FEMINIST IDEAS FOR A POST-COVID-19 WORLD

# Care After COVID-19: Time for a U-turn?

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The UN Women *Feminist Ideas for a Post-Covid-19 World* series features short think pieces by leading researchers on social and economic policy issues to inform the recovery from the COVID-19 pandemic. The think pieces were commissioned to inform a UN Women project, *Beyond COVID-19: A Feminist Plan for Sustainability and Social Justice,* led by the Research and Data team.

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# COVID-19 HAS EXPOSED A GLOBAL CARE CRISIS

The post-pandemic reconstruction period could be an ideal time to make a U-turn from a 'low-road strategy' of undervalued and precarious care work to a 'high road strategy' that provides high quality, universal, publicly-funded care services, and creates well-paid decent employment for care workers.[1] Through investing in care, as a core component of social infrastructure and employment generation, governments can be better prepared for shocks, avoid deleterious impacts on families, and enable societies to emerge intact from the next crisis. On their own, shocks do not usually result in progressive change. For the pandemic to foster a significant reorganization of care, a broad group of stakeholders must form strategic alliances with a clear vision that understands the current care crisis as a social crisis with significant fiscal implications—rather than a fiscal crisis with severe social consequences.[2]

The COVID-19 pandemic has revealed the extent to which economies rely on women's unpaid and underpaid labour. It has also exposed the fragile and unequal nature of existing care arrangements that, when under stress, place ever greater burdens on women. The persistent neglect of care by policymakers has resulted in the partial or total withdrawal of millions of women from the labour force, undermined their economic security and that of their families, increased their risk of poverty and placed greater economic pressures on men.

In terms of social policy, most governments do not recognize care as the essential investment it undoubtedly is. The result is that women and families are left on their own. Despite the overwhelming care needs created by the spread of COVID-19, as of March 2021 only 11 per cent of all social and labour market measures taken in response to the pandemic provided support for unpaid care.[3]

In the labour market, COVID-19 has highlighted the contrast between the central role played by care workers and their working conditions. Despite being labelled 'essential', they receive wages that are far from commensurate with their contribution and they also pay a gender/care penalty.[4] In most countries, the care sector continues to follow a 'low road' approach of 'cost efficiency' at the expense of working conditions and care quality.[5]

With regard to care within families, the current care regime is based on the assumption that women's time is an infinite resource. Before COVID-19, women carried out 76.2 per cent of the total amount of unpaid care work, 3.2 times more than men.[6] During the pandemic, this asymmetry has worsened with care work increasing for everyone, but more so for women and girls. Rapid assessments since the pandemic began, indicate that women are spending on average 30 additional hours per week on childcare alone.[7] Indirect care burdens are especially high where basic infrastructure is absent. In many low-income countries, where women and girls are usually responsible for collecting water, maintain their health has been even more challenging during the pandemic.

The resources that individuals and families have at their disposal to cope with this 'care shock' are unequally distributed. In the absence of collective solutions, the pandemic is perpetuating a system where the greatest costs fall on poor and lower-middle class women. Those with formal jobs and regular incomes have mostly been able to continue working remotely and 'reconcile' the increase in unpaid care through market-based solutions such as, for example, relying on poorly

paid domestic workers.[8] Meanwhile, others have been left without access to basic needs, such as food, running water and Internet access, let alone collective care services that support online schooling.

Remedying the failure to make care a collective endeavour requires placing care at the centre of post-COVID recovery efforts, which is essential if we are to withstand future economic and social shocks.

# THE PANDEMIC OFFERS AN OPPORTUNITY

In 2020, there was widespread state action to roll out emergency cash transfers, in response to the pandemic, which covered both formal and informal workers, who did not otherwise qualify for social assistance programmes.[9] Although most of these emergency cash transfers were short-lived, they potentially created momentum for a scaled up social protection system and increased expectations regarding the role of the state in safeguarding people's wellbeing, including to support care.[10]

COVID-19 has created an opportunity to make a U-turn from treating care as 'private' and feminized to an essential public investment. For this transformation to occur, the relative roles of the state, families, markets, voluntary and community provision—in other words, the configuration of care diamonds[11]—must change. Collective arrangements could take on different configurations, with the private sector expanding to encompass not-for-profit entities such as cooperatives and social enterprises.

Redistributing care responsibilities more fairly would require state and private sector support for affordable care services, increasing men's participation in unpaid care work and expanding the time employers allow for care versus paid work. Interventions to strengthen care systems include childcare benefits and tax credits, family leave and childcare and elderly care services as well as increasing the status, benefits and pay of essential workers.

Schools could be centres for afternoon care, provide meals and reach out to families that are struggling with managing care needs. A flexible and integrated approach could apply to services for both the elderly and the workforce, creatively using existing systems to adapt to local and national needs while also creating a foundation for more holistic national care systems, which have been pioneered in some Latin American countries like Uruguay and are currently underway, for instance in the Dominican Republic.[12]

A recent study of European Union countries showed that spending on care generated more jobs than equivalent spending on construction, an area usually a priority for stimulus investments.[13] Care work overwhelmingly employs women, especially women of colour and migrant women, so ensuring that these jobs are fairly paid and covered by social protection helps further gender equality and family well-being more broadly.

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## Regulation and reorganization

The call to recognize, reduce and redistribute care work is a longstanding feminist demand, first framed by the economist Diane Elson.[14]

Reward and representation have been added, to incorporate a focus on care workers. Two more recent priorities that have emerged are regulation and reorganization.

Regulation of care is key to ensure that the drive for profit does not take precedence over well-being. During the pandemic, in some countries such as Spain, the state regulated COVID-19 related health charges. However, in several countries in Latin America, in the absence of adequate regulation, private companies overcharged for COVID-19 tests, and passed positive cases onto public or social insurance services, even while they benefited from increased demand for non-COVID-19 healthcare, due to longer wait times in over-burdened public facilities.

Inadequate regulation has long had a negative impact on the working conditions of care workers, but during the pandemic this has had deadly consequences, particularly among those caring for older persons. In the United Kingdom, for example, residents in long term care facilities for older persons had high 'excess mortality' during the pandemic (45.9 per cent up on the same period the previous year) while their care assistants, cooks and cleaners had twice the risk of dying as the general population. Many years of neglect of elderly care, austerity and weak state oversight explain the inadequacy of the response.[15] In the United States, lack of such regulation meant that contractors managing elderly care homes received government stimulus funds but failed to pass that on to their workers through increased compensation or additional staffing.[16]

The current patchwork of disparate services that are either unpaid or poorly paid cannot withstand another shock such as the pandemic. A step change in the organization and coordination of care to protect workers and ensure quality services is thus essential. While there is a range of approaches for the reorganization of care, which varies by national income level and whether the state or informal social policy regimes predominate, there are many pathways to an improved care system.[17]

While the state has a critical role to play in care provision, organisation and coordination, these policy pathways can go beyond state-sponsored solutions. This is an important possibility in contexts where state capacity itself may be weak. Informal worker organizations, for example, have taken childcare matters in their own hands, setting up cooperatives to respond to the needs of women waste pickers (in Belo Horizonte, Brazil), handicraft workers (in Villanueva, Guatemala), self-employed workers (in Ahmedabad, India) and market traders (in Accra, Ghana).[18] During the pandemic, community care practices have adapted and included workers in primary care, day care and food banks. Some efforts are built on previous community and feminist organizing; others are recent responses to the crisis. In Argentina, for example, pre-existing community-based kindergartens in the metropolitan district of Buenos Aires made additional hours available for overstretched parents, including material to distribute to each family and – with all its limitations – remote, virtual care services during the pandemic.[19]

While community solutions can work well as part of a well-regulated and coordinated care system, it is currently more common for them to be part of a 'low-road' approach to care work that exploits unpaid or underpaid female labour. Such practices can mean labelling community-based workers as 'collaborators' rather than staff and their payments as 'compensation' or 'incentives' rather than salaries. The 900,000 female Accredited Social Health Activists (ASHA) workers in India are one example of this unsustainable and inequitable practice. These women are on the frontlines against COVID-19, unprotected and largely unrecognised, with their own multiple care responsibilities ignored, furthering inequality among care workers and care recipients.[20]

There is potential, however, in harnessing bottom up/meso level action by community workers in ways that are coordinated and overcome fragmentation. Along with broad coalitions of other social and state actors, their voices and organizing have the potential to put pressure

on governments to invest, equip and formalize their working conditions. One such example is legislation pushed forward by civil society associations in Argentina that aims at creating the notion of 'community worker', establish salaries and ensure social protection.[21]

Such measures could make community organizations part of a 'high road' strategy by tying policy architectures together into a coherent system, regardless of the providers. Care systems that are woven throughout societies might use diverse and multiscale entities, including communities and locally run organizations, as long as they retain a commitment to common and collective interests. In fact, in countries where people distrust the state, reliance on non-state actors might provide a bridge to gradually build such trust – for instance, by explaining in indigenous languages how to access to state transfers and services.

One challenge is how to unify criteria around decent work and quality care. The more unified the 'architectures' involving working conditions, funding, benefits and quality assessment, the more likely they are to result in universal and equalizing solutions.[22] Regardless of public or private providers, regulation of stakeholders with the guiding principles of ensuring well-being and quality and restructuring to make the voices of caregivers and care recipients central is critical for workers to receive fair treatment and remuneration. Adopting such principles would, in turn, create more stable services with higher staff satisfaction and lower turnover.

## New actors and alliances are needed to shift to a high-road strategy for care

On their own, shocks do not necessarily lead to progressive change. In the case of gender norms at the individual and family level, a lockdown could make some men more willing to take on care work, while leading others to prioritize their work time and space.[23] At the policy level, for the pandemic to foster a significant reorganization of care, a broad group of stakeholders must form strategic alliances with a clear vision on what needs to change and how.

National pacts around policy measures involving multiple stakeholders could move care work beyond existing silos to a more prominent position on the policy agenda. Feminist researchers and activists must build ties with policymakers, small scale community and not-for profit providers, and care workers, infusing care into policy discussions around such disparate sectors as renewable energy, sustainable development, labour sector reform and fiscal policy. Social actors with different but overlapping interests in relation to care need to come together and find common ground and build joint agendas: for example, workers' organizations would want to address poor pay and conditions in the care sector; children's rights organizations would be especially motivated by training and skills of workers, to support quality of care provision; organisations of rural people would prioritise investments in basic infrastructure and locally owned renewable energy technologies to reduce the drudgery of care work; and feminist organizations would reach out to informal workers to incorporate care into a larger demand for social protection. Such joint organizing and agenda-setting could unite low- and middle-income women and their constituencies, often from ethnic and racial minorities.

The 'high road' of quality care and fair pay for care work requires strong political links and organizing among care sector workers and between care workers and care recipients.[24] The common ground is the tight link between working conditions and care quality. This trajectory requires alliances between formalized health or education sectors and less formalized childcare and community health workers. Other workers struggling to reconcile work and family could also ally with the high-road strategy. Worldwide, cost-cutting and fiscal tightening has made it more challenging to demand such basic rights as paid maternity leave,[25] let alone the broader agenda of collectivizing the costs of care work.

The experience of the pandemic provides the opportunity to transform care work from a responsibility defined as solely private to a collective organization in the context of the value chain. In care-centred economies, employers all along the value chain would acknowledge that without care work they cannot succeed, so that entities with the greatest profits contribute to the financing of care work. The most powerful actors in the chain would then avoid the 'low-road' strategy of cutting back costs and passing them on to those less powerful.[26]

While increased public investment is critical to solving the care crisis, expansionary efforts must counteract state weaknesses and corporate influence, and avoid channelling rescue packages and fiscal measures to the benefit of large corporations, rather than those hurt by the pandemic.

Taking stock of the pandemic's winners (e.g., medical suppliers, e-platforms, billionaires) and many losers (e.g., micro and small businesses in the service economy) also gives renewed urgency to better structure rescue packages away from a simplistic public/private divide to more meaningful distinctions among private actors—including micro and small businesses, the social economy and not-for-profits.

Care advocates will need to rely on social pressure as much as on state actors capable of mobilizing domestic resources, particularly in middle-income countries. Low-income countries could fund their efforts with a mix of domestic funds and international flows. For this to happen, it is critical to make incremental change with a clear, longer-term strategy to transform national care systems. For instance, countries could respond to the urgent need for care services by reaching poor and middle-income families alike. The state could fully finance public services for those most in need, with co-payments for the better off. These co-payments need not be obvious to providers but would help finance the same services for all the children involved. Although coverage would not increase significantly overnight, creating shared interest among wealthier people with greater political and social 'voice' to demand quality services creates the foundation for expansionary incremental change, which is much harder to achieve when services focus on the poor alone.

A positive pathway could emerge from 'Trojan horses' that take small steps containing incentives for other measures to follow. Who is reached first has long-term implications. The expansion of Costa Rica's social security provides an example: As far back as the 1940s, expansion started from low-income salaried workers to later reach well-off workers and the poor. Partly due to the quality services, this architecture, though not an initial policy declaration, set the stage for a universal trajectory. On the other hand, social insurance systems in other countries with robust arrangements, such as Chile or Uruguay, emanated from white-collar workers who had no incentive to reach out down the social ladder.[27] Targeted early childhood education and care services that were created in Latin America during the 2000s have proved vulnerable to austerity measures and state retrenchment. The lack of universality in provision of these services means that there are not broad class coalitions to defend their maintenance and quality.

Naturally, the challenges depend on whether countries have high or low state capacity in terms of control over the national territory, bureaucratic resources to design and implement measures and the capacity to extract revenues. However, state capacity is an ongoing process and not a pre-condition; it can be built simultaneously as states enter new terrain.

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## Care and the green economy

The undervaluing of care is analogous to the undervaluing of natural and environmental resources, with both the care and climate crisis shifting costs to future generations.[28]

Failing to support care creates hardships for women and their families while undervaluing the natural world leads to extractive industries, unsustainable farming and industrial practices that contribute to climate change, poor health outcomes and destruction of species. Women who are small-scale agricultural producers face the dual pressures of climate-induced decreases in crop yields and their care responsibilities. Restructuring to account for the true value of care and planetary resources requires change in policies, behaviours and values at all levels.

Could the movement for increased investment in care work join forces with the movement for investments in a green economy? At the moment, the policy responses to care and the environment are mostly operating in parallel. Framing investments in the collective reorganization of care as another facet of sustainability would ensure that future stimulus packages and growth plans address current distortions. Incorporating care responsibilities into these efforts would allow women to participate in the green jobs related to renewable energy, sustain their families and meet care responsibilities. Both agendas could cohere around a quality of life that does not require hyper consumption or methods of production that are energy intensive and polluting. One collective solution might be for some people to do less paid work and for everyone to have more time to spend on unpaid care and community service – ironically modelling what is currently more typical of low-income women and their families.

A radical plan to put care at the centre requires bold ideas and far-reaching intent for system change in incremental steps. In a small number of European countries, often cited as the best-case scenarios like Finland, Denmark, Norway and Sweden, but also continental Europe like Germany or France - there were strong foundations for care pre-pandemic. At the other extreme are situations where the state is weak or where care is invisible and not considered an area for state investment. Political will is key. Even in well-resourced countries such as the United States, it will be challenging to shift from a mindset where care is a benefit to individuals, to one that recognizes care as a foundational investment.

## Care at the crossroads: reorganize now or lose ground for decades to come

COVID has revealed the fragility and unsustainability of our economies and societies when we fail to value care. Returning to the old structures is not only unjust but self-defeating, as the next shock could lead societies to collapse. Redressing the weaknesses created by ignoring care requires taking multiple policy measures aimed at an overarching reorganization of care to achieve results that lead to favourable social outcomes. Success requires diverse pathways, unconventional alliances and an expansion of our definitions of essential infrastructure, transfer and services; economically valuable work; and men's roles. Feminist perspectives provide a shared understanding of how a care-centred future would be constructed; the main challenges revolve around how to do it and the political economy of change.

Incorporating care-centred policies as a key part of the effort to rebuild our economies will allow people to withstand the next crisis more successfully, increase welfare and well-being and prevent a drastic reduction in female employment. Changing this course requires down-to-earth analysis, avoidance of sugar coating and, above all, regulation and reorganization of the care work already occurring.

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