Beyond breadwinners, caregivers, martyrs and burdens: a new framework for managing competing claims in care and support policy

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Abstract

Using a case study of an Australian income support policy, Carer Payment (child), this thesis proposes a set of principles for designing care and support policy to advance the rights of multiple constituencies. The principles address two long-standing sources of tension in this field. The first is the tension identified by feminist social policy scholars between supporting women’s unpaid caring roles and supporting women’s participation in paid work. The second is the tension between the claims of carers for policy support and recognition on the basis of the burden of their caring roles, and disability rights claims for policies that afford choice, control and independence to people with disabilities. The case study demonstrates the tendency in Australian care and support policy to favour one activity (unpaid care or paid work), and one constituency (carers or people with disabilities) over the other.

Scholars highlight the advantages and disadvantages for different constituencies of ‘either/or’ policy-making along these lines of fragmentation. Through a discourse analysis of documents relating to the most recent reforms to Carer Payment (child), the study explores the specific causes and consequences of this fragmentation in the Australian case. It highlights the dominant discourses of gender equality, care and disability that led to a policy that supports unpaid care for carers with ‘intense’ care loads (while assuming that all others can participate in paid work), and that prioritises the interests and claims of carers over those of their children. Unpaid care and paid work are assumed to be incompatible activities, parents (usually mothers) are expected to be responsible for providing the majority of care, and the care needs associated with normal childhood and disabled childhood are understood to be fundamentally different. The policy’s either/or approach meets some feminist and carer claims for the greater valuing and support of care, but it does so at the expense of both carers’ ability to participate in paid work, and the recognition of children’s distinct interests and choices.

Some scholars have proposed ways to resolve these tensions and avoid the negative consequences of dichotomous policy approaches, mainly through proposing alternative ways of conceptualising and addressing gender equality, care and disability. However, these attempts have not fully resolved disagreements and inconsistencies between competing perspectives. Drawing on and extending previous academic efforts, I propose six principles for designing care and support policy that overcomes these limitations and
addresses the concerns of multiple care and disability perspectives. Using a citizenship rights framework, the principles provide detailed guidance for formulating policies that afford equal care and support rights to people giving and/or using care or support. By applying the principles to the case study, I demonstrate their usefulness in designing policies that recast care, support and interdependence as core elements of social citizenship, place the interests and voices of all parties to care and support relationships on an equal footing, and offer greater flexibility and choice about care, support and paid work to all.
Declaration

I declare that:

- this thesis comprises only my original work towards the degree of Doctor of Philosophy;
- due acknowledgement has been made in the text to all other material used;
- the thesis is fewer than the maximum word limit of 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Yvette Maker
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## List of abbreviations

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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>CPCR Taskforce</td>
<td>Carer Payment (child) Review Taskforce</td>
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| DCLA 2009    | *Disability Care Load Assessment (Child)*  
   Determination 2009 (Cth) |
| FACSIA       | Department of Families, Community Services and Indigenous Affairs |
| FAHCSIA      | Department of Families, Housing, Community Services and Indigenous Affairs |
| Senate Standing Committee | Senate Standing Committee on Community Affairs |
1. Introduction

1.1 Overview

Australian care policies – policies concerned with meeting the care and support needs of children, people with disabilities, and people with age-related frailty, and policies to support or alleviate the care responsibilities of caregivers – encompass a wide range of activities, interests and actors (Fine 2007). This diversity signals the broad and sometimes controversial meaning of ‘care’, along with disparate views in the political and academic spheres about how care and support issues should be addressed. Care may be used to refer to physical and mental activities, an ethical or moral orientation, or an emotional state or relationship (Rummery & Fine 2012, p. 323). Different forms of care are often distinguished on the basis of the social identity of the person receiving or using it (for instance, child care, aged care, and disability care), and on the basis of the employment status of the person giving it (such as paid or unpaid care and formal or informal care) (Daly & Lewis 2000, p. 285). Social support for care is variously given in the form of cash or financial benefits, or in the form of services, and this support is sometimes targeted at those who give care, and at other times at those who receive it (Daly 2002, pp. 255–6). Care has been characterised as an economic issue, a feminist issue, a disability rights issue, and an ethical issue, among others (Fine 2007). Disability rights scholars have gone so far as to reject the entire concept of care, proposing alternatives like support and assistance that would give more power and control to people with disabilities (Wood 1991; Keith 1992; Finkelstein 1998).¹

Daly and Lewis (2000) bemoan the unnecessary fragmentation of contemporary policy responses to care. They argue that distinguishing between childcare, aged care and disability care, and between paid or formal care and unpaid or informal care, has ‘put limits on the coherence of the concept and affected its capacity to embrace comprehensively a major form of welfare state activity’ (ibid., pp. 285–6). Rummery and Fine (2012, p. 321) make a related observation that “‘care’ is a source of critical tension in current social theory, policy and practice’, with Fine (2004, p. 218) highlighting in

¹ Throughout this thesis, I use the terms ‘people with disabilities’ and ‘children with disabilities’, reflecting “the people first” emphasis that applies within the Australian context of writing (Knight 2013, p. 661). I acknowledge the political relevance of alternatives, such as ‘disabled person’ or ‘disabled child’, used in UK research and policy to emphasise that people are disabled by their environment rather than being inherently different or flawed.
particular that competing conceptualisations of care, and appropriate responses to care
needs, have come to constitute a ‘battlefield’ in the academic literature. Disability studies
scholar Tom Shakespeare (2006, p. 137) similarly notes that it, ‘is clear that ideas about
care, definitions of care, and even terminology like “care” itself, are inherently political’.

Some of the most pressing tensions in this regard arise due to the competing perspectives
of different ‘care constituencies’, or groups making claims in relation to care (Williams
2010, p. 23). In this study, I propose a set of principles for addressing two persistent
sources of tension along these lines, and producing care and support policy that
encompasses the concerns of multiple constituencies. The first is the tension identified
by some feminist social policy scholars between promoting women’s equality through
supporting their unpaid caring roles (particularly maternal care for dependent children)
and supporting their paid work participation (Pateman 1988). The second is the tension
raised by carers and disability rights scholars between supporting and advancing the
claims of caregivers, and supporting and advancing the claims of people who require care
or support (Kröger 2009). In contemporary care policy and scholarship, these tensions
are often treated as either/or choices; policies favour either women’s caring roles or their
paid work, and favour either the interests of those giving care or the interests of those
using it (Beckett 2007; Cass & Yeandle 2009). In other words, policies tend to support
one activity (unpaid care or paid work) over another, and to allocate resources to some
constituencies (carers or people with disabilities) over others.

Feminist social policy scholars identify both pros and cons of care-supportive and
work-supportive policies for gender equality, and link each option with a different vision
of gender equality. Policies that support women’s unpaid caring can offer recognition and
value for women’s difference from men, but at the risk of locking women into these roles
and perpetuating their economic dependence. Policies that support women’s paid working
can enable women to be economically independent, but only if they emulate the male
norm of paid work participation, which often comes at the expense of support for their
caring responsibilities (Pateman 1988; Cass 1995). Scholars concerned with the rights
and interests of carers, and those of people with disabilities, similarly identify pros and
cons of policies that support one group over the other. Carers have secured political
support for their caring roles by conceptualising care for people with disabilities and older
people as a burdensome and costly activity. However, disability rights scholars argue that
this approach positions people with disabilities as passive dependents. They propose
alternative models of disability which emphasise the role of social barriers in creating disability, and call for policy that removes these barriers and facilitates independence and full social participation. In reply, some feminist social policy scholars have claimed that policies prioritising choice, control and independence for people with disabilities (mainly through direct payments) create problems for yet another care constituency, because they can lead to low pay and poor conditions for paid care or support workers (Fine 2004; Kröger 2009).

In the first part of this study, I review and analyse the literature concerned with these tensions. I then use a case study of an Australian care policy, Carer Payment (child), to explore the contemporary manifestations of these tensions and to canvass ways to resolve them and produce more equitable outcomes for multiple care constituencies. Carer Payment (child) is a national pension payment for people who are unable to support themselves through paid work because they are providing constant care to a child with a severe disability or a severe medical condition (Commonwealth of Australia 2009a, p. 3027). It offers a useful case study because it is claimed overwhelmingly by mothers of children with disabilities, and therefore raises both tensions of interest in this study. The analysis is focused on the most recent reforms to Carer Payment (child). These changes were prompted by a government-initiated ‘taskforce review’ of the policy, and were enacted through national legislation with bipartisan political support in mid-2009 (CPCR Taskforce 2007; Commonwealth of Australia 2009a). The reforms produced major changes to the eligibility criteria for the payment, extending access to many more carers on the basis that the previous criteria were overly narrow and excluded many people with ‘intense’ caring roles (CPCR Taskforce 2007, p. 99; Commonwealth of Australia 2009b, p. 3825).

For the first part of the case study, I use Bacchi’s (1999; 2009) ‘what’s the problem represented to be?’ approach to conduct a social constructionist discourse analysis of the policy documents relating to these reforms. Adopting a social constructionist perspective means that I proceed on the understanding that ‘our concepts, theories, ideas, and so forth do not … straightforwardly represent or mirror reality’ (Schwandt 2001, p. 33), but rather that all knowledge ‘is derived from looking at the world from some perspective or other, and is in service of some interests rather than others’ (Burr 1995, p. 6). In social constructionist discourse analysis, policies are treated as responses to subjective constructions of a social problem, influenced by the dominance of particular ways of
thinking about the issue. This is useful for exploring how particular issues (in this case, the two policy tensions) are problematised in policy, and the constructions of gender equality, care and disability that underpin these problematisations. It also paves the way for a consideration of how alternative constructions, and different ways of viewing the problem, might produce different outcomes for different constituencies.

Carer Payment (child) policy supports unpaid care over paid work. It provides for income support in cases of constant, unpaid caring by one person, usually a mother. This financial support is provided in lieu of self-support through paid work, and paid work is discouraged through income tests and weekly and annual limits on the cessation of care. The findings demonstrate the dichotomous thinking about the relationship between unpaid care and paid work underpinning this policy outcome. Care and paid work are assumed to be largely incompatible activities, and unpaid care for children with severe disabilities is assumed to be too intense to accommodate paid work participation. In addition, families are assumed to be the appropriate and necessary providers of this intense and constant care, which is highly valuable to government and society. The dominance of these ways of thinking about care and paid work mean that Carer Payment (child)’s support for full-time unpaid care appears to be the logical and appropriate solution to the ‘problem’ of meeting children’s intense care needs.

The payment’s support for full-time unpaid care does meet some feminist claims for women’s caring roles to be valued and supported. However, Carer Payment (child) is constructed as an exceptional payment for a small group of ‘citizen-caregivers’ with intense, constant care responsibilities (Knijn & Kremer 1997, p. 338). Everyone else is assumed to fit the (masculine) norm of the ‘citizen-worker’, who is unencumbered and therefore capable of independent self-support through full-time paid work (id.). Consequently, the policy does not facilitate care/work combinations other than full-time care or full-time work, providing little support for (women) carers to reduce their caring roles or increase their paid work participation if they want or need to do so.

The analysis also demonstrates that, while Carer Payment (child) has some potential benefits in terms of the recognition of women’s ‘different’ roles to men, gender inequality itself is not problematised in the policy. Gender equality (in terms of sameness, difference, or any other formulation) was never an implicit or explicit goal of the reforms. To the contrary, the policy largely perpetuates the norm of the full-time citizen-worker,
and supports family arrangements where women are financially dependent on a primary earner. Not surprisingly, economic considerations, particularly the economic value of supporting unpaid care rather than providing paid services, were more influential than gender equality concerns in the policy’s support for unpaid care over paid work. These findings demonstrate the need for an approach to policy that explicitly addresses gender inequalities in caring and paid work, and avoids the negative consequences of a dichotomous approach to these activities.

Carer Payment (child) resolves the second tension between the interests and claims of carers, and the interests and claims of people with disabilities, in favour of carers. The reforms were characterised as a reply to carers’ concerns about the limitations of the policy, and carers were extensively consulted prior to the changes being implemented. The payment is available to carers (not their children), and it is characterised as a form of recognition of, and partial compensation for, the hardships involved in intense caring. While this partly meets carers’ claims for recognition and alleviation of the burdens of care, it does so by constructing children with disabilities as passive and dependent objects of care (Morris 1997; Fine 2004). Like women who are citizen-caregivers, children with disabilities are treated as aberrations from the norm. In this case, children are measured against norms of childhood health and development. Eligibility for the payment is determined through an assessment of children’s care needs against the ‘normal’ care needs, abilities and behaviours of children of the same age, and the payment is reserved for cases where those care needs far exceed children’s usual dependencies.

The case study findings demonstrate the complex manifestation and consequences of this second care policy tension. The policy’s support for carers is not underpinned by dichotomous thinking about the interests of the two groups. There was no contemplation in the Carer Payment (child) reform process that the interests of children with disabilities and carers might conflict. More deep-seated dichotomous thinking – about children’s passivity in contrast to carers’ active roles, and about children’s ‘abnormal’ development in contrast to usual childhood – led to a construction of children as dependent and silent, meaning that their interests were assumed to be consistent with, or at least knowable by, carers and medical experts. Children were not consulted in the reform process, and the claims of disability rights scholars and activists for policy to promote children’s choice, control and independence were not discussed or implemented in the reforms.
While Carer Payment (child) appears to benefit carers over their children, the policy is not ideal for either party – it partly meets carers’ claims for support for the financial costs of care, but many other costs are assumed to accrue unavoidably to carers. This is both because caring is their natural duty, and because this caring is valuable to government and society and hence cannot be disrupted. These negative consequences include loss of career opportunities, negative effects on health and wellbeing, and impacts on family cohesion. These findings, too, demonstrate the need for an approach to care and support policy that can avoid these limitations and produce better outcomes for both carers and people with disabilities.

Some scholars have previously grappled with how to better address both of these tensions and avoid the negative consequences of ‘either/or’ policy-making for different constituencies. Most of these reconciliation efforts have proposed alternative ways of conceptualising gender equality in care and paid work, or the nature of care and disability that overcome the tendency towards dichotomous thinking and policy-making. Feminist social policy scholars have proposed a ‘universal caregiver’ model that promotes gender equality in the form of the equal sharing of part-time unpaid care and part-time paid work between women and men (Fraser 1994; Rubery 2015). Ethics of care and disability rights scholars have sought common ground between the interests of carers and people with disabilities, by rejecting the traditional focus on disability as a form of burdensome dependency in favour of a recognition of the universal need to give and receive care or support (Morris 2001; Beckett 2007; Kröger 2009). Each of these approaches calls for the replacement of prevailing norms about the gender division of labour, care and disability, specifically, norms of the male, non-disabled, independent worker-citizen. These norms – which clearly underpin the Carer Payment (child) eligibility criteria – position people (predominantly women) with caring responsibilities, and people who have care or support requirements, as aberrations or exceptions to normal development, social participation and citizenship.

While previous reconciliation efforts offer pointers for challenging these norms and their dichotomous outcomes, none has provided a resolution that is capable of weighing and addressing the multiple tensions and complexities associated with care. Each perpetuates some of the fragmentation that characterises either/or policy-making and its problematic consequences. For example, the universal caregiver approach emphasises the rights and interests of caregivers over those receiving care (for example, Fraser 1994), while
attempts to reconcile the ethics of care and disability rights perspectives tend to fall back on an emphasis on either the claims of carers, or those of people with disabilities (Williams 2001).

In response, I propose a set of principles for evaluating and formulating care and support policies to overcome these limitations and avoid either/or approaches to unpaid care and paid work, and to the interests and claims of carers and people with disabilities. The six care and support rights principles offer guidance for designing policy that breaks down a range of problematic dichotomies that produce policies prioritising some activities, and some constituencies, over others. A commonality between all of the perspectives that I seek to reconcile is the advancement of the social citizenship rights of one or more parties to care or support relationships (such as mothers, carers, or people with disabilities). For this reason, I characterise the six principles as principles for evaluating and formulating policies that afford equal citizenship rights to give and obtain care or support. Characterising the realisation of citizenship rights as the appropriate goal of policy also emphasises the role of the state and community in recognising and facilitating care and support as an exercise of citizenship, and as an inherently valuable contribution to society.

The six principles are adapted from previous efforts to resolve care policy tensions. Each principle deals with an element of policy identified in these literatures as essential to securing the rights of one or more care constituencies. In keeping with the study’s social constructionist approach, the principles are not meant to prioritise any one care or disability perspective as ‘better’ or ‘more accurate’ than another. Rather, they emphasise points of commonality and overlap, integrate the key reconceptualisations of gender equality, care and disability proposed, and arrive at an approach that places diverse claims and rights on an even playing-field.

The first two principles are identified in each of the reconciliation literatures. The first is access to financial resources, specifically direct payments to equip people with the resources to decide what care or support they give and obtain, and access to alternative sources of care or support that offer a diversity of choice including exit. These principles incorporate the key themes of choice and control from the disability rights perspective, and a recognition of the universality of care and support as elements of citizenship from the ethics of care literature (Morris 1993; Williams 2001; Rummery 2011). Access to financial resources and services are also championed in the universal caregiver literature
as key to increasing the value of care, and the more equitable sharing of unpaid care and paid work between women and men (Fraser 1994; Rubery 2015).

In formulating the other four principles, I draw together similar concepts from different literatures, or extend the application of concepts from one literature to all people in care or support relationships. The third of the six principles is the flexibility for caregivers to choose different combinations of unpaid care and paid work, and for all parties to select a variety of combinations of care or support. Flexibility of paid work is identified as a key way of promoting the redistribution of labour under a universal caregiver model, while flexibility of care and support addresses calls for choice in the disability rights literature (Keith 1992; Fraser 1994; Rummery 2011). The fourth care and support rights principle is drawn from ethics of care and universal caregiver scholarship (Knijn & Kremer 1997; Williams 2001; Rubery 2015). It provides for access to time to give care and support and to exercise one’s right to obtain care or support, including choice about how time is split between care and support of others, self-care and paid work.

The fifth care and support rights principle is the inclusion of the voices of all parties to care and support relationships in the policy-making process. This incorporates calls in the disability rights and ethics of care literatures to tailor policy to the needs and wishes of all those in care or support relationships (Keith 1992; Williams 2001; Barnes 2006). The sixth and final principle is that policies should positively recognise difference. This means that policies should address the specific needs arising from disability and impairment, and the constraints on women’s choices and options that arise from the unequal gender division of labour. However, they should do so without measuring people with disabilities or women against a norm of the non-disabled, independent and unencumbered (male) worker. This incorporates the human rights model of disability from the disability rights literature (Morris 2001; Hughes et al. 2005), and the alternative norm of the equal gender distribution of unpaid care and paid work from the universal caregiver model (Fraser 1994).

In the final part of the study, I evaluate Carer Payment (child) policy against the proposed care and support rights principles. This demonstrates how the principles can contribute to the design of policy that overcomes prevailing tensions and promotes equal care and support rights for all. Applying the principles points to a range of reforms and complementary policies that would be necessary to overcome the policy’s current
shortcomings and afford equal care and support rights. These would include changes to the Carer Payment (child) eligibility test, income test, and paid work participation limits, and additional policy measures to increase access to alternative sources of care and support and flexible work options. The analysis shows that truly universal care and support rights would require something more like a basic income, which would be available to all people when they have care or support requirements or responsibilities. Such a payment could be tailored to each person’s specific circumstances, taking into account factors like the impacts of the person’s impairment and the possibility that the current organisation of care and paid work may restrict women’s options. Such a reform would entail a major change to the configuration of Australian care and support policy. It would also be inconsistent with the current trend towards policies that seek to restrict access to income support, and to ‘activate’ recipients (including sole parents and people with disabilities) by obliging them to participate in paid work. Nevertheless, the principles provide a detailed framework to argue for, and pursue, policies that challenge this trend and produce more equitable outcomes for diverse care constituencies.

1.2 Thesis structure
The body of this thesis has two broad sections. In the first three chapters, I introduce my argument, review and analyse the literature concerning the two care policy tensions, and propose the care and support rights principles as an extension of previous efforts to resolve those tensions. This provides the theoretical foundation for the case study presented in the remainder of the thesis. In this introduction, I have provided an overview of my argument. In chapter 2, I first introduce the social constructionist perspective that provides the methodological framework for the study. I then review and analyse the feminist social policy, carer and disability rights literature concerned with the two care policy tensions. I focus on what these literatures say about the advantages and disadvantages of policy that prioritises either women’s care or their paid work, and either the claims and rights of carers, or those of people with disabilities. In the final part of chapter 2, I review previous research that has sought to address and overcome the shortcomings of dichotomous policy responses through reconceptualising gender equality, care and disability, and discuss both the promise and limitations of these previous reconciliation attempts. In chapter 3, I propose the six care and support rights principles as a framework for designing policy to overcome this dichotomous approach to policy and encompass the concerns of multiple care and disability perspectives.
In the remainder of the thesis, I explore how the care policy tensions manifest in a contemporary Australian context, and test the usefulness of the care and support rights principles for resolving them and producing more equitable care and support policy. In chapter 4, I elaborate on why Carer Payment (child) is a useful case study for exploring care policy tensions in the contemporary Australian context. I introduce the case study methodology, including the conceptual background, research methods and selection of data. I also identify potential limitations of the study design and broader research paradigm, and canvass future research options.

In chapters 5, 6 and 7, I explore how the tensions identified in the literature arise, and how the shortcomings of either/or policies manifest, in contemporary Australian care policy. In chapter 5, I discuss how the problem of care was conceptualised and addressed in the Carer Payment (child) reforms. This is a precursor to examining how the policy deals with the tension between supporting women’s unpaid care and their paid work (in chapter 6), and how it deals with the tension between supporting carers’ claims and supporting the claims of people with disabilities (in chapter 7). These two chapters follow a similar format. First, I identify a series of assumptions about care and paid work or care and disability that underpin the policy and link these conceptualisations with the policy’s prioritisation of one side of each tension over the other. I then draw on the existing literature to canvass the consequences of this either/or policy-making for different constituencies.

In chapter 8, I apply the care and support rights principles to the Carer Payment (child) policy case study to explore their usefulness in resolving these tensions and avoiding their negative consequences for different constituencies. I first examine the policy’s particular advantages and shortcomings in terms of each principle, and then identify the reforms and complementary policies that would be necessary to fully resolve the care policy tensions and promote equal care and support rights for all. I also highlight a number of potential shortcomings of the approach. I conclude the thesis in chapter 9, providing an overview of my findings, situating them within the existing literature, drawing conclusions, and canvassing future research directions.
2. Care policy tensions – conflicting claims and fragmented solutions

2.1 Overview

Two key tensions have preoccupied many care and disability policy-makers and scholars in recent decades, and have proven difficult to resolve. The first is the tension between promoting women’s equality through support for their unpaid caregiving roles or through support for their participation in paid work (Pateman 1988). The second is the tension between promoting carers’ rights and promoting the rights of people with disabilities (Kröger 2009). In this chapter, I review and analyse the literature addressing these tensions.

These two tensions are of a different character to one another. The care/paid work tension relates to the advantages and disadvantages for gender equality of policies that support women’s participation in either unpaid care or paid work. These two options reflect different visions of gender equality – equality through recognition of women’s differences from men in terms of their greater roles in the private sphere, or equality through supporting women to participate on an equal basis with men in the public sphere. However, scholars identify downsides to either approach. Support for women’s care can entrench caring roles and preclude support for paid work, while support for women’s paid work often ignores or undervalues their caring roles. In contrast, the carer/people with disabilities tension is a tension between different interest groups or standpoints, which are underpinned by competing conceptualisations of care and disability. The carer and disability rights literature highlights both positive and negative consequences of policies based on carers’ claims that caring for someone with a disability or age-related frailty is intensive, costly, and requires additional resources, and policies based on the claims of people with disabilities for independent living, and choice and control over the kinds of support or care they obtain.

Some scholars have sought to transcend these tensions and (by extension) the binaries on which they are based, mainly through reconceptualising gender equality, care or disability. The most prominent of these are Nancy Fraser’s (1994) universal caregiver model and related feminist attempts to transcend the care/work dichotomy, and the dialogue between ethics of care scholars and disability studies scholars on reconciling the interests of caregivers and care recipients through the concepts of interdependence and
universal human rights (Morris 2001; Beckett 2007). In the final part of this chapter, I review these ‘reconciliation’ literatures, and argue that each offers useful inroads into care policy tensions, but also has limitations.

2.2 Social constructionism as a conceptual framework

The analyses presented in this chapter and throughout the thesis are guided by a social constructionist perspective. Social constructionism is variously described in the literature as an epistemology (Darlaston-Jones 2007; Andrews 2012), an ontology (Sarantakos 2005, p. 31), a model (Silverman 2010, p. 109), a sociological approach (Bacchi 1999, p. 53), a movement (Burr 1995, p. 14), a perspective (Colebatch 2006), and, in relation to policy research specifically, an ‘approach to policy studies and policy analysis’ (Bacchi 2009, p. 32). For the purposes of this study, I follow Silverman’s (2010, p. 109) definition of constructionism as a ‘model’ which ‘tell[s] us what reality is like, the basic elements it contains (“ontology”) and what is the nature and status of knowledge (“epistemology”).’ Epistemologically, I take the social constructionist view that knowledge is ‘the outcome or consequence of human activity… [which is] never certifiable as ultimately true but problematic and ever changing’ (Guba 1990, p. 26). I follow Parker (1992) in adopting a ‘critical realist’ ontology. Unlike ontological relativists, I do not assert that ‘discursive constructions of reality are… free-floating’, but rather are ‘grounded in social and material structures, such as institutions and their practices’ (Willig 2008, p. 130). This means that I recognise, and am most interested in, how particular social constructions affect ‘real bodies and real people’ (Bacchi 1999, p. 46).

In this section, I begin to explore these ‘real’ effects of social constructions by drawing on the prior work of scholars in several academic fields. I focus predominantly on the feminist social policy, critical social policy, critical disability studies, disability rights, and ethics of care literatures to conduct a theoretical analysis of sources of tension in care policy and previous attempts to overcome them. This involves a synthesis of ‘complex conversation[s]’ about care that have long been conducted within and between these overlapping literatures (Beckett 2007, p. 372). My social constructionist orientation means that I do not privilege one perspective over the other, but rather treat each literature as demonstrating an alternative, and socially and historically specific, way of viewing the
world. More specifically, they represent alternative ways of viewing and addressing issues relating to the gender division of labour and gender equality, care and disability.

Burr identifies four principles of social constructionist research. The first of these is ‘a critical stance towards taken-for-granted knowledge’, meaning that research in this paradigm does not accept the belief (characteristic of a positivist perspective) that the true nature of the world is knowable through observation, and that our perceptions of the world are objective and neutral reflections of ‘reality’ (Burr 1995, p. 3). Related to this is a second belief that the ‘ways in which we commonly understand the world, the categories and concepts we use, are historically and culturally specific’, rather than enduring and ahistorical (ibid., p. 3–4). Burr’s third social constructionist principle is that ‘knowledge is sustained by social processes’; meaning that social interactions, particularly interactions through language, are understood to produce and perpetuate constructions of the world (ibid., p. 4). The final principle of social constructionist research is that ‘[k]nowledge and social action go together’, that is, social constructions ‘sustain some patterns of social action and exclude others’ (ibid., p. 5). In keeping with these principles, the study focuses particularly on differences in language and meaning across the different perspectives, and the consequences of these for social action.

My social constructionist orientation does not mean that I have restricted myself to neutrally describing the literatures of interest in this chapter. Rather, I acknowledge scholars’ claims that different ways of viewing and treating care, paid work and disability have real-life impacts on individuals, families and communities. I seek to reconcile the different perspectives so that each of these concerns can be addressed simultaneously in policy. I avoid making claims that would be inconsistent with my conceptual framework – such as claims that one perspective, or one policy option, is objectively best – by clearly acknowledging the sources of these alternative approaches, and clarifying that they should be preferred, not because they are more ‘true’, but because I have demonstrated ‘how they can actually intervene in real struggles’ (McHoul & Grace 1993, p. 35).

2.3 Supporting care or supporting paid work: feminist dilemmas

2.3.1 Wollstonecraft’s dilemma and the care/work dichotomy

Australian academic Carol Pateman famously characterised the key quandary facing feminists concerned with social provisioning for women as ‘Wollstonecraft’s dilemma’
As Lister (1994a, cited in Ungerson 1997a, p. 376) explains, the ‘contemporary variant of the Wollstonecraft dilemma’ arises because feminists:

are torn between wanting to validate and support, through some form of income maintenance provision, the caring work for which women still take the main responsibility in the ‘private’ sphere and to liberate them from this responsibility so that they can achieve economic and political autonomy in the ‘public’ sphere [through paid work].

Each option has pros and cons in terms of gender equality and securing full citizenship rights for women. However, Pateman (1988, p. 252) argues that these ‘two routes toward citizenship that women have pursued are mutually incompatible within the confines of the patriarchal welfare state’. As Cass (1995, p. 50) explains, this is because:

the current circumstances of the patriarchal welfare state accord much more value to men’s work and spheres of participation than they do to the work and spheres of participation of women, whose social and economic value remains largely hidden.

Wollstonecraft’s dilemma can be understood as a social policy-specific analogue of wider feminist debates about the meaning of equality for women – whether it constitutes equal participation with men (sameness feminism), or recognition of, and support for, women’s difference from men (difference feminism). Orloff (2008, p. 22) describes this as ‘the constitutive paradox of feminist politic’ and argues that it is unresolvable, or at least precludes feminists from making an ‘ultimate decision in favour of “symmetry” or “diversity”’.

While this tension may be academically unresolvable, its manifestation in policy has raised practical concerns for feminist social policy scholars. This is because policies tend to support either women’s paid work or their unpaid caring, although often for reasons other than their gender equality implications (Brennan 2007a). For example, Australian scholars have observed a tendency for policies to support women’s unpaid care over their paid work in relation to disability and aged care, and to prioritise women’s paid work over their unpaid caring when addressing childcare (Cass & Yeandle 2009; Craig 2009). Lewis and Giullari (2005, p. 96) have observed a similar ‘tendency for policy to swing between the promotion of women’s participation in the labour market and the support of women as carers’ across Europe. Scholars attribute these different policy responses to governments’ competing economic incentives to support the supply of unpaid care in
light of demographic change (particularly the ageing of the population), or to support women’s paid work participation in light of labour shortages and a declining tax base (Bittman, Hill & Thomson 2007).

In this part of the chapter, I discuss Wollstonecraft’s dilemma in more detail, and outline both the advantages and shortcomings from a feminist perspective of policies supporting women’s roles as unpaid carers – commonly known as ‘maternalist’ policies – and policies supporting women’s roles as paid workers. Cash payments for people with caring responsibilities have been a key focus of analysis in this regard. I draw primarily on feminist social policy research, which I define as research that is politically orientated ‘in favour of (diverse visions of) gender equality’, uses gender ‘as an analytic category’, and/or focuses on ‘the situation of women’ as it pertains to the theory and practice of social and welfare policy (O’Connor J, Orloff & Shaver 1999, p. 10). I focus mainly on the Australian literature, and draw connections with European (including British) scholarship where it adds to the analysis.

2.3.2 Advantages and disadvantages of policies supporting women’s unpaid caring

2.3.2.1 Advantages of policies that support women’s caring

Feminist activists have long identified the undervaluing of women’s caring as a key problem (and cause) of gender inequality, and have argued for the recognition and support of women’s care-giving work on the basis that it is of equal value – and equal effort – to men’s paid work in the labour market (Pateman 1988; Ungerson 1997a). ‘Equality’ here is conceptualised as a recognition and valuing of difference – that women ‘as women… have specific capacities, talents, needs and concerns, so that the expression of their citizenship will be differentiated from that of men’ (Cass 1995, p. 50; emphasis in original). In the care policy sphere, difference feminists have called for policies to support women’s caring roles and confer citizenship rights on this basis alone, without the requirement for women to engage in paid work.

Australian feminist support for these policies has centred mainly on policies that explicitly and intentionally support mothers’ care for their dependent children. Orloff notes that such ‘maternalist’ policies were popular in the affluent welfare states post-World War II, when there ‘was something of a consensus across the Western democracies around the need to support mothers’ caregiving and to lessen their burden of wage earning, and social policy institutionalized that consensus’ (Orloff 2006, p. 240). The
most direct form of maternalist policy support is the provision of cash payments that enable women to forego paid work participation in favour of full-time care (Leitner 2003, p. 356).

In Australia, income support for sole mothers has a particularly long history in this regard, and has been the main focus of feminist analysis of maternalist care policies. From the 1940s to the 1970s, a number of pension payments, along with smaller payments like the Child Endowment, were introduced to enable some mothers to support themselves and their dependent children without participating in the paid workforce (Cass 1995, p. 42). The first national care-based income support payment, introduced by the Curtin Government in 1942, was the Widow’s Pension. It provided means-tested support for women with dependent children under the age of 16 whose husbands had died or deserted them (Murphy 2011, p. 212). The Supporting Mother’s Benefit was introduced in 1973 as a complement to the Widow’s Pension, offering access to the payment to all other sole mothers with ‘custody, care and control’ of a dependent child, regardless of the reason for the lack of a breadwinner partner (FACSIA 2006a, p. 60; Cass 2006, p. 245). Supporting Mother’s Benefit was extended to sole fathers in 1977 with the introduction of the Supporting Parent’s Benefit (Kewley 1980, pp. 115–6; Whiteford 2001, p. 65). In 1989, the Widow’s Pension and Supporting Parent’s Benefit were amalgamated to create the Sole Parent’s Pension (FACSIA 2006b, p. 117). The Sole Parent’s Pension was then combined with Parenting Allowance – which was a means tested, lower-rate payment for partnered parents who ‘undertook the main care’ of a dependent child under the age of 16 – to create Parenting Payment (single) and Parenting Payment (partnered) in 1998 (FACSIA 2006c, pp. 329, 436).

These policies ceased being strictly maternalist when they were extended to men in the late-1970s (Kewley 1980, p. 116; FACSIA 2006b). I nevertheless describe them as maternalist here, on the basis that women are more likely than men to be primary caregivers and to claim income support on that basis, meaning policies that support unpaid caring have a disproportionate impact on women (O’Connor J, Orloff & Shaver 1999, p. 144; Jenson & Jacobzone 2000, p. 12; for recent statistics, see Department of Social Services 2016).

All of these payments fell clearly on one side of Wollstonecraft’s dilemma. They supported sole mothers – and later also partnered mothers – to act as full-time caregivers
to dependent children until they turned 16, and were premised on the idea ‘that the sole mother was predominantly a mother, and not expected to be a paid worker’ (Cass 2006, p. 245). Such payments were lauded by some feminists on the basis that they ‘validate and compensate’ women for the care they provide (Ungerson 1997a, p. 376), addressing the claims of second-wave feminists that women’s work in the home is undervalued, and often invisible, and should be afforded cultural and economic recognition (see Cass 1995, p. 44; Ungerson 1997b, p. 378; Daly 2002, pp. 264–5).

Such payments are also advantageous because they provide a regular income source and ‘buffer women’s vulnerability to poverty’ (O’Connor J, Orloff & Shaver 1999, p. 25). Additionally, they provide some compensation for the opportunity costs of care, meaning mothers’ lower paid workforce participation and incomes across the life course (Cass 1995, p. 43; O’Connor J, Orloff & Shaver 1999, p. 25; Jenson & Jacobzone 2000, p. 33). Some feminist scholars also praise policies that exempt people with caring roles from an obligation to work because they afford the time to care, and in doing so confer a citizenship right to give care (Knijn & Kremer 1997). This represents an acknowledgment of the social value of care, and ‘goes some way towards recognising [women’s] rights as social citizens’ (Cass 1995, p. 43; Shaver 1995).

Some scholars argue that another benefit of maternalist supports is that they reduce women’s financial dependence on a male breadwinner (O’Connor J, Orloff & Shaver 1999, pp. 139, 151). They can give women the option to form ‘autonomous households’ without relying on a male breadwinner, other family members, private charity, or the market (Orloff 1993, p. 319; Shaver 1995; Glendinning 2006). In this way, maternalist policies can be ‘defamilialising’, enabling individuals to ‘uphold a socially acceptable standard of living, independently of family relationships’ when providing care full-time (Lister 1994b, p. 37). Julia O’Connor, Ann Orloff and Sheila Shaver (1999, p. 148) argued that Australia’s maternalist income support policies potentially offered ‘more independence for mothers vis-à-vis marriage and the family than for workers vis-à-vis the market’, giving women the option of leaving a relationship or household without obliging them to look for or undertake paid work. This was ‘contradictory’ (Cass 1995, p. 42) to many other elements of Australia’s welfare state gender regime in the 20th century, which were criticised for entrenching women’s dependence on a male breadwinner (O’Connor J, Orloff & Shaver 1999). These included the fixing of women’s wages as a proportion of the male wage in industrial relations law (Hearn 2006), and
taxation policies that favoured families with one primary earner and thereby incentivised or necessitated women’s positions as secondary- or non-earners (Cass & Brennan 2003; Hill 2007).

In addition to policies supporting mothers with dependent children, another more recent stream of care-based income support has been identified as a key form of support for Australian women’s caring roles. These income support payments for ‘carers’ were a response to a number of demographic, social and political changes in Australia in the 1980s and 1990s, chiefly the deinstitutionalisation of people with disabilities and the shift towards care in the community for both people with disabilities and older people (Jenson & Jacobzone 2000, p. 47; Cass & Yeandle 2009, p. 14). The first payment of this kind, the Spouse Carer’s Pension, was introduced in 1983 (FACSIA 2006b, p. 5). This payment was only available to men providing constant personal care and attention for their Invalid or Age Pensioner wives (id.; Bradbury 1996, p. 9). It was intended to be a complement to the Wife Pension, which was available to women whose husbands were pensioners (Commonwealth of Australia 1983, p. 1089; FACSIA 2006b, p. 32). The Spouse Carer’s Pension was replaced in 1985 with the Carer Pension, which extended eligibility to close relatives (men or women) who lived with the care recipient. In 1988, the Carer Pension was made available to people who were not related to the care recipient (Bradbury 1996, p. 9; FACSIA 2006b, p. 38). In 1996, eligibility was extended to people who did not live with or near the care recipient, and the restriction of eligibility to cases where the care receiver was a pensioner was lifted (FACSIA 2006c, pp. 376–7).

Carer Pension was renamed Carer Payment in 1997 (FACSIA 2006c, p. 405). In 1998, this was split into Carer Payment (adult), for people caring for an adult with a disability or medical condition; and Carer Payment (child), for people caring for a child under the age of 16 with a disability or medical condition (Commonwealth of Australia 1997, p. 3393; FACSIA 2006c, p. 501). These policies have had less attention in the Australian feminist literature than sole mothers’ payments. However, Carer Payment (adult) has been characterised by some scholars as positively valuing and supporting women’s caring roles and compensating for the impacts of women’s caring on their ability to participate in paid work, at least to a limited extent (Jenson & Jacobzone 2000, p. 33; Tilse, Rosenman & Le Brocque 1991, p. 189; Cass 2006).
While support for women’s caregiving has a number of theoretical advantages for women’s equality on the basis of ‘difference’, in reality, explicit policy support for women’s caregiving roles has tended to be partial and inconsistent in Australia. For instance, sole mothers’ payments have always been restricted to those with children under a particular age, regardless of their actual financial and physical dependence on a parent (Brady 2011). The ‘cohabitation rule’ – which excludes people with a breadwinner partner from accessing these income support payments – ‘ensures that wives provide private welfare’ when they have a breadwinner husband, and reinforces their dependence on that breadwinner regardless of whether they are actually being supported (Pateman 1988, p. 247; Sleep, Tranter & Stannard 2006, p. 138; Tranter, Sleep & Stannard 2008, p. 710). In addition, Parenting Payment and Carer Payment have long been criticised for being paid at a low rate that neither affords ‘a reasonable standard of living’ for sole parent families (Cass 2006, p. 246; see also Craig 2009, p. 522) nor meets more than carers’ ‘most basic needs’ (Jenson & Jacobzone 2000, p. 28).

2.3.2 Disadvantages of policies that support women’s caring

Some feminist social policy scholars have characterised maternalist payments as a ‘double-edged sword’, because they have both advantages and disadvantages for women with caring roles (Patterson & Briar 2005, p. 52). The two major criticisms in this regard are closely related – first, that such policies reinforce women’s responsibility for care rather than encouraging its redistribution within families or from families to other sectors; and secondly, that they discourage (or at least do not support) women’s paid work participation, and thereby exclude women from the benefits of paid work.

In regard to the former, maternalist policies are criticised for being based on, and perpetuating, a traditional gender division of labour. For instance, income support for sole mothers has been said to institutionalise a ‘male-breadwinner model’ of the family – women are assumed to be responsible for full-time care of dependent children and domestic duties in the home, meaning they must depend on either a male breadwinner or the welfare state for financial support (Cass 1995, p. 44; Cass & Brennan 2003, p. 39; see also Bryson 1983; Shaver 1983). As Daly (2002, p. 263) puts it, ‘the line between valuing care and confirming it as a woman’s domain is a fine one’. Knijn and Kremer (1997, p. 329) similarly argue that the ‘opportunity’ to provide full-time care for children has often been accompanied by a concomitant ‘moral obligation’ to do so. They further suggest that ‘the recognition of the importance of care, and the conclusion that formal
and informal care can both be beneficial (Ungerson 1990), should not lead to gendered care with its well-known consequences’, including poverty and exclusion from the public sphere (Knijn & Kremer 1997, p. 350).

A significant focus of criticism of maternalist payments in this regard relates to the long-standing reservation of access to such payments – including Parenting Payment and Carer Payment – to women who do not have the support of a breadwinner partner (Sleep, Tranter & Stannard 2006, p. 135). As I touched on above, the cohabitation rule is criticised mainly because it presumes and reinforces women’s dependence on a male breadwinner. Dependence on a breadwinner becomes necessary for survival if women cannot claim income support on the basis of their own lack of income or assets, but do not want to end the relationship (Neave 1992, p. 796). This is the case even if a woman does not want to be financially dependent, or if her partner does not want to be responsible for supporting her (and her children) financially (Hopkins 2005, p. 190; Kelly S 2010, p. 17). Feminist scholars claim that women who cannot access income support have no financial autonomy in the relationship, and are not compensated for lost earnings if they were previously employed part-time or casually as a secondary earner (Bryson 1983, pp. 145–6; Graycar & Morgan 1990, p. 150; Neave 1992, p. 796). The enforcement of women’s dependence on a male breadwinner has also been criticised for making women vulnerable to financial abuse and poverty within intimate relationships. If income is not pooled or shared within the household, the dependent partner ‘may live in poverty despite the wealth or otherwise of the breadwinner’ (Hopkins 2005, p 191; see also Graycar & Morgan 1990, p. 155). Researchers highlight empirical studies showing that the distribution of market income from earners to other family members ‘has not been the reality for many women and children in Australia’ (Tranter, Sleep & Stannard 2008, p. 700; see for example Edwards M 1985, p. 99).

Cash payments for carers of children or adults with disabilities, or adults with age-related frailty, have come under similar criticisms to those levelled at maternalist payments. In their analysis of cash payments for women providing care for ‘the frail elderly’ across the OECD, Jenson and Jacobzone (2000, p. 31) claim that Australia’s Carer Payment (adult) is paid mainly to women who are already in a caring role, and does not seem to offer incentives for people to move from paid work into unpaid caring. Scholars have made similar observations about cash payments for carers in the United Kingdom. For example, Ungerson (1997a, p. 376) surmises that, generally, payments to support care not only ‘act
to validate and compensate the work contained within the private sphere’, but also ‘confine carers (largely women) to it’. Daly (2001, p. 50) similarly asserts that, on a theoretical level, cash payments for care of children or adults actually reinforce women’s responsibility for care – and hence the unequal gender division of labour – by prioritising the status quo within families. She argues that paying women for something that they would ordinarily be doing reinforces and normalises their responsibility for caring and signals that caring is women’s work, while doing little to encourage its redistribution from women to men (see also O’Connor J, Orloff & Shaver 1999, p. 144; Leitner 2003, p. 366; Glendinning 2006, pp. 134–5).

Jenson and Jacobzone (2000, p. 36) assert that such payments also advance the goal of reinforcing ‘provision of care by family members, and thereby… rebalance the welfare diamond in the direction of the family and market’ and away from the state. Bittman, Hill and Thomson (2007, p. 268) similarly claim that Australian policy that supports or relies on informal care for adults with a disability or illness has ‘shifted much of the cost of caring off the budgets of the federal and State [sic] governments, [but] it has done so by transferring the cost to private households, and within these households, predominantly to women’, leading to private disadvantage. Daly (2001, pp. 50–51) makes a related argument that care-supportive policies are ‘familialising’, rather than defamilialising – they encourage and prioritise unpaid family care over other forms of care provision, and do not encourage or facilitate redistribution of responsibility for care from family to other arenas, such as the market, state or voluntary sectors.

The second key criticism of policy support for women’s caregiving roles is that it discourages women from seeking financial independence through paid work, or otherwise participating in public life (Ungerson 1997b, 1997a; Knijn & Kremer 1997). For example, Jenson and Jacobzone (2000, p. 33) note that Australian women caring for elderly people are given only limited support to engage in paid work in addition to their caring roles – they have some access to respite care, and are entitled to take some time off each week to engage in paid work or pursue other activities. Campbell and Charlesworth (2004, p. 37) identify ‘significant tensions in managing paid work and… [the] additional work of caring’ for adults or children who are ‘elderly, disabled, or ill’, including lack of access to alternative sources of care, lack of work flexibility, and loss of skills due to periods out of the workforce. Discussing European policy, Williams (2010, p. 14) suggests that one effect of cash payments that encourage parental care at home is to ‘loosen women’s
attachment to the labour market’. UK scholar Caroline Glendinning (2006, p. 135) warns that policies that encourage women to be available for caring full-time, and treat caring responsibilities and paid work participation as largely irreconcilable, can preclude women from combining the two activities, producing ‘longer-term financial insecurity and social exclusion’ (see also Australian Human Rights Commission 2009).

2.3.3 Advantages and disadvantages of policies supporting women’s paid working

2.3.3.1 Advantages of policies that support women’s paid working

Cass (1995, p. 50) explains that feminists’ other option for pursuing gender equality – the second face of Wollstonecraft’s dilemma – is to advocate for policies that alleviate or accommodate women’s caring responsibilities. Such policies can facilitate women’s participation in the public sphere of paid work on an equal basis with men and hence ‘promote gender-neutral forms of citizenship’ (id.). Feminists have sought women’s equality in the public sphere on several bases, chiefly that paid work participation affords financial security and independence from both a male breadwinner and the state, and gives access to the ‘full citizenship’ that is only available to workers (see Pateman 1988; Lister 1994b). This is based on a view that true autonomy (and hence equality) can only be achieved through economic participation, because breadwinner- or state-support both constitute problematic ‘dependency’ (Ungerson 1997b, p. 378). As Fraser (1994, p. 602) explains, ‘the point [of this approach] is to enable women to support themselves and their families through their own wage earning’.

Many policies to support women’s paid work participation are concerned with alleviating women’s responsibility for unpaid care so as to ‘remove disadvantage and inequality in the workplace where those with care responsibilities are unable to participate in paid labour or are forced to participate under marginal terms and conditions’ (Burgess & Strachan 2005; citing Charlesworth et al. 2002). In the Australian case, such policies are frequently termed ‘work-care’ or ‘work-family’ reconciliation policies (for example Pocock 2005; Craig & Mullan 2010), and these policies fall into several categories (see Australian Human Rights Commission 2013 for a detailed review). The first is access to paid care services to replace unpaid care, such as subsidies or tax breaks for purchasing market-based care (like the Child Care Benefit and Child Care Rebate) (Hill 2007). Another is the right to request flexible working conditions like part-time work and non-standard work hours, which is guaranteed to some workers with caring responsibilities
through national ‘right to request’ legislation (Charlesworth & Campbell 2008). A third type of policy support for women’s paid working is care leave, such as paid parental leave and carer leave, both of which are available to some Australian workers as a matter of right (Broomhill & Sharp 2012; Pocock, Charlesworth & Chapman 2013). In addition to redistributing care responsibilities, these policies are lauded for enabling women to maintain a connection with the workforce after they have children, and (at least ideally) reducing the penalties of taking time away from work for this purpose (Pocock, Charlesworth & Chapman 2013).

2.3.3.2 Disadvantages of policies that support women’s paid working

Policies that support women’s paid work participation raise a number of criticisms from feminist social policy scholars. First, many warn that the ‘commodification of care’ – shifting women’s care responsibilities onto the market to give them the time to work – often involves moving this responsibility onto low-paid, insecure, usually female and often migrant or unskilled workers (Ungerson 1997a; O’Connor J, Orloff & Shaver 1999; Williams 2001; Bretherton 2010). Williams (2010, p. 14) cautions that policies to commodify care may thus have the ‘effect of worsening the affordability of care and the conditions of care workers’.2

A second criticism of policies to support women’s paid work is that not ‘all of women’s current domestic and care work responsibilities can be shifted onto the market and/or the state’ (Fraser 1994, p. 604) due particularly to the fragmented, emotional and complex nature of care (Lewis & Giullari 2005, pp. 84–85). This relates to a further avenue of feminist criticism of care policies that support women’s paid work participation, namely, that these policies do not adequately address women’s disproportionate responsibility for unpaid caring. This means women are not actually equipped to participate in paid work on an equal basis with men. As Cass and Yeandle (2009, pp. 21–22) put it, policies to increase women’s labour force participation frequently:

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2 Scholars in the United States and Europe have drawn attention to intersectional inequalities in paid care work, particularly the movement of ‘(usually female) migrant workers… from poorer countries to provide domestic services for individuals and families in richer countries’ (Williams 2001, p. 470). Some Australian research suggests that Australia’s history of migration has produced a different set of factors, meaning that the marginalisation of migrant workers has not been so pronounced. For example, there is little illegal immigration, the immigration of low-skilled workers has been heavily restricted by policies preferring skilled migration, and informal employment of ‘domestic workers’ in private homes is thought to be limited (Howe 2009).
ignore the nature and worth of care, moving rapidly (yet often ambivalently) from a ‘male breadwinner’ model of family life to an ‘adult worker’ model, without full consideration of how care-giving might best be provided, supported, and the costs of care shared through public and private provision, and between women and men.

The ‘adult worker model’ to which these authors refer is a model of the family wherein both men and women are presumed to be independent full-time workers regardless of their gender, couple status, or the presence of dependent children. Policies based on this model, which have been most prominent in Europe, have been criticised for ignoring women’s disproportionate responsibility for care and failing to provide high-quality paid care services and other supports that would enable women to participate in full-time paid work (Lewis 2001; Lewis & Giullari 2005; Daly 2011; Bowman, Bodsworth & Zinn 2013).

Statistics indicate that, rather than facilitating men’s and women’s equal participation in the workforce, Australian policies generally support a different, ‘modified-breadwinner’ or ‘one and a half earner’ arrangement, wherein women in heterosexual couple families combine primary caregiving with secondary earning, while men continue to be primary earners (Burgess & Strachan 2005; Pocock, Charlesworth & Chapman 2013, p. 608; see also Craig & Mullan 2009; Cortis & Meagher 2009). Women with children who are in employment are much more likely than men in the same circumstances to be engaged in part-time or casual work, and working age carers (the majority of whom are women) are much less likely than non-carers to be engaged in full-time employment (ABS 2009a). Burgess and Strachan (2005, p. 7) explain that supports for work-care reconciliation are equally available to men and women, but ‘the pattern of use is largely gender structured’, with women being much more likely to utilise them. This echoes Cass’s point, made 20 years earlier, that women’s growing paid work participation in Australia and elsewhere was not accompanied by a commensurate increase in men’s responsibility for unpaid care (Cass 1995, p. 58; for the most recent national statistics, see ABS 2016a).

Feminist social policy scholars have demonstrated a number of problems associated with women’s concentration in part-time and casual work in terms of women’s financial security, career options, and job satisfaction. These include poorer job quality, less job security, less access to paid leave, poorer prospects for career advancement, lower pay, lower retirement savings and vulnerability to poverty in the short- and long-term if the
support of a primary breadwinner is lost or withdrawn (see for example Harley & Whitehouse 2001; Pocock 2003; Whittard 2003; Chalmers & Hill 2007; Human Rights & Equal Opportunities Commission 2007; Australian Human Rights Commission 2009; Johnstone, Lucke & Lee 2011; Pocock, Skinner & Williams 2012; Bowman, Bodsworth & Zinn 2013; Australian Human Rights Commission 2013). Some feminist scholars have also challenged the notion that women can ‘adequate[ly] care for their children’ while participating in part-time work, because paid work is often not flexible enough to accommodate the fluctuations and unpredictability of care while also providing an income adequate to enable women to support themselves and their families (Wilson 1997, cited in Edwards J 2006, p. 424; Craig 2009; Bowman, Bodsworth & Zinn 2013). Policies supporting work-care or work-family reconciliation are implicated in these inequalities – for example, Pocock, Charlesworth and Chapman claim that Australian policies like paid parental leave, flexible working rights, and anti-discrimination protections only ‘mitigate the penalties that attach to being a working carer, helping women adjust at the margins to their increasingly [sic] responsibility for earning and caring’. They observe that such mitigation is ‘a long way from equality’ (Pocock, Charlesworth & Chapman 2013, p. 608).

Another key criticism of policies supporting women’s paid work that is raised in the feminist social policy literature is that policies increasingly prioritise women’s paid work participation at the expense of support for their caring roles. Orloff (2006, p. 230) has characterised these changes as part of ‘a series of “farewells to maternalism”’ in the affluent democracies, including Australia, wherein there has been a trend away from policy supporting women’s mothering in favour of policy requiring and assuming women’s labour force participation. This is borne out in the Australian case by recent ‘welfare-to-work’ reforms to Parenting Payment for sole and partnered parents (Cass 2006). Since 2006, sole mothers can only claim income support on the basis of their full-time caring responsibilities until their youngest child turns eight (rather than the previous 16). After this point, they are only eligible for the lower-rate unemployment benefit, Newstart Allowance, unless their child has a disability or medical condition and meets the criteria for Carer Payment (Explanatory Memorandum, Employment and Workplace Relations Legislation Amendment (Welfare to Work and Other Measures) Bill 2005 (Cth), p. 2). A major focus of these reforms was to increase sole and partnered mothers’ paid work participation once their children reach school age, and a new condition was
introduced requiring most claimants to participate in 30 hours of paid work per fortnight in order to preserve their eligibility for support (*Social Security Act* 1991 (Cth), s. 500; FAHCSIA 2011a, paras 3.2.8.30, 3.5.1.160).

Most feminist criticisms of these policies have focused on Parenting Payment (single), and similar reforms combining ‘labour market activation policies’ and ‘the removal of state-sponsored alternatives to employment’ for sole mothers in North America and parts of Europe (Orloff 2006, p. 232; Cortis & Meagher 2009, pp. 636–7; Pulkingham, Fuller & Kershaw 2010). These policy reforms have been attributed to wider neoliberal restructuring of welfare states in many parts of the world. In this program of reform, concerns about the dwindling labour supply, high social spending, and other economic and social pressures were used to justify major cuts to income support and other forms of social provision, as well as the privatisation of many services formerly provided directly by the state (Marston 2008; Mendes 2009; Cortis & Meagher 2009).

Scholars argue that these changes precipitated a transformation in the state’s role, from one of ‘enabling’ sole mothers (and fathers) to remain out of the paid workforce while they had dependent children, to one that sought to activate parents of school-age children to re-enter paid work and become self-sufficient through paid work participation (O’Connor J, Orloff & Shaver 1999, p. 139; Shaver 2002, p. 340). Cass (2006, p. 243) claims that these reforms devalued women’s maternal roles by ‘curtail[ing] markedly the period of a child’s life for which care giving is recognised in the income support system’, meaning that sole mothers are now treated as ‘independent market participants, expected to maintain an autonomous household through their own workforce participation’. Pulkingham, Fuller and Kershaw (2010, p. 268) claim that similar policy changes in Australia, Canada, the United States of America, the United Kingdom and Scandinavia treat women ‘primarily as potential employees and only secondarily as carers’. That is, the devaluation of full-time caring has been accompanied by an almost singular focus on paid work as the most appropriate, if not the only, form of social participation for sole mothers.

According to some scholars, the emphasis on paid work participation as ‘the most central of citizenship obligations’ (Patrick 2012, p. 9) also meant that access to income support was no longer framed in terms of citizenship rights or entitlements, but rather in terms of responsibilities that income support recipients must meet (Lewis 2002, p. 339; Henman
Participation in paid work or work-related activities has been recast as an ‘obligation’ that income support recipients owe to the community (and the government) in exchange for financial support (Macintyre 1999; McClelland 2002), and as ‘the public policy expression of a natural morality’ (Shaver 2002, p. 340). These welfare-to-work reforms have also been criticised for shifting responsibility for both caregiving and financial self-sufficiency onto individual women. Bowman, Bodsworth and Zinn argue that Parenting Payment (single) now ‘exposes women to added risks’, particularly the risks of poor quality or insecure work, and the risks associated with juggling paid work and care (Bowman, Bodsworth & Zinn 2013, p. 284). This individualisation of risk ignores a number of structural barriers that have been identified as major inhibitors of sole mothers’ ability to participate in, and earn a sufficient income from, paid work. These include a lack of availability of flexible, secure and well-paid employment, and a lack of alternatives to unpaid care (McClelland 2002; Gazso 2009; Blaxland 2010; Bowman, Bodsworth & Zinn 2013).

2.3.4 Conclusion

Maternalist policies that support women’s care raise both optimism and concern for feminist social policy scholars, and policy support for women’s paid work participation has had an equally mixed reception. This means that feminist advocacy for either care-supportive or employment-supportive policies will always raise a dilemma. This review of the literature indicates that the dilemma arises in practice because policies predominantly support either care or paid work, implying that a choice must be made to support one pursuit or the other (Knijn & Kremer 1997, p. 350). For instance, Skevik (2005) and Craig (2009) argue that the welfare-to-work reforms promoted mothers’ employment while ‘sidelin[ing] the issue of care’ (ibid., p. 523), while Cass and Yeandle (2009, pp. 2, 40–41) observe a dearth of policies to promote or facilitate the employment of carers of people (including children) with disabilities and those with age-related frailty. As these authors argue, employment and care are set in a ‘complex web of contradictions’ in policy, with women’s choices and obligations to care and to engage in paid work being unevenly and inadequately supported, and most women being obliged to act as either workers-first or carers-first regardless of their needs and wants (ibid., p. 8).

Some feminist scholars have explored ways to overcome both the theoretical and practical stalemates between supporting women’s unpaid care and paid work and, by extension, to
avoid the shortcomings of an either/or approach. The most prominent proposal in this regard is known as the universal caregiver model.

2.4 Resolving Wollstonecraft’s dilemma: the universal caregiver model

2.4.1 Overview

Feminists have long sought ways to transcend the question of whether to pursue gender equality through ‘women fitting the male model’ of participation in the public sphere through paid work (Eveline & Bacchi 2005, p. 498) or through recognition and support for women’s difference from men, particularly their roles in the private sphere of caregiving (Orloff 2008). The most popular approach to resolving this tension in the policy arena is the universal caregiver, or dual-earner/dual-caregiver, model. According to Orloff (2008, p. 1), this constitutes ‘perhaps the most widely-accepted vision of feminists interested in the “social question” in its contemporary manifestations, and with social justice and social policy’. In this section, I explain how and why the universal caregiver model is proposed to overcome the policy dichotomy between unpaid care and paid work, discuss its potential to avoid the shortcomings of care-supportive or employment-supportive policies, and highlight its key limitations. Most of the literature in this regard has arisen outside Australia, but is largely theoretical and, as I demonstrate later in the thesis, has potential application to the Australian case.

2.4.2 Overcoming the care/work dichotomy

The universal caregiver model was first proposed by American scholar Nancy Fraser (1994, pp. 591–2) as a response to the erosion of the traditional gender order associated with the failure of the family wage, women’s increasing paid work participation, and the decline of the dominance of the nuclear, male-breadwinner family form in ‘most industrial-era welfare states’. These changes have led to a crisis in both the welfare and employment systems, because these institutions were designed for a family and working life that no longer existed for many citizens (Rubery 2015, p. 515). Fraser (1994, p 610) canvassed several ‘utopian’ visions of how care and work could be reorganised – and the policy responses necessary to achieve this reorganisation – to overcome the crisis in a manner that also advanced gender equality.

Fraser explored three possibilities for achieving gender equality in postindustrial society, meaning, ‘the type of employment and social system feminists should wish for’ (Rubery 2015, p. 514). Her first two models prioritised one side of Wollstonecraft’s dilemma over
the other: a ‘caregiver parity’ model that would enable women to support themselves and their families while caring full-time, or combining part-time work with care; and a ‘universal breadwinner’ model that would prioritise women’s paid work participation, enabling women to support themselves and their families through full-time paid work and shifting most of their caring responsibilities onto the market and the state (Fraser 1994, pp. 601–6). Fraser also pointed out that policies that pursue either ‘sameness’ or ‘difference’ are premised on the notion that women deviate from a male norm of the unencumbered full-time worker, and should either be equipped to meet that norm through paid work participation, or supported to deviate from that norm with unpaid caring (ibid., pp. 594–5). In response to the many shortcomings of these approaches (discussed above), Fraser (ibid., p. 611) proposed what has come to be known as a universal caregiver model that ‘combines the best of universal breadwinner with the best of caregiver parity’.

The universal caregiver approach treats the persistence of the gender division of labour as the main barrier to gender equality. Fraser (1994, p. 611) argued that this can only be addressed through a deconstruction and reconstruction of the gender order, particularly the establishment of a new norm for both women and men, namely that ‘women’s current life patterns [are treated as] the norm’ (see also Orloff 2008, p. 10). This means that both men and women are assumed to have care responsibilities, and are expected to combine paid work and caregiving equally.

Supporting and achieving a universal caregiver model primarily requires policies to ‘induce men to become more like most women are now – the people who do primary care work’ (Fraser 1994, p. 610). That is, ‘degendering care work’ is treated as ‘the route to gender equality’, because it ensures that the costs and benefits of both activities are shared equally between women and men (Rubery 2015, p. 519). Gornick and Meyers (2008, p. 323) have been at the forefront of more recent advocacy for ‘gender symmetry’ in the public and private spheres through policies that ‘would provide men and women with greater options to equalize their allocation of time between the market and caregiving in the home while ensuring that their children are well cared for’. They explain that:

A dual-earner/dual-carer society supports equal opportunities for men and women in employment, equal contributions from mothers and fathers at home, and high-quality care for children provided both by parents and by well-qualified and well-compensated nonparental caregivers. (Gornick & Meyers 2008, pp. 314–5)
Scholars have made similar arguments that Australian women ‘cannot be full economic, political and social citizens until men accept their full social obligations and take up responsibility for caring work’ (Cass 1995, p. 58; Pocock, Charlesworth & Chapman 2013, p. 608).

By disrupting the norm of the male full-time worker, and supporting both care and paid work in equal measure, this model would appear to avoid the major shortcomings of care-supportive or work-supportive policies identified above. It would not entrench women’s roles as full-time carers, or fail to support their paid work participation (as may be the case with policies that support women’s unpaid care). Nor would it ignore women’s caring roles or reinforce women’s status as secondary earners (as may be the case with policies that support women’s paid work). According to Fraser, a universal caregiver model would promote gender equality on multiple dimensions. In this regard, she proposes a model of gender equality that goes beyond traditional sameness/difference goals, arguing that true gender equality requires income equality, leisure-time equality, equality of respect, ‘antimarginalization’ (meaning ‘full participation on a par with men in all areas of social life’), and ‘antiandrocentrism’ (meaning challenging the notion that ‘men’s current life patterns represent the human norm and that women ought to assimilate to them’) (Fraser 1994, pp. 598–600). By replacing the male norm with a new universal caregiver norm, this model would lead to more equal income between women and men, would challenge the marginalisation of women and care vis-à-vis paid work, and lead to more leisure time for all people (ibid., p. 611).

2.4.3 How can a universal caregiver model be achieved?

Rubery (2015, p. 514) recently criticised Fraser’s proposal for focusing more on ‘dissolving gender’ than on specifying the policy changes that would be necessary to achieve a universal caregiver model. She claims that Fraser’s proposal ‘requires action first on gendered norms and gendered relations’, rather than proposing changes to paid work and welfare to remove institutional support for traditional breadwinner models and actually enable ‘individual households… to change the gender division of labour’ (id.). Fraser did propose some specific policy reforms to promote a universal caregiver model, and Gornick and Meyers (2009a), among others, have further developed this thinking. Most of these proposals relate to altering the organisation of paid work rather than the
organisation of care. These are similar to, but expand on, many of the existing work-care reconciliation policies discussed in section 2.3.3, above.

For instance, Fraser (1994, p. 612) suggested that all jobs be redesigned on the assumption that workers also have caring roles, through shorter standard work hours and universal services to facilitate paid work participation, including publicly funded paid care. Williams (2010, p. 6) points to a range of policy proposals to address ‘androcentrism’, including policies ‘to reduce working hours and become more flexible to allow for better work/care balance; and to protect parents’ rights to time for care and children’s rights for quality care through provision of high-quality childcare provided by well-trained and well-paid care workers’ (see Gornick & Meyers 2003, ch. 8; Pocock, Skinner & Williams 2012, pp. 220–1). Cass (1995, p. 58) similarly notes the importance of increased access to childcare for resolving Wollstonecraft’s dilemma for mothers. Other Australian and European scholars propose additional reforms to facilitate more equal sharing of care and work, including restrictions on long working hours, enabling members of households to adapt and share working hours, providing tax incentives for men and women to work shorter hours, removing tax incentives for secondary earners to withdraw from work, and earmarking care leaves (like ‘daddy leave’) that can only be used by partners of primary caregivers (Bettio, Rubery & Smith 2000; Gornick & Meyers 2003; Pascall & Lewis 2004; Hill 2007; Daly 2011; Pocock, Skinner & Williams 2012; Pocock, Charlesworth & Chapman 2013; Goldin 2014). Improving the security, pay and availability of part-time and casual work is also frequently highlighted as essential to addressing gendered care/work inequality (Pocock, Skinner & Williams 2012, pp. 220–2; Pocock, Charlesworth & Chapman 2013, p. 604).

Recently, Rubery (2015, p. 520) proposed a ‘multi-dimensional assessment framework’ to identify welfare and employment policies to implement a universal caregiver model. The framework entails ‘a dual programme for change aimed at reducing the costs of flexible work options on life chances [and] at the same time developing more support and more options for combining care and paid work’ (ibid., p. 534). This involves considering both ‘reproductive work’ (including care work) and ‘wage work’, and both social policy and employment policy. It also requires that five dimensions of gender equality are met (ibid., p. 520). This framework incorporates a consideration not only of gender equality in the sense defined by Fraser, but also social equity (to include the experiences of women in different social classes and to better contemplate intersectionality), and productive
potential (or the extent to which policies develop capabilities in the human development sense) (ibid., p. 521). The five factors are ‘time, opportunities, resources, respect and security’ (ibid.). Time refers to measures to enhance the compatibility of care and paid work; opportunities refer to measures to increase women’s labour market opportunities through changes to employment and redistribution of care responsibilities; and resources refer to measures that increase women’s access to material resources through the employment and welfare systems. The latter also involves a revaluation of ‘women’s work’ in both care and paid work. Respect refers to measures to afford respect and dignity for women in the workplace and in the private sphere, and security refers to measures to ensure that women’s situation is secure over time (ibid., pp. 521–3).

2.4.4 Limitations of the universal caregiver model

Fraser (1994, p. 613) acknowledged over 20 years ago that ‘[m]uch more work needs to be done’ to develop a welfare state that promotes a universal caregiver model. More recent analyses of Australian and international care policy indicate that this assessment still holds (for example, Pocock, Charlesworth & Chapman 2013; Rubery 2015). While the model may offer a policy approach that challenges the tendency for policy to support only women’s care or women’s paid work, and the male norm that informs both of these options, it raises several issues.

On a theoretical level, Orloff (2008) is critical of the largely unquestioned assumption underpinning this approach, namely, that gender symmetry in paid work and caregiving constitutes a universally desired form of gender equality. She argues that pursuing ‘a 50/50 sharing of paid work and care work’ does not accommodate ‘variation in men’s and women’s preferences vis-à-vis the gender division of labor’, nor variation in their ability to provide care (ibid., p. 13). In other words, the model underemphasises choice and differences among women. Gornick and Meyers (2009b, p. 43) acknowledge that this is a risk in introducing ‘policies that reshape caring practices of parents, and allocation of time between women and men’. Orloff characterises this as a consequence of simply replacing one norm (men’s standard life course) with another (women’s standard life course). She proposes instead changes to ‘open possibilities for men and women, [and] remove policies and practices that impede choice’. These might include ‘a citizen’s wage, or participation income’, changes to training and employment policy to increase women’s access to non-traditional work, improving pay and conditions for paid care workers,
encouraging men to engage in care, and increasing access to care services (Orloff 2008, p. 22).

Lewis and Giullari (2005, p. 94) highlight a major problem with such a choice-based approach. In their analysis of policies to reconcile women’s caring and paid work obligations, they note that ‘choices are made in the context of gendered inequalities in power relations, in all their economic, political and discursive manifestations’. This means, for instance, that men’s choices about paid work and care, and cultural and personal expectations about gender roles, often encroach on women’s choices (Leahy & Doughney 2006). Lewis and Giullari (2005, p. 97) suggest that ‘compulsion, sanctions and penalties’ may be required to disrupt the prevailing gender division of labour and its consequences, but they express concern that this risks both a ‘backlash’ and an undermining of the ethical qualities of care, the importance of which I return to later in this chapter. On this basis, they argue that ‘positive incentives for men as individuals to engage in care’ – such as dedicated leave for secondary caregivers and changes to standard employment conditions – may be the most appropriate way to address gender inequalities in ‘choice’ about care and paid work (id.). Some scholars have expressed a related concern that constructing the gender division of labour as a simple matter of ‘choice’ ignores the structural conditions within which those choices are made. This means that the risks of, and responsibility for, making choices – which are often highly constrained by a lack of resources, differences in bargaining power, adaptive preferences and other factors – are shifted onto individual women (Orloff 2006, p. 260; Brady 2011; Bowman, Bodsworth & Zinn 2013).

A final relevant limitation of the universal caregiver model is that it focuses predominantly on the rights and interests of only one party to the care relationship, namely, the caregiver. Some scholars in this vein have discussed care recipients – for instance, Fraser (1994, pp. 596–7) expressed concern regarding how her models of care and work would mitigate ‘exploitable dependency’, and Williams identifies one of the roles of work-care reconciliation policy as protecting ‘parents’ rights for time to care and children’s rights for quality care’ (Williams 2010, p. 6; see also Gornick & Meyers 2003, p. 249). However, the predominant focus of these scholars is the unequal gender division of labour, and consequently the rights of women providing care. As Pinto (2008, p. 121) explains, the feminist literature has generally expressed ‘no concern about how different ways of organizing care impact those who require assistance to perform daily life
activities’. Consequently, while the model offers at least a partial solution to the fragmentation of care policy along the care/work axis, it does not address fragmentation along the caregiver/care recipient axis.

2.5 Disability rights and carers’ advocacy: to reject or to recognise care?

2.5.1 Choosing sides in the carers/people with disabilities dichotomy

Disability rights scholars and activists have problematised the neglect of the perspective of those who require care or support in much mainstream feminist and care policy literature, and in care policy itself. This is at the heart of a second apparently insurmountable care policy tension at both the academic and political levels, between supporting the claims of carers and supporting the claims of people with disabilities. Unlike the care/work tension, which has arisen predominantly (but not solely) in relation to mother-care for children, this tension has been raised mainly in relation to care or support for adults with disabilities.

Carers’ organisations in Australia and elsewhere have successfully argued for greater policy support for individuals’ caring roles, including cash payments for carers, like Carer Payment (adult) and Carer Payment (child) (Cass & Yeandle 2009). Disability rights scholars and activists have argued instead for policies that enable people with disabilities to live independently and exercise choice and control over the assistance or care they obtain, such as direct cash payments through which people with disabilities can employ personal assistants or purchase other services (Morris 1997; Shakespeare 2006). This reflects wider political and academic debates about how care and disability should be understood and addressed, including whether care and disability constitute a burden and tragedy for carers and people with disabilities (which characterises the carer perspective) or whether disability is actually a consequence of a failure of society to accommodate people’s differences, which is perpetuated by the paternalistic and oppressive practice of ‘care’. The two perspectives have been characterised as ‘oppositional’ and ‘irreconcilable’, and scholars have observed a tendency for policy to prioritise one perspective over the other (Beckett 2007, p. 361; Rummery & Fine 2012, p. 328).

I now discuss this tension in more detail and identify advantages and disadvantages of the different policies advocated for in each perspective. As with the tension between unpaid care and paid work, analysis and activism in this regard has focused particularly on cash payments to either carers or people with disabilities, and the review again focuses
on these policies. As the preceding discussion demonstrated, much of the feminist social policy literature concerned with disability or aged care is focused on the interests of carers. I draw on some of the same sources in this part, as well as literature that is concerned with the circumstances and interests of carers, but not in gendered terms. I also review and analyse research in the overlapping fields of critical disability studies and disability rights (which I collectively term ‘disability rights’ scholarship), which arose in disability rights movements in the United Kingdom, the United States of America and elsewhere. The primary concern of these literatures has been to challenge the marginalisation of people with disabilities in all areas of life and to promote their civil and human rights (Degener 2016). Discussion of this tension – especially disability rights responses to care – has largely taken place in Europe (including the United Kingdom), and I draw heavily on literature from these regions, as well as Australian literature where it is available. Nevertheless, the international literature on which I rely is largely theoretical, and I demonstrate through the case study analysis of Australia’s Carer Payment (child) policy that the main arguments from this literature are useful and relevant in the Australian case.

2.5.2 Advantages and disadvantages of addressing care as a burden

2.5.2.1 Advantages of the conceptualisation of care as a burden

The campaigning of carer movements has been characterised as one factor in the increased policy recognition of care in Australia and many other parts of the world in recent decades. Scholars have observed the success of Australia’s carer movement, spearheaded by the peak body Carers Australia and its series of affiliates at State/Territory level, in gaining bipartisan political support for carers’ issues in this country (Cass & Yeandle 2009). These organisations have their origins in feminist claims for support and recognition of women’s roles in providing ‘community care’. The shift towards community care began in Australia in the 1980s, with policies that encouraged and mandated the closure of large-scale institutions in favour of care ‘in the community’ for people with disabilities or older people, meaning smaller-scale residential accommodation or family homes, with medical and other services being provided in local communities (AIHW 1994, p. 272; Heaton 1999; Cass & Yeandle 2009, p. 4). Both economic considerations and campaigning by the disability rights movement were influential factors in deinstitutionalisation and community care policy in Australia, the
United Kingdom, and many other parts of the world (Williams 2001, p. 476; AIHW 2004, p. 2; Shakespeare 2006, p. 138; Wiesel & Bigby 2015, p. 180).

Feminist criticisms of the shift to community care policy originated in the United Kingdom, with academics arguing that an unspoken and unchallenged assumption of community care was that women were available and willing to provide care to family members in the home (Read 2000, p. 85; see for example Finch & Groves 1980; Finch & Groves 1983). Australian scholars Shaver and Fine (1995, p. 1) explain that households had ‘become the preferred site for the exercise of public responsibility for many of the most vulnerable and dependent citizens’. Critics of community care argued that ‘care in the community’ actually meant ‘care by the community’ (Bayley 1973, cited in Finch & Groves 1980, p. 490) and characterised such policies as ‘regressive and patriarchal, effectively transferring responsibility from the state to the family and, within the family, to women’ (Fine & Glendinning 2005, p. 603; see also Heaton 1999, p. 761).

In this perspective, care is conceptualised primarily as a form of labour with particular, mostly negative, characteristics, including being ‘unpaid… often exploitative and frequently a burden on those charged with its responsibility’ (Rummery & Fine 2012, p. 335–6; see for example Land 1978; Graham H 1983; Glendinning 1992). This characterisation of caring as intense and disruptive is commonly referred to as a discourse or conceptualisation of care as a ‘burden’, meaning ‘the daily grind of care giving and the heavy cost it imposes – emotional, physical and financial’ (Twigg & Atkin 1994, p. 4; see Fine & Glendinning 2005, pp. 603–4; Shakespeare 2006, p. 138). Critiques of the burden of care initially focused on single and married women’s responsibility for caring for elderly relatives, but have since been extended to the care of adults or children with disability, and the non-gendered subject of the ‘carer’ (see for example Twigg & Atkin 1994, p. 7; see also Bytheway & Johnson 1998; Heaton 1999). Scholars in this vein have focused particularly on describing and quantifying the physical intensity and economic costs of unpaid care, that is, the personal and financial disadvantages associated with women’s caring (Rummery & Fine 2012, p. 336). They have also sought to problematise the role of the state in maintaining this exploitative gender division of labour (Williams 2001, p. 475).

A considerable Australian and international literature is concerned with identifying and measuring the impacts of caring on carers, some of which I touched on earlier in relation
to the disadvantages of policy support for women’s unpaid caring. Much of this research has identified financial hardship, and low participation in paid work, as the main costs or burdens of caring. These studies usually draw causal connections between carers’ demanding caring roles, their inability to participate in substantial paid work, and their greater experience of financial hardship and poverty compared with non-carers (for example, Bittman, Hill & Thomson 2007; Edwards B et al. 2008; Hill et al. 2008; Ganley 2009; Lu & Zuo 2010).

For example, Jenson and Jacobzone (2000, p. 12) argue that individuals’ responsibility for informal care of the elderly in Australia and across the OECD involves ‘significant opportunity cost[s]’ for carers, including ‘the costs of foregone earnings and leisure, [and] the displaced expenditure within the household’. Cass (2006, p. 241) elaborates on some of the same problems facing Australian ‘carers responsible for vulnerable adults’ in her discussion of Carer Payment (adult) policy. She cites previous research showing that unpaid caring ‘can extract a high price’ in terms of carers’ ability to participate in paid work, with carers being more likely than non-carers to withdraw from work or reduce their work hours (ibid., pp. 246–7, 252). Cass and Yeandle (2009, pp. 14–16) highlight similar research findings in a more recent comparison of Australian and UK policies relating to the care of adults and children with disabilities and ‘frail aged people’. These include the lower rates of workforce participation and higher rates of part-time employment of carers compared to people who do not have caring responsibilities, and the negative implications of this for individual and household income (ibid., p. 16; see also, Hill et al. 2008; Edwards B et al. 2008; Ganley 2009). The effects of care on employment income have been described as ‘life-course impacts’ (Cass & Yeandle 2009, p. 22), because they lead to ‘poorer earning potential over [the] working life’ and lower retirement savings (Nepal et al. 2011, p. 102; Australian Human Rights Commission 2009). As I discussed above in relation to the care/work tension, Campbell and Charlesworth (2004, p. 37) note statistics showing that many carers would like to increase their work hours, but experience a number of barriers to doing so, including lack of access to alternative care or flexible work (see also Gray, Edwards B & Zmijewski 2008).

Other studies have found that women’s workforce participation is more adversely affected by their caring roles than that of either men who are carers or women who are non-carers (Cummins et al. 2007, pp. 43–44; Burton-Smith et al. 2009, p. 196; Lu & Zuo 2010, p. 230). Other scholars problematise the ‘gendered’ nature of the provision of care
in Australia, arguing that women’s disproportionate responsibility for caring while they are of ‘workforce age’ means that they are more likely than men to experience ‘lower labour force participation rates, lower earning[s] and vulnerability to income poverty’ (Cass & Yeandle 2009, p. 16; see also Gray, Edwards B & Zmijewski 2008; Nepal et al. 2011).

Aside from the implications of caring for carers’ ability to participate in paid work and the associated financial insecurity, scholars concerned with the impacts of care have also identified a number of ‘detrimental effects’ of intense caring on carers’ health, wellbeing and family lives (Jenson & Jacobzone 2000, p. 17). These costs include a higher incidence of pain, chronic injury, mental health issues, marriage problems, social isolation, and stress (Edwards B et al. 2008; Ranmuthugala et al. 2009; Hayes et al. 2015). Some of these studies have also found that women are more likely than men to have poorer health and wellbeing outcomes related to caring (Cummins et al. 2007; Nepal et al. 2008; Burton-Smith et al. 2009).

Carers’ advocacy groups have utilised some of this research, and published similar research of their own, to demonstrate these costs and burdens of care (see Fine & Glendinning 2005, p. 604; for example, Cummins et al. 2007; Nepal et al. 2008). Carers Australia has also commissioned research to demonstrate the economic value of carers’ caring, especially as it pertains to the rising care costs of the ageing population (for example, Access Economics 2005; Deloitte Access Economics 2015). Fine and Glendinning (2005, p. 604) suggest that this is another reason for carers’ lobbying success – their claims about the economic value of care coincide with governmental concerns about the dwindling supply of carers and growing demand for care services.

According to Fine, the conceptualisation of care as a burden has ‘dominated discussions and policy advocacy’ in Australia for several decades, producing a strong emphasis on ‘the plight of primary and sole carers in national policy’ (Fine 2004, p. 220). He characterises this emphasis on burden in carers’ claims-making as both necessary and highly problematic. It has been necessary to secure support for many people who have ‘taken on the duties of providing care as primary carers… at great personal cost’ (ibid., p. 220). This has included achieving greater access to respite and home-based support services, securing increases to the rate of income support payments (particularly Carer Payment), protecting those payments from the cuts and limitations associated with
welfare-to-work-type reforms, and securing some limited employment support to enable carers to enter or re-enter the workforce (Cass 2006; Cass & Yeandle 2009, p. 20; see also Morris 1997, p. 55). Beckett (2007, p. 364) claims that a similar discourse has helped carers in the United Kingdom to establish the value of care, and has contributed ‘to the strength of carers’ identification with providing emotional and physical care’. However, support for carers on this basis is also considered to be highly problematic, largely because of its implications for people with disabilities.

2.5.2.2 Disadvantages of support for carers on the basis of burden

Disability rights scholars argue that the recognition of carers’ claims based on a characterisation of care as burdensome and costly marginalises and oppresses people with disabilities (Morris 1991a, p. 143). As Hughes and his colleagues (2005, p. 261) explain:

Care is associated with institutional confinement, limited social engagement, partial citizenship, disempowerment and exclusion. To be cared for is to be in deficit and to have one’s competence as a social actor denied or questioned.

In this perspective, people with disabilities are positioned as objects of care who are dependent on both their carers and the state, and are incapable of contributing meaningfully to society (Keith 1992; Silvers 1995; Morris 1997). They are reduced to being “dependents” whose existence [is] a threat to non-disabled women’s economic opportunities’ (Morris 2001, p. 7).

The burden discourse, and the care practices associated with it, are problematised particularly for producing an unequal relation of power between carer and care recipient. Care implies that, rather than providing ‘help with daily living activities’, the person providing care must take ‘responsibility for the person requiring help’, leading to paternalistic attitudes and practices (Pinto 2008, p. 122). This means ‘it is the “carer” who is active, [while] the other partner is seen as entirely passive’ (Keith 1992, p. 169; Keith & Morris 1995). Priestley (1999, p. 47) explains that community care policy positions people with disabilities as ‘those who “cannot help themselves”’ and who thereby require “care” (or control)’ by another. He links this with the ‘more general cultural construction of disability as “personal tragedy”’, which ‘conveys much more than simple misfortune; it conveys the idea of powerlessness – of impotency’ (ibid.). Silvers (1995, p. 40) similarly argues that there is a power imbalance at the heart of care, because ‘the very structure of helping or caring relationships invites the marginalization of whoever is
consigned to the position of dependence’. While the concept of care has been criticised generally, unpaid family care has been deemed to be particularly problematic from a disability rights perspective (Morris 1997, p. 56). For example, Brisenden (1989, cited in Rummery & Fine 2012, p. 327) describes unpaid family care as:

the most exploitative of all forms of so-called care delivered in our society today for it exploits both the carer and the person receiving care. It ruins relationships and results in thwarted life opportunities on both sides of the caring question.

The power inequality between ‘carers’ and ‘dependents’ (Keith & Morris 1995, p. 37) has long been implicated in the exploitation, neglect, abuse and marginalisation of people with disabilities by family members on whom people have been forced to rely due to a lack of alternative supports and services (Morris 1997; Williams 2001, p. 479; Kelly C 2011, pp. 564–5). It is also criticised for preventing people with disabilities from exercising choice about how they live their lives, because: ‘[h]elp-givers choose how they are willing to help, but help-takers cannot choose how they will be helped’ (Silvers 1995, p. 40; see also Morris 1997, p. 54). Tom Shakespeare notes that this negative conceptualisation of people with disabilities has also affected research on disability, with the opinions of people with disabilities rarely being sought directly and their experiences being considered to be irrelevant (Shakespeare 2000a, p. 56). This means that ‘the problematic aspects of the experience for them are neglected’ (ibid., p. 57; see also Morris 1991a, p. 157). A similar criticism has been levelled at research with children both with and without disabilities (Shakespeare & Watson 1998).

Critiques of the discourse of the burden of care are part of the wider disability rights project to problematise the highly negative, disempowering medical or individual model of disability that represents the dominant discourse of disability in Western societies. In this model, disability is constructed as an individual medical deficit resulting from ‘personal tragedy’ – ‘some terrible chance event which occurs at random to unfortunate individuals’ (Oliver 1990, p. 3). Degener (2016, pp. 3–4) explains that disability ‘is seen as a deviation from the normal health status. Exclusion of disabled persons from society is regarded as an individual problem and the reasons for exclusion are seen in the impairment’. Quinn and Degener characterise this as a particular social construction of the category of disability which ‘has the effect of locating the “problem” of disability within the person’ (Quinn & Degener 2002, p. 14).
Policy responses based on the medical model focus on individual treatment, cure and prevention, and disability ‘remains the exclusive realm of helping and medical disciplines: doctors, nurses, special education teachers, [and] rehabilitation experts’ (Degener 2016, p. 3). Morris (2001, p. 3) links this with an assumption underpinning the medical model that:

it is impairment which determines our life chances. If impairment determines our experiences then the only things that can be offered are treatments and cures, and services (residential care, segregated schooling, etc.) which prevent us from doing the kinds of things that non-disabled people do because we are not recognized as full human beings. It is this approach which leads to segregation and exclusion – and ultimately to the assumption that our lives are not worth living and that we would be better off dead, or not being born in the first place.

Charitable and welfare provision – which position persons with disabilities as pitiable, needy and passive objects of charity and protection – have been the other dominant policy responses to the individual, medical ‘problem’ of disability. They have also been rejected by the disability rights movement on the basis that they are disempowering, demeaning and exclusionary (Finkelstein 1993; Shakespeare 2000a, p. 64; Kayess & French 2008, pp. 5–6; Degener 2016, p. 13). Bartlett (2012, p. 758) explains that the ‘social welfare’ model ‘may focus less on people with disabilities as medical objects, but still focuses on their limitations’, meaning the problem ‘is still firmly located in the individual, and the social response is to provide care’.

2.5.3 Advantages and disadvantages of supporting independence

2.5.3.1 Advantages of policies for independence, choice and control

Beckett (2007, p. 363) observes that the disability movement’s criticisms of the prevailing discourses of disability and care, and their manifestation in policy, have established that “care” should not be regarded as an unquestioned social good, and by extension, that welfare states that provide care are not necessarily always fulfilling any obligation to treat people with justice and respect. Disability rights researchers and activists have utilised the language and theory of rights – in opposition to the medical, welfare and charitable approaches associated with traditional care – to argue particularly for the right to ‘independent living’ as fundamental to the self-determination, full social participation and independence of people with disabilities (Priestley 1999; Spandler 2004, p. 192; Beckett 2007, p. 363). As Richard Wood (1991, p. 199) proclaimed, ‘[d]isabled people
have never demanded or asked for care! We have sought independent living which means being able to achieve maximum independence and control over our own lives’. Disability scholars have proposed alternative concepts, including ‘assistance’, ‘support’ and ‘help’, to distinguish oppressive care from other practices that might facilitate such independent living (Finkelstein 1998; Shakespeare 2000a; see Kelly C 2011, p. 563; Berridge 2012, pp. 12–3).

Shakespeare (2006, p. 139) explains that the disability movement’s calls for independent living were ‘based on living in an accessible home and the availability of accessible environments and services and information’. He claims that a ‘vital element in the panoply of independent or integrated living services was personal assistance’, meaning the provision of direct payments to enable people to decide on and purchase the assistance or support they require, often through contracting or employing a personal assistant (ibid.; Morris 1993, pp. 162–70). Watson and his colleagues (2004, p. 335) similarly note that, whilst the [disability] movement endeavours to promote the full range of human and civil rights of disabled people, the promotion of personal assistance as the key strategy in breaking the link between disability and dependency in everyday life has traditionally been its key focus.

Direct cash payments or budget allocations to people with disabilities are intended to give individuals the opportunity to choose, design, commission and purchase the care or support they require (Berridge 2012, p. 12). Such payments were argued for on the basis that they would deliver ‘a depersonalised model of help’ which ‘assumed that care could be disaggregated into practical tasks, that were necessary, and emotional content, which was rejected’ (Shakespeare 2006, p. 139). Dickinson, Needham and Sullivan (2015, p. 418) explain that direct payments and related policies are based on the assumption ‘that specifying an individual’s budget and allowing the individual to decide how this is spent should enhance control, choice and flexibility’. Rummery and Fine (2012, p. 337) describe this approach as a “citizenship” model of welfare delivery, with support being framed as a means of facilitating the exercise of citizenship (see also Krogh 2004; Berridge 2012, p. 12). Direct payments have a shorter and patchier history in Australia than they do in the United Kingdom and many parts of Europe, with policy configurations differing considerably from state to state (Purcal, Fisher & Laragy 2014). However, Australia’s Federal Government recently sought to address inconsistencies and
inefficiencies in disability support provision by implementing the National Disability Insurance Scheme, a national system of individualised funding for people with disabilities under the age of 65, designed to enable people to have greater choice of service providers, or cash-out their budgets to directly purchase support (Dickinson, Needham & Sullivan 2015, p. 418; Foster et al. 2016).

Calls for direct payments to support independent living and the exercise of choice and control reflect a radically different conceptualisation of disability to the traditional medical model, and this has been termed a ‘social model’ of disability. While several variations of this model have been formulated, they share a common assertion that disability is socially constructed (Mitra 2006, p. 237). A distinction is drawn between impairment and disability (Oliver 2004) – the former refers to ‘functional limitations experienced by an individual’ which may be the legitimate domain of medical professionals, while the latter constitutes ‘a social state understood to be the outcome of social, political and economic processes’ (Humpage 2007, p. 217). According to the social model, while individuals may experience a physical, intellectual, or psychosocial impairment that affects their appearance or functioning, people are only ‘disabled’ to the extent that society creates (or does not remove) barriers to their ability to live an independent life and to participate and be fully included in society on an equal basis with others (Morris 2001; Shakespeare 2000a; Kayess & French 2008). These include not only physical barriers like inaccessible housing, public spaces and transport, but also cultural and social barriers like stigma and discrimination (Marks 1999; Pfeiffer 2001, p. 35; Beckett 2007, p. 364). As Shakespeare (2013a, p. 216) explains, impairment is considered to be ‘individual and private’, while disability is ‘structural and public’. Policy responses based on the social model – like direct payments and other independent living measures – focus on adapting society, rather than the individual. They do so by removing the barriers that produce disability and marginalise and exclude people with disabilities, and by shifting power and control from care providers to people with disabilities (Williams 2010, pp. 7–8; Shakespeare 2013a, p. 216).

Some scholars observe that arguments in favour of direct payments to individuals with disabilities have dovetailed with government efforts to stimulate a mixed economy of care, particularly efforts to shift responsibility for direct provision of care away from the state and onto the market (Rummery 2011, p. 140; Rummery & Fine 2012, pp. 336–7; Purcal, Fisher & Laragy 2014, p. 89; see also Shakespeare 2006, p. 137). Such policies
reposition people with disabilities as ‘active consumers of welfare’ (Williams 2010, p. 14). As Purcal, Fisher and Laragy (2014, p. 89) observe,

Choice is a central policy driver in both paradigms: neoliberalism emphasises choice of providers in a free market, and human rights advocates emphasise choice of the person with disability over their lifestyle and support services (Stevens et al. 2011; Needham 2011).

2.5.3.2 Disadvantages of policies for independence, choice and control

Calls for independent living and direct payments from a disability rights perspective partly overlap with carers’ claims that the burden of care must be alleviated. Nevertheless, there have been a number of criticisms of policies to support independent living and the rights of people with disabilities, and of the social model on which such policies are based.

The individualisation and marketisation of care associated with direct payment and independent living policy has raised a number of issues for social policy scholars, particularly those aligned with a feminist or carer perspective. First, the implications of such policies for paid workers – predominantly women – who provide support or care have been a major source of concern. Hughes and his colleagues (2005, p. 263) claim that an independent living approach ‘reverses rather than abrogates the master/slave relation’ by empowering people with disabilities at the expense of those employed by them, or on their behalf, to provide support (see also Shakespeare 2000a, p. 53). In other words, ‘the disability movement puts the needs of the cared for above the needs of the carer’, with the independence and rights of people with disabilities trumping those of paid care or support workers (Watson et al. 2004, p. 339). Cash, Hodgkin and Warburton (2013, p. 667) observe a similar dynamic in the growing emphasis on choice for older people in community care policy – because these policies assume a high level of family responsibility, they do not extend choice to unpaid carers (see also Arksey & Glendinning 2007).

As I noted earlier in relation to policies that support women’s paid work by shifting their care responsibilities onto the market, feminist social policy scholars have expressed concerns about the poor pay and conditions of personal assistants and other paid care or support workers, the majority of whom are women (Ungerson 1997a; O’Connor J, Orloff & Shaver 1999, p. 144). Echoing feminist concerns about the undervaluing of care,
Rummery and Fine (2012, p. 329) argue that ‘carers, both in the family and paid sphere, are often undertaking work that is undervalued, unpaid or subject to low wages, viewed as unskilled, and open to exploitation and abuse’. This challenges the idea, key to disability rights critiques of care, that those providing care are always in a position of power. It also raises concerns about the quality of care – it is less likely to be ‘ethical care’ if it is provided by someone working ‘in undervalued conditions for low pay’ (ibid, p. 337; Ungerson 1997a). Rummery and Fine (2012, p. 337) further argue that the historic feminisation and undervaluation of care may persist, if not worsen, if economic considerations are the dominant factor in the introduction of direct payment policies; this is particularly so in the wider context of the deregulation and ‘casualisation’ of the workforce (see also Spandler 2004, p. 198; Macdonald & Charlesworth 2016).

A second, related concern about the disability rights emphasis on choice is that market-based services may mean that direct payments do not afford meaningful choice to people with disabilities (Rummery & Fine 2012, p. 337). Fawcett and Plath (2014, p. 754) caution that:

> When a liberal/market perspective is adopted and the individual is defined as a consumer, outcomes are likely to reflect the structural disadvantages and access inequitities evident in wider free market systems. The market is under no obligation to respond to the wants and needs of individuals and will only do so if it is economically worth the effort.

Spandler (2004, p. 197) similarly argues that there is a risk that policies driven by (or at least intersecting with) neoliberal interests in reducing welfare spending and privatising service provision will not deliver ‘quality services, social justice or equality’. In this context, the withdrawal of the state from direct service provision and the replacement of those services with inadequate alternative supports risks making people with disabilities individually responsible for the financial and other risks associated with impairment and disability (Ferguson 2007; Foster et al. 2012). Some Australian scholars have noted that the requirement on people to be ‘active citizens’ – as discussed earlier in relation to sole mothers claiming Parenting Payment – often involves ‘taking more responsibility for meeting their own needs’, without necessarily having the structural support to do so (Foster et al. 2012, p. 340). A related criticism of direct payments is that focusing on individualising services removes attention (and resources) from collective provision,
innovation, and ‘an understanding of the wider structural context in which oppression is experienced’ (Spandler 2004, p. 195).

A third, overarching criticism of the disability rights approach is that its focus on enabling people with disabilities to participate equally in the public sphere through purchasing assistance in the market ‘idealizes masculinist notions of autonomy’ (Hughes et al. 2005, p. 263). Some of these criticisms have come from within disability studies, and they coincide with wider claims that advocates of independent living have been ‘male-centric’ and ignored the experiences and concerns of women with disabilities, particularly mothers (Pinto 2008, p. 124; see also Morris 1991b; Lloyd M 2001). Shakespeare argues that the disability rights emphasis on independence also represents an individualistic approach to rights that is inconsistent with the collectivist intentions of the disability movement more broadly (Shakespeare 2000a, p. 63). He relates this partly to the origins of the independent living movement in the work of the Union of Physical Impaired Against Segregation in the United Kingdom, a ‘hard-line, male-dominated, and determined’ organisation (Shakespeare 2013a, p. 215) of ‘adults with physical impairments’ (Shakespeare 2006, p. 136). Consequently, the experiences and claims of the many other constituencies ‘who each require different forms of care, help and assistance’ were not identified or problematised, and there was an over-emphasis on the employment of personal assistants, along with choice about living arrangements and access to mainstream employment and services, as the appropriate solutions for all (Shakespeare 2006, p. 136).

Many advocates for independent living do argue in favour of individual choice-making and the market-based provision of personal assistance as the primary means through which people with disabilities can determine their own needs, exercise agency, and realise their right to independence. However, some disability rights scholars have sought to clarify that the notion of independence employed in this field has a distinct meaning from the liberal definition of independence as autonomous, self-sufficient rationality. For example, Morris claims that independence for people with disabilities does not equate to self-sufficiency, but rather the right ‘to adequate support which would give them choice and control in their lives’ (Morris 1997, p. 55). Shakespeare prefers Brechin’s ‘useful formulation’ (Shakespeare 2006, p. 137) that the care should aim at ‘promoting autonomy in the context of supported living’ (Brechin 1998, p. 175).
Kröger (2009) suggests that disability rights scholars’ characterisation of all family care relationships as inherently exploitative is an over-simplification that ignores the diversity of choice and circumstances of people with disabilities. For example, some people will ‘still prefer close family members, like spouses, to provide them with help and manifold support they need in their everyday lives’, and ‘[p]arents of disabled children will continue to care for their children’ (ibid., p. 410; see also Morris 1993, p. 154). There has been much less attention in the disability rights literature on whether the shortcomings of ‘care’ are as problematic for children with disabilities as they are for adults, and the extent to which the social model of disability ‘provides an adequate explanatory framework for [children’s] experiences’ (Connors & Stalker 2007, p. 19). Some scholars have discussed how the social model, and concepts of independent living and personalisation, apply to children with disabilities. They suggest that individualised childcare and personal assistance – and, more broadly, services and supports that are based on a social model of disability and take into account children’s wishes and choices – are also useful for, and desired by, children with disabilities (Shakespeare & Watson 1998; Middleton 1996; Lenehan 2008; Goodley & Runswick-Cole 2012).

A fourth criticism of the emphasis on independence in the disability rights field is that it has led many activists and researchers to downplay or deny the experience of impairment (Watson et al. 2004, p. 338). Morris (2001, p. 17) notes that the pressure to ignore bodily experience is ‘considerable because of the way that our bodies have been considered as abnormal, as pitiful, as the cause of our lives not being worth living’, while Shakespeare suggests that a ‘fear of reinforcing a hierarchy of disability’ may also underpin this reluctance to interrogate impairment too closely (Shakespeare 2013b, p. 81). However, ignoring or minimising impairment is problematic because it can lead to the ‘error of conflating and simplifying the variety of disabled people’s different experiences, or of trivialising life with severe impairment’ (ibid., p. 80). It can also lead to the assumption that providing a physically accessible environment is all that is required to achieve justice and equality for people with disabilities, meaning issues like discrimination and access to resources are not identified or addressed (Morris 2001, p. 17). Outside the disability rights field, scholars like Eva Feder Kittay (1999) have also written influentially about the need to theorise and account for some people’s need for specific, often very intensive, forms of care or support, such as people with severe cognitive impairment, who may not be
accommodated by mainstream disability rights thinking (see also Lynch, Baker & Cantillon 2009, pp. 31–32).

2.5.4 Conclusion

The emphasis on the burden and costs of care in the carer literature, along with arguments about the economic value of care, have been influential in the Australian carer movement’s claims-making. However, the conceptualisations of disability and care on which these claims are based are clearly inconsistent with concerns in the disability rights field to establish the conditions for people with disabilities to live independently and participate fully in the community. Beckett (2007, p. 375) observes that a dualism between ‘care and control’ is at the centre of the tension between the claims of care providers and people with disabilities. It also reflects dichotomous thinking about disability – in the former case, a medical model that locates the problem of disability in the individual and identifies treatment, care and welfare as the appropriate policy responses, and in the latter, a social model that locates the problem of disability in society and identifies the removal of social barriers to participation and independent living as the appropriate policy solutions. This can also be understood as a dichotomy between an assumption of the dependence of people with disabilities (in the carer perspective) and an assumption of the independence of people with disabilities (in the disability rights perspective). Beckett suggests that such binary understandings lead to policies that ‘either value and reward care and care giving as a function that is primarily connected with women, and offers a role that is socially necessary or work to value the independence of disabled people’ (Beckett 2007, p. 375; emphasis in original).

Both the carer and disability rights perspectives reviewed here have been criticised for prioritising the claims of one group over the other, risking exploitation, marginalisation and abuse (Morris 1997; Ungerson 1997a). Despite these differences, Beckett (2007, p. 375) argues that the perspectives must find common ground, because, if ‘the question is framed as a dichotomy – support care givers or care receivers – then it is too easy for it to become a simple discussion of who has the greater claim’ when policy makers are deciding how to use limited resources (see also Barnes 2006, p. 150). Scholars have sought this common ground through a reconciliation of the disability rights perspective and an alternative conceptualisation of care from a feminist perspective, the ethics of care.
2.6 Resolving carer/people with disability tensions: ethics of care and disability rights

2.6.1 Overview

Some scholars have explored the potential of an ethics of care approach to overcome one of the dichotomies at the heart of the tension between carer and disability rights perspectives, namely the contrast between dependency and independence. Scholars following this approach argue that policies should recognise and support interdependence – care should be reconceptualised as a universal need, experience and moral value, and all people should be supported to give and receive care (Williams 2001, pp. 486–7). Some disability rights scholars have sought to engage with the ethics of care perspective, and ethics of care scholars have in turn engaged with the disability perspective, to propose ways to reconcile these two ‘alternative theoretical models available for reforming care’ (Shakespeare 2000a, p. 59). It is these attempts to reconcile the two perspectives that I identify as the most developed approach to resolving the carer/disability rights tensions troubling contemporary care policy.

In the remainder of this chapter, I explain how and why a reconciliation of the ethics of care and disability rights perspective is proposed to overcome the dichotomy between the claims and perspectives of carers and those of people with disabilities, discuss its potential to avoid the shortcomings of either/or policy-making in this field, and highlight a number of limitations.

2.6.2 Overcoming the dependence/independence dichotomy

Described as ‘one of the most popular theoretical perspectives within care research’ (Kröger 2009, p. 401), the ethics of care has been posed as a challenge to the marginalised position of care in modern society. Theorists in this perspective claim that giving and receiving care must be reconceived as normal and universal human experiences, rather than exceptions to, or deviations from, the liberal norm of autonomy, independence, self-sufficiency and ‘privileged irresponsibility’ (Tronto 1993, p. 121; Sevenhuijsen 1998, p. 28; Sevenhuijsen 2003, pp. 183–4). This means conceiving of care as a ‘central concern of human life’, rather than ‘a parochial concern of women, a type of secondary moral question, or the work of the least well off in society’ (Tronto 1993, p. 180). This echoes the assumption advanced in the universal caregiver model of the family that all people have caring responsibilities, and these responsibilities should be equally borne by women
and men (Fraser 1994). However, the ethics of care perspective entails a greater focus on the need to receive care, conceptualising dependency as a normal state that is ‘an integral part of human existence’ rather than ‘something which can suddenly overtake us’ (Sevenhuijsen 1998, p. 147). This, too, constitutes a challenge to the norm of the autonomous, independent man. As Sevenhuijsen (ibid., pp. 139–40) explains:

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

Ethics of care scholars propose the concept of interdependence to replace the binary concepts of independence (the caregiver) and dependence (the care-receiver) that comprise the traditional model of care, and which raise major concerns from a disability rights perspective. Interdependence recognises that, ‘[w]e are all, after all, neither just givers nor receivers, but at some level, the givers and receivers of care to and from others’ (Williams 2001, pp. 486–7; Lynch, Baker & Cantillon 2009, p. 32; although see Kittay 1999, p. 180). This also begins to address the concerns of some scholars working at the intersection of feminism and disability rights that neither perspective adequately accounts for the experience of women with disabilities, who are often involved in both giving and using care or support (Morris 1991b; Lloyd M 2001; Rummery 2011). Fine and Glendinning (2005, p. 612) clarify that interdependence is not only intended to signify contemporaneous reciprocity; it also encompasses ‘exchanges between dependent actors over time, and the networking of these relations of dependence’. Consequently, the recognition of interdependence in the ethics of care ‘is not to deny but to acknowledge relations of dependence’ (ibid., p. 612; see also Kittay 1999, pp. 67–8).

From this perspective, care is conceived of as an ethical orientation ‘in which mutuality, reciprocity and tactility are the mainsprings of moral life’ (Hughes et al. 2005, p. 263). Fisher and Tronto (1990) influentially characterised care ‘as a continuous social process’ (Sevenhuijsen 2003, p. 184) and proposed four phases of care and associated values of ethical care. They are, ‘caring about’ (attentiveness to what is required for ‘continuity, maintenance and repair’), ‘taking care of’ (‘responsibility for initiating and maintaining caring activities’), ‘caregiving’ (‘the concrete tasks, the hands-on work of maintenance and repair’) and ‘care-receiving’ (‘the responses to the caring process of those to whom caring is directed’) (Fisher & Tronto 1990, pp. 40–42). This characterisation of care as
‘an ethical form of social relationships’ (Beckett 2007, p. 372) originated in the work of psychologist Carol Gilligan (1982; see Williams 2001, p. 475; Kröger 2009, p. 402). Gilligan posited that women and men are guided by different moral frameworks. While men’s decision-making is concerned with justice, in the sense of ‘rights and rules’ determined via rational detachment and abstract principles, women are morally oriented towards care, meaning their decision-making is relational, being focused on ‘responsibility and relationships’ (Gilligan 1982, p. 19; Fine 2007, p. 140). Scholars have been critical of the gender essentialism of Gilligan’s perspective, but Barnes (2012, p. 18) explains that a valuable insight of this work was that ‘care and care ethics are grounded in everyday interactions where moral decisions have to be made’, rather than being based in logical, detached argumentation.

Gilligan’s initial concern with personal morality established care and justice – and, by extension, care and equality – as opposing concepts (Lynch, Baker & Cantillon 2009, p. 30). This was criticised as a major limitation of the ethics of care from a political perspective. However, a second generation of scholars elaborated on this work to argue for the political recognition of care, extending beyond a ‘feminist ethics of care’ to a ‘judicial or legal ethic of care’ (Beckett 2007, p. 372). These researchers, most notably Joan Tronto (1993, pp. 166–7) and Selma Sevenhuijsen (1998, p. 142), sought to position the recognition of care as a precondition to justice, arguing that a lack of recognition and valuing of care was a factor in women’s and, to a lesser extent, care recipients’, inequality (see Fine & Glendinning 2005, p. 605; Barnes 2012, p. 14). As Tronto (1993, p. 9) argues, ‘care can serve as both a moral value and as a basis for the political achievement of a good society’.

Williams (2001, p. 478) claims that the ‘universalist paradigm’ associated with a political ethics of care also ‘seems to offer much by way of argument for balancing the current preoccupation with the ethic of work’. This perspective seeks to establish care as a part of citizenship, along with paid work, meaning that care both contributes to citizenship – by teaching the ‘civic virtues of responsibility, trust, tolerance for human limitations and frailties, [and] acceptance of diversity’ – and necessitates citizenship rights in the giving and the receiving of care (ibid.; Knijn & Kremer 1997, p. 353; Pinto 2008, p. 125).
2.6.3 Reconciling ethics of care and disability rights perspectives

Since the early-2000s, a number of scholars from both the carer and disability rights perspectives have argued that the ethics of care offers a promising challenge to the traditional conceptualisation of care as a burden, and could help to overcome the stalemate between the interests of carers and those of people with disabilities (Morris 2001; Williams 2001; Watson et al. 2004; Beckett 2007; Kröger 2009; Kelly C 2011; Rummery 2011). Those interested in bringing together the ethics of care and disability rights perspectives point to significant similarities between them. For example, each entails a critique of the historical organisation of care, is troubled by the ‘simplistic binary relationship between “carers” and “the cared for”’ (Kröger 2009, p. 410), and has highlighted the fact that people’s subject positions are rarely this clear-cut (Williams 2001, p. 487; Shakespeare 2006, pp. 144–8; for example, Keith 1992; Morris 1993; Barnes 2006). Each perspective is also centrally concerned with addressing marginalisation. Kröger (2009, p. 406) describes this as a shared ‘paradigm of equality’, noting that the concepts of justice, rights and citizenship are common to both, especially since second generation care ethicists began to address the ‘false dichotomy’ between care and justice.

Both approaches also entail some level of critique of the norm of independence and autonomy in the traditional liberal sense, and seek to normalise interdependence and the need for support and care, although the disability rights movement has posed much less of a challenge to this norm than have feminists (Shakespeare 2000a; Williams 2001; Hughes et al. 2005; Kröger 2009; Rummery 2011). According to Hughes and his colleagues (2005, p. 266), the recognition of this commonality is crucial to addressing the marginalisation of both women with caring responsibilities and people with disabilities. This is because it is the comparison of both groups to the norm of the autonomous male that leads to their constitution ‘as flawed subjects; as inferior or defective men’ (for a slightly different view, see Morris 1993, p. 49). This is another commonality with the universal caregiver approach, which proposes the replacement of a (male) norm of the full-time worker-citizen with that of the (female) norm of the part-time worker/part-time carer citizen (Orloff 2008).

The two perspectives also complement one another, addressing some shortcomings of each. Shakespeare characterises the ethics of care as ‘a valuable correlative to the
independent living model’, because it challenges the sometimes excessive emphasis on independence in the disability rights perspective (Shakespeare 2000a, p. 63). It also maintains a critical focus on the assistance or support relationship, and accommodates people for whom a direct payment model is not appropriate. This includes, for instance, people who ‘want to be able to receive care from family and friends, or do not want the stress of employing their own workers, or may not be capable of the negotiation and responsibility which this involves’, as well as children (especially young children) who are not expected to, or are not considered capable of, making decisions alone about their care (Shakespeare 2000a, p. 63; Kröger 2009, p. 410). This leaves open a space for the recognition of relationships or arrangements that might be deemed unacceptable in a strict disability rights perspective, and guards against the undervaluing of women’s care that is identified as a risk of the disability rights focus on independent living.

Rummery (2011) suggests that the two perspectives complement one another in other respects. She claims that an ethics of care ensures that the moral and emotional aspects of care are addressed in formal and informal care relationships, while the introduction of notions of choice and control from the disability rights perspective not only puts people with disabilities ‘in a much stronger position to ensure that the care they receive is attentive, competent and responsive’, but also puts carers ‘in a much stronger position to be able to be attentive, competent, responsive and take responsibility for people’ (ibid., p. 148). Shakespeare (2000a) similarly notes the mutual benefit of the notion of interdependence. He acknowledges (ibid., p. 64) that direct payments and personal assistance:

cannot solve all the problems. Disabled people and others still often depend on good will and mutual aid, as all people do. The danger comes when disabled people have no choice and no alternative, and are reliant on unresponsive services or demeaning charity which renders them marginalized and dependent. Yet empowered disabled people will achieve a better quality of life in a community in which each recognizes their responsibility to the other, rather than a world made up of competing and selfish individuals seeking to maximize their own advantage.

Morris (2001) suggests that the ethics of care and disability rights perspectives can be reconciled if a consideration of the human rights of people with disabilities is incorporated into an ethics of care perspective. This addresses the criticism that neither perspective adequately accounts for the effects of impairment (Watson et al. 2004).
Morris argues that the ethics of care’s emphasis on the universality of dependence (through its prioritisation of interdependence) fails to acknowledge that impairment produces ‘qualitative differences’ in experience – such as pain and shorter life expectancy – and that both impairment and disabling barriers produce higher needs for assistance and support, and higher costs of daily living (Morris 2001, pp. 12–13). That is, theorising care as a universal need means little guidance is offered in terms of how to measure or account for different care needs. In discussing some difficulties in reconciling the ethics of care and disability rights perspectives, Rummery and Fine make a related point that ‘an ethic of care is arguably most important where there is the least reciprocity’, meaning there must be ‘[s]ome recognition of the need for care without care being oppressive’ (Rummery & Fine 2012, p. 328; emphasis in original). Morris (1991a, p. 10) also argues that the disability rights literature must redress its own neglect of ‘the personal experience of physical or intellectual restrictions, of illness, of the fear of dying’. This has been characterised as a consequence of ‘narrow and instrumental reading of the social model’ that identifies the external causes of disability alone and downplays the consequences of impairment (Watson et al. 2004, p. 338; Degener 2016).

Morris (2001) proposes a human rights approach to disability as a way to reincorporate impairment into both perspectives without falling back on problematic notions of dependency or burden. She argues in favour of ‘an ethics of care which recognizes our common humanity and the consequences for all of us of a denial of human rights’ (ibid., p. 13). In this model, impairment is conceptualised as an element of human diversity, rather than an aberration from normal health. The impacts of impairment are not denied, but nor are they characterised as burdensome or tragic. This model establishes people with disabilities as active holders of rights who have a legitimate claim on the state, rather than ‘objects of welfare’ or passive dependents (ibid.). This shifts the focus from fixing or accommodating the differences of persons with disabilities to providing the resources necessary to ensure that all people can exercise their human rights.

The human rights model of disability has been characterised as an extension of the social model of disability. Like the social model, it ‘locates the main “problem” outside the person and in society’, and emphasises the responsibility of society (and the state) to address the social causes of disability (Quinn & Degener 2002, p. 14). Morris (2001, p. 13) argues that such a model also acknowledges that ‘some people’s experience of their bodies (their impairment) places them at much greater risk of losing their human (and
civil) rights than the majority of the population’. However, ‘the recognition of our difference becomes the gateway to the provision of what we require in order to access our human and civil rights’, when in the past it has often been used to deny those rights (ibid., p. 12). As in the ethics of care, needs are reconceptualised as inevitable aspects of human life, rather than a consequence of deficiencies. That is, both the ethics of care and the human rights model focus on ‘what we all share in common’ (ibid., p. 11). However, the human rights model offers one key innovation – rather than emphasising that we are all dependent and needy at least sometimes, it emphasises all people’s shared dignity and human rights, broadly defined as the right to what is needed to live life with dignity (see Kröger 2009, p. 414). This shift in focus specifically addresses concerns that the ethics of care preserves problematic notions of dependence and neediness (Silvers 1995).

2.6.4 Policies to achieve an ethics of care/disability rights reconciliation

Ethics of care scholars and disability rights scholars have proposed a range of policy changes that would be required to implement these alternative, preferable conceptualisations of care and disability. Williams (2001, p. 478) argues that adopting a construction of care consistent with the ethics of care means assuming that we all have ‘the potential and responsibility to be caring and cared for’. According to Barnes (2012, p. 13), this recognition means that ‘we cannot and should not confine the need for care to a group of people who are defined and distinguished specifically by their need for care’. She argues that the policy implication of this ‘is that a fundamental responsibility of states is to ensure that all receive the care that is necessary to survival and growth, not only for the benefit of the individuals themselves, but for that of society as a whole’. This means a focus on ‘the well-being of all’, rather than only those deemed dependent or needy (ibid., p. 15). Sevenhuijsen (2000, p. 22) notes that adopting an ethics of care means that ‘democratic societies should take it as falling within the range of their political responsibilities to guarantee equality of access to all its members to the most important spheres of social life, not only work and education, but also informal care, health care, education, leisure and political decision-making’.

According to Berridge (2012, p. 15), a ‘public ethic of care’ would ‘locate responsibility for care in the public sphere where the work of care is assigned value because it is a public good and a demanding, skilled activity’. Williams claims that realising a political ethics of care would involve more than ‘income maintenance benefits and social services
provision’, requiring also ‘time, financial and practical support and the recognition of choices’ (Williams 2001, p. 487). This includes time to give care to others, time to participate in paid employment and be economically self-sufficient, and time for care of the self. Williams proposes a suite of complementary policies in this regard, including policies to prevent poverty and discrimination, and policies to facilitate access to public space and work (id.). Knijn and Kremer (1997, p. 354) also emphasise that resources, including ‘time, money, rest, respite, and being involved in a (formal and informal) support network’, would be needed to ensure both a right to time to care and the right to receive care.

Rummery (2011, pp. 142–4) argues that policies combining ethics of care principles with disability rights principles would have a number of features, including being flexible (that is, they can be used to pay for any combination of formal care services and informal/family care, and do not simply refamilialise care), well-regulated (to ensure that they are used to purchase care and support, that care workers are not exploited, and that care is of good quality), and sufficiently, if not generously, funded. Direct payments with these features would offer people ‘choice about which caring tasks they undertake (or want unpaid carers to undertake) and which they “outsourced” to formal carers’ (ibid., p. 148). Pinto (2008, p. 125) also emphasises the importance of choice for all parties, which requires ‘adequate supports and real possibilities so that caregivers and care-receivers can choose the care arrangements that best suit their preferences and needs’. This is the only way to ensure that care relationships are ‘supportive and empowering’, and not ‘patronizing and oppressive’ (id.).

In proposing a reconciliation of the ethics of care and disability rights perspectives through a human rights model of disability, Morris (2001, p. 15) acknowledges that the exact content of the human rights held by people with disabilities is ‘not an entirely simple question’. She does not propose specific policies or other actions necessary to achieve those rights, but rather suggests that these particularities are less important than the power of the human rights discourse to establish all people’s common humanity and establish that additional resources are sometimes required to provide equal access to all people (id.; see also Pinto 2008). Both Morris (2004) and Kröger (2009) do identify the right to support and assistance in particular as essential to the exercise of other rights – effectively, these are characterised as a precursor to the exercise of a broader range of human rights. Morris gives the example of the right to a family life and the right to
privacy, both of which can only be exercised if a person can access the support they require to live in a residential setting (Morris 2004, p. 428). Twenty years earlier, Morris (1993, p. 162) similarly argued that access to independent living relates to ‘both human and civil rights’, because without ‘control over the very basic activities of daily living then [disabled people] cannot hope even to begin to participate in society on an equal basis’.

2.6.5 Limitations of care/independence reconciliation efforts

Some conceptual differences between the ethics of care and disability rights perspectives have not been satisfactorily addressed in the literature. Most of these criticisms relate to the preservation of the concepts of care and dependency in the ethics of care perspective, and the importance of independence in the disability rights perspective. First, while those promoting an ethics of care advance a reconceptualisation of care as a universal aspect of interdependence, some critics claim that most of the ethics of care literature nevertheless focuses on the perspective of the caregiver, and on relationships in which one (largely independent) person primarily provides care, while another (largely dependent) person primarily receives it (Lloyd L 2006, p. 1183). This means that the power inequality at the heart of the caring relationship is not adequately addressed (Hughes et al. 2005, p. 271; Beasley & Bacchi 2007, pp. 284–5). It also means that ‘it is sometimes assumed that all disabled people need care of a kind or to a degree that non-disabled people do not need’ (Lynch, Baker & Cantillon 2009, p. 31). In this regard, Shakespeare (2000a, pp. 62–63) suggests that ethics of care theorists have failed to ‘break the link between physical and social dependency’ – by characterising care as necessary, they do not contemplate care itself as a cause of disability in the sense established in the social model of disability.

In a related criticism, some disability activists and researchers have been adamant that attempts by ethics of care theorists to repurpose care as a ‘positional ethics’ cannot overcome the shortcomings of the concept (Silvers 1995, p. 31; Morris 1997, p. 54; Kröger 2009, p. 399). The assumption and requirement of dependency in the ethics of care perspective – and its support for the provision of care that perpetuates relations of dependency – is deemed to be inherently problematic. Silvers (1995) is particularly insistent that the historical connection between dependency and vulnerability and the marginalisation of people with disabilities means that these concepts cannot be deployed in the name of equality (see also Williams 2001, p. 479). This contrasts with Kittay’s
assertion that accepting dependency as ‘an aspect of what it is to be the sorts of beings we are’ could lead to a positive reconceptualisation of disability as part of ‘the species norm’. Tronto (1993, p. 120) has similarly suggested that people who receive care are only devalued and characterised as needy because dependency is presumed to be an undesirable state when set against the ideal of autonomy (see also White & Tronto 2004, pp. 433–4).

The ethics of care’s emphasis on interdependence and the universality of dependency has also been dismissed as ‘idealistic’ because it ignores both the immediate reality of the disempowerment of people with disabilities (Shakespeare 2000a, p. 63) and the importance of independence in ‘collective struggles around care’ (Williams 2001, p. 481). However, this emphasis on individual independence is completely contradictory to the ethics of care’s emphasis on interdependence. As Watson and his colleagues (2004, p. 339) argue, such an approach ‘does not adequately observe the role of interpersonal relations between parties… [and] invests need and power unilaterally in the receipt of care and assumes a mechanical relationship in which intimacy is eclipsed’ (see also Barnes 2006, p. 147). In doing so, there is a risk that ‘the possibility of an ethic of care and responsibility in which many feminists place much hope’ will be closed off (Hughes et al. 2005, p. 263).

Rummery (2011, p. 141) succinctly explains the apparently intractable difference between the perspectives, saying that, ‘care ethicists would like to see both the emotional and practical aspect of caring properly legitimised and valued’, while ‘disability activists would like to see “care” removed altogether and replaced with a notion of independence that involves being in control of the type of support individuals receive’ (see also Barnes 2006, p. 147). Williams (2001, p. 481) argues along similar lines that:

whereas it is possible to argue that, in the longer term, disabled people’s (and older people’s and children’s) interests would be better served by a society that valued interdependence and acknowledged the vulnerability of all, the immediate strategy for disabled people is for rights to secure the conditions for independence.

This inconsistency means that each perspective, and even each attempt to reconcile them, tends to place the concerns of one constituency above those of others (Watson et al. 2004, pp. 332, 339; Kröger 2009, p. 405). Even Morris’s (2001) attempt to accommodate disability rights within an ethics of care is focused on the human rights of persons with
disabilities as recipients of care or support, rather than the rights of those providing care or support (although she does challenge this binary in one sense, by pointing to women’s often contemporaneous roles in giving and using care or support). Ethics of care/disability rights reconciliation efforts have also failed to offer a holistic response to Wollstonecraft’s dilemma, as the primary focus of the literature has been on reconceptualising care, with less attention being paid to how care and paid work might fit together (cf. Williams 2001). Consequently, this approach is insufficient to overcome the multiple lines of fragmentation of care policy.

2.7 This study

In this review and analysis of the literature, I have demonstrated the scope and significance of two key sources of tension in care and support policy, and established the limitations of either/or policy-making in terms of advancing the divergent interests of different care constituencies. I have also identified a number of shortcomings of previous attempts to overcome these tensions and the competing conceptualisations of gender equality, care and disability underpinning them. This gives rise to the study’s primary research question:

1. How can the tensions between unpaid care and paid work, and between the interests of carers and people with disabilities, be better managed in care and support policy?

In the next chapter, I propose the care and support rights principles as a framework for evaluating and formulating policies that better manage these tensions, avoiding either/or policy-making and promoting equal care and support rights for all. In order to assess and establish the need for, and utility of, the principles for this purpose in the contemporary Australian context, I pose two further research questions, which I address in chapters 5–7 and chapter 8 respectively:

2. How do the tensions between unpaid care and paid work, and between the interests of carers and people with disabilities, manifest in Australian policy? What are the consequences for different care constituencies?

3. How could the proposed care and support rights principles resolve the care policy tensions, and produce equitable outcomes for multiple constituencies, in a practical policy context?
3. A new set of policy principles for equal care and support rights

3.1 Overview

In this chapter, I propose a new set of principles to guide the evaluation and design of care and support policy. The principles have two purposes. First, they provide a set of criteria for evaluating the extent to which existing policies encompass the concerns of multiple care and disability perspectives, particularly whether they resolve the tensions between supporting unpaid care and paid work, and between the claims of carers and those of people with disabilities. Secondly, the principles can inform the design or reform of policies to produce more equitable outcomes for people in care and support relationships, specifically by promoting equal social citizenship rights to care and support for all parties.

I begin this chapter by discussing why I have characterised the principles as essential components of equal citizenship rights to give and obtain care and support rather than, for instance, focusing on care and support needs or human rights. I then identify six key principles to guide the evaluation and design of policies that resolve care policy tensions and promote equal care and support rights. The principles bring together key elements from the previous efforts to reconcile competing perspectives on gender equality in unpaid care and paid work, and competing perspectives on the meaning of care and disability, that I outlined in chapter 2.

In formulating the principles, I have emphasised and developed the commonalities between these reconciliation literatures, such as a common concern with rights, justice, equality and the rejection of male, non-disabled standards of social participation. The principles also incorporate, as far as possible, the different reconceptualisations of gender equality, care and disability that these perspectives offer. I draw different principles from different perspectives, and augment some of them to address the limitations of previous reconciliation efforts. As I discussed in chapter 2, this is also a social constructionist exercise, because it involves synthesising different approaches rather than prioritising one over the other, in order to formulate a set of principles that can ‘intervene in [the] real struggles’ of the diverse groups impacted by these policies (McHoul & Grace 1993, p. 35).
3.2 Citizenship rights to care and support

3.2.1 Overview

Different care constituencies may disagree on the nature and purpose of their claims, but Williams (2010, p. 5) notes that they share a common pursuit of social rights. Both citizenship rights and human rights discourses are drawn upon in the different perspectives discussed in chapter 2, and alternative discourses, particularly a discourse of need, also arise. In this section, I outline the relative merits of social citizenship rights, human rights, and needs-based approaches to care and support policy, and the major feminist and disability rights criticisms of each. This discussion is not intended to be comprehensive, as this would be beyond the scope of the thesis. Rather, it is intended to demonstrate that a set of principles for advancing social citizenship rights to care and support can effectively draw together and reconcile the different care and disability perspectives discussed in chapter 2, and offer a useful backbone for designing policies to meet the claims of multiple constituencies.

3.2.2 The focus on citizenship rights in relation to care

Scholars in the feminist social policy, political ethics of care and universal caregiver perspectives utilise the language and concepts of citizenship (and specifically social citizenship) rights relating to care, or discuss policy as a means to meet needs, rather than rights, associated with care. I noted in chapter 2 that Wollstonecraft’s dilemma arises from different feminist conceptualisations of citizenship, particularly different responses to women’s traditional exclusion from full citizenship associated with their caring roles (Pateman 1988). Much of the feminist social policy literature emphasises the importance of ‘citizenship’ and ‘social’ rights for transforming prevailing policy approaches to care and achieving greater equality in women’s and men’s sharing of unpaid care (for example, Cass 1995; Jenson & Jacobzone 2000; Gornick & Meyers 2008). Rights are also identified as key in the universal caregiver literature; Rubery (2015, pp. 533–4) refers to a range of ‘rights’ necessary to establish welfare and employment systems based on a universal caregiver model, such as a right to social protection and a right to equal pay. Nancy Fraser’s (1994) initial proposal of a universal caregiver model did not use the language of either rights or needs, although her problematisation of women’s caring responsibilities assumes that children and others have care needs that give rise to those responsibilities. From an ethics of care perspective, Sevenhuijsen (2000, p. 18) proposes that:
Caring practices should form part of a citizenship status, not only because citizenship arranges the rights and obligations that are connected to parenting and parent–child relationships, but also because the status of citizenship should be built upon the recognition of the need for intimate desires, pleasures and “being in the world”.

Williams (2001, pp. 468, 487) refers to a political ethic of care as affording an ‘inclusive citizenship’ that better incorporates ‘care needs’ and complements the other element of ‘welfare citizenship’, namely, the ethic of work. Knijn and Kremer (1997) propose both a citizenship right to time to care and a citizenship right to receive care. Rummery and Fine (2012, p. 326) characterise the ‘justice’ model underpinning the ethics of care as being concerned with ‘social rights associated with care’.

This focus on citizenship rights, and specifically social rights, reflects the origins of most of this literature in social policy and associated traditions. Hartley Dean (2007) observes that the discipline of social policy has been mainly concerned with citizenship rights in the sense coined by T H Marshall (1963). Marshall referred to a triad of ‘civil or legal rights, political or democratic rights and social or welfare rights’ (Dean H 2007, p. 1) that ‘defines the (legal) position of the individual in a modern nation state’ (Davy 2014, p. 207). According to Marshall (1963, p. 74), the social element of citizenship entails ‘the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society’. He highlighted the education system and social services as key institutions for the delivery of social citizenship rights (id.).

Marshall (ibid., p. 99) characterised social or welfare rights as the most recent of the citizenship rights, arising from the establishment of the welfare state in the 20th century. These rights ‘conferred a new form of status equality by which all members, by virtue of being ensured a minimum of economic resources, could be full participants in their society’ (Shaver 2002, p. 332). In other words, social rights are ‘rights to resources to meet an individual’s needs’, which Rummery and Glendinning (2000, pp. 532–3) argue must include access to both income and services. Davy (2014, p. 208) identifies four key characteristics of Marshallian citizenship rights: they are ‘created, not god-given or inferred from reason’, they are individual, they are equally available to all ‘full members of the community of citizens’, and they are ‘granted by the nation state’.
In regard to the Australian case, Shaver claims that ‘Australian social citizenship is a substantial, though incomplete, representation of T.H. Marshall’s idealized vision’ (Shaver 2002, p. 332). It is incomplete because Australia’s welfare system is highly residual – it has always comprised a safety-net for the alleviation of poverty, meaning income support payments are targeted at those most in need, rather than being a universal entitlement (Smyth P 2010; Shaver 2002, p. 340). In addition, citizenship rights – and access to the resources associated with them – are commonly criticised for being partial and incomplete for women, and for women and men with disabilities. This is because women’s disproportionate responsibility for care, and the exclusion of women with caring responsibilities and people with disabilities from paid work, have precluded either group from being recognised as full citizens (Rummery & Glendinning 2000; see also Cass 1995; Oliver 2004). Some scholars argue that these citizenship rights have been further eroded over the last two decades by welfare-to-work reforms that have placed greater emphasis on individuals’ obligations to the state and society in terms of paid work participation. This means citizenship is connected ‘less with membership of social community than with participation in it, paradigmatically as an employed worker’ (Shaver 2002, p. 335; Cortis & Meagher 2009, p. 630).

3.2.3 Feminist concerns about rights-based approaches

Despite the emphasis on rights in much of the feminist literature discussed in chapter 2, some feminist scholars have long expressed reservations about rights-based approaches to the pursuit of gender equality (Lynch, Baker & Cantillon 2009, p. 26). This is largely because traditional theories of rights were deemed to be individualistic, with rights being assumed to only apply to rational, autonomous (male) individuals (Lloyd L 2006, p. 1175; see also West 2003). The emotional and interrelational aspects of human life – central in the ethics of care – are alien to mainstream theories of rights and justice. Dependence and need have not been considered to be matters of right, but rather private requirements of ““other” weak or needy people’, like women, people with disabilities and older people (Lloyd L 2006, pp. 1175–6; see Sevenhuijsen 1998, pp. 130–1; Sevenhuijsen 2000, p. 14). Consequently, as West (2003, p. 90) notes, rights ‘have never been viewed, within liberalism, as a source of support for caregivers’. This has not been entirely the case in Australia – maternalist income support payments were supported by some feminist social policy scholars because they conferred citizenship entitlements on the basis of the caring role, albeit only partially, and in ways that assumed both women’s dependence on a

As I discussed in chapter 2, the ethics of care arose as a response to the emphasis on ‘male values and male power’ in theories of rights (Lynch, Baker & Cantillon 2009, p. 26). Berridge (2012, p. 10) explains that the ethics of care was initially ‘defined in opposition to ethics of justice’. The former – concerned with ‘responsibility and relationships’ rather than ‘rights and rules’ – was welcomed as a corrective to the latter’s neglect of human interdependence and forms of justice and morality with which at least some women identified (Gilligan 1982, p. 19; Koggel & Orme 2010, p. 109; Berridge 2012, p. 10).

Some scholars expressed concern that ‘attempts to codify care and bring it within the public domain of “justice” run the risk of divorcing it from its ethical and emotional roots’ (Rummery & Fine 2012, p. 330). However, White and Tronto (2004, p. 427) claim that ‘the vast majority of work on care argues for the necessity of justice to both the ethic and practice of care’.

Scholars proposing a political ethics of care have sought to challenge the dichotomy traditionally drawn between care and justice, arguing that justice can only be fully achieved if interdependence (and the care it necessitates for all people) is recognised and supported as a matter of right (Barnes 2006, p. 156; see section 2.6.2, above). Berridge (2012, p. 15), drawing on Ruddick (1998), claims that ‘justice is deprived of a language in which response to need becomes a matter of social justice’ if concepts of need and dependency are only thought of as relating to care. Fraser (1989, p. 182) cites similar arguments that rights should be emphasised over needs because the former, and not the latter, include ‘assumptions of entitlement’ and have ‘egalitarian implications’ (see also Fiske & Briskman 2007). On this basis, Fraser (1989, p. 183) argues that ‘translating justified needs claims into social rights’ is the most promising way to pursue democratic social change. Waldron (1996, p. 105) argues that a discourse of rights has a key advantage, namely, that ‘by taking needs… as a basis for rights, rather than an alternative to rights… we can give them a certain integrity and dignity that claims of need do not always have on their own’.

White and Tronto (2004, p. 433) suggest that an acceptance of the universality of neediness and interdependence as the norm, rather than autonomy, challenges the subordinate place of needs vis-à-vis rights (see also Lynch, Baker & Cantillon 2009,
However, Fine and Glendinning (2005, p. 611) caution that concepts like interdependence may be problematic if they simply ‘pose the issue as inter-personal and effectively preclude the role of the state in managing risk and regulating resources and behaviours’ – this does not offer a discourse to argue for the resources required by people with particular needs. A claim to rights, on the other hand, brings care out of ‘the private world in which [it] is usually understood to operate’ (Barnes 2006, p. 152), addressing the calls of both feminists and disability rights activists for public recognition and support of the traditionally private activities of care and support (see also Williams 2001, pp. 487–8).

3.2.4 Alternative rights discourses from disability rights activism and scholarship

Calls for social or welfare rights have also raised issues from a disability rights perspective. The disability rights movement has focused largely on securing the civil rights of people with disabilities (Kröger 2009, p. 405; Degener 2016, p. 4), which Rummery and Glendinning (2000, p. 532) explain ‘are those rights protected by law, which govern an individual’s relationship with the state and with other citizens’. The movement’s insistence on disrupting the link between social welfare provision and the problematic construction of people with disabilities as dependent objects of care, charity and welfare meant that the pursuit of social rights was generally avoided (Degener 2016). However, some scholars have characterised claims for a right to personal assistance and direct funding as claims for social or citizenship rights, albeit social rights that emphasise choice and control rather than dependency (for example, Krogh 2004; Beckett 2007; Degener 2016).

Some scholars in this field have also prioritised the language of human rights in disability rights claims-making (for example, Morris 1993, 2001; Watson et al. 2004), and this has come into greater focus with the coining of the human rights model of disability. This model draws on international human rights instruments to identify rights in the two traditional categories of ‘civil and political’ and ‘economic, social and cultural’ human rights (Dean H 2007; Degener 2016). In this perspective, the right to personal assistance or support is recognised as both a human right in and of itself, and an important facilitator of the exercise of other rights (Morris 2004, p. 428). Turner (1993, p. 498) argues that human rights have a distinctly different character to citizenship rights – for instance, they
are considered to be universal and international, rather than being linked to recognition by a single nation-state.

Davy (2014, p. 205) observes that the concept of citizenship has been given numerous meanings by sociologists, legal scholars and political scientists, but that ‘citizenship concepts seldom connect citizenship and international human rights’. Hartley Dean (2007, p. 1) has attempted to bridge this divide from a social policy perspective. He first claims that citizenship rights ‘provided the foundations upon which modern global conceptions of human rights have been constructed’. He then suggests that one of the two key categories of human rights – the social, economic and cultural rights – is ‘loosely captured’ by the social or welfare citizenship rights described by Marshall (ibid., p. 2; see also Dean H 2002). On this basis, he argues that the welfare ‘right to social care’ corresponds with ‘a right to asylum from the risks of impairment and isolation associated with disability’ (Dean H 2007, p. 8). Degener (2016, p. 6) makes a similar claim that rights to disability support (specifically independent living and personal assistance) do not have their roots in traditional human rights principles, but rather arose as a claim for citizenship rights. However, she claims that this right can nevertheless be understood within the human rights framework as one of the economic, social and cultural rights.

3.2.5 Conclusion: a focus on social citizenship rights to care and support

Each of the academic perspectives that I seek to reconcile in this study is concerned to some extent with social citizenship rights relating to care and support. On this basis, I characterise the proposed principles for resolving care policy tensions as essential elements of policy to advance equal citizenship rights to care and support. This also ensures that the principles are easily applicable to social policy analysis and design. Given the importance of the human rights model of disability to reconciling the ethics of care and disability rights perspectives, I expressly identify this model in the principles as key to the realisation of the citizenship right to obtain care or support (see section 3.3.7, below).

I use both ‘care’ and ‘support’ in conceptualising these rights, and the verb ‘to obtain’ rather than ‘to receive’, to acknowledge disability rights concerns with the disempowering nature of care, while not denying feminist and care ethicists’ arguments that care is a necessary and valuable aspect of life (see for example Finkelstein 1998; Shakespeare 2000b; Fine & Glendinning 2005; Kröger 2009). This also means that
situations in which ‘care’ and, by extension, dependency, are considered to be less problematic – such as childcare – are not excluded from the principles, while also keeping open the option of support, assistance and independence where it is desired. While I noted in chapter 2 that a number of alternatives to care have been proposed in the disability literature, I have selected ‘support’ rather than the other most commonly used concept, ‘assistance’ (Watson et al. 2004). This is because the latter could be construed overly narrowly to refer to personal assistance, that is, employing someone to perform a range of practical tasks to facilitate independent living. This would potentially undermine the importance of interdependence and the complexity of the care or support requirements of some people (Shakespeare 2008, p. 136), and preclude policy that creates other options like support from family when it is chosen by all parties (Kröger 2009, p. 409).

3.3 Six principles for policies to deliver care and support rights

3.3.1 Introduction

In this section, I introduce the six care and support rights principles (set out in fig. 3.1, below). Each principle captures an element of policy that is identified in one or more of these literatures as key to resolving care policy tensions and producing better outcomes for one or more constituencies. In doing so, the principles incorporate the more beneficial conceptualisations of gender equality, care and disability proposed in those literatures. The principles also offer ways to overcome some of the key limitations of these prior efforts. They are, first, that each of the universal caregiver, ethics of care and disability rights perspectives tends to focus on one side of care and assistance relationship over the other; secondly, the absence of meaningful choice about unpaid care and paid work combinations in the universal caregiver approach; and, thirdly, the persistence of a dependence/independence dichotomy in the ethics of care and disability rights perspectives.

Each principle invites a consideration of how the right to give care or support interacts with the right to participate in paid work, incorporating the care/work tension at the heart of Wollstonecraft’s dilemma, and protecting against fragmentation in this regard. Each principle also provides guidance on what is required to extend equal rights both to people giving, and to people obtaining, care or support. This is intended to encourage policy that addresses the rights of all parties simultaneously, rather than prioritising one over the other, or assuming that people are necessarily only giving or obtaining care or support.
(and are either independent or dependent) (Morris 1997; Barnes 2006). In doing so, the principles also guard against fragmentation along the carer/people with disabilities axis.

### 3.3.2 Access to financial resources

Access to financial resources, meaning cash ‘paid in substitute for care services and support’, is the first crucial principle for designing policies to afford equal rights to give and obtain care and support (Rummery 2011, p. 138). Direct payments have been central to disability rights claims for policy that affords rights to personal assistance, independent living and support, and gives choice and control to people with disabilities and older people regarding the type of care and support they obtain (for example, Morris 1993, p. 162; Shakespeare 2000a). Scholars seeking to reconcile disability rights and ethics of care perspectives note that payments can also extend choice and control to people giving care or support (Rummery 2011). Proposals for a universal caregiver model also identify access to material resources, and equality of income between women and men, as key to equalising the gender division of labour (Fraser 1994, p. 604; Rubery 2015, p. 532). Finally, ethics of care scholars, and others concerned with feminist social policy, have argued that unpaid care and paid work must be valued more equally in order to establish the legitimacy of care as a citizenship activity (Cass 1995; O’Connor J, Orloff & Shaver 1999; Jenson & Jacobzone 2000; Williams 2001).

Payments would need to have several specific features to afford equal rights to different constituencies. First, financial support will only deliver care and support rights if it is paid at a high enough rate to prevent poverty and exploitation (Fraser 1994, pp. 596–7). Furthermore, payments should be generous enough to offer a meaningful choice to all parties. This means, first, that payments should give meaningful choice about whether someone will give care or support, meaning there should not be a financial penalty for choosing to give care or support over paid work. Secondly, payments should give meaningful choice about the care or support that someone obtains, meaning people with disabilities and other care or support users should be able to purchase or reimburse different combinations of informal or formal providers (Rummery 2011). In order to further secure the rights of people giving care or support, access to payments should not be contingent on their paid work participation by, for instance, being limited to people who meet welfare-to-work requirements. This can further ensure that mothers and other carers have real and expansive choice about whether they provide unpaid care or participate in paid work, and in what combinations. This is also necessary to ensure that
Figure 3.1: The six care and support rights principles

- Access to financial resources
- Access to alternative sources of care and support
- Flexibility
- Time
- Voice
- Positive recognition of difference
people in caring roles have long-term financial security regardless of how they combine care and paid work over the life course (Rubery 2015, p. 533). To give caregivers a meaningful choice between unpaid care and paid work, access to resources needs to extend beyond welfare or social benefit payments to the resources associated with paid work. This suggests the need for reforms beyond care and support policy. In particular, inequalities in the valuing of women’s paid work (such as the gender pay gap and the undervaluation of work in female-dominated industries) should be addressed to ensure that women have meaningful choice about how they combine unpaid care and paid work (Rubery 2015, p. 530; Pocock, Charlesworth & Chapman 2013).

Care and support policy design can also directly address the undervaluation of one traditionally female-dominated field – care and support work. This requires payments that are high enough to enable care or support users to pay a sufficient wage to attract quality workers and offer decent and secure work. Such payments can ensure that the right (and choice) to obtain care and support does not come at the expense of the rights of those providing it (Ungerson 1997a; Hughes et al. 2005; Macdonald & Charlesworth 2016). All parties will likely benefit from such arrangements, because decent pay and conditions are also more likely to lead to good quality care or support (Knijn & Kremer 1997, p. 355; Rummery & Fine 2012, p. 337). Complementary reforms to employment policy may also be necessary in this regard, such as a ‘re-evaluation… of the principles that govern the recruitment, pay, conditions and training of care workers’ (Williams 2001, p. 487).

Characterising access to cash payments as an essential element of policy to afford care and support rights clearly establishes the state’s responsibility for providing the resources necessary for these activities and requirements (Williams 2001, pp. 487–8). This means that care and support are recognised as a ‘social good’, and that the social solidarity expressed through citizenship entitlements extends to relations of care and support, rather than being confined to paid work participation (Sevenhuijsen 2000; Daly 2002; Lynch, Baker & Lyons 2009). Rubery (2015, p. 529) argues that state funding of care services and entitlements is also essential to remove the incentive for employers to discriminate against people with ‘greater’ resource needs than the traditional unencumbered worker – that is, neither disability, nor responsibility for care, would be cause for employers to discriminate if the resources required by people in either situation are guaranteed by government.
3.3.3 Access to alternative sources of care and support

An essential complement to rights-based cash payments is the availability of quality, affordable and personalisable care and support services (Rummery & Glendinning 2000). Financial resources will only be useful, and will only provide meaningful choice and control to both those giving and those obtaining care or support, if people have something to spend them on. That is, policy should create ‘variety’ in the care and support available, and these options should be of high quality (Williams 2001, p. 488). Access to services is discussed as a key policy element in each of the universal caregiver, disability rights and ethics of care perspectives.

Access to alternative care and support arrangements is important to ensure that people’s choices about the care or support they give or obtain is not curtailed, and to ensure that neither party is stuck in an arrangement that is disempowering or not of their choosing. As Rummery (2011, p. 148) explains:

if carers feel ‘trapped’ into providing care then both the practical and emotional aspects of care giving will feel exploitative and abusive. If those who are cared-for feel ‘trapped’ into receiving care that they are not in control of, they will feel exploited and abused.

When combined with sufficient funding of cash payments, policies that offer access to a variety of services can create the possibility of ‘exit’ for those giving and those obtaining care or support (Ungerson 1999, pp. 594–5; Williams 2001, p. 482). It is particularly important that unpaid family care is not the only option available, in light of the agreement across perspectives that this is ‘the worst case scenario’ for all parties to care relationships (Kröger 2009, p. 409).

The possibility of exit ensures that all people with disabilities or other care or support requirements have real options about who provides care or support and, by extension, greater control over how they live their lives (Wood 1991; Barnes 2006). It ensures that people will not be placed in a position of depending on a family member or other sole provider of care and support (Morris 1997, p. 56). While unpaid care should not be the only option, cash payments should be available to pay family members or friends to ensure that this choice is also available where appropriate (such as parental care for children, or care and support arrangements between adults that are mutually desired). This illustrates the importance of advancing both rights simultaneously in care and support policy – the right to obtain unpaid (family) care or support will only be available where
the right to give that care or support is also facilitated (see Knijn & Kremer 1997, p. 354).

Rummery and Fine (2012, p. 331) suggest that care or support users who have a choice about ‘the type of care they receive (including who provides that care, what they do, and how and when they do it)’ are ‘also freer to fulfil the moral and ethical dimensions of being a “good” recipient of care’. Access to a variety of services or support options is also important for those who do not wish to claim cash payments for giving or obtaining care and support. For instance, Shakespeare (2000a) observes that not all people with disabilities will want or be able to be individually responsible for managing their own budgets. This means support for decision-making, and case management, may also be needed to ensure the right to care and support can be exercised by all.

Policies that offer variety and the power of exit can also give people with unpaid caring roles a real choice about whether, and the extent to which, they provide care or support. This addresses the concerns of feminist social policy scholars that policies that support unpaid care institutionalise women’s caring roles and discourage (or at least fail to facilitate) women’s paid work participation (Leitner 2003; Jenson & Jacobzone 2000; Williams 2010). It thereby partially meets the dimension of ‘opportunities’ – specifically by providing opportunities to redistribute care – identified by Rubery (2015, p. 522) as a key element of gender equality. Access to a variety of services can also protect against marginalisation, meaning exclusion from social participation, which Fraser (1994, p. 599) argues is also necessary for overcoming gender inequality in the distribution of unpaid care and paid work.

Giving unpaid caregivers options other than full-time care can also ensure that they do not individually bear responsibility for the risks associated with giving care and support, such as reduced capacity to earn a sufficient income through paid work (for example, Daly 2001; Ferguson 2007; Foster et al. 2012; Bowman, Bodsworth & Zinn 2013). An important complement to this is access to opportunities (or variety) regarding paid work – as I touched on above in relation to paid care or support workers, all jobs must be of sufficient quality, security and remuneration to make paid work participation a worthwhile alternative to unpaid care, and to avoid locking women into low-paid and insecure work in any field (Rubery 2015, pp. 527–8; see also Williams 2001).

The rights to give and obtain care or support will only be simultaneously available if alternative sources of care or support are accessible, affordable, and of high quality (Knijn
Governments in many parts of the world have prioritised efficiency through the privatisation and marketisation of care provision, and some scholars have claimed that regulation is necessary to ensure that the moral and ethical dimensions of care are not sacrificed to economic principles (Rummery & Fine 2012). Regulation can also ensure that cash payments are actually used to purchase care and support, that care workers are not exploited, and that the care provided is of good quality and does not become ‘incompetent and unresponsive’ (Rummery 2011, p. 147; Macdonald & Charlesworth 2016).

Rummery (2011, pp. 149–50) acknowledges that compromises between the interests of different parties need to be carefully calibrated in this regard. For example, strict regulation of employment conditions or monitoring of spending may ensure choice and control for care or support workers, but may restrict users’ freedom to make flexible and tailored arrangements. However, Rummery claims that even those interests that seem to be opposed are not necessarily so. For instance, while a lack of regulation of employment conditions may appear to offer greater flexibility, the quality of care provided by low-paid or exploited workers is unlikely to be as good as care provided by someone with greater protection (id.). In other words, the quality of care is likely to be higher if unpaid and paid carers or support workers have a meaningful choice about whether to provide care or support (Knijn & Kremer 1997, p. 355). Rummery and Fine (2012, p. 330) argue that regulation is also necessary for another reason, namely, that ‘the right to receive care [and support] must always be regarded as qualified by the fact that it is difficult to enforce emotion’, meaning that ‘legal sanctions against abuse and neglect in all care relationships remain essential’.

While the importance of providing alternatives to unpaid care has been the main focus of both disability rights and feminist social policy perspectives, alternatives to market-based care or support have also been identified as essential to ensuring that access to care and support is provided as a matter of right. Critiques of the marketisation of care services – such as the individualisation of responsibility for making ‘choices’, the negative impacts on pay and conditions (and subsequent risks to the quality of care), and the fact that market forces do not necessarily lead to services offering meaningful choice (for example, in sparsely populated areas) – suggest that state-provided services will continue to be necessary in many situations (Ungerson 1997a; Rummery & Fine 2012; Fawcett & Plath...
Cash or budgets must therefore be available to ‘purchase’ state services, as well as to support unpaid care where it is desired by both parties (Kröger 2009).

Disability studies scholars have, however, expressed concerns over feminist proposals to shift responsibility for the provision of care back onto the state, because this historically meant the institutionalisation of people with disabilities, or the use of other ‘care’ practices that do not recognise the claims and rights of people with disabilities (Keith 1992; Rummery & Fine 2012). This points to the importance of policies that provide financial resources and access to services that empower people to make their own decisions about care or support. However, it also points to the challenges of balancing a person’s right to choose whether or not to give care or support with another person’s right to choose what care or support they will obtain, especially in situations where the preferences or needs of different parties conflict.

3.3.4 Flexibility in how care or support is used and given, and in how care and paid work are combined

Flexibility is another key element of care and support policies to afford the rights to give and obtain care or support. Flexibility in care and support policy is touched on in the ethics of care/disability rights reconciliation literature, and flexibility in employment policy is identified in the universal caregiver literature as key to promoting gender equality (Williams 2001, p. 487; Rummery 2011, p. 150; Rubery 2015). Flexibility relates closely to the availability of both adequately-resourced cash payments and a variety of services. It first means that people giving and obtaining care or support can design – and spend payments on – any combination of formal and informal provision, and can easily change these arrangements as their circumstances change. This allows people to avoid having to make dichotomous choices between, for example, full-time paid support or full-time family care – which in the former case risks ‘the possible strains connected to an unequal dependence’, and in the latter case raises the potential for ‘lack of control, passivity and inefficiency’ (Knijn & Kremer 1997, p. 355). It also means that people can choose the level and type of care or support that they obtain from different sources, including having the choice ‘to carry out their own caring duties’ to whatever extent possible and desirable (Rummery 2011, p. 148).

In addition to offering greater choice and control, policies that facilitate flexibility in care and support arrangements are more likely to accommodate the messiness and
changeability of people’s lives. This can lead to policies that better recognise and support ‘the complexity of caring relationships’ and the ‘interconnected moral, emotional and physical dimensions of an ethic of care’ (Rummery 2011; see also Keith 1992, p. 172; Morris 1993, p. 154).

To address feminist concerns about the gender division of labour, policies should also provide flexibility in relation to paid work. This can ensure that people have a choice about how they combine care and paid work, and challenge the assumption that full-time paid work is the norm of social citizenship participation (Fraser 1994, p. 599). This first means that access to care- and support-related payments and services should not be limited to mothers or other carers with low or no incomes. This may also require changes to employment policy, such as wider availability of flexible work options, flexible conditions that can be tailored to any care/work combination, and policies to reduce the penalties that accompany the use of flexible working, such as lower status work, poorer job security, and low income. All of these policy features are proposed by proponents of a universal caregiver model and others advancing work-care reconciliation policy (Fraser 1994; Gornick & Meyers 2009b; Pocock, Charlesworth & Chapman 2013; Rubery 2015).

3.3.5 Time for care or support, time for paid work, and time for self-care

Ethics of care scholars and feminists aligned with the universal caregiver model have argued that time is a crucial factor in addressing women’s inequality in care-giving. Knijn and Kremer (1997, p. 341) in particular identify the right to time for care as a crucial element of the right to give care. This means that ‘care [must be] made possible’ (ibid., p. 354) by alleviating carers’ responsibility for self-support through paid work, or by providing access to care leave, flexible working conditions, paid care services, and other features of paid work that allow time for care responsibilities. This is one care and support rights principle that is potentially more relevant to the right to give care or support than it is to the right to obtain it, because it arises mainly from feminist concerns about the unequal gender division of labour and the tendency in some feminist literature and care policy itself to treat unpaid care as a disruption to, or incursion on, paid work time (see Knijn & Kremer 1997; Williams 2001, p. 488).

Williams (2001, p. 488) argues that ‘time and space’ need to be thought about differently in order to challenge the prevailing expectation that care needs and responsibilities will fit around paid work. This means that policies should afford both ‘care time and space’
(what ‘we need to care properly for others’) and ‘work time and space’ (what ‘we need to enable us to gain economic self-sufficiency’ and to balance this with care) (id.). Time and space for paid work may also require employment policy that enables people with care roles to incorporate care and paid work, and for care policy that allows people to redistribute their caring responsibilities to others to give them time for work. Rubery (2015, p. 521) similarly identifies time – meaning addressing the ‘competing demands’ of paid work and unpaid care – as a key aspect of gender equality in the universal caregiver perspective.

Williams introduces another element of care that is often neglected in research focusing on the care/work dichotomy, namely, self-care. This requires policy provision for a third kind of time and space, ‘personal time and space’, which requires a consideration of what ‘we need for the care of self and maintenance of body, mind and soul’ (Williams 2001, p. 488). In proposing a universal caregiver model, Fraser similarly argues that equality of leisure time between women and men is a key dimension of gender equality. She advocates ‘a social world in which citizens’ lives integrate wage earning, caregiving, community activism, political participation, and involvement in the associational life of civil society – while also leaving time for some fun’ (Fraser 1994, p. 613). Reconceptualising time and space in this way would mean that policy prioritises ‘opportunities to give and receive care’ (Williams 2001, p. 489). It would also mean that that having responsibilities for providing care and support and having care and support requirements are normalised, in keeping with ethics of care and disability rights arguments.

Time is also an important factor for care or support users, because the time for self-care and the time to organise and actually receive care or support is also necessary in order to fully realise the right to obtain care or support. Policies should also create time for people with disabilities and other care or support users to ‘participate socially in the way they would wish’ in a range of activities, including paid work (Rummery & Fine 2012, p. 331; see Morris 2001) This means, for example, that the quantum of any cash payment should be high enough to enable people to employ or reimburse a support worker or carer to facilitate their participation in paid work. The time and space to work is not relevant for pre-teen children with or without disabilities, but policies should facilitate other activities that children want to, or must, participate in, such as education or extra-curricular activities (Kemp 2016). This extends Fraser’s argument that policies should ensure ‘full
participation on a par with men in all areas of social life’ – a key element of gender equality in her universal caregiver model – to all parties in care or support relationships (Fraser 1994, p. 599).

3.3.6 Incorporate the voices of all parties to care and support relationships

Another crucial principle for policies to afford equal rights to give and obtain care or support is the use of participatory and consultative policy-making practices. This means ensuring that the voices of ‘all those involved in the social processes of care’ are meaningfully heard and incorporated into the design of policies (Williams 2001, p. 487).

In chapter 2, I discussed the influence of feminist, carer and disability rights movements in getting issues of care and support on the policy agenda in Australia and many other parts of the world, and establishing these issues as matters of public concern. However, the tendency to treat these groups as mutually exclusive and opposed means that one voice is generally prioritised over others in policy responses to care or support claims. This is problematic because, as Williams (2010, p. 23) explains, ‘groups need to have a voice to make their claims, to be partners in setting the policy agenda, and ultimately to have a say as citizens and not only consumers in the delivery of services’. This ensures that the choices of people exercising their right to give and obtain care or support – choices between payments, services, and care or support activities – are choices that are informed by the experiences, needs, wants and opinions of those affected by policies (see Keith 1992). Consultation must be meaningful and representative and should not be used merely ‘as a means to legitimise rather than formulate policy’ (Frawley & Bigby 2011, p. 28).

Williams (2001, p. 483; and citing Yuval-Davis 1999) argues that ‘dialogues’ between different constituencies, including ‘unpaid carers, paid carers, those who receive care and support and trade unionists representing paid carers’ are particularly crucial for bringing together different ‘perspectives and positionings’. This can help to establish ‘a common vocabulary of values’ while respecting and accommodating the inevitable differences (id.). This process must also include children with and without disability (Shakespeare & Watson 1998). In fostering such dialogues, the ‘false dichotomy of carer and cared for, and the relations of power inherent in this’, are challenged (Williams 2001, p. 487). Barnes (2006, pp. 157–8) argues that this requires more than just consulting on specific policy proposals, and should ‘address not only the meaning that care has for people in the context of their one-to-one relationships, but how caring values can inform the decisions
about policies which shape the circumstances in which people live their lives’. The six
care and support rights principles proposed here offer one structure within which such
discussions about ‘caring values’ could take place.

Attending to the voices of all people who give and obtain care or support ensures that
policy, and the care and support facilitated by it, is consistent with the ethics of care. This
is because the policy will be ‘attentive’ to individuals’ needs rather than imposing an
‘interpretation of need’ from above (Barnes 2006, p. 156). From a disability rights
perspective, attention to voice can also ensure that the key disability rights principles of
independence, choice and control are realised, because people with disability (and other
parties) are able to ‘set the agenda, to dictate the priorities and to have a real voice in
decision making about their lives’ (Shakespeare & Watson 1998, p. 18). It also ensures
that policies do not perpetuate the ‘silencing of care receivers’ that disability scholars
argue has been commonplace in research and policy, and which is associated with the
construction of people with disabilities as passive objects of care rather than active
subjects or rights-holders (Keith 1992, pp. 172–3; Shakespeare 2000a, pp. 56–57; Pinto
2008, p. 126). Jill Rubery argues that ‘voice’ is also essential from a universal caregiver
perspective to ensure that women are ‘respected’ in both welfare and employment policy
(Rubery 2015, pp. 522–3, 532).

Some feminist scholars argue that some people with disabilities ‘are not able to make
rational choices for one kind of care or another’ or cannot ‘foresee the pros and cons of
different kinds of care’, restricting their ability to exercise their right to receive care
(Knijn & Kremer 1997, p. 355; and citing Knijn 1997). However Barnes (2006, p. 156)
argues that ‘direct testimony’ from people with disabilities, along with ‘older people,
people with mental health problems and others often regarded as incompetent or lacking
in capacity’, as well as people giving care, is essential to justice-based care. This is
consistent with the arguments of some disability rights scholars that people with
disabilities must be afforded adequate support to enable them to communicate their
preferences and exercise their rights (Saaltink et al. 2012). An implication of this for
policy design is that the provision of rights-based cash payments and services should also
be accompanied by access to adequate supports to enable all people to exercise those
rights and to have their voices heard. To assume that some people are not equipped to
hold those rights on the basis of their impairment would be inconsistent with the notion
that these rights are truly universal (see Flynn & Arstein-Kerslake 2014).
3.3.7 Positively recognise difference by rejecting the norm of the independent, non-needy worker

A final principle for the design of policy to afford equal care and support rights is a positive recognition of difference. This ensures that policy incorporates key elements of the model of gender equality from the universal caregiver perspective, and the human rights model of disability from the ethics of care/disability rights reconciliation literature. For care and support policies to positively recognise difference, they should provide for the different circumstances and resource needs of people on the basis of the unequal gender division of labour, and on the basis of impairment and disability. However, this recognition must not entail an assessment of those needs against an independent, non-needy, full-time male worker. This ensures that policy does not position people with care or support requirements, or people who give care or support, as deviating from the norm of ‘the autonomous adult male who neither requires nor delivers care’, and who is capable of full-time paid work participation (Hughes et al. 2005, p. 265).

Another way to conceptualise this principle is that care and support policies should exhibit ‘caring solidarity’—policy should reflect ‘forms of solidarity in which there is room for difference, and in which we find out what people in particular situations need in order for them to live with dignity’ (Sevenhuijsen 1998, p. 147). The origins of this solidarity differ in the different perspectives that this principle reconciles. From a disability rights perspective, it can be seen to arise in the universal human right to live with dignity, which necessitates a recognition of human diversity and the different needs arising from it (Morris 2001). For care ethicists, we all ‘must be able to count on solidarity because vulnerability and dependency, as we know, are a part of human existence; we need each other’s disinterested support at expected and unexpected moments’ (Sevenhuijsen 1998, p. 147). For some feminist social policy scholars, solidarity is similarly associated with the unrecognised value of care, but in terms of its relationship with paid work. Solidarity is required because care responsibilities are unequally distributed between women and men, and must be recognised, supported and valued alongside paid work in order for this inequality to be addressed (see for example Daly 2002; Lewis & Giullari 2005).

In order to positively recognise difference, care and support policies should first facilitate the redistribution of responsibility for care and support from women to men. This reflects the argument by feminist proponents of a universal caregiver model that the gender division of labour will only be equalised if the norm of the independent male worker is
replaced with a norm of the part-time carer/part-time worker for both women and men (Fraser 1994). This has been criticised for ignoring the fact that different women will have different preferences about how they combine these activities (Orloff 2008). Ethics of care scholars have argued for the establishment of a somewhat different norm unrelated to paid work participation, namely, that of the interdependent person who both gives and obtains care, either contemporaneously or at different points in his or her life (Fine & Glendinning 2005, p. 612). Political ethics of care scholars draw these two concerns together – they argue for policy that treats the right to care as equally important to the right to paid work, which again entails establishing care as a normal and essential aspect of life and citizenship (Sevenhuijsen 1998; Williams 2001).

The positive recognition of difference overlaps with several of the other care and support rights principles, but this principle incorporates an explicit consideration of the unequal gender division of labour, and of the possibility that men’s care/work choices to inhibit those of women. For example, in terms of flexibility, a positive recognition of difference necessitates flexible working that is available and appealing to men (and which treats men’s participation in unpaid care as the norm), as well as incentives for men to take up caregiving (see Daly 2011, p. 12; Pocock, Skinner & Williams 2012, pp. 219–21). This also has implications for the quantum of cash payments; they should be paid at a high enough rate to create a viable choice for people (particularly men) to leave or reduce paid work in order to take up more care (see Jenson & Jacobzone 2000). Access to services should also encourage or facilitate the redistribution of responsibility for care from the family (and particularly women in the family) to other sectors (Daly 2001). Finally, policy should address gender differences in ‘time pressures’ to make care and paid work equally available to women and men (Rubery 2015, pp. 526–7).

To avoid limiting women’s options, policies should facilitate arrangements other than 50/50 sharing of care; this can be facilitated through policies that provide access to a variety of services, and flexibility and meaningful choice in how women (and men) can combine unpaid care and paid work (Orloff 2008). As I discussed in chapter 2, Lewis and Giullari (2005, p. 97) argue against compelling men to take up unpaid care, suggesting that it would be unlikely to have the desired gender equality outcome or lead to ‘ethical’ care (see Rummery & Fine 2012, p. 330). This balance between expanding choice for all and ensuring that men’s choices do not impede women’s choices is undoubtedly a different balance to strike.
A second aspect of the positive recognition of difference is that policies should not make access to support contingent on a demonstration of how a person’s care or support needs deviate from any norms of health or non-disability. As I discussed in chapter 2, some disability rights scholars have argued that a human rights model of disability can overcome the neglect of impairment in both the carer and disability literatures without perpetuating problematic conceptualisations of disability as a burden or deficit. Morris (2001, p. 14) argues that a focus on human rights is crucial due to the vulnerability associated with ‘one person having a greater need for physical assistance than the person who is in a position to provide it’ and ‘the nature of the assistance required’, which is often practically greater than the assistance required by people without impairment.

To positively recognise difference in a manner consistent with this human rights model, policies should treat impairment as an inevitable aspect of human diversity, rather than an aberration from the norm of the non-disabled person that needs to be corrected or managed. This means that they should focus on providing the resources necessary to realise a person’s human rights, which includes the right to support and independent living (Morris 2004). Policies should not only meet people’s needs in a strictly medical sense, or only in a sense determined by others (such as medical professionals or caregivers). Policies based on this human rights conceptualisation of disability will also recognise disability (as distinct from impairment) as socially-caused, meaning addressing the barriers beyond an individual’s impairment that preclude their social participation (Kayess & French 2008). This ensures that need is not denied or ignored – and recognises that many children and adults want and require care or support – but in a manner that is less likely to objectify or marginalise them. This ensures a ‘recognition of the need for care without care being oppressive’ (Rummery & Fine 2012, p. 328).

3.4 Conclusion: breaking down dichotomies for more equitable care and support policy

In this chapter, I have identified six principles to inform the evaluation and formulation of policies to promote equal care and support rights for multiple care constituencies, including mothers of dependent children and other unpaid carers, people with disabilities and other care or support users, and paid care or support workers. These principles bring together elements from previous efforts to reconcile the tension between supporting women’s unpaid care and women’s paid work, and the tension between recognising the claims of carers and those of people with disabilities. The principles also address the
major limitations of previous attempts to reconcile them. They promote policies that address the unequal gender division of labour without assuming that 50/50 sharing is the universally desired outcome, and place the rights of all parties to care and support relationships on an equal footing. The principles also treat interdependence as the norm, rather than drawing a distinction between independent and dependent people.

Several elements of the principles are particularly crucial for challenging the problematic dichotomies that limit existing policy responses to care tensions. The principles encourage the design of policies that do not distinguish so starkly between traditional categories of care or support like childcare, aged care and disability care/support, and that envisage that people are not necessarily either caregivers or care or support users, but may be both. They also encourage policies that are flexible and accommodate a variety of needs and choices about unpaid care and paid work. Such policies could better accommodate ‘the fluid identities and experiences of those involved in caring relationships’, including the possibility that people’s roles and needs cross traditional lines of fragmentation (Barnes 2006, p. 150; see also Morris 1991b; Keith 1992). By breaking down the dichotomy between caregivers and care or support users, the principles also challenge the prevailing ‘view of society as comprising isolated individuals in competition with each other for social goods’, because policy issues are not posed as a choice between the competing rights of different social groups (Barnes 2006, pp. 150–1).

Further, the emphasis on flexible, varied and high quality cash and services, and the treatment of care and support as normal and essential aspects of citizenship, firmly establishes care and support as an ‘issue of public and political concern’ (Williams 2001, p. 487).

Encouraging policies that facilitate different combinations of unpaid care and paid work can also guard against the reproduction of the care/work dichotomy at the heart of Wollstonecraft’s dilemma. The principles promote each of the multiple dimensions of gender equality proposed by Fraser (1994) and Rubery (2015), including income equality, leisure-time equality, respect, participation in all areas of life, and access to time, opportunities, resources and security. However, introducing the notion in several of the principles that choice must be ‘meaningful’ (Rummery & Fine 2012, p. 337) – meaning that choice must be adequately resourced for both unpaid carers and care and support users, and must be broader than the choice to purchase services – addresses the key criticism that the universal caregiver model only promotes equal gender sharing of care
(Orloff 2008). The principles also encourage policy that recognises feminist concerns about the implications of the disability rights focus on market-based services and independent living for (women) carers and care and support workers, and recognises that the commodification of care or support is not necessarily the preference of all people (Shakespeare 2000a; Spandler 2004; Lewis & Giullari 2005). In normalising both care/support and impairment, the principles also offer a means to challenge the norm of the independent, non-needy and unencumbered male worker that has been problematised in each of the universal caregiver, ethics of care, and disability rights perspectives (Hughes et al. 2005).

For the remainder of this thesis, I explore the practical manifestation of care policy tensions, and the utility of the care and support rights principles for designing or re-designing policy to resolve them, through a case study of Carer Payment (child), an Australian policy that sits at the intersection of the two tensions. In the next chapter, I explain why I have selected Carer Payment (child) policy for the case study and describe the method that I have adopted for the analysis.
4. The Carer Payment (child) case study: methodology and background

4.1 Overview

Carer Payment (child) is a pension payment administered by Australia’s federal government. It is available to people whose constant care for a child with a severe disability or medical condition prevents them from supporting themselves through paid work (Commonwealth of Australia 2009a, p. 3027). In this chapter, I explain why I have selected this policy to explore the two care policy tensions, and to demonstrate the usefulness of the proposed principles for overcoming these tensions and promoting equal rights for all parties to care or support relationships, in answer to my second and third research questions. Before I describe Carer Payment (child) policy in detail and explain why it is a useful case study for the analysis, I outline the methodology that I have used for the case study. This includes the conceptual background, the specific two-step research method that I have developed from Carol Bacchi’s ‘what’s the problem represented to be?’ approach to policy analysis, the data selection, and potential limitations of the study design and broader research paradigm.

4.2 Case study methodology

4.2.1 Social constructionist policy analysis

As with the earlier elements of the analysis in this study, I have conducted the Carer Payment (child) case study within a social constructionist paradigm. For the case study, I have drawn more specifically on social constructionist approaches to policy analysis. In recent decades, growing numbers of researchers in the fields of sociology and social policy have adopted this perspective to investigate ‘the role of policy in constructing the world via language and discourse’ (Goodwin 2011, p. 167). Such research seeks to elucidate ‘how certain phenomena and/or issues in society come to be defined and understood as problematic by some portion of the citizenry’ and the consequences of different problematisations (Fawcett et al. 2010, p. 25), as well as ‘to de-inevitabilise something that we take for granted’ in order to open up possibilities for challenge and change (Hacking 1997, p. 14).

Social constructionist policy analysis offers both a challenge and a complement to more common positivist approaches. Positivist policy analysis is concerned with objectively identifying, describing and quantifying social problems that exist ‘out there’, and this
approach has long dominated policy research in Australia and around the world (Goodwin 2011, p. 167; see also Bacchi 1999, pp. 55–57; Marston 2004, p. 12; Fawcett et al. 2010, pp. 25–28). From a positivist perspective, policy-making and policy research are about ‘problem-solving’, because policies are conceptualised as ‘technical “fixes” to readily identifiable problems’ (Bacchi 1999, p. 17). Policy-makers and policy researchers are assumed to be objective actors who are simply serving the public interest by formulating rational solutions to social ills (Bacchi 2009, p. 251; see also Colebatch 2006).

In contrast, social constructionist approaches examine the role of policy in ‘making’ social problems (Goodwin 2011, p. 170; see also Hastings 1998). Rather than only being concerned with finding the best ‘problem solution’, researchers in this tradition are interested in ‘problem representation’ or ‘problematisation’ – the social (or socio-political) processes by which situations or phenomena come to be viewed and addressed as social problems (Bacchi 1999, p. 21; Bacchi 2009, p. 33; see also Phillips 1995, p. 8). Social constructionist research is focused on ‘meaning creation’, ‘shifts in understanding’ (Fawcett et al. 2010, pp. 26–27) and ‘underlying conceptual logics (or ways of thinking) that shape understandings of policy issues’, rather than with discovering the truth about a particular issue (Bacchi 2009, p. 252).

Sue Goodwin (2011, p. 170) characterises social constructionist forms of policy analysis as ‘the analysis of policy as discourse’, and most such approaches draw on discourse theory as developed by the French philosopher Michel Foucault (Bacchi 2005, 2009; Eveline & Bacchi 2010). Foucault tends to be associated with post-structuralism, rather than social constructionism (Schwandt 2001, p. 203). Burr observes that social constructionists frequently utilise post-structuralist concepts and theories, and argues that Foucault’s work is appropriately characterised as social constructionist on the basis that two of his guiding principles, and key foci, were ‘the constructive power of language’ and the historically and socially contingent nature of knowledge (Burr 1995, pp. 8–9, 32; see Schwandt 2001, p. 203). Post-structuralism, like social constructionism, can be understood as a challenge to positivism on the basis that it critiques the notion that it is possible to objectively observe, describe and analyse the world (Agger 1991, p. 106). However, post-structuralism – as its name indicates – is primarily characterised as a response to structuralism (Schwandt 2001, p. 203). In my view, post-structuralism and social constructionism can be usefully understood as distinct approaches that are nevertheless ‘in sympathy’ with one another due to their common stances of anti-
humanism and anti-essentialism, and their common ‘backcloth’ of postmodernism (Burr 1995, pp. 13, 32). I draw concepts from both traditions (and particularly the points where they overlap) in the Carer Payment (child) case study analysis. The most significant overlap between the two approaches for purposes of the present study is their common concern with the construction of the social world through language. However, a post-structuralist perspective introduces an extra dimension, being concerned with how language and the construction of knowledge relates to the exercise of power (Burr 1995; see also Bacchi 2009, p. 34); I elaborate on this point below.

Carol Bacchi’s ‘what’s the problem represented to be?’ approach constitutes one particularly well-developed variant of a group of methods of discourse analysis that draw specifically on Foucauldian discourse theory for social constructionist analysis (Burr 1995, p. 163; Graham L J 2005; Willig 2008, p. 122). In Bacchi’s methodology, ‘problem representations’ – meaning what issues are considered to be the appropriate and necessary subjects of government action – are understood to be ‘elaborated in discourse’ (Bacchi 2009, p. 33). In the next section, I explain what is meant by discourse and discourse analysis, and outline why Bacchi’s specific method of discourse analysis is useful, with some augmentation, for exploring research questions two and three in this study.

4.2.2 The analysis of policy as discourse

4.2.2.1 Defining discourse

The term ‘discourse’ is notoriously difficult to define, and scholars have been critical of ‘the loose use of the term’ in academic writing (Bacchi 2005, p. 198). In the Carer Payment (child) case study, I use it in the sense outlined by Foucault and post-Foucauldian scholars. According to Foucault, discourses comprise ‘practices which form the objects of which they speak’ (Foucault 1972, p. 49). In Parker’s more straightforward terms, a discourse is ‘a system of statements which constructs an object’ (Parker 1992, p. 5). Eveline and Bacchi (2010, p. 142) further explain that discourses comprise ‘relatively well-bounded areas of social knowledge that both constrain and enable what can be written, spoken or thought within specific historical limits’ (see also McHoul & Grace 1993, p. 31; Bacchi 2009, p. 35).

Discourses offer ‘a frame of reference, a way of interpreting the world and giving it meaning that allows some “objects” to take shape’ (Burr 1995, p. 57). They do this by providing particular ‘concepts, objects and subject positions [which are] used to fashion
a social world’, including ‘meanings, metaphors, representations, images, stories, statements and so on’ that together ‘produce a particular version of events’ (McDonald, Marston & Buckley 2003, p. 512; Burr 1995, p. 48). Bacchi (2009, p. 35) explains that discourses are ‘fictions’ in the sense that they only exist insofar as they are elaborated in language. They nevertheless ‘accomplish things’ and ‘make things happen’, particularly by restricting how we can think and speak about both our experiences and ourselves (id.).

In this perspective, language is considered to be ‘structured into a number of discourses’, with the meaning of language being determined by the discursive context in which particular words are embedded (Burr 1995, p. 50; Weedon 1987, p. 25). However, the same concepts can have multiple meanings because multiple discourses circulate at a given time (Eveline & Bacchi 2010, p. 142). Each discourse has ‘a different story to tell about the object in question’ (Burr 1995, p. 48), entailing different ‘rules for what it is possible to know’ (McHoul & Grace 1993, p. 38), and consequently differences in ‘what it is possible to think, write or speak’ in relation to that particular thing (Bacchi 2009, p. 35). Another implication of this is that meaning ‘is always open to challenge and redefinition with shifts in its discursive context’ (Weedon 1987, p. 25). As Burr (1995, p. 49) puts it, ‘numerous discourses surround any object and each strives to represent or ‘construct’ it in a different way. Each discourse brings different aspects into focus, raises different issues for consideration, and has different implications for what we should do.’ Hence, analysing the discourses underpinning particular policies and problem representations means ‘seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based’ (Foucault 1994, p. 456 cited in Bacchi 2009, p. 39).

In chapter 2, I characterised the care policy tensions as a consequence of dichotomous thinking about the relationship between care and paid work (and women’s and men’s appropriate roles in each activity), and about the nature of care and disability. I characterised the different literatures addressing these tensions as sources of alternative ways of conceptualising, and addressing, these issues. Consequently, discourse theory provides a useful scaffolding for assessing how the tensions are dealt with in Carer Payment (child) policy, examining the thinking (dichotomous or otherwise) underpinning the policy, and assessing how the policy does or does not align with feminist, carer and disability rights perspectives. As I outline in more detail below, I have used the analytical
concept of an ‘assumption’ in the case study analysis to identify the constituent elements of dominant discourses in Carer Payment (child) policy for this purpose (Bacchi 2009).

4.2.2.2 Discourse, knowledge and power

While numerous discourses may be available in relation to any particular matter, some meanings appear to be more fixed, enduring or logical than others, and are more widely accepted as appropriate, correct, and true. This reflects the dominance of some discourses and the subjugation or marginalisation of others (Bacchi 2009, p. 36; see also Foucault 2003, p. 316). As Gavey (1989, p. 464) puts it, ‘dominant discourses appear “natural”, denying their own partiality and gaining their authority by appealing to common sense’. Attention to the processes by which particular discourses become accepted as truth, and the effects of these discourses, can provide insight into how particular relations of power arise and manifest in society (Burr 1995, p. 62).

From a post-structuralist perspective, the dominance of some discourses is not assumed to be a neutral or arbitrary eventuality; rather, the ‘truth status’ of some discourses inevitably serves some values and interests over others and ‘legitimate[s] power’ in some way (Willig 1998, p. 95; 2008, p. 126; see also Weedon 1987, p. 37). Foucault proposed that all forms of knowledge exist in a reciprocal relationship with power – that, as Mills (2003, p. 69) puts it, ‘knowledge is not dispassionate but rather an integral part of struggles over power’. In this perspective, knowledge cannot be produced and established as truth without power, and power cannot be exercised without the production of truth (Foucault 1980a, pp. 93–94; McHoul & Grace 1993, p. 59). Mills (2003, p. 58) notes the importance of ‘a whole range of practices and institutions’ in establishing what is true, including ‘universities, government departments, publishing houses, scientific bodies and so on’.

This is where post-structuralist analysis departs from much social constructionist analysis, because it involves a consideration of the political implications of particular discourses and how they relate to the exercise of power (Burr 1995, pp. 54, 57; Bacchi 1999, p. 54; 2009, p. 34). As Willig (2008, p. 113) explains:

Dominant discourses privilege those versions of social reality that legitimate existing power relations and social structures. Some discourses are so entrenched that it is very difficult to see how we may challenge them. They have become ‘common sense’.
Bacchi (2009, p. 33) extends this analysis to the specific case of policy problem representations when she argues that governments ‘play a privileged role’ in establishing the truth status of particular versions of the policy problem. Governments are seen to be ‘active in the creation or production of policy “problems”’, rather than merely responding to pre-existing problems; these official understandings of policy problems ‘stick’ because they are formalised in legislation, policies and other instruments that are ‘used to govern’ individuals and the population (ibid.). Consequently, Bacchi argues that analysing the problem representations in government policy gives insight into the more fundamental forms of rule and relations of power prevailing in a particular society (ibid., p. 31).

4.2.2.3 The effects of problem representations and discourses

In the case study of Carer Payment (child), the purpose of identifying the dominant problem representations and discourses in the policy is not to assess them against an objective standard, for instance, to identify the most accurate conceptualisations of gender equality, care or disability on which policy should be based (Bacchi 2009, p. 40). Rather, as I touched on in chapter 2, it is to assess the implications of particular ways of thinking and responding to care issues ‘in terms of how they can actually intervene in real struggles’ (McHoul & Grace 1993, p. 35). I am interested in real struggles in several senses in this study, namely, feminist, carer, and disability rights struggles around how gender equality, care and disability are understood and addressed in policy, and the consequences of different approaches to these issues identified by scholars in each field.

For this part of the analysis, I follow Bacchi in utilising the analytical concept of ‘effects’ to assess the consequences and implications of discourses and problem representations in terms of ‘where and how [problem representations] function to benefit some and harm others’ (Bacchi 2009, pp. 15, 69–71). The first kinds of effects of interest are ‘discourse effects’ (ibid., p. 16). A corollary of the assumption that discourses structure what it is possible to think and do in relation to a particular matter is that the dominance of certain discourses closes off other ways of thinking and acting. In the context of policy problem representations, this means that certain ways of thinking about a ‘problem’, and the discourses underpinning them, ‘make it difficult to think differently’ (ibid.). Consequently, ‘some options for social intervention’ are rendered unthinkable, or at least illogical or unreasonable (ibid.). In this case study, I focus on Carer Payment (child) policy’s discourse effects in terms of whether the different constructions of gender equality, care and
disability proposed by different care constituencies are conceivable and influential in the policy.

This opens the way to examining a second set of effects of problem representations and discourses proposed by Bacchi, namely ‘lived effects’. These are the direct, material impacts of particular problem representations and ways of thinking on people’s lives (Bacchi 2009, pp. 17–18). These material impacts can include whether a person is able to access income support or other payments and services, or whether a particular child is labelled as having ‘a disability’. The impacts on individuals of different approaches to women’s care and paid work roles, and to supporting carers or supporting people with disabilities, are a key focus of the feminist, carer and disability rights literature, and a key rationale for criticisms of each approach. Focusing on the lived effects of Carer Payment (child) offers a method for assessing the second limb of the second research question, namely, ‘what are the consequences for different care constituencies’ of the policy’s approach to these issues?

4.2.3 Data selection

The first step in analysing policy as discourse in the sense outlined above is “‘working backwards” from concrete policies, programs and policy proposals to reveal what is represented to be the “problem” within them’ (Goodwin 2011, p. 171; Bacchi 2009, p. 21). Bacchi echoes Foucault’s suggestion to focus on ‘prescriptive’ or ‘practical’ texts, or ‘the supposedly minor texts of those who actually made policy and wielded power’ (Rabinow 2003, cited in Bacchi 2009, p. 34). These are texts that were ‘written for the purpose of offering rules, opinions, and advice on how to behave as one should’, were ‘designed to be read, learned, reflected upon, and tested out, and [that] were intended to constitute the eventual framework of everyday conduct’ (Foucault 1986, cited in Bacchi 2009, p. 34). The selection of particular texts for analysis is inevitably ‘an interpretive exercise’ (Bacchi 2009, p. 20; Goodwin 2011, p. 171), and discourse analysts’ text selection is always open to criticism and accusations of partiality (Taylor 1999, p. 134). I have sought to counter any such criticism in three ways. First, I have analysed a variety of policy texts in order to build up a comprehensive picture of Carer Payment (child) policy at or around the time of the 2009 reforms (Bacchi 2009, p. 20; see appendix A, below). Secondly, I explain my process of data selection and analysis in detail below; in doing so, I willingly expose my research to challenge and scrutiny (Hastings 1998,
Thirdly, I canvass some limitations of the data selection and discuss further research to address these limitations later in this chapter.

For the case study analysis, I selected a range of documents that I considered to constitute ‘prescriptive texts’ in relation to Carer Payment (child) policy. Most of the texts were produced around the time of, and in relation to, the most recent legislative reforms to the policy in 2009. My decision to focus on reform-related documents was based on several factors. The fact that the policy was the subject of reform indicated that policy support for this particular category of care had been problematised, or called into question (see Bacchi 2009, p. 267). I also favoured documents produced during the reform process because they offered a detailed and recent elaboration of the Government’s policy, as well as giving insight into the process by which particular problem representations were constructed and privileged over others (Dean M 2010, p. 38). A considerable number of reports, parliamentary speeches and Centrelink publications were produced as part of the reform process, many of which went into great detail about the nature, purpose and function of Carer Payment (child), offering a large volume of detailed data to work with. A complete list of the data selected for analysis can be found in appendix A. The documents include records of the Federal Government’s announcements of the reforms, the discussion paper and final report of a Carer Payment (child) Review Taskforce (‘CPCR Taskforce’) that reviewed the policy and proposed the 2009 reforms, the Senate Standing Committee on Community Affairs’ report on its review of the proposed reforms, and transcripts of parliamentary debates concerning the reforms. Other documents in the analysis include the social security legislation and legislative instruments that list the criteria that a person must meet in order to qualify for the payment, and against which all applications for the payment are assessed, the questionnaires and assessment processes that applicants must complete and submit to Centrelink in order to make a valid application for Carer Payment (child), and information

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3 Two sets of documents from the reform process that I did not include in the analysis were the public submissions to the Carer Payment (child) Taskforce review in 2007 and the Senate Standing Committee on Community Affairs’ review of the reform bill in 2009. These documents numbered in the thousands, making it impractical to include them all. My interest in the dominant and official discourses in Carer Payment (child) policy meant that these documents were also less relevant to the analysis than those produced by government bodies. As I outline in more detail in section 4.4.4, below, I did include a Government document that drew on these submissions to tell the stories of 19 carers (FAHCSIA 2008). However, the inclusion of the submissions could have bolstered the analysis in some respects, especially in terms of establishing which constituencies’ ‘voices’ were heard in the reform process; I return to this in chapter 8.
brochures produced by Centrelink which describe and explain the reforms. I explain the relevance of these documents in the more detailed description of Carer Payment (child) policy, and particularly the 2009 reforms, below.

It is artificial to prescribe a start and end point of any reform process, but I nevertheless did so in order to set some practical boundaries for gathering and analysing the data. I focused on policy texts and developments beginning with the Government Minister’s announcement in 2007 of a review of Carer Payment (child) policy, and concluding with Centrelink brochures addressed at existing and/or prospective Carer Payment (child) claimants which explained the practical implications of the reforms that were eventually introduced.

I identified relevant texts using several methods. I began with the Australian Government’s database of legislation, Comlaw (<http://www.comlaw.gov.au>). I used Comlaw to access copies of the reform bill (the draft legislation that was debated in parliament and passed into law on 1 July 2009), the explanatory memorandum (the ministerial statement explaining the purpose and details of the bill), and other relevant materials. I then used the search engine Google, and browsed and searched the websites of the Parliament of Australia (<http://www.aph.gov.au>) and Centrelink (<http://www.centrelink.gov.au>) to locate documents produced by the Government in relation to that bill. References and links in one document led me to identify further texts, and I repeated this process until I was satisfied that I had exhausted the search and found all relevant documents.

Some of the documents had several versions; for instance, Centrelink updated the Carer Payment (child) application forms several times between 1 July 2009 (when the reforms came into effect) and mid-2012, when I began collecting the data. I decided to focus on only one version of each of these documents, and sought copies that were produced at or around the time of the reforms. I also read subsequent versions of the documents to ensure that they did not show significant differences that should be factored into (or at least acknowledged in) the analysis. Some of these documents were no longer available on Government websites or in Australian libraries. However, I was able to access them using the ‘Internet Archive’, a non-profit, US-based internet archive that preserves complete copies of superseded versions of websites (<http://archive.org/web>). Versions of the Centrelink website from 2 July and 5 July 2009 were available in the archive, and these
enabled me to access documents that were practically contemporaneous with the implementation of the reforms on 1 July 2009.4

4.2.4 Data analysis

I used a two-step approach to the case study analysis. The first step involved the application of Bacchi’s (1999; 2009) ‘what’s the problem represented to be?’ (WPR) approach, adapted to the present study. The second step introduced a normative dimension to the analysis, applying the six proposed care and support rights principles to the case study. For the first step, I collected electronic versions of all of the documents in my data set and used the computer program NVivo to organise and code the documents. The coding and subsequent analysis was guided by six questions that Bacchi proposes for a WPR analysis. As its name suggests, the initial stage of a WPR analysis is to identify the ‘problem representations’ or ‘problematisations’ in the policy – that is, the issues, people, circumstances or other phenomena that are identified as ‘the problem’ to which the policy is seen as the appropriate solution (see Bacchi 2009, ch. 1). Each subsequent question elucidates one or more relevant dimensions of a social constructionist discourse analysis. For instance, different questions invite the researcher to identify the discourses that determine what can be spoken about and thought about in that policy area and the effects of different problem representations on alternative problem representations and solutions. The six questions are:

1. What is the problem represented to be?

This question invites the researcher to identify and describe the problem representations in a policy field, to pave the way for analysing the thinking behind the policy and to assess its effects (Bacchi 2009, pp. 2–3). It is assumed that there will be multiple problem representations in a single policy area, and even in a single policy text (ibid., p. 4).

2. What presuppositions or assumptions underlie this representation of the problem?

This question invites the researcher to investigate the ‘presuppositions or assumptions’ underpinning each problem representation, meaning the ‘background “knowledge” that is taken-for-granted in the policy area’ (Bacchi 2009, p. 5). These presuppositions and assumptions point to the discourses, conceptual logics and forms of knowledge that make the problem representation possible and sensible in this policy area. Bacchi emphasises

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that this does not entail an identification of policy-makers’ intentions or beliefs, but rather the knowledge that makes it possible for policy-makers to think about the problem in this particular way (id.).

3. How has this representation of the ‘problem’ come about?
This question encourages the researcher to trace ‘the practices and processes that have produced a problem representation’ (Bacchi 2009, p. 43). This recognises that different problem representations, and the discourses underpinning them, are socially and historically specific, ‘and hence susceptible to change’ (ibid., p. 10).

4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought about differently?
The fourth WPR question encourages the researcher to consider what ‘gaps’ and ‘silences’ exist in the policy; for instance, what is not considered to be problematic, and what is not considered to be an appropriate solution to the problem. Answering this question can assist the researcher to destabilise taken-for-granted problem representations and identify alternative understandings of the problem (Bacchi 2009, pp. 66–68).

5. What effects are produced by this representation of the problem?
The next WPR question relates to the consequences of particular problem representations and discourses in terms of what it is possible to think and speak about a particular issue, how the subjects of the policy are constituted, and the real-life impacts of particular problem representations and discursive formations on individuals (Bacchi 2009, pp. 70–71).

6. How could this representation of the ‘problem’ be questioned, disrupted or replaced?
The final WPR question directs attention to possibilities for resistance to dominant problem representations and their effects, and to alternative ways of viewing the problem that would have preferable effects (Bacchi 2009, p. 45).

The WPR questions are not intended to be a fixed checklist but rather provide a framework for analysis that can be adapted to suit the researcher’s purpose (Bacchi & Eveline 2010, p. 116; Goodwin 2011, pp. 173–4). While I initially focused on all of the WPR questions in the data analysis, questions 1, 2, 4 and 5 were ultimately the most relevant to the case study. I later drew on my analysis in relation to the sixth WPR
question (‘How could this representation of the “problem” be questioned, disrupted or replaced?’) when devising the proposed care and support rights principles and applying them to Carer Payment (child) policy to identify alternative policy options that produce more equitable outcomes for multiple care constituencies.

In addition to Bacchi’s WPR questions, I also utilised the analytical tool developed for ‘critical frame analysis’ as a coding scheme (Verloo & Lombardo 2007). Critical frame analysis extends the WPR approach by introducing the central analytical concept of the ‘policy frame’, which originated in Erving Goffman’s work on frame analysis (Verloo & Lombardo 2007; Snow et al. 1986). In critical frame analysis a ‘policy frame’ contains one problem representation (the diagnosis), one or more solutions (prognoses), and the various forms of knowledge, assumptions and presuppositions – elements of discourse – that underpin them. Relevant dimensions of a policy frame include the roles attributed to different actors, structures and mechanisms in the problem and solution, such as who or what is seen as the cause of the problem, who or what holds the solution, and how the solution is to be achieved (Verloo & Lombardo 2007, pp. 47–49).

A set of ‘sensitising questions’ constitutes the main methodological tool in critical frame analysis. There is a question for each dimension of the policy frame/problem representation (see appendix B, below). Individual policy texts are coded by answering each of the sensitising questions to produce a ‘super-text’ which reveals that document’s subtext (Verloo & Lombardo 2007, p. 36). The developers of critical frame analysis incorporated different theoretical traditions and conceptual frameworks to those underpinning the WPR approach, most notably social movement theory. However, for the purposes of this study, I treated ‘policy frames’ and ‘problem representations’ as comparable concepts, with the multiple dimensions of policy frames in the sensitising questions providing a structured way to code and analyse problem representations and the thinking behind them.

The sensitising questions were also designed to enable the researcher to evaluate the likelihood that particular policies would promote gender equality, where gender equality is broadly defined as freedom from domination and oppression on the basis of gender (Verloo & Lombardo 2007, p. 23). The designers of critical frame analysis proposed that the presence (or absence) of three gender sub-dimensions in a policy text were important indicators of the extent to which a policy promotes some form of gender equality (ibid.,
These sub-dimensions were derived from feminist theory and feminist social policy analyses. They are: the extent to which the gendered nature of paid work, private care and citizenship is addressed; the extent to which the intersectionality of gender inequality with other, related inequalities (such as class, race, sexuality and disability) is addressed; and the extent to which key stakeholders, including women and feminists, have a ‘voice’ in the policy process. The first of the three questions was clearly the most relevant for coding the issues arising in relation to Wollstonecraft’s dilemma. I retained the other questions, but expanded them to focus more broadly on gender- or disability-related inequalities (in the case of question two) and on the voices of all stakeholders, including feminists, carers, and children with disabilities (for question three), in order to encompass the other matters of interest in this study.

In the first stage of the case study analysis, I assessed each policy text using the sensitising questions from critical frame analysis. I created codes for each sensitising question – for example, ‘What is the problem’ (for problem representations), ‘What to do’ (for problem solutions) and ‘Target group’ (for policy targets) – and coded the text of each document using that system. I then used the results of the coding to prepare a ‘super-text’ using Microsoft Word. The super-text comprised a compilation of quotes from the text that were relevant to each sensitising question, and a short summary of the contents and significance of the text (see Verloo & Lombardo 2007, p. 36).

I next embarked on a second round of coding, this time coding the super-texts. I created new codes reflecting my answers to the sensitising questions, categorising them according to the WPR questions to which those questions related. For instance, the super-text for Minister Jenny Macklin’s parliamentary speech introducing the reforms to parliament (Commonwealth of Australia 2009a) was one of the first super-texts that I coded. I created six codes under the heading of the first WPR question, ‘What is the problem?’, such as ‘Caring responsibilities preclude paid work’, ‘Eligibility provisions are too restrictive’, and ‘Terminal illness is tragic’. I similarly created a series of codes related to the second WPR question ‘What presuppositions or assumptions underlie this representation of the

\footnote{The designers of critical frame analysis urged researchers to be sensitive to at least three key approaches to gender equality. These broadly coincide with the two sides of Wollstonecraft’s dilemma and the challenge posed in the universal caregiver approach discussed in chapter 2: equality through sameness (including women in public life on the same terms as men), equality through difference (recognising women’s difference from the male norm), and equality through transformation (problematising and deconstructing the entire binary gender system) (Verloo & Lombardo 2007, pp. 23–4; Walby 2005).}
problem?’, which were guided by both the content of the initial analysis and my knowledge of the issues arising in the literature. These codes included ‘Problem cause: disability is a result of fate or nature’, ‘Problem cause: demographic change’, ‘Norm group: children without disabilities’, and ‘Norm group: non-carers’. Through this process, I gained a sense of which problem representations, solutions, assumptions and so forth were cited most frequently and in the most detail in the documents. This guided the formulation of the findings presented in chapters 5, 6 and 7.

The discourse analysis of Carer Payment (child) in those chapters involves a deconstruction of dominant conceptualisations of these matters and their taken-for-granted status in contemporary Australian policy, as well as a discussion of that policy’s implications for different care constituencies. However, discourse analysis is not only deconstructive, it also paves the way for a ‘rethinking’ of troubling problem representations and discourses. That is, the assumption in discourse theory that multiple discourses are circulating at any given time (Eveline & Bacchi 2010, p. 142; Burr 1995, p. 8) raises the possibility of challenging dominant discourses once ‘their current status as the “truth” [is] questioned’ (Bacchi 2009, p. 4). In chapter 8, I present the second step in the two-step case study analysis by assessing Carer Payment (child) against the normative care and support rights principles that I have proposed. The purpose of this final part of the case study is to demonstrate how policies designed using the principles could avoid the problematic consequences of existing responses to care policy tensions and produce more equitable outcomes for all parties to care or support relationships.

While I present the case study in this second part of the thesis, I actually conducted the first stage of the case study analysis prior to the full analysis of the literature in chapter 2. The initial findings from the WPR analysis guided my formulation of the overall argument and dictated the focus of the literature review and analysis. This initial analysis also indicated that Carer Payment (child) policy had many shortcomings from feminist social policy, carer and disability rights perspectives. However, I recognised that the mainly deconstructive focus of WPR analysis meant that it would not in itself enable me to arrive at normative conclusions about how to overcome these issues. This led me to propose the care and support rights principles in chapter 3. However, I had not formulated the six principles prior to the data coding, and I did not code the data using them. Rather, I used my findings from the WPR analysis to inform my assessment of Carer Payment (child) against the principles later in the research process.
4.3 Limitations and suggestions for further research

4.3.1 Overview

The design of the Carer Payment (child) case study has several limitations. In this section, I identify key limitations of the case study design, and address common criticisms of research conducted within a social constructionist paradigm. These latter criticisms apply equally to the earlier parts of the study (chapters 2 and 3), but I address them here in the context of the other case study limitations for conciseness. I also mention some limitations of my status as an ‘outsider’ to the study, and identify avenues for further research to address these limitations and expand the study’s contribution.

4.3.2 Limitations of the case study design

The case study design has some potential limitations. When I first devised the study, I intended to conduct a second case study analysis of the most recent legislative reforms to Parenting Payment (single) policy in 2012, which extended the 2006 welfare-to-work reforms (which introduced shortened periods of eligibility and mandatory paid work participation) to all sole parent claimants, rather than only new applicants (Commonwealth of Australia 2012, p. 6467). I collected large amounts of data on these reforms and, after conducting a preliminary analysis of a number of texts, I concluded that I could not give detailed attention to both Carer Payment (child) and Parenting Payment (single) policy within the constraints of a doctoral study. For the reasons outlined later in this chapter, I decided that it would be more beneficial to focus on Carer Payment (child). However, a comparison of Carer Payment (child) with one or more policies that fell on different sides of these tensions would have enabled a more detailed exploration of these tensions and their contours in the Australian care policy landscape. These might have included policies that appear to prioritise mothers’ paid working over their caring roles (such as Parenting Payment), and policies that appear to prioritise choice and control for children and adults with disabilities over those of carers (such as the National Disability Insurance Scheme) (Craig 2009; Foster et al. 2016).

Multiple case studies would also have enabled me to explore whether the conceptualisations of gender equality, care and disability in Carer Payment (child) are common to other Australian policies, and to explore their implications for other constituencies. Policies addressing other forms of care or support (such as paid childcare) and other care or support users (such as people with age-related frailty) could be
particularly useful in this regard. Future research applying the two-step policy analysis (the WPR approach followed by the care and support rights principles) to a wider range of existing care and support policies could also provide a fuller picture of the extent to which care and support rights are currently realised in Australian policy, and the reforms that might be necessary to universally secure these rights. Many of the care and support rights principles – such as access to financial support and services, incorporating the voices of affected people, and positively recognising difference – are potentially relevant to other areas of social policy, such as housing, unemployment, and health. Exploring the usefulness of the principles in these areas could offer new insights for rights-based reform across a wider field.

4.3.3 Social constructionist analysis precludes normative conclusions

Conducting this study within a social constructionist paradigm, and particularly using discourse analysis for the case study, means the findings and conclusions are open to ‘a charge of relativism frequently made against theories which talk about the construction of meaning’ (Bacchi 1999, pp. 37–38). As I outlined in chapter 2, a basic premise of social constructionism is that there is no ‘reality which stands outside representation’ (ibid., p. 37). This means that we cannot claim to have access to truth or reality and therefore cannot claim that any one version of reality – such as a particular construction of a social problem and policy response to it, or a particular way of conceptualising gender equality, care or disability – is better or worse than any other (Burr 1995, p. 60; see also Fawcett & Featherstone 2000, p. 7). As Burr (1998, p. 14) succinctly explains, ‘[h]ow can we say… that certain groups are oppressed, if these “groups” and their “oppression” are constructions which can have no greater claim to truth than any other?’.

It is argued that this inability ‘to commit to a definitive political position’ means that researchers end up being ‘paralysed’, and relegated to the role of ‘observer and commentator’ rather than political activist (Willig 1998, pp. 92, 95). For this reason, social constructionist and post-structuralist studies concerned with discourse are criticised for having no practical or political application, and being ‘only of academic interest’ (Colebatch 2006, p. 17; see also Marston 2004, p. 11).

Social constructionists and post-structuralists have responded to these criticisms in several ways. According to Burr, many critics simply misunderstand the basic principles of constructionism. The crux of this misperception is that constructionists’ rejection of
reality (meaning an underlying essence or existence outside of language) is often conflated with a belief that all of our experiences and perceptions are ‘illusion and/or falsehood’ (Burr 1998, p. 23). Burr (id.) argues that most constructionists would not actually claim that ‘the world is a figment of our imaginations and has no materiality’; rather, constructionists consider that things are ‘at one and the same time socially constructed and real’ (see also Willig 1998, p. 92).

To illustrate this point, Burr gives the example of ‘the individual’. From a social constructionist perspective, one’s own experience of individuality and selfhood is a construction ‘that is practised daily and is given life and validation in our legal system’ (Burr 1998, p. 23). Conceiving of the individual as a social construction does not make it somehow intangible or false; rather, it ‘is more than real in its effects, since it informs all our daily practices, our deliberations about who we are and what we should do, and our thinking about conflicts, moral dilemmas, choices of jobs and so on’ (id.). In devising her WPR approach to policy analysis, Bacchi (1999, p. 64) expressed a similar interest in ‘discourses as practices’, meaning we must ‘attend to their material effects’ and ‘the implications of problem representations’, rather than ‘reduc[ing] everything to texts and “readings” of texts’.

In an exploration of whether a social constructionist perspective can be reconciled with a revolutionary socialist agenda, Willig (1998) argues that it is simply not possible (and is somewhat disingenuous) to undertake relativist research without making some moral and political decisions. She asserts that it ‘could be argued that any contribution to a body of knowledge is always also a recommendation about how things should or should not be done’, because it at least entails a political decision about the subject matter and conduct of the research (ibid., p. 94; see also Adams 2007, p. 102). Despite this, Willig (1998, p. 95) points out that researchers who conduct discourse analysis often decline to make recommendations for ‘improved (social, political, and/or psychological) practice’. She argues that this reluctance, while understandable, ‘is unhelpful at best and dangerous at worst’, because if we accept that no one construction is better than another, ‘we may as well stick with our current dominant constructions’ (ibid., p. 96). Researchers operating within this paradigm must therefore adopt a political position while acknowledging the binding nature of our own cultural and historical location (see also Burr 1998, p. 21). It is almost impossible not to do so, because:
we as human agents find ourselves within a context in which things are always already going on or being done. Within this context it is impossible to abstain from involvement since inaction is always a form of action. Thus, we can only ever argue for or against, support or subvert particular practices or causes but we can never disengage ourselves from them. (Willig 1998, p. 96)

Bacchi (1999, p. 62) similarly argues that we must recognise (and acknowledge) ‘the impossibility of objectivism’ and deal with this by being open about ‘how particular problem representations, in our view, contribute to or undermine visions we support’. In this study, I have sought to overcome these limitations by focusing on the ‘effects’ of different constructions of the policy problem, and of the different conceptualisations of the relationship between unpaid care and paid work, and the nature and meaning of care and disability, on different constituencies (Bacchi 2009). I compare these effects with scholars’ proposals of alternative, more beneficial policy formulations, and argue for the adoption of some of these alternatives (which are incorporated into the six care and support rights principles) on this normative basis. In this regard, I have also followed McHoul and Grace’s (1993, p. 35) guidance on the types of intervention or challenge that a social constructionist discourse analyst can make:

if discourses don’t merely represent ‘the real’, and if in fact they are part of its production, then which discourse is ‘best’ can’t be decided by comparing it with any real object… Instead, discourses (forms of representation) might be tested in terms of how they can actually intervene in real struggles.

Adopting this approach also involved exercising reflexivity – acknowledging that the analysis, and the academic perspectives on which I have drawn, are just as constructed as the policy I am critiquing, while also opening up possibilities for change in light of the effects of dominant discourses and problem representations ‘in the real’ (Bacchi 1999, p. 64; 2009, p. 18). As Swan (2008, pp. 394–5) explains, a commitment to reflexivity means ‘identifying the political and social location of the researcher and their knowledge’ in order to deny the possibility of ‘universalist, detached, disembodied knowledge production and the idea of the transcendent researcher, associated with traditional science, and to demonstrate that research comes from a particular standpoint’. This means that I cannot ultimately make authoritative statements or findings regarding options for ‘more effective policy’ (Bacchi 2009, p. 34) from a social constructionist perspective. However, I seek to demonstrate how things could be different – and argue that those differences
could benefit mothers, children with disabilities, and others with care and support requirements or responsibilities – if alternative discourses and problem representations inform future policy.

4.3.4 Problems with (and advantages of) being an outsider

Practicing reflexivity throughout the study was important for other reasons, particularly for acknowledging the limitations of my particular ‘standpoint’, or who I am and how I see myself ‘in relation to others and in relation to society’ (Walter 2013, p. 11). According to Walter (id.), our standpoint ‘underpins the questions we see, the answers we seek, the way we go about seeking those answers, and the interpretation we make, the theoretical paradigms that make sense to us’ (see also Silverman 2010, p. 101). My selection of research topic and approach was undoubtedly influenced by my personal biography. My primary interests when embarking on this study were income support policy and law, and feminist social policy. My interest in these fields arose mainly from my academic and professional background. I completed a Bachelor of Laws and a Bachelor of Arts (Psychology) in 2005, and during my studies I had the good fortune to meet several feminist legal academics and was able to pursue my interests in feminist and queer legal theory through coursework and an Honours project.

My first professional job was as an associate at the Administrative Appeals Tribunal, an independent statutory body that hears appeals of decisions by a range of government bodies, including decisions about individuals’ eligibility for income support payments like Carer Payment and Parenting Payment. I attended dozens of hearings and witnessed the real-life implications of income support law and policy for many people. This included people whose eligibility for support was affected by the then-recent welfare-to-work reforms to Parenting Payment and Disability Support Pension. I was troubled by the more punitive elements of the welfare-to-work reforms, and the obvious fact that they mainly affected women with children, and people with disabilities, who relied on very low incomes. These academic and professional experiences led me to develop a particular interest in drawing together my legal knowledge and skills, my feminist orientation, and my interest in the day-to-day impacts of social policy and law. When I began to review the literature in preparation for my thesis proposal, I became aware of the 2009 Carer Payment (child) reforms and developed a wider interest in the apparently inconsistent treatment of care in these different income support policies, and the competing claims of
different constituencies. This ultimately led to the formulation of the research questions in this study.

Some of my personal characteristics meant I was an ‘outsider’ in this research on several dimensions (see Couture, Zaidi & Maticka-Tyndale 2012). I am a cis-gender woman without children, I do not identify as having a disability, and I was in a same-sex relationship for most of the duration of my doctoral research. I have been in many relations of interdependency and dependency during my life, but I have not been in the specific type of relationship addressed by the case study policy, Carer Payment (child).

Scholarship on the issues surrounding outsider (and insider) research has focused mainly on research involving direct interaction with research subjects (see Breen 2007). Nevertheless, similar issues arise in desk-based research, and my status as an outsider presented both risks and opportunities in the current study. On the one hand, Patricia O’Connor (2004, p. 169) argues that outsiders ‘may achieve greater clarity’ than insiders because we are less likely to make presumptions or assume knowledge. Bonner and Tolhurst (2002, pp. 10, 13) also point to the risks of over-familiarity with the subject matter and loss of ‘research perspective’ or objectivity for insider researchers. On the other hand, outsider researchers who claim to speak for, or in the best interests of, the subjects or targets of their research have been criticised for being unrepresentative and paternalistic, and for perpetuating rather than challenging subjects’ oppression and marginalisation (see also Stanley & Wise 1983; Morris 1991b; Stone & Priestley 1996; Kilty 2014).

I addressed my outsider status in several ways in the research design, particularly through reflexive practices. I acknowledged that I am not an objective expert whose analysis and opinions trump those of (mothers who are) carers, or children with disabilities, or members of any other constituency, but rather offers one perspective that could contribute to the missions of feminist, carer and disability rights scholarship and advocacy. I utilised and privileged these emancipatory perspectives in reviewing and analysing the literature and proposing the six care and support rights principles. I accepted the voices of scholars in those fields as authoritative, and a key purpose of the study was to bring those multiple perspectives together in a manner that does not privilege one over the other and thereby leads to more equitable policy for all. My outsider status may have been advantageous in this regard – I was possibly more inclined to be probing and critical of each of the
perspectives, and less likely to fall into the trap, discussed above, of claiming that any one of these perspectives is preferable because it reflects a greater truth. As I discuss in more detail in chapter 8, this limitation could be further addressed with additional research that incorporates the voices of those directly affected by the policy, such as carers and children with disabilities.

4.4 The case study policy: Carer Payment (child)

4.4.1 Overview

In this section, I explain why Carer Payment (child) is a useful and appropriate subject for exploring care policy tensions and ways to resolve them. I also provide more detail on the history and most recent changes to the policy that are the focus of the analysis. For this policy summary, I have drawn on many of the documents that I used in the analysis. These include the social security legislation setting out the eligibility criteria for Carer Payment (child) and policy documents such as transcripts of parliamentary debates and explanatory memoranda that describe the reform process and the implications of the reforms. I also refer to legislation and other documents published by Australian Government departments or social policy scholars that trace or describe the history of Carer Payment (child) policy. This section is largely descriptive. However, in keeping with the social constructionist model that I have adopted for the study, I acknowledge that the supposedly natural policy history presented here is interpretive and subjective. It merely represents my construction of the policy’s history which is, in turn, based on the constructions of others.

4.4.2 Carer Payment (child) as an appropriate case study

I have selected Carer Payment (child) policy to explore the manifestation and resolution of care policy tensions because it touches on both of the pressing care policy tensions of interest in this study. Carer Payment (child) concerns both mother-care – because the majority of people who claim the payment are mothers – and disability care, because the recipients of the payment are characterised in the policy primarily as ‘carers’ for people with disabilities (CPCR Taskforce 2007, p. 28; FAHCSIA 2007, p. 12). Focusing on a policy relating to mother-care most squarely encapsulates the competing feminist claims that constitute Wollstonecraft’s dilemma. Focusing on a policy that also concerns disability care, and specifically the care of children with disabilities, simultaneously brings into play the tension between the interests of carers and those of people with
disabilities. These points of overlap allow me to demonstrate the utility of the proposed
care and support rights principles for evaluating and designing policies that incorporate
the concerns of multiple care and disability perspectives and constituencies.

Carer Payment (child) is also particularly useful for the study because it is concerned
primarily with informal, unpaid care in the home – the type of care that raises the most
concerns in regard to Wollstonecraft’s dilemma, and in regard to the carer/disability rights
tension (Pateman 1988; Morris 1997; Rummery 2011). As I explain in detail later in this
chapter, eligibility for the payment hinges on both the extent of carers’ paid work
participation and how much they share that care with others, including paid workers.
Consequently, the relationships between unpaid and paid care provision, and between
women’s participation in unpaid care and paid work, also arise in the policy and can
thereby be explored through the analysis. A case study of Carer Payment (child) also
facilitates an exploration of the issues surrounding cash payments. As I discussed in
chapter 2, cash payments to either caregivers (such as mothers or carers) or care and
support users (such as people with disabilities or older people) have been a key focus of
both criticism and claims-making in regard to both sources of tension, and I identified
access to financial resources as the first principle for designing policies to afford
citizenship rights to give and obtain care and support. Focusing on a policy concerning
children with disabilities highlights an additional point of intersection and complexity in
care and support policy. This is because it is located between (unpaid) childcare and
disability care or support, which tend to be treated as separate issues in the literature. It
also raises the relative dearth of research and analysis on this form of care in the social
policy literature in comparison to the care of children generally (Bittman, Hill & Thomson

I next describe the features of Carer Payment (child) policy in more detail, placing it in
the context of the wider income support system and explaining how it has developed since
its introduction in the late-1990s, up to and including the 2009 reforms that produced the
current version of the policy.

4.4.3 The context and history of carers’ income support policy

Since the first half of the 20th century, Australia’s Federal Government has administered
a range of means- and assets-tested income support payments (FACSIA 2006a, pp. 1–3,
43, 69; Smyth P 2010). Different income support payments are available depending on a
person’s social characteristics or circumstances, several of which I discussed in the analysis of the literature in chapter 2. For instance, Carer Payment is provided on the basis of responsibility for the constant care of a child or adult with a significant disability or medical condition; Parenting Payment is provided on the basis of responsibility for the day-to-day care, welfare and development of one or more dependent children under the age of 6 (for partnered parents) and 8 (for sole parents); the Age Pension is provided on the basis of advanced age; Disability Support Pension is provided on the basis of disability that precludes self-support through paid work; and Newstart Allowance and Youth Allowance are provided on the basis of unemployment (Centrelink 2009a). Each of these payments is means and assets tested, meaning it is only available to people who do not have access to a private source of income above a specified threshold (id.).

Income support payments have traditionally been categorised as either pensions or benefits. Pensions entail more generous payment rates and conditions, and less stringent income and assets tests, than do benefits. Generally speaking, pensioners – such as people claiming the Age Pension, Carer Payment and Disability Support Pension – are expected to rely on income support for longer periods of time and are not expected to engage in paid work. Benefit recipients, such as people claiming Newstart Allowance, are expected to enter or re-enter paid work after a shorter period of income support receipt and are required to actively seek paid work as a condition of entitlement (Davidson & Whiteford 2011, p. 8). There has been some blurring of these traditional categories in recent years; for example, Parenting Payment is now paid at a basic rate that differs from both the pension and benefit rates, and recent changes to Disability Support Pension mean that some people receiving a partial Disability Support Pension payment are subject to paid work requirements (see Centrelink 2015; Department of Social Services 2015, para. 3.6.1). Smaller supplementary payments or allowances – such as Rent Assistance, Pharmaceutical Allowance and Telephone Allowance – are available to some people on low incomes in addition to, or instead of, income support payments (FACSIA 2006b, pp. xxiii, xxxi). Centrelink is the government body responsible for delivering income support payments and other government payments and services. People who want to claim an income support payment must complete and submit one or more prescribed application forms, and their applications are assessed and approved or rejected by Centrelink officers (Australian National Audit Office 2010, p. 38).
As I mentioned in chapter 2, income support specifically directed at carers was first introduced in 1983 (FACSIA 2006b, p. 5). Until 1998, this payment was only available to carers for adults, meaning someone aged 16 years or over. The Howard Coalition Government established the first income support payment for carers of children – Carer Payment (child) – for the purpose of extending ‘more assistance’ to ‘people providing a high level of attendant care’ to a child who was deemed to be profoundly disabled (Commonwealth of Australia 1998, pp. 233–4; see also FACSIA 2006c, p. 501). This greater assistance took the form of a payment with more ‘beneficial’ income and assets tests, access to better concessions, and less frequent reviews of circumstances than other benefits and allowances payments that were available to carers in these circumstances (Commonwealth of Australia 1998, p. 234).

Carer Payment (child) was initially only available to people who were personally providing constant care for a ‘profoundly disabled child’, meaning the child had a ‘severe’ multiple disability or medical condition and required continuous personal care for at least six months (Social Security and Veterans’ Affairs Legislation Amendment (Budget and Other Measures) Act 1998 (Cth), sch. 1, item 3). The carer would only qualify for income support if the child met at least three of seven specified criteria relating to his or her physical medical needs. These included receiving ‘all food and fluids by nasogastric or percutaneous enterogastric tube’; having a tracheostomy; using ‘a ventilator for at least 8 hours each day’; having ‘faecal incontinence day and night’; being unable to ‘stand without support’; being certified by a medical practitioner as having ‘a terminal condition for which palliative care has replaced active treatment’; and requiring ‘personal care on 2 or more occasions between 10 pm and 6 am each day’ (id.; FACSIA 2006c, p. 501).

Carer Payment (child) could also be claimed by someone personally providing constant care for two or more disabled children if the children’s combined level of care was equivalent to that required by a ‘profoundly disabled child’ (Social Security and Veterans’ Affairs Legislation Amendment (Budget and Other Measures) Act 1998, sch. 3, item 7;

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6 The other circumstance in which Carer Payment (child) was available was when the child had a ‘terminal’ condition and the child had a life expectancy of less than six months.
7 In 2002, eligibility was extended to people caring for a terminally ill child where the child did not meet at least three of the standard medical criteria but a medical practitioner certified that the child was ‘in the advanced phase’ of a terminal condition and it was unlikely that the child would live ‘for a period substantially longer than 12 months’ (Family and Community Services Legislation Amendment (Budget Initiatives and Other Measures) Act 2002 (Cth), sch. 3).
8 If the child was under six months, the child must be ‘expected to require’ such personal care ‘at the age of 6 months’.
FACSIA 2006c, p. 501). Claimants would only qualify if the care receiver and the carer (and their spouse or partner) met income and assets tests.⁹

Carer Payment (child) recipients were entitled to ‘temporarily’ cease providing care for up to 63 days per year without affecting their qualification for the payment (Social Security and Veterans' Affairs Legislation Amendment (Budget and Other Measures) Act 1998, sch. 1, item 15; FACSIA 2006c, p. 500). In addition, if the child was hospitalised and the carer continued to be involved in the child’s care, the carer could only remain qualified for income support for a further 63 days a year (Assistance for Carers Legislation Amendment Act 1999 (Cth), sch. 1, pt. 1, item 7). Carer Payment (child) recipients could also stop providing care to engage in training, education, unpaid voluntary work or paid employment for up to 20 hours per week (id.; FACSIA 2006c, p. 405). This was extended to 25 hours per week on 1 April 2005 (Family and Community Services and Veterans' Affairs Legislation Amendment (2004 Election Commitments) Act 2004 (Cth)).

The eligibility criteria for Carer Payment (child) were liberalised in 2006, when the social security legislation was amended to introduce a new category of ‘profoundly disabled child’ (Families, Community Services and Indigenous Affairs and Other Legislation (2006 Budget and Other Measures) Act 2006 (Cth), sch. 6). This category now included children aged between six and 15 years of age who required continuous personal care for six months or more (or less if they had a terminal condition) due to a ‘severe intellectual, psychiatric or behavioural disability’ or ‘severe intellectual, psychiatric or behavioural medical condition’. Carers would only be eligible under the new provisions if the child’s disability or medical condition had certain consequences, namely, causing the child to repeatedly engage in certain dangerous, aggressive, violent, or sexually inappropriate behaviours which put the child or other people at risk of harm and resulted in the child’s exclusion from ‘community programs, activities, services or facilities’ (ibid., sch. 6, item 2). According to the Howard Government, these reforms were directly related to the welfare-to-work reforms to Parenting Payment introduced at the same time. The new provisions were intended to ensure that parents of children with severe intellectual, psychiatric or behavioural disabilities who were only eligible for Parenting Payment

⁹ The income and assets of the child’s parents were also tested if the child lived with their parents but the Carer Payment (child) claimant was not a parent (Social Security Act 1991, ss. 198A, 198D).
would not be subject to the new paid work participation requirements if they faced ‘very significant’ caring demands (Commonwealth of Australia 2006, p. 6).

An additional qualification criterion was introduced for individuals making a claim under the new definition of a ‘profoundly disabled child’. Applicants would only be eligible if the continuous personal care they were providing ‘severely restrict[ed] the person’s capacity to undertake paid employment’ (Families, Community Services and Indigenous Affairs and Other Legislation (2006 Budget and Other Measures) Act 2006, sch. 6, item 4). The Howard Government did not give a detailed explanation for the introduction of this requirement, although the emphasis on paid work participation as the norm was consistent with the welfare-to-work reforms to which the Government referred (Maker & Bowman 2012, p. 446).

4.4.4 The most recent reforms to Carer Payment (child)

Less than a year after the 2006 reforms came into effect, the Howard Government commissioned an independent review of Carer Payment (child) policy. This culminated in the most recent changes to Carer Payment (child) in 2009, which established the eligibility criteria as they currently stand (Social Security Legislation Amendment (Improved Support for Carers) Bill 2009 (Cth); Commonwealth of Australia 2009a, p. 3027).

The CPCR Taskforce was established pursuant to a direction of the then Minister for Families, Community Services and Indigenous Affairs, Mal Brough. The review was characterised as a response to ‘concerns that the payment is not available to all those families who are most in need’ (FACSIA 2007, p. 5). The Minister stated that this issue had been raised by ‘members of the community including a number of families who have not met the eligibility criteria for Carer Payment (child)’ (id.).

The Government set six terms of reference for the inquiry:

1. Engage with the community and key stakeholders through the development of a discussion paper and public submission process, and other relevant consultative activities, to establish the range of concerns held in the community about accessing Carer Payment (child).
2. Identify the challenges and critical role for carers of children with significant care needs, which go beyond the expectations of the caring role of a parent of a child who does not have a severe disability or medical condition.

3. Determine the most appropriate mechanism for assessing the care requirements of children under 16 years with severe illness and/or disability, including examining options for amending the existing carer and medical eligibility criteria to reflect current medical, technological and carer approaches and practice.

4. Compare the circumstances of carers of children under 16 years with severe illness or disability that currently qualify for the payment with recent cases which have not qualified, drawing on Carer Payment (child) and Carer Allowance (child) application, eligibility and recipient data and case studies.

5. Consider the relationship of Carer Payment (child) to other income support payments and government financial assistance, including the possible need for short-term financial assistance in some circumstances.

6. Develop advice to the government on practical and cost-effective options to extend Carer Payment (child) to provide an effective safety net for carers of children with severe disability or illness. (CPCR Taskforce 2007, p. 22)

The CPCR Taskforce (ibid., p. 105) was chaired by Anthony Blunn, a former Secretary of several government departments and chair of ‘a range of committees and inquiries in recent years’. The taskforce had nine members, comprising five men and four women. They included the CEO of Families Australia (a ‘not-for-profit organisation dedicated to promoting the needs and interests of families’); a Professor of Mental Health at the University of Sydney; a carer and member of the Social Security Appeals Tribunal (which hears appeals of Centrelink decisions); the CEO of the Association for Children with a Disability (an advocacy and information service for children with disabilities and their families); a Group Manager at the Federal Department of Families, Community Services and Indigenous Affairs (‘FACSIA’); a Professor of Paediatrics; and an Indigenous Australian man who was a teacher and carer (ibid., pp. 105–6).

In May 2007, the Government released a discussion paper for the review ‘to assist individuals and organisations who wish to have input, with an overview of some of the

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10 Families Australia 2009, p. 3.
issues, discussion questions and a submission template’ (Brough 2007). In inviting submissions, Minister Brough reiterated that the ‘taskforce is interested in better understanding the experiences of carers and the children they care for’. He explained that the CPCR Taskforce’s purpose was ‘to consider the effectiveness of the payment in providing a safety net for carers of children under 16 years with a disability or severe medical condition’ (id.).

The CPCR Taskforce (2007, p. 23) placed advertisements in newspapers inviting submissions to its review, and distributed the discussion paper to more than 300 ‘interested parties’. It also wrote to current recipients of Carer Payment (child) and Carer Allowance (child) – a lower-rate, non-means tested income supplement – to inform them about the review and invite them to participate in focus groups and/or make a submission (ibid.; p. 108).11 The CPCR Taskforce received over 4,000 submissions. The majority of the submissions were from individual carers, and 23 were from organisations, including Carers Australia, National Disability Services and the Mental Health Council of Australia (ibid., pp. 24, 108; Senate Standing Committee 2009).

The CPCR Taskforce (2007, p. 108) also commissioned a consultant to conduct a series of focus groups around Australia in order to investigate ‘issues surrounding Carer Payment (child) in addition to broader carers [sic] issues’. Participants included organisations representing or assisting children with severe disabilities or medical conditions or their parents and carers, professionals (and their representative bodies) providing services to these children, and ‘as many self-selected carers as was practicable, given the CPCR Taskforce’s time and resource constraints’ (ibid., pp. 23, 107). Targeted focus groups were also conducted, including ‘Indigenous specific’ and ‘ethnic specific’ groups, and groups comprising paediatric specialists and occupational therapists (ibid., p. 109). The CPCR Taskforce reported that 150 people attended 19 focus groups and eight targeted consultations overall (ibid., p. 110).

There was a change of government soon after the review was announced, and the CPCR Taskforce delivered its report to Jenny Macklin, the Rudd Government’s Minister for Families, Housing, Community Services and Indigenous Affairs, on 30 November 2007.

11 Carer Allowance is currently available to people providing ‘care and attention on a daily basis’ for a dependent child, where either the applicant has been given an ‘intense’ rating under the Disability Care Load Assessment (Child) Determination 2010, or the child’s disability is included in a list of ‘recognised disabilities’ in that determination (Social Security Act 1991, ss. 38E, 953; FACSIA 2006c, p. 526).
The report contained 32 recommendations, with the ‘key to these recommendations’ being ‘that eligibility [for Carer Payment (child)] should be assessed based on care needed and care provided, where that care precludes carers from substantial workforce participation’ (ibid., p. iii). Most of the CPCR Taskforce’s recommendations concerned specific changes to the legislation, such as introducing a new ‘care load’ test that would assess eligibility more accurately and comprehensively than the seven medical criteria specified in the original test (recommendations 18–24), and extending Carer Payment (child) to situations of short-term or episodic care (recommendation 7) and to situations where divorced parents shared the care of multiple children (recommendation 12) (ibid., pp. 14–15). The CPCR Taskforce also proposed that the 63-day limit on the ‘cessation’ of care should not apply when the child was hospitalised, because carers usually continue providing care even when their child is in hospital (recommendation 11) (ibid., p. 14).12

The report was released in conjunction with two other Australian Government publications compiled by the Department of Families, Housing, Community Services and Indigenous Affairs (‘FAHCSIA’).13 The first was a ‘Statistical Compendium’ containing statistical information about children with disabilities, carers, Carer Payment recipients and Carer Allowance recipients (FAHCSIA 2007, p. 1). The CPCR Taskforce cited some of this data in its final report. The second publication was released the following year. The ‘Carers Storybook’ described ‘the experiences of 19 carers whose children have a severe disability, medical condition or terminal illness’ (FAHCSIA 2008, p. 3). It included 19 four-page stories, including photographs of carers and their children and quotes from the carer and other family members (but not the child himself or herself), about the experiences of the carer and their family, and about the child’s disability, medical condition or terminal illness, including details of his or her diagnosis, prognosis and care needs. The Storybook was ‘inspired by and… dedicated to all those families who shared their moving and powerful stories’ in the 4,000 submissions to the CPCR Taskforce review (ibid., p. 2).

12 The CPCR Taskforce (2007, pp. 56–58) also recommended changes to the provisions relating to terminally ill children, on the basis that many carers and medical practitioners considered the existing provisions to be insensitive and inappropriate. These provisions required medical practitioners to estimate the child’s life expectancy, and in some cases required carers to choose between continuing ‘active treatment’ of their child or accessing income support.
13 Previously FACSIA.
The Federal Government’s response to the CPCR Taskforce report – which involved implementing most of its recommendations – was first announced by the then Federal Treasurer, Wayne Swan, in his 2008–09 Budget speech on 13 May 2008 (Commonwealth of Australia 2008). Legislative reforms to implement the changes were introduced to parliament on 18 March 2009 in the form of the *Social Security Legislation Amendment (Improved Support for Carers) Bill 2009* (Cth). Following debates in the House of Representatives and the Senate, and a review of the reforms by the Senate Standing Committee (2009), the legislation was passed on 16 June 2009 (Commonwealth of Australia 2009c, p. 3402). The current eligibility criteria for Carer Payment (child) came into operation on 1 July 2009 (*Social Security Legislation Amendment (Improved Support for Carers) Act 2009* (Cth), s. 2).

### 4.4.5 Current eligibility criteria

Carer Payment (child) has a number of key features. Some were introduced with the 2009 reforms, and others have applied since the payment was introduced. First, Carer Payment (child) applicants may apply for income support regardless of whether they are single or partnered. However, a person will be precluded from claiming Carer Payment (child) if his or her income and/or assets, combined with those of his or her partner, exceed a nominated threshold (*Social Security Act 1991*, ss. 198B, 198D). Different payment rates apply for single and partnered claimants, with the partnered rate being lower than the single rate (Centrelink 2009a, pp. 8, 11).

The cohabitation rule, which I discussed in chapter 2 as a key cause for feminist criticism of Australian maternalist payments, applies to Carer Payment (child). This means that a person is considered to be a member of a couple if he or she is legally married, is in a legally registered relationship or is deemed to be in a ‘marriage-like relationship’ (*Social Security Act 1991*, s. 4(2)). Even if a claimant does not disclose that he or she is partnered, Centrelink officers can investigate the person’s circumstances and determine that they are in a marriage-like relationship. A number of factors are considered to be relevant in this regard, including ‘the financial aspects of the relationship’, ‘the nature of the household’, ‘the social aspects of the relationship’, ‘any sexual relationship between the people’ and ‘the nature of the people’s commitment to each other’ (*Social Security Act 1991*, s. 4(3)).

In addition to the relevant income and assets tests, Carer Payment (child) applicants must meet two broad eligibility criteria to qualify for the payment. The first is that they are...
personally providing ‘constant care’ to a child or children with a disability or severe medical condition (Social Security Act 1991, s. 197B). The second is that the care load associated with the child or children’s disability or medical condition is rated as ‘intense’ (id.). Several categories of carer can qualify, provided that they meet these criteria. These include people who are personally providing constant care to one child under the age of 16 who has a ‘severe’ disability or medical condition; to two or more children with combined care needs equivalent to those of a child with a severe disability or medical condition; and to both an adult with a disability and one or more children with a disability or medical condition (Social Security Act 1991, ss. 197B, 197C, 197D).

Two separated or divorced parents who equally share the full-time care of two or more children with a disability can also claim Carer Payment (child), as long as each parent is providing constant care to at least one child at all times (Social Security Act 1991, s. 197F). Carer Payment (child) is also available for carers whose child has been medically diagnosed as ‘terminally ill’, if a treating health professional certifies that the child has an average life expectancy of ‘not substantially longer than 24 months’ (Social Security Act 1991, s. 197E) and ‘will need continuous personal care for the remainder of his or her life’ (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009 (Cth), p. 12).

Generally, the child or children with a disability or medical condition must require constant care for a period of six months or more. However, a person will also qualify if the child has ‘episodic or short-term’ care needs that are expected to persist for between three and six months (Social Security Act 1991, s. 197G). The claimant must be providing constant care in the child’s private residence (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 7). ‘Constant care’ means ‘at least equal to a normal working day’ (Centrelink 2009b, p. 13). As with previous versions of the eligibility criteria, Carer Payment (child) recipients can cease providing constant care for up to 63 full days per calendar year, and for up to 25 hours per week to engage in ‘training, education, unpaid voluntary work or paid employment’ without affecting their eligibility for the payment (Social Security Act 1991, s. 198AC(4)). A carer who is still participating in the care of a hospitalised child is not considered to have ceased providing constant care for these purposes (Social Security Act 1991, s. 198AA).
Claimants of Carer Payment (child) will only qualify if the ‘provision of constant care… severely restricts the person’s capacity to undertake paid employment’ (for example, *Social Security Act 1991*, ss. 197B(1)(d), 197C(1)(d)). When applying for Carer Payment (child), applicants are not required to directly state that their paid work capacity is so restricted. Several elements of the eligibility criteria act as proxy tests in this regard. Applicants must confirm that the care they are providing is ‘at least equal to a normal working day’ except where they have temporarily ceased caring, and the test used to measure an applicant’s care load (which I describe in detail below) appears to have been designed in such a way that only people whose caring responsibilities preclude paid work will achieve a qualifying score of ‘intense’. When recommending the new test that was ultimately introduced in 2009, the CPCR Taskforce (2007, pp. 72, 76) explained that a test which measured the carer’s care load would ‘require carers to describe or substantiate the level of care’ they were providing and hence ‘directly support or substantiate the claim that the carer is not available for full-time work’. Applicants for Carer Payment (child) are also required to describe the ‘impact’ that their child’s disability, and ‘providing everyday care for the child’, has on a number of facets of their life, including ‘e.g. the emotional impact, the physical impact such as the effect on your sleep, meals, shopping, ability to talk on the phone or the ability to undertake work outside the home’ (Centrelink 2009c, pp. 4, 7, 10). The restriction of eligibility to people who engage in 25 hours or less of paid work per week (and whose income and assets fall below a certain threshold), and to people who cease caring for other reasons for 63 days or less per year, also serve to preclude applicants who are substantially engaged in non-care activities and/or earn a ‘sufficient’ income from paid work or have financial support from another source (Centrelink 2009b, pp. 13–14).

In addition to providing constant care, applicants for Carer Payment (child) must also establish that the care load associated with the child or children in their care is sufficiently high to warrant the payment of income support. The care load is measured using a legislative instrument called the *Disability Care Load Assessment (Child) Determination 2009* (Cth) (‘DCLA 2009’). Only carers of children who receive an ‘intense’ rating under the DCLA 2009 will qualify for income support (see for example *Social Security*.

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14 The DCLA 2009 was replaced by the *Disability Care Load Assessment (Child) Determination 2010* (Cth). The minor differences between the two versions of the instruments are not relevant to the analysis presented in this study. Because the case study analysis focuses on the 2009 Carer Payment (child) reforms, I refer to the 2009 version throughout.
The measurement of care load involves a consideration of the child’s attributes in three domains: functional abilities, behaviours, and his or her special care needs. The impact of the care load on the carer’s life is also relevant. The applicant must answer 43 questions about the caring activities he or she performs in relation to the child. For instance, questions about the child’s functional abilities inquire about the amount of supervision or physical help the child requires with activities such as eating, bathing and using the toilet on a four-point scale ranging from ‘does not require me to provide any help’ to ‘is completely dependent’ (Centrelink 2009c, pp. 5–6). Questions in the behavioural domain include inquiries about how frequently the applicant has to ‘intervene or supervise’ (never, not very often, sometimes, or constantly) because the child may ‘wander away or abscond’, or behaves ‘in ways that other people/family think is bizarre or unusual’ (ibid., p. 3). Questions about the child’s special care needs include whether the applicant does ‘postural drainage’ or ‘suctioning’, provides ‘care and/or interventions for poorly controlled major seizures’, or provide ‘stoma care’ (ibid., pp. 8–9).

The method for calculating the overall care load score involves the conversion of raw scores on the basis of either the band of scores into which the raw score fits, or an age adjustment that compares the child’s actual abilities with the appropriate abilities of a child of the same age (DCLA 2009, sch. 2, pt. 1). Generally speaking, a qualifying rating of intense will only result if the carer reports that the child has considerable care needs in multiple areas.\(^{15}\) For instance, an applicant would obtain a qualifying score in respect of a child aged 12 months or more who is verbally disruptive or noisy most or all of the time, physically aggressive most or all of the time, and gets extremely emotionally distressed most or all of the time, if those behaviours mean the carer has ‘to constantly (ie every

\(^{15}\) There are some cases where the applicant must meet only one criterion to qualify. For example, someone caring for a child who uses a ventilator or tracheostomy would qualify on this basis alone (DCLA 2009, pt. 2; sch. 1, pt. 1; sch. 2, pt. 1).
day) supervise the child and avoid specific situations or triggers that lead to this behaviour’. However, an applicant would not qualify if the child engages in two of these behaviours most or all of the time, but the third behaviour only ‘sometimes’ (DCLA 2009, pt. 2, s. 10; sch. 1, pt. 1; sch. 2, pt. 1). An applicant caring for a child aged seven years or over would achieve a qualifying score if the child is completely dependent on the carer for eating, grooming, bathing, dressing and using the toilet, and has complete bowel and bladder incontinence which requires the carer’s assistance. However, a carer would not qualify with this assessment if the child has all of the same attributes but is deemed ‘continent’, meaning he or she is not completely incontinent, but still has ‘frequent’ bladder and/or bowel accidents during the day and/or night (id.).

The professional questionnaire differs considerably from the carer questionnaire, and it must be completed by a treating health professional, meaning a medical practitioner, nurse, occupational therapist, physiotherapist, psychologist, Aboriginal or Torres Strait Islander health worker, or speech pathologist (Social Security (Treating Health Professionals) Determination 2010 (Cth); FAHCSIA 2011a, para. 1.1.T.170). In addition to naming or describing the child’s disability or medical condition, and confirming that the child requires constant care and attention from a specified number of carers, the treating health professional must answer ten questions (many with multiple sub-questions) about the child’s behaviours, functional abilities, and special care needs (Centrelink 2009c). Many, but not all, of the questions address similar features to those listed in the carer questionnaire. Unlike the carer questionnaire, the child’s functional abilities are measured against abilities considered to be ‘appropriate for the age of the child’ (Centrelink 2009d, p. 4), rather than being measured in terms of the care load they produce for the carer. For example, the treating health professional is asked to choose from a list of statements about the child’s ‘feeding and mealtime skills’, which describe age appropriate abilities. A child aged between six months and one year is expected to ‘drink from a modified cup when the cup is held by an adult’, while a child aged between 12 and 15 years is expected to be able to ‘follow a recipe and prepare a simple meal’ (Centrelink 2009d, p. 5).

The treating health professional is also asked to indicate whether the child (regardless of his or her age) displays a range of behaviours, such as, ‘consistently uncooperative and disruptive during treatment or assessment episodes’ and ‘extremely active and is unable to concentrate on a task for more than 30 seconds’ (Centrelink 2009d, pp. 8, 29). The
treating health professional must also state whether the child has any of a number of special care needs, such as ‘has a tracheostomy’ or ‘is assisted with the administration of medication on a daily basis to control seizures and [sic] medication does not substantially reduce the frequency of seizures and the child may require immediate or emergency attention to prevent harm resulting from a seizure’ (ibid., p. 8). A rating of ‘greater than 0’ must be obtained on the professional questionnaire for the applicant to qualify for Carer Payment (child) (DCLA 2009, pt. 2, s. 10). This rating is also determined through a detailed scoring system; essentially, the treating health professional must confirm that the child has functional abilities that are not age appropriate, or exhibits the problematic behaviours or has the special care needs described in the carer questionnaire (ibid., sch. 2, pt. 2).

4.5 Conclusion

The history and features of Carer Payment (child) policy, and the methodology guiding the analysis of this policy presented in this chapter, provide the backdrop to the case study presented in the remainder of the thesis. In the next chapter, I present the first part of this analysis, namely, identifying ‘what’s the problem represented to be?’ in Carer Payment (child) policy. This preliminary analysis paves the way for a detailed analysis in chapters 5, 6 and 7 of how the tensions between unpaid care and paid work and between the interests of carers and people with disabilities are addressed, and the conceptualisations of gender equality, care and disability underpinning them.
5. What’s the problem represented to be in Carer Payment (child) policy?

5.1 Overview

In this chapter, I present the first part of the case study analysis by identifying the key ‘problem representations’ in the documents relating to the most recent reforms to Carer Payment (child) policy. These four problem representations appeared the most frequently, and in the most detail, in the policy documents. The most prominent is that caring for a child with a severe disability or medical condition prevents some people from supporting themselves through paid work. Other key problems are that the original eligibility test applying to Carer Payment (child) was too rigid and inequitable, that caring is difficult and costly for carers, and that carers are inadequately recognised and supported by the Australian community. These problems are presented in such a way that they appear to lead logically to two specific policy solutions. The first is to provide income support for carers who cannot support themselves through paid work, and the second is to reform the social security legislation to extend Carer Payment (child) to more carers, and thereby improve the level of support and recognition they receive.

5.2 The four key problems addressed in Carer Payment (child) policy

5.2.1 The overarching problem: caring responsibilities preclude paid work

The overarching problem that Carer Payment (child) policy addresses is that some people are unable to earn a living through paid work because of their caring roles. Throughout the 2009 reform process, Carer Payment (child) was described as ‘an income support payment for carers who, because of the demands of their caring role, are unable to support themselves through substantial participation in the workforce’ (for example, Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009b, p. 3795 (Steve Georganas); Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 2). The payment was also described in this way in the Centrelink brochures and application forms produced after the 2009 reforms (Centrelink 2009b, pp. 1, 12; 2009e, p. 1). The eligibility criteria for Carer Payment (child), set out in the Social Security Act 1991, centre on the two matters that constitute this problem – first, claimants’ inability to support themselves through paid work (measured using the income and assets tests), and secondly, the intensity of claimants’
caring responsibilities (measured using the care load test and ‘constant care’ requirement) (see section 4.4.5, above).

This problem is primarily a financial one – an inability to engage in paid work entails ‘a loss of income’ (Commonwealth of Australia 2009a, p. 3029 (Jenny Macklin)), meaning that carers ‘are unable to support themselves’ (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 2). These financial difficulties are exacerbated by the higher costs, particularly medical costs, associated with having a child with a disability or medical condition (Commonwealth of Australia 2009b, p. 3834 (Sharryn Jackson); CPCR Taskforce 2007, p. 112; FAHCSIA 2008, pp. 12, 18, 31, 44, 48, 54, 78). As the Parliamentary Secretary for Disabilities and Children’s Services, Bill Shorten, explained, ‘carers are [generally] poorer simply because they have greater expenses and fewer opportunities to earn money’ (Commonwealth of Australia 2009b, p. 3839).

The people affected by this problem (and each of the other problems discussed in this chapter) were described as ‘carers’, ‘parents’ or ‘people’ (see for example, Centrelink 2009e, p. 5; Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009b, pp. 3795, 3796 (Steve Georganas), 3840 (Bill Shorten)). Gender-specific nouns and adjectives like women, men, mothers, fathers, male or female were almost entirely absent from the policy documents. Some parliamentarians did use the terms ‘mother’ and ‘father’ when discussing specific constituents who were carers (and it is notable that most of these examples referred to either non-gendered ‘carers’ or mothers), but their gender was never identified as being a relevant factor in determining their circumstances or the problems they faced (for example, Commonwealth of Australia 2009b, pp. 3792 (Amanda Rishworth), 3805 (Sharman Stone), 3811 (Judi Moylan), 3825 (Graham Perrett), 3831 (Nick Champion)).

16 The major exception to this was the explanatory memorandum to the policy reform bill, which included hypothetical examples to illustrate the operation of the new Carer Payment (child) provisions. Some of these examples used ‘mother’ or ‘father’, and others used given names and pronouns that indicated that the subject was either male or female. Around half of these examples involved male subjects, and the other half used female subjects. There were five examples of women (Cristina, Nathalie, Esmay, Gade and ‘the mother’), four examples of men (Reginald, Lynden, Mikel, and ‘Gregor’s father’), and four examples of heterosexual couples (Georgie & Blain, Molly & Jaxson, Wade and Maxine, Clarice & Hannibal) (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, pp. 7–28).
Carers’ inability to engage in paid work was attributed mainly to the high care loads associated with their children’s disability or illness, with politicians on both sides of parliament echoing Graham Perrett MP’s claim that, due to ‘the constant demands on their time, many carers are unable to work’ (Commonwealth of Australia 2009b, p. 3825; see also pp. 3810 (Judi Moylan), 3823 (Richard Marles), 3830 (Mike Symon), 3836 (Catherine King); FAHCSIA 2008, pp. 12, 18, 31, 54). That is, embedded in the broad policy problem were two more fundamental problems: a child’s severe disability or severe medical condition produces care needs, and those care needs result in a care load for the carer in terms of time and physical effort. These problems are measured using the carer questionnaire and the professional questionnaire (Centrelink 2009c; 2009d). The cause of a child’s disability or medical condition was rarely mentioned in the documents, although several politicians referred to disability as a consequence of ‘fate’ or ‘accident’ (Commonwealth of Australia 2009b, p. 3840 (Bill Shorten); see also pp. 3823–4 (Richard Marles); Commonwealth of Australia 2009c, p. 3387 (Gary Humphries)).

It was noted in some of the policy documents that this care goes beyond the ‘usual’ parental responsibility for care, in the sense that it involves ‘extra care and support’ (CPCR Taskforce 2007, p. 37; Commonwealth of Australia 2009a, p. 3029 (Jenny Macklin)). The eligibility criteria dictate that the extra care needs of a child with a severe disability or severe medical condition are only a policy problem in cases where the care is ‘constant’ (‘at least the equivalent of a working day’), and if ‘the level of care [is] so high that it severely restricts the carer’s ability to support themselves through substantial paid employment’ (Social Security Act 1991, ss. 197B,197C; Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 8).

In the policy documents, the solution offered to carers’ inability to engage in paid work was the provision of regular financial support in the form of Carer Payment (child) (for example, Commonwealth of Australia 2009a p. 3027 (Jenny Macklin); 2009b, pp. 3795 (Steve Georganas), 3807 (Jim Turnour); 2009c, p. 3377 (Carol Brown); Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 2). Many parliamentarians also advocated for other financial supports, including access to Carer Allowance and other supplementary payments (for example, Commonwealth of Australia 2009b, pp. 3808 (Jim Turnour), 3826 (Graham Perrett)).
5.2.2 A related problem: the current test does not meet its purpose

The umbrella policy problem described above informed a more specific problem that necessitated the Carer Payment (child) reforms – that the original eligibility test precluded some people from accessing the payment even though their caring responsibilities prevented substantial workforce participation. The test was problematic because it was based on ‘rigid medical criteria’ that were ‘restrictive and inflexible’ (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. i; Commonwealth of Australia 2009a, p. 3072 (Jenny Macklin); 2009b, pp. 3809 (Judi Moylan); 3816 (Nola Marino)). This was leading to ‘inequitable outcomes’, namely that ‘thousands and thousands of parents who were providing intensive care for their children were ineligible for the payment’ (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas)), even when ‘their caring responsibilities may have been as great as those of carers who qualified for the payment’ (ibid., p. 3820 (Yvette D’Ath)).

The shortcomings of the test were the main focus of the CPCR Taskforce’s review and recommendations. The Taskforce (2007, pp. 23, 66) emphasised that carers and other stakeholders had identified the limitations of the original test as the main problem with Carer Payment (child) during the public consultations and in submissions to the review.\(^{17}\) According to the CPCR Taskforce, the test was problematic because it meant that Carer Payment (child) was ‘not effectively achieving its intended purpose’ of ‘support[ing] carers who are engaged in the full-time care of children with severe disability or medical conditions and as a result have no capacity to undertake work’ (ibid., pp. 66, 76; see also Commonwealth of Australia 2009b, p. 3836 (Catherine King)). This included people who did not meet the ‘strict’ medical criteria despite providing long-term care for a child or children, as well as people who were providing short-term or episodic care and ‘whose ability to work may fluctuate because of their caring responsibilities’ (CPCR Taskforce 2007, pp. 100–1).

\(^{17}\) These problems were alluded to even prior to the review; the government’s terms of reference asked the CPCR Taskforce (2007, p. 22) to consider ‘amending the existing carer and medical eligibility criteria’, and the discussion paper released prior to the review explained that criticisms of the eligibility restrictions by carers and ‘the community’ were a key rationale for the review (FACSIA 2007, p. 5). An even earlier review of Carer Payment (child), conducted by the Department of Family and Community Services (1999) 12 months after the payment was first introduced in 1998, identified similar problems with the test and recommended changes to improve access.
The CPCR Taskforce (ibid., p. 99) argued that the original test was based on ‘a very narrow set of circumstances [which] must be met’, meaning it did not ‘accurately measure the level of care provided by the carer or needed by a child with severe disability or medical condition’. The CPCR Taskforce reasoned that the payment could not meet its purpose – of providing income support for those whose care load interfered with their ability to work – if the test did not accurately measure that care load (ibid., p. 65–66, 77, 99; see also Commonwealth of Australia 2009b, pp. 3791 (Amanda Rishworth), 3799 (Jon Sullivan), 3811 (Judi Moylan)).

In a series of case studies, the CPCR Taskforce gave examples of carers who were disadvantaged by the ‘arbitrary’, ‘inequitable’ and ‘rigid’ medical test, and the same or similar examples were cited by Government representatives during the parliamentary debates (Commonwealth of Australia 2009b, pp. 3839 (Bill Shorten), 3792 (Amanda Rishworth)). Again, the group of people affected by this problem were referred to in non-gendered terms as ‘carers’ or ‘parents’. For example:

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A child who is blind, deaf and unable to speak, who cannot walk and cannot use his hands was deemed not to be eligible for Carer Payment (child) because he didn’t meet three of the seven ticks on the medical report. However, a full day’s work is required by his carer each day to support him, making it impossible for the carer to gain paid employment. (CPCR Taskforce 2007, p. 68)

Improving the test was described throughout the policy documents as the main purpose of the legislative changes introduced by the Government (Commonwealth of Australia 2009a, p. 3028 (Jenny Macklin); 2009c, p. 3113 (John Faulkner); Centrelink 2009f; Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009). Some politicians also linked the restrictiveness of the eligibility test with the wider problem of excessive ‘red tape’ or a ‘bureaucratic maze’ facing carers (Commonwealth of Australia 2009b, pp. 3798 (Alex Hawke), 3812 (Judi Moylan)). This red tape included an excessive number of application forms, a complicated process, and the requirement to undergo new assessments – usually of the child’s disability – every time families applied for a new payment or service (Commonwealth of Australia 2009b, pp. 3808 (Jim Turnour), 3827 (Julie Collins), 3831, 3832 (Nick Champion), 3839 (Bill Shorten)).
The Government’s solution to these problems, based on the CPCR Taskforce’s recommendations, was to replace the existing test with new qualification criteria and a new assessment process ‘based on the level of care required’ (Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. i). This test would be ‘fairer and more equitable’, and would extend income support to around 19,000 individuals (ibid., p. 2; Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009b, pp. 3794 (Scott Morrison), 3803 (Jim Turnour), 3820 (Yvette D’Ath).

Other aspects of the reforms – such as the extension of access to Carer Payment (child) to some short-term or episodic care situations, to ‘exchanged’ care situations between divorced parents, and to people caring for a hospitalised child for more than 63 days a year – were also intended to address the dual problems of carers’ inability to support themselves through paid work and the undue restrictiveness of the original test (CPCR Taskforce 2007, pp. 23, 48; Commonwealth of Australia 2009b, pp. 3820 (Yvette D’Ath), 3830 (Mike Symon), 3832 (Nick Champion), 3841 (Tony Zappia); 2009c, p. 3113 (John Faulkner)).

5.2.3 Intense care has negative consequences for carers

While the Carer Payment (child) reforms were mainly concerned with the impact of caring on carers’ ability to support themselves financially through paid work, a range of other problems affecting carers were also identified in the policy documents. These related mainly to the physical and emotional intensity of caring for a child with a severe disability or medical condition and its impacts on carers’ health, wellbeing, and life opportunities. The most commonly cited causes of these problems was the carer’s caring responsibilities and, by extension, the child’s intense care needs (for example, Commonwealth of Australia 2009b, pp. 3788 (Joanna Gash), 3810 (Judi Moylan), 3825 (Graham Perrett); FAHCSIA 2008, pp. 12, 18, 31, 54). As with the policy problems described above, these problems were said to affect ‘carers’, ‘parents’ and ‘families’, and the gender of carers or parents was not mentioned or identified as a relevant consideration (for instance, CPCR Taskforce 2007, pp. 23, 27; Commonwealth of Australia 2009b, pp. 3797 (Steve Georganas), 3839 (Bill Shorten)).

Many parliamentarians focused on the negative impacts of caring on individuals’ health, emotional wellbeing, and financial circumstances when discussing the policy reforms. For example, Labor MP Steve Georganas referred to carers’ ‘lower levels of health and
wellbeing, [and] chronic grief’ (Commonwealth of Australia 2009b, p. 3797), while his colleague Shayne Neumann discussed ‘the physical challenges and the intellectual and financial challenges’ that members of his own family experienced when caring for their ‘profoundly mentally disabled son’ (ibid., p. 3840). Bill Shorten also decried the ‘financial and emotional cost’ of caring (ibid., p. 3838). One Liberal MP, Judi Moylan, argued that carers’ lack of paid work participation contributed to some of the other costs of care, arguing that, ‘[f]inancial stress that arises from not being able to engage in the workforce serves to further compound the feelings of social isolation and desperation that carers reported’ (ibid., p. 3809).

The implications of caring for carers’ social, familial and working lives (beyond the financial consequences outlined above) were also discussed by many parliamentarians. For instance, Julie Collins MP argued that the demanding nature of caring ‘leaves little or no time for any other activities’ (Commonwealth of Australia 2009b, p. 3826; see also pp. 3790–2 (Amanda Rishworth); CPCR Taskforce 2007, p. 2). Her colleague Sharryn Jackson observed that ‘[e]ven if their care requirements ease, their education and careers are interrupted and they have no superannuation for the time spent caring’ (Commonwealth of Australia 2009b, p. 3834; see also p. 3827 (Julie Collins); CPCR Taskforce 2007, p. 40). Other MPs made similar claims that carers and families were unable to engage in a range of activities ‘that we all take for granted’, including having a social life, pursuing careers and work opportunities, and maintaining family and intimate relationships (Commonwealth of Australia 2009b, pp. 3819 (Nola Marino), 3826 (Julie Collins), 3829 (Mike Symon)). Bill Shorten referred to ‘the sad toll’ that caring for a child with a disability or a medical condition ‘can take upon families and marriages’ (ibid., p. 3839), while Steve Georganas referred to carers’ ‘limited opportunities to participate in community life and build and maintain the social networks that all of us take for granted’ (ibid., p. 3797; see also CPCR Taskforce 2007, p. 38). These were sometimes referred to as the ‘sacrifices’ that carers make (Commonwealth of Australia 2009b, pp. 3807 (Jim Turnour), 3820 (Yvette D’Ath), 3825 (Graham Perrett); 2009c, pp. 3368 (Mitch Fifield), 3383 (Catryna Bilyk)). In a section of its report titled ‘Challenges for carers’, the CPCR Taskforce (2007, pp. iii, 3) listed many of these (and other) ‘consequences for carers and their families’ and explained that these issues were raised by many carers in the submissions and consultation process.
The constancy of caring – both its day-to-day intensity and its persistence over many years – was characterised as a key source of the emotional, social and other difficulties experienced by carers (for example, Commonwealth of Australia 2009b, pp. 3786, 3787 (Joanna Gash), 3826 (Julie Collins)). The CPCR Taskforce (2007, p. 2), and several parliamentarians, described caring as ‘a full-time, multiskilled and very demanding job’ (Commonwealth of Australia 2009b, p. 3790 (Amanda Rishworth); see also pp. 3826–8 (Julie Collins)). Shayne Neumann MP explained that caring occupies ‘24 hours a day, seven days a week, 52 weeks a year, year after year’ (Commonwealth of Australia 2009b, p. 3803). Jill Hall MP explained that carers ‘are parents who spend each and every waking hour of their day caring for their children. They have dedicated their lives to their children’ (ibid., p. 3815), while Judi Moylan MP said that ‘[f]or parent carers, meeting the daily needs of their children is more than a full-time job. It often becomes a way of life’ (ibid., p. 3810). The intensity and constancy of the caring role was mentioned in almost all of stories in the Carers Storybook (FAHCSIA 2008, pp. 6, 18, 26, 28, 34). For example, in the story of Dianne and Shaun and their three children with a disability or medical condition (Ryan, Kieran and Erin), the parents’ caring responsibilities were described as ‘overwhelming’, and Dianne said:

> Being a carer is a very demanding role. You’re not paid for it and it is a 24-hour-a-day job. There are times when I feel we are just existing and not living a life. The reality is my caring role and my husband’s caring role will be till the day we die… (ibid., p. 23).

Judi Moylan also emphasised the long-term nature of caring, stating that carers could not ‘expect much relief from the unrelenting need for care, which eventually and inevitably takes its toll on the carer or carers’ (Commonwealth of Australia 2009b, p. 3810; see also Commonwealth of Australia 2009c, p. 3367 (Mitch Fifield)). This was also identified as problematic in the review report when the CPCR Taskforce (2007, p. 37) stated that:

> Parents who are also carers may not have the same decrease in their caring and supervisory roles [as other parents when their children grow up], which are coupled with increases in personal responsibility for the judgments and decisions about the care, disability or medical condition.

No particular policy solutions were offered for these hardships. However, many politicians suggested that carers were deserving of, or morally entitled to, income support because of the costs and hardships of their caring roles. Bill Shorten MP asserted that the
reform bill would give carers the ‘better go’ that they ‘deserve’ (Commonwealth of Australia 2009b, p. 3840; see also p. 3789 (Joanna Gash); Commonwealth of Australia 2009c p. 3367 (Mitch Fifield)). Labor Senator Catryna Bilyk argued that carers ‘need and deserve all the support they can get, both financially and emotionally’ because they ‘have a demanding job and their lives are significantly changed when they undertake to look after a loved one’ (Commonwealth of Australia 2009c, p. 3385). Similarly, MP Steve Georganas stated that:

Carers shoulder an enormous responsibility for their loved ones and they deserve every single bit of support government can provide. In fact, it is our duty to provide them with every bit of support that we possibly can. The Australian government recognises this and it values their incredible devotion and the incredible hard work that they do. (Commonwealth of Australia 2009b, p. 3796)

5.2.4 Carers are not adequately recognised or supported

The fourth dominant problem representation in the Carer Payment (child) policy documents – a general lack of support for, and recognition of, carers – overlaps with the three problems described above. This problem was said to affect carers as a broad social group, and there was no mention of gender or any other personal characteristics of this group in the policy documents. According to the Government, this problem was addressed by ‘an $822 million package from the 2008 budget to support and recognise carers’ (Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009c, p. 3377 (Carol Brown)). The package included the Carer Payment (child) reforms, as well as a ‘one-off payment of $1,000’ for Carer Payment (child) recipients and some other pension recipients, a payment of $600 for Carer Allowance recipients, the allocation of $20 million for ‘carers who have experienced a catastrophic event involving a young child’ (including the diagnosis of a severe disability or medical condition, or an accident or injury resulting in major disability), and the allocation of $100 million for ‘supported accommodation facilities for people with disabilities with ageing parents’ (Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); CPCR Taskforce 2007, p. 32). These policy solutions all involved financial payments or funding for services, indicating that this problem was considered to be largely financial and, in the case of the supported accommodation funding, to be caused by a gap in service provision. As Liberal Senator Mitch Fifield explained, ‘[e]asing the financial burden is just one way that we can show our support for carers’ (Commonwealth of Australia 2009c, p. 3369).
Some Government speakers conflated financial support and ‘recognition’. Financial payments were characterised not only as a form of financial assistance for people who could not support themselves through paid work, but also as a form of recognition of carers’ hardships and the arduous work of caring. For instance, Bill Shorten described Carer Payment (child) as ‘a recognition of the difficulties that [carers] face and the unpaid work they do to support their child’ (Commonwealth of Australia 2009b, p. 3839; see also p. 3828 (Julie Collins)). He stated that he was ‘proud that we have recognised the sacrifices that carers make’ via earlier reforms to increase the rate of Carer Payment (child) and to introduce a $600 annual carer supplement (Commonwealth of Australia 2009b, p. 3840). Senator Carol Brown stated that, ‘countless Australians around the country spend thousands of hours each year caring for others who have a disability. The acts of such people deserve to be recognised and valued’ (Commonwealth of Australia 2009c, p. 3376). Jill Hall MP made a similar claim that ‘we particularly acknowledge with the payments [in the budget]… the fact that carers have a very hard job’ (Commonwealth of Australia 2009b, p. 3815), while Graham Perrett MP described the legislation as ‘a small step towards dignity and justice’ for carers (ibid., p. 3826). Liberal MP Scott Morrison implied that the acknowledgement of carers’ roles was just as important as (if not more important than) the actual financial support provided when Carer Payment (child) was granted. He argued that, for the 87 per cent of applicants who were denied access to Carer Payment (child):

a lot of it would not have been about the money. The money would have been gratefully received—and that was one reason why they applied—but for 87 per cent we considered their cases not worthy of acknowledgement or support. (Commonwealth of Australia 2009b, p. 3793)

Politicians on both sides of parliament also pointed to the economic value or contribution of carers, acknowledging that they save money for the Government by providing care in the home, and that it would be very expensive for the Government or society to replace informal care with formal care (Commonwealth of Australia 2009b, pp. 3787 (Joanna Gash), 3815 (Jill Hall), 3818 (Nola Marino); 2009c, p. 3387 (Gary Humphries)).

Many parliamentarians were critical of the failure to do more to support carers in the past, although only a few attributed blame to a particular source (namely, the poor decisions of previous opposition governments) (for example, Commonwealth of Australia 2009b,
p. 3839 (Bill Shorten)). Labor MP Shayne Neumann (ibid., p. 3802) was particularly emphatic in this regard, noting that ‘it was more than eight decades after the Australian Federation that we eventually brought in a payment that we called the carers payment’. He said that it was:

really quite extraordinary that we say we are a humane and compassionate society but we have not had the will and the wisdom to do what we are doing in relation to the carer payment supplement and also this improved support for carers in this proposed legislation. (ibid., p. 3803)

Some parliamentarians also decried a lack of recognition of carers – meaning a failure to acknowledge the hardships that they face and the valuable contribution they make – beyond the lack of access to Carer Payment (child) or other financial support. For instance, Bill Shorten MP stated that ‘[s]omehow they cop it invisibly, unheralded and unsung. They are the ones we never see, or never see separately from their charge… They get no medals or monuments’ (Commonwealth of Australia 2009b, p. 3840). He said that, if ‘there was an honorary Olympic gold medal for love beyond love, and beyond the call of duty, carers would get it. That is what we should do, perhaps, along with this bill’ (id.). Jim Turnour, another Government MP, noted that carers ‘do not always get the credit they deserve’ (Commonwealth of Australia 2009b, p. 3807), and Shayne Neumann complained that the veneration of ANZACs was not extended to carers who were ‘the real unsung heroes in our community’ (Commonwealth of Australia 2009b, pp. 3802, 3803). He also proclaimed that carers should be honoured ‘every day’ (ibid., p. 3804).

The first of the CPCR Taskforce’s 32 recommendations to the Government following the Carer Payment (child) review was to increase carer recognition. The Taskforce (2007, p. 27) did not explicitly discuss why this lack of recognition was a problem, but simply stated that there was ‘an opportunity for national leadership in recognising the role of carers in the community’ by introducing ‘carer recognition legislation’ and ‘the development of a national action plan for carers’. It explained that these initiatives would ‘demonstrate acknowledgement at the federal level of the contribution made by Australian carers’, noting that several state and territory governments had ‘already been active in related areas and their experience could inform the way forward’ (ibid., pp. xii, 27). Recognition legislation was not discussed in the 2009 Carer Payment (child) reform.
documents, but national legislation was introduced by the Gillard Labor Government in 2010 (*Carer Recognition Act 2010* (Cth)).

### 5.3 Conclusion

The four dominant problem representations identified here were raised the most frequently during the 2009 reform process, and were apparent across different policy documents, such as the social security legislation, Centrelink forms, and transcripts of the parliamentary debates about the reforms. The extension of the eligibility test, and the provision of Carer Payment (child) to people who cannot support themselves through paid work, were identified as solutions to all of these problems. However, complete solutions were not proposed, or implemented, for all of them – for example, the costs and hardships of intense care (such as the impacts on carers’ wellbeing) were cited mainly to establish carers’ deservingness, without any claim that providing Carer Payment (child) would address all of those costs.

Many other problem representations can also be found in the policy documents. However, these problems were only identified in a relatively small number of documents, and none of them were addressed or solved in the Carer Payment (child) policy reforms. These included claims by the CPCR Taskforce and some politicians that the pension rate was too low, calls for greater access to respite care, and some criticisms of the existing system of support for carers to re-enter the workforce (CPCR Taskforce 2007, p. 42; Commonwealth of Australia 2009b, pp. 3810, 3812 (Judi Moylan), 3822 (Yvette D’Ath); 2009c, p. 3388 (Steven Fielding)). Some parliamentarians – and some of the carers interviewed for the Carers Storybook – also pointed to wider issues with the disability and carer support systems, including the inflexibility of services, insufficient funding, and a lack of access to equipment and aids (Commonwealth of Australia 2009b, pp. 3786–7 (Joanna Gash), 3812 (Judi Moylan), 3834 (Sharryn Jackson); FAHCSIA 2008, pp. 31, 43). I return to these more minor problem representations when I discuss the gaps and silences in Carer Payment (child) policy and alternative ways of addressing care issues later in the analysis.

In the next chapter, I identify key assumptions about unpaid care and paid work underpinning these dominant problem representations in order to demonstrate the policy’s fragmented, binary treatment of the two pursuits at the heart of the first tension of interest in this study, Wollstonecraft’s dilemma.
6. The fragmented treatment of unpaid care and paid work in Carer Payment (child) policy

6.1 Overview

In this chapter, I demonstrate that Carer Payment (child) policy treats unpaid care and paid work in a fragmented and binary fashion, with the tension between supporting unpaid care and supporting paid work being resolved largely in favour of unpaid care. I link this to three key sets of assumptions about unpaid care and paid work that underpin the dominant problem representations identified in chapter 5. These assumptions demonstrate the dominance of a particular discourse that defines the boundaries of ‘what it is possible to think, write or speak’ about unpaid care, and about the relationship between unpaid care and paid work (Bacchi 2009, p. 35; McHoul & Grace 1993, p. 31). They are, first, that unpaid carers (preferably parents) should provide the majority of care for children with a severe disability or medical condition; secondly that carers with intense care roles must forego paid work in favour of full-time caring; and thirdly, that informal caring should be supported because it is valuable for government and society.

The analysis shows that these assumptions are all based on a dichotomous understanding of the relationship between unpaid care and paid work. In particular, unpaid care and paid work are assumed to be largely incompatible activities, and unpaid care is assumed to legitimately preclude paid work participation due to both its intensity and its value to society. Drawing on the feminist literature that I discussed in chapter 2, I conclude the chapter by canvassing the effects of this policy’s either/or approach to unpaid care and paid work in terms of Wollstonecraft’s dilemma, and identify both positives and negatives for gender equality.

6.2 The construction of unpaid care and paid work in Carer Payment (child) policy

6.2.1 Informal carers (parents) should provide the majority of care

The first relevant set of assumptions about unpaid care and paid work in the Carer Payment (child) policy reforms relates to the role of unpaid carers (and others) in the provision of care for children with a severe disability or medical condition. These include assumptions that families are responsible for providing constant care, that this responsibility falls predominantly to parents, and specifically to one parent (usually the
mother), and that medical professionals and other paid care workers play a secondary, supporting role in diagnosing and treating those children.

6.2.1.1 Families are responsible for providing constant care

The overarching problem representation and solution in the policy documents – that Carer Payment (child) should be paid to carers whose intense care loads preclude self-support through paid work – are underpinned by the notion that family has primary responsibility for care, while the government’s role is to support this arrangement. Family responsibility for care was borne out by a number of statements in the policy documents. The CPCR Taskforce (2007, p. 32) explicitly noted that it had:

proceeded on the premise that the objective of Carer Payment (child) is to facilitate the provision—usually by parents and other close family members—of the attention and care required by children diagnosed as having severe disability or medical conditions.

Labor Senator Catryna Bilyk confirmed that it is ‘the government’s role to provide this support to ensure that people can continue on in their roles as carers’ (Commonwealth of Australia 2009c, p. 3383). Steve Georganas MP stated that the ‘government has an absolute commitment to assist those in need and to support them in their very important role of caring’; he also described carers’ ‘primary task’ as ‘looking after their loved one who is profoundly disabled’ (Commonwealth of Australia 2009b, p. 3797; see also pp. 3790 (Amanda Rishworth), 3823 (Richard Marles)). Senator Mitch Fifield suggested that some people did not submit a claim for carer payment because they considered caring to be ‘their duty, it is just something that you should do’ (Commonwealth of Australia 2009c, p. 3369).

Several parliamentarians indicated the presumption of long-term familial responsibility for care when discussing the need for better residential options for people with disabilities. In particular, families were presumed to be responsible for full-time care in the home until they were no longer physically capable of providing it. Nick Champion MP explained that supported accommodation facilities were intended for ‘people whose ageing parents can no longer care for them at home’ (Commonwealth of Australia 2009b, p. 3832; see also pp. 3815 (Jill Hall), 3821 (Yvette D’Ath); FAHCSIA 2008, p. 19). Liberal MP Sharman Stone similarly decried the long wait that two of her older constituents had faced in finding an appropriate home for their foster child, saying:
I do not think that sort of stress should be visited upon any family who have done their best for a young person but who are physically beyond being able to care for a person 24 hours, seven days a week in the way they were able to many years before. (Commonwealth of Australia 2009b, p. 3806)

The conflation of the concepts of the child’s ‘care needs’ and the carer’s ‘care load’ in the policy documents shows the extent to which the assumption of family responsibility for care was taken-for-granted in this policy. This is most apparent in the structure and content of the carer questionnaire (Centrelink 2009c). Most of the questions in the questionnaire consist of a headline question, and the respondent is required to select one of four or five possible answers. Question 14 is a typical example. It begins with the question, ‘[d]oes the child get extremely emotionally distressed and shows that distress by, for example, intense crying OR screaming OR emotional withdrawal OR anxiety OR intense fear?’ (ibid., p. 3; see fig. 6.1 below). The carer must choose one of several responses, ranging from, ‘[t]his never happens. The child does not have a problem in this area. I never need to intervene or supervise because of this type of behaviour’ to, ‘[t]his happens much or all of the time. I need to constantly (ie every day) supervise the child and avoid specific situations or triggers that lead to this behaviour’. The seamless move from the child’s behaviour (‘This happens much or all of the time’) to the carer’s care load (‘I need to constantly (ie every day) supervise the child’) in this and many other questions indicates that all of the child’s care needs are seen to naturally and inevitably constitute the carer’s care load.

![Figure 6.1: Typical questions in the carer questionnaire (Centrelink 2009c, p. 3)](image)
6.2.1.2 Parental care is expected

While any carer can claim Carer Payment (child) regardless of their relationship to the child, the policy documents indicate that carers are generally assumed to be one or both of the child’s parents. Carer Payment (child) is equally available to women and men, and as I observed in chapter 5, responsibility for care was not attributed particularly to either women/mothers or men/fathers in the reform documents. Parliamentarians often used the terms ‘parents’ and ‘carers’ interchangeably. For instance, when introducing the reforms, the Minister Jenny Macklin referred to the targets of the policy as ‘carers’ at several points, but also explained that parents ‘providing the extra care and support needed by these children are often restricted in how much time they can be available to perform paid work’ (Commonwealth of Australia 2009a, p. 3029). Similarly, Steve Georganas referred to ‘carers’ throughout his speech, but also said that the original Carer Payment (child) test was problematic because ‘[t]housands and thousands of parents who were providing intensive care for their children were ineligible for the payment’ (Commonwealth of Australia 2009b, p. 3796; see also pp. 3807 (Jim Turnour), 3814 (Jill Hall), 3837–8 (Catherine King)). The legislation and the Centrelink brochures, on the other hand, used the terms ‘person’ and ‘carer’, and never ‘parent’, to refer to the targets of the policy. However, the Centrelink forms invited the applicant to make statements about ‘your child’ (Social Security Legislation Amendment (Improved Support for Carers) Bill 2009; Centrelink 2009e, p. 9; 2009f). All of the primary carers profiled in the Carers Storybook were the parents of a child or children with a disability or medical condition (FAHCSIA 2008). Some parliamentarians acknowledged that different groups, including ‘parents, grandparents, siblings, partners, relatives and friends’, can be carers (Commonwealth of Australia 2009c, p. 3367 (Mitch Fifield); see also Commonwealth of Australia 2009b, pp. 3786–90 (Joanna Gash), 3826–8 (Julie Collins)). However, the CPCR Taskforce (2007, p. 112) observed that many carers who are not the child’s parents – such as foster carers and grandparents – find it more difficult to access support.

6.2.1.3 One person is expected to provide the majority of unpaid care

Accompanying the assumption of parental responsibility for care is a closely related assumption that one person within the family will meet most of a child’s care needs. Only carers who are providing constant care (‘at least equal to a working day’) can qualify for Carer Payment (child) (Centrelink 2009b, p. 13). They must disclose in the carer questionnaire how often they share care with an organisation or other individuals who
they do not live with, and how often their child is absent from their care ‘for education, training or treatment other than hospitalisation’ (ibid., p. 12). This ‘sharing’ or ‘temporary cessation’ of care precludes qualification for Carer Payment (child) if it means that the carer ceases his or her continuous caring for more than 63 periods of 24 hours each year (Social Security Act 1991, s. 198AC; Centrelink 2009b, p. 13).

Even more significantly, the social security legislation specifies that only one person will qualify for Carer Payment (child) unless a treating health professional certifies (in the professional questionnaire) that more than one person is needed to meet the child’s care needs (Social Security Act 1991, s. 197B(1)(c)(ii); Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 7). The treating health professional must only certify that more than one person is needed if ‘the care load associated with the child [is] so high that more than one carer is required…’ (Centrelink 2009d, p. 3). Consequently, multiple carers (such as a mother and a father, a parent and a friend, or two parents and a grandparent) will not qualify for Carer Payment (child) if they split a single ‘constant’ care load between them (Senate Standing Committee 2009, p. 8). This indicates that the targets of Carer Payment (child) policy have not changed since the policy’s inception in the late-1990s, when (according to the Government) it was introduced to provide income support to ‘either single or both parents’ who are ‘precluded from substantial workforce participation’ because of the severity of their child’s disability (FACSIA 2007, p. 3). Further, while the 2009 reforms extended access to Carer Payment (child) to divorced or separated parents who shared the care of their children, these new provisions only applied in situations where each parent was providing constant care to at least one child at all times (Social Security Act 1991, s. 197F; Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 14).

6.2.1.4 Paid care workers and medical professionals play a secondary role

A corollary of the assumption that one or both parents are primarily responsible for providing care is an assumption that treating health professionals and other paid workers play only a secondary role in the treatment and care of children with a severe disability or medical condition. As I have discussed, the carer’s ‘care load’ is understood to entail a wide range of activities that are described in the carer and professional questionnaires. These include assisting the child to ascend and descend stairs, assisting him or her with eating and toileting, supervising his or her behaviour and interactions with others,
dressing wounds, administering medication, and travelling to and from health care appointments (Centrelink 2009c, pp. 6, 9). A much smaller role is envisaged for treating health professionals, who are expected to diagnose the child’s condition and to confirm that he or she has particular ‘care needs’ that must be met by the informal carer (Centrelink 2009d; Social Security (Treating Health Professionals) Determination 2010). References to medical professionals in the Carers Storybook also indicated that these actors were expected to be responsible for the initial diagnosis of the child’s disability or medical condition, and the supervision of their ongoing care (FAHCSIA 2008, pp. 8, 16). This contrasts with the detailed descriptions of the day-to-day activities of caring performed by the child’s parent or other carer.

Paid care workers, such as paid support workers, assistants or carers, were not explicitly mentioned at all in the Carer Payment (child) documents. The use of one form of paid care – respite care – was raised in a Centrelink brochure as a legitimate reason for temporarily ceasing care. The brochure states that carers can temporarily cease caring for formal respite, as well as holidays, visiting family and friends, or if the carer is sick (Centrelink 2009e, p. 8). However, as the name indicates, respite care was characterised as a temporary physical and psychological reprieve from full-time caring, rather than an alternative to it, throughout the policy documents. For instance, Liberal MP Joanna Gash argued in favour of more respite on the basis that, ‘there needs to be provided a system of support services to alleviate the psychological pressures that will inevitably arise during the term of care’ (Commonwealth of Australia 2009b, p. 3788). Similarly, the CPCR Taskforce (2007, p. 101) argued in its report that ‘government policy may not be able to reverse the impact of providing care for children with severe disability or medical conditions’, but one manner in which it could ‘lessen the impact’ was ‘by providing or subsidising services that assist carers and care receivers, such as respite and mobility assistance’. Practically speaking, the role that paid workers can play is limited by the temporary cessation provisions, which mean that carers lose eligibility for Carer Payment (child) if they redistribute their caring responsibilities to others, including any organisations or individuals, for more than 63 days per year or 25 hours per week (Centrelink 2009b, p. 12; Social Security Act 1991, s.198AC).

6.2.2 Some parents cannot participate in full-time paid work

A second set of assumptions about care and paid work underpinning the Carer Payment
(child) reforms relate specifically to the connection between unpaid care and paid work. The first is that carers with intense caring roles are simply unable to support themselves through paid work. The second, which is a corollary of the first, is that parents with less intense caring responsibilities can and should support themselves through full-time paid work.

6.2.2.1 Carers’ intense caring roles preclude substantial paid work participation

As I discussed in chapter 5, the main solution offered to the policy problem of carers’ inability to support themselves was to provide income support as a replacement for paid work income. It was assumed to be appropriate, if not inevitable, that people with intense care loads would forego full-time paid work in favour of full-time caring. I proposed in chapter 4 that the measurement of the carer’s ‘care load’ acts as a proxy measure of carers’ inability to support himself or herself through paid work, with carers not being required to directly state that the ‘provision of constant care… severely restricts the person’s capacity to undertake paid employment’ (Social Security Act 1991, s. 197B(1)(d)). This means that Carer Payment (child) is not just available when a person expressly shows that he or she cannot support himself or herself through paid work. Rather, an inability to engage in paid work is assumed if the child’s care needs, and the care load that inevitably follows, exceed a certain threshold of intensity.

This assumption was given voice by several parliamentarians during the reform debates. For instance, Labor MP Amanda Rishworth dedicated a large part of her speech to describing the circumstances of her constituent Wendy, who did not qualify for Carer Payment (child) under the original test despite her young son’s considerable care needs and ‘expensive therapy’ (Commonwealth of Australia 2009b, p. 3790). Rishworth explained that Wendy was struggling financially because she had ‘been spending huge amounts of money – not only to support her going to work, because of the full-time care that her son needs, but also to pay the extra costs incurred from the provision of intensive therapy’ (id.). The appropriate solution to these problems was to extend Carer Payment (child) to Wendy, enabling her to forego paid work – and paid childcare – in order to care for her child at home, and to better afford his medical treatment. Another Labor MP, Jon Sullivan made this point even more explicitly, stating:

for people to be required, as they were simply by the fact that their payment was in the area of $52 per week as a carer, to go out and find work to raise children—one or more
with a disability—is I think really flying in the face of what we are about as a country that does have a welfare system in place to assist people in difficult circumstances. (Commonwealth of Australia 2009b, p. 3800)

Some parliamentarians characterised carers’ lack of paid work participation as one of the sacrifices or hardships associated with caring. Richard Marles MP implied that forgoing paid work ‘and perhaps the ambitions that they may have had for their professional lives’ was inevitable, because ‘[f]ull-time caring simply limits the ability of people to fully participate in the workforce’ (Commonwealth of Australia 2009b, p. 3823; see also pp. 3839 (Bill Shorten); Commonwealth of Australia 2009a, 3029 (Jenny Macklin)).

The policy does not treat full-time care and paid work as completely incompatible activities, because carers can participate in paid work or other activities for up to 25 hours per week without affecting their eligibility for income support (Social Security Act 1991, s. 198AC(4)). This equates to approximately three standard working days per week. However, the phrasing of the social security legislation and Centrelink documents, and comments of the CPCR Taskforce, all indicate that any paid work participation is expected to be secondary to caring. Carers’ involvement in paid work is characterised in the legislation and Centrelink forms as one of several activities that constitute a ‘temporary cessation’ of care, and ‘paid employment’ is the final activity in this list (Social Security Act 1991, s. 198AC). The Centrelink application forms and information brochures phrase this eligibility criterion in the negative, explaining that carers will only qualify for Carer Payment (child) ‘if the total hours you work, study or train (including voluntary work and travel time) do not exceed 25 hours per week’ (Centrelink 2009f, p. 2). Unlike other income support payments, including Parenting Payment, paid work participation is not actively encouraged or required through ‘activation’ requirements such as mandated minimum paid work hours (see Cass 2006; Pulkingham, Fuller & Kershaw 2010).

Care itself was characterised as a form of work, or as equivalent in time and effort to full-time paid work, in some of the Carer Payment (child) policy documents. For example, parliamentarians used terms like ‘difficult job’ and ‘hard work’ to emphasise the arduous, time-consuming and valuable nature of care (Commonwealth of Australia 2009b, pp. 3796 (Steve Georganas), 3800 (Jon Sullivan), 3808 (Jim Turnour), 3815 (Jill Hall), 3820 (Yvette D’Ath), 3836 (Catherine King)). The Carer Payment (child) application
form published by Centrelink defines ‘constant care’ as ‘at least equal to a normal working day’, and applicants will not qualify for the payment if they are not providing this amount of care (Centrelink 2009b, p. 13). Several carers profiled in the Carers Storybook also characterised their roles as ‘a full-time job’ (FAHCSIA 2008, pp. 13, 71). The CPCR Taskforce (2007, p. 2) similarly described intense caring as ‘a full-time, multi-skilled and very demanding job’. Liberal MP Mitch Fifield asserted that carers’ contribution to society was of equal value to that of a paid worker:

Carers may not be on the payroll of a corporation… but that does not mean that they are not making a significant contribution to our society. According to the [Australian Bureau of Statistics] in 2008, a primary carer’s role is equivalent to a traditional full-time paid job of 40 hours or more per week in the labour market. (Commonwealth of Australia 2009c, p. 3368)

6.2.2.2 Other parents are capable of full-time paid work participation

The connection between carers’ intense caring roles and their inability to support themselves through paid work signals another assumption in Carer Payment (child) policy – that parents with less intense caring roles can participate in paid work. This assumption is apparent in several aspects of the Carer Payment (child) eligibility criteria, including the income testing provisions and the limitation of the payment to people whose ability to undertake paid work is ‘severely restrict[ed]’ (Social Security Act 1991, s. 197B(1)(d)). Some politicians’ explanations of the Carer Payment (child) reforms also indicated an expectation that most parents can and should engage in full-time work. For example, MP Mike Symon argued that the extension of Carer Payment (child) to episodic and short-term care situations was appropriate because ‘parents [in these circumstances] may be unable to sustain full-time work whilst simultaneously providing the care needed by their child’ (Commonwealth of Australia 2009b, p. 3830). This implied that parents of children with lower care needs were not so restricted (see also Commonwealth of Australia 2009c, p. 3402 (Chris Evans)). Minister Jenny Macklin strongly suggested that even sole parents without ‘intense’ caring roles were considered to be so capable, stating:

the hospitalisation of a child with a serious illness or the diagnosis of a disability can often mean one parent has to stay home to take on the caring role, which can therefore mean the loss of an income. For many single parents in this circumstance, it may be impossible to sustain full-time work and provide the care needed. (Commonwealth of Australia 2009a, p. 3029)
The CPCR Taskforce did note one exception to the general assumption of self-support – when a parent is caring for any child who is under the age of seven. In this situation, the Taskforce explained that Parenting Payment also ‘provide[s] for the full-time care needs of a child’ (CPCR Taskforce 2007, p. 84).

6.2.3 Informal caring is valuable for government and society

A third relevant assumption underpinning the Carer Payment (child) reforms was the value of the caring role, particularly its economic value to the government and society. This relates particularly to the ‘problem’ that carers were not adequately recognised or supported, and the related solution of extending access to income support to more carers (see section 5.2.4, above). As mentioned in chapter 5, a number of politicians observed that informal care provided by family members is less expensive for the government and society than formal care services (for example, Commonwealth of Australia 2009b, pp. 3787 (Joanna Gash), 3815 (Jill Hall)). During the parliamentary debates, some politicians observed that informal family carers are an essential element of the community care system. Steve Georganas explained that:

The task force recognised the vitally important role of carers, and it also acknowledged that the willingness and ability of carers to provide care are integral components of the broader care system. Their contribution… is essential to sustain the current system of community based person-centred care. (Commonwealth of Australia 2009b, p. 3797; see also p. 3819 (Yvette D’Ath); CPCR Taskforce 2007, p. 3)

Senator Catryna Bilyk described carers as ‘the foundation of our aged and community care system’ (Commonwealth of Australia 2009c, p. 3383). Other Government MPs expressed the view that supporting carers was economically and socially valuable for the government and society. Jill Hall MP explained that ‘if these dedicated parents and carers within our community were not prepared to give all of their life to their children then governments throughout Australia would have to spend a lot more money on caring for those children’, while Sharryn Jackson claimed that ‘we owe [carers] a great debt’ (Commonwealth of Australia 2009b, pp. 3815, 3834). The CPCR Taskforce (2007, p. 42) explicitly linked the value of care to demographic change, noting the greater demand for, and lower supply of, care that is associated with the ageing of the population generally, and carers in particular, as well as women’s greater paid work participation. In its report, the CPCR Taskforce (ibid., p. 29) stated that, while this ‘effect is most evident in the
ageing of the population... carers of children with disability are a small but important
group in this wider informal caring population’.

Parliamentarians from the opposing Liberal Party made similar observations. Alex
Hawke MP noted that caring ‘is work that the government could never do or fund people
to do in their place... we could never afford to replace the effort and endeavour of this
core of people who are looking after their family members and profoundly disabled
people within our society’ (Commonwealth of Australia 2009b, p. 3798). Nola Marino
MP reported the assertion of a carer in her electorate that the carer’s family ‘saves the
government many thousands of dollars by not placing their children in care and by caring
for them themselves’ (ibid., p. 3818). Joanna Gash also stated that ‘carers save the
government money’, saying that there would probably be a ‘huge gap’ between the cost
of a ‘full-time carer’ and the cost of a ‘voluntary carer’ (ibid., p. 3787). Another Liberal
MP, Scott Morrison, observed that ‘[t]he price of their work, if we had to replace it, would
be a bill which we could never pay’ (ibid., p. 3795).

Providing carers with long-term access to income support without participation
requirements was considered to be appropriate because it enabled people to ‘continue on
in their roles as carers’, to the benefit of carers, the government and society
(Commonwealth of Australia 2009c, p. 3383 (Catryna Bilyk)). In contrast, the economic
value of citizens’ paid work participation to the government and society was barely
discussed in the policy documents. For example, economic issues that were influential in
the welfare-to-work reforms to sole parents’ income support discussed in chapter 2 – such
as the need to address the declining supply of labour, the problem of growing social
spending and the long-term ‘unemployment’ of sole mothers claiming income support –
were not raised in the Carer Payment (child) policy documents (cf. Cortis & Meagher
2009; Mendes 2009; Blaxland 2010; Brady 2011). The one exception to this was a brief
(and non-gender-specific) mention in the CPCR Taskforce’s report of the quandary facing
governments:

On the one hand, the value of informal care to the economy is indisputable, as is the need
for an increasing number of carers as the population ages; on the other hand, encouraging
carers to enter or re-enter the labour market provides benefits not just for the carer but for
the economy as a whole through improved productivity. (CPCR Taskforce 2007, p. 42)
6.2.4 Conclusion: care and paid work as dichotomous concepts

The tension that troubles feminists concerned with Wollstonecraft’s dilemma is resolved in favour of unpaid care in Carer Payment (child) policy. The dominance of the assumptions that family care (particularly constant care by a sole parent) is inevitable and appropriate, that intense care inevitably interferes with paid work participation, and that such care is highly valuable, mean that the policy supports only one arrangement – full-time unpaid care by a sole family member. These assumptions reflect binary, and largely dichotomous, thinking about the relationship between care and paid work. Citizens were presumed to be primarily unpaid carers, or primarily paid workers, and intense unpaid care was assumed to preclude, or at least significantly restrict, paid work participation. However, full-time caring was constructed as an exception to the norm for citizens – everyone without an intense caring role (and without a breadwinner partner) was presumed to be able to support himself or herself through paid work. In other words, Carer Payment (child) policy measures carers against the male norm of the full-time worker that is the heart of both sides of Wollstonecraft’s dilemma, and treats carers as a rare exception to this norm (Fraser 1994).

Carer Payment (child) is consistent with the wider trend, observed by some scholars, of Australian disability and aged care policy supporting carers’ unpaid caring roles over their paid work participation. This is contrasted with policy relating to women caring for dependent children without disabilities, which has tended to focus on facilitating (or requiring) mothers’ paid work (Cass 2006; Cass & Yeandle 2009; Pulkingham, Fuller & Kershaw 2010). While this policy sits at the intersection of these traditional fragmentations of care, care for a child with a severe disability or medical condition was characterised primarily as a form of disability care, and not really as a form of childcare, in the policy documents. This was signalled by the predominant use of the term ‘carer’ – mainly associated with disability care – in most official statements of the policy. It was also demonstrated by the limitation of access to the payment to people providing the extra care required by children with a severe disability or medical condition, and by the fact that most references to policies to complement Carer Payment (child) were to traditional disability services, like respite care and supported housing (CPCR Taskforce 2007, p. 37; Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009b, p. 3798 (Alex Hawke)).
The analysis also points to the different economic calculations that governments are assumed to make in relation to disability care and childcare. In addition to the supposed inevitability of full-time family care, a major impetus for the policy’s support for unpaid care was economic considerations, specifically, the cost of providing care for children with high care needs and, to a lesser extent, the increasing demand for care associated with demographic change (for example, CPCR Taskforce 2007, p. 29; Commonwealth of Australia 2009b, p. 3815 (Jill Hall); 2009c, p. 3387 (Gary Humphries)). This, too, is consistent with suggestions in the feminist social policy literature that other disability care policy (such as Carer Payment (adult)) has been protected from labour market ‘activation’ reforms like welfare-to-work because of the high intensity of disability care compared to mother-care of children, and the economic incentive that governments have to support informal carers and support the community care system (Cass 2006; Bittman, Hill & Thomson 2007; Cass & Yeandle 2009; Cash, Hodgkin & Warburton 2013).

The analysis of the literature in chapter 2 highlighted both feminist support for, and concern about, policies that fall on one side of Wollstonecraft’s dilemma or the other. Drawing on this literature, I next assess the effects and limitations of the binary thinking about unpaid care and paid work, and consequent support for unpaid care, in Carer Payment (child) policy.

6.3 The consequences of policy support for unpaid care over paid work

6.3.1 Paid work is not encouraged or facilitated

The first and most obvious consequence of Carer Payment (child)’s primary support for the unpaid caring role is that the policy does not include measures to increase carers’ paid work participation, or to address the negative consequences of women’s typical paid work patterns. In particular, feminist concerns about the lower workforce participation of women with caring responsibilities and their concentration in part-time and casual work were not identified as policy problems (for example, Cass 1995; Johnstone, Lucke & Lee 2011; Pocock, Charlesworth & Chapman 2013).

The relationship between carers’ responsibility for unpaid care and their involvement in paid work was undoubtedly a key focus of the Carer Payment (child) reforms, and carers’ relatively low rates of paid work participation were discussed in some of the documents. For example, the CPCR Taskforce (2007, p. 43) cited a range of statistics from the Australian Bureau of Statistics (‘ABS’) and other Government bodies regarding carers’
labour force participation, the impact of caring on this participation, carers’ reported
desire to engage in paid work, and perceived barriers to this participation. It reported that
‘the majority (61 per cent) of all primary carers are not in the labour force’, and that:

A lower proportion of primary carers of children with a severe or profound core activity
limitation (11 per cent) were employed full-time compared with all primary carers (17
per cent), and conversely a higher proportion were employed part-time (27 per cent
compared to 21 per cent). (ibid., p. 43)

Carers’ low paid work participation was also discussed in the parliamentary debates, with
parliamentarians identifying the disruptions to carers’ careers and work opportunities,
earnings, and ability to ‘balance work and financial obligations… with being a fulltime
carer’, as problematic consequences of constant, intense care (see section 5.2.1, above;
Commonwealth of Australia 2009b, pp. 3789 (Joanna Gash), 3819 (Nola Marino), 3820
(Yvette D’Ath), 3834 (Sharryn Jackson)). As I outlined in chapter 2, some feminists
problematisie carers’ lack of paid work participation for similar reasons – they emphasise
the negative consequences of low or no paid work participation, including limited
earnings, poorer financial security, limited opportunities for career advancement, less job
satisfaction, difficulties re-entering the workforce if the caring role ends, and lower
retirement savings. However, many of them also argue (or at least imply) that measures
to increase women’s ability to engage in paid work are essential to addressing these
problems (for example, Jenson & Jacobzone 2000; Cass 2006; Cass & Yeandle 2009).

More fundamentally, some (sameness) feminists have argued that support for women’s
paid work participation, and a commensurate alleviation of their caring responsibilities is
essential to women’s equality, because it is necessary for securing women’s economic
autonomy and self-sufficiency and ensuring that women are not dependent on either a
breadwinner (or other family) or the state (Ungerson 1997b; Knijn & Kremer 1997).

However, it was taken for granted in the Carer Payment (child) policy documents that
intense care loads restricted people’s ability to participate in paid work, and caring was
characterised as a legitimate and expected disruption to parents’ paid work participation.
The apparent inevitability of this situation meant that only the financial consequences of
this disruption – and not the disruption itself – were identified as a policy problem.
Consequently, the only policy solution offered was to provide a substitute income, and
the reforms were not concerned with measures to increase carers’ paid work participation,
like greater access to paid care services or flexible work options. The reforms also failed to address other shortcomings of carers’ limited paid work participation, such as a lack of superannuation contributions. The barriers to carers’ re-entry into the workforce once their caring role ends were also ignored. For example, a 14-week limit on Carer Payment (child) eligibility after the caring role permanently ceases has been criticised by some social policy scholars for being too short, in terms of giving carers enough time and support to re-enter work (Tilse, Rosenman & Le Brocque 1991, p. 184; Australian Human Rights Commission 2013, p. 45). This limitation was preserved without comment in the 2009 reform process.

Carer Payment (child) recipients can cease caring to undertake paid work for a certain number of hours per week, meaning that the policy does contemplate that carers may combine unpaid care and paid work. However, this eligibility exception merely removes an obstacle to carers’ paid work participation, rather than actively supporting it. In addition, the assumption that carers will only cease caring for their children temporarily in order to participate in paid work, and the restriction to 25 hours, indicates that carers are expected to emulate the role of the caregiver in male- or modified-breadwinner households, combining primary caring with no, or at most secondary, earning.

The necessity of greater policy support for carers’ paid work participation was identified in a small number of the Carer Payment (child) policy documents. For example, the CPCR Taskforce (2007, p. 3) identified ‘numerous additional barriers to workforce participation’ for carers who had the ‘desire to enter or re-enter the workforce when care requirements allow’. It cited ABS research from 2003 showing that 51 per cent of primary carers of children with a severe or profound disability who were unemployed or not in the labour force reported that they would like to work (ibid., p. 44). The main ‘perceived barrier to re-entering the workforce while caring’, identified by 47 per cent of these carers, was ‘no alternative care arrangement’, followed by ‘difficulty in arranging working hours’ (id.). Some of the carers quoted in the Carers Storybook also referred to a lack of ‘day care places for young children who required specially trained staff to give one-on-one time’ and an inability ‘to find paid employment that is flexible enough’ to accommodate their caring responsibilities (FAHCSIA 2008, pp. 30–31, 50). The CPCR Taskforce (2007, p. 42) also referred to the benefits of paid work, and its advantages compared to long periods of income support receipt, which included greater ‘financial security’ and ‘psychological and social benefits’.
The CPCR Taskforce, along with several Liberal parliamentarians, characterised these issues as problematic for reasons other than their immediate financial consequence. In particular, they argued that carers’ lack of choice about how they combined care and paid work must be addressed. This is similar to the arguments of some feminist social policy scholars, discussed in chapter 2 in relation to the universal caregiver model, that policies to promote gender equality must ensure that women and men have choice about how they combine unpaid care and paid work, although the gendered nature of these choices was not discussed in the policy documents (see Orloff 2008). For instance, the CPCR Taskforce (2007, p. 42) claimed that:

> carers who wish to continue in their caring role and carers who want to participate in education, training or employment should both be supported by government. The solution to this dilemma may be to provide sufficient options, choice and flexibility for carers so they are in a position to decide on the best solution for them, according to their individual circumstances.

Liberal Senator Sue Boyce explicitly challenged ‘the assumption that having a child with a severe disability will mean that a parent cannot work’ (Commonwealth of Australia 2009c, p. 3382). She said that:

> I want to get [sic] the situation of saying that having a parent who wants to work and cannot because they have a child with a disability is a failure of our system and not a necessary requirement that we are putting onto them because we do not have sufficient paid support services to allow them to undertake work in the same way as other people can. (id.)

Boyce’s Liberal colleagues also argued in favour of more support services to increase women’s ability to engage in paid work similar to those proposed in the feminist social policy literature, although again these references did not explicitly acknowledge the unequal gender division of labour (for example, Fraser 1994; Cass 1995; Pocock, Charlesworth & Chapman 2013). For instance, Senator Mitch Fifield noted that ‘there are some [carers] who are required to quit work and access the carer payment because the support services are simply not there’ (Commonwealth of Australia 2009c, p. 3369). Judi Moylan MP argued that ‘flexible working arrangements’ were also needed ‘so that carers are able to also participate in the workforce – not just for financial gain but also as an important part of self identity and of overcoming the social exclusion that many carers
feel in their community’ (Commonwealth of Australia 2009b, p. 3812). The CPCR
Taskforce (2007, p. 45) also proposed better access to ‘appropriate, flexible child care’,
specialist Job Network assistance, and government intervention to encourage and assist
employers to offer flexible working arrangements, better access to care leave, and more
training opportunities.

In reviewing the proposed reforms, the Senate Standing Committee (2009, pp. 2–3)
acknowledged the CPCR Taskforce’s recommendations, but it did not propose changes
to the Carer Payment (child) reform bill in this regard, and the suggestions to increase
choice and remove barriers to paid work participation were not adopted in the subsequent
reforms. They do, however, indicate that there were some ‘discursive spaces’ (Brady
2011, p. 278) for options other than male- or modified-breadwinner arrangements to be
contemplated and discussed in this policy sphere.

6.3.2 Unpaid care is valued and supported

While Carer Payment (child) raises concerns about women’s paid work participation, one
positive consequence from a feminist perspective of the policy’s prioritisation of support
for unpaid care is that it affords some value and recognition to full-time, unpaid care.
Many parliamentarians argued that Carer Payment (child) was important as both a form
of financial support and a symbolic recognition or acknowledgement of the contribution
that carers make to society and the sacrifices involved (Commonwealth of Australia
2009b, pp. 3793 (Scott Morrison), 3815 (Jill Hall), 3838, 3840 (Bill Shorten)). Some used
glowing language to describe the value of carers to Australian society – they lauded them
as ‘unsung heroes’, ‘saints’ who go ‘beyond the call of duty’, and people whose
commitment others ‘marvel at’ (ibid., pp. 3802 (Shayne Neumann), 3808 (Jim Turnour),
3839, 3840 (Bill Shorten)).

Carer Payment (child) is equally available to women and men, but the majority of
claimants are mothers, meaning it can be likened to earlier ‘maternalist’ income support
payments like the Supporting Mother’s Benefit that was introduced for sole mothers in
the 1970s (Cass 2006, p. 245). It recognises and supports the caring responsibilities of
some people, and provides some citizenship entitlements (specifically, access to income
support payments) on the basis of those responsibilities. As I discussed in chapter 2,
maternalist payments have been supported by some feminists because they offer
economic security and autonomy to women (and men) with dependent children, giving
them the option of being full-time carers, increasing their bargaining power in relationships, and providing some social protection for people who are not connected to the labour market (Orloff 1993; Cass 1995; Knijn & Kremer 1997). They can also compensate women for some of the costs of care, particularly inhibited paid work participation, as well as signalling that care is an economically and socially valuable activity (Ungerson 1997a; O’Connor J, Orloff & Shaver 1999; Jenson & Jacobzone 2000; Daly 2002).

The support for unpaid care in Carer Payment (child) indicates that the ‘farewell to maternalism’ (Orloff 2008) observed in relation to sole-mother care has not occurred in all care policies in Australia. The reforms were underpinned by an assumption that carers would rely on income support for long periods of time. This was constructed as legitimate and unproblematic because carers were making a valuable economic and social contribution through the ‘hard work’ of caring (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas)). In its report, the CPCR Taskforce (2007, p. 42) did mention some benefits of paid work participation over long-term receipt of income support, citing a Government report entitled ‘Building Stronger Families – The Benefits of Moving from Welfare to Work’. It explained that ‘[p]aid employment increases financial security for individuals and families’, and, in contrast with ‘long periods on income support rather than paid work’, was associated with ‘psychological and social benefits’ (id.). However, unlike sole mothers’ ‘welfare dependency’ that was said to justify the welfare-to-work reforms, carers’ current dependence on income support was not problematised (see Brady 2011). Instead, the CPCR Taskforce (2007, p. 42) used this information to argue that carers needed greater support to participate in the workforce; although, as I outlined above, this was not ultimately addressed in the reforms.

Carer Payment (child)’s exclusion from welfare-to-work style reforms meant that the policy avoids some of the shortcomings of this farewell to maternalism in other policy areas. For example, unlike Parenting Payment, carers’ income support does not impose individual responsibility for both care and self-sufficiency on carers. It partly acknowledges some of the structural barriers to women’s self-support through paid work, including a lack of care services and the poor quality of much part-time and casual work, by providing some financial compensation for it. In doing so, Carer Payment (child) preserves collective responsibility for the ‘risk’ of having a child with a severe disability or severe medical condition (see Blaxland 2010; Bowman, Bodsworth & Zinn 2013). In
this regard, parliamentarians characterised the payment as a form of ‘support from the rest of society’ (Commonwealth of Australia 2009b, p. 3791 (Amanda Rishworth)), and referred to ‘the capacity of the Australian community to help share the load that so many people with disabled people in their care shoulder on behalf of the whole Australian community’ (Commonwealth of Australia 2009c, p. 3387 (Steven Fielding)). Carer Payment (child) policy also avoids the symbolic and practical devaluing of care that some scholars argue was a consequence of the welfare-to-work reforms (see McDowell 2005, p. 372; Blaxland 2010, p. 144).

Despite these apparent advantages, there are also some significant limitations on Carer Payment (child)’s support for maternalism from a feminist perspective. The 2009 changes to the eligibility test extended access to Carer Payment (child) to around four times as many carers as previously qualified, and to new groups such as those providing care to a child with ‘episodic or short-term’ care needs of between three and six months’ duration (Commonwealth of Australia 2009b, p. 3825 (Graham Perrett); Social Security Act 1991, s. 197G). However, the Government reported that this amounted to only around 26,000 people, a figure far lower than the ‘approximately 54,600 [Australians] who were the primary carers of children with severe or profound core activity limitations’18 reported by the CPCRT Taskforce (2007, p. 7; see Commonwealth of Australia 2008, p. 2602 (Wayne Swan); Commonwealth of Australia 2009b, pp. 3822 (Richard Marles), 3828 (Julie Collins); 3830 (Mike Symon)). It also excluded the many more people caring for a child with a less ‘severe or profound’ disability, and those caring for a child without any diagnosed disability or medical condition at all (see Australian Human Rights Commission 2013, p. 3, 5). Hence, while Carer Payment (child) extended access to income support to more carers, unpaid care for children is only valued and supported for this small group of people, and some others with very young children who are eligible for Parenting Payment. That is, still only a subset of people with caring responsibilities for children are considered to have problematic caring roles that warrant the payment of income support. One parliamentarian noted this disparity, observing that the number of people receiving Carer Payment or Carer Allowance was ‘well below’ the number of people identified as carers by the ABS (Commonwealth of Australia 2009b, p. 3837 (Catherine King)). However, neither she, nor any other politician, explicitly identified

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18 The categories of ‘severe’ and ‘profound core activity limitations’ are used by the ABS to signify the highest extent of disability (ABS 2009d, p. 26).
this as a problem, emphasising instead that some more carers would be able to access the payment under the new eligibility test (ibid., pp. 3796 (Steve Georganas), 3807 (Jon Sullivan), 3833 (Sharryn Jackson)).

This means that Carer Payment (child) perpetuates the fragmented policy responses to care observed in the literature (Daly & Lewis 2000, pp. 285–6). The policy only recognises the importance and value of care in a narrow and ‘exclusive’ way, meaning neither a ‘right to time to care’ nor an ‘autonomous choice’ about whether to care are extended to people whose caring responsibilities do not match the specific criteria applying to the payment (Knijn & Kremer 1997, pp. 347–8). This produces ‘a strict division between citizen-workers and citizen-caregivers’, leaving little space for full-time workers to pursue caring roles or for full-time carers to engage in paid work (ibid., pp. 333, 348). This also means that the ideal and norm of the ‘citizen-worker’ remains unchallenged – most citizens will not be eligible for carers’ income support, and are expected and required to be self-sufficient, independent and unencumbered workers (ibid., p. 352; see also O’Connor J, Orloff & Shaver 1999; West 2003). Consequently, the reforms – and the policy more generally – represented only a relatively minor exception to the farewell to maternalism in income support policy, and certainly did not signify a broader return to the support for women’s caregiving roles offered by maternalist payments like the Supporting Mother’s Benefit (Cass 2006).

Another limitation on the policy’s valuing of maternalism relates to the quantum of the payment, with some parliamentarians suggesting that it was not high enough to afford sufficient value to care. In particular, care is not valued as highly as paid work, despite it being conceptualised in the policy as a form of work (for example, Commonwealth of Australia 2009b, pp. 3796 (Steve Georganas), 3800 (Jon Sullivan)). At the time the reforms were introduced, the regular payment for both sole or partnered Carer Payment (child) claimants (including linked benefits such as Rent Assistance, Carer Allowance, and Family Tax Benefit A) was less than half the full-time adult ordinary time earnings estimated by the ABS (Centrelink 2009a; ABS 2009b; 2009c).19 Non-Government parliamentarians expressed concerns about the rate of the payment, noting that it did not (and was not designed to) compensate for all of the costs of care, and did not constitute a

19 This calculation is based on a sole or partnered family with two children aged 13 or under. Slightly higher or lower rates of Family Tax Benefit A apply to children in other age groups (Centrelink 2009a, p. 2).
wage either symbolically or financially (CPCR Taskforce 2007, p. 1). For example, Senator Steve Fielding (of the minor party Family First) acknowledged that Carer Payment (child) payments ‘are by no means adequate compensation for the care provided in many cases’, while Liberal MP Judi Moylan said that Carer Payment (child) ‘is not designed to compensate carers for the costs associated with caring or to replace the wages or salary foregone’ (Commonwealth of Australia 2009c, p. 3388; 2009b, p. 3810).

A few Government representatives acknowledged that Carer Payment (child) was a ‘safety net’, and that the reforms constituted ‘a small, incremental step towards a higher level of support over time’ (Commonwealth of Australia 2009b, pp. 3830 (Mike Symon), 3837 (Catherine King); 2009c, p. 3386 (Gary Humphries)). However, this state of affairs was not considered to be problematic, and no solutions were offered. Similar cash payments for carers have been criticised by some feminist scholars on the basis that they are insufficient to prevent financial hardship or to provide financial independence either in the present or during retirement, or to adequately value care beyond mere symbolism (for example, Knijn & Kremer 1997; Jenson & Jacobzone 2000; Cass & Yeandle 2009).

The cohabitation rule restricting access to the payment to people without a breadwinner partner further limits the policy’s support for unpaid care. Under this rule, people who meet all of the eligibility criteria will not be eligible for income support if they are in a marriage-like relationship and their partner is deemed to have sufficient income and assets to financially support them (Social Security Act 1991, s. 4(2)). This means that the assumption in Carer Payment (child) that carers with ‘intense’ caring roles cannot support themselves through paid work does not extend to carers who have a breadwinner partner. Such carers are assumed to rely on a breadwinner rather than the state, and some feminist scholars have critiqued such provisions for reinforcing women’s dependency on a primary breadwinner and failing to compensate them for the costs of foregoing paid work (for example, Neave 1992; Hopkins 2005).

6.3.3 Individual, familial responsibility for care is encouraged

The negative financial, emotional and social consequences of family responsibility for caring were one of the four major problems identified in the Carer Payment (child) policy documents (Commonwealth of Australia 2009a, p. 3029 (Jenny Macklin); 2009b, pp. 3796 (Steve Georganas), 3840 (Bill Shorten)). Nevertheless, the policy gives rises to feminist concerns about the familialising and individualising effects of policies that
support informal family care, namely, that they reinforce the responsibility of one family member (predominantly women) to provide care, and shift the costs and burdens of that care away from other sectors and other family members (Jenson & Jacobzone 2000; Daly 2001; Bittman, Hill & Thomson 2007).

Data showing the high prevalence of informal care in the home were presented as general ‘background’ information throughout the policy documents, and were also cited as evidence that a large population of carers existed and required financial support. In a chapter of its report entitled ‘Context’, the CPCR Taskforce (2007, p. 25) reported a range of statistics collected by several Government bodies, including the ABS, FACSIA and the Australian Institute of Health and Welfare (‘AIHW’). For example, it referred to ABS figures showing that, in 2003, the ‘majority (80 per cent) of assistance with self-care for children with severe or profound core activity limitations was informal only’.

Similar data provided by the advocacy group Carers Australia was cited in Parliament. These included statistics showing that ‘79 per cent of assistance required by Australians due to disability or illness is provided by family carers – that is, someone within the family household’ (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas)) and that ‘23 per cent of primary carers were parents caring for a child’ (Commonwealth of Australia 2009c, pp. 3375, 3376 (Carol Brown)). The negative experiences of carers – such as their financial hardship, social isolation and stress – were frequently linked to this responsibility, and particularly to its intensity and constancy (for example, CPCR Taskforce 2007, pp. iii; 3; Commonwealth of Australia 2009b, pp. 3819 (Nola Marino), 3829 (Mike Symon), 3838–40 (Bill Shorten)). However, the assumption underpinning the policy that full-time family care is appropriate and inevitable meant that alleviating this responsibility was not offered as a necessary or appropriate policy solution in the Carer Payment (child) reforms.

Several parliamentarians did call for greater access to services to redistribute some responsibility for care outside the family, although these calls only took the form of short-term ‘respite’ rather than changes to encourage sharing of care more broadly within or beyond families (Bittman, Hill & Thomson 2007, p. 268). Liberal MP Alex Hawke called for ‘mechanisms to help carers to get some relief and to have time off’ (Commonwealth of Australia 2009b, p. 3798). His colleague Judi Moylan argued that ‘carers have little opportunity to engage in community activities, to spend time with their
other children or to spend time with their partner’ (which can lead to ‘relationship breakdowns’) if they do not have ‘adequate care for respite’ (ibid., p. 3812; see also pp. 3822 (Yvette D’Ath), 3827 (Julie Collins)). Several carers cited in the Carers Storybook reported difficulties in accessing respite care (FAHCSIA 2008, pp. 46, 66), and the Statistical Compendium published alongside the CPCR Taskforce report cited statistics showing that ‘[a]most half (48%) of primary carers of children with severe or profound core activity limitations reported needing more support… 40% [of them] reported more respite care as their greatest need’ (FAHCSIA 2007, p. 10; see also CPCR Taskforce 2007, p. 29). Judi Moylan also acknowledged the shortcomings of community care policies, and her criticisms were similar to some of the early feminist criticisms of community care (Finch & Groves 1983), although Moylan did not acknowledge the gendered implications of these policies. She stated that the ‘end of institutional care was widely supported, but despite the expansion of more personal assistance the system has left parents to take full responsibility without satisfactory community based support’ (Commonwealth of Australia 2009b, p. 3811). However, these concerns were not addressed in the Carer Payment (child) reforms, and were not mentioned in any of the other policy documents.

Carer Payment (child) policy also has the potential to reinforce an unequal division of caring within families, which feminists argue tends to mean women’s disproportionate responsibility for care (Jenson & Jacobzone 2000, p. 36; Cass & Yeandle 2009, p. 16). This accords with recent findings of the ABS (2016b) that women continue to comprise the vast majority of carers for a child with a disability (88 per cent in 2015). Sole responsibility for providing the majority of care is actively reinforced in Carer Payment (child) policy – the documents refer mainly to a sole ‘carer’, and only one person can access the payment unless multiple people are each providing ‘constant’ care (Social Security Act 1991, s. 197B(1)(c)(ii); Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009, p. 7). This has the potential to reinforce carers’ individual responsibility while relieving others in the family and community from that responsibility, or at least failing to encourage and support such shared responsibility (Glendinning & McLaughlin 1993, p. 248; Ungerson 2000, pp. 367–8). Jenson and Jacobzone (2000, p. 31) have argued that this is particularly so where income support is paid at a low rate, because it does not provide an incentive for other people to take on the caring role.
In the Carer Payment (child) policy reform documents, the Senate Standing Committee (2009, p. 8) noted that the advocacy groups Carers Australia and Carers Victoria had called for access to Carer Payment (child) for people sharing the care of one child. The Committee observed that the existing eligibility criteria failed to ‘recognise care shared with other family members, for example, grandparents’, which might discourage people from entering into such care arrangements. The CPCR Taskforce (2007, pp. 15, 54) had earlier recommended that the payment be made available where care of one child was shared part-time. Such a change would mean that the policy supported alternative, non-breadwinner-based family models, including potentially the equal gender division of paid work and care envisaged in the universal caregiver model (Fraser 1994). The Senate Standing Committee did not recommend these reforms in its report, although Australian Greens Senator Rachel Siewert agitated for the changes during the parliamentary debates, and in her role as a member of the committee (Commonwealth of Australia 2009c, pp. 3374–5; Senate Standing Committee 2009, pp. 15–16). This again indicates that there were some limited discursive spaces to contemplate alternatives to full-time, individual family care.

6.3.4 The gender division of labour is not addressed or alleviated

Gender differences in unpaid care and paid work participation were hardly addressed, and were certainly not problematised, in Carer Payment (child) policy. Policies that do not acknowledge the gendered nature of caring have been criticised for perpetuating a ‘myth of equality’, obscuring the unequal division of labour and discouraging policy responses to it (Patterson & Briar 2005, pp. 49, 54). The CPCR Taskforce (2007, p. 43) did cite gender-specific statistics about carers’ workforce participation, stating that:

the majority (62 per cent) of mothers who were primary carers of children with a severe or profound core activity restriction were not in the labour force, compared with 36 per cent of mothers of children the same age without a disability.

However, this was the only time the gendered nature of carers’ paid work participation was mentioned in the policy documents, and – unlike in the feminist social policy literature – it was not recognised as a problem requiring a policy solution (for example, Jenson & Jacobzone 2000; Bittman, Hill & Thomson 2007).

The policy documents were also largely silent on women’s disproportionate responsibility for unpaid care. The main exception to this was the CPCR Taskforce’s recitation of
statistics about women’s – particularly mothers’ – roles as carers. The CPCR Taskforce noted that the ‘majority of primary carers of children with a severe or profound core activity limitation were mothers (91 per cent)’ (CPCR Taskforce 2007, p. 28; see also FAHCSIA 2007, p. 12). These figures were presented without comment in a section labeled ‘Carer population characteristics’.

As mentioned earlier in this chapter, the CPCR Taskforce (2007, pp. 29, 42) also explained that demographic changes (the ‘ageing population’) and policy tensions between wanting to promote female workforce participation and wanting to ensure a supply of informal carers were likely to affect ‘younger, working age groups (particularly women)’ who may fall into the ‘sandwich generation’ of women who have caring responsibilities for their children or grandchildren and their elderly parents at the same time. In other words, the CPCR Taskforce highlighted an economic analogue to Wollstonecraft’s dilemma – a tension facing governments between addressing the problems of a shrinking workforce and tax base by increasing women’s paid work participation, and addressing the problems of an increasing demand for care and declining supply of carers by supporting women’s unpaid care participation (see Burgess & Strachan 2005, p. 6; Fine 2012, p. 59). However, while this coincides with Wollstonecraft’s dilemma, it reflects distinct, non-feminist concerns – the tension between supporting either unpaid care or paid work is understood as a tension between competing economic incentives, rather than a disagreement about the meaning and pursuit of gender equality. This economic calculation was also alluded to by a number of parliamentarians, who emphasised the economic value of unpaid care in the Carer Payment (child) policy reforms (for example Commonwealth of Australia 2009b, p. 3815 (Jill Hall); 2009c, p. 3387 (Gary Humphries)).

The gendered nature of care was mentioned only twice during the parliamentary debates. Liberal MP Scott Morrison cited AIHW research demonstrating that ‘most carers of a child with a severe or profound disability are their mother’ (Commonwealth of Australia 2009b, p. 3795), while Labor Senator Chris Evans acknowledged that ‘one of the things that has always struck me as a bloke is how many children with disabilities are cared for by women singly’ (Commonwealth of Australia 2009c, p. 3395). The gender of carers was not mentioned or identified as a relevant factor in any of the other Carer Payment (child) policy documents. As mentioned in chapter 5, the targets of the policy were most frequently described using non-gendered terms like ‘carer’ and ‘parent’ (for example,
Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009b, pp. 3795, 3796 (Steve Georganas)). While Senator Evans claimed that the prevalence of sole mother carers ‘does not do the male gender much credit’, neither he, nor the CPCR Taskforce or any other parliamentarians, identified the unequal gender division of labour as a problem requiring a policy solution (Commonwealth of Australia 2009c, p. 3395).

The only other document to mention carers’ gender was the Carers Storybook, which mainly featured primary carers who were women. They included four sole mothers, one father who was the carer for his children and his wife (who each had a disability), one heterosexual couple who each combined their caring with part-time work, and 12 partnered mothers whose male partners were the family breadwinner and appeared to be less involved in caring (FAHCSIA 2008). For example, Linda said of her partner that, ‘[l]uckily, Kevin is a hands-on dad and is great with her when he comes home from work’ (ibid., p. 34); while Teegan’s father was said to have had the ‘important role [of] supporting all the family throughout the years’ (ibid., p. 27). Bree and Michael’s arrangement was similar, with the Storybook stating that, ‘most of the load [of care for their son Connor] falls to Bree, allowing Michael to keep working to support the family’ (ibid., p. 48; see also pp. 4, 42, 46, 76). The inequality of the gender division of labour, or its implications for different family members, was not remarked upon in the document. This failure to problematise the unequal gender division of labour meant that the consequences of this inequality – particularly the fact that the costs of caring fall mainly to women – were also ignored in the Carer Payment (child) reforms.

6.4 Conclusion

The 2009 Carer Payment (child) reforms presented a fragmented response to the tension between supporting unpaid care and supporting paid work. The policy supports unpaid care over paid work in the case of intense care for a child with a severe disability or medical condition, but assumes paid work participation is possible (if not necessary) for all others. I have linked this to the predominance of three sets of assumptions about the relationship between care and paid work which signal the dominance of a particular discourse of unpaid care. These assumptions – that one family member should take primary responsibility for providing care, that care precludes substantial paid work participation, and that unpaid care is economically valuable – mean the policy’s prioritisation of unpaid care over paid work appears essentially inevitable. Consequently,
unpaid care and paid work are treated as largely dichotomous activities. This discourse was dominant; there was little recognition that a policy tension may exist between supporting the two activities in the case of carers with intense caring roles, with only very limited attention being given to policy responses to carers’ low paid work participation.

The policy’s support for unpaid care has both positive and negative consequences in terms of Wollstonecraft’s dilemma. It gives partial support and recognition to the caring roles of more carers than were previously eligible for Carer Payment (child), but in doing so it risks reinforcing familial responsibility for that care, which in practice more often means women’s responsibility for care. However, it is relevant to note that policy solutions favouring the other side of Wollstonecraft’s dilemma would simply produce different pros and cons from a feminist social policy perspective. For example, a policy that only supported or necessitated women’s paid work would be problematic because it would produce little or no recognition or support for the caring role, a criticism previously levelled at the welfare-to-work reforms that prioritise paid work over unpaid care for sole mothers claiming Parenting Payment (Pulkingham, Fuller & Kershaw 2010; Blaxland 2010). Less dichotomous solutions, such as those advanced by supporters of a universal caregiver model to facilitate more equal sharing of unpaid care and paid work between partners, were almost unthinkable in this policy space. This is not surprising given the policy’s reproduction of the norm of the full-time (male) worker, wherein full-time care is constructed as exceptional, and only appropriate, in quite extreme cases.

This also points to a more fundamental limitation of Carer Payment (child) in terms of feminist gender equality goals. While the policy has some potential benefits from a feminist perspective, the policy reforms were not explicitly – or even implicitly – concerned with feminist issues. That is, the specifically gendered nature of the tension between supporting unpaid care and supporting paid work was not acknowledged or addressed, and the policy’s positives from a feminist perspective were mostly incidental rather than a result of feminist ‘thinking’ about the relative merits of supporting unpaid care or supporting paid work. The policy is not intended to support either the sameness or difference goals referenced in Wollstonecraft’s dilemma, or the transformation goal of the universal caregiver model. Rather, the main justification for the reforms was that supporting unpaid care had economic value for the government and society, and feminist issues such as the cultural undervaluation of women’s caring, the inability of women to form ‘autonomous households’ (Orloff 1993, p. 319) without relying on paid work or a
breadwinner partner, or the gender division of labour, did not arise. As a result, the policy advances feminist goals in a narrow and limited way. This confirms the need for a different policy approach that explicitly addresses gender inequality and creates the possibility of resolving Wollstonecraft’s dilemma.
7. The fragmented treatment of the interests of carers and people with disabilities in Carer Payment (child)

7.1 Overview

In this chapter, I demonstrate that Carer Payment (child) policy also treats the interests of carers and those of people with disabilities in a fragmented, binary fashion similar to that identified in the analysis of the literature in chapter 2. In particular, the policy focuses primarily on the interests of carers, and only indirectly on those of children with disabilities. Unlike feminist concerns about gender equality, which hardly arose and certainly did not dominate the thinking behind Carer Payment (child) policy, the policy’s support for carers is underpinned by assumptions about the burden and tragedy of disability that are closely aligned with the discourses of care and disability that have previously been identified as key to carers’ successful claims-making (Fine 2004).

In Carer Payment (child) policy, these assumptions lead apparently logically to a predominant view of caring and disability as a burden on individual carers, and to policy solutions focused on addressing – or at least acknowledging – this burden and its impacts on carers. There is little discursive space in Carer Payment (child) policy to contemplate the distinct interests of children with disabilities, or the alternative conceptualisation of care as oppressive and inappropriate that has long been advanced by some disability rights scholars and activists (for example, Keith 1992). Drawing on the carer and disability rights literature discussed in chapter 2, I identify both positive and negative consequences of Carer Payment (child)’s handling of this tension for both carers and children with disabilities.

7.2 The construction of disability and care in Carer Payment (child)

7.2.1 Disability is individual, tragic and burdensome

Several assumptions about the nature of disability underpinned the Carer Payment (child) reforms, and made the dominant conceptualisations of the ‘problem’ in the reform process appear to be common-sense and inevitable (Bacchi 2009, p. 16). In particular, it was assumed that disability constitutes an individual medical deficit, and a tragic and unwanted occurrence for carers, and that children with disabilities are passive and silent objects of care whose needs can be entirely defined by their carers and medical professionals. These assumptions are consistent with the medical model (or discourse) of
disability that disability rights scholars argue has ‘dominated policy responses to persons with impairments’ in Australia and much of the world (Kayess & French 2008, p. 6).

7.2.1.1 Disability is a medical deficit affecting individual children

The assumption that disability constitutes an individual medical deficit is apparent in many of the Carer Payment (child) policy documents. The assessment test for the child’s disability or medical condition introduced with the 2009 reforms does have a much wider focus than the eligibility test that applied when Carer Payment (child) was first introduced, under which a child had to meet at least three of seven specific medical criteria. Nevertheless, the new carer and professional questionnaires locate the problem of disability squarely within the body and/or mind of the child, and the extent to which the child differs from other children whose abilities are ‘age appropriate’ (Centrelink 2009d, p. 4) is central to the assessment of a carer’s eligibility. The questions in the Carer Payment (child) questionnaires are almost entirely concerned with the abilities, behaviours and care needs of the child, and these needs are assumed to translate directly into a ‘care load’ for the carer (see section 4.4.5, above). In the questionnaire completed by the carer, questions inquire about a range of behavioural issues, such as the child’s ‘extreme irritability’, ‘high-risk and reckless behaviour that causes a danger to himself/herself or to others, including family members’, and ‘extreme difficulty settling before going to sleep at night’ (Centrelink 2009c, pp. 2, 4). Functional abilities that are assessed include the child’s ability to ‘go up and down 12 steps indoors himself/herself’, ‘dress himself/herself from the waist up’ and ‘from the waist down’, and ‘do everyday grooming tasks (e.g. brush teeth, brush/comb hair, wash and rinse hands and face)’ (ibid., pp. 5, 7). Special care needs encompass a child’s need for dialysis in the home, postural drainage, assistance with chewing, physical assistance to turn and move, and a range of other matters (ibid., p. 8). In some instances, the carer must also indicate whether the child’s abilities ‘are similar to other children of the same age’ (ibid., p. 2).

In addition, a carer cannot qualify for Carer Payment (child) without a treating health professional’s confirmation of the child’s care needs in the professional questionnaire (Centrelink 2009d). Only people in medical or allied health professions can complete the professional questionnaire, meaning the authority to determine and diagnose disability remains in the medical realm. As with carers completing the carer questionnaire, a treating health professional is required to compare the child’s behaviours and functional abilities with age-appropriate norms, and to itemise the child’s special care needs.
The child’s medical diagnosis and the care load this creates for the carer are the central feature of the 19 stories in the Carers Storybook. For example, the story of Timmy and his parents begins as follows:

Six-year-old Timmy has a great sense of humour and keeps everyone amused with his one-liners. He is also learning to play the keyboard and loves to entertain his family. But this cheerful little boy is trapped inside an uncooperative body. Born 10 weeks premature, he has spastic quadriplegia cerebral palsy. (FAHCSIA 2008, p. 28)

The story goes on to describe Timmy’s medical diagnosis, and what his care involves for his parents. For example, it is explained that, Timmy ‘relies on a wheelchair because he cannot stand or sit unassisted’, and that the ‘level of care for Timmy is also constant. He wakes frequently throughout the night. He is drip fed through a “kangaroo pump” which needs to be flushed every three to four hours’. The main consequence of this was ‘years of disturbed nights for Jessica and her husband Michael’ (FAHCSIA 2008, pp. 28–30).

This is a typical example of the stories in the book, each of which is accompanied by a large photograph of the carer and child (see fig. 7.1). Many begin with a statement about how the child is similar to other children, before going into detail about his or her medical condition or disability, focusing predominantly on the care load that results for the child’s family. I return to this emphasis on the burden of care later in this chapter.

Figure 7.1: A photograph of Timmy and his father Michael from the Carers Storybook (FACHSIA 2008, p. 29).
7.2.1.2 Disability is a tragedy

The structure of Timmy’s story points to another disability-specific assumption underpinning the problem representations in the 2009 Carer Payment (child) reforms, namely, that disability constitutes a tragedy. Two Labor MPs – Steve Georganas and Bill Shorten – explicitly described having a child with a disability as an unfortunate consequence of fate. Shorten stated that disability arises ‘nearly always by accident, by an unplanned shaft of fate’ (Commonwealth of Australia 2009b, p. 3840; see also Commonwealth of Australia 2009c, p. 3387 (Gary Humphries)). Georganas claimed that the ‘sheer twists of fate’ that befall carers can take a variety of forms, ‘such as finding yourself in the situation of having a child born with a disability or having a loved one who acquires a disability later on in life through an accident or some other means’ (Commonwealth of Australia 2009b, p. 3796). The first sentence of the introduction to the Carers Storybook reflects a similar conceptualisation of disability: ‘[a]n unforeseen diagnosis, an accident or a twist of fate – for each family in this storybook there was a moment when their lives changed forever’ (FAHCSIA 2008, p. 3).

Several politicians also highlighted the tragic nature of having a child with a disability or medical condition. Labor MP Richard Marles used the word ‘tragedy’ several times to describe the circumstances of carers, while Scott Morrison MP said that ‘those of us who are blessed with children who do not suffer from these conditions… can only thank God’ (Commonwealth of Australia 2009b, pp. 3823, 3794). A number of the stories in the Carers Storybook emphasised that the child’s disability or medical condition was unexpected and a source of ‘shock’ or ‘grief’ for the child’s parents – for instance, Kate’s diagnosis of ‘severe intellectual disability’ led to a ‘period of grieving for the “normal” baby [her parents] had lost’ (FAHCSIA 2008, p. 16; see also pp. 10, 24, 32, 76). Many other politicians observed that carers do not choose to be carers, but are the unfortunate victims of circumstance. Liberal MP Sharman Stone stated that people become dedicated carers ‘[o]ften through no fault or predisposition on their part’ (Commonwealth of Australia 2009b, p. 3804). Senator Bilyk explained that there ‘is no prescribed background for people who become carers. It can hit people at any time in their lives. It is not something you can necessarily really prepare for’ (Commonwealth of Australia 2009c, p. 3383; see also Commonwealth of Australia 2009b, pp. 3802–4 (Shayne Neumann), 3817 (Nola Marino), 3822–3 (Richard Marles)).
7.2.1.3 *Children with disabilities are passive, carers are active*

A third assumption signalling the predominance of the medical model of disability is that children with a severe disability or medical condition are passive, dependent recipients of carers’ care. Children with disabilities were described in passive terms throughout the Carer Payment (child) policy documents. The legislation establishing the Carer Payment (child) eligibility criteria refers to the ‘care receiver’ who ‘must require constant care’ in order for his or her carer to be eligible for Carer Payment (child) (*Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009*, p. 4; *Social Security Act 1991*, s. 197B(4)). These care recipients were mentioned far less often than their carers, and in addition to being termed ‘children with severe disability or medical conditions’ throughout the documents (CPCR Taskforce 2007, p. 24) were also called carers’ ‘charges’, ‘those least able to care for themselves’, the ‘cared for’ and in one instance, ‘the life that the carers are caring for’ (Commonwealth of Australia 2009b, pp. 3788, 3789 (Joanna Gash), 3791 (Amanda Rishworth), 3802 (Shayne Neumann), 3821 (Yvette D’Ath)).

There were a few instances in which the agency and personal interests of children with disabilities was discussed, but these were the exception rather than the rule. They were also incidental to the policy reforms rather than indicating that the policy treated them as active subjects. For example, a few parliamentarians described children with a disability or medical condition as active and engaged members of the community. Yvette D’Ath MP referred to ‘a respite centre which focuses on people with disabilities – but on their skills and their abilities. They are artists and musicians first; they are not known for their disability’ (Commonwealth of Australia 2009b, p. 3821; see also p. 3805 (Sharman Stone)). Likewise, the stories in the Carers Storybook were dedicated mainly to describing the child’s medical care needs and the care load borne by carers, but they did include information about the hobbies, personalities and future potential of the children. For example, Bianca’s seven-year-old son Lachlann was described as ‘autistic, intellectually impaired and incontinent’, but the family’s story concluded with an observation that Lachlann is ‘really proud of the way he is and he thinks he’s cool because he does things no-one else can do’ (FAHCSIA 2008, p. 4, 5).

In contrast, carers were consistently described as the active (and usually the sole) givers of care, and as the central targets of the policy. For example, the carer questionnaire measures the child’s care needs, but is focused mainly on whether these needs require
action by the carer. A typical example is a question about a child’s ‘self-harm behaviours’, which asks whether carers ‘never need to intervene or supervise’, ‘on some occasions…need to intervene or supervise’, ‘sometimes need to avoid specific situations or triggers that lead to this behaviour’, or ‘need to constantly (i.e. every day) supervise the child to avoid specific situations or triggers that lead to this behaviour’ (Centrelink 2009c, p. 4).

Parliamentarians focused mainly on the circumstances and experiences of carers in their discussions of the Carer Payment (child) reforms, relying on data provided by Carers Australia and the ABS about the prevalence, consequences and benefits of care from the carer’s perspective (for example, Commonwealth of Australia 2009b, pp. 3796–7 (Steve Georganas)). Several parliamentarians also referred to contact they had had with constituents who were carers, discussing their difficult financial circumstances or the challenges they faced in making a successful claim for Carer Payment (child) (for example, Commonwealth of Australia 2009b, pp. 3790–1 (Amanda Rishworth), 3809 (Jim Turnour), 3820–2 (Yvette D’Ath), 3833 (Sharryn Jackson)). Even data specifically about people with disabilities was cited mainly in relation to the role that carers played in their lives. For example, Senator Carol Brown cited a range of statistics about the number of people with disabilities in Australia in order to demonstrate the great need for assistance in the community, including that ‘there are a significant number of children around the country living with a disability who require carer assistance and support’ (Commonwealth of Australia 2009c, p. 3376). Similarly, Liberal MP Scott Morrison quoted statistics published by the AIHW on the numbers of children with a disability, and particularly the number with a ‘core activity limitation’, for the purpose of demonstrating ‘the all-pervasive presence’ of care for children with disabilities in the community (Commonwealth of Australia 2009b, p. 3794).

### 7.2.2 Caring (unlike usual parenting) is a burden

As I have already noted, the high intensity of care is key to establishing an individual’s eligibility for Carer Payment (child), and only those providing this high level of care – which is presumed to flow inevitably from a child’s high care needs – will qualify for support. I argued in chapter 5 that the costs and hardships of this care – including financial costs, and negative impacts on carers’ wellbeing, family lives and careers – were one of the four major policy ‘problems’ apparent in the Carer Payment (child) documents. Many
of these costs are identified in the carer literature as key sources of the ‘burden’ of care (for example, Twigg & Atkin 1994; Edwards B et al. 2008). This points to an additional set of assumptions underpinning Carer Payment (child) policy that are closely related to this construction of disability, but which relate specifically to the burdensome nature of caring for someone with a disability. In the 2009 reform documents, some politicians explicitly referred to caring as a ‘burden’ (Commonwealth of Australia 2009b, p. 3792 (Scott Morrison); 2009c, p. 3388 (Mitch Fifield)). Others used similarly emotive language to describe the experiences of carers as a ‘torment’ and ‘stress’, as ‘mentally excruciating’ and ‘taxing on the soul’ (Commonwealth of Australia 2009b, pp. 3786, 3787 (Joanna Gash); see also p. 3840 (Tony Zappia)). Mitch Fifield, a Liberal Senator, stated that ‘in many cases, [carers] have more reasons to cry than to celebrate’ (Commonwealth of Australia 2009c, pp. 3387–8). There were two more specific elements to the construction of care as a burden in Carer Payment (child) policy – first, such care was assumed to be much more burdensome than parenting generally, and secondly, carers were assumed to be willing and able to bear this burden because of their love and devotion to their child.

7.2.2.1 Disability care is more burdensome than usual parenting

The burden of caring is established in the Carer Payment (child) documents mainly through a comparison of disability care with the ‘usual’ parental care of children without a severe disability or medical condition (CPCR Taskforce 2007, p. 37). The policy documents indicate that all parents, regardless of whether their child has a disability or medical condition, were assumed to be responsible for providing the majority of care for their children. However, a distinction was drawn between usual parenting and intense care, with caring for a child with a severe disability or medical condition being constructed as fundamentally different to usual parenting due to the greater effort and commitment involved. As Jon Sullivan MP explained, ‘a child requires a degree of care from a parent simply by being a child. The disability degree will add to that level of care’ (Commonwealth of Australia 2009b, p. 3800). Liberal Senator Mitch Fifield similarly observed that, ‘the caring requirements of a child with a disability or a severe medical condition often go much further than that of day-to-day parenting’ (Commonwealth of Australia 2009c, p. 3368). The discussion paper released at the commencement of the CPCR Taskforce review explicitly invited carers to explain ‘how in your experience, your caring role goes beyond usual parenting responsibilities due to your child having a severe
disability or illness…’ (FACSIA 2007, p. 7), and one of the terms of references for the review was to:

Identify the challenges and critical role for carers of children with significant care needs, which go beyond the expectations of the caring role of a parent of a child who does not have a severe disability or medical condition (CPCR Taskforce 2007, p. 22).

The CPCR Taskforce (ibid., p. 65) stated that the original Carer Payment (child) eligibility test (which required children to meet three of seven specific medical criteria) was formulated so narrowly due to concerns that it was difficult to distinguish between the needs of a child with a disability and ‘the general, and particularly the age-related, care responsibility inherent in parenthood’. It asserted that introducing a more comprehensive care load test would address this concern because the difference between the ‘additional care necessarily involved’ in caring for a child with a severe disability or severe medical condition ‘can be identified in the majority of cases and becomes increasingly demonstrable with older children’ (id.).

Many parliamentarians elaborated on the distinction between ‘the level of care’ required of carers and people in a ‘usual parenting role’ (Commonwealth of Australia 2009b, p. 3819 (Yvette D’Ath)). In addition to the greater intensity of these daily caring activities, they highlighted the constancy of caring every day and its persistence over many years as features that distinguished caring from usual parenting (ibid., pp. 3800 (Jon Sullivan), 3819 (Yvette D’Ath); Commonwealth of Australia 2009c, p. 3368 (Mitch Fifield)). For instance, Bill Shorten MP discussed how carers’ experiences differed to those of other parents:

These children [with a severe disability or medical condition] are loved as other children are loved. But the sacrifices that are demanded of their parents and the pressures placed upon them are greater than those placed on other parents. Their lives are not their own. Each hour of sleep can be interrupted by the deeply-rooted instinct to help, and the vigilance and attention needs to be constant. Every day can bring a new crisis or new joy, and every change in their child’s situation—from starting school to leaving school—brings a new set of challenges. (Commonwealth of Australia 2009b, pp. 3839–40)

The dependency of children with disabilities was assumed to be a deviation from normal childhood development. Children were not expected to develop into competent subjects, and their parents could not ‘ever hope for their child to enjoy the milestones in life that
most of us celebrate as our children go to adulthood and independence’ (Commonwealth of Australia 2009b, p. 3810 (Judi Moylan)). The fact that parents’ caring responsibilities usually decrease as their child gets older, but not in the case of a child with a severe disability or medical condition, was highlighted by politicians on both sides of parliament. Bill Shorten stated that:

For many, the task of caring for their child does not get easier as the child gets older. The gradual gaining of independence does not happen and the child remains dependent on an ageing parent or parents into their adulthood. (Commonwealth of Australia 2009b, p. 3839; see also Commonwealth of Australia 2009c, p. 3370 (Mitch Fifield))

Julie Collins MP likewise explained that, ‘we all know that a child born with profound disability does not get better; their care only continues’ (Commonwealth of Australia 2009b, p. 3826), while Senator Gary Humphries said, it ‘is very likely that a person with disability will only have greater needs in the future rather than lesser needs’ (Commonwealth of Australia 2009c, p. 3387; see also p. 3367 (Mitch Fifield)). In explaining how it drew a distinction between usual parenting and intense caring – the latter of which necessitated access to income support – the CPCR Taskforce (2007, p. 37) stated that:

the fundamental nature of parenting is a level of care that decreases over time and is replaced by monitoring [sic] supervision and, finally, independence as the child becomes more competent. Parents who are also carers may not have the same decrease in their caring and supervisory roles, which are coupled with increases in personal responsibility for the judgments and decisions about the care, disability or medical condition.

The expectation that caring is long-term and constant is also apparent in the Carer Payment (child) eligibility criteria – there is no time limit on the payment as long as the child is aged under 16, and carers will generally qualify for the payment if the child’s care needs are expected to persist for at least six months (Social Security Act 1991, s. 197B).20

7.2.2.2 Carers bear the burden of care out of love and devotion

Despite the intense and long-term nature of children’s dependency, the Carer Payment (child) documents indicated that carers of children with a severe disability or medical

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20 The 2009 reforms introduced an exception for short-term or episodic conditions, about which there must be a (medical) expectation that care will be required for between three and six months; nevertheless, care needs during this time must be constant and intense (Social Security Act 1991, s. 197G).
condition were assumed to be able to bear the burdens of caring through natural feelings of love and self-sacrifice. The care receiver was frequently described as the carer’s ‘loved one’ or ‘those whom they love’ in the policy documents (Commonwealth of Australia 2009b, pp. 3790 (Amanda Rishworth), 3796–7 (Steve Georganas), 3803 (Shayne Neumann)). As well as being described as heroes (see section 6.3.2, above), parents were celebrated for displaying ‘incredible devotion’ to their child, and for being willing to ‘do it all again’ despite the sacrifices involved (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas), p. 3790 (Amanda Rishworth)). Bill Shorten explained that, while the diagnosis of disability or illness may produce grief and mourning, parents find ‘love and acceptance and the desire to do whatever it takes to make their child’s life as painless and as fulfilling as possible’ (ibid., p. 3838). Similarly, Senator Carol Brown stated that ‘caring for others, especially those who have particular needs, requires a certain degree of dedication, patience, persistence and lots of love’ (Commonwealth of Australia 2009c, p. 3376). Scott Morrison also characterised caring as ‘a burden that [carers] bear out of love’ (Commonwealth of Australia 2009b, p. 3792; see also p. 3831 (Nick Champion)).

Some parliamentarians suggested that carers’ devotion and love meant that they were naturally and inevitably inclined to dedicate themselves to full-time care, and to make the ‘sacrifices’ associated with this role. For instance, Nola Marino MP explained that, for some constituents in her electorate, caring for their children at home (rather than ‘placing them in care’) was ‘exactly what they want to do and they would not have it any other way’ (Commonwealth of Australia 2009b, p. 3818; see also p. 3831 (Nick Champion)). Richard Marles MP said that there ‘is a wonder associated with looking after a child in that circumstance with that complete devotion… [carers] come the closest to touching pure and unadulterated love – the love that they provide for their disabled children’ (Commonwealth of Australia 2009b, p. 3823). Graham Perrett MP claimed that ‘carers and parents would do anything for their children to give them the best life possible’ (ibid., p. 3825), while Yvette D’Ath MP stated that:

most carers would tell you that it was not a difficult choice [to become a carer], that it probably was not a choice at all; it was just something that they needed to do and wanted to do. (ibid., p. 3820)

Other politicians emphasised carers’ willingness to undertake the role despite its difficulties. Richard Marles noted that ‘you will never hear a complaint about the cards
that life has dealt them’ (Commonwealth of Australia 2009b, p. 3823), while Senator Fielding of Family First claimed that carers ‘do not ask for rewards or grand recognition’ (Commonwealth of Australia 2009c, p. 3388). Catherine King MP also explained that she supported the reform bill because ‘carers really are amazing people and selflessly spend their days supporting others’ (Commonwealth of Australia 2009b, p. 3838). When discussing the group of people who would benefit from the Carer Payment (child) reforms, Liberal MP Joanna Gash said that she did not ‘begrudge them one iota – not even for a minute. I can only admire their tenacity, their total commitment and their endless patience’ (ibid., p. 3788). She also claimed that both sides of parliament shared a ‘common will to help those who selflessly help’ (ibid., p. 3787). This overlaps with the assumption, discussed in chapter 6, that individual carers must forego paid work (and, by extension, most other activities) to be full-time carers.

In addition to the economic value of care (also discussed in chapter 6), the burden of caring and its consequences were often cited as the reason for supporting carers through Carer Payment (child). For example, Steve Georganas MP argued that carers ‘deserve every single bit of support government can provide. In fact, it is our duty to provide them with every bit of support that we possibly can’ because of the ‘enormous responsibility’ involved in caring (Commonwealth of Australia 2009b, p. 3796). Similarly, Senator Bilyk said that the government’s role was to create ‘security and certainty for carers in our society, who work tirelessly to provide both emotional and practical assistance to the person in their care’ (Commonwealth of Australia 2009c, p. 3383). She further explained that:

> Carers make huge sacrifices every day to look after their loved ones and this can place huge emotional and financial burdens on them. Carers deserve all the support they can get to help them in their efforts to make the life of someone they care about easier and to help make their own lives a little easier as well. (id.)

Scott Morrison suggested that the tragic (or at least highly undesirable) nature of having a child with a disability highlighted a ‘need for us to have profound compassion for those who deal with this situation’ (Commonwealth of Australia 2009b, p. 3794). Labor MP Nick Champion similarly explained that the Carer Payment (child) reforms reflected ‘the community’s expectation that we should have compassion and should support’ carers (ibid., p. 3833). In decrying the insufficiency of support for carers in the past, Champion’s
colleague Graham Perrett claimed that, ‘[w]e judge a society by how it treats those who are most vulnerable. Australia, unfortunately, does not have an unblemished record when it comes to such judgements’ (ibid., p. 3826). Jill Hall MP also claimed that the bipartisan support for the reforms was due to the vulnerability and need of carers – ‘when it comes to an issue where we are providing support to some of the most vulnerable people – some of the people in our communities and electorates who need support more than anyone else – it is important we all join together’ (ibid., p. 3813).

**7.2.3 Conclusion: disability care and usual childcare as dichotomous concepts**

Carer Payment (child) policy is focused primarily on how disability and care affects carers. The policy solutions – providing income support, and extending access to it to more carers – apply to carers, and only indirectly to their children. In this way, carers are constructed as the bearers and subjects of the policy problem, and the appropriate targets of the policy solution. This is reflective of the assumptions that structure the thinking behind the policy – particularly, the assumption that children with disabilities are tragic victims of impairment, and that their carers are heroes surviving in the face of great hardship.

Many elements of the reform process demonstrated this predominant focus on carers rather than children with disabilities. Each of the four main problem representations that I identified in chapter 5 was concerned with the experiences and circumstances of carers – the problem of care disrupting their paid work participation and income, the problem of the eligibility test precluding many carers from accessing support, the problem of the costs and hardships of care, and the problem of a lack of support and recognition for carers. Even children’s disability or medical conditions were defined primarily from the carer perspective – children’s medical care needs are measured in terms of the care load they produce for the carer, and the tragedy of disability is mainly a tragedy for the carer.

In chapter 6, I argued that the resolution of Wollstonecraft’s dilemma in favour of supporting unpaid care reflected dichotomous thinking about unpaid care and paid work in Carer Payment (child) policy. The analysis in this chapter does not demonstrate such dichotomous thinking about the interests of carers and those of children with disabilities. Rather, the interests of children with disabilities were narrowly construed to mean the medical care needs arising from their impairment, and it was assumed that those care needs could and should be met by their carers. Consequently, reforms to support carers’
caring roles were assumed to also support the interests of their children. Jill Hall MP directly linked the interests of carers and their children, arguing that, ‘we should be providing more support to these parents. In doing so, we are providing more support to their children’ (Commonwealth of Australia 2009b, p. 3814). Liberal MP Judi Moylan similarly claimed that the Carer Payment (child) reforms were ‘a good step in the direction of caring for Australian carers and those who depend on them for quality of life’ (ibid., p. 3809), while Labor’s Catherine King described ‘carer payments’ as ‘a safety net for these families and these children with a profound disability or medical condition’ (ibid., p. 3837).

Providing greater support for unpaid family care was characterised in the policy documents as a good policy outcome for carers (for example, Commonwealth of Australia 2009b, p. 3803 (Shayne Neumann)), and the policy documents indicated a similar assumption that full-time care by one person is also the best outcome for children with disabilities. Liberal Senator Mitch Fifield particularly emphasised the desirability of full-time unpaid care, explaining that ‘[t]o be cared for in the familiar surroundings and the loving environment of the family is often –and you would hope – the preferred option’, and that ‘carers are critical to enabling children with a disability to remain at home, where they would prefer to be’ (Commonwealth of Australia 2009c, pp. 3368, 3370). Labor’s Graham Perrett also characterised carers’ caring as giving their children ‘the best life possible’ (Commonwealth of Australia 2009b, p. 3825).

This assumption that carers’ and children’s interests can be advanced in concert also meant that there was no recognition that a tension may exist between the interests of different parties to care relationships. The only indication that there was discursive space to contemplate divergent interests was a brief statement by Liberal Senator Sue Boyce that:

> there is obviously a tension between the needs of people with disabilities and the needs of their carers. Their needs are obviously inextricably linked but they are not always the same. There is the potential for a conflict of interest between the needs of carers and the needs of people with disabilities. We must remember this and recognise it, whether we are talking about children or adults. (Commonwealth of Australia 2009c, p. 3381)

While the interests of carers and those of their children were not explicitly dichotomised in any of the other policy documents, the analysis demonstrates the influence of more
fundamental binary thinking about disability and care in Carer Payment (child) policy. The first is the binary of usual parental care and intense parental care, the former of which is expected of all parents, and the latter of which goes beyond these expectations in terms of effort, constancy and duration. This dichotomy was also important in the second distinction drawn in the policy between carers, who are presumed to be unable to support themselves through paid work, and parents, who are presumed to be available for full-time paid work (see section 6.2.2, above). These assumptions are informed by a further distinction between normal and not-normal child development. Children without a severe disability or medical condition are assumed to be ‘becomings’ in the sense coined by some sociologists of childhood – while childhood is understood to be a time of ‘vulnerability and dependence’ for all children (Boyden 2003. p. 4), usual childhood development involves ‘progressing from a state of vulnerability to sophistication, from an earlier lack of skills to a later possession of abilities’ (Young 1990, cited in Uprichard 2008, p. 305). These children’s dependence is transient, and will eventually be replaced by independence, whereas children with a disability or medical condition are assumed to be dependent and passive both now and in the future (see also Priestley 2000). This is consistent with Middleton’s (1996, p. 53) linking of the assumption of the dependency of adults with disabilities to the unequal treatment of children with disabilities:

A disabled adult is viewed as less than a full citizen, as dependent: in fact, as occupying a permanent childlike status. The preparation of a disabled child for full adulthood is therefore overridden by their preparation for life as a permanent child. As such, a disabled child is likely to experience neither a normal childhood, nor adolescence, and is conditioned into an adulthood of dependency.

The passivity of children with disabilities is also contrasted with the active role of carers in providing care; these roles are also mutually exclusive, as carers are not presumed to require care, and their children are not presumed to provide it (see Morris 2001, p. 6; Barnes 2006, p. 142). This means that an ‘asymmetric and one-to-one’ relationship between carer and child is assumed (Bytheway & Johnson 1998, p. 251).

These distinctions, and the dominant discourses of care and disability they indicate, clearly accord with the characterisation of care as a burden that some social policy and disability rights scholars argue has dominated ‘discussion and policy advocacy’ about disability care in Australia and other parts of the world (Fine 2004, p. 220; Cass 2006; Cass & Yeandle 2009). These scholars argue that establishing care as a burden (especially
by quantitatively demonstrating its impacts on carers), along with establishing the economic value of care (discussed in section 6.2.3), have been key to the success of those groups in securing policy support and recognition for their caring roles and the impacts of caring on carers’ lives. In the remainder of this chapter, I discuss the advantages and limitations of Carer Payment (child)’s resolution of the carer/disability rights tension in favour of carers from both carer and disability rights perspectives.

7.3 The consequences of policy support on the basis of the burden of care

7.3.1 Some of the burdens of care are alleviated (but others are not)

The construction of care as burdensome, in combination with the assumption that it is appropriate and inevitable for carers to fulfil the intense caring role, led apparently logically to the policy solution of extending access to Carer Payment (child) to a greater number of carers (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas); 2009c, p. 3385 (Catryna Bilyk)). According to the Government, the 2009 changes meant that around four times as many people would qualify for the payment (Commonwealth of Australia 2009b, p. 3825 (Graham Perrett)). This indicates that the dominance of the burden discourse did have some positive impacts for carers. In particular, and as I highlighted earlier in relation to Wollstonecraft’s dilemma, by providing income support for carers who are not engaged in paid work, or whose incomes are deemed insufficient to support themselves and their families, Carer Payment (child) policy addresses the financial consequences of carers’ low workforce participation. Carer Payment (child) was described as partial compensation for, or at least recognition of, the burdensome nature of care, and particularly the ‘hard work’ it entailed (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas)) and ‘the load that so many people with disabled people in their care shoulder on behalf of the whole Australian community’ (Commonwealth of Australia 2009c, p. 3387 (Gary Humphries)).

The disruption of carers’ paid work participation, and the associated lack of income, is one of the main consequences of care that has been investigated and problematised in the literature concerning the circumstances of carers (see for example, Cass 2006; Bittman, Hill & Thomson 2007; Edwards B et al. 2008; Ganley 2009). During the Carer Payment (child) review process, the CPCR Taskforce (2007, pp. iii, 3, ch. 4) and the Senate Standing Committee (2009) observed that carers who made submissions to the review similarly identified the financial consequences of their lower workforce participation as
a key source of hardship, and also that several carers’ advocacy groups expressed support for the increased access to income support afforded by the reforms.

However, the Carer Payment (child) reforms did not address all of the burdens and costs of caring that are identified in the literature, or that were raised by carers in the Carer Payment (child) review process. This overlaps considerably with the limits of the policy’s support for maternalism that I discussed in chapter 6 (see section 6.3.2). First, in only valuing and supporting care for a subset of carers, the policy only addresses the financial costs of care for that small group. The limited scope of the policy in this regard was mentioned, but not problematised, in the policy documents (for example, Commonwealth of Australia 2009b, p. 3837 (Catherine King)). Secondly, the extent to which Carer Payment (child) compensates for the financial costs of care is limited by the fact that it is intended to be a ‘safety net’ payment rather than compensation for lost earnings or any other financial costs associated with care (ibid., pp. 3810 (Judi Moylan), 3830 (Mike Symon); Commonwealth of Australia 2009c, p. 3388 (Steven Fielding)). The CPCR Taskforce (2007, p. 112) pointed to a range of costs in this regard, including ‘medication, special diets and supplements, mechanical equipment (e.g. wheelchairs), home modifications, tests and medical appointments, appointments with therapists, travel and transport, supported accommodation, hiring of babysitters or home workers’. It recommended a Government review of all financial and other supports for carers to ensure that they were adequate in terms of the costs of disability and care, but this recommendation was not mentioned or addressed in the subsequent reforms (ibid., p. 13). Thirdly, and more broadly, the policy’s support for full-time unpaid care means that the identified cause of the burden of care – its intensity, which is itself assumed to be caused by the child’s impairment – was not considered to be problematic in itself, and is therefore supported rather than alleviated by the payment, regardless of what carers want.

Some other costs of care that are highlighted in the literature were at least mentioned by the CPCR Taskforce and parliamentarians. The CPCR Taskforce (2007, p. 38) dedicated a chapter of its report to the ‘Challenges and critical role of carers’, and noted that many carers experience ‘… lower levels of health and wellbeing, chronic grief or anger, and limited opportunities to build or maintain social networks and participate in community life’. As I discussed in chapter 6, the Taskforce also noted carers’ low rates of workforce participation and cited 2003 statistics showing that ‘just over half (51 per cent) of the primary carers of children with a severe or profound disability reported that they would
like to work’ (ibid., pp. 43, 45). Quantifying and problematising the impacts of care on carers’ health and wellbeing, and on their ability to participate in paid work, have also been a major focus of the care literature (for example, Jenson & Jacobzone 2000; Cass & Yeandle 2009).

In the Carer Payment (child) reform process, the recognition of these hardships appeared to offer some moral justification for the Government’s, and wider society’s, support for and solidarity with carers (Commonwealth of Australia 2009b, p. 3796 (Steve Georganas); 2009c, p. 3385 (Gary Humphries)). However, no specific solutions to them were offered. The reforms did not contemplate increased access to alternative sources of care that would enable carers to increase their paid work participation, facilitate the sharing of care responsibilities within or outside families, or otherwise alleviate the intensity of the caring role (see section 6.3, above). This was despite the CPCR Taskforce’s (2007, p. 45) recitation of statistics showing that the main barrier to carers’ increased paid work participation was a lack of access to ‘alternative care’, and calls from several parliamentarians to increase carers’ options and supports for paid work participation (Commonwealth of Australia 2009c, pp. 3382 (Sue Boyce), 3369 (Mitch Fifield)). The health and wellbeing impacts of care were also not addressed, although Liberal MP Joanna Gash partly acknowledged this issue when she called for ‘access to psychological support in times of dire need’ and ‘a system of support services to alleviate the psychological pressures that will inevitably arise’ from intense caring (Commonwealth of Australia 2009b, p. 3788). Her colleague Judi Moylan referred to the lack of adequate support for carers in the community care system and made a similar argument to Gash, claiming that:

> The parliament… must continue to work to address the physical, financial, social and psychological impact of caring. Addressing these needs in a holistic manner is vital to caring for carers and is in the interests of the children that they care for. Clearly there is still considerable work that needs to be done. (ibid., p. 3812)

The failure of subsequent reforms to address this, and the range of other ‘costs’ identified here, indicates that most of the costs and burdens of care are expected to be borne by the family in the home. This is referable to two assumptions about care identified earlier in the analysis – that parents can, and should, provide the majority of care with minor support from paid care workers and medical professionals (see section 6.2.1, above); and
that, while caring is difficult, it is a natural and inevitable expression of carers’ love, devotion and familial duty to their children (see section 7.2.2, above). While this emphasis on care as a positive and valuable activity bears some features of both feminist social policy and ethics of care efforts to increase the recognition and valuing of care, and (in the latter case) to recognise and celebrate it as an ethical orientation, the recognition afforded by Carer Payment (child) is considerably more limited than is called for in these perspectives. Specifically, care is not recognised as universally valuable, and nor are dependence or interdependence recognised as common to all people; rather, carers are constructed as exceptions to the norm both in terms of the hardships they face and the virtues they show in bearing those hardships as individuals and families (for example, Commonwealth of Australia 2009b, pp. 3788 (Joanna Gash), 3838 (Catherine King)).

7.3.2 The social causes of disability are not addressed

The key purpose of extending access to income support to children’s carers was to ensure that carers could meet their child’s medical needs and in doing so give their children ‘the best life possible’ (Commonwealth of Australia 2009b, p. 3825 (Graham Perrett)). As I have outlined, the policy’s focus on children’s individual, medical needs is consistent with a medical model of disability (Shakespeare 2013a, p. 216). A consequence of this is that Carer Payment (child) only addresses the individual or impairment-related causes of disability, while ignoring the social barriers that disability rights scholars promoting the social and human rights models argue are also a major cause of disability (Oliver 1990; Shakespeare 2000a; Colver 2006). To use Morris’s characterisation of the medical model, the policy assumes that ‘impairment determines [children with disabilities’] experiences’ (Morris 2001, p. 3).

Carers quoted in the Carers Storybook did refer to some social causes of their child’s disability. For example, some carers described a lack of access to equipment, aids, assistance and services. Odette identified an unmet need for a ‘wheelchair van’ for her son Lochie (FAHCSIA 2008, p. 53), while Tim’s mother Jessica said that she could not ‘get things he needs for his development, things like a walker’ (ibid., p. 31). Several carers in rural areas, and their parliamentary representatives, decried the lack of availability of medical or disability services in their area and the consequent expense of travelling to major centres (ibid., p. 44, 76; see also Commonwealth of Australia 2009b, pp. 3805, 3806 (Sharman Stone); 2009c, p. 3372 (Rachel Siewert)). Labor MP Yvette D’Ath also
noted a lack of appropriate housing – meaning ‘a household, not an institution’ – for her constituent and his teenaged son with a disability (Commonwealth of Australia 2009b, p. 3821), and some parliamentarians also addressed this when noting that the government had recently allocated $100 million for ‘supported accommodation facilities for people with disabilities’ (Commonwealth of Australia 2009a, p. 3027 (Jenny Macklin); 2009c, p. 3112 (John Faulkner)). Nevertheless, most of these social barriers were characterised as sources of further burden or cost for carers, and there was no discussion of the importance of the removal of these barriers in order to increase children’s (and their families’) social participation or equality (Kayess & French 2008; Goodley & Runswick-Cole 2010).

Some social barriers were also alluded to in the Centrelink questionnaires. Carers completing the Carer Payment (child) application forms are required to take into account ‘any aids, appliances or home modifications that assist with the care of the child’ when describing their care load (Centrelink 2009c, p. 5). Treating health professionals must also answer the questions in the professional questionnaire in terms of what the child ‘can do when using his/her aids, appliances or special equipment items’ (Centrelink 2009d, p. 4). However, there is no scope in the documents to identify or request unavailable aids, appliances or home modifications that would assist the child (and potentially also the carer).

Disability discrimination and a lack of awareness about disability are also identified as key social causes of disability in the disability rights literature, and these were also mentioned in some of the policy documents (Marks 1999; Ryan 2005). In his speech to Parliament, Bill Shorten MP referred to stigma and a lack of awareness, saying:

> As well as dealing with their child’s condition, [carers] deal with the community’s lack of understanding of disability and with the sense of internal exile that our nation places upon people with a disability and their carers in too many circumstances. They have to deal with the mix of unease and pity that is a common reaction from those who are strangers yet fellow members of the same community. (Commonwealth of Australia 2009b, p. 3839)

While this was considered to be problematic, it was not specifically addressed in the resulting policy reforms, and Shorten’s concern was primarily with its impact on carers, rather than on people with disabilities. Some carers quoted in the Carers Storybook also
mentioned this stigma and its negative effects, although again no solutions were offered in Carer Payment (child) policy. They particularly criticised the lack of understanding of disability of friends and strangers they encountered in public. For example, Lachlan’s mother Megan was quoted as saying that, ‘[i]f Lachlan has a seizure when I’m out shopping people almost do a back flip to get away from him thinking they might catch it’, while Michael gave examples of the ‘dreadful’ reactions that strangers had to his son Connor, who has ‘Epidermylosis Bullosa (EB), a rare genetic skin disorder characterised by fragile skin which blisters after the slightest trauma or friction’ (FAHCSIA 2008, pp. 42, 38, 51). Again, these issues were not raised or addressed in the Carer Payment (child) reforms, and some of the questions in the new eligibility test seemed to accept stigma and discrimination. For example, the carer questionnaire inquires about how frequently the applicant has to ‘intervene or supervise’ because the child behaves ‘in ways that other people/family think is bizarre or unusual’ (Centrelink 2009c, p. 3). This phrasing of the question suggests that the child’s behaviour is a problem that needs to be managed; an alternative phrasing that encompasses the social causes of disability might inquire how frequently the applicant and the child experience discrimination because ‘other people/family’ do not understand or accommodate the child’s disability.

7.3.3 Choice, control and independent living are not contemplated or supported

Another consequence of a medical, individual construction of disability problematised in the disability rights literature is that it leads to charitable, welfare-based responses that are disempowering, because they position people with disabilities as passive objects of care who are in a one-way, highly dependent relationship with their carer (Morris 1991a, pp. 143–5; 1993, p. 154; Barnes 2006, pp. 142–3). Children with disabilities were characterised in this way in Carer Payment (child) policy; they were primarily constructed as the producers of a care load and burden on their carers, and passive recipients of the care and devotion of their carers and, to a lesser extent, wider society (Commonwealth of Australia 2009b, pp. 3791 (Amanda Rishworth), 3802 (Shayne Neumann), 3823 (Richard Marles)). As I have discussed, it was assumed that this passivity and dependency is long-term, as opposed to the transitory dependence of normal childhood (ibid., p. 3826 (Julie Collins); Commonwealth of Australia 2009c, p. 3387 (Gary Humphries)). This was further borne out by the emphasis on the economic value of caring – children with severe disabilities are seen to produce a cost for society and the government that is heroically borne by carers. In consequence, Carer Payment (child) treats children with disabilities
as having little ‘use value’ – they are not expected to participate in society or contribute as citizens either now or in the future (Quinn & Degener 2002, p. 19).

This assumption of children’s long-term dependency on both the state and their families meant that there was no contemplation of their possible independence – even in the broader sense of ‘autonomy in the context of supported living (Brechin 1998, p. 175) – nor an exploration of how such independence might be achieved either in the present (as appropriate for their age), or when they later advance to adulthood. It also means that there was no contemplation that children might have a role in choosing or controlling the kind of care or support they obtain. The disability rights literature’s rejection of the concept of care in favour of policies that support independence and treat people with disabilities as rights-holding citizens did not arise in Carer Payment (child) policy discourse (Wood 1991; Morris 2001).

A complicating factor here is that the policy concerns children with disabilities, whereas most of the disability rights literature advocating for independence, choice and control is focused on adults. The assumption that all children (regardless of disability) are dependent on their parents for care, and for decision-making about care, is not challenged in the disability rights literature. Scholars who address children with disabilities specifically often discuss children and their families in combination as the relevant and appropriate subjects of research and policy, and argue that they are mutually disadvantaged by medical model thinking and the social barriers that such thinking neglects (for example, Dowling & Dolan 2001; Fisher & Goodley 2007; McLaughlin et al. 2008; Goodley & Runswick-Cole 2010). Nevertheless, there was no mention in Carer Payment (child) policy of the need for choice or control for ‘families’ as a whole; and, as I discussed in chapter 6, the policy does not offer choice for carers in terms of care arrangements or combinations of care and work.

A more specific implication of the lack of choice for children or carers relates to the assumption that ‘constant’ family care is the appropriate and preferable arrangement for children and their carers. This assumption – which produced a policy solution that supports and prioritises full-time family care over other arrangements – means the policy does not consider any potential negative implications of family care arrangements for children, or the desirability of those arrangements from the child’s perspective. Family care, especially in the absence of choice for both those giving and receiving care, has been
described as ‘exploitative’ of carers and people with disabilities (Brisenden 1989, cited in Morris 1997, p. 57). Feminists and disability rights scholars (and those working at the intersection of these disciplines) have identified ‘family as the location of women’s oppression… and too often the location of disabled people’s oppression’, particularly where either group relies entirely on one person for economic and/or physical support (Morris 1991a, pp. 143–5; see also Pahl 1980; Powers & Oschwald 2004).

Access to alternatives to family care that might mitigate power inequalities and lack of choice for both parties was not discussed or addressed in Carer Payment (child) policy, such as funding for individualised childcare or personal assistance services (Lenehan 2008; Goodley & Runswick-Cole 2012). As I have discussed, the only alternative to full-time family care contemplated in the 2009 reform process was respite care as a temporary reprieve for carers – rather than as an alternative for the benefit of children – and greater access to respite or any other form of care was not actually provided for in the reforms (see CPCR Taskforce 2007, p. 101; Commonwealth of Australia 2009b, pp. 3788 (Joanna Gash), 3798 (Alex Hawke), 3812 (Judi Moylan)).

7.4 Conclusion

Carer Payment (child) policy resolves the tension between carers and people with disabilities in favour of the interests of carers. Several assumptions about the nature of disability and care led to the apparently logical conclusion of providing income support for people providing intense care (but not usual parental care) in order to alleviate some of the burdens associated with the caring role. In particular, the financial cost of carers’ inability to support themselves through paid work was identified as a cost that should be shared by the community, in recognition of the value and contribution of the caring role and the hardship and vulnerability associated with it. The CPCR Taskforce (2007, p. 5) emphasised the seriousness of these impacts on carers’ lives by quoting one carer’s submission to the review:

I’m a person who pays their bills first and then lives on what’s left over. For a long time all I had left for groceries was $5. I’d buy a loaf of bread, a small bag of frozen peas, two onions and a bag of pasta. The next week I would buy the same, but I’d have rice instead. That’s what I lived on. For Christmas lunch and Christmas dinner, Boxing Day lunch and dinner I had one sandwich with a slice of ham and some chutney someone had given me.
for a Christmas present. … To pay an electricity bill I had to sell the first ring a boy ever gave me. I got $10 for it. I felt really sad that day.

Despite the considerable elaboration of, and concern expressed about, these impacts, the analysis in this chapter indicates that many of the burdens of care, including work-related and disability-related financial costs, and impacts on health and wellbeing, are not compensated or alleviated by Carer Payment (child) policy. Consequently, the policy does not entirely address the claims of carers, and many of the costs and impacts are assumed to accrue naturally and inevitably to individual carers. Nevertheless, the analysis does demonstrate the importance of the conceptualisation of care as a burden for securing at least some social support for carers in times of retrenchment and cost-cutting in many other areas of policy.

Liberal Senator Sue Boyce noted another difficulty that the burden discourse raises for carers; she argued that carers applying for income support ‘must set out to make your child out to be as bad as possible; you are setting out to fail… so that you can become eligible for the funding’ (Commonwealth of Australia 2009c, p. 3381). Boyce suggested that this is problematic for people who are trying to ‘talk them up… in the rest of their lives’ (id.). This accords with some Australian and international studies indicating that carers do not predominantly experience their roles as burdensome (see for example Burton-Smith et al. 2009, p. 196; Gundersen 2012, p. 380). Boyce’s statement also indicates some awareness of how polarising such an approach is – it requires the marginalisation of the agency and perspective of the child, and perpetuates very negative notions of the passivity and dependency of children with disabilities (Fine 2004).

This is clearly an unsatisfactory response to the tension between the interests of different parties to this kind of care relationship. Indeed, as I touched on earlier, the existence of a tension was not acknowledged in the Carer Payment (child) policy documents. To the contrary, the needs of the two parties were implied to be one and the same – supporting carers was assumed to be necessary to meet children’s care needs, leading to comfort and a better quality of life for the child (for example, Commonwealth of Australia 2009b, p. 3804 (Sharman Stone)). This assumption, in combination with the characterisation of disability as an individual, medical condition that produces hardship for carers, raises disability rights concerns that the policy ignores the social causes of disability and perpetuates children’s long-term dependency rather than offering them choice, control
and independence. However, solutions that favoured the other side of this carer/disability rights tension would simply produce different problems. For example, an emphasis only on the choices or rights of children with disabilities would raise concerns about the potential marginalisation of the rights of paid care or support workers, as well as concerns about the extent to which children with disabilities have the structural support to meaningfully exercise those rights (Rummery & Fine 2012; Foster et al. 2012).

The analysis of Carer Payment (child) presented in chapters 5, 6 and 7 has demonstrated that the dominance of certain discourses means that the care policy tensions between supporting unpaid care and supporting paid work, and between the interests of carers and people with disabilities, are not acknowledged or adequately dealt with in Carer Payment (child) policy. Rather, unpaid care is prioritised over paid work, and the claims of carers are prioritised over those of people with disabilities. Consequently, the policy largely ignores feminist claims for support for women’s paid work, and disability rights claims for choice, control and independence.

The case study analysis introduces an additional factor that was not apparent from the analysis of the literature in chapter 2, namely, that neither of the care policy tensions identified in the literature was recognised as a problem in Carer Payment (child) policy. Feminist concerns about supporting women’s unpaid caring and paid working were not a predominant concern in the policy reforms, and the policy’s support for unpaid care over paid work was attributed largely to economic, rather than gender equality, concerns. While a limited range of carers’ claims were acknowledged and addressed in the policy reforms, other burdens of concern to carers were ignored, and the interests of children with disabilities were presumed to be the same as those of their parents, meaning they were not directly contemplated. Hence, neither a universal caregiver model of the family, nor a recognition of interdependence as universal and valuable, were thinkable (or made possible) in this policy.

The multiple and overlapping limitations of Carer Payment (child) confirm the need for a new approach to care and support policy that addresses feminist social policy, carer and disability rights concerns about the current organisation of care and work, and the limiting conceptualisations of gender equality, care and disability on which it is based. This necessitates a shift away from dichotomous thinking about care, paid work and disability, and the explicit introduction of a concern for gender equality and disability rights. In the
next chapter, I explore and demonstrate the utility of the six care and support rights principles proposed in chapter 3 for achieving this, and delivering equal care and support rights to all parties.
8. Options for more equitable policy: applying the care and support rights principles to Carer Payment (child)

8.1 Overview

The analysis in chapters 5, 6 and 7 demonstrates that Carer Payment (child) does not acknowledge or address either the tension between supporting unpaid care and supporting paid work, or the tension between supporting the interests of carers and those of people with disabilities. The care and support rights principles that I proposed in chapter 3 offer guidance for designing policies that can resolve these tensions, avoiding either/or policy-making and offering equal rights to all parties to care and support relationships. In this chapter, I further develop the Carer Payment (child) case study to demonstrate the application and value of the principles in this regard. I first identify the particular flaws in Carer Payment (child) policy in terms of each principle, and then canvass the reforms and complementary policies that would be necessary to encompass the concerns of multiple care and disability perspectives and afford citizenship rights to give and obtain care or support. I also discuss how these changes could overcome the problematic binary thinking at the heart of the current policy, and the many gaps and shortcomings that arise from it. Applying the principles to a particular care policy also highlights some potential limitations of this approach, and I conclude the chapter by discussing those limitations and identifying avenues for future research to address them.

8.2 Does Carer Payment (child) afford rights to give and obtain care or support?

8.2.1 Introduction

The six policy principles that I proposed in chapter 3 are drawn from, and augment, key insights from previous academic efforts to reconcile the care policy tensions. I argued that policies should fulfil each principle in order to afford equal care and support rights to both those giving, and those obtaining, care or support. The first and second principles are access to financial resources to purchase or otherwise enable care or support, and access to alternative sources of care or support. The third principle is flexibility in terms of how care or support, and care and paid work, are arranged. The fourth and fifth principles are time for care, work and self-care, and incorporation of the voices of diverse care constituencies. The final principle is positive recognition of difference, including difference associated with the gender division of labour and difference associated with
impairment and disability. In this part of the chapter, I map the analysis of Carer Payment (child) from chapters 5, 6 and 7 onto the six-principle framework in order to pinpoint the policy’s shortcomings in terms of each of these principles. This is a precursor to demonstrating how the principles can be used to identify reforms and complementary policies to overcome the care/work and carer/people with disabilities tensions and afford equal care and support rights.

8.2.2 Access to financial resources is limited

Carer Payment (child) policy partly meets the first care and support rights principle, because it provides access to financial resources for some people on the basis of their caring roles alone. However, this cash payment is not broad enough to afford rights to give and obtain care or support to all. First, the payment is only available to carers, rather than to everyone giving or requiring care or support. This reflects the policy’s focus on the interests and perspectives of carers, along with an assumption in the policy that care relationships are dichotomous, with one person being the caregiver and the other person being the care recipient (see section 7.2.3, above). Secondly, the binary distinction that is drawn between intense disability care and usual parental care means that Carer Payment (child)’s support for care is fragmented (FACSIA 2007, p.7; Commonwealth of Australia 2009c, p. 3368; see section 7.2.2, above). Many carers cannot access the payment, including parents of children who have some of the ‘functional disabilities’, ‘special care needs’ or ‘behaviours’ assessed using the Carer Payment (child) questionnaires, but not enough to amount to an intense care load, as well as parents of school-aged children who do meet any of the eligibility criteria (see DCLA 2009). The payment is only available in cases of care for someone with a medically diagnosed disability or medical condition, and it supports only unpaid care. Consequently, other common lines of fragmentation are perpetuated, such as the distinctions between disability care, childcare and aged care, and between unpaid care and paid care (Daly & Lewis 2000).

The fact that governmental support is provided to some carers through Carer Payment (child) means that intense care is recognised as a social good (Daly 2002) and a valuable activity — another essential element of policy that realises citizenship rights to care and support. However, this recognition relates primarily to the economic value of care, and care’s negative consequences for carers, rather than because care is considered to be inherently valuable or a key element of citizenship in itself (Williams 2001, pp. 487–8).
The purpose of Carer Payment (child) is also considerably more limited than would be necessary to afford comprehensive care and support rights. It is intended to alleviate some of the financial hardships associated with caring, and to enable carers to continue in their unpaid caring roles, but not to provide meaningful or expansive choice for carers or their children in terms of the types of care or support that can be given or obtained (CPCR Taskforce 2007, pp. 66, 76; Commonwealth of Australia 2009a, p. 3029 (Jenny Macklin); 2009b, p. 3796 (Steve Georganas)). For instance, it is not calculated for the purpose of enabling carers or children to pay for alternative sources of care such as paid childcare or personal assistance. Rather, as an income support payment, Carer Payment (child) offers a ‘safety-net’ to guard against poverty (CPCR Taskforce 2007, p. 1). Questions were raised during the reform process about the sufficiency of the payment even for this more narrow purpose (for example, Commonwealth of Australia 2009b, p. 3810 (Judi Moylan); 2009c, p. 3388 (Mitch Fifield)).

The policy does partly promote the right to give care or support by ensuring that eligibility is not contingent on carers’ paid work participation. Carer Payment (child) claimants, unlike parents of children aged six or over claiming Parenting Payment or Newstart Allowance, are not required to demonstrate that they are participating in paid work or work-related activities as a condition of eligibility (Social Security Act 1991, s. 500; Cass 2006; Rubery 2015). This means that Carer Payment (child) makes full-time care a viable alternative to self-support through paid work, or reliance on family, for carers who meet the other criteria. However, the fact that only a limited range of paid work options are available to people claiming the payment raises issues in terms of other principles, which I return to below.

8.2.3 Access to alternative sources of care or support is not advanced

Unpaid care by a sole family carer was supported and prioritised over other care or support arrangements in Carer Payment (child) policy. Consequently, access to alternative sources of care or support was not a major consideration in the policy reforms, and the policy does not adequately advance care and support rights in terms of this principle. As I discussed in chapters 6 and 7, there was some acknowledgement by Opposition parliamentarians that carers do not have enough access to respite care services. These services were characterised as necessary to offer some relief from the burdens of care (Commonwealth of Australia 2009b, pp. 3798 (Alex Hawke), 3812 (Judi
Moylan); see also FAHCSIA 2007, p. 10). The CPCR Taskforce, and some parliamentarians, also called for ‘appropriate, flexible child care’ and ‘support services’ to facilitate carers’ paid work participation (CPCR Taskforce 2007, p. 45; Commonwealth of Australia 2009c, p. 3369 (Mitch Fifield)). However, no provision was actually made for these services. More fundamentally, constant care was treated as inevitable and natural, even though it was identified as the main cause of carers’ hardships and their reduced paid work participation (Commonwealth of Australia 2009b, pp. 3790 (Amanda Rishworth), 3792 (Scott Morrison)). The lack of recognition of children’s interests (or that these interests might differ from those of carers) meant that services that would offer other options for meeting children’s care or support needs – such as personal assistance or childcare – were not discussed, or identified as necessary policy interventions in any of the policy documents (see section 7.3.3, above). In short, the absence of options for either carers or children means that Carer Payment (child) does not offer the possibility of exit from one-to-one, full-time family care to either party.

Policies that support care and support rights should also entail appropriate regulation to prevent abuse of those giving and/or obtaining care or support (Rummery 2011, p. 147). Carer Payment (child) policy does incorporate some forms of regulation of access to income support, but this relates to establishing need – the means and assets tests are used to establish and monitor a carer’s financial need for support, and the care load assessment establishes the child’s physical, medical need for intense care. Claimants are also subject to regular reviews of their circumstances to ensure that they still meet the eligibility criteria, and they are obliged to notify Centrelink if their financial or other circumstances change (FAHCSIA 2011a, para. 6.2.5.55; Social Security Administration Act 1999 (Cth), s. 67(2)). However, this regulation is not concerned with the care relationship or the quality of care involved – for instance, it does not examine whether either party is being exploited or abused, or whether the quantum of the payment is sufficient for any particular purpose, such as paying a sufficient wage or preventing financial hardship (Rummery 2011).

8.2.4 The policy does not increase flexibility

Carer Payment (child)’s predominant support for one care arrangement, namely, constant care by a sole family carer, also means that the policy does not provide the flexibility necessary to secure rights to give and obtain care or support for all. Carers, and their
children, are potentially ‘trapped’ in a narrow range of care or support arrangements (Rummery 2011, p. 148). Some flexibility is afforded by the availability of the payment to carers who are providing care for more than one person, such as multiple children, or an adult and children (Social Security Act 1991, ss. 197B, 197C, 197D). However, many other configurations of care or support are not supported by Carer Payment (child). Most obviously, as the CPCR Taskforce (2007, pp. 15, 54) and the Senate Standing Committee (2009, pp. 8–9) highlighted, the payment cannot be split between multiple unpaid carers, such as partnered or separated parents (or any other combination of unpaid and/or paid providers) who each provide part-time care to their child.

Carer Payment (child) does offer some flexibility in terms of how unpaid care and paid care or support are combined. The temporary cessation provision, which allows carers to cease providing care for up to 63 days per year, refers to 24-hour periods of cessation (Social Security Act 1991, s. 198AC(3)). This means that a personal assistant, childcare worker, or other paid care or support worker could provide support in the carer’s absence for regular, shorter periods without triggering this limitation. However, because the costs of these services are not contemplated in the calculation of Carer Payment (child), the policy does not actively create this choice for either carers or children with disabilities – this would only be possible where families were entitled to funding for this purpose or could otherwise afford to purchase such services.

The 25-hour cap on weekly paid work hours also means that carers have some flexibility in how they combine unpaid care and paid work (see section 6.2.2, above). However, the assumption that constant care necessarily precludes substantial paid work participation means that only a limited range of care/work combinations are contemplated and supported by the policy. As I have already noted, the payment does not offer full flexibility in this regard. For example, it does not provide for a universal caregiver arrangement (with two parents sharing part-time work and part-time care) or more complex arrangements between multiple people. Nor does the quantum of the payment provide adequate compensation for any reduction in paid work participation (Jenson & Jacobzone 2000; see section 6.3.2, above).

8.2.5 Time for care, paid work, and self-care is limited

Carer Payment (child) policy does afford some time to give care or support – a ‘right to time for care’ (Knijn & Kremer 1997, p. 332) and ‘care time and space’ (Williams 2001,
However, this time is only extended to carers who meet the eligibility criteria both in terms of the extent of their caring roles (measured by the questionnaires) and their lack of alternative sources of support (measured by the income and assets tests).

It is unclear whether Carer Payment (child) offers the time to ‘care properly’ (Williams 2001, p. 488). The CPCR Taskforce review was most interested in the impact of intense care on carers, rather than children’s experiences of this care, and there was no explicit discussion or problematisation of the quality of that care in the policy documents. However, the emphasis throughout the documents on the intensity and ceaselessness of carers’ activities, and the statistics cited by the CPCR Taskforce (2007, p. 29) that, ‘[a]lmost half (48%) of primary carers of children with severe or profound core activity limitations reported needing more support’ suggests that many carers felt that their ability to care properly was constrained (see also FAHCSIA 2007, p. 10). One of the carers quoted in the Carers Storybook raised these concerns directly; Timmy’s mother Jessica said, ‘[t]he financial stress is really hard to cope with and I’m on the verge of putting Timmy into an institution or foster care because I just can’t afford to look after him properly’ (FAHCSIA 2008, p. 30).

By prioritising unpaid care over paid work, and treating them as dichotomous pursuits, the policy also offers only limited time and space for paid work. The extent to which carers can participate in paid work is limited by the temporary cessation provisions and the means and assets tests, and the payment’s support for full-time unpaid care means that economic self-sufficiency is not expected or supported for these carers. The need for greater support for carers’ paid work was noted in some of the policy documents, but Carer Payment (child) policy did not actively support this paid work (CPCR Taskforce 2007, p. 3; see sections 6.3.1, 7.3.1, above).

Another aspect of the principle of ‘time’ is time and space for self-care; this was hardly contemplated in the Carer Payment (child) reforms. The eligibility requirement of ‘constant care’ indicates that a lack of time for self-care was implicitly assumed, and this was not considered to be a policy problem requiring a solution (Social Security Act 1991, ss. 197B, 197C, 197D). Rather, intense care was presumed to be natural, inevitable and economically desirable, despite the fact that it was identified as the cause of the many costs and burdens of care. These include impacts that can affect the ‘maintenance of body, mind and soul’ (Williams 2001, p. 488), such as negative implications for carers’ health
and wellbeing, their family relationships, and their ability to pursue careers and social lives, all of which were identified by the CPCR Taskforce, parliamentarians, and carers as being key issues affecting carers (for example, CPCR Taskforce 2007, p. 2; FAHCSIA 2008, p. 12; Commonwealth of Australia 2009b, p. 3825 (Graham Perrett); see section 5.2.3, above). The need for more respite to alleviate some of these effects was identified, but this was not a major focus of the reforms (for example, Commonwealth of Australia 2009b, pp. 3788 (Joanna Gash), 3798 (Alex Hawke)). The exemption from constant care for up to 25 hours per week is unhelpful in this regard – it can only be used if the carer is participating in paid work or work-related activities, namely, ‘training, education, [or] unpaid voluntary work’ (Social Security Act 1991, s. 198AC(4)).

By extending the time to give care to some carers, the policy does give time to receive that care to children with intense care or support needs. It may also offer the time for these children to participate in education or other activities by ensuring that their carer is available to attend with them. However, their carer may have other responsibilities that preclude this, such as care for other children. The 2009 reforms extended the time to receive care to more categories of care recipients, such as the many children with intense care needs who did not meet three of the seven medical criteria in the original Carer Payment (child) test, and children with ‘episodic or short-term’ care needs that are expected to persist for between three and six months (Social Security Act 1991, ss. 197G). However, unpaid care is the only option made available to them, and this time to receive unpaid care is not extended to children with lower care needs, whose parents are assumed to be available to engage in full-time work (Commonwealth of Australia 2009a, p. 3029 (Jenny Macklin); see section 6.2.2, above).

8.2.6 Only some voices were heard in the reform process

Carer Payment (child) does not incorporate the voices of all parties to care and support relationships. There was little recognition that different ‘perspectives and positionings’ might exist in relation to the policy, and the resulting policy did not bring the perspectives of multiple care constituencies together (Williams 2001, p. 483). Most notably, the voices of children with disabilities were not directly sought in the Carer Payment (child) reform process. Rather, it was assumed that the children with disabilities’ interests were the same as those of their carers, and that their needs could be fully determined by carers and medical professionals (see section 7.4, above).
In contrast, the voices of carers were quite prominent in the policy documents. The Senate Standing Committee (2009, p. 2) observed that the CPCR Taskforce review ‘was commissioned by the Government in response to concerns raised by carers in the community’. According to the Government and the CPCR Taskforce, the consultation of carers during the review was expansive, and contributed to setting the agenda for the reforms. Most of the 4,000 submissions to the review were made by individual carers (CPCR Taskforce 2007, pp. 24, 108). In its report, the CPCR Taskforce frequently justified its findings and recommendations on the basis that they reflected carers’ concerns (ibid., pp. iii, 3, ch. 4, app. C). For example, early in the report, it explained that it had mainly confined itself to ‘issues raised by carers and other interested parties during the consultation phase that fell within the scope of the Taskforce’s terms of reference’ (ibid., p. 24).

Current recipients of Carer Payment (child) and Carer Allowance (the lower-rate payment available to a wider range of carers), carers’ organisations, disability services providers, medical professionals, and some organisations representing the interests of children with disabilities and their families were invited to make submissions or to participate in focus groups in the review (CPCR Taskforce 2007, p. 23, 107). The organisations that gave oral evidence to the Senate Standing Committee’s (2009) review of the subsequent reforms were representatives of carers’ organisations (including Carers Australia and Carers Victoria), representatives of disability or health services providers (including National Disability Services and Palliative Care Victoria), and public servants from the Federal Government department responsible for Carer Payment (child) policy. These bodies were described as ‘key stakeholders’ in the reform process, and when recommending the implementation of the reforms, the Senate Standing Committee noted that specific carers’ and disability services organisations supported particular elements of them (ibid., pp. 3–5, 10–11). For example, the Committee observed that most of the organisations that made submissions, including the Mental Health Council of Australia and Carers Australia ‘supported the proposed amendments’ (ibid., p. 3) and that Carers Australia supported the new assessment tool (ibid., p. 3–4).

Many care constituencies identified in the academic literature, such as people with a disability who give care or support (Morris 1993, p. 89), young carers (Smyth C, Blaxland & Cass 2011), and paid care or support workers and their representative bodies (Williams 2010) were not singled out for consultation. I observed in chapter 6 that feminist concerns
about gender inequality in caring were hardly contemplated in the reform process, which points to a further absence of a distinctly feminist (or even gendered) voice in the consultation process (see section 6.3.4).

There were efforts to consult with some specific groups of carers, meaning the intersectional nature of experience was recognised and considered to some extent. The Federal Government invited submissions to the review from a wide range of carers, saying that the CPCR Taskforce:

would like to hear from families and parents from all cultural or environmental settings, for example: families at different life stages; families isolated from mainstream services by physical remoteness or language; indigenous families and communities; people from culturally diverse backgrounds; single parent families, or those without extended family support; and people other than parents, who are carers, such as grandparents, siblings, foster parents or guardians. (FACSIA 2007, p. 6)

The CPCR Taskforce (2007, p. 109) subsequently held focus groups dedicated to Indigenous carers and carers from culturally and linguistically diverse backgrounds. It ultimately recommended ‘that the government undertake further work to ensure that the barriers facing carers from Indigenous and culturally and linguistically diverse backgrounds in accessing Carer Payment (child) are recognised and addressed’ (ibid., p. 94). Opposition MP Sharman Stone argued that the government should:

look very carefully at the needs of carers from ethnic minorities—whether they are responsible for children or adults—and to take special measures including translating information and making sure carers understand what support there is in the Australian community, have respite that is culturally appropriate and are given a great deal more support than they currently are. (Commonwealth of Australia 2009b, p. 3806)

However, neither these – nor any other – intersectional issues were specifically addressed in the subsequent reforms.

The analysis in chapters 5, 6 and 7 indicates that many other issues raised by carers during the review were also downplayed, or not problematised, in the reforms. These included calls for greater access to services, and solutions to many of the burdens and hardships of care (for example, Commonwealth of Australia 2009b, pp. 3812 (Judi Moylan), 3822 (Yvette D’Ath)). This indicates that, while carer voices were more prominent than those of other parties to care or support relationships, their interests and experiences were not
the only (or even the driving) factor in the reform process, with the analysis pointing to assumptions about the economic value of care as being far more influential in this regard (see sections 6.2.3, 6.3.2, above).

8.2.7 Prevailing norms are reinforced, meaning difference is not positively recognised

Carer Payment (child) policy does not positively recognise difference in terms of either the unequal gender division of labour or the impacts of impairment and disability. Rather, the policy is based on, and perpetuates, related norms of the full-time, independent (male) paid worker and the independent, non-needy person (or the related, child-specific norm of temporary dependence leading to independence in adulthood) (see sections 6.2.4, 7.2.3, above). Both carers and children with disabilities are measured against these norms to determine eligibility for Carer Payment (child), and the payment acts as compensation for both parties’ inability to meet these norms of participation.

As I discussed in detail in chapter 6, neither the gendered nature of care nor its consequences were recognised or problematised in the Carer Payment (child) reforms. Several of the eligibility criteria – including the paid work limitation and the cohabitation rule – mean that the policy supports the unequal division of care and paid work associated with the male breadwinner and modified breadwinner models of the family (see section 6.3.4, above). The policy affords some choice to carers in terms of how they combine paid work and care. However, it closes down other choices by both restricting the amount of paid work that can be combined with care, and failing to introduce measures necessary to ensure that women’s choices are not constrained by the gender division of labour, and particularly men’s choices about paid work and care (Lewis & Giullari 2005). The policy does not encourage or require the redistribution of responsibility for care from women to men, or from families to other sectors. This might entail facilitating a universal caregiver arrangement, or including ‘gender egalitarian strategies’ (Gornick & Meyers 2008, p. 331) like being paid at a quantum that encourages men to reduce their paid work participation in favour of more unpaid care (see for example Jenson & Jacobzone 2000). It also perpetuates the norm of the full-time paid worker, because the right to care is not established as universal, but is rather afforded to those who can show that they cannot meet this norm of self-support through paid work participation, or through the support of a (male) breadwinner.
The second sense in which Carer Payment (child) fails to positively recognise difference is in relation to impairment and disability. As I discussed in chapter 7, the policy does recognise difference associated with impairment, but only in the narrow manner associated with the medical model of disability. This means that children’s care needs, which are used to measure carers’ care loads (and hence decide their eligibility for income support), are determined by comparison to the individual functional abilities, behaviours, and absence of ‘special care needs’ of non-disabled children. The latter provide the norm against which children with disabilities are compared, meaning the payment is restricted to a narrow subset of children with severe disabilities. The criteria do not give a broader consideration to the social causes of disability, nor to what is necessary to afford independence, choice and control, or the ability to participate in society on an equal basis with others (Morris 2001; Kayess & French 2008; see sections 7.3.2, 7.3.3, above).

8.2.8 Conclusion: shortcomings on multiple care and support rights principles

Carer Payment (child) does not fully meet any of the six care and support rights principles. Consequently, it does not afford either the right to give, or the right to obtain, care or support to most people. Limitations on the right to give care or support result from the payment’s restriction to carers with ‘intense’ care loads, the limited choice it offers in terms of how people may combine care, paid work and other activities, and the equally limited choice regarding how carers share care or support with other informal carers and/or paid care workers or assistants. Carer Payment (child) performs even more poorly in terms of the right to obtain care or support. It cannot be paid directly to children, it does not offer any flexibility in terms of the type of care or support that a child obtains, and the reform process did not incorporate the voices of children with disabilities at all. The policy at best indirectly offers a small cohort of children with severe disabilities the right to obtain unpaid care from a family member, but not paid care or support.

As I concluded in chapters 6 and 7, these shortcomings reflect the persistence of binary understandings of the care relationship (that one unpaid family caregiver should provide constant care to one dependent care-recipient), as well as binary understandings of the relationship between care and paid work (that unpaid care must be prioritised over paid work), along with a complete conflation of the interests of carers and children with disabilities. They also reflect the persistence of norms of the independent worker-citizen and the non-disabled child, which mean that difference is not positively recognised and
accommodated, but rather is treated as an exception to normal life that necessitates special treatment.

8.3 Essential reforms to deliver care and support rights

8.3.1 Overview

In addition to providing a standard against which to assess the current performance of policies, the care and support rights principles offer guidance on the kinds of reforms that would be necessary to ensure that policies offer equal rights to give and obtain care or support to all parties. In this section, I identify a range of reforms, and some complementary policies, that would be necessary to break down the binaries and norms that currently structure and limit Carer Payment (child) policy’s support for the rights to give and obtain care or support.

8.3.2 Access to financial resources should be extended to all care and support situations

Carer Payment (child) would be more likely to offer care and support rights to all parties if it is reformulated as separate payments to carers and children, or alternatively as a payment to families as a whole (although the latter option, which would not establish an individual right, may increase the risk of the choices of one party trumping those of another). Breaking down this binary would challenge the tendency for governments to think dichotomously and allocate financial resources to only caregivers or care or support users (Beckett 2007, p. 375). It may not always be necessary or appropriate for children to be given sole decision-making power over how cash payments are spent in order to meet their right to obtain care or support, particularly in the case of young children. However, characterising payments as budgets for children as well as their parents or carers may assist in shifting the focus away from the burden of children’s care needs and onto children’s own preferences and interests alongside those of their caregivers.

This cash payment would need to be paid at a high enough rate to not only alleviate poverty, but also to offer choice about what care or support is given and obtained, and from whom. For instance, it should be high enough to enable children and families to employ paid care or support workers, and to offer them a decent wage and conditions (Rummery 2011). In order to realise the right to give care or support, the payment should also create a meaningful choice for carers between unpaid care or paid work, meaning that eligibility should not be contingent on paid work participation (consistent with the
current design of the policy), and choosing different combinations of care and paid work should not produce vastly different immediate and long-term financial outcomes, such as different standards of living or superannuation savings (Jenson & Jacobzone 2000). Inequitable outcomes in this regard are more likely to affect women, and I discuss specific reforms to address this below.

Transforming Carer Payment (child) into a better-resourced budget for carers and children with severe disabilities or medical conditions would come closer to affording equal rights to give and obtain care or support, but it would still preserve the fragmentation of the policy on two key dimensions. First, it would be restricted to the care of children, and secondly, it would be restricted to situations where the child has a severe disability. Consequently, many people in relationships of care or support may still not be afforded the rights that I have argued must be universal features of citizenship. This raises the question of whether a payment similar to the ‘basic incomes’ proposed by Jordan (1989, 2000), Pateman (2004), Standing (2011) and others is the only way to afford a truly universal right to give and obtain care or support (see also Rubery 2015). Raventos (2007, p. 8) defines basic income as:

> an income paid by the state to each full member or accredited resident of a society, regardless of whether he or she wishes to engage in paid employment, or is rich or poor or, in other words, independently of any other sources of income that person might have, and irrespective of cohabitation arrangements in the domestic sphere.

Such payments are proposed for various reasons, including for helping to ‘break the link between income and employment’, ending ‘the mutual reinforcement of the institutions of marriage, employment and citizenship’ (Pateman 2004, p. 90), ‘compensating care’ (Pascall & Lewis 2004, p. 383), responding to ‘increased income inequality within wealthy countries’ and responding to ‘greater economic insecurity associated with labor market restructuring and automation’ (Mays & Marston 2016, p. 9). Mays and Marston (ibid., p. 18) recently sketched the key features of a hypothetical Australian basic income, explaining:

> Payment of the grant would be to individuals, rather than family units (Standing, 2002, 2011, 2014; Van Parijs, 1997, 2001, 2007) and could be made in either monthly or fortnightly installments. Depending on available resources, a basic income could also be paid to children, at a reduced rate. The basic income would be non-taxed, it would be
retained regardless of how much is earned through labor, and all earned income would be taxed at the standard rate.

A payment to afford the care and support rights elaborated in this study would need to differ from basic incomes in some respects. In particular, it would need to incorporate the costs of care or support, including the possibility of paying for services, employing paid workers, and compensating unpaid carers who are not in full-time paid work. Such a payment could take the form of a basic care and support budget, for which all people with care or support responsibilities and care or support requirements are eligible regardless of age, income and assets, participation in paid work, relationship status, disability status, or the extent of their care responsibilities or needs. This would reflect the complexity of real-life care and support situations, where individuals may be giving and/or using multiple forms of care or support at any one time. The starting assumption would be that every citizen will be in one position or the other at some time in their lives, reflecting the key concept of interdependence from the ethics of care literature and the notion of the universality of dignity from the human rights model of disability (Williams 2001, pp. 486–7; Morris 2001, pp. 11-12; Barnes 2006, p. 156). The payment could then be tailored to the specific needs and choices of all parties to the relationship. I elaborate on what is necessary to achieve this in terms of the other principles below.

8.3.3 Access to alternative sources of care or support must be expanded

Expanding eligibility for a higher-rate cash payment to all those giving or requiring care could increase citizens’ ability to access alternative sources of care or support. For instance, it would enable people to purchase care or support services as desired, or to share care responsibilities with multiple unpaid carers. However, cash payments would only afford full rights to care or support – and particularly choice and control – if multiple options exist. This highlights the need for policy change beyond simply reforming Carer Payment (child), particularly through the creation of adequate care and support services to complement or replace unpaid family care. I discuss such complementary policies later in this chapter.

8.3.4 Flexibility must be offered in multiple life domains

Carer Payment (child) will only be sufficiently flexible for people giving and obtaining care or support if it can be shared between multiple caregivers or support workers, even in cases where each of these people is not required for ‘constant’ care. This means that
the constant care requirement, and the care load (intensity) test, should not be threshold tests for determining eligibility for the payment, although they will still be relevant in calculating the appropriate quantum of the payment (albeit in a modified form, discussed below in terms of the positive recognition of difference). Such reforms could create options other than full-time care by a family carer, and could further challenge the policy’s assumption of – and support for – a one-to-one carer/care-recipient relationship. This also raises the need for the quantum of the payment to accommodate different options across the spectrum, from supporting unpaid family care, to supporting a combination of unpaid care and paid care or support, to full-time personal assistance or other paid services. Flexibility would also require the removal of the 25-hour per week limit on paid work participation, and the means, assets and cohabitation tests, to ensure that the payment was available regardless of how a carer combines unpaid care and paid work, or their relationship status.

8.3.5 Time for care or support, paid work and self-care should be available to all

Carer Payment (child) will only provide equal care and support rights if it more fully recognises the time to give and obtain care or support, and the time for carers to engage in paid work (Williams 2001). This, too, could only be achieved through the removal of some key eligibility limitations. Extending access to carers without constant and intense care loads or care needs would extend the time to give and obtain care or support to all people regardless of the degree of care or support involved. Expanding access to all people regardless of their paid work participation or financial circumstances, and regardless of the extent of their care loads or care or support needs, could also create more time for self-care. Such a change would give people greater choice and control over how they combine caregiving, paid work and other activities (including self-care), and would remove the necessity for people to be constantly engaged in only one activity. Extending access to care or support to all care or support users, if paid at a sufficient rate, could universally provide the time to participate in other activities like education and paid work, by enabling people to employ or reimburse a support worker or carer to facilitate this participation.

Removing the limit on allowable hours of paid work, and income earned from paid work, could also expand time to work for people giving care or support. However, this would need to be accompanied by greater possibilities of redistributing responsibility for care so
that carers have a meaningful choice between paid work and care. Abolishing the cohabitation rule in favour of an individual right to claim income support or allowances, and a universal rate of payment regardless of relationship status, could help ensure that the choices of one partner do not inhibit those of the other, and further extend the right to time to care and work to women – and men – with breadwinner partners (Neave 1992; Sleep, Tranter & Stannard 2006).

8.3.6 A wider range of voices should be brought together when designing policy

Any reforms to bring about these changes would need to encompass a wider range of voices, to ensure that the different perspectives of all those potentially affected by the policy are recognised and incorporated. Incorporating voice into Carer Payment (child) would mean that both those giving, and those obtaining, care or support would be treated as active subjects of the policy, and as relevant constituencies. This includes children and adults with disabilities, particularly self-advocates and their representative organisations. This would ensure that these voices are consulted directly, rather than through potentially unrepresentative intermediaries (see Frawley & Bigby 2011). People with age-related frailty, unpaid care or support providers in all kinds of relationships from very ‘intense’ to much lower intensity, and paid care or support workers, should also be consulted. Consultation should also recognise the gender-specific experiences of those giving and obtaining care or support, as well as other elements of intersectionality (such as ‘race’/ethnicity and sexuality) and the diverse experiences and needs of all those potentially affected by the policy. These voices should be incorporated meaningfully into the design of the policy, and not simply used to validate existing plans.

Listening to the voices of all care constituencies might lead to the identification of additional, or different, reforms to those identified in this study. It must be assumed that claims and interests will differ between and within groups, and the focus of such consultations should be on establishing a ‘common vocabulary of values’ (Williams 2001, p. 483; and citing Yuval-Davis 1999) – a task begun in this study’s efforts to bring together multiple academic perspectives on care, disability and gender equality.

Policy-makers may raise concerns about the consultation of children with disabilities or others who are often not considered to be competent to express their opinions or make decisions on their own behalf. Nevertheless, a different conceptualisation of children and others with care or support needs that prioritises their rights and recognises their agency,
rather than assuming that some people are burdens and passive objects of care, would ensure that policy-making and consultation focuses on maximising individuals’ independence and ability to participate fully in society (Shakespeare 2000a; Saaltink et al. 2012). In addition, as I discussed in chapter 3, some disability rights scholars argue that it is always possible and necessary to consider the will and preferences of people with disabilities regardless of their supposed capacity to make decisions or express themselves, as long as they have access to appropriate support (Flynn & Arstein-Kerslake 2014).

8.3.7 There should be positive recognition of, and support for, difference

Difference relating to the gender division of labour, and to disability and impairment, will only be recognised in Carer Payment (child) with significant reforms. Extending access to the payment for all those giving or obtaining care or support would promote such recognition. It would acknowledge care and support as universal, inevitable parts of life, and in doing so disrupt the problematic norms of independence on which Carer Payment (child) is currently based. Specific reforms may also be necessary to ensure that gender differences, and particularly women’s disproportionate responsibility for care, are addressed. Until there are sufficient changes to the organisation of paid work, which I discuss further below, higher budgets may be required for people (more often women) whose choice to give care incurs costs greater than those borne by people who choose full-time paid work. This could include ‘carer credits’ or superannuation contributions equal to those attached to paid work, and the ability to access payments after the caring role ends to facilitate the transition into (greater) paid work (Tilse, Rosenman & Le Brocque 1991; Jenson & Jacobzone 2000; Cass 2006). Cash payments would need to be paid at a high enough rate to serve as an inducement for non-carers (traditionally men) to take up the caring role (Jenson & Jacobzone 2000, p. 34). As I have already noted, abolishing the cohabitation rule could increase the extent to which the policy positively recognises difference. It would expand women’s choices about combining unpaid care and paid work beyond male-breadwinner or modified-breadwinner care arrangements, and ensure that breadwinners’ choices about paid work and care did not limit the options of their partners (Sleep, Tranter & Stannard 2006, p. 145; Hopkins 2005, p. 192).

Full support for difference may require the availability of higher budgets to people with greater needs, thus recognising the impact of disability and impairment without needing to equate it with tragedy or aberration (Morris 2001). That is, in keeping with the human
rights model of disability, assessments of care or support needs and loads should only be used to calculate the cost of providing the care or support necessitated by the person’s particular circumstances, and chosen by those giving and using it. They should not have a cut-off point based on a distinction between having a disability and not having a disability, and eligibility should not be based on establishing the burdensome nature of care or support.

In order to positively recognise difference, the tests used to determine eligibility for payment would also need to be revised to incorporate factors other than disability needs in a strictly medical sense, incorporating the social and human rights models of disability. This means they should include a consideration of both the child’s (individual, medical) impairment and his or her (socially-produced) disability (Morris 2001, pp. 12–13). For example, assessments should take into account the equipment and aids available to a person, the accessibility of his or her home, school, and other public and private places, and the range of supports that might be necessary to enable the person to fully participate in society on an equal basis with others (Kayess & French 2008). A number of measures of disability have been proposed that could further this aim, including the World Health Organization’s ‘International Classification of Functioning’ (ICF) (2001) and approaches based on Martha Nussbaum’s work on the capabilities approach (see Burchardt 2004; Nussbaum 2006; Mitra 2006; Harnacke 2013). Both approaches seek to place impairment in its wider context. The ICF assesses disability along multiple dimensions intended to capture medical and social causes of disability, including both medical or health-related factors and contextual or environmental factors (Mitra 2006, p. 242). The capabilities approach treats impairment as ‘one characteristic among many which interacts with the social, economic, and physical environment to produce a profile of advantage or… disadvantage for an individual’ (Harnacke 2013, p. 773). Each has shown promise in offering a more holistic disability measure, although there is also disagreement over the extent to which they adequately incorporate the social model or ‘solve the difficult problem of establishing a standard for the determination of disability’ (Mitra 2006, p. 242; see for example Bickenbach et al. 1999; Burchardt 2004, pp. 742–3).

Consultations to satisfy the principle of ‘voice’ discussed above could offer the opportunity to further explore relevant and useful measures of disability and care or support requirements. Recent developments in other areas of Australian care and support policy may also provide guidance in this regard. As I noted in chapter 2, the National
Disability Insurance Scheme is a national system of individualised funding for ‘supports directly related to… [the] ongoing disability support needs’ of people with a disability aged under 65 (Revised Explanatory Memorandum, National Disability Insurance Scheme Bill 2013 (Cth), p. 1). The determination of what supports can be funded under the scheme is based on an assessment of what is ‘reasonable and necessary’, and this might offer a useful precedent for assessing care and support needs across a wider spectrum (although see Foster et al. 2016).

8.3.8 Complementary care, support and workplace policies are required

As I have noted, complementary policies beyond cash payments would also be necessary to ensure that Carer Payment (child) avoids either/or policy-making and offers equal care and support rights to all parties. First, attention is needed to alternative sources of care or support, both market-based and state-based (Rummery & Fine 2012). These alternatives should be well-regulated to ensure against the abuse of any party, and to guarantee the quality of both the care or support obtained and the employment conditions of those providing it (Rummery 2011). A wide range of services are also necessary to ensure that flexibility is extended to people giving and obtaining care or support. As I touched on above, these services should not be confined to meeting medical needs, but should also provide support in terms of providing choice about how people live their lives and overcoming the social barriers that create disability.

Changes to employment policy would also be necessary to ensure that flexible working conditions support diverse combinations of care and paid work, and that people who use this flexibility do not experience disadvantage in the labour market such as poorer quality or security of their work (Burgess, Campbell & May 2008, pp. 162–3; Pocock, Skinner & Williams 2012, p. 203). This flexibility is also necessary to ensure that people in paid work have time for care and time for self-care (Williams 2001, p. 488). Flexible working conditions should particularly challenge ‘androcentrism’ (Williams 2010, p. 6) so as to support the redistribution of traditional care and paid work responsibilities rather than simply perpetuating the assumption (reflected in the modified-breadwinner model) that individual women are responsible for fitting their paid work participation around their caring roles (Pocock, Charlesworth & Chapman 2013). This is also likely to require broader changes to the structure of work to make it easier to combine care and paid work, such as measures to curb long working hours, greater access to childcare, and better pay
and conditions for care and support workers and other female-dominated industries (Cass 1995; Pocock, Skinner & Williams 2012; Pocock, Charlesworth & Chapman 2013).

8.3.9 Conclusion: a comprehensive challenge to prevailing norms and binaries

Extending and reformulating Carer Payment (child) policy in the manner discussed here would overcome the prevailing binary thinking about care and paid work, and the prioritisation of the interests of carers over those of people with disabilities. The policy would no longer favour one side of each tension over the other, and could offer equal rights to care or support givers, and care or support users. In doing so, it would address many of the gaps and shortcomings of the current iteration of the policy – and of other policies that fail to address care policy tensions – that I identified in chapters 6 and 7.

First, the proposed reforms to Carer Payment (child) would address each of the problematic consequences of the policy in terms of Wollstonecraft’s dilemma. They would disrupt the assumptions underpinning these issues, and promote gender equality in a sense similar to that advanced in the universal caregiver literature, but with greater emphasis on diversity in the gender division of labour. In chapter 6, I identified four key consequences of Carer Payment (child) policy in this regard. The policy’s support for unpaid care over paid work firstly meant that paid work is not encouraged or facilitated; secondly, that only some kinds of unpaid care are valued and supported; thirdly, that individual familial responsibility for care is prioritised regardless of its consequences; and, finally, that the gender division of labour is not addressed. I linked these gaps and shortcomings with several assumptions or discourses of care and paid work, including that one informal carer (parent) should provide the majority of care and bear most of its costs, that parents with intense caring roles – unlike other parents – cannot participate in full-time paid work, and that informal caring should be supported because it is valuable for government and society.

In regard to Carer Payment (child)’s lack of support for paid work, the proposed reforms would create flexibility in the care and support that can be given and obtained, and expand the time for care and support to all through universal access to cash payments. This would ensure that the policy does not inhibit women’s paid work participation (Cass 2006, p. 252). Making the payment flexible to facilitate a range of care and support arrangements, and to give time and flexibility for other combinations of unpaid care and paid work, would avoid the binary distinction between citizen-workers and citizen-carers
that is currently at the heart of Carer Payment (child) policy (Knijn & Kremer 1997). It would also mean that both unpaid care and paid work would be treated as the norm for parents and all other citizens, rather than full-time unpaid care being seen as an exception to the norm of paid work in situations of extreme need (Fraser 1994). This would also disrupt the problematic assumptions that a sole family member should be responsible for providing care, that having a child with a disability necessarily precludes paid work participation, and that this is the inevitable and appropriate consequence of carers’ love and devotion.

A policy revised in accordance with the six principles could actively support paid work participation by creating real options in terms of how women share their care responsibilities with others. These options would ensure that male-breadwinner or modified-breadwinner arrangements are not the only choices for women and their families, offering a challenge to the unequal gender division of labour (Burgess & Strachan 2005, p. 7). In combination with the complementary supports for paid work participation proposed above, this would also ensure that the policy not only treats the symptoms of ‘intense’ care – low income from inhibited paid work participation – but creates the possibility of avoiding those consequences through increased paid work participation.

The proposed changes to Carer Payment (child) policy could also contribute to a more equal valuing of unpaid care and paid work (Williams 2001), rather than paid work being prioritised over unpaid care in usual parenting situations and unpaid care being prioritised over paid work in intense caring situations. Increasing the quantum of the payment and expanding access to all people with care and support responsibilities and needs would extend the valuing of care and maternalism to all types and extents of care, challenging the binary distinction between intense care and usual parenting. It would also more fully meet the financial costs of various forms of care and support, rather than simply providing a safety net to ‘buffer some women’s vulnerability to poverty’ (O’Connor J, Orloff & Shaver 1999, p. 25). Recognising the universality of care and support through universal access to the payment and ensuring access to a variety of services is key to disrupting the masculine norm of independence that feminist and disability rights scholars agree is key to the ‘othering’ of women and people with disabilities (Hughes et al. 2005, p. 264; Kröger 2009, pp. 406–7).
Universalising access to care and support payments would also entail a greater recognition of all forms of care and support as a social good (Daly 2002). Consequently, individual carers would not be expected to bear the majority of the costs of care, and care and support would be treated as valuable in themselves, instead of only being supported when they have economic value to the government, or when they create great hardship or vulnerability for carers. It would also mean that responsibility for care of others and the self would not be individualised, but would be shared more equally and collectively, both in terms of financial support through redistribution, and in terms of sharing the physical work of care and support (Bowman, Bodsworth & Zinn 2013, p. 284).

The reforms proposed in this chapter would also address the gaps and shortcomings of Carer Payment (child) policy’s support for carers, and the problematic discourses of care and disability as a burden and tragedy, identified in chapter 7. I identified three key issues in this regard: that some of the burdens of care are alleviated, but many are supported and assumed to be inevitable; that the social causes of disability are not addressed; and that choice, control and independent living are not contemplated or supported. Reforming Carer Payment (child) according to the care and support rights principles has the potential to prevent care becoming burdensome for carers, and to thereby challenge the characterisation of disability as a burden and a tragedy. In particular, expanding choice and control over the support obtained and how one’s daily life is organised would mean that constant, full-time care by one person in intense care situations is only one option among many. It could also help to ensure that this arrangement, and its consequences, could be avoided if not desired (Kröger 2009, p. 409).

Making the payment universal and sufficiently generous could also create the time for self-care, further protecting against the negative health and wellbeing effects associated with intense care (Jenson & Jacobzone 2000, p. 35; Williams 2001). Making the payment available and flexible for people with care or support needs, and ensuring that the voices of all affected parties are heard, could also break down the binary between passive, dependent ‘care recipients’ and active caregivers, because it contemplates and treats as relevant both agency and choice for all parties (Shakespeare 2000a; Fine 2004). Requiring consultation of people giving and obtaining care and support would mean that choice and control would be incorporated throughout the policy process, and not only when the policy has already been formulated. It would also open a space for different constituencies to raise different claims (Williams 2001), rather than assuming consistency.
Addressing the lack of choice and the possibility of independence for children with disabilities (and others with care or support needs) means a reformed policy could also mitigate power inequalities and avoid the potentially negative consequences for all parties of forced unpaid care (Morris 2001). Requiring care services to be well-regulated, ensuring the power of exit for all, and ensuring that cash payments are sufficient to enable people with disabilities to pay carers or support workers, would protect against the disempowerment of care and support workers that has been associated with marketised, choice-based provision (Hughes et al. 2005; Rummery 2011).

Providing cash as a matter of citizenship right, and establishing interdependence as a norm would also avoid perpetuating the notion that support for care or support constitutes welfare and charity for unfortunate, dependent people with disabilities (Kayess & French 2008, pp. 5–6). This, and the incorporation of a wider definition of disability, could de-centre the binary distinction between children (and others) with disabilities and children (and others) without disabilities currently drawn in Carer Payment (child) policy, and move away from assessment that treats disability as a deviation from the norm (Morris 2001; Degener 2016).

### 8.4 Limitations of the care and support rights principles

Applying the six principles to Carer Payment (child) policy demonstrates their usefulness in transcending some of the tensions that commonly trouble policy and designing policy that can offer equal care and support rights to traditionally competing constituencies. It also makes clear some potential limitations or shortcomings of the principles. On the one hand, some elements of the design may be overly narrow, excluding additional relevant perspectives or the input of other groups who have an interest in care or support policy. On the other hand, the wide scope of the principles means that the major policy changes that they necessitate would be likely to require considerably greater government resources than are currently committed. This would be contrary to the general trend towards retrenchment and conditionality in welfare policy in Australia and other liberal welfare states. For the remainder of this chapter, I discuss and explain these potential limitations, and propose ways around them or avenues for additional research to further strengthen the principles.
8.4.1 Gaps in the content or design of the principles

Evaluating a specific policy using the principles highlighted a number of gaps in their content and design. First, I designed and assessed the principles with a focus on only some care or support users (people with disabilities), and some care or support providers (unpaid carers, and particularly mothers of dependent children). The principles do incorporate some key concerns raised by other constituencies, such as the impacts of marketisation on paid care workers. In addition, I have intentionally designed the principles to be broad enough to encompass the rights of all parties to care and support relationships, in recognition of the universality of care, support and dignity. Nevertheless, the application and limitations of the principles may be quite different for other people, such as older persons with dementia or working-age adults with physical disability who also have care responsibilities. As I touched on in chapter 4, further testing and refinement of the principles through analysis of other policies and perspectives would ensure that they adequately encompass the circumstances of these other constituencies and can overcome fragmentation along these lines.

A second limitation of the design of the principles is that they do not fully meet their own requirement to incorporate the voices of diverse care constituencies in the design of policy. The principles bring together multiple academic perspectives, but I did not consult directly with all relevant constituencies in formulating or testing them. There are several ways that voice could have been further incorporated into the study; for example, by including the public submissions to the CPCR Taskforce and Senate Standing Committee reviews of Carer Payment (child) in the analysis (see section 4.2.3, above), and by incorporating ethnographic or interview research with the different groups affected by Carer Payment (child) policy. I did not undertake this kind of analysis or consultation due to the time and content limitations of the doctoral study. Nevertheless, such work is a necessary (and likely fruitful) avenue for further fortifying the principles and establishing their legitimacy among different claims-making groups.

8.4.2 The possibility of incompatible choices

Applying the care and support rights principles to Carer Payment (child), and particularly canvassing how policy could provide choice and control to multiple constituencies, raises the possibility that the choices of one person may constrain, or be inconsistent with, those of another. For example, parents may want to place their children in childcare while they
engage in paid work, while their children might only want to receive care from their parents. A mother might wish to re-enter the workforce and share with her partner the care of their child with a disability, but her partner might choose full-time paid work. Relationships are complex, and resolving incompatible choices will require negotiation and compromise. Policies designed according to the principles could offer support for such processes, by providing resources to challenge prevailing power relations in care and support relationships, incorporating the voices of all, and protecting against any party being trapped by a lack of options. However, the principles’ emphasis on placing the rights of all parties on an equal footing, and their prioritisation of choice, means that there may be times that parties reach an impasse that cannot be resolved using the principles alone.

It is also important to note that care and employment policy change on its own is unlikely to be sufficient to ensure that men’s choices about care and work do not impede those of women. Policies that coerce people to behave in a particular way raise the possibility of an unhelpful ‘backlash’ against them (Lewis & Giullari 2005, p. 97). Orloff (2008, p. 13) argues that ‘men’s attachment to the powers and privileges of masculinity’, and issues like ‘plain old discrimination… and cultural beliefs in gender difference’ must also be addressed to fully tackle the unequal gender division of labour (id.; see also Pocock, Charlesworth & Chapman 2013, p. 608). Disability rights scholars similarly raise the need for anti-discrimination laws, and other legal and policy measures, to fully address the stigma and discrimination that contributes to the social construction of disability as an individual tragedy and burden (Shakespeare 2000a; Degener 2016).

The fact that policies designed using the principles may raise incompatible or conflicting choices also points to a wider issue with its design. Incorporating both ‘care’ and ‘support’ into the principles may be considered to be problematic by some disability rights scholars or some feminist scholars. Including both concepts represents a compromise between competing positions, rather than a complete resolution of the concerns of some disability rights activists about care and its connections with dependency and oppression, or the concerns of care ethicists and other feminists about support and its connection with independence and market-based choice. Consequently, the principles may not satisfy all of those who identify with one or other of these perspectives (Beckett 2007; Kröger 2009). Nevertheless, using both terms is intended to encourage a consideration of a wide range of activities and services relating to care and support, challenging the tendency to ignore
one perspective in favour of another and de-emphasising the dependence/independence binary that continues to trouble efforts to reconcile the ethics of care and disability rights perspectives. In other words, it offers a ‘discourse bridge between feminist and disability perspectives’ (Watson et al. 2004, p. 345; see Fraser 1989, pp. 11–13), and incorporates the awareness that extreme positions do not produce the best policy outcomes for any parties, a sentiment that has been expressed to some extent by all sides (Shakespeare 2000a, p. 64; Kröger 2009).

8.4.3 Resource limitations and the likelihood of major policy change

Policies designed according to the six principles would ensure that social support is extended to all those who give or obtain care and support, not just people in situations of high or intense need. This invites a more holistic approach to care and support requirements and rights, and establishes interdependence, rather than independence, as the norm. However, expanding eligibility for financial support to such a broad group of citizens, and prioritising choices rather than financial need, means that a broad care and support payment would be likely to require far greater resources than the current system allows. It would also disrupt some of the basic features of Australian welfare policy. In the American context, Orloff (2008, p. 22) has noted that these kinds of sweeping reforms would not be pragmatic, and Pascall and Lewis (2004, p. 383) observe that problems with basic or participation income proposals ‘lie with funding sufficiently to provide a worthwhile income’. In the Australian case in particular, such major changes would be contrary to a number of ‘fundamental principle[s] of Australian social security’ (Tranter, Sleep & Stannard 2007, p. 212), including the targeting of income support to those most in need, and the emphasis on working-age income support payments as only a temporary compensation for unemployment. Further, the emphasis on the economic value of care as a rationale for the extension of Carer Payment (child) to more carers suggests that there may be limited discursive spaces to argue for policies that do not have such significant economic benefits.

This relates to a broader issue raised by the application of the principles to Carer Payment (child) policy. The problem representations in the Carer Payment (child) policy reforms, and the discourses of care and disability underpinning them, are likely to be difficult to disrupt. The care and support rights principles do offer a new and organised way to challenge them by incorporating other, less dominant discourses from the academic
literature. The alternative conceptualisations make alternative views of the problem ‘thinkable’, such as a lack of flexibility in care/work and care and support combinations, a lack of voice, and a lack of time for care or support, paid work, and self-care. These alternatives are not entirely ‘subjugated’ – they are well-established in the literature, and some were also identified during the 2009 reform process (Bacchi 2009, p. 36; and citing Foucault 1980b, p. 131). For example, the CPCR Taskforce (2007, p. 42) and Liberal (Opposition) parliamentarians argued that policy reform was needed to offer more flexibility and expand carers’ choices about how they combined care and paid work (Commonwealth of Australia 2009b, p. 3812 (Judi Moylan); 2009c, p. 3382 (Sue Boyce); see section 6.3.1, above). Nevertheless, Bacchi notes that governments are particularly influential in establishing the truth status of problem representations, and have an interest in preserving them (for instance, in terms of the economic benefits of supporting constant care), meaning they can be difficult to challenge and dislodge (Bacchi 2009, p. 33).

8.4.4 Inconsistency with the activation trend

Lewis (2001, p. 164) notes another problem with proposals for major policy change like a basic income model, namely, that they are ‘unlikely to prove popular with governments increasingly concerned about responsibilities and preoccupied with promoting active rather than passive welfare’ (see also Mays, Marston & Tomlinson 2016). The few scholars who have discussed Carer Payment policy have characterised it as an exception to this trend, which they attribute specifically to the economic benefits of caring and the higher burden of caring for someone with a disability (Cass 2006; Cass & Yeandle 2009). Introducing a care and support income that encompasses other categories of income support claimant, such as sole parents of dependent children (currently eligible for Parenting Payment (single)) or adults with disabilities (currently eligible for Disability Support Pension), would be in contrary motion to the welfare-to-work reforms that have introduced paid work participation requirements for these groups (see for example Blaxland 2010; Soldatic & Pini 2012). As Foster and her colleagues (2016, p. 29) note:

Though the idea of fairness remains [in the disability welfare field], it has come to be synonymous with deservingness rather than rights (Lantz & Marston 2012), with more restrictive entitlement rules, and with eligibility tests to target those most deserving (Soldatic & Pini 2009).
This raises a wider issue, namely, the political palatability of a rights-based framework in the current policy climate in Australia and other liberal welfare states. Hartley Dean has argued that citizenship rights (and human rights) are capable of either ‘contractarian’ or ‘solidaristic’ interpretation. The former sees the purpose of rights as advancing the independence of individuals (Dean H 2007, p. 7; see also Fraser 1989, p. 183). The latter sees the purpose of rights as ‘seek[ing] to enable people to engage with one another in mutually protective solidarity’ (id.). A similar argument, that rights arise from relationships and are inherently relational, can be found in some feminist scholarship (Lynch, Baker & Cantillon 2009, p. 28). In their emphasis on interdependence and universal access to support, the proposed principles (and the perspectives which inform them) pursue rights in the solidaristic sense. However, solidaristic interpretations of citizenship and human rights have been ‘under pressure’ from the increasing work-related conditionality on social support (Dean H 2007, p. 6). Many scholars have observed a shift away from the language of ‘rights’ and ‘entitlements’ towards a language of ‘responsibilities’ and ‘obligations’, particularly in the welfare sphere (for example, Harris 2001; Shaver 2002; Fiske & Briskman 2007; Lantz & Marston 2012).

Lewis (2001, p. 164) cites Atkinson’s (1995, 1996) proposals for a ‘participation income’ system that may offer a middle ground in this regard; this would recognise a broader range of activities, including care, as legitimate forms of participation and activation for determining eligibility for income support. However, depending on the specific types of ‘socially useful’ participation that are recognised by such a payment, this proposal risks the exclusion of people – such as people with disabilities – who cannot participate in the prescribed ways (Raventos 2007, pp. 77–78). Consequently, while the appropriateness of non-conditional payments may be more difficult to establish discursively and politically, the analysis in this thesis suggests that they are worth fighting for in order to achieve truly inclusive policy that does not compromise on key issues.

8.5 Conclusion

As it currently stands, Carer Payment (child) does not afford either a social citizenship right to give care and support, or a social citizenship right to obtain care and support. In this chapter, I have demonstrated how the six care and support rights principles can be used to identify particular points of weakness in this regard, and the reforms and complementary policies that would be necessary to overcome them, transcending care
policy tensions and meeting the concerns of multiple constituencies. I have also identified some potential limitations of the principles, and suggested solutions or responses to them. I review and summarise the study and its contributions, and return to some of the wider limitations of the study and future research directions, in the next chapter.
9. Conclusions

9.1 Overview

In this chapter, I review and summarise the study, providing an overview of the findings and situating them within the wider literature. I outline how the proposed care and support rights principles extend previous efforts to reconcile competing theoretical and policy perspectives on gender equality, care and disability. I then discuss the insights that the case study offers into the causes and consequences of care policy tensions, and the study’s implications for designing care and support policy that resolves those tensions and promotes equal care and support rights for all. I also revisit the study’s limitations and canvass opportunities for further research.

9.2 Extending existing efforts to overcome care policy tensions

In this study, I have focused on two tensions that affect contemporary care policy, and that constitute ‘battlefield[s]’ across a number of policy-related disciplines (Fine 2004, p. 218). I began by reviewing and analysing the literature that addresses and seeks to resolve those tensions – the first, between supporting women’s unpaid care and supporting their paid work; and the second, between supporting the rights and interests of carers and supporting those of people with disabilities. Throughout the study I was guided by social constructionist principles. I focused on the role of language in creating meaning, and treated different perspectives on gender equality, care and disability as sources of alternative social constructions or discourses that benefit some people and not others. I did not attempt to identify the ‘correct’ perspective, but rather sought to find common ground across perspectives and identify a set of principles for designing policy that can contemplate and address the key concerns and proposals raised in each of them (Burr 1995).

Policies that favour women’s unpaid care or paid work, or favour the claims of carers or those of people with disabilities, are inherently limited. While they undoubtedly produce some advantages for some people, either/or policies are often accompanied by concurrent negative consequences for their target constituencies, such as the simultaneous advantages and disadvantages of care-supportive or work-supportive policies for mothers identified by feminist social policy scholars. Alternatively, either/or policies may create positive impacts for some constituencies at the expense of others’ access to resources and life options. For example, policies supporting carers on the basis of the burden of care
can marginalise and ignore the perspective of people with disabilities, while policies supporting the rights of people with disabilities by offering choice and control may do so at the expense of the quality and security of employment for paid care or support workers (Beckett 2007).

Previous academic efforts to overcome the limitations of either/or policy-making offer non-dichotomous ways of conceptualising the relationship between unpaid care and paid work (and how this relates to gender equality), and the relationship between care and disability. The universal caregiver model challenges the tendency for policy to support only women’s care or women’s paid work. It does so mainly through disrupting the (masculine) norm of the full-time earner that informs both of these options – care-supportive policies recognise women’s difference from this norm, while work-supportive policies support or require women to pursue the male standard (Fraser 1994). The universal caregiver model encourages instead a new norm of part-time paid work and care for both women and men. However, this approach has several limitations. First, it assumes that the equal sharing of unpaid care and paid work between women and men in heterosexual couple relationships is universally desirable, and does not prioritise choice or diversity in care/work combinations (Orloff 2008). Secondly, it is concerned mainly with equality between women and men in care-giving, and does not equally prioritise the interests of children or other ‘recipients’ of this care.

Efforts to reconcile the carer and disability rights perspectives have largely proposed some combination of disability rights and ethics of care thinking. The notion of interdependence has been proposed in ethics of care scholarship as a way to break down one of the dichotomies at the heart of the carer/people with disabilities tension, namely, that between dependence (assumed and prioritised in the carer perspective) and independence (sought and prioritised in the disability rights perspective) (for example, Tronto 1993; Sevenhuijsen 1998). This also challenges the norm of the non-disabled, autonomous person against whom people with disabilities are frequently measured and found lacking (Tronto 1993, p. 121). However, these reconciliation efforts have not overcome all points of contention between the perspectives. These include the ethics of care’s preservation of the concepts of care and dependency (albeit with more positive connotations than traditional care scholarship) (Shakespeare 2000a, pp. 62–63; Williams 2001), and the promotion of independence for people with disabilities (potentially at the
expense of those providing care or support) in the disability rights perspective (Watson et al. 2004; Barnes 2006).

The limits of these reconciliation efforts led me to pose the first research question, ‘How can the tensions between unpaid care and paid work, and between the interests of carers and people with disabilities, be better managed in care and support policy?’ In response to this question, I drew on and augmented the existing literature to propose six principles for designing policy that reconciles apparently competing perspectives and guards against either/or policy and its shortcomings. The principles offer a means to evaluate the extent to which care policies encompass the concerns of multiple care and disability perspectives (particularly in regard to the care/work and carer/people with disabilities tensions). They also provide guidance for formulating or reforming policy to more effectively do so.

The principles are directed specifically towards promoting equal social citizenship rights to care and support, rather than alternative goals like meeting care needs, or securing human rights, for several reasons. Each of the perspectives that the principles bring together is concerned with advancing the social rights of a particular constituency – women (mothers) with caring responsibilities, carers more broadly, or people with disabilities. Consequently, social citizenship rights comprise a common discourse for bringing those perspectives together (Williams 2010, p. 5). Emphasising citizenship rights also clearly establishes the responsibility of the state to provide resources and services, and means that policy designed according to the principles can contribute to a reconceptualisation of care and support as usual and valuable components of citizenship alongside paid work participation (see Williams 2001; Barnes 2006; Lynch, Baker & Cantillon 2009).

The six principles incorporate elements from each of the reconciliation literatures. They bring together the key reconceptualisations of gender equality, care and disability that each perspectives offers to dissolve traditional dichotomies and lines of fragmentation. Like the universal caregiver model, and attempts to reconcile the ethics of care and disability rights perspectives, the principles reject the norms of the full-time (male) worker and the independent, atomised individual (Fraser 1994; Hughes et al. 2005). Policies designed according to the principles would not measure people (or determine their eligibility for social support) against these norms, instead assuming that giving and requiring care or support is the usual and expected state of being. The principles
encourage policy that incorporates other, related assumptions – that unpaid care and paid work are compatible activities that can be shared more equally within and beyond families, that the interests of different constituencies are of equal importance, and that different sub-categories of care or support (such as care or support for children, people with disabilities, and people with age-related frailty) are all part of a spectrum of activities, responsibilities and needs rather than discrete or mutually exclusive activities (Daly & Lewis 2000, pp. 285–6; Barnes 2006, p. 143).

The care and support rights principles address the shortcomings of previous approaches to overcoming care policy tensions in several respects. The principles encourage policy that places the rights of all parties on an equal footing, rather than prioritising either the givers or users of care or support. This addresses a limitation of both the universal caregiver and ethics of care/disability rights approaches (Beckett 2007). The principles incorporate both care and support, rather than preferring one concept and activity over another, creating common ground between the ethics of care and disability rights perspectives (Kröger 2009). By incorporating an assumption of interdependence as the norm, but expanding this to emphasise the universality of dignity from the human rights model of disability, the principles further de-centre the traditional dependence/independence binary and guard against policy that reserves support to those who can establish the burden or tragedy of disability (Morris 2001). The principles address other limitations of the universal breadwinner model by promoting policies that afford meaningful choice – choice that is well-resourced and not constrained by the choices of others – for people giving care or support, and for those using it. This rejects the assumption that all women want ‘gender symmetry’ in unpaid care and paid work, but aims to stimulate policy that makes such equality a real option (Gornick & Meyers 2008, p. 323; Orloff 2008, p. 13). Ensuring that choice is meaningful for all parties can also mean that the choice and control called for by disability rights scholars is extended beyond care or support users to people giving care or support (Rummery 2011).

9.3 The complex manifestations and consequences of either/or policy-making

The remainder of the thesis took the study out of this theoretical realm and into the Australian policy context, through the case study of Carer Payment (child). In chapters 5, 6 and 7, I responded to research question 2, ‘How do the tensions manifest in Australian policy, and what are the consequences for different care constituencies?’ For this part of
the analysis, I used Bacchi’s (1999; 2009) ‘what’s the problem represented to be?’ approach to discourse analysis to explore the practical manifestations and consequences of the two policy tensions. The analysis of policy documents associated with the most recent reforms to Carer Payment (child) provided a detailed, current example of the tendency identified in the literature for policies to support either unpaid care or paid work (Cass & Yeandle 2009; Craig 2009) and to support either carers or people with disabilities (Beckett 2007). It also enabled me to explore and elaborate on the causes and consequences of either/or policy-making in this field.

The case study findings supported previous arguments in the literature that government assumptions about the economic value of unpaid care, and about the intensity of the caring role, are key to policy decisions to support unpaid care over paid work in relation to disability care (Cass 2006; Cass & Yeandle 2009). The discourse analysis demonstrated how deep-seated assumptions about the nature and value of care and paid work led ‘logically’ to this either/or policy outcome. It also opened a path to challenging these assumptions through alternative discourses. First, the analysis highlighted the influence of a number of distinct, but related, dichotomous assumptions that made support for full-time care by a sole carer appear to be the preferable and inevitable policy outcome. Intense care and paid work were treated as essentially incompatible activities, and unpaid care for children with severe disabilities was prioritised because it is valuable to government and society, and because parents (and predominantly one parent) are assumed to be the natural and appropriate providers of this care. This led apparently inevitably to a conclusion that carers should be supported to provide constant care. Consequently, any real consideration of what might be needed to facilitate the redistribution of care from women to men or from families to other sectors was excluded, and carers’ paid work participation was not considered to be a policy priority. The dichotomous distinction that was drawn between intense care (which precludes paid work) and usual parenting (which does not) also meant that all people with less-than ‘intense’ caring responsibilities were assumed to be capable of self-support through paid work, reinforcing paid work and independence as the norms of social citizenship and participation for all but the most extreme care situations.

The case study analysis highlighted the fact that care policy does not necessarily deal with the care/work tension in a completely straightforward manner. Carer Payment (child) policy does not fall completely on one side of Wollstonecraft’s dilemma. It facilitates
some combinations of unpaid care and paid work; specifically, carers can participate in paid work for up to 25 hours per week without affecting their eligibility for the payment, although this reinforces carers’ positions as part-time (secondary) earners and the policy does little to actually enable this participation. The choice facing governments between supporting unpaid care or paid work was explicitly recognised as a source of economic tension, and the need to support carers’ paid work (to improve their financial circumstances and expand their choices) was championed unsuccessfully by a minority in the Parliament. In contrast, the significance of this policy tension for gender equality – the key focus of the feminist literature on Wollstonecraft’s dilemma – did not arise either explicitly or implicitly. The gendered nature of care was barely mentioned, and certainly not problematised. As a result, the few advantages of the policy from a feminist social policy perspective (namely, the greater valuing and recognition of this form of care) were coincidental, and the promotion of gender equality depended on the alignment of feminist goals with the Government’s economic interests.

Similarly, the possibility that a tension might exist between carers’ interests and those of their children was not recognised in the policy reform process. I have argued that this was a consequence of the construction of children with disabilities as passive and silent, and a construction of disability as a consequence of children’s individual, medical needs. Because children’s ‘interests’ were assumed to begin and end with the satisfaction of their physical care needs, it was further assumed that those interests could be fully determined, and met, by their carers and medical professionals. Consequently, the possibility that children might have a different perspective, or choose different care or support arrangements, was not ‘thinkable’ at all in this policy space. This suggests that there were more discursive spaces for challenging some of the shortcomings of Carer Payment (child) policy (such as the problem of carers’ lack of paid work participation) than others (such as the problem of children’s lack of choice, control and voice).

Analysing a policy that is concerned with the care of children with disabilities also offered additional insights into how dependency and disability are thought about – and responded to – in policy (for example, Silvers 1995; Morris 1997). In Carer Payment (child), both children without disabilities and children with disabilities were assumed to be dependent on their parents for meeting the majority of their care needs. A distinction was nevertheless drawn between these two groups based on a dichotomy between ‘normal’ development and non-normal development. The former was expected to lead eventually
to independence in adulthood, while the latter was assumed to entail long-term dependency. This indicates that slightly different policy reforms to those prioritised in the disability rights literature (such as independent living and the outright rejection of unpaid care for adults) would be required to realise the interests of children with disabilities (Morris 1997; Kröger 2009). These might include access to appropriate childcare, in-home support, and measures to enable better sharing of unpaid care between parents or within wider families. These services and supports should be tailored to a child’s current requirements without assuming that they can never be ‘independent’ in the sense of having agency and voice in how they live their lives and the support they use for this purpose. As I discuss below, the six care and support rights principles are broad enough to incorporate these nuances and facilitate the design of policy that realises the rights of both children and adults.

The case study findings were also consistent with previous observations that the construction of care and disability as burdensome, individual and tragic is key to securing social support for carers. They also demonstrated how this discourse of disability obscures the social causes of disability identified by disability rights scholars and activists. However, the case study also showed that the burden discourse does not necessarily lead to the alleviation of many of the burdens of care. Assumptions about the naturalness and inevitability of carers’ responsibility for constant care, and the economic incentive for the Government to support this, reinforced carers’ responsibility for very intense care, which is associated in the literature (and some of the Carer Payment (child) policy documents) with a range of hardships and costs, including financial hardship, poorer health and wellbeing, and disrupted family relationships (Twigg & Atkin 1994; Edwards B et al. 2008). In other words, the policy had only limited advantages for the constituency it claimed to support. This provided further confirmation of the relevance of a new approach to designing policy that overcomes either/or approaches and encompasses the concerns of all parties to care and support relationships.

9.4 A flexible and inclusive framework for substantive change

Applying the proposed care and support rights principles to the case study tested the framework’s usefulness for designing policies that challenge the limiting conceptualisations of gender equality, care and disability that produce either/or policy and thereby promote rights for all parties to care and support relationships. This
responded to the third research question, ‘How could the proposed care and support rights framework resolve the care policy tensions, and produce equitable outcomes for multiple constituencies, in a practical policy context?’

The principles promote policy responses to women’s unpaid care and paid work participation that (unlike Carer Payment (child)) do not treat them as mutually incompatible activities, and recognise both activities as integral, but not determinative, elements of citizenship. The principles also invite an explicit response to the potentially divergent interests of different parties to care and support relationships, guarding against the tendency (demonstrated in Carer Payment (child) policy) to allocate resources to either caregivers or care or support users. The principles can also encourage policies that, unlike Carer Payment (child), attend to the unequal gender division of labour, and the effects of impairment and disability, and offer the resources and recognition that different people need to live life with dignity.

I first used the principles to evaluate the extent to which Carer Payment (child) policy currently extends citizenship rights to care and support to carers and children with disabilities. This revealed shortcomings in regard to each principle, and affecting both carers and children with disabilities. The policy reserved access to financial resources to a small group, did not contemplate a diversity of services, and did not facilitate flexibility in combining care and paid work, or in combining different forms of care and support (Rummery 2011; Rubery 2015). It did not fully afford time for care and support, paid work, or self-care, and it did not incorporate the perspectives of all those who give care and support, or all those who use it (Williams 2001). Finally, it did little to support the gender redistribution of labour, and it only contemplated the needs of children with disabilities insofar as they arose from their individual, medical circumstances and created a care load for others (Fraser 1994; Morris 2001).

I then demonstrated how the principles can be used to identify the kinds of reforms necessary for policy to avoid either/or approaches and afford equal citizenship rights to care and support to all. As I noted above, the first part of the case study analysis indicated that there were more discursive spaces to challenge some elements of care policy tensions than others in the reform process. The approach I have proposed may open new discursive spaces, because it draws together all of the more beneficial ways of conceptualising gender equality, care and disability from the literature into a coherent and indivisible set
of policy principles to ensure that all of the key concerns identified in the literature can be addressed simultaneously.

Applying the principles to the case study analysis demonstrated their flexibility and potentially broad application. Policy designed according to the six principles could avoid not only the broad binary distinctions identified in the literature review, but also the distinct dichotomies that led to either/or thinking and policy-making in Carer Payment (child) policy, such as between ‘normal’ and not-normal childhood development and usual and intense parenting. The study’s focus on only some lines of care policy fragmentation – unpaid care of children, and specifically care of children with disabilities – meant that I did not fully incorporate academic perspectives on other forms of care or support (such as paid or unpaid aged care, and paid childcare), or test the utility of the principles for designing policies for the benefit of other categories of care or support providers and users. The principles do seek to encompass all categories of care or support by encouraging policy that recognises the universality of care and support requirements and responsibilities. They could be fully adapted to these other circumstances with some further testing and refinement.

The principles cannot on their own remove conflict or contestation between policy goals and care constituencies. The choices of one party to a care or support relationship may conflict with and inhibit those of another, and it may not be possible to design policy that always produces an equal realisation of the rights for all. The principles do, however, provide practical guidance for designing policy that supports diverse choices and provides resources to expand people’s options, reducing the likelihood that anyone will be trapped in an undesirable or inappropriate situation.

The case study analysis suggests that comprehensive reforms to Carer Payment (child) policy would be necessary to afford full care and support rights to carers and children with disabilities, and that complementary changes to employment policy would also be required. Many current limitations on access to the payment would need to be removed in order to ensure that care and support rights are equally available to all. These include the limitation of eligibility to sole carers with intense, constant care loads, the income tests and paid work requirements that limit carers’ paid work options, and the care load test’s singular focus on individual, medical needs. Other necessary measures might
include increasing the variety and availability of care and support services for all parties, and increasing the availability and appeal of flexible working for men and women.

The realisation of truly universal care and support rights would require a significant change to the current configuration of Australian care and support policy more broadly, and I have argued that the realisation of care and support rights for all might require a single basic care and support income. Such a payment could ensure that the interdependence and dignity of all, and the value of care and support as social goods and features of citizenship (regardless of their economic value), are recognised (Williams 2001; Daly 2002). This would replace not only Carer Payment (child) but also a range of other policies that are currently formulated along traditional lines of fragmentation. This would include other elements of ‘Australia’s welfare regime caring-net’ (Cass 2006, p. 250) – the income support payments Carer Payment (adult) and Parenting Payment – as well as policies concerning the funding of, and access to, childcare, residential and domiciliary aged care or support, and payments to children and adults with disabilities under existing state-based disability support systems and the National Disability Insurance Scheme.

Expansive reforms of this kind may not be readily accepted by governments (or a community) with limited resources and guided by long-established principles of welfare policy (Tranter, Sleep & Stannard 2007, p. 212; Orloff 2008, p. 22). Fiona Williams (2001, p. 489) proposes a means to secure ‘broader and less fragmented’ policies in a manner that could offer a middle way between the current fragmentation of care and support policies and the more utopian vision that I have proposed. This is to produce a ‘joined-up’ strategy that brings together:

- strategies for childcare, for the care and support of older people and disabled people, for income support, for family policies and family law, for employment and education policy, for anti-poverty and anti-discrimination measures, and for the environment. (Williams 2001, p. 489)

The six care and support rights principles could inform the development of such a strategy. As Williams suggests in the UK context, this could build on and integrate existing Australian strategies, like the National Disability Strategy and National Carer Strategy developed by the Rudd and Gillard Labor Governments and their state and local counterparts in the early 2010s (FAHCSIA 2011b; FAHCSIA 2011c).
9.5 Conclusion

In this thesis, I have argued that there are persistent tensions between supporting women’s unpaid care and paid work, and between supporting the interests of carers and those of people with disabilities, in Australian care policy. A failure to deal with these tensions and the dichotomous thinking that underpins them makes either/or policy appear logical and common-sense, producing negative policy outcomes for most (if not all) of the constituencies affected by such policy.

The six care and support rights principles offer a fruitful starting point for overcoming traditional stalemates and designing more just and equitable policy. In proposing the principles and demonstrating how they could inform policy design and reform, the study’s major contributions are to map new common ground, elaborating a ‘bridge discourse’ (Fraser 1989, p. 13) between traditionally competing perspectives on care and support, and offering detailed, practical guidance for formulating policy that incorporates and accommodates the concerns of multiple care and disability perspectives. Such an exercise is necessary for the simple reason identified by Watson and his colleagues (2004, pp. 339–40) – ‘it is not acceptable for one group of oppressed people to fight for their liberation at the expense of another group of oppressed people’.
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Appendix A: List of case study data

Reports and papers

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
<th>Document type</th>
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<tr>
<td>Review of Carer Payment (child) discussion paper</td>
<td>May 2007</td>
<td>Public discussion paper released by the Australian Government Department of Families, Community Services and Indigenous Affairs.</td>
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<tr>
<td>Review of Carer Payment (child) statistical compendium</td>
<td>2007</td>
<td>Statistical summary of populations of children with disabilities, carers, Carer Payment (child) recipients and Carer Allowance (child) recipients, published by the Department of Families, Housing, Community Services and Indigenous Affairs.</td>
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<tr>
<td>The carers storybook: stories of carers of children with severe disabilities and medical conditions</td>
<td>2008</td>
<td>Report based on public submissions to the Carer Payment (child) Review Taskforce, published by the Department of Families, Housing, Community Services and Indigenous Affairs.</td>
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<td>Title/speaker (in order of delivery)</td>
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<td>Wayne Swan, Australian Labor Party (Treasurer; Member for Lilley, QLD)</td>
<td>13 May 2008</td>
<td>House of Representatives Hansard excerpt</td>
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<td>Jenny Macklin, Australian Labor Party (Minister for Families, Housing, Community Services and Indigenous Affairs; Member for Jagajaga, VIC)</td>
<td>18 March 2009</td>
<td>House of Representatives Hansard excerpt</td>
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<td>Joanna Gash, Liberal Party of Australia (Member for Gilmore, NSW)</td>
<td>13 May 2009</td>
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<td>Amanda Rishworth, Australian Labor Party (Member for Kingston, SA)</td>
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<td>House of Representatives Hansard excerpt</td>
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<td>Scott Morrison, Liberal Party of Australia (Member for Cook, NSW)</td>
<td>13 May 2009</td>
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<td>Steven Georganas, Australian Labor Party (Member for Hindmarsh, SA)</td>
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<td>Alex Hawke, Liberal Party of Australia (Member for Mitchell, NSW)</td>
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<td>Jon Sullivan, Australian Labor Party (Member for Longman, QLD)</td>
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<td>Shayne Neumann, Australian Labor Party (Member for Blair, QLD)</td>
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<td>Sharman Stone, Liberal Party of Australia (Member for Murray, VIC)</td>
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<td>Jim Turnour, Australian Labor Party (Member for Leichhardt, QLD)</td>
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<td>Judi Moylan, Liberal Party of Australia (Member for Pearce, WA)</td>
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<td>Jill Hall, Australian Labor Party (Member for Shortland, NSW)</td>
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<td>Nola Marino, Liberal Party of Australia (Member for Forrest, WA)</td>
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<td>Yvette D’Ath, Australian Labor Party (Member for Petrie, QLD)</td>
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<td>Graham Perrett, Australian Labor Party (Member for Moreton)</td>
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<td>Julie Collins, Australian Labor Party (Member for Franklin, TAS)</td>
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<td>Mike Symon, Australian Labor Party (Member for Deakin, VIC)</td>
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<td>Nick Champion, Australian Labor Party (Member for Wakefield, SA)</td>
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<td>Sharryn Jackson, Australian Labor Party (Member for Hasluck, WA)</td>
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<td>Catherine King, Australian Labor Party (Member for Ballarat, VIC)</td>
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<td>Bill Shorten, Australian Labor Party (Parliamentary Secretary for Disabilities and Children’s Services and for Victorian Bushfire Reconstruction; Member for Maribyrnong VIC)</td>
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<td>Tony Zappia, Australian Labor Party (Member for Makin, SA)</td>
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<td>Jenny Macklin (Minister for Families, Housing, Community Services and Indigenous Affairs; Member for Jagajaga, VIC)</td>
<td>13 May 2009</td>
<td>House of Representatives Hansard excerpt</td>
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<td>Michael Kelly, Australian Labor Party (Parliamentary Secretary for Defence Support and Parliamentary Secretary for Water; Eden-Monaro, NSW)</td>
<td>14 May 2009</td>
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<td>John Faulkner, Australian Labor Party (Minister for Defence; Senator for NSW)</td>
<td>15 June 2009</td>
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<td>Mitch Fifield, Liberal Party of Australia (Senator for VIC)</td>
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<td>Rachel Siewert, Australian Greens (Senator for WA)</td>
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<td>Carol Brown, Australian Labor Party (Senator for TAS)</td>
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<td>Sue Boyce, Liberal Party of Australia (Senator for QLD)</td>
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<td>Catryna Bilyk, Australian Labor Party (Senator for Tasmania)</td>
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<td>Gary Humphries, Liberal Party of Australia (Senator for ACT)</td>
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<td>Steven Fielding, Family First Party (Senator for VIC)</td>
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<td>Chris Evans, Australian Labor Party (Senator for WA)</td>
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<td>Committee of the Whole debate (Rachel Siewert, Chris Evans, Mitchel Fifield)</td>
<td>16 June 2009</td>
<td>Senate Hansard excerpt</td>
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# Bills, explanatory memoranda, legislation and legislative instruments

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<tr>
<td>Explanatory Memorandum, Social Security Legislation Amendment (Improved Support for Carers) Bill 2009 (Cth)</td>
<td>Undated</td>
<td>Explanatory memorandum to bill</td>
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<td>Social Security Act 1991 (Cth), part 2.5</td>
<td>As in force on 1 July 2009</td>
<td>Excerpt of legislation</td>
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<tr>
<td>Disability Care Load Assessment (Child) Determination 2009 (Cth)</td>
<td>26 June 2009 (in force 1 July 2009)</td>
<td>Legislative instrument</td>
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<td>Explanatory Statement, Disability Care Load Assessment (Child) 2009 (Cth)</td>
<td>Undated</td>
<td>Explanatory statement to the legislative instrument.</td>
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# Centrelink publications

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<td>Undated (Centrelink website 2 July 2009)</td>
<td>Centrelink information sheet</td>
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<tr>
<td>Information you need to know about your claim for Carer Allowance and Carer Payment</td>
<td>Undated (Centrelink website 5 July 2009)</td>
<td>Centrelink information booklet</td>
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<tr>
<td>Claim for Carer Payment and/or Carer Allowance: Caring for a child under 16 years (SA337)</td>
<td>Undated (Centrelink website 2 July 2009)</td>
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<td>Carer Payment care needs Assessment (for a child under 16 years) (form SA394)</td>
<td>Undated (Centrelink website 2 July 2009)</td>
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Carer Payment – medical report including functional assessment and special disability trust beneficiary status (for a child under 16 years) (SA397)

Undated (Centrelink website 5 July 2009)

Centrelink claim form

**Other documents**

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Appendix B: Super-text template

*Extract from Verloo and Lombardo (2007, pp. 47–9) with minor alterations.*

**SUPER-TEXT TEMPLATE**

**NUMBER/CODE/ TITLE**
- Full title
- Date
- Type/status of document
- Actor(s) and gender of actor(s) if applicable
- Audience
- Event/reason/occasion of appearance
- Parts of text eliminated

**Voice**

**SUMMARY**
- Voice(s) speaking
- Perspective
- References: words/concepts (and where they come from)
- References: actors
- References: documents

**Diagnosis**

**SUMMARY**
- What is represented as the problem?
- Why is it seen as a problem?
- Causality (what is seen as a cause of what?)
- Dimensions of gender (social categories/identity/behaviour/norms & symbols/institutions)
- Intersectionality
- Mechanisms (resources/norms & interpretations)
- Form (argumentation/style/conviction techniques/dichotomies/metaphors/contrasts)
• Location (organization of labour/organization of intimacy/organization of citizenship)

**Attribution of roles in diagnosis**

**SUMMARY**

• Causality (who is seen to have made the problem?)
• Responsibility (who is seen as responsible for the problem?)
• Problem holders (whose problem is it seen to be?)
• Normativity (what is a norm group if there is a problem group?)
• Active/passive roles (perpetrators/victims, etc.)
• Legitimization of non-problem(s)

**Prognosis**

**SUMMARY**

• What to do?
• Hierarchy/priority in goals
• How to achieve goals (strategy/means/instruments)?
• Dimensions of gender (social categories/identity/behaviour/norms & symbols/institutions)
• Intersectionality
• Mechanisms (resources/norms & interpretations)
• Form (argumentation/style/conviction techniques/dichotomies/metaphors)
• Location (organization of labour/intimacy/citizenship)

**Attribution of roles in prognosis**

**SUMMARY**

• Call for action and non-action (who should [not] do what?)
• Who has voice in suggesting suitable course of action?
• Who is acted upon? (target groups)
• Boundaries set to action
• Legitimization of (non)action
Normativity

SUMMARY

- What is seen as good?
- What is seen as bad?
- Location of norms in the text (diagnosis/prognosis/elsewhere)

Balance

SUMMARY

- Emphasis on different dimensions/elements
- Frictions or contradictions within dimensions/elements

Comments
Author/s: 
Maker, Yvette

Title: 
Beyond breadwinners, caregivers, martyrs and burdens: a new framework for managing competing claims in care and support policy

Date: 
2017

Persistent Link: 
http://hdl.handle.net/11343/191869

File Description:
Complete thesis

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