

The treatment of informal care as a social risk in England: Conceptual and methodological innovations in undertaking comparative care policy analysis

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Abstract

The combined challenges of population ageing and the reliance on informal carers to meet the care needs of older people is requiring post-industrial welfare states to address these demands through the implementation of a diverse array of care policies. These policy interventions seemingly demonstrate that states are increasingly recognising and treating the informal care of older people as a social risk. This paper argues that it is essential to undertake detailed comparative analysis at a national level to assess the effectiveness of current care policies in providing adequate social protection against the care-related risks experienced by different types of care relationships. The paper focuses on discussing the design of a policy simulation tool, 'the model care relationship matrix', used to analyse and compare the statutory entitlements of different care relationship types across policy areas, localities, and practitioners, in England. Using this innovative methodological and conceptual approach exposed that the English state does not treat informal care as a social risk on account of the inconsistent and inadequate statutory protection provided to different care relationships, and how the care policy system itself can generate secondary risks for care relationships.

Introduction

It remains critical that care policy research is conducted to analyse state responses to long-term care needs and informal care provision, particularly as both contingencies are being increasingly accentuated by the challenges arising from population ageing. In post-industrial states, growing numbers of people are surviving into old age who experience chronic health problems which require long-term care support (Eurostat, 2011; Vlachantoni et al., 2011). Moreover, informal carers remain the key providers of that support (Fry et al., 2011; Vlachantoni et al., 2013). In this paper it is argued that care policy analysis requires a number of factors to be taken into account. Firstly, it requires the treatment of both members of the caring dyad by care policies to be analysed on account of the inter-related nature of care. From a social risk perspective this necessitates the research assessing the extent to which care policies recognise and address the wide range of care-related risks affecting both members of the care relationship. As noted previously in Morgan (2015; under review), both informal carers and the older people they care for may experience poverty risks arising out of care-

related expenditure (see for example, Carers UK, 2014), with care-giving also acting as a barrier to labour market participation which can affect informal carers' current income and future pension entitlements (Evandrou & Glaser, 2003; King & Pickard, 2013). Informal carers may also experience welfare risks including injuries, and health problems such as anxiety and depression (Tommiss et al., 2009; Schmitz & Stroka, 2013), which the time poverty risks associated with care-giving may exacerbate (Bittman et al., 2004). Secondly, this paper is based on the premise that state responses to social risks, in the form of policy intervention and social protection mechanisms, can be uneven. Contingencies such as informal care and long-term care may either be recognised to a greater or lesser extent, or may remain unrecognised, as social risks by states (see Morgan, 2015; under review, for a full discussion of the concept of social risk). Moreover social protection mechanisms may treat different groups of affected risk-bearers inconsistently (Baldwin, 1990), leading to the care-related risks of some care relationships being socialised, while others remain privatised. To address this analytical complexity, a methodological approach is needed which can assess the statutory entitlements of different types of care relationships across the full range of care policy mechanisms available to address their care-related risks, including cash benefits, employment support and care services. The design of the policy simulation tool, in the form of a 'model care relationship matrix', permitted this detailed empirical analysis of a single national care policy system to be undertaken. It was capable of extending the analysis across a number of comparative dimensions to reveal variations in the treatment of care relationships across policy domains, policy mechanisms, localities and practitioners. This methodological and conceptual approach helped to expose that English care policies provide inconsistent and inadequate statutory protection to different care relationships and revealed how institutional structures, processes and actors can maintain and exacerbate individuals' care-related risks.

Analysing care policies: an overview

This paper will firstly consider the existing care policy literature; what it tells us about state policy responses to addressing the contingencies of long-term care and informal care; how it has categorised the UK's care policy arrangements; and the limitations of these existing studies for understanding the complexity of national care policy systems. Existing care policy research has undertaken comparative cross-national analyses and formulated typologies and taxonomies which have usefully categorised care-related trends found within and across national contexts. Care regime types have been identified by analysing different countries' care arrangements and the extent to which care is provided via the institutions of the state; the family; the community; and the

market. The UK, for example, has consistently been classified as an Anglo-Saxon or means-tested care regime model (Anttonen & Sipilä, 1996; Burau et al., 2007; Lamura et al., 2008), which operates a “safety-net” system (Comas-Herrera et al., 2010). In this type of regime the state is noted to play a significant albeit residual role in the provision of formal care services to meet the long-term care needs of individuals with low incomes, while the market serves the needs of more affluent citizens. Kraus et al. (2010) also state that there remains a heavy reliance on informal care provision in the UK, with Rummery and Fine (2012) noting strong political support for a ‘family care first’ ideology. Other comparative studies have analysed the care policy strategies adopted by different states over time to address the needs of older people and their informal carers. For example, Kautto (2002) and Pavolini and Ranci (2008) found most countries, including the UK, to be gradually moving away from the traditional dichotomy of either providing cash transfers to promote family care or providing care services to replace family care, towards a greater ‘care mix’ combining both sets of strategies. Meanwhile further studies have focused their analysis on the three main types of care policy mechanisms implemented by post-industrial welfare states. These include social security and other monetary benefits which compensate people financially for either the provision of care or the costs incurred in requiring care (Lundsgaard, 2005; Ungerson & Yeandle, 2007); employment-related measures such as care leave and flexible working arrangements which facilitate the reconciliation of caring and employment roles (Yeandle et al., 2007); and cash benefits or services in-kind which provide support and replacement care thereby maintaining or substituting informal care provision (Mestheneos & Triantafyllou, 2005; EUROFAMCARE Consortium, 2006; Burau et al., 2007; Yeandle & Fry, 2010).

These studies provide useful generalisations and categorisations for the comparative analysis of welfare states’ treatment of long-term care and informal care, and insights into how individual states are addressing the risks associated with these contingencies by identifying the scope of the care policies that are being implemented. However, they generally lack the analytical breadth and depth required for providing a more nuanced and detailed understanding of the complexity of individual states’ care policy environments. These limitations have been previously acknowledged by Pfau-Effinger (2012) and Daly and Rake (2003) who note that national care arrangements are complex and often contradictory, and can lack overarching policy coherence within and across policy domains. Moreover, other studies have revealed states to use diverse policy measures underpinned by different principles simultaneously (Burau et al., 2007; Powell & Barrientos, 2011; Bihan & Martin, 2012). This is illustrated by Anttonen et al.’s (2003) attempt to develop a taxonomy of social care arrangements in five advanced capitalist countries which found: universal social care provision

conferring genuine citizenship rights to exist alongside selective and sharply rationed care provision; policies that replace family care being simultaneously pursued alongside those which shore up weakening patterns of obligation among families; and local and regional variations occurring in how social care is delivered and used in the same national context.

This paper argues that there is a need to undertake a detailed empirical analysis of the entire care policy system located within individual national contexts in order to fully understand the extent to which states are addressing the care-related risks that informal carers and older people can face. Moreover, this analysis needs to address the fact that state care policies may treat different types of risk-bearers, in this case care relationships, inconsistently. This requires three key factors to be incorporated into the analysis. Firstly, the full scope of care policy mechanisms located across each care policy domain must be included to demonstrate which care-related poverty and welfare risks are recognised by the state. Secondly, the eligibility criteria used by states to define who is entitled to access the social protection that is available must be considered in order to reveal which risk-bearers are recognised and protected by policy mechanisms and whose risks remain unrecognised by the state and therefore privatised. Thirdly, the impact of the institutional structures, processes and actors found within the care policy system on the statutory entitlements of informal carers and the older people they care for must also be analysed. This includes the territorial variations in statutory entitlements that can arise within national contexts due to the operationalisation of certain policy domains and policy mechanisms being decentralised to the level of regional or local government and agencies (Bell, 2010; Brand et al., 2012). Furthermore, the impact of practitioners' discretionary decision-making on account of their subjective interpretations of the statutory guidelines (Lipsky, 1980; Fernandez & Snell, 2012); their attitudes (Moran et al., 2013); and their negotiations with other institutional actors such as managers (Evans, 2011; Carey & Foster, 2011), must also be considered.

Methodology

The English care policy system served as the empirical case study on account of the UK having undergone substantial devolution, contributing to substantive differences emerging across the social care policies of the four nations. A qualitative methodological approach was applied to undertake a holistic and detailed analysis of the English care policy system using a policy simulation tool designed in the form of a set of 'model care relationship matrices'. Eardley (1996) and Ditch et al. (1998) note how policy simulation methods capture the intended effort made by states through their policies to

mitigate specific risks from the perspective of different types of potential policy recipients. Although this method produces a description of the way the system *should* work rather than how it necessarily does in practice (Bradshaw et al., 1993; Eardley, 1996; Kilkey, 2000), this served the purpose of the research. The intention was to document the *intended policy outputs* provided by the state, a term used in this case to denote statutory provision in the form of cash transfers, service provision, and legal rights to support, which would provide the necessary evidence to assess the extent to which the English state recognises and treats informal care as a social risk. The matrices recorded the statutory entitlements different care relationships were assessed to be eligible to receive by policies and practitioners. This method also permitted the consistency of the treatment of care relationship types to be systematically compared across multiple dimensions, including policy domains, individual policy mechanisms, localities and practitioners.

Designing the policy simulation tool

Several methodological innovations were applied to designing the ‘model care relationship matrices’, in relation to the breadth of the policy context and dyadic design of the risk-bearers. In terms of the former, previous studies had primarily used policy simulation tools to undertake large scale cross-national comparisons of the statutory support outputs available to policy recipients in a single policy domain, such as child support packages (Bradshaw et al., 1993); social assistance schemes (Eardley et al., 1996); and family policies (for example, Ditch et al., 1998). In contrast the policy simulation in this study sought to compare the treatment of policy recipients across three policy domains within the single national context of England. The breadth of the policy context required three separate matrices to be designed, one for each of the care policy domains analysed, with each containing all of the available policy mechanisms in the specified domain. This enabled the full extent of the state’s recognition of the care-related risks faced by informal carers and older people to be captured. Moreover it allowed the treatment of a greater diversity of care relationship types to be analysed, given that different types of informal carers may require different configurations of policy mechanisms to address their risks depending on their characteristics and the nature of their caring role. The cash benefits matrix allowed the extent to which the state seeks to alleviate the current and future poverty risks of informal carers and older people with care needs to be assessed. It contained all the cash benefits and associated passported benefits (relating to housing and health costs) that are available for care relationships to receive. This included needs based benefits such as Carer’s Allowance and Attendance Allowance (the disability benefit for people over 65); and means-tested benefits such as Income Support, as well as Jobseeker’s

Allowance and Working Tax Credits, even though the latter do not actively acknowledge informal carers. However it was important to record these policy 'absences' in the matrix because they indicate that the state does not recognise the risks relating to care-giving for certain types of informal carers. The care services matrix was divided into two separate charts to provide space to record the statutory entitlements of each member of the care relationship. These matrices were used to demonstrate the state's intention to alleviate informal carers' welfare risks through the provision of support provided either directly to them, or through the provision of replacement care services to the older person with care needs. The state's intention to alleviate the poverty risks experienced by informal carers engaged in paid employment could also be assessed via this matrix, since the provision of replacement care services can grant informal carers time to work. These matrices recorded the legislative rights of the caring dyad to an assessment of need, their eligibility to access statutory support, the types of care services and support available to meet individuals' eligible needs, and whether individuals are expected to pay a financial contribution towards the cost of those services. The employment support matrix incorporated the policy mechanisms available to working-aged carers which demonstrate the state's intention to alleviate the poverty and welfare risks of carers who are either in employment or seeking employment. This included Jobcentre Plus (JCP) support for informal carers seeking to re-enter employment and the statutory requirements associated with their entry into the labour market; and statutory rights to flexible working and emergency care leave which can support carers to reconcile their work and caring roles.

The second methodological innovation related to the construction of the risk-bearers whose statutory entitlements were to be analysed. Whereas previous studies had generally constructed model family types consisting of children and parents, this study used dyadic care relationship models, featuring an informal carer and the older person they care for. It was only through using a dyadic unit of analysis that the research would accurately capture the treatment of informal care and informal carers by state care policies. This is because the relational nature of care requires policy responses which address the needs and risks of both members of the caring dyad. For example, a key way in which informal carers' welfare risks can be addressed is through the provision of replacement care services provided directly to the person they care for. Furthermore, a dyadic analytical approach would help expose the extent to which state policies, processes and practitioners treat the caring dyad as a relationship as opposed to treating both members in opposition or exclusion to one another. The selection of characteristics listed in Figure 1 used to construct the care relationship types, were informed by two key factors. Consideration was given to the eligibility criteria used within existing care policy mechanisms to determine access to statutory

support. Statistical data about informal carers in England¹ were also used to promote the salience of the care relationships types with empirical reality. Ultimately thirteen care relationship types were devised, each made up of a different configuration of characteristics to reflect the diversity of informal caring. They were formulated into vignettes to provide a more user-friendly mini synopsis of each care relationships' circumstances and facilitate their use in interviews with policy experts and practitioners who would assess the statutory entitlement of each care relationship type.

Figure 1: Characteristics used to construct the care relationship types

Key Characteristics	Age of carer	Below pension age (25-60)		Above pension age (65+)		
	Income/savings levels	Lowest income		Lower income		
	Level of care provided/required	Constant 168 hours	Daily 35 hours		Weekly 16 hours	
Secondary Characteristics	Relationship of carer to care-receiver	Son/ Daughter	Spouse		Other relative	Neighbour/ Friend
	Marital status	Single (never married, divorced, widowed)			Married	
	Living arrangements	Co-resident			Living separately	
	Employment status	Full-time carer	Employed		Unemployed and seeking work	Retired
	Full-time worker		Part-time worker			

The selected characteristics were categorised into key and secondary characteristics according to their significance for exposing the logics of the policy system. The key characteristics included the age of the informal carer, the level of need of the older person/level of care provided by the informal carer, and the financial circumstances of the care relationship members. Two age bandings were used: carers over pension age (aged 65 and over) and carers of working age (aged between 25 and 60). Both groups are statistically significant to the provision of informal care in England (Young et al., 2006; Glendinning et al., 2009) and experience distinctive treatment in the cash benefits domain. Moreover, they may experience different welfare risks on account of working-aged carers attempting to reconcile work and care, and older carers being more likely to have their own health

¹ A key source of data was the Survey of Carers in Households conducted in 2009-2010 (The NHS Information Centre, 2010), 63 per cent of survey participants were providing care to older people.

problems (Fry et al., 2011). Three levels of care were used: a *constant care* banding for carers providing full-time care during the day and night; a *daily care* banding for those providing 35 hours of care per week; and a *weekly care* banding for carers providing 'part-time' care for 16 hours per week. The intensity of care-giving served to reflect the welfare risks carers may experience, and how it can restrict the ability of working-aged carers to earn money in the labour market, with studies showing the provision of more than 14-15 hours of care per week to have a negative impact on labour market participation (Spiess & Schneider, 2002; Gabriele et al., 2011). This characteristic was also associated with the complexity of the older person's care needs in the vignettes. These details reflected statistical data showing that carers providing over 20 hours of care per week are more likely to be providing personal care and physical help for someone with a mental and physical health problem, while carers providing under 20 hours are more likely to be providing help with administrative tasks and social support for someone with a physical health problem (The NHS Information Centre, 2010). As befits a predominantly means-tested care regime, two financial bandings were devised to denote the care relationships' financial circumstances, with this characteristic also being associated with the employment status of the informal carer. Those care relationships assigned to the *lowest income* banding were provided with income and savings levels to ensure their eligibility to receive means-tested benefits. Their savings levels were set below £6,000; and the working-aged carers were assigned no income due to not being engaged in paid employment, while the carers over pension age and all the care-receivers were assumed to be retired and in receipt of Basic State Pension (BSP) only. The care relationships assigned to the *lower income* banding were awarded income and savings levels to exclude them from access to means-tested benefits while retaining a risk of poverty.² Consequently their savings levels were set at £16,000, one pound above the upper savings limit for entitlements to most means-tested benefits. The Minimum Income Standard compiled by Joseph Rowntree Foundation was used to set the informal carers' income level below £240.89 per week, the amount a single person working full-time is considered to require to achieve a minimum socially acceptable standard of living (Hirsch, 2011). All care-receivers and carers of pension age were in receipt of Basic State Pension and an occupational pension amount calculated using Department for Work and Pensions data (2011), to set their income level above the threshold for an entitlement to means-tested Guarantee Pension Credit. Meanwhile the working-aged carers were assigned a net income of £203.73 per week, calculated using the 2011-2012 National Minimum Wage rate of £6.08 per hour (Gov.uk, 2014). This figure was associated with their employment status: the constant carer was not employed and

² Except care relationship 8b which was designed to analyse a more affluent household and assess how a care-giver's marital status can impact on their statutory entitlements.

generated their weekly income from renting out their empty property; one daily carer was single and working part-time, while the other was not employed but was married to someone who worked full-time, both in professional occupations; the weekly carer worked full-time in an elementary occupation. Additional secondary characteristics were incorporated into the vignettes to help calculate the care relationships' statutory entitlements in light of their ability to affect individuals' eligibility to access support. They included; the relational status of the care-receiver and carer (whether they were spousal or filial carers or caring for a friend or neighbour); their living arrangements (living together or apart); and their marital status. Certain characteristics were intentionally excluded from the construction of the care relationships. Care-receivers were not prescribed a specific medical diagnosis, and the gender and ethnicity of the caring dyad were not specified. This was in part to promote the manageability of the analysis. As noted by Schunk (1996) selecting too many characteristics can make the analysis too complex and time-consuming, with Kilkey (2000) adding that it can also result in the constructed policy recipients being less representative of the actual population being studied. Moreover, this lack of specificity permitted practitioners to embark on a broader discussion of how different characteristics could affect their decision-making, including how the health condition or gender of the caring dyad could affect the level of care services provided,

'[it would] depend very much on the person and their illness....You know if they've got rheumatoid arthritis or a respiratory disease you can't rush people';

'I think the older person is likely to get more services if she has got a son. It's deemed to be...OK for a woman to give personal care to their mother than it would be for a son'.

Data Collection

A range of data sources were used to calculate the statutory entitlements of the 13 care relationship types in the matrices, including documentary evidence and data collected from 26 research participants during 2012-2013. Documents such as legislation, statutory regulations, application forms and websites from Government, third sector, and private sector sources, were used to determine the care relationships' statutory entitlements and rights to support where applicable. An online benefits calculator also assisted with undertaking the more complex benefit calculations (Turn2us, 2012). This information was supplemented and verified by conducting interviews with experts and practitioners to ensure the intricacies of care policy regulations were properly understood, particularly in relation to the cash benefit and employment support domains. In some cases participants opted to respond in writing rather than be interviewed so specific queries were converted into a questionnaire format to facilitate this. Interviews were also undertaken to

calculate the entitlements of care relationships to care services and Jobcentre Plus support because the discretionary decision-making of practitioners determines the statutory support awarded to individuals in these domains. The interviews were structured using the vignettes and matrices. The care relationship types were described in a set order and the policy mechanisms listed in each matrix were used to prompt practitioner responses. A completed matrix was produced from each practitioner interview. Interviewees were also provided with the opportunity to explicitly discuss their decision-making with supplementary semi-structured interview questions serving as prompts. This permitted a more in depth understanding of how institutional processes and inter-personal factors and negotiations can impact on the statutory support care relationships receive.

In the English care policy system, the level at which care policy mechanisms are operationalised varies across domains. Consequently, national level data sources were used to record the entitlements to cash benefits and statutory employment rights in the matrices, due to these policy regulations being managed or devised centrally. Meanwhile the care services and Jobcentre Plus data were collected at a locality level due to the administration of these policy areas being decentralised to local authorities and local government agencies respectively. Two key localities with differing geographical and demographic characteristics were selected, while a third locality was used to gain supplementary data on local authority provision. This enabled territorial variations in statutory entitlements across different localities to be captured. Moreover, to ensure the equivalence of data across localities, participants with similar institutional roles were recruited for interview. These included front line practitioners and managers from statutory agencies including Adult Social Care teams and JCP district and locality offices, and third sector agencies who are either delegated powers by the local authority to conduct carers' assessments or commissioned to provide carer services. To explore practitioner effects and variations in the assessed entitlements of care relationships several front-line practitioners were interviewed in each local authority.

Data Analysis

Qualitative approaches were used to analyse the data and provide a micro- and macro-level analysis of the treatment of informal care by the English state. Firstly, an interpretive policy analysis approach was used to analyse the data recorded in the completed matrices and reveal the logics of the care policy system. According to Yanow (1996) this approach considers how policy entitlements and policy absences reveal which citizens are awarded the status of legitimate claimants for government action. The process of constructing the matrix, collecting the data, as well as the

entitlement data itself, all helped to expose the inconsistency and gaps in care relationships' entitlements. It highlighted which care relationships are deemed to warrant statutory protection whose care-related risks are socialised, and the policy gaps which leave particular types of risk-bearers unprotected and their care-related risks privatised. Secondly, thematic coding techniques were used to analyse; the micro-level interview data of front line practitioners and operational managers who provided the entitlement data for completing the matrices; and the macro-level data of strategic managers who discussed the treatment of informal carers more generally. This enabled patterns and trends to be identified within and across policy domains and practitioners in how informal care and care relationships are treated. It exposed how the construction and operationalisation of the English care policy system, its institutional processes, and the interactions of actors engaged within it, give rise to the inconsistent and inadequate protection of informal carers and care relationships. This permitted the conclusion to be drawn that the English state does not treat informal care as a social risk.

Findings and Discussion

This paper provides a few illustrative examples to demonstrate how the micro-level data contained in the matrices and associated interviews served to inform the wider research findings, by revealing the complex ways in which specific factors contribute to the inconsistent treatment and entitlements of care relationship types, and ultimately permitted conclusions to be drawn about the treatment of informal care by the English state overall. These factors include the variable treatment of characteristics across the eligibility criteria of policy mechanisms; the ways in which the decentralisation of policy implementation produces territorial variations in policy regulations and entitlements; and how the discretionary decision-making of practitioners can either mitigate or support official policy objectives leading to inconsistent policy outputs. Links are also made, where appropriate, to how using a dyadic unit of analysis helped to expose the marginalised treatment of informal carers in the English care policy system on account of their derived rights to certain elements of support; and how the disaggregation of the caring dyad in institutional processes allows policies to shift risks across the members of the caring dyad and gives rise to policy outputs which undermine the overarching wellbeing of care relationships. A fuller discussion of the research findings are provided in Morgan (2015; under review) which present an overview of the ways in which the inadequate and inconsistent treatment of care relationship types demonstrate how the English state does not treat informal care as a social risk, and how the design and operationalisation of the care policy system itself produces secondary risks which can either create, maintain or

exacerbate care-related risks for care relationships. Meanwhile in Morgan (forthcoming), the findings are discussed from a governance analysis perspective, including how the institutional structures, processes and actors engaged in the care policy system operate and interact, and the implications of this complexity for the treatment of informal care and the lived experience of care relationships.

Figure 2 provides a visual illustration of the overarching lack of consistency applied to the significance of characteristics used in the eligibility criteria of policy mechanisms across the English care policy system. This inconsistency derives from specific characteristics being weighted as more significant than others within the eligibility criteria of individual policy mechanisms; and the significance of a specific characteristic also varying considerably due to being subject to contradictory or anomalous treatment across policy domains, policy mechanisms, localities, practitioner decision-making and according to which member of the caring dyad it is being applied to. It is this inconsistent treatment of characteristics by state policies, agencies and practitioners that results in variations in the level of statutory protection the same care relationship can access across care policy domains, and also leads to some care relationships being able to access statutory support while others remain excluded from accessing statutory protection altogether.

Figure 2: Evaluating the overall significance of characteristics across policy domains

Policy Domain	Cash Benefits	Care Services		Employment	
		Care-receivers' entitlements	Carers' entitlements	JCP Support	Employment policies
Level/type of need of CR	Significant (AA,CA,CC, IS)	Significant	Less significant (practitioner variation)	Less significant (indirect)	Less significant (implicit)
Level/type of care provided by carer	Significant (CA,CC, IS/JSA)	Less significant (practitioner variation)	Significant	Significant	Less significant (implicit)
Impact of caring role	Less significant (IS only)	Less significant (practitioner variation)	Significant	Less significant (practitioner variation)	Not significant
Income of CR	Less Significant (Means-tested benefits only)	Significant	Not significant	Not significant	Not significant
Income of Carer	Significant (CA, IS/JSA, WTC)	Not significant	Less significant (Local Authority variation)	Not significant	Less significant (implicit)
Employment status of carer	Significant (CA/IS/JSA/WTC)	Less significant (practitioner variation)	Less significant (practitioner variation)	Significant	Less significant (Flexible Working only)
Age of carer	Significant (AA/CA/means-tested benefits)	Less significant (Subordinate/practitioner variation)	Not significant	Not significant	Not significant
Health status of CR and /or carer	Less significant (Passported benefits only)	Less significant (practitioner variation)	Less significant (practitioner variation)	Significant	Less significant (Care leave only)
Relational status/ Marital Status	Less significant (CTB only) CA (indirect)	Less significant (practitioner variation)	Less significant (practitioner variation)	Significant	Significant
Living arrangements	Less significant (SDA/CTB only)	Less Significant (practitioner variation)	Less Significant (practitioner variation)	Significant	Significant
Quality of care relationship	Not significant	Less significant (practitioner variation)	Less significant (practitioner variation)	Not significant	Not significant
Gender	Not significant	Less significant (practitioner variation)	Not significant	Not significant	Not significant

Key: rating the significance of characteristics

Significant	<ul style="list-style-type: none"> The characteristic features explicitly in the eligibility criteria of all policy mechanisms in the policy domain. The characteristic is significant in the decision-making of all practitioners.
Less significant	<ul style="list-style-type: none"> The characteristic features in some policy mechanisms in the policy domain The significance of the characteristic varied across the decision-making of practitioners The characteristic is implicitly rather than explicitly used to determine eligibility.

Not significant	<ul style="list-style-type: none"> The characteristic is not significant in either the eligibility criteria of policy mechanisms or practitioner decision-making.
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The following examples illustrate the divergent ways in which the variable treatment of specific characteristics across different policy dimensions could affect care relationships' entitlements and treatment. The level of care provided by the informal carer is the most consistently significant characteristic for determining access to statutory support across the care policy system, even so its application still varied considerably across policy domains and mechanisms. This ranged from a fixed minimum number of hours of care provision (35 hours per week) being prescribed in the regulations to access Carers Allowance in the cash benefits domain, thereby restricting entitlement to full-time carers. Meanwhile access to a carer's assessment in the care services domain prior to the introduction of the Care Act 2014, required carers to be providing a 'substantial amount of care on a regular basis' (HM Government, 1995); similarly access to Income Support for low income non-employed carers depended upon,

'the proportion of the claimant's life....that is taken up by the care' and 'how disruptive the caring is to the claimant's life' (DWP Manager).

The ambiguity of these subjective phrases used in the legislation and regulations permitted inconsistency to arise across local policies and practitioner interpretations. Consequently, part-time carers were not consistently assessed by local authority practitioners to be eligible to access a carer's assessment;

'My interpretation of substantial care is if the carer is living with the person they care for and are providing 24 hour care support. Regular care is if the carer is popping in every day';

'A carer's assessment is an entitlement regardless of how much care you are putting in....even if they are just picking up their next door neighbour and taking them to the supermarket once a month'.

Moreover, the discretionary decision-making of Benefit Agency Decision Makers could result in part-time carers having to claim Jobseeker's Allowance (JSA) instead of Income Support. This decision could have significant implications for informal carers' wellbeing because, unlike Income Support, JSA does not recognise individuals' caring responsibilities and leaves carers to face the same stringent conditionality applied to all other unemployed workers to enter paid employment as soon as possible. This example exposes a key policy absence for informal carers in the cash benefits system. Meanwhile the characteristic of the type of care provided was subject to contradictory treatment across the benefit entitlements of caring dyad members. While personal care tasks are unanimously accepted as legitimate care activities for eliciting statutory intervention across policy

domains, domestic care tasks are subject to variable treatment as to whether they constitute a private rather than a statutory responsibility. Consequently, the eligibility regulations underpinning Attendance Allowance, the disability benefit for older people, explicitly exclude domestic tasks (Carers Direct, 2012), whereas Carers Allowance and Income Support regulations are more generous in recognising activities such as cooking and other domestic duties relating to caring for the care-receiver (Carers Direct, 2011; Department for Work and Pensions, 2012). However, because entitlements to all carer benefits are contingent upon the person they care for being eligible to receive Attendance Allowance, carers' benefit claims remain overwhelmingly affected by the more restrictive rules applied to care-receivers' disability benefits.

The characteristic of income level was treated inconsistently on account of contradictory regressive and universal approaches being applied across policy mechanisms, localities and caring dyad members, leading to variations and anomalies in statutory entitlements and treatment. For example, care-receivers' access to Attendance Allowance is determined by needs not financial means thereby allowing even the most affluent care-receivers to access this financial support from the state. Meanwhile Carers Allowance treats different sources of income inconsistently as well as anomalously to the overarching cash benefit system. This allows potentially affluent non-employed carers to claim Carers Allowance because no limit is applied to the amount of savings or **unearned** income a carer can receive (DWP Manager). Conversely potentially low income carers with an **earned** income of more than £100 per week are excluded from accessing this financial protection (Directgov, 2012b), which arguably contributes to the privatisation of financial risks for those least able to afford it. Meanwhile in the care services domain, where local authorities have ongoing discretionary powers to charge individuals for the statutory care services they receive (HM Government, 2000, 2014; Department of Health, 2003), the treatment of the caring dyad's income is reversed. Means-tested charging policies for care-receivers consistently operate across local authorities, whereas variations occur as to whether they provide free carer services, or apply means-tested or regressive flat-rate charges for carer services, amounting to £14 per hour for self-funders in one local authority (Third Sector Manager). This highlights the significant geographical variations that can occur when local authorities are permitted to determine how they operationalise care policies, and the significant territorial inequalities in the treatment of care relationships that can emerge as a result. These discretionary charging policies also demonstrate how policies can shift risks across the members of the caring dyad which has the potential to cause inter-personal conflicts and dilemmas (Morgan, 2015; under review). For example, charging care-receiver's for replacement

care services which are intended to give their informal carer a break could lead to them refusing the service, thereby leaving the carer's welfare risks unaddressed.

The characteristics of the relational status and living arrangements of the caring dyad were also used to determine eligibility to statutory entitlements, but their variable use could lead to informal carers being simultaneously granted and excluded access to different types of statutory support on account of exactly the same characteristic. For example in the employment domain, the relational status of the caring dyad was used to determine eligibility to the right to request flexible working (HM Government, 2006; Directgov, 2012d), and permit carers in receipt of means-tested benefits to apply restrictions to the job searching requirements set out in their Jobseeker's Agreement (DWP Manager). Both policies required carers to be caring for close relatives such as a partner, parent, child or sibling or someone living in the same household. The eligibility regulations underpinning access to JCP support to return to work (Department of Health, 2008) and the right to take time off work in an emergency (HM Government, 1999), permitted even greater relational distance by including the care of friends, neighbours and more distant relations as well, whether or not the carer is living with them. However, closer relational proximity guarantees exclusion from accessing other types of entitlements. Consequently access to a Council Tax exemption is only permitted if the carer is caring for someone in the same household other than their spouse or partner (Directgov, 2012c). Furthermore state funding cannot be used to pay close relatives or people living in the same household to provide care using a direct payment in the care services domain (Directgov, 2012a), or to pay them to provide replacement care to enable a carer to attend a job interview or training in the JCP domain (JCP Practitioner). Meanwhile, living arrangements do not formally feature in the eligibility criteria underpinning the care services domain. However, this characteristic could significantly affect practitioner decision-making and led to them enhancing or reducing the level and type of support provided. This highlights the significant influence practitioners' attitudes can have over the statutory support care relationships are assessed to be eligible to receive. For example, where care relationships lived separately some practitioners assessed the care-receivers to be eligible to access domestic care support including meal preparation which they would not provide if the same individuals lived together.

'[Y]ou must look at why you are providing services when there are...able-bodied people in the household. So it would be a different scenario to somebody who was living alone where those people were coming in from outside and travelling' (Local Authority Practitioner).

Only one practitioner considered the negative implications that this assumption could have for live-in carers not being able to take a break from caring. Meanwhile, other practitioners awarded live-in

carers more carer break services due to considering these living arrangements to produce additional stress,

'[If] the cared for person has....dementia....he just says the same thing over and over....somebody living with the person day in, day out is possibly going to need more....of a break' (Local Authority Manager).

These findings help to expose some of the key features of the English care policy system. The system is characterised by overarching complexity on account of structural fragmentation caused by policy silos and decentralisation, which arguably affects the parity of the design of eligibility criteria across policy mechanisms. It is also subject to unpredictability and inconsistency on account of institutional and practitioner led variations. A key result of these institutional features is the existence of inequalities in the statutory entitlements of care relationships which take a variety of forms. Firstly, individual members of the caring dyad can themselves face inconsistent access to statutory entitlements across individual policy mechanisms and policy domains on account of the differential treatment of characteristics. Consequently they may receive statutory support in relation to some of the care-related risks they face while other risks remain unprotected and privatised. Secondly, the findings demonstrate how the members of the caring dyad may receive unequal statutory treatment, leading to the entitlements of one member having implications for the other, which has the potential to create inter-dyadic conflicts and dilemmas. Thirdly, only certain informal carer types are formally recognised as risk-bearers whose care-related risks require protection from the state: the main type being full-time, non-employed carers of working age. Even so, as argued in Morgan (2015; under review), the state cannot be said to adequately protect even this recognised group of informal carers due to the inadequate levels of statutory support that are available. Meanwhile the care-related risks of other types of informal carers, including part-time carers, older carers and employed carers, remain either unrecognised or only partially recognised by the state. These groups may be provided with some statutory protection in relation to other recognised social risks which affect them, such as being unemployed, over retirement age, or a low income worker, however their care-related risks remain fully or partially privatised. For example, despite the age-related restriction for accessing Carers Allowance being removed in 2002 (HM Government, 2002), older carers in receipt of a basic state pension are generally only granted an underlying, rather than an actual, entitlement to Carers Allowance due to overlapping benefit rules, leaving them reliant on their pension income to cover any care-related costs. Overall these findings expose the state's incomplete acknowledgement, recognition and treatment of informal care as a social risk in England. The fact that no single characteristic or configuration of characteristics

guarantees automatic entitlement to statutory support across every policy domain also highlights the lack of transparency affecting the overall care policy system. A key consequence of this overarching institutional complexity and opacity is that it creates substantive uncertainty for care relationships by undermining their ability to know what support is available, how to access it, and whether they are eligible to receive it. This illustrates how the structuring of the policy system itself can produce poverty and welfare risks for care relationships as they expend time and energy seeking access to the statutory protection that is available (Morgan, 2015; under review).

Conclusion

Using a policy simulation tool to conduct the research enabled the conclusion to be drawn that the English state to some extent recognises, but does not treat, informal care as a social risk. Consequently this outcome helps to highlight that the implementation of care policies in post-industrial welfare states cannot be assumed to demonstrate that those states fully acknowledge the contingencies of long-term care and informal care as social risks which require the protection of the state. The research findings also serve to justify using this methodological approach to undertake nuanced and detailed empirical analyses of national care policy systems. The key strengths of using policy simulation tools include the ability to undertake a comprehensive and comparative systematic analysis of the treatment of a range of risk-bearers by state policies and practitioners across multiple domains and dimensions in a single national context. Flexibility is also permitted in the methods used to collect the data and the source and level of data used, which supports the collection of rich data. An additional strength of the matrix design was the construction of a dyadic unit of analysis which allowed conclusions to be drawn about the way in which state policies and practitioners manage the inter-relational nature of care. This helped to expose the extent to which carers' needs are marginalised in the care policy system on account of their derived rights to statutory support; and institutional processes undermining the wellbeing of the caring dyad through risk-shifting and disaggregating the caring dyad within institutional processes (Morgan, forthcoming). However the methodological limitations must also be acknowledged. Administering the interviews using the matrices could be very time consuming, often taking up to two hours of busy professionals' time, and involved repetition of certain details across similar care relationship types which participants may have found tedious. One participant also criticised the use of static vignettes to simulate practitioners' assessments of care relationships, stating,

'You see the thing is....I would ask for so much more information because I would be there saying....what kind of support are they asking for, what are they still prepared to do....So it's very situational....You can't actually answer things like this' (Local Authority Manager).

This paper set out to demonstrate that there is a need to undertake nuanced, comparative analysis of care policies at a national level in order to acknowledge the complexity of state care policy arrangements, and how this affects the coverage and level of social protection provided to affected groups of risk-bearers in a single national context. However, it is worth noting that this policy simulation approach and the design of the 'care relationship matrices' could also be applied to conducting larger scale cross-national comparative research studies. For example, this methodological tool could be used to undertake additional national case studies with a view to comparing the findings of states' care policy outputs and their treatment of different care relationship types cross-nationally. Moreover, while it is reasonable to limit the analysis to determining the extent to which different states recognise or treat the informal care of older people as a social risk, a broader cross-national study could also offer the opportunity to extend the analysis to seeking to *explain* the similarities and differences in different states' treatment of informal care.

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