RECOGNISING AND REWARDING CARE WORK: THE ROLE OF PUBLIC POLICIES

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Further articles by Prof. Jayati Ghosh in this series:
- Defining care: conceptualisations and particularities
- The structure of care work and inequalities among care workers

THE SUPPLY OF CARE WORK(ERS)

Measurement of the care economy and of the extent of care work presents enormous challenges, for reasons that were noted in the previous article, 'The structure of care work and inequalities among care workers'. It is hard enough to estimate paid care work, since it is provided both in formal institutionalised contexts as well as in more informal settings. But the inclusion of unpaid care makes the task truly challenging. The bulk of direct care as well as much indirect care has historically been provided within families, and this remains the case, not only in relatively less developed countries with smaller formal care sectors, but in rich countries as well. This obviously makes it near impossible to measure the supply of care, especially as very few countries conduct time-use surveys that would allow for some estimation of the hours devoted to care in its various forms. A further difficulty is that some activities that clearly form part of the care economy when provided within families and households in an unpaid manner (such as cooking for the family) do not necessarily constitute care when they are provided as market services, in the form of chefs and cooks, whether they work in formal or informal establishments or in private homes.

Since many of the tasks typically performed in unpaid fashion are essential activities without which society could not continue, the supply of such work tends to rise to meet the demand, even though quality may suffer because of the greater time pressures this creates for care providers. As UN Women noted, 'involvement in this work varies greatly across countries depending on the extent and coverage of public services such as water and sanitation, energy, health and childcare. Within countries, there are also significant variations in the amount of unpaid care and domestic work carried out by women based on age, income, location and the presence of young children in the household.'[1]

The difficulty of measuring both care work and the number of care workers is compounded by the fact that even specific forms of care are often shared across formal and informal settings and providers. Samman et al consider the specific case of child care, and point out that child care services are not just provided by mothers or parents in general: 'many other people are involved as families patch together solutions to the almost universal dilemma of how to both care and provide for a family. These range from organised care in schools and nurseries, to

1 UN Women. 2016. Leave No One Behind: A call to action for gender equality and women's economic empowerment. Report of the UN Secretary General's High Level Panel on Women's Economic Empowerment. New York: UN Women, p. 84.

informal agreements with grandmothers or other children, to domestic workers in the home.'[2] Indeed, the role of extended family – particularly grandparents – in providing child care is often not adequately considered in the policy discussion, yet the evidence is that grandparents, and particularly grandmothers, provide significant unpaid care services.

The standard way of determining the extent of unpaid care work is through time-use surveys or activity analyses. Gardner lists the following five ways of measuring the time spent on unpaid domestic care work:[3] (1) direct observation observed by an enumerator, either continuously or at random times; (2) databases of time-stamped information, eg records of stays in institutions or social media entries; (3) stylised questions in surveys (eg how much time did you spend on preparing meals during the last week?); (4) experience sampling, in which the respondent provides data about current activity in response to a prompt such as a beeper or text message; (5) a time-use diary self-completed or interview-assisted diary that shows how time is allocated to various activities throughout a day. Each of these has its own advantages and disadvantages: the more accurate ones are also much more expensive, labour-intensive and demanding of the respondent, while the faster and cheaper methods tend to be less comprehensive and accurate. Most methods (other than direct observation) suffer from the weakness that they do not capture all dimensions of time use, and find it difficult to incorporate multi-tasking which is a typical feature of a lot of care activities.

What is more, both direct and indirect unpaid care services are not only delivered by adults but also by children, especially within households, and here too the gender disparity is sharply evident. UNICEF (2016) found that girls between 5 and 14 years old spend 40 per cent more time than boys their age on unpaid household chores and collecting water and firewood. The disproportionate burden of domestic work begins early, with girls between 5 and 9 years old spending 30 percent more time, or 40 million more hours a day, on household chores than boys their age. These disparities grow as the children get older, with 10- to 14 year-old girls spending 50 percent more time, or 120 million more hours each day.

An impressive attempt to quantify health care workers in a large number of countries was undertaken by Scheil-Adlung.[4] She took a supply-chain approach to identify the number of all workers contributing to the production of health protection, regardless of their occupation and employment status in the public or private sector, including estimates of the unpaid health workforce providing informal care. Given the significance of these results, they are worth quoting in some detail. She found that at the time of writing, health employment provides jobs for 234 million workers in 185 countries, with 14 million jobs in the health economies of Africa; 44 million in the Americas; 5 million in the Arab States; 109 million in Asia and the Pacific; and 62 million in Europe and Central Asia. Much of this health care is produced by large numbers of unpaid women and non-medical workers. Scheil-Adlung identified 106 million jobs for workers in non-health occupations, such as unskilled workers maintaining facilities, or cleaning bed linen, as compared to 71 million jobs for workers in health occupations, eg nurses. In addition, there are around 57 million unpaid workers in non-health occupations. This means that the hidden workforce in non-health occupations needed to achieve health objectives constitutes of more than 60 percent of all paid workers employed in health economies and amounts to 70 percent of all paid and unpaid workers.

This example of health care work underlines a larger point: the 'supply' of care work is not fixed but fluid, changing over time and across socio-economic contexts and often depending upon specific requirements. However, in most societies there is probably inadequate development of the skills required in different kinds of care work, and an associated relative absence of trained personnel to provide important forms of care. This is generally true in normal situations, but becomes even more of an issue in extraordinary social circumstances. For example, war-torn societies typically require, in addition to personnel dealing with the physical health of victims, trained people to provide counselling for those affected with post-traumatic stress disorder and other psychological disturbances resulting from the experience of violence. Yet precisely such people are usually scarce in such societies and contexts, and there are few incentives to train them or even for people to seek to enter into such activities.

THE DEMAND FOR CARE

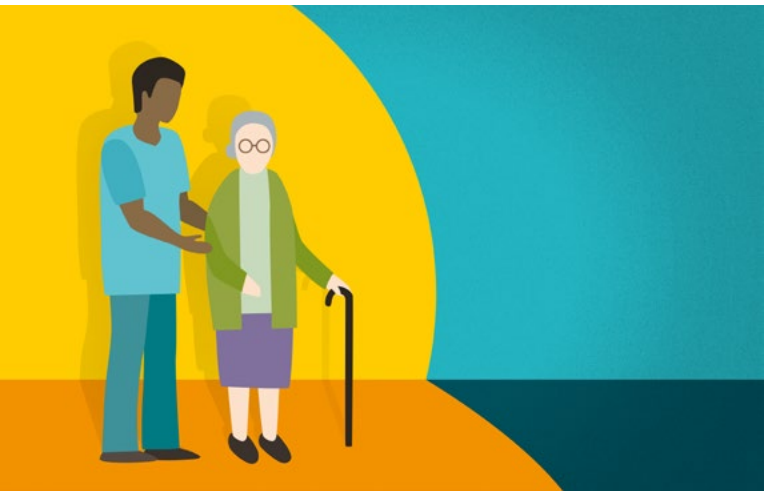
If the supply of care is hard to measure, then estimating the demand for care is near impossible. This is primarily because the extent of required care and its quality

2 Emma Samman, Elisabeth Presler-Marshall, Nicola Jones et al. 2016. Women's Work: Mothers, Children and the Global Childcare Crisis. London: ODI, p. 30.

3 Jessica Gardner. 2015. "Measuring own-use provision of services", ILO, December.

4 Xenia Scheil-Adlung. 2016. "Health workforce: A global supply chain approach. New data on the employment effects of health economies in 185 countries" *ESS Working Paper No 55*, Social Protection Department, ILO.

are themselves determined by changing social norms. Is care a basic human right, or is it a privilege that can be accorded to only a chosen few? And what level and intensity of care is required for each particular human need? Does the demand for care activities change depending on whether they are confined within households, or are marketed or publicly provided? How do societies at different levels of per capita income perceive the need for care? Since income inequalities even within societies tend to affect the demand for care (richer families are more able to demand and pay for care services), what norms should be taken as the appropriate standard for the required levels of care services? Clearly, these



are issues that relate not only to the extent of care work, but also to the very size of the broader care economy. Early childhood care, for example, has traditionally in many societies largely been seen as the preserve and the responsibility of mothers. Yet, as noted above, it has been shared more generally across family members and communities, depending upon social context. And it is now recognised in all the developed societies, and in many developing ones as well, that effective and desirable levels of early childhood care that would ensure a healthy, well-adjusted and productive future generation for society require much more social input, including with the participation of skilled and trained personnel. At present, the provision of skilled care services in this area of early child care is hugely inadequate. Samman et al use data from 67 developing countries covering around a quarter of the global population to suggest that on average just under one third of children aged 3 to 5 participated in formal ECCE (early childhood care and education) programmes.[5] In some countries, such as Afghanistan, Burkina Faso, Somalia, Yemen and Iraq, the proportion was less than 5 percent; while in other countries, like Thailand, Jamaica and Belarus, more than 80 percent of children attended such programmes.

The care of persons with disabilities, similarly, depends not only on the extent of disability and the conditions that would enable as normal a life as possible, including access to decent work, but also on the specific needs of those who are coping with this. Indeed, it has been pointed out that there tends to be little or no acknowledgement of the voices or needs of persons with disabilities in debates about care.[6] 'Care as a concept has symbolized a century-long confinement of disabled people to institutions and of lives controlled and colonized by others, by professional social workers and by care providers as well as by other family members'.[7] This in turn has generally meant a focus on the needs of care-givers and a distancing from the needs of those who require such care, who are seen implicitly as a social and/or familial burden.

Several factors therefore determine the demand for care activities in a society: the level of per capita income; the income distribution or extent of economic inequality; social attitudes with respect to those who are dependent in a relative sense (children and the elderly) and those with specific care needs; the gender construction of society and the status of women, which affect both their own unpaid care responsibilities and the extent to which their own care needs are recognised; the availability of basic infrastructure and amenities such as electricity, piped fuel, piped water and sanitation, that reduce the need for some indirect unpaid care activities; social attitudes to care, the role of the state and social protection systems and the extent of public responsibility for the delivery of care services (and therefore the fiscal imperatives associated with this and the willingness to allow the state to appropriate a part of current incomes to allow for widespread or universal provision); the available technologies, including labour-saving appliances, that reduce the more manual or tedious jobs that have to be performed by care-givers; and so on.

Another critical issue in assessing the future demand for care relates to the role of governmental and public provision, including social protection systems, of various care services. It is important to note that these levels of

5 Samman et al, *Women's Work: Mothers, Children and the Global Childcare Crisis*.

6 Kate Bedford. 2010. "Harmonising global care policy? Care and the Commission on the Status of Women", *UNRISD Gender and Development Programme Paper No 7*, Geneva: UNRISD.

7 Teppo Kröger. 2009. "Care research and disability studies: Nothing in common?" *Critical Social Policy*, 29(3): 398–420, p. 43.

additional employment will not be delivered by market forces on their own, and nor will such jobs be 'decent work' if the market alone is to determine this. Nor is it the case that it is better for society if such care is provided 'on the cheap' by untrained household members operating in unrecognised and unremunerated ways. There is an entire range of care services that is best provided by specialised professionals who have been trained for these, even in cases where the relational aspect means that empathy and emotions are also required. The need for state intervention – and for public provision of these essential care services – is therefore paramount. Therefore, another way of looking at the potential for new employment in care services is to consider the implications of additional investment in such care activities in future, based on some estimates of the employment generation resulting from different quantities of investment.

In this context, a 2016 study by the ITUC (International Trade Union Confederation) attempted a projection of the employment increases of public investment in care, finding very significant increases in employment (both directly and indirectly from multiplier effects) resulting from increased investment in care activities in the developed countries.[8] The study used input-output tables for seven high-income OECD (Organisation for Economic Co-operation and Development) countries (Australia, Denmark, Germany, Italy, Japan, UK and US) and official statistics to estimate the direct and indirect employment effects of an increase of public investment in both the construction sector and the care industries (child and social care) as examples of physical and social infrastructure respectively. It found that care investment would yield roughly double the number of jobs that investment in construction would generate. The main finding was that 'if 2% of GDP were invested in caring industries, we estimate that it would generate increases in overall employment ranging from 2.4% to 6.1% depending on the country. Nearly 13 million jobs would be created in the US, 3.5 million in Japan; between nearly 1 million in Italy to just over 2 million in Germany, and 1.5 million in the UK; 600,000 in Australia and nearly 120,000 in Denmark.'[9] Given the concentration of women in care work, the majority of jobs (between 59 and 70 percent) would be taken up by women, thereby also reducing the gender gap in employment rates in these countries. Obviously, as brought out by this study, the future potential for employment creation in the care economy will depend crucially on social and public choices determining patterns of public expenditure.

A similar study, by Women's Budget Group, for some developing countries (Brazil, Costa Rica, PR China, India, Indonesia and South Africa), has found that if only 2 percent of GDP were invested in the health and care sector, it would generate increases in overall employment ranging from 1.2 percent to 3.2 percent, depending on the country.[10] Notably, for these countries it was found that similar investment in construction would generate similar increases in employment of between 1.3 and 2.6 percent. But investment in health and care would be more effective because it would address many other concerns: 'the under-provision of affordable and high quality healthcare overall, especially for low-income people and those living in remote regions; problems linked to demographic changes including population ageing, typically associated with growing health needs; urbanisation and the erosion of extended families and family care leading to growing needs for more formal provision of child and elder care; and continuing gender inequality in paid and unpaid work.' As noted above, these in turn could reduce many barriers to women's involvement in the paid labour market, and therefore contribute to increased GDP overall.

Kim, Ilkkaracan and Kaya, in a study of Turkey using macroeconomic simulations based on input-output tables, found that expansion of the early childhood care and preschool education in Turkey would create more jobs – and do so in a more gender-equitable way – than an equivalent expansion of the construction sector.[11] Further, it would narrow the gender employment and earnings gaps, generate more decent jobs, and achieve greater short-run fiscal sustainability.

CARE AND PUBLIC POLICY

Public policy plays an integral role in determining the extent, coverage and quality of care services as well as the conditions of care workers. It is in this context that the multiple R framework has been put forward by different analysts and advocates in recent times. Originally, the triple R framework proposed by Diane Elson focused on the

8 ITUC. 2016. *Investing in the Care Economy: A gender analysis of employment stimulus in seven OECD countries*, International Trade Union Confederation, March.

9 Ibid, p. 7.

10 Women's Budget Group. 2016. *The Impact on women of the 2016 Budget*, available at: https://wbg.org.uk/wp-content/uploads/2016/03/WBG_2016Budget_Response_PDF.pdf

11 Kijong Kim, Ipek Ilkkaracan and Tolga Kaya. 2017. "Investing in Social Care Infrastructure and Employment Generation: A Distributional Analysis of the Care Economy in Turkey", *Discussion Paper No 882*, Levy Institute of Economics of Bard College, New York.

recognition, reduction and redistribution of care work.[12] A fourth component has been added by the ILO (International Labour Organization), as well as by the IDS (Institute of Development Studies), Action Aid and Oxfam:[13] the representation of care-givers in policy making. In this article I suggest adding a fifth component that should inform policy: that of rewarding care work, not only in purely financial and material terms, but also in terms of social attitudes and broader institutional support that would provide broader appreciation of its importance and simultaneously focus on improving the quality of care and easing the difficulties of such care work.

As has been suggested throughout my contributions in this articles series, the availability, quality and affordability of care services contribute hugely to current social well-being, social cohesion and stability as well as to the future health of the society and progress of the economy. Care employment is also likely to be a huge job generator in the future, particularly if it is sought to be provided as decent work engaged in by qualified professionals and rewarded as such. It would therefore provide a critical source of new jobs that also improve human welfare, in a period when other traditional forms of employment may be shrinking because of emerging patterns of technological change.

It is argued here that public policy should be directed towards the 5Rs: recognising, reducing, rewarding, redistributing and representing care work. All of this is affected not only by government regulation and public provision of infrastructure and care services, but also by the mobilisation of care workers and their greater representation in decision-making. Each of these aspects is considered in turn below.

RECOGNISING CARE WORK

This refers to the nature, extent and role of unpaid care work in any given context, taking into account social norms, gender stereotypes and power relations and discourses. The invisibility of much care work has been discussed at length in this articles series and need not be elaborated upon again; suffice it to say here that without much more comprehensive, regular and systematic employment of time-use surveys that are gender and age disaggregated, the extent of care services performed in a society and their distribution will not be amenable to estimation or measurement. And without such estimation, social recognition of the significance of care work and the degree to which it underwrites and subsidises the formal economy will not occur and policy measures to deal with this will be correspondingly constrained, limited and potentially ineffective. Therefore, for obvious reasons, this is a precondition for the other important tasks of addressing the care economy and ensuring that it plays an important positive role in future socio-economic development.

REDUCING CARE WORK

This refers to identifying ways to lower the disproportionate costs of care by investing in household and public infrastructure and integrating care concerns into the planning and implementation of labour-saving infrastructure investment projects. Provision of basic infrastructure and amenities would go a long way towards reducing unpaid care work, particularly of women. This is now increasingly recognised as an important focus of public policy, and indeed appears to be a no-brainer in terms of its significance among official goals. However, the unfortunate fact remains that because members of poor households (usually women) do undertake the work for household consumption, and because these are people who typically have less political voice whose labour is not even recognised, governments take for granted the continued social contribution of such work, and do not prioritise its reduction. This amounts to a huge, if undesirable, form of subsidy provided by the informal economy to the formal economy and social protection systems. Therefore, it is obvious that much more direct attention must be paid to all forms of physical and social infrastructure provision that would reduce the need for unpaid care performed within households and communities. These policies may be technological, or just involve more public investment in infrastructure, organisational, or relate to how public services are managed and the extent to which they rely on unpaid/underpaid labour.

REDISTRIBUTING CARE WORK

This includes challenging gender stereotypes, norms, customary law and institutions in which they are embedded but also changing economic incentives given that the opportunity costs for women to assume unpaid care roles tend to be lower than those for men. The redistribution

12 Diane Elson. 2001. "For an Emancipatory Socio-economics", paper presented at the UNRISD Conference The Need to Rethink Development Economies, Cape Town, South Africa, 7–8 September, available at www.unrisd.org

13 IDS, ActionAid and Oxfam. 2015. Redistributing Care Work for Gender Equality and Justice – a Training Curriculum, IDS/ActionAid/Oxfam, available at https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/6600

of care work can occur in a variety of ways: unpaid work within the family by gender and generation; unpaid 'voluntary' work within the community; between unpaid, paid informal and formal care services delivered by the market; between all of these and publicly provided services. Obviously affordable and good-quality public care services are the ideal form that would ensure greater equality as well as universal access. However, public provision, while critically important, is not the only way in which public policy influences the redistribution of care work in a society. As Folbre has noted: 'Virtually all welfare state policies – including taxes as well as benefits – affect the distribution of the costs of caring for dependents between rich and poor, parents and non-parents, men and women, old and young.'[14] It should be added that they also affect distribution between the differently abled and others, as well as across different social categories depending upon how various responsibilities for care work are organised.

Discussions about the distribution of care work within families also need to be sensitive to the diversity of family forms and kinship arrangements through which care is provided.[15] Filgueira, Gutierrez and Papadopoulus claim that middle-income welfare states often model a system of entitlements based on a welfare regime that assumes stable two-parent families, a traditional breadwinner model, full formal employment, and a relatively young age structure.[16] Much public policy – and even the most well-meaning of analysts – tend to be focused on the notion that care is provided within a standard nuclear family and then consider the ways in which the male-female partnership could be strengthened to share both care and paid work in an egalitarian way. But in many societies family formation is both more complex and more diverse, requiring different and possibly more flexible approaches to the internal distribution of paid and unpaid work. Thus, extended or joint family contexts are likely to have different requirements of care work and have different systems of distribution of such work, compared to single-parent semi-nuclear families, and public intervention has to be sensitive to this.

Folbre points out that most forms of social insurance are vulnerable to a double-edged sword of moral hazard.[17] Excessive emphasis on reducing dependency can punish those committed to caring for the genuinely dependent, including children and disabled family members. Efforts to discourage the formation of single-parent families can lead to an increased incidence of 'no-parent' families. Incentives to increase hours of paid work can have adverse effects on parental care of children and larger participation in community life. Policies designed to reduce the number of people receiving public assistance can hurt the deserving and eligible needy.

Social protection programmes are obviously desirable in general and more specifically in terms of enhancing care provision in a society, but they can have dual – and sometimes contradictory – impacts on both the supply and the quality of care. Insofar as they substitute unpaid family labour-based provision of care through direct public provision, or enable greater access to better-quality private care services through cash transfers, they contribute both to a reduction in unpaid labour (typically of women) and to an improvement in the availability and quality of care. However, conditional cash transfers that require effort on the part of family members (most usually mothers) can add to the burden faced by such persons who are also care providers within the home, adding to their time poverty and adversely affecting their ability to participate in the labour market. This has been found to be the case with respect to certain cash transfer programmes in Mexico and Guatemala.[18] For instance, some maternity benefit schemes have inbuilt conditionalities, which are designed to enhance the use of services or to encourage behaviour change, in the form of: minimum age (to prevent early pregnancy, usually as a result from social pressure against state support for adolescent pregnancy); institutional delivery (to

14 Nancy Folbre. 2014. *Who Cares? A feminist critique of the care economy.* New York: Rosa Luxemburg Stiftung New York Office.

15 Kate Bedford, "Harmonising Global Care Policy?'

16 Fernando Filgueira, Magdalena Gutierrez and Jorge Papadópulos. 2011. "A perfect storm? Welfare, Care, Gender and Generations in Uruguay: a Cautionary Tale for Middle Income Countries," *Development and Change*, 42(4): 1023–1048.

17 Nancy Folbre, *Who Cares? A feminist critique of the care economy*, p. 10.

18 See, for example, Elaine Fultz and John Francis. 2013. *Cash Transfer Programmes, Poverty Reduction and Empowerment of Women: A Comparative Analysis. Experiences from Brazil, Chile, India, Mexico and South Africa.* Working Paper. Geneva: ILO.

ensure safer deliveries); number of children (as part of or in coherence with national family planning policies); attendance at pre-natal checks; and post-natal monitoring visits. By inducing extra burdens and costs in accessing often very low benefits, conditionalities limit women's entitlements. Women may simply not be able to afford transport costs or waiting wards in institutions if the value of the transfer does not offset them, and even in the case that it does. In India, it is estimated that conditionalities limit benefits to 52 per cent of potentially eligible women in maternity benefit programmes.[19]

REWARDING CARE WORK

States that are obliged to treat all citizens as equal should obviously tackle the inequalities created by heavy and unequal unpaid care workloads. This necessitates a range of measures, including the enforcement of international labour standards, including those on equal pay for work of equal value, non-discrimination, maternity protection, workers with family responsibilities and social security, providing time to care (ie parental leave, sick leave) and a living wage to finance caregiving. It also requires states to provide quality accessible public services and comprehensive social protection systems.

The case of early-education teachers in Argentina[20] demonstrates that even in a care occupation traditionally identified with 'mothering' (and therefore less likely to be valued in monetary terms), working conditions and pay can improve with professionalisation and registration, with the latter being critically dependent upon both public sector provision and a strong legal framework.

However, the significance of public involvement in care activities also depends upon its nature and the attitudes of public employers. How this works, even at the bottom of the care work pyramid, is explored by Palriwala and Neetha in the context of India.[21] They compare Anganwadi workers/helpers employed in the government of India's Integrated Child Development Scheme, which is largely rural, on the one hand, with hired domestic workers in private households in urban India, on the other. The former are among the most discriminated of public sector workers: they are not even classified as workers but rather as 'volunteers' who are paid "stipends" rather than wages (and, indeed, they receive much less than minimum wages). Nevertheless, they seem to be marginally better off than domestic workers in private homes, whose conflicts between their own unpaid domestic work responsibilities and their paid work also tend to be greater. For both categories, however, the 'gendered familialism' that pervades the social undervaluation of care work is strongly evident.

Williams has noted that care policies in Europe are imbued with tension and contradiction from the perspective of those who provide and receive care support.[22] On the one hand, the last decade has seen important changes: for example, the recognition of the employment potential of those previously marginalised from paid work such as mothers and disabled people; the recognition of men's caring capacities; the rise of state responsibilities for care provision, especially in child care and early childhood education; and the recognition of family carers. On the other hand, these opportunities have been accompanied by constraints, including a sense of obligation by mothers and disabled people to find work often in the more precarious parts of the labour market; the increased commodification of care services; and the construction of parents/carers, older and disabled people exercising choice as consumers in the care market, rather than exercising their voice and rights as citizens in the public domain of care.

REPRESENTATION OF CARE WORKERS IN DECISION-MAKING

This refers to the significance of involving care providers (both paid and unpaid) in decision-making and the policies that shape their lives and those for whom they care. This can include replacing or reforming welfare state programmes that have divisive effects, such as pitting the 'officially poor' against those whose resources place them just out of range of eligibility for benefits. This requires work-family policies that facilitate and support family care-givers, expanded provision of affordable, high-quality child care and early education, greater adult care services in home and community-based settings as well as nursing homes, and improved wages, benefits, training and working conditions for child care and adult care workers.

19 Dasgupta, J., Y. Sandhya and A. Mukerjee. 2012: *The Crisis of Maternity. Health care and maternity benefits for womenwage workers in the informal sector in India*, Lucknow: SAHAYONG.

20 Ibid.

21 Rajni Palriwala and N. Neetha. 2011. "Stratified familialism: The care regime in India through the lens of child care", *Development and Change*, 42(4): 1049–1078.

22 Fiona Williams. 2010. "Claiming and Framing in the Making of Care Policies: The Recognition and Redistribution of Care," *Gender and Development Program Paper No. 13*, Geneva: UNRISD.

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Recent books

The Making of a Catastrophe: Covid-19 and the Indian Economy, Aleph Books (forthcoming 2022).

When Governments Fail: Covid-19 and the Economy, Tulika Books and Columbia University Press (2021, co-edited).

Women Workers in the Informal Economy, Routledge (2021, edited).

Never Done and Poorly Paid: Women's Work in Globalising India, Women Unlimited, New Delhi (2009).

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Care4Care Project @ feps-europe.eu

Care4Care Project @ fes.de

ABOUT THE PROJECT

It took us a global pandemic to realise that we depend on care. But despite all the clapping from the balconies, caregivers continue to live and work in precarious and vulnerable conditions. It is high time for a care revolution! We need to move away from a profit-driven model of growth to a care-driven model. In this spirit, the Foundation for European Progressive Studies and the Friedrich-Ebert-Stiftung launched a Social Democratic Initiative for the EU Gender Equality Strategy, placing the role of care work and care jobs at the center of our common activities. By raising the question "Does Europe Care for Care?", we focus on care as a cross-cutting issue and promote the cross-fertilization of progressive thinking between stakeholders across Europe. Building on our network of care experts, this Care4Care Policy Brief Series gives center stage to a long overseen phenomenon that deserves the fullest political relevance and attention. The series identifies common challenges and possible good practices across countries, whilst drawing concrete recommendations with the objective of feeding into national and EU level policy responses.

ABOUT FEPS

The Foundation for European Progressive Studies (FEPS) is the think tank of the progressive political family at EU level. Our mission is to develop innovative research, policy advice, training and debates to inspire and inform progressive politics and policies across Europe. We operate as hub for thinking to facilitate the emergence of progressive answers to the challenges that Europe faces today. FEPS works in close partnership with its members and partners, forging connections and boosting coherence among stakeholders from the world of politics, academia and civil society at local, regional, national, European and global levels. In addition to this network of organisations that are active in the promotion of progressive values, FEPS also has an extensive network of partners, including renowned universities, scholars, policymakers and activists.

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Design and Layout
pertext, Berlin | www.pertext.de

This publication series was produced with the financial support of the European Parliament. It does not represent the collective views of the Foundation for European Progressive Studies and the Friedrich-Ebert-Stiftung, but only the opinion of the respective authors. The responsibility of the Foundation for European Progressive Studies and Friedrich-Ebert-Stiftung is limited to approving its publication as worthy of consideration for the global progressive movement.

JAYATI GHOSH CARE4CARE SERIES IN ONE LOOK

Defining Care: Conceptualisations and Particularities

The Structure of Care Work and Inequalities Among Care Workers

Recognising and Rewarding Care Work: The Role of Public Policies

DISCOVER THE OTHER CARE4CARE POLICY BRIEFS

Part-time Work: Risk or Opportunity?

In this second article of the FEPS-FES Care4Care Policy Brief Series, Dr. Janna Besamusca and Dr. Mara Yerkes (Utrecht University) outline why part-time work (PTW) is inextricably linked to care and to gender. Whilst the pandemic has only contributed to increasing the already existing inequalities associated with it, the authors offer a more nuanced picture of part-time workers' profile whilst addressing the socio-economic risks and opportunities this type of employment presents. Drawing on the EU context, this policy brief concludes by outlining a set of policy measures to ensure that PTW is not synonymous with precarious and gender unequal work in a post-pandemic perspective.

Vital Yet Vulnerable: Europe's Intra-EU Migrant Caregivers

In this first article of the FEPS-FES Care4Care Policy Brief Series, Dr. Petra Ezzedine (Charles University, Prague) questions the migration angle in the face of late modern societies' chronic care shortage. Their populations are ageing, and the traditional assumption that families (and predominantly their female members) represent an unlimited, endlessly flexible reservoir of care has been challenged. There is an indisputable social need for institutions to care for elderly people and for hired domestic care workers. The author explores how the EU relies on internal predominantly female) migrants to provide much of the workforce to meet these needs. In view of how current care policies put them in a highly vulnerable labour position, this policy brief concludes with a set of short- and long-term conclusions.