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ARTICLE

Gender inequality, the welfare state, disability, and distorted commodification of care in Turkey

Reyhan Atasü-Topcuoğlu

Hacettepe University, Ankara, 06800 Turkey, and Humboldt Universität zu Berlin, 10099 Berlin, Germany.
Emails: ratasu@hacettepe.edu.tr, atasuere@hu-berlin.de

Abstract

Reforming care regimes to cover the care deficit and enhancing the marketization of care to promote individualism and gender equality have been on the European agenda since the 1990s. However, both implementation and results have been path-dependent. This study first underlines some specificities in the Turkish case—namely, the limited welfare state, a large shadow economy, gender roles, patriarchal backlash, Islamization, and neoliberalism, all of which receive little treatment in the welfare state literature. It then analyzes how these specificities interact in the construction of the care regime in Turkey, conceptualizing the outcome as *distorted commodification of care*—namely, the continuing ambiguity of care services despite these activities producing precarity and positional suffering for caregivers and recipients. Finally, the study provides concrete examples from the less studied topic of long-term disability care. It presents a perspective on Turkey that foregrounds the connections between gendered care imagery and case-specific qualities of the commodification of care shaped by the long-standing shadow economy, the outsourcing of disability services to for-profit private companies, and the introduction of the cash-for-care policy. The study analyzes the outcomes of distorted commodification of care under these conditions in Turkey vis-à-vis visibility, valuation of work, working conditions, and gender inequality.

Keywords: Welfare state; Social policy; Gender inequality; Care work; Disability

Introduction

All care is about abilities—to think, to feel, to do, and to control. Children become more able by the day; the elderly less so. These phases in life change and pass by rather quickly, but severe disability care, where abilities are permanently impaired, is a long, challenging marathon. Currently in Turkey, 520,000 cash-for-care beneficiaries provide twenty-four-hour home care to their close relatives who are entirely dependent, have proven severe disabilities, and suffer significant poverty.[1]

Author's note: I am grateful for the rigorous reviews that significantly contributed to and improved the work.

[1] Ministry of Family, Labor and Social Services (MFLSS) *Statistical Bulletin, March 2020*, https://ailevecalisma.gov.tr/media/46090/bulten_en_200508.pdf.

Alongside this fact is the limited capacity (8,293 beneficiaries) of public twenty-four-hour disability care institutions and the policy of outsourcing to private firms (20,949 beneficiaries).[2] New public management (NPM)—the shrinkage of public social services via outsourcing[3] and marketization[4]—has become a general trend globally; however, implementation "is a highly context-specific process."[5] In fact, each country context hides some original sociological interactions resulting in life-changing differences in social rights.

This study aims to underline and conceptualize some specificities of the Turkish care regime with a particular focus on twenty-four-hour severe disability care. It does so for three reasons. The first is that severe disability care is now the only care branch for which the government is increasing funding, after the closing of public kindergartens and the small scale of elderly care. Second, severe disability care need is relatively more intensive, long term, and complicated due to varying severe impairments. Finally, disability in Turkey is a relatively underdiscussed topic; the rights of disabled individuals and their caregivers thus deserve attention and discussion both at practical and theoretical levels.

The study seeks to frame analysis of the Turkish care regime by problematizing the commodification of care in terms of the welfare state, patriarchy, and capitalism. After reviewing the care literature, the study offers the concept of *distorted commodification of care* to capture the links between the limited welfare state, the patriarchal gendered care imagery, the shadow economy (i.e. informal sector), and outsourcing policies. These factors work together to limit social rights within the Turkish context.

Methodologically, the study draws on a desk review and the author's observations from previous field studies with service providers and cash-for-care beneficiaries in various Turkish cities between 2014 and 2018.[6] Empirically, it provides concrete examples of the effects of *distorted commodification* in the twenty-four-hour disability care sector in terms of the remuneration of work and positioning of caregivers and recipients. In so doing, it shows that the Turkish case falls short of what would be expected in a system dominated by markets[7] and the commodification[8] of care.

[2] MFLSS, *Statistical Bulletin, March 2020.*

[3] Orley Benjamin, *Gendering Israel's Outsourcing* (Cham: Palgrave, 2016).

[4] Deborah Brennan, et al., "The Marketisation of Care: Rationales and Consequences in Nordic and Liberal Care Regimes," *Journal of European Social Policy* 22, no. 4 (2012): 377–91.

[5] Brennan, et al., "The Marketisation of Care"; Emmanuele Pavolini and Costanzo Ranci, "Reforms in Long-term Care policies in Europe: An Introduction," in *Reforms in Long-term Care Policies in Europe*, ed. Emmanuele Pavolini and Costanzo Ranci (New York: Springer, 2013), 3–22.

[6] 2014–16, Samsun, Diyarbakır, Van, Istanbul, Muğla, Ankara, Antalya, research supported by the Word Bank and SIDA, see Betül Altuntaş and Reyhan Atasü-Topcuoğlu. "Engelli Bakımı Alanında Bakım Emeği, Sosyal Bakım ve Kadın İstihdamı." World Bank Working Paper no. 110376 (Washington, DC: World Bank Group, 2016), http://documents.worldbank.org/curated/en/561391479488663095/Engelli-bakimi-alaninda-bakim-emeği-sosyal-bakim-ve-kadin-istihdami; 2017–18, Ankara, under the project EuropeAid/136124/IH/SER/TR, reported as Paulo Pedroso, et al., "A Turkish Model for Cooperation in Social Services" (project report, Ankara, 2017).

[7] Rebecca M. Blank, "When Can Public Policy Makers Rely on Private Markets? The Effective Provision of Social Services," *The Economic Journal* 110, no. 462 (2000): 34–49.

[8] Elizabeth Anderson, *Value in Ethics and Economics* (Boston: Harvard University Press, 1993).

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Problematizing care regimes and the commodification of care

Feminist scholarship[9] has emphasized the gender-blind nature of the mainstream literature on welfare states and the need to discuss the gendered effects of social policy. The welfare state structure constitutes the general framework of social rights, defining and limiting citizens' access to opportunities and resources. The right to work has become a key criterion for achieving social rights[10] in most welfare states. Therefore, labor market inequality is no longer only a result of patriarchy; it has become a mechanism perpetuating patriarchal inequalities in the realm of citizenship.

The care regime—namely, the organization of care among the state, the market, and families—has a critical role in determining women's participation and position in the labor market and the quality of life and the rights and freedoms of disabled citizens as recipients. At the extremes of the care regime, responsibility is left solely to the family, meaning a complete coverage of care through unpaid domestic work, or exclusively to the market, which brings about a total commodification of care. As Anderson notes, "what confers commodity status on a good is not that people pay for it, but that exclusively market norms govern its production, exchange, and enjoyment."[11]

As a third extreme, care can be left entirely to the state and provided as a public service. This implies the unconditional provision of care as a social right to every citizen (i.e. perfect decommodification).[12] It also entails the potential of every citizen to live without the obligation to participate in the labor market. These three extremes are ideal-types, not practical options. Every welfare state has a unique care regime: an original blend of roles, responsibilities, and conditionality in organizing care among the state, the market, and families.

Different care regimes produce varying structural positions among care recipients and caregivers. The former differ in terms of purchasing power and access to quality care, while the latter work under varying conditions and may be paid or unpaid. The care regime thus impacts the well-being and opportunity structure for caregivers and recipients (meaning, women, disabled people, the elderly, patients, and children—in short, the majority of any society). In other words, it affects everyday lives, employment and hence eligibility to welfare state opportunities, purchasing power, provision of well-being, and available means and free time for social and political participation. The care regime thus remains an essential part of the modern social order. Every positioning of caregivers and recipients affects social rights, their usability, and the possibilities of everyday time allocations as well as the imperative of physical and emotional labor required within any such positioning. This outlines

[9] Carol Patemann, "The Patriachal Wellfare State: Women and Democray," Working Paper no. 7 (1987), http://www.people.fas.harvard.edu/~ces/publications/docs/pdfs/CES_WP7.pdf; Ann Shola Orloff, "Gender and the Social Rights of Citizenship: State Policies and Gender Relations in Comparative Perspective," *American Sociological Review* 53, no. 3 (1993): 303–28; Diana Sainsbury, *Gendering Welfare States* (London: Sage, 1994).

[10] Ann Shola Orloff, "Women's Employment and Welfare Regimes: Globalization, Export Orientation and Social Policy in Europe and North America," Social Policy and Development Programme Paper, no. 12 (Geneva: United Nations Research Institute for Social Development, 2002).

[11] Anderson, *Value in Ethics and Economics*, 156.

[12] Gosta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge: Polity Press, 1990).

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the abrasion capacity of citizens and society. In more abstract terms, the care regime is a site of the reproduction of market, family, and citizenship relations—namely, capitalism, patriarchy, and varieties of democracy and welfare. Against this backdrop several crucial questions arise. How is care discussed and framed in current debates? What does distorted commodification of care mean? What are the Turkish care regime's contours vis-à-vis the welfare state, the gendered imagery of care, and late capitalism? What is distinctive about Turkey's care regime? Finally, what have been the results of distorted commodification of care in Turkey in terms of long-term disability care?

Framing the debate: current perspectives on care

Debates on housework[13] and domestic labor,[14] which resulted in highlighting the issue of unpaid work and the double burden of working women in the political agenda, have been among the main successes of second-wave feminism. This was followed by the debate on care as services delivered to the household, emphasizing the care deficit[15] and making calls for social policy.

Feminists have theorized care in terms of social reproduction[16] and ethics.[17] However, in Europe the liberal feminist view—which sees the care crisis as resulting from women being torn between labor market participation and care burdens and underscores the need for work–family balance policies—has become mainstream.[18] Against this backdrop childcare moves to the center of social policy since it interrupts the careers of many working-age women. Labor supply and the reproduction of new generations of workers remain a central concern of the state. At the EU level, policy has been focused on short-term remedies depending on employers as the implementing body (such as paternal leave and kindergartens).[19] Here, active labor force participation becomes a prerequisite for accessing care, and care for the elderly and the disabled is overlooked or underappreciated.

The right to affordable long-term care (LTC) has recently emerged on Brussels' agenda as a non-binding principle,[20] with little indication of concrete

[13] Ann Oakley, *The Sociology of Housework* (London: Robertson, 1974).

[14] Wally Seccombe, "Domestic Labour and the Working-Class Household," in *Hidden in the Household: Women's Domestic Labour Under Capitalism*, ed. Bonnie Fox (Toronto: The Women's Press, 1980), 25–99.

[15] Arlie Russell Hochschild, "The Culture of Politics: Traditional, Post-modern, Cold-modern, and Warm-modern Ideals of Care," *Social Politics* 2, no. 3 (1995): 331–45.

[16] Nancy Fraser, "Capitalism's Crisis of Care," *Dissent* 63, no. 4 (2016): 39–17.

[17] Joan C. Tronto, "An Ethic of Care," *Generations: Journal of the American Society on Aging* 22, no. 3 (1998): 15–20.

[18] Saniye Dedeoğlu, "2000'li Yıllarda Türkiye'de Toplumsal Cinsiyet Eşitliği Politikaları: Muhafazakarlığın ve Neoliberalizmin Gölgesinde Mi?" in *Himmet, Fıtrat, Piyasa*, ed. Meryem Koray and Aziz Çelik (İstanbul: İletişim, 2015), 259–77.

[19] Diane Elson, "Recognize, Reduce, and Redistribute Unpaid Care Work: How to Close the Gender Gap," *New Labor Forum* 26, no. 2 (May 2017): 52–61.

[20] The European Pillar of Social Rights in 20 Principles, https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

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implementation.[21] In the absence of a consensus on whether LTC covers severe disability, concrete EU-wide standards have not developed.[22] However, the *European Disability Strategy 2010–2020* aims at "developing personal assistance funding schemes, promoting sound working conditions for professional carers, and support for families" to enhance participation among the disabled. The European strategy points to a marketized care regime. Thus, European countries continue to develop disability care regimes according to their welfare systems, even as the logic of NPM[23] and marketization[24] prevail.

Contemporary studies try to quantify care[25] to make it visible, showing its economic worth and recently measuring the extent of the paid care sector.[26] Marketization brings about the commodification of care, making it possible for some women to purchase care (to free up their own time). It also provides new job opportunities, especially for women. Some feminist studies have advocated care markets, assuming that commodification of care dissolves patriarchal care regimes and fosters egalitarian family relations.

Disability movements have also demanded commodification, although some have criticized feminist scholars for focusing solely on caregivers' experience to the exclusion of recipients.[27] This critique has resulted in a reticence within disability studies to explore care and has underscored the distance between the two social movements.[28] Since the 1990s the British disability movement has championed "independent living" informed by the principles of self-determination, consumerism, and demedicalization.[29] This advocacy has been echoed in other European countries and comports with neoliberal arguments in a time of shrinking welfare states.[30] Within this dialogue, European welfare states have addressed disability care via commodification, gradually implementing cash-for-care schemes targeting care receivers to purchase care services.[31]

[21] Christine Mayrhuber, "Social Policy", in *The European Illusion* (Vienna: Rosa Luxenburg Stiftung, 2018): 89–106.

[22] Pavolini and Ranci, "Reforms in Long-Term Care."

[23] Ibid.

[24] Stanisława Golinowska, et al., eds. *Diversity and Commonality in European Social Policies* (Warsaw: Friedrich Ebert Stiftung, 2009).

[25] Ibid.; Emel Memiş and Özge İzdeş, "Türkiye'de Yaşlı Bakımı ve Kadın İstihdamı," in *Feminist Sosyal Politika*, ed. Çağla Ünlütürk Ulutaş (Ankara: NotaBene, 2018), 99–141.

[26] Mignon Duffy, et al., "Counting Care Work: The Empirical and Policy Applications of Care Theory," *Social Problems* 60, no. 2 (2013): 145–67.

[27] Eva Feder Kittay, "When Caring Is Just and Justice Is Caring: Justice and Mental Retardation," in *The Subject of Care: Feminist Perspectives on Dependency* ed. Eva Feder Kittay and Ellen K. Feder (Oxford: Rowan and Littlefield Publishers, 2002), 257–76; Teppo Kröger, "Care Research and Disability Studies: Nothing in Common?" *Critical Social Policy* 29, no. 3 (2009): 398–420.

[28] Janice McLaughlin, "Conceptualising Intensive Caring Activities: The Changing Lives of Families with Young Disabled Children," *Sociological Research Online* 11, no. 1 (2006): 51–61; Jenny, Morris, ed. *Encounters with Strangers: Feminism and Disability* (London: The Women's Press,1996); Alison Sheldon, "Personal and Perplexing: Feminist Disability Politics Evaluated," *Disability & Society* 14, no. 5 (1999): 643–58.

[29] Gerben DeJong, "Independent Living: From Social Movement to Analytical Paradigm," *Archives of Physical Medicine and Rehabilitation* 60 (1979): 435–46.

[30] Clare Ungerson, "Social Politics and Commodification of Care," *Social Politics* 4, no. 3 (1997): 362–81.

[31] Ungerson, "Social Politics."

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Against this backdrop Turkey exhibits a somewhat different dynamic. In Turkey, cash-for-care policy was not demanded by the disability or women's movements or civil society, but has been planned and implemented by the central government. It is also based on outsourcing to private firms and on the provision of cash-for-care benefits to caregivers of severely disabled kin and is criticized only by some feminists.

What are the implications vis-à-vis the socially accepted meanings of care and expected roles of the family, the welfare state, and the market in Turkey? The care literature cannot directly answer this question since it is overwhelmingly focused on advanced capitalist societies.[32] The particular dynamics of developing countries—especially the shadow economy (i.e. informal sector)[33] and its relations with gender, as well as the effects of patriarchal backlash and rise of the new religious conservatism in Muslim societies—remain relatively understudied.

At the local level, disability studies in Turkey have offered either a narrow sociological reading or have focused on the experience of the disabled and their families from a medical perspective. Little research has analyzed the connection between the Turkish welfare state and disability. The present study seeks to address this gap by examining Turkey's care regime, particularly the cash-for-care policies and outsourcing. In so doing, it aims to reveal the links between the welfare state, the market, and patriarchy.

Defining distorted commodification of care

In the European context, care and social services, traditionally the preserve of local governments, have been largely marketized. The marketization of social care "refers to government measures that authorize, support, or enforce the introduction of markets, the creation of relationships between buyers and sellers, and the use of market mechanisms to allocate care."[34] Marketization strategies include *outsourcing* (i.e. purchasing service delivery from either for-profit firms or nonprofit civil society organizations), *cash schemes* that finance users to purchase care services in the market, and *mandating care insurance* against the need for LTC, such as in Germany. Scholars have assessed the challenges of this approach, noting the difficulty

[32] Fraser, "Capitalism's Crisis"; Duffy, et al., "Counting Care Work"; Tronto, "Ethic of Care"; Nancy Folbre, "Reforming Care," *Politics and Society* 36, no. 3 (2008): 373–87; Lise Widding Isaksen, *Global Care Work: Gender and Migration in Nordic Societies* (Lund: Nordic Academic Press, 2010); Arlie Russell Hochschild, "Love and Gold," in *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*, ed. Barbara Ehrenreich and Arlie Russell Hochschild (New York: Metropolitan/OWL, 2002), 15–30; Clare Ungerson, "Commodified Care Work in European Labour Markets," *European Societies* 5, no. 4 (2003): 377–96.

[33] Most of the developing countries specialized in labor-intensive sectors that rely on the advantage of low wages. In some this process has gone hand in hand with subcontracting chains binding formal and informal sectors, resulting in vast shadow economies producing precarity and the concentration of women's work in informal jobs, where their labor force participation in the formal economy has remained low. For a detailed overview see Fuat Ercan and Melda Yaman-Öztürk, "1979 Krizinden 2001 Krizine Türkiye'de Sermaye Birikimi Süreci ve Yaşanan Dönüşümler," *Praksis* 19 (2012): 55–93; Reyhan Atasü-Topcuoğlu, "Kadın Emeği Nasıl Değersizleşir? Enformel Alan ve Ataerkilliğin Eklemlenme Mekanizmaları: Bilinçli Saklama ve Saklayarak Değersizleştirme," *Praksis* 20 (2009): 87–104.

[34] Brennan, et al., "The Marketisation of Care," 379.

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of making an informed choice in market care provision[35] and of measuring the quality of care provided in this way.[36] In the wake of these developments in Europe, marketization strategies such as the "choose and choose again" approach have arisen, where the disabled can change their care arrangement at any time, which has boosted competition.[37] There has also been competitive tendering in outsourcing[38] and new competition between for-profit and nonprofit providers. A search for "quality assurance disability services" in scientific databases yields around 3,000 hits. Finally, there has been a swathe of care roles created,[39] with new job titles such as casual service support workers, relief recovery support workers, residential assistants, and the like.

Scholars[40] emphasize the similarities between the Turkish welfare state and the Southern European model[41] (Portugal, Italy, Spain, and Greece), where the family is central in the absence of meaningful social assistance; the structure of health and pension benefits is also similar. Such comparisons are doubtless correct insofar as they address macro similarities; differences, however, do stand out when one compares more specific structures such as care regimes. From this perspective, Turkey differs in several ways from the abovementioned countries, including in terms of the bureaucratic system of provision. Social services are mainly directed by the central government in Turkey, whereas municipalities are responsible in Southern European countries. Also, Turkey's shadow economy is much larger,[42] and for-profit firms are favored over nonprofit organizations such as non-governmental organizations (NGOs), which are much more prevalent in outsourcing in Spain and Portugal. Finally, *familialistic and gender equality policies* are different within the Southern European cluster.[43] These differences lie at the heart of the distorted commodification of the care regime in Turkey.

In short, in Europe, since the 1990s, private sector care services have given rise to a "care industry" that is modeled according to market logics.[44] The research shows that commodification of care results in three outcomes. First is *visibility*, where care

[35] Ian Greener, "Markets in the Public Sector: When Do They Work, and What Do We Do When They Don't?" *Policy & Politics* 36, no. 1 (2008): 93–108.

[36] Brennan, et al., "The Marketisation of Care."

[37] Gabrielle Meagher and Marta Szebehely, "Long-term Care in Sweden: Trends, Actors, and Consequences," in *Reforms in Long-term Care Policies in Europe*, ed. Costanyo Ranci and Emmanuele Pavolini (New York: Springer, 2013), 55–78.

[38] Jane Lethbridge, *Changing Care Policies in Europe* (London: Public Services International Research Unit, 2005), 6.

[39] International Labour Office (ILO) *Care Work and Care Jobs for the Future of Decent Work* (Geneva: ILO, 2018).

[40] Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation," *Journal of European Social Policy* 16, no. 3 (2006): 211–28.

[41] Maurizio Ferrera, "The 'Southern Model' of Welfare in Social Europe," *Journal of European Social Policy* 6, no. 1 (1996): 17–37.

[42] Leandro Medina and Friedrich Schneider, "Shadow Economies around the World: What Did We Learn over the Last 20 Years?" IMF Working Paper, WP/18/17 (2018).

[43] Sigrid Leitner, "Varieties of Familialism: The Caring Function of the Family in Comparative Perspective," *European Societies* 5, no. 4 (2003): 353–75.

[44] Susan Himmelweit, "Caring: The Need for an Economic Strategy," *Public Policy Research* 12, no. 3 (2005): 168–73; Karin Schwiter, et al., "Neoliberal Austerity and the Marketisation of Elderly Care," *Social & Cultural Geography* 19 no. 3 (2018): 379–99.

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provision enters the public debate and detailed definitions of care services proliferate.[45] The second outcome is *regulation*, involving standardization of techniques, quality measurement,[46] and cost–benefit accounting. Finally, we see *remuneration* in the form of paid jobs,[47] fees for service, and a "customer orientation towards patients and responsibility of wards and units to make a profit."[48]

However, in the Turkish context the commodification of care has not produced these hypothesized outputs. Visibility has been limited because conditions of caregivers and the quality of care are not a part of the public debate. There are regulations, but the production, exchange, value, and enjoyment of care services are not governed by the market rationale, as expected. Care has become a remunerated service, but there are inexplicable differences in remuneration for similar work. Hence, in Turkey what we find is a distorted commodification of care in contrast to Europe's standard form.

In Turkey a large shadow economy has led to *a double commodification of care*, with marketization in both the informal and formal sectors. In the recently established formal care sector, private companies sell care services and home care, with much new employment created in the process. Simultaneously the many unregistered care workers in the shadow economy result in poorly defined care services, precarious and often poorly paid care work, and the distorted commodification of care.

The shadow economy, increasing conservatism, and the patriarchal system reinforce one another in the Turkish care regime. Distorted commodification of care works against the backdrop of a limited welfare state and a gendered imagery that sees care as the domain of women, a noncompetitive formal care market based on outsourcing, and kin-based cash-for-care.

The shadow economy of care in Turkey

A shadow economy flourishes within the complex interaction between the limited welfare state and the gendered image of care in Turkey. The emotional labor and intimacy aspects of that gendered imagery have distorted the commodification of care by distorting skill recognition and making unregulated trade in it acceptable. And the social policy has favored outsourcing in this context due to the confluence of neoliberalism and increasing Islamization in Turkey,[49] reinforcing the gendered image of care provision. The interaction of inadequate care services and patriarchal gendered care imagery produced the initial commodification of care in the informal market, resulting in the prolongation of patriarchal ideology, marketization of care without quality measures, and societal disinterestedness.

[45] Brennan, et al., "The Marketisation of Care."

[46] Gun-Britt Trydegård, "Swedish Care Reforms in the 1990s," *Revue Française des Affaires Sociales* 4 (2003): 443–60.

[47] Lethbridge, *Changing Care Policies*.

[48] Marita Husso and Helena Hirvonen, "Gendered Agency and Emotions in the Field of Care Work," *Gender, Work & Organization* 19, no. 1 (2012): 29–51, 38.

[49] Ayhan Kaya, "Islamisation of Turkey under the AKP Rule: Empowering Family, Faith and Charity," *South European Society and Politics* 20, no.1 (2015): 47–69.

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An outsourced formal care market

Outsourcing has been a core aspect of NPM. However, in many countries social services are generally outsourced to nonprofit organizations. In Turkey, tenders have gone exclusively to for-profit firms. The blooming of private firms has not occurred under free market conditions. Rather, the disability care market has emerged via outsourcing, with the state channeling public funds to firms, which the government seeks to control closely. Recipients cannot choose their service provider but are directed to one by the state, which funds the care on their behalf. There is no competition nor any market mechanism that might engender visible quality of care. The formal care sector is horizontally and vertically segregated by gender, offering precarious jobs outside the equal-pay-for-equal-work principle, and without a feedback mechanism for recipients.

Outsourcing via kin-based cash-for-care

Turkey's public provision of subsidies in the cash-for-care scheme offers recipients little choice and no option of using the funds to offset the family carer's foregone wages, and is available only to the neediest. It turns in-family care into an activity done for money. However, it commodifies care in an absurd fashion. Specifically, it designates care as a duty of the family—reinforcing the existing gendered imagery of care—and instrumentalizes the family's care duty as a tool to access social assistance under conditions of severe poverty.

The distorted commodification makes care something to be bought and sold but produces none of the expected outcomes of commodification, such as competitive bidding and pricing. In other words, it does not give rise to market norms governing the production, exchange, enjoyment, and pricing of care and to formal care jobs. Instead, as I detail further below, it generates precarious working conditions and low remuneration. It also brings little quality management. At the time of writing, no quality measures and no feedback mechanism for care recipients in either public or private care centers have been implemented in Turkey. Under such conditions the care regime deprives caregivers and recipients of social rights and subjects them to extreme precarity.

The current care regime in Turkey: legal and institutional foundations

Delayed industrialization and a long-standing paternalistic state ideology mean social security and welfare were institutionalized relatively late and inadequately in the Republic of Turkey,[50] producing a weak, fragmented social safety net not predicated on the principle of social rights.[51] Societal solidarity has been based mainly on family and kinship relations, limited social services and social assistance, and some small-scale philanthropy.[52]

[50] Meryam Koray, *Sosyal Politika* (Ankara: İmge, 2005).

[51] Cahit Talas, *Toplumsal Ekonomi, Çalışma Ekonomisi* (Ankara: İmge, 1997).

[52] Ayşe Buğra, "Türkiye'nin Değişen Refah Rejimi: Neoliberalizm, Kültürel Muhafazakârlık ve Yeniden Tanımlanan Toplumsal Dayanışma," in *Türkiye'de Refah Devleti ve Kadın*, ed. Saniye Dedeoğlu and Adem Yavuz Elveren (İstanbul: İletişim, 2012), 47–70, 59.

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The United Nations proclaimed 1981 as the international year of disabled persons and announced the Decade of Disabled Persons from 1983 to 1992. To follow these international developments and prepare policy suggestions concerning disabled people, the Turkish government established a National Coordination Board for the Protection of the Disabled (*Sakatları Koruma Milli Koordinasyon Kurulu*) in 1981. This became the General Directorate of Disability (*Başbakanlık Özürlüler İdaresi Başkanlığı)* in 1997.

The implementation of institutional care for disabled people was organized with the Law of Social Services and Child Protection Institution of 1983 (*1983 Sosyal Hizmetler ve Çocuk Esirgeme Kurumu Kanunu*, SSCPI Law) that established public social services and defined its target as people who are *muhtaç* (in severe need of protection, care, and assistance). The law comprises a minimal variety of services and defines its target groups as (1) "children in need," namely orphans and those subject to abuse or abandonment; (2) "elderly people in need," namely those who suffer severe social and economic deprivation and require protection, care, and assistance; and (3) "disabled in need," namely those diagnosed with severe disabilities, and in need of daily care to go on living. The SSCPI Law was amended in 2005, and again in 2011 with the establishment of the Ministry of Family and Social Policy (*Aile ve Sosyal Politikalar Bakanlığı*). It was further amended in 2013, 2014, and 2018 when the department was reorganized into the Ministry of Family, Labor, and Social Services. Despite the various changes, the definition of the target groups of social services has not expanded. During all these institutional developments, three characteristics have determined the care regime: (1) public social services are not a citizenship right, (2) the family is assumed to be the primary responsible institution for care provision, and (3) the conditionality of public social services is based on dysfunction or absence of the family and neediness officially assessed and proved. In fact, neediness as the means-tested criterion has become detailed and linked to poverty: "the target of social policies has narrowed down to the worst of the neediest, the bottom of the subordinates, best defined with the slogan of 'we will stand by the destitute' (*Kimsesizlerin kimsesi olacağız*)."[53]

Limited institutionalization meant that public care services in 2012 only served around 2 percent of the target populations—the disabled, elderly, and children.[54] Since 2000 the ministry budget has expanded. Still, public services have been shut down or remained limited, with some being outsourced to the private sector or substituted with cash for family care.[55] This emphasis implies that all kinds of care

[53] Meryem Koray, "AKP Dönemi: Neo-liberalizm, Neo-muhafazarlık, Neo-popülerizm Beşiğinde Sallanan Sosyal Devlet ve Sosyal Politika," in *Himmet, Fıtrat, Piyasa: AKP Döneminde Sosyal Politika*, ed. Meryem Koray and Aziz Çelik (İstanbul: İletişim, 2015), 11–54.

[54] Yıldız Ecevit, "Feminist Sosyal Politika Bağlamında, Türkiye'de Çocuk Bakımı ve Eğitimi'ne İki Paradigmadan Doğru Bakmak," in *Geçmişten Günümüze Türkiye'de Kadın Emeği*, ed. Gülay Toksöz and Ahmet Makal (Ankara: Ankara UÜniversitesi Yayınevi, 2012), 220–65.

[55] For example, public kindergartens were closed in 2014, leaving the entire sector to private firms. The social quota for poor children directed from social services fell from 5 to 3 percent. See Reyhan Atasü-Topcuoğlu, "Feminizmin Refah Devleti ve Sosyal Politika Alanına Eleştiri ve Katkıları," *Amme İdaresi Dergisi* 49, no. 4 (2016): 37–64. Then in 2017 a scheme of cash payments to grandmothers taking care of their grandchildren started. See Başak Can, "Caring for Solidarity? The Intimate Politics of Grandmother Childcare and Neoliberal Conservatism in Urban Turkey," *New Perspectives on Turkey* 60, no. 1 (2019): 85–107.

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services should be rendered within the family—namely, via unpaid women's labor. It thus foregrounds and reproduces a specific gendered imagery of care.

Care work at home is generally accepted as a part of domestic work and has become conceptually inseparable. It has become invisible within the patriarchal ideology's notion of the "intimacy of the family." In Turkey, three mutually reinforcing aspects have undergirded the patriarchal gendered care imagery —namely, emotional labor,[56] the notion of family intimacy, and the infantilization of care recipients. The first two combine to render invisible both care work and power relations in care, and the shadow economy of care. They also reinforce the third aspect, infantilization, which itself reinforces conservatism and the emphasis on the family. This gendered care imagery, reinforced by Islamic discourse, affects the formation of the formal care market and the acceptance of kin-based cash-for-care.

Emotional labor

Care always involves attention and tenderness, which is why it is closely associated in patriarchal ideology with "femininity." In patriarchal cultures, gender is constructed as a binary opposition: manhood is tied to being an assertive, strong, and vigorous breadwinner; and womanhood with being tender, attentive, patient, and tolerant. This "affective inequality"[57] is an acutely gendered problem and results in horizontal and vertical segregation in the care regime, squeezing women through poorly paid or unpaid care work.

Patriarchal stereotypes of womanhood indicating tenderness, softness, and patience are functional in increasing the quality of unpaid daily care at home and maintaining its continuity at low cost. At the same time, these characteristics reinforce gender inequality by reinforcing the woman caregiver's secondary position. Patriarchal ideology asserts that care out of love is better than care for money;[58] hence the initial preference is family care. As the demand for paid care in the current care regime is low, so are wages.[59] Patriarchal stereotypes of womanhood render skill and emotional labor[60] invisible in care work and dictate that "any good woman can do it." The distortion of skill recognition makes the formation of a shadow care economy easily acceptable for caregivers and buyers.

Family intimacy

Care is directly related to the body, and therefore the body's privacy and private space are considered together. This consideration again reinforces patriarchal ideology and binds the concept of care to the notion of family. Within patriarchal ideology care becomes an invisible field under the acceptance of "family intimacy." Women's

[56] Arlie Russell Hochschild, *The Managed Heart: Commercialization of Human Feeling* (Berkley: University of Berkley, 1983); Nurcan Özkaplan, "Duygusal Emek ve Kadın İşi/Erkek İşi," *Çalışma ve Toplum* 2, no. 21 (2009): 15–23.

[57] Kathleen Lynch, "Affective Equality: Who Cares?" *Development* 52, no. 3 (2009): 410–15.

[58] Julie A. Nelson, "Of Markets and Martyrs: Is It OK to Pay Well for Care?" *Feminist Economics* 5, no. 3 (1999): 43–59.

[59] Nelson, "Of Markets and Martyrs."

[60] Özkaplan, "Duygusal Emek."

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identity as being good wives, mothers, and daughters veils their intensive care work within family relations. To meet the needs of those in the intimate field of the family is considered a "natural duty" for women.

There has been a tension between the traditional Turkish policy of *implicit familialism*[61]—where neither enough social services are provided nor the family adequately supported—and the well-documented[62] fact that women's care responsibilities in the family have been the greatest obstacle to their labor market participation. This tension underscores the well-documented phenomenon of upper-middle-class professional women buying care and domestic services in the shadow economy.[63]

The commodification of care via the shadow economy has provided middle-class women with some opportunity to outsource their traditional roles to domestic and care workers with low wages. The class distinction in the formation of the shadow economy of care is highlighted in the literature.[64] The shadow economy of care has four significant implications for the organization of Turkey's care regime.

First, as an informal market where both the employer and employee are women, it does not change the sexual division of labor at home, contributing—despite commodification—to the *prolongation of patriarchal ideology*. Second, the shadow economy distorted the commodification of care services; in other words, it led to immature commodification. *No standards and no quality indicators* have been described, and the necessary skills remain unnamed. Precarious and unregistered care work has become general. Third, since the care need in society has been met (in the shadow economy), the perception of care as a social right has not spread, and social and political demands for care rights have been delayed and met with general *societal disinterestedness* (as seen in the 2015 campaign for cash-for-care beneficiaries). Finally, care is not accepted as a social right, hence it is not recognized as a *duty of the state*.

The infantilization and neglect of recipients

The emotional labor and intimacy aspects of the gendered care imagery result in an overemphasis and mystification of care's relational aspects. Disability scholars criticize this perspective on care as it connotes pity, charity, and optionality and diverges the discourse from rights,[65] focusing attention on individual pathologies or

[61] Leitner, "Varieties of Familialism."

[62] Yıldız Ecevit, *Türkiye'de Aile ve İş Yaşamının Uyumlaştırılması* (Ankara: Çalışma Bakanlığı Yayını, 2007); Saniye Dedeoğlu and Melda Yaman-Öztürk, eds., *Kapitalizm, Atarkillik ve Kadın Emeği: Türkiye Örneği* (Istanbul: SAV, 2010).

[63] Sibel Kalaycıoğlu and Helga Rittersberger-Tılıç, *Evlerimizdeki Gündelikçi Kadınlar: Cömert 'Abla'ların Sadık 'Hanım'ları* (İstanbul: Su Yayınları, 2000); Helga Rittersberger-Tılıç and Sibel Kalaycıoğlu, "Çocuk ve Yaşlı Bakıcıları: Enformel Sektördeki Kadınlar," in *Türkiye'de Refah Devleti ve Kadın*, ed. Saniye Dedeoğlu and Adem Yavuz Elveren (İstanbul: İletişim, 2012), 301–28; Gül Özyeğin, *Başkalarının Kiri* (İstanbul: İletişim, 2005); Seyhan Erdoğdu, and Gülay Toksöz, *The Visible Face of Women's Invisible Labour: Domestic Workers in Turkey* (Geneva: ILO, 2013).

[64] Kalaycıoğlu and Rittersberger-Tılıç, "Evlerimizdeki Gündelikçi Kadınlar"; Rittersberger-Tılıç and Kalaycıoğlu, "Çocuk ve Yaşlı Bakıcıları."

[65] Bill Hughes, "The Constitution of Impairment: Modernity and the Aesthetic of Oppression," *Disability & Society* 14, no. 2 (1999): 155–72; Kate Lindemann, "The Ethics of Receiving," *Theoretical Medicine and Bioethics* 24, no. 6 (2003): 501–9.

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disabilities at the expense of the social problems underpinning them.[66] Kittay underlines how "care" provided in the context of "extreme dependency" is seen as being given "out of a gratuitous kindness, a kindness [recipients] have no right to demand."[67] I argue that such a conception of care reflects the patriarchal gendered imagery that sees the mother and child as symbolic of the notion of ideal care. This brings about bias in perceiving all care receivers as infants. Infantilization is best symbolized by the nicknaming of carers as "caregiver mothers" (*bakıcı anne*)[68] in Turkish institutions. This, in turn, reinforces the acceptance of top-down approaches, "helping disabled brothers"[69] has been a theme in political discourse in the last two decades, followed by top-down policies on the side of public and private decision makers organizing care. This is silently accepted by the relatively less organized and timid voices of people with impairments.[70] Infantilization also underpins *familialization*, such that care is cast as the individual's problem and thus not a matter of social rights. Current understanding driving disability care policy does not prioritize the individual's independence. As stated by scholars,[71] it imposes *supported familialism*[72] via cash transfers, prolonging the role of family and unpaid women's work in care provision.

European disability movements' strong criticisms of infantilization have weakened the conceptual ties between care, generosity, family, gender, and unpaid care work. Quite the reverse is the case in Turkey, where the patriarchal gendered imagery of care has been hardened via Islamization. Intimacy—the public/private division—is central to all aspects of care and does change in time as well as in secular and religious contexts.[73] Islamization discourse brings about norms and institutions that continuously organize one's private sphere in terms of spatial gender division and gendered roles, and by describing kin closeness, age, and clothing as parameters of men's and women's coming together in the public and private spheres.[74] With the rise of neoconservative movements and political parties in Turkey, Islamic discourse reinforcing

[66] McLaughlin, "Conceptualising Intensive Caring."

[67] Kittay, "When Caring Is Just."

[68] Altuntaş and Atasü-Topcuoğlu, "Engelli Bakımı," 90.

[69] Politicians from the AKP and other political parties use the "disabled brothers" discourse, as examples see: https://www.haberler.com/56-bin-engelli-kardesimizi-kamuda-istihdam-ettik-11743863-haberi/, https://t24.com.tr/haber/kemal-kilicdaroglu-chp-grup-toplantisinda-konusuyor,821237. Ayşen Candaş "Birinci Oturum Moderatör Raporu," in *Başka Bir Aile Mümkün mü?*, ed. Nihal Boztekin (İstanbul: Heinrich Böll Stiftung Derneği, 2014), 48–57, 49, also underlines the top-down discursive working with motives of "brotherhood."

[70] Kasım Karataş and Turhan İçli, "Mevcut Engelli Örgütlenmesi Modelleri ve Yeni Model Arayışları" (paper presented at Hak Temelli Mücadele ve Engelli Örgütlenmesi: Dünden Yarına Arayışlar Çalıştayı, Beşiktaş Belediyesi: İstanbul. 12 January 2017).

[71] İdil A. Aybars, et al., "Familialization of Care Arrangements in Turkey: Questioning the Social Inclusion of 'the Invisible'," *Research and Policy on Turkey* 3, no. 2 (2018): 115–37; Başak Akkan, "The Politics of Care in Turkey: Sacred Familialism in a Changing Political Context," *Social Politics* 25, no. 1 (2018):
72–91.

[72] Chiara Saraceno, "Social Inequalities in Facing Old-Age Dependency: A Bi-generational Perspective," *Journal of European Social Policy* 20, no. 1 (2010): 32–44.

[73] Cynthia Nelson, "Public and Private Politics: Women in the Middle Eastern World," *American Ethnologist* 1, no. 3 (1974): 551–63.

[74] Hidayet Tuksal, *Kadın Karşıtı Söylemin İslam Geleneğindeki İzdüşümleri* (İstanbul: Otto, 2018).

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patriarchal gender imagery has become noteworthy in the organization of both the public and private spheres. This discourse is put into circulation by the Directorate of Religious Affairs as the state apparatus for organizing Turkish Sunni Islam, by the daily statements of politicians, and by civil and religious authorities.[75]

Turkey's ruling Justice and Development Party (*Adalet ve Kalkınma Partisi*, AKP) underlines the traditional role of women as wives and mothers[76] and reinforces the three-generation extended family as the ideal model.[77] This approach does not simply leave care to the private sphere but actively designates good Muslim women as altruistic mothers responsible for the family, thus increasing the functions expected from the family against a backdrop of a shrinking welfare state. The Islamization of Turkey and the mixing of neoliberal social policies with neoconservative[78] religious forms of governmentality[79] over the last two decades has served to boost the gendered care imagery and channeled government spending to the outsourcing of care services to private firms and families via social assistance.

Negligence and ambiguity in the Turkish care regime

Negligence and ambiguity have been among the peculiarities of the disability care regime in Turkey. They are the product of late and limited institutionalization, state-led marketization, and outsourcing via cash-for-care. Together they have prolonged the distorted commodification of care in Turkey.

Negligence and ambiguity are best evidenced by the dearth of accurate demographic data. To make or evaluate any kind of social policy and social services for target groups, basic demographic data are required, including the total number, gender, education, and age distribution of target groups and the distribution of various impairments. Such data have seldom been forthcoming, and there remain no census statistics on the disabled population in Turkey. There have been two sample-based studies and estimates, the first being the 2002 Disability Research for Turkey,[80] which underscored the severe lack of access to medical services. This is still the most comprehensive research ever undertaken on the question.[81] The biannual general health surveys provide percentages of disability in different age groups, but no total number. The 2012 General Health Survey estimates that 9.6 percent have severe difficulties in one or more functions, and 2.1 percent cannot function at all in one or more of the five basic functional areas (orthopedic, sight, hearing, speech, and

[75] Kaya, "Islamisation of Turkey"; Feride Acar and Gülbanu Altunok, "The 'Politics of Intimate' at the Intersection of Neo-liberalism and Neo-conservatism in Contemporary Turkey," *Women's Studies International Forum*, 41 (November, 2013): 14–23; Buğra, "Türkiye'nin Değişen Refah Rejimi."

[76] Acar and Altınok, "Politics of Intimate."

[77] Kaya, "Islamisation of Turkey."

[78] Koray, "AKP Dönemi."

[79] Ayşe Buğra and Ayşen Candaş, "Change and Continuity under an Eclectic Social Security Regime: the Case of Turkey," *Middle Eastern Studies* 47, no. 3 (2011): 515–28.

[80] Devlet İstatistik Enstitüsü/Özürlüler İdaresi Başkanlığı (DİE/ÖZİDA), *Türkiye Özürlüler Araştırması* (Ankara: ÖZİDA, 2002).

[81] İsmail Tufan, et al., "Brief Note: Disability in Turkey," *International Social Work* 50, no. 6 (2007): 839–45.

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mental function).[82] The data imply that approximately twenty-five million people are somehow affected by and concerned with disability,[83] nearly a third of the Turkish population.

All smaller-scale academic studies indicate that disabled people declare poverty, unemployment, the need for care, and psychological support as severe problems and that existing pensions are insufficient.[84] Access to education and hence to employment is a common problem among disabled people. Some 63 percent of the disabled population are literate, 6.9 percent have high school diplomas, and 2.4 percent are university graduates.[85] The disabled are more disadvantaged in reaching literacy and education, and the gender gap widens at higher levels of education.[86] Babies and small children with impairments are not accepted to kindergarten, and many school-aged impaired children cannot go to school even though it is a constitutional obligation.[87] Although this used to be the central theme in governmental statistics, action plans, and rights-based NGO advocacy, employment rates are relatively low.

Late and limited institutionalization

Severe disability care was institutionalized in the 1990s with the opening of public care services. However, for a long time their capacity remained far below the number of applicants. In 2005, thirty-five public institutions existed with a capacity of 2,755 beds, and 3,658 disabled people were on the official waiting list.[88]

A noncompetitive formal care market is formed through outsourcing

The opening of private rehabilitation centers was presented as the solution to the insufficient capacity of public twenty-four-hour care institutions and was regulated with an amendment to the SSCPI Law in 2005. The government authorizes firms to open disability care institutions and keeps the firm number and the bed capacity under control in every city; social services direct people to institutions and the government funds firms per patient. Private institutions have blossomed through this noncompetitive process, and total capacity now exceeds that of public ones, as shown in Figure 1. In 2010, when no one was on the waiting list, there were sixty-nine public and seventy-seven private institutions.[89] Ten private centers were established in 2007, and the number rose to 231 in 2018 and 251 in May 2019.

[82] Mert Tunga Ekenci, "2012 Türkiye Sağlık Araştırması'nın Engelliliğe İlişkin Yaygınlık Ölçümü Açısından İncelenmesi," *Sosyal Politika Çalışmaları Dergisi* 35, no. 2 (2015): 95–112.

[83] Nazmiye Güçlü, "Engelliler," in *Türkiye'de Hak Temelli Sivil Toplum Örgütleri*, ed. Gökmen Özgür (Ankara: Odak Ofset Matbaacılık, 2019): 175–208.

[84] Güçlü, "Engelliler"; Yusuf Genç, "Engellilerin Sosyal Sorunlari ve Beklentileri," *Sosyal Politika Çalışmaları Dergisi* 35, no. 2 (2016): 65–92.

[85] Tufan, et al., "Brief Note."

[86] Ibid., 840.

[87] Ibid.

[88] Betül Altuntaş and Reyhan Atasü-Topcuoğlu, *Engelli Bakımı: Sosyal Bakım ve Kadın Emeği* (Ankara: Nika, 2016).

[89] MFLSS, *Statistical Bulletin, May 2019*, https://ailevecalisma.gov.tr/media/6598/bu-lten_mayıs2019_20190624–1.pdf.

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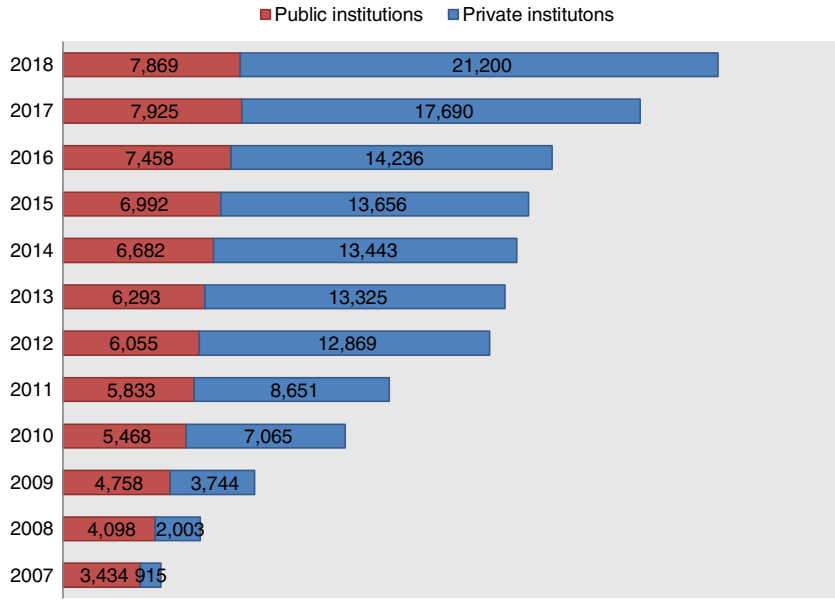

Figure 1. Bed capacity of public and private twenty-four-hour rehabilitation centers.
Source: MFLSS, Statistical Bulletin, March 2020.

Outsourcing via top-down home care allowance

Since 2006, home care has been supported as an alternative to institutional care via the home care allowance. It is paid directly to those giving care to a severely disabled relative. There were 30,628 cash-for-care beneficiaries in 2007, 481,141 in 2016, 499,737 in 2017, and 513,276 in 2018.

The three disability care options (public or private services and cash-for-care) are used as perfect substitutes and have the same eligibility criteria: (1) a medical impairment report indicating that the person is severely disabled and in need of care and (2) the family being below the poverty line (income per person should be less than two-thirds of the minimum wage). Additionally, there must be a kinship bond between the caregiver and recipient. These criteria differentiate the Turkish cash-for-care policy from individuality, self-determination, and consumerism, the core concepts of the "independence movement." As the family's centrality and close kinship in these criteria indicate, patriarchal gender imagery is central to Turkey's care regime.

Outsourcing and costs

As mentioned, the three modes of disability care provision are treated as perfect substitutes in Turkey's current social work system. However, the cost per care recipient differs significantly among the modes, based on differences in care provision. These include physical and working conditions (e.g. work shifts, the number of responsible people, provision of social security).

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Outsourcing to private firms clearly decreases government spending per beneficiary. However, the cash-for-care policy has seen the most significant "savings" for the government. In 2019, the government spent 770 million TL on 19,658 disabled persons staying in private centers, 790 million TL on public centers with 7,358 disabled in twenty-four-hour care service and 735 disabled benefitting from day care services, and 8,158.7 million TL in on daycare services.[90] The home care allowance is below the minimum wage (i.e. 1,219 TL in 2019). Annual government spending per beneficiary is thus around 97,000 TL in public institutions, 39,000 TL in private ones, and 15,000 TL under the cash-for-care scheme.

This care regime assumes state responsibility in disability care only under severe conditions of impairment and extreme poverty. Despite the commodification that this implies, there is wide variation in remuneration of care work and likely differences in the quality of care provided (which are assumed to be similar) from case to case. It is crucial to unpack the differences for each of the three abovementioned options for twenty-four-hour care and the implications for care quality.

Distorted commodification outcomes in Turkey

The outcomes of distorted commodification within the severe disability care regime can be traced by analyzing the differing positions of (1) caregivers in the three different disability care settings and (2) caregivers and recipients in the current cash-for-care scheme.

The position of caregivers in different disability care settings

Gender shapes the expectations of private and public institutions and families in the disability care sector. All the institutions' directors are men, showing the vertical segregation and glass ceiling for female social workers, who make up half of the professional staff. Some directors have asserted that women are "more patient, attentive and docile," being thus "better suited" to caregiver jobs.[91] Thus the care sector produces formal job opportunities for women, opening a path to regular market employment and benefits, including health insurance and even a retirement pension if they manage to work for twenty-five years. Women represent the vast majority of caregivers; men are generally only employed for providing body care to male clients, again reflecting gendered intimacy.

The cash-for-care beneficiaries are predominantly women; the number of male applicants is meager, according to the Social Work Center (*Sosyal Hizmet Merkezi*, SHM). Patriarchal ideology dictates that care is not men's responsibility (even for those currently not in paid work) and that female members of needy families should approach the SHM to apply for assistance.

Remuneration for care work

Employment in the sector is precarious. Some public sector social workers have job security, but most do not. Despite similarities in job descriptions across workplaces, a

[90] MFLSS, *Statistical Bulletin, March 2020*.

[91] Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

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Table 1. The pay gap for 2015

	Social workers at social work centers	Social workers at institutions	Caregivers at institutions	Caregivers at home
Min. wage (TL)	1,850	900	950	846
Max. wage (TL)	3,750	10,000	1,450	846
Average wage (TL)	1,878	2,360	1,100	846

Data source: Altuntaş and Atasü-Topcuo lu, *Engelli Bakımı*.

range of contracts are employed (e.g. permanent, temporary, paid hourly) and pay different wages, as shown in Table 1.

Caregivers in disability care work in shifts since they are directly responsible for clients' ongoing needs twenty-four hours a day, seven days a week. Although public sector caregivers earn slightly more, there is no less precarity in public institutions, which often hire via private recruitment agencies. Staff work on annual contracts that entail long probation periods, with lower pay and no retirement or insurance contributions.

Although the cash-for-care beneficiaries perform the same tasks as caregivers in institutions and work around the clock, their remuneration is the lowest.

Care providers education and training

There is a clear education gap between social workers, caregivers at institutions, and cash-for-care beneficiaries. Social workers are university graduates. According to the relevant bylaw,[92] caregivers at institutions must be high school graduates and have a course certificate in disability care. There is no education or course requirement or care training for cash-for-care beneficiaries. The typical education level is primary school and lower.[93] The education gap throws doubt on caregivers' ability to develop skills and capacities in care on an even playing field. Since the cash-for-care and institutional care options are treated as perfect substitutes, one may also question whether disabled people have equal opportunity in access to quality care.

Workload and turnover

According to the relevant bylaw, during daytime hours the ratios of social workers to disabled people should be 1:36, for healthcare personnel 1:48, and for caregivers 1:6. The workplace hierarchy from director to social worker to caregiver also works to promote active care and face-to-face time with individual clients. At the bottom,

[92] Bylaw on the Official Institutions and Organizations for Disabled People in Need of Care and Centers O.G., July 30, 2006, Issue: 26244, art. 38.

[93] Bilal Erdoğan, "Evde Bakım Hizmeti Alan Özürlü Bireye Sahip Ailelerin Sosyo-Ekonomik Durumlarının İncelenerek, Umutsuzluk ve Yaşam Doyum Düzeylerinin Belirlenmesi" (Master's thesis, Selçuk University, 2013); Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

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caregivers spend eight hours a day face-to-face with clients, while the others plan and monitor care activity.[94]

Nonetheless, care work is professionally organized and supervised, and its responsibility is shared. Since there is no kinship, there is emotional distance. Studies underline the fast turnover rate among caregivers in private centers, with the average tenure being two years for social workers[95] and around one year for caregivers.[96] This may be related to the fact that severe disability care work is incredibly challenging and often tedious. However, for women caring for disabled relatives at home, the duration of care provision can be as much as twenty to thirty years. The maximum age of cash-for-care beneficiaries is seventy-three, which burdens the elderly[97] and shows how inalienable women's care responsibilities can be even well into old age.

Burnout

International studies show that paid care workers do experience stress and burnout and that workplace support is a significant factor buffering the adverse effects on job and life satisfaction.[98] For employees working in disability care, the Turkish literature shows low or medium levels of burnout.[99] This may be due to the fast turnover in the sector (one–two years) or care workers' religious motives. On the other hand, studies underline that cash-for-care beneficiaries also experience burnout[100] and that the position of bearing sole responsibility for taking care of a relative with severe impairment causes anxiety and depression.[101] Plus they have low education levels and receive no specific training in disability care. As mentioned, patriarchal ideology asserts that care out of love is better than care for money. One should consider cash-for-care policies in terms of quality of care in the face of isolation, low education, poverty, and burnout. In any case, many care personnel think that family care is better than institutional care.[102] Infantilization also obscures the quality implications of education and the training gap among caregivers.

To sum up, the current distorted commodification of care based on outsourcing to private firms and low-income families via social assistance leads to illegitimate remuneration differences in care work and precarious employment. In addition, from the beginning of outsourcing in the 1990s until 2020, no clear criteria for measuring care

[94] Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

[95] Muhammet Kiremitçi and Nur Kesen, "Özel Bakım Merkezinde Görev Yapan Sosyal Çalışmacıların Profili," in *Güncel Sosyal Hizmet Çalışmaları*, ed. Mehmet Kıroğlu and Hasan Hüseyin Tekin (Konya: Çizgi Kitabevi, 2019), 43–55.

[96] Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

[97] Ibid.

[98] Isabel Hombrados-Mendieta and Francisco Cosano-Rivas, "Burnout, Workplace Support, Job Satisfaction and Life Satisfaction among Social Workers in Spain," *International Social Work* 56, no. 2 (2013): 228–46.

[99] Oğuz Başol, et al., "Engelli ve Yaşlı Bakım Personelinin Tükenmişlik Seviyeleri İle Çalışma Yaşamı Kalitesi Algısı İlişkisi," *Toplum ve Sosyal Hizmet* 29, no. 2 (2018): 71–97.

[100] Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

[101] Ali Yavuz Karahan and Serkan İslam, "Fiziksel Engelli Çocuk ve Yaşlı Hastalara Bakım Verme Yükü Üzerine Bir Karşılaştırma Çalışması," *Clinical and Experimental Health Sciences* 3 (2014): 1–7.

[102] Altuntaş and Atasü-Topcuoğlu, *Engelli Bakımı*.

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quality have emerged. This is even though attempts have been made to manage care quality via subsidizing on-the-job training in institutions.

Caregiver and recipient positions in cash-for-care

As mentioned, women make up the bulk of cash-for-care beneficiaries. The cash-for-care policy does not aim to change the existing gender regime and the sexual division of labor in the home in Turkey. The policy assumes that the current burdens are "manageable" and that beneficiaries need no further support from the state in the discharge of their heavy care duties and responsibilities, and the fact that they are often isolated and poorly supported.

An isolated care relationship may bring about suffering for both caregivers and recipients. Disability care involves an incredible mix of tasks, including nutrition, lifting and lowering, bathing and body cleaning, night care, drug monitoring, blood pressure monitoring, catheterization, and hospital follow-up. In the cash-for-care policy, all these activities must be done by women with no assistance. Most women carers in the scheme have no training related to care and simply run off a feeling of devotion to the family; they have "learned to live with" having no time of their own.[103] Hence many often feel inadequate, which puts their emotional well-being at risk.[104] Often the primary resource family caregivers have to draw on is the belief in God's will and providence. Recent studies[105] show that family caregivers are likely to develop mental health problems because of the caregiving burden. Some studies indicate that they also have anxieties about what will happen to their disabled children or relatives after they pass away.[106] Studies further denote that caregivers of disabled relatives, mostly mothers, have anxiety but consider the issue to be a personal problem.

Social exclusion and the subordination of people with impairments have social and psychological effects. Research shows that family caregivers in many Middle Eastern cultures are likely to develop a mental illness due to the caregiving burden. Besides, having someone in the family who is mentally ill brings about social exclusion as well as feelings of shame,[107] as "seeking treatment for family members or for the caregivers themselves risks their status in the society."[108] Another critical and

[103] Alev Dramalı, et al., "Evde Kronik Hastaya Bakım Veren Hasta Yakınlarının Karşılaştıkları Sorunlar," in *I. Ulusal Evde Bakım Kongresi Kitabı*, ed. Güler Cimete (İstanbul: Marmara Üniversitesi,1998), 117; Duygu Samav Cantürk, "Ötelenmiş Hayatlar Engelliye Bakan Kadın Olmak," *Toplum ve Demokrasi* 11, no. 24 (2017): 127–39.

[104] Sahar S. Al Makhamreh, "Exploring Experiences of Informal Carers of Mental Health: Developing Community Intervention in Social Work in Jordan," *International Social Work* 61, no. 6 (2018): 1042–53.

[105] Benjamin Gray, et al., "Patterns of Exclusion of Carers for People with Mental Health Problems—the Perspectives of Professionals," *Journal of Social Work Practice* 24, no. 4 (2010): 475–92; Joseph Guada, et al., "Assessing the Family Functioning of Inner-city African-American Families Living with Schizophrenia with the McMaster Family Assessment Device," *Social Work in Mental Health* 8, no. 3 (2010): 238–53.

[106] Rukiye İnekçi, "Serebral Palsili Çocuğa Sahip Annelerin Annelik Algısı" (Master's thesis, Hacettepe University, 2018).

[107] Robin E. Gearing, et al., "Adaptation and Translation of Mental Health Interventions in Middle Eastern Arab Countries," *International Journal of Social Psychiatry* 59, no. 7 (2013): 671–81.

[108] Al Makhamreh, "Exploring Experiences."

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undiscussed aspect is domestic violence. Some female caregivers suffer violence and physical abuse by their mentally ill husbands or sons.[109]

Given the combination of isolated care relations and social exclusion, what is at stake for both caregivers and recipients here is not a mere burden of labor or the inability to reach rehabilitative care; it is *sheer suffering*. This "positional suffering"[110] experienced by caregivers and recipients is subjective. These social positions, meaning conditions of individual suffering, are produced within the current care regime. Social institutions (the welfare state, the market, and the family) are where impairment turns into disability, where differences become inequality, and where inequities are legitimized and serve as the basis of exploitation. Hence, we must analyze care regimes as social structures vis-à-vis the welfare state, neoliberalism, and patriarchy.

The current version of the cash-for-care policy has minimal potential to empower caregivers and recipients. It is nearly impossible for women to carry on a life of their own due to the care burden.[111] This is because the policy provides no support and ensures that the hardships remain constant in women carers' lives. In practice these women have scant time or resources for recreation and personal development. Caregivers' responsibilities and the psychology of continually trying to surmount obstacles on a 24/7 basis eviscerate the opportunity for women carers to exercise mobility and pursue leisure activities.

Some studies find that—as a result of being left alone in the face of difficulties in everyday life—the Islamic concepts of faith, patience, and life on this earth as just a test before eternity have become important motives in women's discourse.[112] Some studies recommend encouraging spiritual values as a helping method.[113] Spirituality may be subjectively important but should not overshadow discussing relevant social policies and rights. Additionally, Islam has a major role in determining the self-perception of disabled people, bringing about ideas that disability is a form of being put to the test before God and that one should accept God's will and be grateful under any circumstances, thus limiting the rights-based attitude among the disabled and their relatives.[114]

One should underline the parallels between caregivers and recipients in the cash-for-care scheme. They are expected to remain quiescent in the face of demanding circumstances, eschew claims for work rights and extra services to improve care and living conditions, and rely on faith. It is also crucial to note that living in severe poverty is the legal condition for receiving social assistance.

[109] Ibid.

[110] Pierre Bourdieu, "The Space of Points of View", in *The Weight of the World*, ed. Pierre Bourdieu et al. (Stanford, CA: Stanford University Press, 1999).

[111] Duygu Samav Cantürk, "Evde Engelli Bakım Ücreti Hizmetlerinin Sosyal Modeli Gerçekeştirmedeki Rolü" (PhD dissertation, Süleyman Demirel University, 2017), 183–9.

[112] Samav Cantürk, "Evde Engelli Bakım Ücreti," 143–51; Altuntaş and Atasü Topcuoğlu, "Engelli Bakımı," 202–22.

[113] Zeki Karataş, "Evde Bakım Hizmeti Sunan Aile Bireyi Bakıcıların Moral ve Manevi Değerlerinin Başaçıkmadaki Etkisi" (PhD dissertation, Rize University, 2011).

[114] Dikmen Bezmez and Sibel Yardımcı, "In Search of Disability Rights: Citizenship and Turkish Disability Organizations," *Disability & Society* 25, no. 5 (2010): 603–15, 607.

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In 2015 women's organizations demanded that the precarity and limits of the cash-for-care benefits be addressed, with the position being treated as a job for people receiving benefits, meaning a full salary, retirement pension, health insurance, and paid holidays.[115] In 2016 the state rebuffed this by amending the wording of the relevant bylaw from "care wage" (*bakım ücreti*) to "care assistance" (*bakım yardımı*) to underscore the discretionary, allowance-based nature of the benefit. However, as shown by Toksöz,[116] cash-for-care beneficiaries have continued to be counted as being employed in the service sector, thus boosting the statistics on women's labor force participation.

The adverse policy outcomes are reflected in the fact that the women's organizations' demands have not been heeded either by the general public or disability NGOs, and therefore have not turned into a broad campaign. This goes a long way to explaining why the state was able to rebuff these demands so easily. The general lack of social interest is thus directly related to the gendered imagery of care and the distorted commodification of care in Turkey.

Conclusion

This study problematizes the care regime as the organization of care among state, market, and family institutions. It underlines the relations between the effects of patriarchal ideology through a gendered imagery of care underpinned by expectations of emotional labor, family intimacy, and infantilization of care recipients. Overall, the care regime in Turkey reflects the interaction between the gendered imagery of care and *late capitalism* (the shadow economy), *neoliberalism* (a retreating welfare state and expanded outsourcing), and *neoconservatism* (in which patriarchal ideology and family expectations are reinforced by religion).

In the global context of the shrinking of welfare states under modern financial capitalism, the state does not have sufficient access to ideological resources or international financial tools and resources to invest in welfare services. Concerning ideology, the focus of policy and the European care debate is mainly on labor market regulations to address the care crisis, which may work for short-term needs but has no clear answer for long-term disability, old age, and chronic diseases care. In terms of financing, as Fraser notes, "debt is the instrument by which global financial institutions pressure states to slash social spending, enforce austerity, and generally collide with investors in extracting value from defenseless populations."[117]

The capitalist economy depends on social relations that provide labor and reproduce populations and the societal game of people working, buying, and believing in the capitalist market and its omnipotence. Hence the government is constantly under

[115] KEİG, "Haneiçi karşılıksız emek nedir?" 2015, http://www.keig.org/haneici-karsiliksiz-emek-nedir-nisan-2015/; KEİG, "Türkiye'de İnsanlar Zaman Yoksulu, Kadınlar Daha da Yoksul," 2019, http://www.keig.org/turkiyede-insanlar-zaman-yoksulu-kadinlar-daha-da-yoksul/; KEİG, "Bakım Emeği Paneli Bilgi Notu," 2019, http://www.keig.org/bakim-emegi-paneli-bilgi-notu/; Derya Acuner, et al., "Ekonomik Haklarımız Var!" Women for Women's Human Rights—New Ways 2016, https://www.kadinininsanhaklari.org/wp-content/uploads/2018/08/EkonomikWeb-yeni.pdf.

[116] Gülay Toksöz, "Transition from 'Woman' to 'Family': An Analysis of AKP Era Employment Policies from a Gender Perspective," *Journal für Entwicklungspolitik* 32, no. 1/2 (2016): 64–83.

[117] Fraser, "Capitalism's Crisis of Care."

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pressure to reinforce the regime of values and messaging that assuages populations' hardships in late capitalistic countries. The effects of neoliberalism, particularly low employment rates,[118] contribute to increased poverty and the gap between a wealthy minority and the poor masses.

Turning to the issue of policies of familialism and the reinvention of Islamic discourse, we observe the image of the ideal Muslim woman as patient, silent, and undemanding being reinforced. Indeed, casting women caregivers in this way is a governmental technique, a coping strategy of the AKP regime, rather than an arbitrary motive in Islamic discourse. Turkish Islamic conservatism's gender imaginary intensifies patriarchal ideology and basically reintroduces what Mies calls "housewifization,"[119] and it is central to reducing the costs to the state of maintaining and reproducing the current care regime in Turkey. That regime is based on the distorted commodification of care comprising a care market in the shadow economy, a government-led uncompetitive formal care market, and the instrumentalization of care for social assistance under severe poverty. The example of twenty-four-hour disability care illustrates that the current care regime produces precarious jobs and social positions of suffering for caregivers and recipients.

Within this framework people are doomed to suffer, especially those who are not male, rich, and able. This situation brings about an erosion of social rights and democracy. It may become a persistent condition without alternatives, as the opposition parties in Turkey keep silent about the state of the care regime and the responsibility being left to women in the family alone. They cannot invent a discourse for giving voice to and bridging social rights and needs.

In terms of social policy, balancing work and family life is necessary but not sufficient. We also need transformative care, a transformative social reproduction system, and a transformative citizenship and welfare regime. In short, we need a transformative reorganization and facilitation of social reproduction based on human rights.

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[118] The employment rate in Turkey in 2000 was 46 percent and has been lower in the twenty years since then. Kuvvet Lordoğlu and Hakan Koçak, "AKP döneminde istihdam, işgücü ve işsizlik," in *Himmet, Fıtrat, Piyasa*, ed. Meryem Koray and Aziz Çelik (İstanbul: İletişim, 2015), 259–77.

[119] Maria Mies, *Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour* (London: Zed Books, 1986).

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