Feminist Economics 11(2), July 2005, 7–36

Warm Hands in Cold Age – On the Need of a New World Order of Care

Agneta Stark

ABSTRACT

The world is aging as fertility and mortality are both decreasing. This article focuses on practical care work for the elderly. Such work is done primarily by women even though a larger portion than previously is paid rather than unpaid. All over the world, most elderly care work is organized within the family, most often unpaid. Men receive more care from partners than women, while women receive more care from female relatives. When care work is paid, the payment is generally low. A comparison between Germany, Spain, and Sweden demonstrates similar gender patterns, even though the role of the state in supporting care differs considerably as do care workers' conditions. The sustainability of today's distribution and organization of care work is questioned as the need for care increases, and the possibility of more equal sharing of care work between women and men is explored.

KEYWORDS

Elder care work, unpaid work, care insurance, Germany, Spain, Sweden

JEL Codes: J14, I38, J16

The world is aging. More people grow old than ever before, and the old form a greater proportion of the population in almost all countries. Care for the elderly must be expanded quickly to cope with increasing needs. However, suggestions and policy debates regarding care for old and very old people often focus on financial issues. The organization and distribution of the practical work of caring for the elderly are rarely seen as central themes. This article focuses on practical care activities.

Today, care for the elderly is deeply gendered, both in terms of the care that aging women and men receive and regarding those who perform care work and their working conditions. Women provide both unpaid and paid care work, often with great skill and creativity, and often with much satisfaction to the care worker herself and to the person needing care. But unacceptable situations also exist: overworked carers who receive little emotional or financial support, carers who lack skill and motivation, and old people whose care needs are largely unmet.

For many women, the unpaid care they provide for aging husbands and other relatives may actually decrease the amount or quality of care that they

Feminist Economics ISSN 1354-5701 print/ISSN 1466-4372 online © 2005 IAFFE
http://www.tandf.co.uk/journals
DOI: 10.1080/13545700500115811

can expect in their old age. This is especially true in countries with pension systems that closely connect benefits to years in paid work. The ability of these women – who may have given up years of salaried employment to tend to a spouse or relative – to pay for their own care needs in old age will be small, and they will need to depend on the existence and willingness of relatives to perform or pay for their care. In a sense, these retired caregivers will be competing for caregivers with the majority of men, who depend on women for both unpaid and paid elderly care, both for their own parents and for themselves.

There are countries in which a large public sector organizes care, countries in which family care is supported by public general insurance, comparatively affluent countries in which families are left to care for the elderly with almost no outside support, and, finally, there are many countries in which poverty is widespread and many care needs – not only for the elderly – go largely unmet. In all countries, women provide the great majority of practical care work, and the need for care is growing fast. A new world order of care is needed.

I question the sustainability of today's gendered order of care for the elderly for several reasons. Changing demographics is one of the most important: people are having fewer children and living longer. As a result, more people will grow old without adult children to care for them, and more individual children will face great care burdens.[1] Another factor that threatens the current, gendered order of care is migration, which puts greater distances between family members. That more women now engage in paid work increases the demands on their time and makes it difficult for them to provide unpaid, family-based care for elderly relatives. Contributing to the squeeze, countries in economic transition have cut back on services they earlier provided to the elderly, who now must rely even more heavily on their families. Affluent countries, facing their own financing difficulties, have cut back as well, or not increased services as the elderly grow in numbers.

These trends could – in principle – be balanced by other factors: in the future, people might remain in good health as they age, so that they need less care; or partners in marriage could provide more care for each other as they live longer; or paid care could be expanded, whether organized by the market or by the state; or voluntary organizations could provide more care work. These factors are important, but also problematic, and their impact may not be enough to meet the demand for care.

Today's gendered order of care is based on women's paid and unpaid work, and there are few signs that this situation will change. I question the sustainability of this order not because women seem to be refusing to provide care for husbands, parents, other relatives, clients, customers, or patients. Instead, the problems are that the need for care of the elderly is rapidly increasing, the structures organizing that care have adapted badly

to the new demands, efforts to combine the institutions that provide care work have proved difficult, economic resources are inadequate, and the economic conditions of those who provide care are poor. In the debates about aging populations and their corresponding care needs, women's care contributions are often taken for granted, and the problem is sometimes defined as women not doing enough or shrinking from taking their proper responsibilities. This conception is based on a gendered concept of social obligation that is inconsistent and unfair.

AN AGING WORLD

Two declines have led to the aging of the world's population: one in fertility and the other in mortality.

During the last half of the twentieth century, the world fertility rate decreased from 5.0 children per woman to just 2.7. In the more-developed regions, the fertility rate fell from 2.8 to 1.5 children per woman, which is well under the so-called zero-growth rate of 2.1.[2] In the less-developed regions, the average number of children born to each woman dropped from 6.2 to 2.9. Regional differences are substantial. In China at the turn of the millennium the fertility rate stood at 1.8; in India, 3.0; and in Eastern, Western, and Middle Africa, at more than 5.5 children per woman (United Nations 2002: 5–6).

During the same period mortality declined among the young but also among the elderly and the already old. The average life expectancy of a person born in the 1950s was 46.5 years; for someone born at the turn of the millennium, the figure had increased by almost twenty years. Improved and more accessible healthcare, maternal welfare and childcare programs, better basic education, higher standards of living, and successful vaccination programs have all helped people in most countries – not just in the North – live longer. In 2000, the global life expectancy at age 60 was 18.8 years. The corresponding figure for age 80 was 7.2 years, and these figures are expected to continue increasing (United Nations 2002: 6).

There are also contrary trends. AIDS has led to high mortality among the adult population in some countries in sub-Saharan Africa, mainly because it is young adults who die. Old people and young children – who may also be infected – are left to care for each other. As a result, the number of children living in households headed by grandparents has increased; of the 8.2 million AIDS orphans recorded in 1997, 95 percent lived in sub-Saharan Africa, where grandparents, most often grandmothers, served as the main caregivers for many of these children (United Nations 2001: 77).

In prosperous Western countries, the growing numbers of elderly have caused considerable concern. Most notably, the German parliament launched an *Enquête-Kommission* to examine the issue: "*Demographischer Wandel–Herausforderungen unserer älter verdenden Gesellschaft an den Einzelnen*

und die Politik." The commission's final report introduces the issue of an aging population in the very first sentence: "The population pyramid in the Federal Republic of Germany stands on its head" (Deutscher Bundestag 2002). This statement reflects a strong normative view of what the age composition of national populations should be, as does the notion of a "population pyramid" itself. For several decades, the population diagrams of Germany and most other European states have resembled boxes more than pyramids. Another increasingly common German concept, "over-aging" (*Überalterung*[3]), reflects the same concern – that population norms have gone awry. The population norm implicit in the commission's report reflects the age composition of some Western countries fifty years ago, which coincides with the period when important social security systems such as pensions and child allowances were constructed in those same countries.

Such systems were mainly designed when these countries had smaller percentages of elderly citizens and expected life spans were shorter. Post-war economic growth created the possibility of distributing new wealth, and a number of Western European countries focused on ensuring reasonable economic standards for families with young children and for the elderly. Pension systems that included all workers, rather than just the higher-income earners covered in earlier plans, became a feature of the new welfare systems. The new pension systems were constructed differently in different countries; some covered all citizens regardless of labor-market status, while others were restricted to people with paid work. Minimum qualification periods differed, as did maximum benefits. Since the early 1990s, however, when both the numbers and proportions of old-age pensioners grew, policy-makers have been concerned about the systems' sustainability.

In some Organisation for Economic Co-operation and Development (OECD) countries where low birth rates have been seen as problematic, policy-makers have proposed increased access to affordable childcare as a suitable solution. Other suggestions have included tax incentives for having children or improved conditions for parents in the labor market, etc. But in certain respects, the problems associated with obtaining childcare are easier than, and certainly different from, those related to caring for the elderly. A healthy child's care needs can be roughly predicted. Minors often live with at least one of their parents. When everything is as it should be, a child grows up and acquires new abilities and increasing independence. In addition, not everyone becomes a parent and some people do not want to be one. Bringing children into the world today is to some extent a choice. Influencing this choice has been a high priority for some policy-makers in countries with both low and high birth rates.

Parents, on the other hand, are not a matter of choice: everyone has or had them. The care needs of an individual elderly person, parent or not,

cannot be predicted, neither in terms of time nor amount. The number of elderly people in a population is, unlike many other social phenomena, easy to forecast. All the people who will be 65 or older in the first half of the twenty-first century have already been born. Their present health status is roughly known, as are their different patterns of living. On a general level, we can make many prognoses for the future of the elderly, with great accuracy.

The conditions of providing care for the elderly are changing rapidly, both for care workers and recipients of care. In a well-developed Western country, for instance, there is a large gray area between the care work a family is able to provide for an aging relative and medical treatment that is obviously too extensive to be furnished within the family circle. An elderly stroke patient in an affluent country may receive extensive specialist care to help her regain lost abilities. In a less-developed country, however, she may stay with her family, receiving only basic care and no rehabilitation at all. Migration, both between countries and within a single country, reduces the abilities of people to provide daily care of elderly relatives; the distances between families may simply be too great. Also, the family disruption that follows migration will diminish family networks. Finally, the disadvantaged positions of migrants in most social hierarchies will make it more difficult for these families, in particular, to care for their older members (Gail Wilson 2002).

Old people make their own choices and claims within the limitations they experience, just as younger people do. The act of growing older does not change these essential aspects of being human. But aging may lead to deteriorating abilities and decreasing independence. The physical, financial, medical, and emotional conditions of aging are, possibly even more so than the conditions of early childhood, the results of class, gender, ethnicity, sexual orientation, etc., and in addition they reflect the life the old person has led and the resources to which she has had access.

AGING IS A GENDERED ISSUE

> In most countries, older women greatly outnumber older men. In many cases, the difference is so large that the concerns of the older population should in fact be viewed primarily as the concerns of older women. This is especially true in the case of the oldest-old populations, as the female share increases markedly with age. (United Nations 2002)

A significantly larger proportion of men than of women are married or cohabiting with a partner when they die. This situation results not only from the longer expected life spans of women but also from social convention. In heterosexual partnerships all over the world, the man is

often older than the woman. Remarriage after divorce or death of a partner is more common among men, and their new marriage partners are again women younger than they are. In Sweden in 1940, the mean age of first marriage for women was 26.3 years; in 1960, the figure dropped to 24.3 (the lowest in the entire twentieth century), and by 2000 the mean age at which women first married had risen to 30.6 years.[4] The corresponding ages for men's first marriages were three years older than for women in 1940, decreasing to 2.5 years older in 2000. For second or later marriages, the mean age for women in 1940 was 37.7 years; in 1960, 37.8; and, in 2000, 43.2 years. For men in 1940, the age of second or later marriage was six years older than for women; by 2000, this age gap decreased to a little more than four years (Statistics Sweden 2003: Table 5.9 "Mean, median and quartile age at marriage 1940–2002"). The UN reports similar age differences for most parts of the world, with even wider gaps in those countries where women marry youngest, including those of southern Asia and sub-Saharan Africa, except southern Africa (United Nations 2000: 24–5).

The effect of the age gap is that many more men than women spend their last years in households with spouses or partners and that much higher proportions of women are widows than men are widowers (United Nations 2000: 29–30; 2001: 70; Richard A. Posner 1995: 139, 277). Seventy-nine percent of older men are married, against only 43 percent of older women (older most often being defined as 60 plus), and these percentages are virtually identical in more and less developed countries. Most older people who do not have spouses have been widowed (United Nations 2001: 75–6). In the West, many old people, especially women, live alone rather than with other family members. The increase of Western single-person households has largely resulted from female longevity.

In countries with pension systems that cover large sectors of the population, men usually age and die in two-income households (or in households that live on one pension income constructed for a typically male wage earner and his home-working wife). In such households, the most common situation is that the wife provides unpaid care for her husband during the last period in his life, sometimes assisted by children or outside services. She helps contact other relatives, arranges for market services, contacts medical services and home help, and provides company and support. In countries that lack widespread pension coverage, the wife cares for the husband in much the same way, but she has smaller economic resources and often has less assistance from actors outside the family.

The world's women much more often spend the last years of their lives as widows (or are divorced or never-married). They age and die on just one income – their own – but only if there is a pension system covering them or if they generate income from work or other sources. As the husband or

partner is dead, they must receive unpaid, family-based care from children, children's spouses, or other relatives, or they must pay for assistance from outside the family. But their pension incomes are typically smaller than men's are, so they find it more difficult to pay for care.

Thus, paradoxically, the people who receive the most unpaid care from their spouses are men, who as a group also have higher retirement incomes. The people who receive much less unpaid care from spouses are women, who as a group have lower retirement incomes. Also, men and women tend to receive their family-based care from different family members. Men more often receive such care from their wives, while women are given care by daughters or daughters-in-law. "Family care," then, will have different meanings for women and men. Receiving help with personal hygiene will, for instance, be qualitatively different when provided by a partner in a long marriage than when provided by a daughter-in-law.

The core of the UN statement quoted earlier is that "the concerns of the older population should in fact be viewed primarily as the concerns of older women." Alan Walker, writing on politics and aging in Europe, takes an optimistic view of this fact:

> Because women outnumber men in old age the new politics will be feminized increasingly.... Of course women will also form an increasing proportion of voters as European societies age. This raises the prospect of issues that affect women in particular gaining a higher political profile – issues such as the long-term care of older people and the rights of family carers. (Alan Walker 1999: 23–4)

It is, however, hard to find the perspective of older women in current European policy debates on pensions, care for the elderly, healthcare, and long-term care for the old and frail. Neither are important groups of women of any age well represented in high-level decision-making in these areas. Instead, middle-aged and elderly men dominate. Very few signs of "new politics" and policy-making are discernible during the first years of the millennium. A parallel may be drawn: increasing numbers of poor women and men will not necessarily lead to poverty issues becoming central in politics. The power aspect of "class" has been recognized for a long time. The same aspect of "gender" should not be disregarded. Women must start moving into the political positions now dominated by men and make the decisions that will deeply affect their own futures.

CARE FOR THE ELDERLY – FOUR INSTITUTIONS ORGANIZE CARE WORK

Four institutions play particular, key roles in organizing care work for the elderly. The starting point for each is *a person who needs or desires a good or*

service that includes care work provided by other people. To whom or where can she or he turn?

Examples are a person who wants a haircut, a person who needs medical treatment, a disabled person who needs assistance with personal hygiene, or a person suffering from dizziness who is no longer able to go for the walks she once enjoyed. How do these people get what they want, and under what conditions?

The four institutions are: the family, the market, the public sector, and *voluntary organizations.*[5] These four are here seen as social and complex organizations.[6] They are used to analyze how care work for the elderly is organized and to discuss how different needs and desires may be met. What is required by the person with a need and desire to approach the different organizations? Which needs are seen as legitimate, and what are the bases for legitimacy? To some extent I also discuss the conditions for the people carrying out the care work in the four organizations. For in-depth explanations of the four institutions used in a more general model for analyzing work, for background, and for the different parts of the model see Agneta Stark and Åsa Regnér (2002). While these four institutions have many purposes and functions, I focus here on their role in care work. This role includes connecting a person with a care need to someone who can do the work needed under existing conditions and finding resources of time, knowledge, and money. There are vast differences among a private company, a small family, the Red Cross/Red Crescent, and publicly organized home help. Payment – when it occurs – is differently organized, the amount of formal or informal planning differs, and the relationship between the elderly person and the carer is also different.

What someone needs or desires may be dispensable or vital. I make no distinction here between fundamental needs, such as food or rest, and desires or wishes, such as for cinema tickets or fashionable clothes. Consequently, levels of needs or desires are not classified here in order of precedence, nor are certain phenomena classified as needs and others as desires. Care organizations usually do distinguish between needs and luxuries; a family celebration may be a legitimate reason for asking a family member to prepare a rich and expensive meal, while making the same request of a voluntary organization delivering "meals-on-wheels" would be considered inappropriate. Publicly financed or subsidized services are generally limited to what are regarded as basic needs, while market services that are privately paid for do not have such restrictions. For policy-making purposes, the definition of needs and establishing of hierarchies between needs and wishes or desires would be crucial. But policy is not the issue here. Rather, it is the daily care work that older people request and receive.

Care work for the elderly is defined here as *a set of activities useful and often necessary to daily life that an elderly person is not – or most often no longer – able to provide for herself.* Self-care is thus excluded, even if such care forms a large

part of most elderly people's daily lives. Those activities that we are able to continue doing for ourselves generally do not cause problems as we age. Instead, the aging process often involves losing earlier capabilities, in turn requiring assistance from others.

The definition is connected to other people's work, and it focuses on activities, rather than motives or settings. It does not assume payment or nonpayment to the person performing the work, and it does not connect care work to specific attitudes in the recipient or the care worker. However, these conditions are not incompatible with Joan Tronto's view: "Caring seems to involve taking the concerns and needs of the other as a basis for action" (1993: 105). The care work provided by a specialized physiotherapist, a paid cleaner, a more-or-less willing teenager who helps a grandparent go shopping, a wife who checks on her sick husband at midnight, or a volunteer who drives an elderly person to the dentist may involve different motives and attitude; yet the older person's need is still the basis for it.

The boundary between what someone can or cannot do is not clear-cut, and overprotective care workers may not distinguish it very well. For instance, an aging man who had never cooked would perhaps be physically able to prepare a meal for himself and mentally able to learn cooking techniques. An Alzheimer patient's ability to perform daily activities may differ from day to day. Thus, while a negligent care worker may ignore an older person's needs, an overprotective one may not fully understand them.

Payment for care work may exist in all of the four institutions.[7] Pay levels and conditions are important factors influencing care work in a multitude of ways, and I argue that the monetary aspects of care work are important. Julie Nelson, in discussing payment for care work, and the uses the worker may have for her earnings, poignantly states: "Squeamishness about money is a luxury only affordable to those who can assume that someone else will take care of them. The rest of the world knows all too well that gaining access to money is a necessity" (1999: 49).

The four institutions organize care work for the elderly all over the world, in widely differing proportions. For an individual elderly person, only one institution may provide care work, for instance, either the family or the public sector. But care work for the elderly as a group is provided by a combination of the four institutions everywhere in the world.

THREE EUROPEAN COUNTRIES AND CARE FOR THE ELDERLY

The following discussion of conditions in three countries within the European Union, all with rapidly aging populations, will briefly highlight

some differences and similarities in care for the elderly in three comparatively affluent countries.

Spain

Spain serves as an example of a comparatively affluent country that bases its care regime for the elderly on the family. Very few outside resources are available to help or support family carers. Local authorities assist only economically disadvantaged elderly people, and only about one-tenth of all local authorities have a developed home help service. As a result, approximately 2 percent of the elderly with help needs received such home help in the late 1990s (Lorenzo Cachon 1998). The market organizes little care for the elderly. Some part is probably organized by families hiring labor without paying tax or social insurance, or hiring illegal immigrants, but these figures are not available. Few people can afford to pay for commercial services or for private nursing homes (OECD 1996). Two Eurobarometers from spring 1993 report that 3–5 percent of the Spanish elderly in need of care receive private, paid assistance, and 3 percent receive assistance from voluntary organizations (SOU 1993: 111).

The solution for Spanish families is often that elderly parents move between their children's homes, a phenomenon now so common that it has been given a name by some sociologists, who call it the "modified extended family" ("*familia extensa modificada*") (Inés Alberdi 1999). The parent continues to be registered as having a home of his or her own, but in practice moves around between the children. Generations often live close, and have frequent contacts. A third of those responding to a government survey say that parents and adult children meet every day, and nearly 70 percent report at least weekly meetings (Ministerio de Trabajo y Asuntos Sociales 1997).

Of all people reporting that they needed daily assistance, 35 percent were helped by a daughter, 18 percent by a spouse, 6 percent by a daughter-in-law or other female family member, and 5 percent by a son (Victor Perez-Díaz, Elisa Chulia, and Berta Alvarez-Miranda 1998).

With a rapidly aging population, birth rates among the lowest in the world, and a growing economy, there are conflicting demands on Spanish families today and especially on Spanish women. In order for Spain to live up to the EU employment goals – to which the Spanish government is firmly committed – almost twice as many women as those who now have paid jobs will have to find their way into the labor market in a few years. At the same time, increasing numbers of older people need care, and the government's plans target helping older people to stay at home, cared for by families. Women, especially middle-aged women with brief formal educations, stand in the middle of this conflict of time use. Very few activities focus on increasing Spanish men's unpaid care work, although

both elderly people and their daughters think that men should make themselves more useful in this respect (Perez-Díaz, Chulia, and Alvarez-Miranda 1998). The low birth rate means that in the not-too-distant future, many older people will not have children to provide practical care for them.

A care crisis seems to threaten. If it is not averted, the country will be in the position of tolerating the unmet care needs of elderly people at the same time that standards of living for the not-yet-old are increasing rapidly. The country lacks a profession of care work with corresponding professional standards, a situation that will probably be less acceptable in the future than it has been. The willingness of families to provide care may not decrease, but with the increasing proportion of elderly in the population, and with a foreseen general lack of labor, the pressure on Spanish women's time will increase. Including men as carers would expand family care possibilities. But an infrastructure of care for those without family members seems necessary. Such an infrastructure has yet to be constructed. The sustainability of the present Spanish care for the elderly must be questioned.

Germany

The family as the antithesis of the state has a prominent place in social thought and legislation in Germany. The role of the family is laid down in the Constitution, which was created after World War II and built on an analysis of what made the Nazi regime possible. It includes special measures to limit the role of the state. In order to avoid too strong a state, the family is deemed central, but the Constitution also regulates the roles of churches, trade unions, and other voluntary organizations. A person needing help should primarily be assisted by the family, then by other social organizations, and only thirdly by the government/Bundesland/municipality.

In 1995, the country introduced a universal Care Insurance (*Pflegeversicherung*), financed by employers and employees together. Any elderly person who considers herself or himself in need of care may apply for an assessment to the care-insurance administration or to a health and advice center (*Sozialstation*). During this procedure, an independent physician assesses the degree of the applicant's care needs according to the very detailed insurance regulations, which strictly prescribe the needs that entitle the person to assistance. Twenty-one categories are listed; care of the body, for instance, includes the seven categories of washing, showering, dental care, combing, shaving, and voiding the bowels and bladder. Hair washing and nail cutting are not included, as they are not classified as daily needs. Other needs covered are nutrition, mobility, and domestic work such as shopping, cooking, and care of clothes (Andreas Jürgens 1996: 40–6). There are three levels of needs, with the first and lowest level implying a

"considerable" ("*erheblich*") need. The third level is reserved for people who require attendance day and night.

Benefits may take the form of monthly payments or material help including home help, specialist treatment, or time in a nursing home. A fundamental precept of the insurance is that help should primarily be given in the home and principally arranged by relatives, neighbors, and volunteers. This is consistent with the basic German principle that the family – rather than the individual – is the basic unit of society, and that only when the family is unable to cope with its responsibilities should outside resources be made available.

The most common option, and least expensive one for the insurance, is providing money that the elderly person may use to pay a helper. The recipient is asked to designate a carer, who may or may not be a relative.[8] The money, a fixed sum for each level of need, is paid to the recipient, and does not qualify the care worker for more than rudimentary social insurance: it covers accidents that occur during the actual performance of care work, includes retraining when the responsibility for care ends, and provides a minimal pension scheme. Care workers do not have any legal claim on the money paid from the insurance, and are not classified as economically active in labor statistics.

If no relative or other person is available, or if the elderly person prefers professional help, the aid is financed by the insurance and takes the form of material help, provided by trained staff from a voluntary organization that has entered into an agreement with the municipality. This is more costly for the insurance (Jürgens 1996: 129–33). However, even the highest level of insurance payment does not fully cover nursing home costs. If such care is necessary, the recipient's children are means tested by the social services to establish their ability to pay for it. If they can pay only a part – or none – of the costs, social services will pay the difference.

Home care performed by a relative is a common situation in Germany. Of the 1.3 million elderly people who live at home and need care, three-quarters receive it from relatives. In more than 80 percent of these cases, wives, daughters, and daughters-in-law perform the care. Among adult children with parents older than 80 needing care, 61 percent of daughters and only 6 percent of sons provide such care (Bundesministerium für Familie Senioren Frauen und Jugend 2001: 84–5).

The German system has been criticized by feminists and others for putting pressure on women to stay at home as housewives, for conserving old gender patterns, and for the low remuneration of the relatives who perform care; the system is set up so that hourly earnings actually decrease when care needs increase (Ute Behning 1997). Others have argued that the insurance enables women, who would perform the care work anyway, to receive some payment for their work, which is better than none at all. Yet payment from the care insurance is never enough to live on, and the

legislation clearly states that money paid to the elderly person is an insurance benefit rather than a grant intended to pay another's wages.

Policy-makers generally recognize that the strain on family care workers can be considerable. Therefore, projects and help lines have been set up to address risks of violence towards the elderly. One project manager in Hanover estimates that about 6 percent of all the elderly people in that city with care needs have been assaulted in their home environment. The majority of victims are women, as are the majority of the batterers. Men are, however, over-represented among the abusers in relation to their proportion of care workers.

One class-based consequence of the insurance is that some low-income families tend to keep elderly relatives at home, since they need the insurance money, even if the elderly person might fare better in a nursing home.

The case of Germany, where as previously mentioned voluntary organizations have a strong legal position, shows how voluntary work can be integrated into ideology and have strong gendered norms. Gertrud Backes (1987) traces the historical background of the concept of *ehrenamtliche Arbeit*, a specifically German concept that signifies work that is done without payment,[9] in connection with different voluntary and public organizations. The concept is unique to Germany and difficult to translate, but it is connected to *Ehre*, honor, and *Beamter*, an employee with a privileged and protected position. In Germany, *ehrenamtliche Arbeit* has a fairly strict gender division: men dominate the administration of both the public and voluntary sectors, a continuation of a long tradition of male citizenship. Women dominate in the area of social work, especially in providing concrete assistance of people in need. For women, Backes describes such work as an intermediary form between (family-based) household work and gainful employment in a market (1987: 103–23). Similarly, she characterizes *ehrenamtliche Arbeit* in the social sector as another intermediary form, an area, which has often been a compromise between the privatization of certain tasks in the family and their being performed by professional care organizations.[10]

In Germany, a large part of publicly financed care for the elderly is organized by voluntary organizations, again as a consequence of the Constitution's limiting the role of the state. Some such organizations have no unpaid volunteers, while others do. A formal system of carefully specified rules governs their activities.

The quality of services that elderly people receive, especially from for-profit organizations, has been a subject of debate in the German media. Private contractors that own nursing homes can do little to increase their incomes. Reimbursement levels are fixed in contracts with the care insurance, and patients and their relatives are generally not able to contribute much more for extra services. The road to profit is cost-cutting,

but this tactic can be difficult, since the numbers, qualifications, and training of personnel are also regulated by the insurance contracts. Yet inspections of nursing homes are rare. Thus, the media have reported instances of personnel that exist on paper only, or have no formal training at all. The development of care aids to save on labor costs is also profitable. In the spring of 2002, for instance, a diaper with an absorption capacity of 3.4 liters was demonstrated in a ZDF program (a national German television channel) on care for the elderly. A weak person wearing a wet diaper of that weight cannot rise from a chair.

The sustainability of the German care insurance is under debate, as mentioned. Financing the foreseen increase in needs is one problem. The lack of personnel in the professional part of the care system, especially with the necessary training, is often discussed. Hopes are often expressed that trained people from Eastern Europe will solve the problem. Yet although some trained care personnel have been recruited from abroad, their numbers have not been enough. Another problem is a foreseen shortage of labor in general, as exists in Spain.[11] The low pay for family carers that the insurance provides is not attractive for women with other labor-market options, and it attracts very few men at all. As labor-force participation increases among women, and divorce continues to be not unusual, there are reasons to expect that in the future, fewer elderly than today will be cared for by middle-aged daughters and daughters-in-law.

However, a German infrastructure is in place for care for the elderly, with professional training and corresponding standards. The work provided by family members is recognized. Attention is paid to important problems in care for the elderly, like violence. For women and a few men who provide care for elderly family members, the system means that they may receive some payment, which is better than none at all. The system does conserve gender roles, and for women and men who are dissatisfied with these roles, this is a considerable disadvantage.

Sweden

In the Nordic welfare systems, the individual is the smallest unit – rather than, as in Germany and Spain, the family. This concept is reflected in the legal framework of the Swedish system for care of the elderly. Every individual with a need for assistance has a formal right to it, provided by the local authority and paid for according to means testing of the old person or couple. Married people have a duty to assist each other, but adult children in Sweden, after 1979, no longer have a legal responsibility to pay for or perform care of aged parents. This formal picture does not, however, reflect everyday reality.

Sweden and the other Nordic countries have the largest publicly financed and organized care sector for the elderly among the EU members. Services

play a comparatively large part in the welfare systems compared to the role they play in other industrialized countries, and such services are essentially tax financed. A small but increasing part of care work is contracted to private agencies while publicly employed workers still perform the majority of services to the elderly. Both the home services and the special accommodations for the elderly are considered to be of internationally high standard.

In contrast to the procedure in Germany, the assessment of needs is not performed by an independent specialist, but by social-service assessors of care needs. These individuals are supposed to evaluate needs regardless of current budget restrictions, but in practice budgets influence their decisions considerably. Thus, although no changes have occurred in the legal framework, rationing of care services has in the last decade tightened, so that it is now very rare for a married person, with a healthier partner, to receive any assistance. The National Board of Health and Welfare (*Socialstyrelsen*) has observed that social-service personnel increasingly concentrate on what services can and must be provided for an elderly person, rather than on assessing the old person's needs (Socialstyrelsen 1997: 62). The key issue is the definition of a "need." Examples of activities that used to be "needs" but are now generally cut are cooking in the older person's home (replaced by delivered ready meals, not always of high standard) and cleaning (replaced by lists of firms from which the person may hire at her own cost). A large proportion of places in nursing homes have been closed, and hospitals send elderly people home as soon as they no longer require hospital-based medical care – even if they still need care day and night. Thus, local authorities now devote many more hours than formerly to very sick and frail people, and a large proportion of elderly with considerable care needs receive little or nothing from the public services (Marta Szebehely 2000).

Contrary to what non-Swedes sometimes assume, the networks of family and friends surrounding elderly people in Sweden are comparatively large and close. Sixty-four percent of people older than 75 who lived at home met one or several of their children at least once a week. Ninety-three percent speak with their children on the phone at least once a week (Socialstyrelsen 2000: 16–17). These figures compare with those reported in Spain, as discussed above. The geographical distance between elderly parents and adult children has not increased appreciably since the 1950s, and the majority of people over 75 have children living within twenty to thirty kilometers (Regeringens proposition 1997/98: 113: 2).

As public services have suffered cutbacks, social service workers have assisted, and sometimes pressed, relatives to take up more care work. A system similar to the German one described above allows relatives to be employed to care for an aging person. It is still in use but covers fewer people than before, even though the number of people needing care has

grown and public services have been reduced. Ann-Britt Mossberg Sand (2000: 145) reports on two cases within the same local authority. A woman, 52 years old, whose husband suffered a stroke, was subjected to hard pressure to reduce her paid working hours and accept part-time employment as a hired carer for her husband. When she hesitated, she was branded "reluctant to care." She says, "The home help assistants would come to my home and ask if I had taken a lover, since I did not want to – or did not have the energy to – take my husband home." A man of similar age chose to work as the hired carer for his wife. As a first alternative, the couple had been offered professional care in the home, during both weekdays and weekends, for the wife. No one in social services counted on the husband's assuming the care work, and officials exerted no pressure on him to leave his job, which had required less education and training than that of the woman above.

Although no laws support the practice, social workers routinely reject elderly persons' requests for assistance, referring instead to the existence of daughters or daughters-in-law. Social services' expectations of relatives are gendered.

With the cutbacks in public services, husbands are now expected to provide care for wives to the same extent that wives do for husbands, which was not the case twenty years ago. As a result of demographics, however, there are many more wives than husbands available; in 2003, in the age group 85–89, 14 percent of women were married (86 percent were widows, divorced, or never married), as opposed to 52 percent of men. The group contained twice as many women as men. Of the 90+ group, 5 percent of women and 36 percent of men were married – and there were three times as many women as men in the group (Statistics Sweden 2004: 15).

In paid as in unpaid care work for the elderly, women dominate. In Sweden, unlike both Spain and Germany, more of this work is performed on the labor market and is professionalized. According to a recent government report, the two largest occupations in Sweden are "assistant nurses and hospital ward assistants" and "home-based personal care and related workers," both of which employ more than 90 percent women (Statistics Sweden 2004: 56). Such figures contribute to making the Swedish labor market more gender segregated than markets in other countries.

Among Swedish residents, publicly organized care for the elderly enjoys strong public support. In opinion polls, the public year after year expresses willingness to pay high taxes, and even increase taxes, if the money is used for care for the young, the old, the sick, and for education. The problem of sustainability concerns financing this public-sector care and to some extent also finding qualified personnel. High employment levels are needed to generate tax income for the state, and unemployment is a severe strain on such income. The sensitivity of the care system to state financial problems was demonstrated during the 1990s.

In conclusion, an infrastructure for care of the elderly exists in all of Sweden. There are education and training programs, and satisfaction with the services is reasonably high among the elderly and their families. One problem is that many who need help do not receive it. The gender segregation of care workers is high, both for paid and unpaid work, with the exception of married men, who now provide care work as often as married women – if they are alive when their wives need care. As in Germany, payment for professional care work is low. However, Sweden's public system does not have the formal rule structure of the former nation, which in practice has proved a disadvantage, since unmet needs remain invisible in Sweden.

In addition, there is a tendency to disregard the care work performed by family members in Sweden. In public discourse it is often mentioned that family members provide the vast majority of all such care, but policy-makers may then make assumptions about unused capacity in families, or about family members' habit of ignoring the elderly, without any factual basis, or even in contrast to what statistics or well-researched facts demonstrate.

A RESPONSE TO AGING – TRANSFERRING WORK BETWEEN INSTITUTIONS

In Germany, Sweden, and other countries, stretching resources and cutting public spending has been tried through reorganizing care work. Many transferals of care work between institutions are taking place, often with significant impact on the daily lives of elderly needing care and their relatives, as well as on professional care workers. These transferals merit attention in a comparison between countries, since in a national context "other countries" are often described as having organized care more efficiently, more cheaply for the taxpayer, or with more choice for the elderly person. Underlying assumptions behind such transferals are also of interest.

In Sweden, some policy-makers and researchers argue that elderly people in southern Europe, for instance in Spain, are more respected, enjoy more contact with their families, and lead better lives since they receive care from their loved ones, rather than from impersonal, publicly organized care. Implicit in the argument is that cutting back the public-sector services would improve the lives of the elderly, since their relationships with their families would improve. The German system, with its separate care insurance, has been praised for lightening the burden on the taxpayer. And the US market-based care for the elderly has been presented as providing more free market-based choice for the elderly than do the restricted choices in Sweden. In Germany and elsewhere, politicians of the left and the right have presented Sweden as providing affordable, good quality services to those who need them or as a country in which no one

cares about the old, care is cold and impersonal, and interference from the public sector is dissolving families.

One transferal has attracted a lot of attention, not only in wealthy countries, but globally: the movement of public services to other sectors.[12] Often this has been labeled "privatization." But the term is deceptive since it covers very different changes, with very different contents and meanings of "private."

A few examples, all of them labeled "privatization": a voluntary organization takes over a service that had been run by publicly employed carers, a public service is discontinued in the hope that volunteers will continue to run it without payment, or hospitals provide shorter care after an operation and send patients home earlier. Backes (1987) uses "privatization" to signify the transferal of paid work into unpaid work carried out within the family. As a consequence, she regards voluntary work as an intermediary form between paid wage work and unpaid domestic work.

The aim of such transferals is often to reduce the size, or rather the cost, of the public sector, and to make sure that some types of services are not run with public personnel or public funding. The hope of greater effectiveness may be a main ingredient, but ideological reasons have often been important driving forces.

Decision-makers sometimes move work out of the public sector without evaluating the results. When a hospital's resources are insufficient, family members might be expected to provide patients' food or take up nursing tasks. When care for the elderly is cut back, through more restrictive assessments of who should receive help, there is at times no follow-up of the consequences. The older person's needs might remain unmet, or she might be able to buy what she needs on the private market, or family members or voluntary organizations might assist.

Another kind of transferal of care work takes place when the market begins to offer certain services or goods that satisfy needs another institution previously met. One example of this kind of transfer is the new abundance of convenience foods in the grocery store; cooking has moved from being unpaid work in the family to paid work on the market. Yet another example is a voluntary organization that relieves relatives by opening a day center for elderly people who need care.

All in all, many kinds of transfers are taking place all the time. For those who need or desire a commodity or service, changes such as those mentioned above might be easy and cause them no difficulties in finding what they want. But some transfers cause problems. Finding a private provider of cleaning services may seem too hard when the former, publicly organized cleaning help for the elderly has been closed. A main deterrent is lack of money to pay for the service. For an aging person who has never purchased cleaning services before and finds the necessary negotiations difficult, a list of recommended cleaning companies might be of little use.

And class, color, or other structural issues may restrict choice. For instance, a person who used to work as a cleaner may find it harder to hire someone to clean her or his home than someone who formerly worked as a personnel manager, even if the payment is guaranteed by public or insurance funding. Finally, some language skills are necessary to find information or negotiate terms, which may be an obstacle for migrants.

In short, when transferals occur, people who need information must learn to find it in new ways. As this discussion has shown, the methods and rules of the family, the voluntary sector, the market, and the public sector are very different. As a result of transferals from one sector to another, there is a risk that people who cannot find the new information or understand the changing rules will have their important needs go unmet.

A problem not often discussed is how aging migrant workers find help for their care needs. Navigating public and private organizations that are completely different from those in one's home country, identifying rules perhaps in a new language, and approaching the right institution are not easy tasks. Doing so when communication has become difficult, mobility is reduced, and previous knowledge becomes less useful can be extremely hard. When, in addition, the rules of one's adopted country suddenly change – and responsibilities for care of the elderly move between institutions – the extra effort required may prevent the person who needs help from finding her way at all.

FAMILY-ORGANIZED CARE – A SUSTAINABLE SOLUTION?

The family, in different forms, plays a major role in providing care for the old everywhere, and its importance is most vital in less-developed countries. When other sources of care work are unavailable or malfunctioning, the last resort is often the family, whose members have difficulty saying, "This is not our responsibility." But family-organized care may also be a preferred option, offering closeness and high-quality care to those who need it, by family members who know they are doing what they can for a loved person.

Is family-based care sustainable as care needs of the elderly increase?

> Family support is particularly crucial in the case of the oldest-old, whose physical and economic needs are usually greater. The parent support ratio gives an indication of the overall demand for family support for the oldest-old. The continuing increase of this ratio implies that more and more frequently the young old will find themselves responsible for the care of one or more oldest-old family members. (UN 2002: 2)

The parent support ratio, as defined by the UN, is the number of persons 85 years old and older per 100 persons aged 50 to 64 years. Thus, it is a general measure that disregards specific family ties and is only usable as a

very rough indicator. In 2000, the parent support ratio was 4.3 for the world, 1.6 for Africa, 2.6 for Asia, 8.6 for Europe, 3.5 for Latin America and the Caribbean, 9.9 for Northern America, and 7.2 for Oceania. In principle, this measure implies that many people aged 50 to 64 years are available, willing, and equipped to care for the old. In practice, both specific family ties and the gender of the 50-to-64-year-olds – as well as those of younger and older family members – determine who provides actual family-organized care for the elderly.

Families are changing rapidly, and countries that depend almost exclusively on family care for the elderly may face considerable difficulties in sustaining the quality of such care. But countries in which family care is taken for granted, even if combined with other care sources, also need to consider supporting family carers better.

Some conclusions we can draw from the above discussion of elderly care follow.

From the elderly person's perspective:

- Men receive more care from partners than women do, and such care is largely unpaid.
- Men seem to pay less often for care work than women, in spite of larger economic resources.
- Women, more than men, receive care from female relatives other than partners.
- Women and men who lack access to family members may experience difficulties in receiving necessary care, but where other institutions organizing elderly care exist, these may play an important part.

From the care worker's perspective:

- The majority of care work for the elderly is not paid. However, paid work exists in all four institutions. For family members, payment is not common or is nonexistent in most of the world. But in some countries, like Germany, a person who needs care may receive money with which to pay a family carer. In others countries, family members may be employed by the public sector to provide care. For care work organized by the market or the public sector, payment is the norm. In voluntary organizations, both paid and unpaid work is common. Thus, labor-market conditions cut across all four institutions. Assuming that "family-organized work" and "voluntary work" by definition always mean "unpaid work" may be misleading as regards care for the elderly.
- If the work is paid, the payment and other benefits are generally low compared to levels for other kinds of work in the same country or

region. Absolute levels differ widely, as does the size of the pay gap between other types of work.

- Conditions for family carers differ vastly among well-developed countries and between these countries and those in the developing world. Those who provide care for the elderly in their families often do so in addition to carrying out other responsibilities, which may not diminish as care needs increase.

UNPAID CARE WORK AND LABOR-MARKET WORK – MUTUALLY EXCLUSIVE?

The discussion of sustainability above outlines a time conflict: If women are to increase their paid labor-market work, can they at the same time continue providing – or even increase amounts of – unpaid family-based care for the elderly? An important part of care work lies outside of this conflict, namely that provided by partners who are past the formal retirement age and who live in developed countries with adequate pension systems. But the time conflict does concern adult children, especially middle-aged women, as well as the many elderly who are still in paid work in developing countries or in countries with small or no pensions, such as those in economic transition. Since it is central to the issue of sustainability of family care, it merits further attention. Is this conflict real and important?

The United Nations reports that in developed countries, women performing labor-market work are as likely to be caregivers as women who do not participate in the labor market; employment outside the home does not prevent women from care giving (UN 2001: 77).

However, the level of labor-market activity may be influenced by care responsibilities. A comparative study of twelve European Union countries in the mid-1990s shows that mid-life women already in the labor market adapted to starting or increasing informal care work for an elderly person by decreasing their labor-market hours. When the informal care work ended or decreased, the women did not increase their labor-market hours; the response to care responsibilities was thus asymmetrical. The authors express concern about the longer-term effects of mid-life women permanently withdrawing partly or wholly from labor-market work after performing family-organized care work for the elderly (C. Katharina Spiess and A. Ulrike Schneider 2003).

A Japanese study asks, "Can women do both – hold down a job and look after the elderly?" The background to the question is the worry of Japanese policy-makers that women who work may not be willing – or able – to care for elderly family members at home. According to the authors, the result that policy-makers fear is fewer women remaining in the workforce, greater government outlays on care for the elderly, or

both. The authors feel able to reassure policy-makers, and they abstract their work thus:

> Findings from Nihon University's 1999–2000 Japan Longitudinal Study of Aging show that more than half of Japanese women who live with an elderly parent or parent-in-law are employed outside the home. Even in households where the elderly family member is very old or seriously disabled, large proportions of women continue to hold down full- or part-time jobs. These finding [*sic*] should be reassuring to Japanese policymakers who are concerned that middle-aged women remain in the labor force while continuing to care for elderly family members at home. (Naohiro Ogawa, Robert D. Retherford, and Yasuhiko Saito 2003)

One reason given for this outcome is that, although care for the elderly is mainly family-based, long hospital stays are common for elderly with severely restricting disabilities. These care-working women are almost exclusively daughters and daughters-in-law.

A striking result of these studies is that the traditional division of labor expressed as "men earn money working on the market, women provide care by unpaid family organized work" is empirically dissolved. Women are here shown to work both in the labor market and at the same time to provide unpaid care for the elderly in the family. The Japanese study explicitly includes full-time work, and it is also present in the two other studies. The number of labor-market hours obviously has an important impact on the possibilities of performing family-based care work, but it should be noted that full-time and part-time are not absolutes. The OECD defines 30 hours per week as the lower limit for full-time work. Yet there is still a wide gap between the 35-hour work week that constitutes a full-time job in large parts of the German and French labor markets, and the typically much longer hours worked in, for instance, the UK, the US, Australia, the Czech Republic, and Japan[13] (OECD 2001: 224–5). By logic, then, the traditional explanation for men not taking part in such care work can easily be dissolved: If women are already today combining the two responsibilities, why are not men doing the same?

No absolute obstacles to combining labor-market work and unpaid family care for the elderly seem to exist. As conditions on the labor market may be changed, and as care commitments require different levels of time, improving labor-market and care conditions for carers would be a way to improve sustainability. However, plans to increase weekly working hours as debated in, for instance, France and Germany and to push back the formal retirement age in many Western countries may hinder such developments.

PREFERENCES OF THE ELDERLY

What solutions do women and men prefer to the problem of organizing care work for the elderly? Do women and men have a choice regarding who should organize such work, and if not, should they be able to choose? A comparative study examines norms and ideals for the support and care for older people among urban populations in Norway, England, Germany, Spain, and Israel (Svein Olav Daatland and Katarina Herlofson 2003). The study focuses on the relative responsibility for care of adult children and the welfare state.[14] Respondents from all five countries advocate for greater welfare-state responsibility. In Norway and Israel, the relative strengths of formal service and family provision, as indicated by the respondents, approximately reproduce the actual balance in care provision, but among respondents from the other three countries, the expressed preference for formal services is far higher than the actual provision of them.

The authors conclude: "When alternatives are available, today's older people seem more reluctant to receive help from the family than are adult children willing to provide such help, and the young are *more* inclined towards family care provision than the old" (2003: 556, italics in original). The exception is Spain, where the older generation favors family solutions. In each country, the authors find a substantial minority who do not accept filial obligations to parents. The largest such minority is in Germany, where one-third of respondents reject such obligations. As the German system for long-term care for the elderly relies heavily on filial obligation, while in England and Sweden this is not formally the case, the result indicates that there may be considerable discrepancies between formal systems and norms on the one hand, and the preferences of the people concerned on the other. The authors find no consistent gender differences. Gender is, however, treated technically as a variable among others in the study.

It must be kept in mind that the preferences of the elderly will vary considerably and that generalizations should be made with caution. However, there is little doubt that many elderly people are satisfied with partners providing care work for them and that they express more concerns about accepting or requiring assistance from adult children.

General requests for more informal care, more family responsibility, and more care in the community are increasingly common from both politicians and policy-makers in countries where alternatives to family-organized care exist or where such alternatives are contemplated. Such requests rarely mention gender aspects. An exception is William A. Jackson, who discusses gender and informal care, explicitly addressing male nonparticipation:

> There is no pre-existing excess supply of informal carers waiting for someone to look after. The low supply of care from male relatives

> could perhaps be interpreted as an untapped source of informal activity. Most males, however, have chosen not to become involved in informal care, and they will be reluctant to participate in caring unless it is made compulsory or induced by financial or other incentives. (1998: 191–2)

He thus does not see increasing family-organized care for the elderly as a viable solution to the new population composition. Instead, he connects care needs to unemployment and underemployment in the labor market. Complicating this argument, at least in Europe, is the forecasted lack of labor, which is expected to result from the present low birth rates and increasing number of elderly. However, Jackson highlights the lack of easy solutions as well as the close interaction between different sectors of the economy that takes place in the family.

One can easily develop Jackson's view that most men have *chosen* not to perform informal, family-based unpaid care. The male choice not to perform such work influences and is influenced by female carers performing it instead – as it is rarely work that both women and men in the family can refuse simultaneously. Whether this situation is best described as a choice for females, and in what meaning of that term, can be debated.

Male care work must not be underestimated. Male partners in heterosexual marriage care for their wives, partners in male homosexual partnership provide care work for each other, and sons to a smaller extent perform care work, too. Exploring the conditions under which sons, especially, and other male nonspouses (choose to) perform care work is important.

CARE FOR THE ELDERLY – FUTURE PROSPECTS

The contributions of feminist research to developing policy for and thinking about the future care of the elderly could have important consequences for that care. Clearly, such contributions would not only enrich policy work, but could also deepen understanding of issues important to the development of feminist economic research itself. A few possibilities will be outlined here.

Interesting opportunities for further research into both male and female care giving are outlined by Michael Bittman, Janet E. Fast, Kimberly Fischer, and Cathy Thomson (2004). They use the concept of "time signature" to explore time-diary surveys, and they present gendered analyses of carers' workdays and the interaction between care responsibilities and other aspects of carers' lives. Corresponding research in other parts of the world could point to ways of assisting family carers and to adapting present systems to different needs.

The relationship between payment and care could be explored further by comparative research on the experiences of family members who receive payment for their care work and the experiences of those belonging to the large majority who do not. There are even care workers in some countries that have moved both in and out of the paid care work sector while caring for the same elderly person. Have payment and pay levels had any influence on the relationship between the person needing care and her carer? If so, what sort of influence have they had?

Payment may play a part in creating either distance or closeness between the person needing care and the carer. Sometimes distance seems desirable; at other times closeness is preferable, depending on what needs are to be met. There are no grounds to expect symmetry between the preferences of the cared for and the carer; both perspectives need to be explored further.

The increasing numbers and proportions of elderly women and men in the world will by necessity mean that more care work will be needed at a societal level. To some extent, the needs for childcare will diminish.

When care work is organized in the market or in the public sector, moving resources from care for the young to care for the elderly is feasible, even if the training and the skills needed are not identical. The same transfer of resources may be valid for some voluntary organizations. But when the work is family organized, the situation is different. Elderly women themselves perform a large proportion of family care work for the elderly, while younger women provide the majority of family childcare, even when older family members assist them. Living conditions and the physical distances between members are important factors that influence who is able to carry out certain tasks. The increasing participation of women in the formal labor markets of many countries is another consideration. As I emphasize above, many countries expect women to increase their labor-market participation – to increase economic growth, to meet future shortages of labor, or to be eligible for a pension of their own – while at the same time insisting that care for the elderly should take place unpaid in the home.

This expectation creates an interesting opportunity for research into the social demands made on women and men. Are there areas in which society asks men to pursue contradictory activities to the same extent it asks women who have elderly family members needing care? What are the class, race, caste, and religious intersectional aspects of such requirements on women and men?

Moving care work from one institution to another may change the conditions of the work, but there is little empirically grounded evidence to support the view that these transfers will change the gendered structure of the work, unless other action is taken at the same time. No organizational changes will by themselves draw men into performing care work.

How might care work for the elderly be distributed in a fairer and a more sustainable way? The question leads into the area of policy, and the brief discussion here will be restricted to developed and fairly affluent countries, not because they are more important than other areas of the world – the opposite is rather the case – but because of my own restricted knowledge and experience.

There is little reason to expect that any one of the four institutions will be the single key to future care for the elderly. Women and men of different ages need to perform different parts of such work. Organizing paid labor-market work so that people also have time for family-based work or voluntary work is in my mind a core requirement. This will be more difficult in those countries with cultures of long paid work hours (the US, the UK, Australia, and the Czech Republic) than in Germany, Norway, or the Netherlands.

Encouraging women and men to share care work more equally, not only "in principle" but also in practice, is even more important. Developing the knowledge and affordable everyday technology to make heavy and difficult care tasks easier would enable elderly people to keep their independence longer and would also help carers. Volunteer organizations and others are developing support structures for the elderly and for their carers, but these structures need more attention.

All of us, women and men, will probably need care in our old age. At present, women are the ones caring for the elderly, and they are doing it unpaid, underpaid, half-paid, or just reasonably paid. Women are even combining full-time labor-market work with considerable care responsibilities for the elderly. Men are under-represented in all types of such care. Now that the world is aging, a new world order of care is needed. The absurd fact is that I have been unable to find any but very marginal suggestions of policies to include men as carers. In childcare, the connection of giving birth physically and providing practical care for the baby and the young child is often emphasized. In care for the old, such a visceral connection is not evident. The starting point for exploring the possibilities of men performing care work for family members should be the sharing of new and increasing burdens. And yet emphasizing the burdening aspect of providing care would be a mistake. The fact that more people lead long lives and thus grow old represents tremendous progress. Providing practical help and assistance to people close to you can give satisfaction to both the carer and the cared for. As men share care-giving responsibilities, traditional, stereotypical male traits such as physical strength may be extremely useful. Innovative technology might also be introduced, not because care-working women are not using and developing technology already, but because new actors may bring new perspectives. In addition, since men generally have more economic resources than women, they might target these resources to increasing the quality of care. New

caring skills might be developed, adding new and deeper dimensions to life for the elderly. Finally, perhaps younger men, who have more experience caring for their children than their predecessors did, will be better prepared to care for elderly people than men in earlier generations.

The possible inclusion of men in family-organized care for the old would mostly concern sons and sons-in-law. Given current demographics, husbands are simply not available when their elderly wives and partners need care, or are there much less frequently than wives are there for their aging husbands.

The present world is deeply gendered, and so is its care.

If economic conditions, including pay, insurance, and pension rights, were improved for care workers, living conditions would be better both for them and for the elderly in their care. It is important that care workers receive such benefits, whether they perform their work in the family, in market-based organizations, in the public sector, or in voluntary organizations. Improved wages and conditions would acknowledge the value of good care work, and they would make the care workers' own old age easier. They might also attract more men to such work. Bettering economic conditions would be a small step, and even as such, not easily accomplished. But it would be a good first step towards a new world order of care for the elderly.

And then? Finding a marriage partner is of course a deeply personal issue. It may be seen as a sign of the gendering of such deeply personal and intimate issues that the age differences between women and men in marriage are so uniform all over the world, and seem quite stable over time. Not until men stop sub-viving women, and not until heterosexual partnerships are formed as often with the female partner older than the man as with the male partner older than the woman, will married men as a group be able to provide their wives as much care work as married women as a group provide their husbands today. Other possibilities exist: heterosexual women could live with men during part of their life cycles only, moving in with other older women and providing mutual care in their old age, in another kind of partnership.[15] Would that be breaking the rules of nature? Or trespassing into the individual choice of modern women and men? I would prefer to see it as a bold vision of a future, when liberation from stereotyped gender roles frees women and men to fully express their caring abilities.

Agneta Stark, Dalarna University,
SE-791 88 Falun, Sweden
e-mail: Agneta.Stark@du.se

ACKNOWLEDGMENTS

I thank Nancy Folbre and Lois Shaw for their many thoughtful comments and suggestions and a number of participants in IAFFE conferences and other readers for comments on earlier parts and versions of this work.

NOTES

1 David R. Phillips (2002: 43) mentions China, Japan, and Singapore – countries in which filial piety has an important role – where a single child potentially may have responsibility for up to six direct adult relatives (parents and grandparents).

2 In nineteen countries, the rate is below 1.3. Population change patterns are sometimes described in terms of crises and in violent metaphors: "population explosion," "the aging bomb." Such metaphors seem misleading, since aging on an individual as well as to some extent on a societal level is a comparatively slow and steady process. It should also be noted that a population unchanged in size should not be seen as a goal in itself, just as growing or diminishing populations are not necessarily good or bad.

3 See for instance, Angelika Hensolt (2002: 6).

4 It should be noted that the mean age for a woman giving birth for the first time at the turn of the millennium was almost two years younger; in Sweden marriage often comes after a period of cohabitation, and after the birth of at least a first child.

5 These organizations are in alphabetical order here, and the order does not reflect any normative view.

6 This view of the market is shared by Julie A. Nelson and Paula England (2002).

7 The issue of commodification or decommodification of care work will not be discussed here, as the definition of care work used does not necessitate any specific distinction between market-organized work on the one hand and work organized by the other institutions on the other.

8 Cases are reported in which the elderly person designates a carer, especially a spouse, without asking that person first (Stark and Regnér 2002: 155).

9 However, it is not unusual that compensation for expenses is paid, for example, for transportation in connection to the work.

10 "Consequently there is an attempt at getting the social '*Ehrenamt*' accepted as a *compromise between privatization in the family and professionalization* (as the most far-reaching process of *socialization*)" (Backes 1987: 101, italics in the original); ("Folglich wird soziales Ehrenamt als *Kompromiss zwischen familialer Privatisierung und Verberuflichung* (als weitgehendste *Vergesellschaftung*) durchzusetzen versucht").

11 In the political debate 2000 on recruiting labor abroad, the Christian Democrats used the slogan "Kinder statt Inder" (Children instead of Indian people) to promote support for families with children instead to solve the labor shortage. The slogan was quickly withdrawn after criticism that it fueled hostility towards immigrants.

12 This is certainly not a phenomenon only, or even mainly, connected to policy responses to aging populations.

13 It should be noted that Japanese labor market hours per person have shortened considerably since 1990.

14 A representative age-stratified sample of 6,016 people aged 25 and older, living in the community (not institutions) in urban areas, and in each country 400 people aged 75 or older and 800 from ages 25 to 74 years were interviewed.

15 This connects to existing patterns: older women have long lived with other older women, as relatives, sisters, and friends.

REFERENCES

Alberdi, Inés. 1999. *La Nueva Família Española.* Madrid: Taurus.

Backes, Gertrud. 1987. *Frauen und soziales Ehrenamt: Zur Vergesellschaftung weiblicher Selbsthilfe.* Augsburg: MaroVerlag.

Behning, Ute, ed. 1997. *Das Private ist ökonomisch: Widerspruche der Ökonomisierung privater Familien- und haushaltsleistungen* Berlin: Edition Sigma.

Bittman, Michael, Janet E. Fast, Kimberly Fischer, and Cathy Thomson. 2004. "Making the Invisible Visible: The Life and Time(s) of Informal Caregivers," in Michael Bittman and Nancy Folbre, eds. *Family Time: The Social Organization of Care.* New York: Routledge.

Bundesministerium für Familie Senioren Frauen und Jugend. 2001. *Bericht zur Gesundheitlichen Situation von Frauen in Deutschland: Eine Bestandsaufnahme unter Berücksichtigung der unterschiedlichen Entwicklung in West- und Ostdeutschland.* Stuttgart: Kohlhammer.

Cachon, Lorenzo. 1998. *Nuevos yacimentos de empleo en España. Potencial de crecimiento y desarollo futuro. Informes y Estudios. Ministerio de Trabajo y Asuntos Sociales.* Madrid: Ministerio de Trabajo y Asuntos Sociales.

Daatland, Svein Olav and Katarina Herlofson. 2003. "'Lost Solidarity' or 'Changed Solidarity': A Comparative European View of Normative Family Solidarity." *Ageing and Society* 23: 537–60.

Deutscher Bundestag. 2002. *Schlussbericht der Enquête-Kommission "Demographischer Wandel – Herausforderungen unserer älter verdenden Gesellschaft and den Einzelnen und die Politik,"* Drucksache 14/8800, 28.03.2002.

Hensolt, Angelika. 2002. "Überalterung zwingt Politik zum handeln." *Tageszeitung* 18.04.2002.

Jackson, William A. 1998. *The Political Economy of Population Ageing.* Cheltenham, UK: Edward Elgar.

Jürgens, Andreas. 1996. *Mein Recht bei Pflegebedürftigkeit: Das neue Pflegeversicherungsrecht für Betroffene, Angehörige und Helfer.* München: C. H. Beck.

Ministerio de Trabajo y Asuntos Sociales. 1997. *Envejecimento en el sector rural. Problemas y soluciónes.* Madrid: Ministerio de Trabajo y Asuntos Sociales.

Mossberg Sand, Ann-Britt. 2000. *Ansvar, kärlek och försörjning: om anställda anhörigvårdare i Sverige.* Göteborg: Göteborg University.

Nelson, Julie A. 1999. "Of Markets and Martyrs: Is It OK to Pay Well for Care?" *Feminist Economics* 5(3): 43–59.

—— and Paula England. 2002. "Feminist Philosophies of Love and Work." *Hypatia* 17(2): 1–18.

OECD. 1996. *Caring for Frail Elderly People: Policies in Evolution. Social Policy Studies No 19.* Paris: Organisation for Economic Co-operation and Development.

—— 2001. *Employment Outlook.* Paris: OECD.

Ogawa, Naohiro, Robert D. Retherford, and Yasuhiko Saito. 2003. *Caring for the Elderly and Holding Down a Job: How Are Women Coping in Japan?* Honolulu: East–West Center.

Perez-Díaz, Victor, Elisa Chulia, and Berta Alvarez-Miranda. 1998. *Família y sistema de bienestar. La experiencia española con el paro, las pensiónes, la sanidad y la educación.* Madrid: Fundación Argentaria.

Phillips, David R. 2002. "Family Support for Older Persons in East Asia: Demise or Durability?" in United Nations, ed. *Sustainable Social Structures in a Society for All Ages. Prepared in Cooperation with HelpAge International* pp. 42–7. New York: United Nations.

Posner, Richard A. 1995. *Aging and Old Age.* Chicago: University of Chicago Press.

Regeringens proposition. 1997/98. *Nationell handlingsplan för äldrepolitiken.* Stockholm: Socialdepartementet, 1997/98: 113:2.

Socialstyrelsen. 1997. *Behov, bedömning, beslut i äldreomsorgen. SOS-rapport 1997: 8.* Stockholm: Socialstyrelsen.

——. 2000. *Bo hemma på äldre da'r. Äldreuppdraget 2000: 11.* Stockholm: Socialstyrelsen.

SOU. 1993. *Borta bra men hemma bäst? Fakta om äldre i Europa.* Stockholm: Fritzes, 1993: 111.

Spiess, C. Katharina and A. Ulrike Schneider. 2003. "Interaction between Care-Giving and Paid Work Hours among European Midlife Women, 1994 to 1996." *Ageing and Society* 23: 41–68.

Stark, Agneta and Åsa Regnér. 2002. *In Whose Hands? Work, Gender, Ageing and Care in Three EU-Countries.* Linkoping: Department of Gender Studies.

Statistics Sweden. 2003. *Befolkningsstatistik 2002, del 4. kap 5. Födda och döda, civilståndsändringar m.m.* [*Population Statistics 2002, Part 4. Ch. 5. Births and Deaths, Changes in Marital Status etc.*] Stockholm: Statistics Sweden.

——. 2004. *På tal om kvinnor och män. Lathund om jämställdhet* 2004. Stockholm: Statistics Sweden.

Szebehely, Marta. 2000. "Äldreomsorg i förändring – knappare resurser och nya organisationsformer," *SOU 2000: 38,* pp.171–223. *Välfärd, vård och omsorg.* Stockholm: Fritzes.

Tronto, Joan. 1993. *Moral Boundaries. A Political Argument for an Ethic of Care.* New York: Routledge.

United Nations. 2000. *The World's Women: Trends and Statistics.* New York: United Nations.

——. 2001. *World Population Monitoring 2000: Population, Gender and Development.* New York: United Nations.

——. 2002. *World Population Ageing 1950–2050.* New York: United Nations.

Walker, Alan. 1999. "Political Participation and Representation of Older People in Europe," in Alan Walker and Gerhard Naegele, eds. *The Politics of Old Age in Europe,* pp. 7–24. Buckingham, UK: Open University Press.

Wilson, Gail. 2002. "Globalisation and Older People: Effects of Markets and Migration." *Ageing and Society* 22: 647–63.