributes of personal quality rather than qualification or training (Shakespeare, 2000: 65). Shakespeare quotes from

Barbara Hershey's experience of trained workers as less able to be responsive to the person they are caring for: 'After all it's not brain surgery we're talking about', and she goes on to say that the tasks required to care for someone else are the same as you need to care for yourself: 'She only needs to listen to the directions being given' (quoted in Shakespeare, p.65).

5. My thanks to Sue Yeandle for providing me with this framework. This is adapted from Yeandle, 1999.

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