What Works in Improving Gender Equality

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The Partnership Model of care policy

Introduction

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

There are two case study examples discussed in this chapter, namely, Germany and the Netherlands. As stated previously we did not use pre-existing welfare state models for sampling but carried this out inductively based on the nature of care policies and gender equality outcomes. Nevertheless, it is noteworthy that both countries in our sample that are

**Germany**

Thirty-three per cent of children under the age of 3 have access to a childcare place (either in nursery facility or with a family-based childminder), but demand outstrips supply. Only 41.5% of these attend full-time, whereas demand in 2014 was 68.2% (Jurczyk and Klinkhart, 2014). Additional childcare hours are either purchased by working parents, shared between parents or supported by grandparents. A key difference in childcare use is between mothers who return to work full time after parental leave who mostly use public childcare, and the majority who return part-time, who are more often supported by grandparents or other informal forms of childcare (Kluve and Tamm, 2009). This has implications for the risk of poverty and underemployment of low-income mothers, and of their children — educational outcomes are poorest for those children who do not attend formal day care prior to school (Esping-Andersen, 2009). Recent changes to parental leave include a move away from a flat-rate benefit for mothers after a year’s parental leave, towards an earnings related benefit for a year followed by job protection which can be paid for up to 3 years (OECD, 2017b). This has had the effect of reinforcing incentives for mothers, particularly low-income/low-skilled mothers, to stay at home until their children reach 3 years or older, and reinforces the gendered division of parenting labour.

The most significant recent change to long-term care policy occurred with the introduction of long-term care insurance. This is a national scheme that offers benefits based on three levels of need with fixed lump-sum benefits, along with cash
payments for carers which can be supplemented by means-tested benefits. The purpose is to enable those who need care and support to purchase their own services from a mix of formal and family carers, using insurance-based state benefits topped up either through their own means or additional benefits. Eligibility and levels of payment are decided at a federal level according to national guidelines, but the structure of fees payable for services is highly variable across different local contexts.

Unlike countries in the Universal Model, Germany has opted to support women’s care labour in both parenting and long-term care by reimbursing them through cash payments, rather than encouraging women into the labour market and providing universal formal care services. Although cash benefits to recompense mothers were heralded as supporting and valuing care work undertaken by women, they have been criticised for leading to greater gender inequality, particularly among low-paid/low-skilled women for whom the cash benefits incentivise remaining away from the formal labour market for longer periods.

Moreover, higher-income women are more likely to make use of formal publicly funded day care services for younger children, creating further social division. However, this does mean that higher-skilled women are less likely to take long career breaks, meaning that employers are likely to benefit from their re-entry into the workforce and income inequality between genders in higher-income families is reduced. This pattern (of higher-income women having more ability to use state benefits to avoid having to leave work to provide care themselves than lower-income women) is mirrored in the results of the long-term care insurance policy (Theobald and Kern, 2011). Lower-income women are more likely to have a financial incentive to provide care to family members because they can receive payments through the long-term care insurance scheme and cash benefits directed at them.
The Netherlands

Around 62% of Dutch children aged 0–4 years are in formal childcare (either a public day care centre or in-home care), with that rising to 90% of 2–3 year olds (Plantenga, 2012). Private childcare centres provide full-time care for children whose parents are employed, but most working mothers in the Netherlands work part-time. Publicly funded playgroups provide around ten hours of care per week for 2–4 year olds and tend to be used more by lower-income families. Playgroups are not used much by working parents because the hours are so limited, but they do provide a formal introduction to schooling that is at least as effective as full-time day care in aiding the cognitive development of children (Akgündüz and Plantenga, 2015). The state provides subsidies for working parents through reimbursements to allow them to choose formal care (which can include in-home childminding and grandparent care as well as formal day care), rather than subsidising providers. The most recent changes to policy involve formal childcare being financed by three parties: central government, employers and parents, with the goal of increasing female labour force participation.

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

The Netherlands has always operated a shared care/shared work approach to combining work and care, presuming that
parents with young children will combine flexible working with part-time formal childcare. However, it is overwhelmingly mothers rather than fathers who take advantage of part-time and flexible working, and there is no non-transferable parental leave to encourage more fathers to work fewer hours and take greater responsibility for parenting of young children. While high-income women can use market means as well as government subsidies to purchase full time childcare, this is less feasible for low-skilled/low-income women who are more likely to work fewer hours. While a move towards familial/private care and away from publicly provided long-term care is presented as a gender-neutral policy option (focusing on risk-sharing and social responsibility) in reality gendered norms of care provision, combined with gendered patterns of part-time work to combine work and childcare, mean that the burden of social responsibility is likely to fall more heavily on women than on men.

**Childcare, long-term care and gender equality**

In contrast to the Universal Model, gender equality was not a dominant norm driving welfare provision in the Partnership Model, and consequently, women’s unpaid labour as mothers was taken for granted. Childcare was therefore not a central feature in the design of welfare systems in countries in this model, but they have nevertheless carried out reforms of their childcare systems comparatively recently, in response to three kinds of pressure. The first was economic pressure to increase women’s participation in the labour force, both to improve economic performance and enhance the tax base. The second was pressure from the European Union and other supra-national bodies to improve women’s equality through greater labour market participation (Tomlinson, 2011). The final pressure was a concern to extend preschool education to deal with a perceived relative educational underperformance from children, particularly those from poorer backgrounds.
This was particularly the case following the reunification of Germany amid concerns about differences in educational outcomes between East and West German children.

In contrast to childcare, the provision of long-term care in the Partnership Model has always been seen as the responsibility of the state to a certain extent, and the Netherlands, in particular, has seen relatively high spending in this area. Social rights to long-term care provided by municipalities have been a feature of this model since the mid-1980s, but both of our case study countries underwent substantial revision in the 1990s and again in recent years, reflecting the growing demand for these services from an ageing population (Grootegoed and van Dijk, 2012). In both childcare and long-term care the state is seen as having an important role, but not being the sole provider of services and support. Instead, support is seen as being funded and delivered in a partnership between the state, employers, the community, families and individuals.

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

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

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

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**Table 3.1: Partnership Model characteristics**

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>EGEI score*</th>
<th>% of GDP spent on services (OECD data)</th>
</tr>
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<tbody>
<tr>
<td>Germany</td>
<td>80.62m</td>
<td>0.79 equal sharing of paid work 0.47 equal sharing of money 0.51 equal sharing of power 0.58 equal sharing of time</td>
<td>0.6% on childcare 0.1% on pre-primary care 1.25% on long-term care</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>16.8m</td>
<td>0.8 equal sharing of paid work 0.56 equal sharing of money 0.53 equal sharing of power 0.7 equal sharing of time</td>
<td>1.0% on childcare 0.5% on pre-primary care 3.7% on long-term care</td>
</tr>
<tr>
<td>(UK)</td>
<td>64.1m</td>
<td>0.82 equal sharing of paid work 0.39 equal sharing of money 0.46 equal sharing of power 0.58 equal sharing of time</td>
<td>1.2% on childcare 0.4% on pre-primary care 2% on long-term care</td>
</tr>
<tr>
<td>(Scotland)</td>
<td>5.295m</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
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*Source: Based on Plantenga et al (2009), using EU/OECD data
and the level of cash benefits is set nationally, not locally, which provides an equitable and uniform level of subsidy regardless of location. The local market rates for the provision of services can differ substantially leading to considerable regional variation.

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

*Communities* also play a more significant role in providing services and support in the Partnership Model than in the
Universal Model. Often the third sector is drawn into the market of providing formal services, and there is sometimes a great reliance on informal social networks to provide low levels of support (for example, after-school care, befriending services, housework and monitoring). Families, particularly women, who do not have access to these social networks are at a disadvantage in this model, as they are more likely to have to fill in the gaps themselves or to have to pay for formal support. However, social networks and social capital can be strengthened by community involvement in the provision of care, with carers who might otherwise be isolated building and sustaining emotional as well as functional support networks.

*Families* are perhaps the most important partner in the Partnership Model. It relies heavily on collaboration between parents and wider families (particularly grandparents in the case of childcare and children in the case of long-term care) to take the responsibility both for providing care and support and for arranging, coordinating and integrating with the formal delivery of services. Reliance on ‘family’ care usually hides the fact that such care is usually (but not always) provided by women. Cultural preferences for mothers over fathers, and for daughters over sons, coupled with a lack of family leave or other incentives to make increased participation in care work attractive financially to men, mean that care work remains gendered.

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

- The Partnership Model offers a great deal of flexibility and choice to parents and people needing long-term care. It enables people to put together packages of care and support that reflect their individual circumstances and can be adapted to changes in those circumstances.
- The care work of women as mothers and family carers is valued and supported. Women (and some men) who choose to undertake childcare and long-term care have access to an income and are not necessarily reliant on their partners for access to resources.
- Access to benefits is tailored to individual circumstances but is also universal (nationally set) and fair. While municipalities play a significant role in providing services, they do not set the level of cash benefits to which parents and service users are entitled.
- There is significant scope for municipalities to develop care services that are flexible and accommodate local needs and circumstances. Because services are not homogenous there is the ability to deal with variations in demand for and supply of formal services, and to harness local community resources to provide support.
- There is the potential for community and kinship networks to be developed and strengthened. Because this model relies heavily on inter-generational care (grandparents providing care for young children, and children providing care for their parents) as well as intra-generational support (between spouses, siblings and friends) there is the potential for strengthened social networks and social capital. This can lead to emotional as well as practical support for carers, reducing isolation and the mental and physical burden of providing childcare and long-term care.
- This model is robust and able to deal with fluctuations in demand, particularly the rising demand for long-term care. Individuals have a significant responsibility
to arrange their own long-term care through insurance. Directing subsidies at parents rather than providers enables economic and social policy to be flexible to respond to changes in economic and political circumstances (it is far easier to make changes to subsidies and tax benefits than to withdraw funding from large scale publicly funded capital infrastructure).

- The Partnership Model ensures that the risks and benefits of care provision are shared between the state, employers and individuals. Rather than the state being the main provider and commissioner of services, and therefore having the sole responsibility for protecting against social risks, employers and the market share the risks and benefits with the general population. Therefore, there is an incentive for employers to develop family- and care-friendly policies and to support a flexible and well-trained workforce.

- Formal care for some workers, particularly those working in the public sector, is highly valued. There is strong competition for qualified workers, and clear educational and training routes to both childcare and long-term care. Pay and conditions are thus relatively generous.

**Drawbacks**

- This model reinforces gendered patterns of labour. It provides little or no incentive for fathers to become more involved in the care of young children, or for men (unless they are relatively low paid) to become more involved in the formal or informal provision of long-term care.

- The Partnership Model relies heavily on the family and this masks its reliance on women’s labour. By presenting the policy frameworks as gender-neutral and enabling choice, this model hides women’s unpaid care and relies on cultural norms that expect women to provide care.

- This model offers significantly more choice and flexibility to higher-income women. The use of the market to
provide services, and linking receipt of childcare benefits to participation in the labour market, means that higher-income women will be able to benefit from exercising choice and supplement state benefits with bought-in care. Lower-income women are more likely to have financial incentives to withdraw from the labour market and provide care themselves, or to be trapped in low paid part-time work because of the need to combine paid and unpaid work. This reinforces inequality between different groups of women. It also means that lower-income women are at far greater risk of poverty over the life course due to their underemployment.

- The lack of universal early years formal care mitigates against egalitarian outcomes and life chances for children. Although part-time provision of playgroups does enable cognitive development, it does not enable low-income women to work and raise their income, which means that access to material resources is limited for low-income families. The opportunities for formal support to mitigate against the effects of child poverty are limited, and it is therefore highly likely to translate into greater inequality in later years.

**Key transferable features**

- **Providing cash benefits directly to parents and service users is fairly simple to do.** In fact, cash benefits, tax credits and childcare benefits already form a significant part of social policy provision in most developed welfare states, including the UK.

- **This model could easily be adapted for different governance, legislative and political contexts.** Federal and devolved government and municipalities can develop their own versions if they have sufficient tax raising and social policy powers. A strong centralised social democratic
state is not needed to deliver this model, and it can adapt to different political and ideological priorities.

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

Notes of caution

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

Achieving gender equity?

Table 3.2 examines how the Partnership Model measures up to Fraser’s (1997) framework of universal care and gender equity, the universal caregiver model.
Table 3.2: Fraser’s seven principles of gender equity and the Partnership Model

<table>
<thead>
<tr>
<th>Principle</th>
<th>Progress (substantial; good; neutral; poor; very weak)</th>
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| anti-poverty;              | • **Good**, because care which removes women from the labour market is compensated for.  
• However, it would be better if women were either encouraged to remain in the labour market to increase their income or if compensation for care were at full market rates.                               |
| anti-exploitation;         | • **Good**, because care which removes women from the labour market is compensated for.                                                                                                                                                                                   |
| income equality;           | • **Neutral**. Compensation for care work is set at a level that does not encourage men into taking a greater role in parenting or care of older relatives. It also encourages low paid women to withdraw from the labour market to provide care and increases inequality between low- and high-income women.  
• However, greater encouragement (through shared and non-transferable parental leave) for men to share care work and for women to remain in the labour market, as well as addressing occupational segregation would further reduce income inequality. |
| leisure time equality;     | • **Good**, due to support for flexible working for both genders (particularly in the Netherlands) and formal provision of preschool. The availability of market alternatives to family-provided long-term care prevents overburdening informal carers.                                  |
| equality of respect;       | • **Substantial**, due to recognition of and compensation for women’s care labour. Formal care workers are also supported as part of the labour market.                                                                                                                   |
| anti-marginalisation;      | • **Good**, due to value being given to women’s care work.  
• However, greater encouragement to remain in the labour market and for men to take a greater share of care work would reduce the risk of marginalisation for lower-income women.                                                      |
| anti-androcentralisation   | • **Poor**, due to the reinforcement of the gendered division of labour.  
• More equal sharing of care work across genders would improve this.                                                                                                                                         |
Summary

• We have chosen to look at two countries that fit into the Partnership Model, namely Germany and the Netherlands.
• Germany supports women’s care labour in both parenting and long-term care by reimbursing them through cash payments. These benefits are seen to support and value the previously unacknowledged care work of women but have been criticised because:
  • they encourage low-paid, low-skilled women to stay out of formal paid work for longer;
  • higher-income women are more likely to use formal publicly funded day care services for younger children, creating further social division;
  • however, this does mean that higher-skilled women are less likely to take long career breaks meaning that employers are likely to benefit from their re-entry into the workforce, and income inequality across the genders in higher-income families is reduced.
• Private day care for children is the only feasible option for parents who work full time in the Netherlands, and makes up a significant portion of the supply because public provision cannot meet demand in Germany.
• The Netherlands makes much more use of formal childcare with about 62% of Dutch children aged 0–4 years in formal childcare (either a public day care centre or in-home care), with that rising to 90% of 2–3 year olds (this compares with 33% of German children aged under 3).
• Long-term care in the Netherlands has recently changed as part of an ongoing policy drive to reduce costs to the state:
  • those with medically-related chronic health problems are entitled to care within a health funded institution;
  • others are now eligible for support to help them stay in their own homes and participate in society;
• eligibility for direct payments for disabled people has been reduced, which enabled those living at home to employ their own carers (including family members).

• In the Partnership Model the state:
  • acts both as a commissioner, rather than a direct provider of services, and as a broker of support in partnership with individuals;
  • provides a regulatory framework for the quality of the delivery of care including regulating:
    ◦ who can provide the care;
    ◦ how payments to individuals to purchase care can be spent;
    ◦ who is eligible for long-term care.
  • plays some role in directly providing services at both a national and a municipal level. However, services are not funded through taxation, as in the Universal Model, but through a combination of taxation, insurance, employer and employee contributions.

• The market plays a significant role in providing formal care services in both childcare and long-term care. This results in:
  • a system that relies on unpaid work which tends to be most often that of women; and
  • a two-tier care system benefiting higher-income women who can afford to supplement formal care through the market, and return to and remain in the labour market.

• Communities play a more significant role in providing services and support in the Partnership Model than in the Universal Model:
  • often the voluntary sector is drawn into the market of providing formal services;
  • the Partnership Model often relies on informal social networks to provide low levels of support and families, particularly women, who do not have access to these social networks are at a disadvantage;
  • these social networks and social capital can be strengthened by community involvement in the provision of care.
THE PARTNERSHIP MODEL

• Families are perhaps the most important partner in the Partnership Model. It relies heavily on collaboration between parents and wider families both for providing care and support, and for arranging, coordinating and integrating with the formal delivery of services. Reliance on ‘family’ often means reliance on women.

• Individuals are involved in the Partnership Model:
  • to contribute to the tax and insurance base that funds services;
  • to provide some or most of care themselves; and
  • in the coordination (and sometimes provision) of higher level long-term care.

• In comparison with the Universal Model, the Partnership Model relies much more on women’s unpaid labour although this is sometimes mitigated through the need to involve women in the workforce, particularly in more highly-skilled, highly-paid positions.

• The state plays an important regulatory role in countries that fit into the Partnership Model but is not necessarily the main provider or even commissioner of services.

• In Partnership Model countries, while the state provides the legislative framework, the welfare state involves a more important role for municipal authorities, which allows for a greater variability of availability and quality.

• Gender equality is seen as a major driver in the development of social policy in countries that fit into the Partnership Model but it is not necessarily the most important factor in the development of childcare or long-term care policies in such countries.

• The United Kingdom fits with the Partnership Model more closely than the Universal Model, as does Scotland at present. However, both the case studies discussed here score more highly overall on the EGEI than the UK.