Research Paper

Learning from COVID-19: How to Make Care Central to Economic Policy Around the World

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About the Grand Challenge

Inequality and exclusion are among the most pressing political issues of our age. They are on the rise and the anger felt by citizens towards elites perceived to be out-of-touch constitutes a potent political force. Policymakers and the public are clamouring for a set of policy options that can arrest and reverse this trend. The Grand Challenge on Inequality and Exclusion seeks to identify practical and politically viable solutions to meet the targets on equitable and inclusive societies in the Sustainable Development Goals. Our goal is for national governments, intergovernmental bodies, multilateral organizations, and civil society groups to increase commitments and adopt solutions for equality and inclusion.

The Grand Challenge is an initiative of the Pathfinders, a multi-stakeholder partnership that brings together 36 member states, international organizations, civil society, and the private sector to accelerate delivery of the SDG targets for peace, justice and inclusion. Pathfinders is hosted at New York University's Center on International Cooperation.

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Scenes of healthcare workers at Thailand Bamrasnaradura Infectious Disease Institute, Ministry of Public Health. Photo Credit: UN Women/Pathumporn Thongking (CC BY-NC-ND 2.0).

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Summary

After decades of neglect, the COVID-19 pandemic has made visible the vital role that the care economy plays in the functioning of economies and societies—and highlighted the deep crisis at the heart of it. Care recipients and providers of care have been on the COVID-19 frontlines, and the ability of governments to mount an effective response to the pandemic has been hampered by decades of policies that undervalued and neglected the care economy.

Several factors have combined to create this perfect storm.

Globally, care needs have been on the rise for some time, and funding has failed to keep up. In many contexts, market-driven approaches have resulted in fragmented sectors, particularly around social and elder care, seeking to drive down labor costs. The result is high levels of unmet need and poor working conditions for the largely feminized workforce.

Beyond the paid care sector, and partly because of its inadequate reach, women continue to bear the disproportionate burden of unpaid care, carrying out 76% of all unpaid care work. This reduces opportunities for paid employment, further exacerbating gender inequalities, and is a trend that has only intensified in the course of the pandemic.

Thriving economies and societies depend on care in all its forms. It is imperative that economies and societies rebuild better, with care at the centre of their recovery plans. Prioritizing the care economy will pay dividends not only for those in need of care and those that provide care, but also help to build stronger economies and more equal societies. Investment in the social infrastructure has been demonstrated, time and again, to deliver employment and fiscal benefits as well as to promote gender equality and social inclusion. It is also consistent with the need to reduce our carbon footprint and move to greener economic models.

This paper sets out six key steps for building sustainable and thriving care economies:

- Make visible unpaid work in headline economic indicators to ensure that caring work recieves due recognition and comes to the attention of social and economic policymakers.
- Redefine spending on care as “investment” rather than “expenditure,” in recognition of the long-term dividends that investment in care yields, including its employment and fiscal benefits.
- Develop ongoing, sustainable funding to invest in care, including from novel financial instruments, to ensure that provision is adequate to meet needs.
- Recognize the value of unpaid care work and encourage a more equal gender distribution in order to reduce the burden on women and promote gender equality.
- Transform paid care work to provide decent pay, conditions, and standards in recognition of the value that caring provides to all of us.
- Reframe the care debate to put care at the heart of the economy and society in order to build a political consensus to support the care economy.

With our dependence on the caring economy more visible than ever, there is considerable public support for such measures. This has created a unique political opportunity to fix the care crisis and leave a positive legacy for future generations.

1. Introduction

The COVID-19 pandemic has ensured that the significance of the care economy, and the crisis within it, can no longer be ignored. While social policy analysts and feminist economists have been concerned with the increasing challenges of care activity for some time, mainstream institutions and social and economic policy makers largely ignored the care economy until the onset of the pandemic. Yet supporting and delivering appropriate care—for infants and children, for dependent family members, for adults with disabilities and for frail older people—is important for several reasons:

- Firstly, it is a **moral and ethical imperative**. Without the appropriate care at all stages of our lives, it is impossible to build inclusive and sustainable societies. It is a human right to be cared for in an appropriate manner at all stages of our lives.
- Secondly, **without a range of care activities, economies would not function**. The care economy is key to the social reproduction of societies.
- Thirdly, the international community's commitment to **gender equality, social inclusion, and sustainable development, as laid out in Sustainable Development Goals (SDGs) 5, 10, and 16, cannot be fulfilled without thriving care economies**.

In short, the care economy is vital to the functioning of economies and societies. However, it is also in deep crisis and, in its current state, is actively contributing to inequality and social exclusion. Even before the pandemic, care needs were rising globally and there were high levels of unmet need. Care work, whether paid or unpaid, has consistently been undervalued. Its burden has fallen, and continues to fall, disproportionately on women and those that are marginalized within societies, including migrants and minority ethnic groups. Care recipients and those delivering care have been on the frontlines of the pandemic. Urgent action is required to enable a thriving care economy that ensures the well-being of all people and allows everyone to maximze their capacity, regardless of their age and (dis)abilities.

This discussion paper maps out the necessary steps to transition to a caring economy in which care is central to the way economic and social life functions.

It is structured as follows:

Section 1 presents the main features of the care crisis

Section 2 describes the impact of the COVID-19 pandemic on the care economy

Section 3 sets out key recommendations for building a caring economy.

Box 1: What is the care economy?

The care economy is generally understood to comprise a range of activities, actors, and sectors. Care work is undertaken in both the paid and unpaid economy, and is delivered by a range of providers in the formal, informal, and household sectors. It includes childcare, early childhood education, disability and long-term care, and elder care. There is significant overlap and interconnectedness between different kinds of care services, providers, and activities.[1] Care work is increasing worldwide, and that it often disproportionately falls on women and girls.

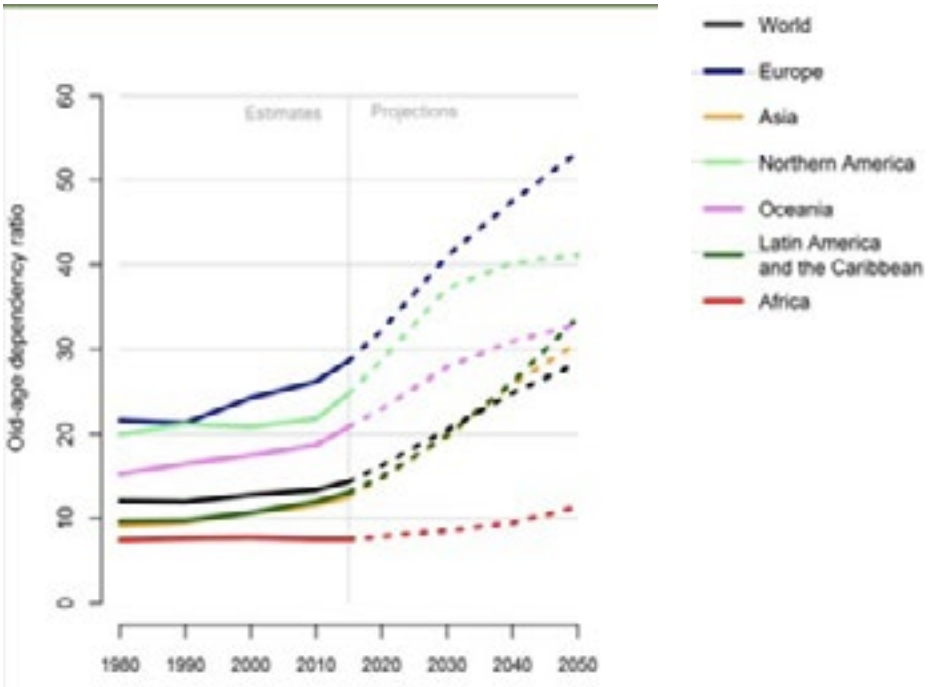
2. Features of the Care Crisis

The crisis in the care economy shares several common features across a range of national contexts.

Growing demand

The rapid process of demographic aging, which results in a growing number of older people requiring varying degrees of care, means that elderly care is now one of the most pressing concerns many countries face.[2] This is not only the case in the industrialized economies of the world, but also increasingly so in low- and middle-income countries, which are also experiencing population aging as a result of improved life expectancy and reduced fertility. The combination of increased life expectancy and declining birth rates means that there is a shrinking working population to support the larger numbers in need of care. This trend leads to an increase in the Old Age Dependency Ratio (OADR), which is the proportion of the population aged 65+ relative to the working age population (20 to 64 years). Figure 1 depicts the OADR by region from 1980 (estimated) to 2050 (projected), and clearly shows that it is increasing globally.

Figure 1: Old Age Dependency Ratio (Source: United Nations, 2017)[3]



These demographic changes in life expectancy and birth rate have been accompanied by changes in family structure, population mobility, and increases in women's economic participation rates. Together, these shifts have combined to further increase demand for paid care not only for older family members, but also for pre-school aged children and those with disabilities, which in previous eras might have been carried out by family members and local relatives. The International Labour Organization (ILO) estimates that in 2015, there were 2.1 billion people in need of care.[4] By 2030, the number of care recipients globally is expected to increase to 2.3 billion.

Hidden (women's) work

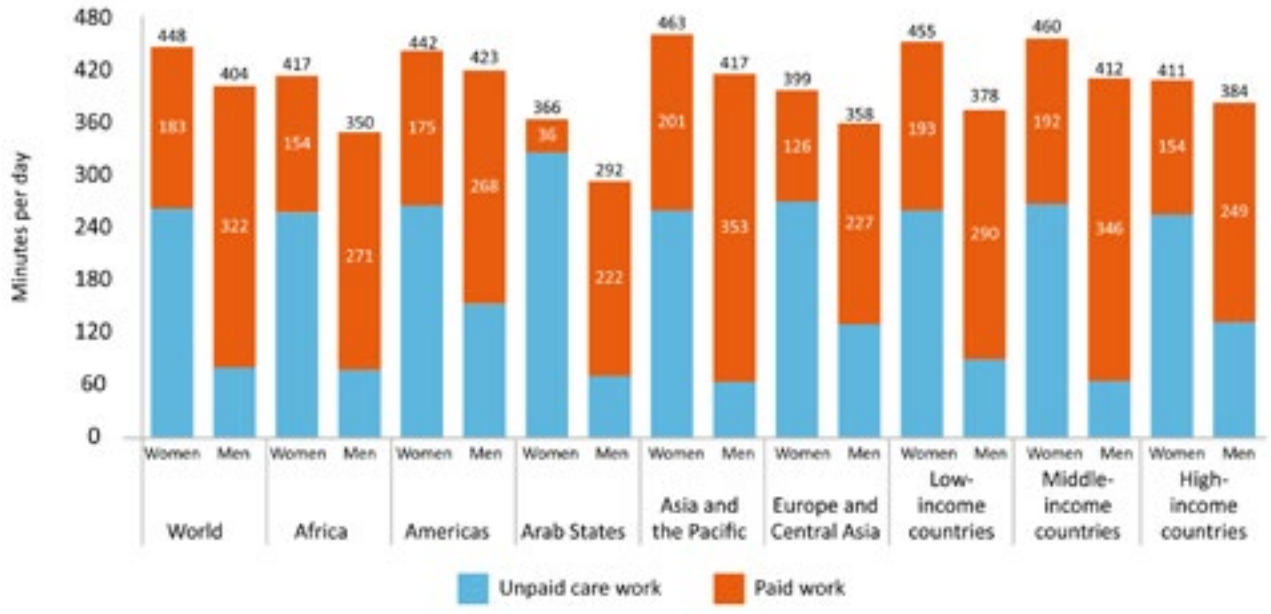
The rising levels of need are compounded by the invisibility of many forms of care work. In addition to elderly care and care for those with disabilities, caring activity includes the care of infants and children, as well as everyday domestic activities such as cleaning, washing, and food preparation. Much of the latter—and some of the former, when it is unpaid or in the informal sector—remains largely hidden from view despite its crucial role in the economy.

Unpaid care work is defined as work provided without a monetary reward by an unpaid carer, and includes three kinds of activities: domestic labor for own use within the household; caregiving services for household members; and community services and help to other households.[5] The economic contribution of unpaid care workers is roughly estimated at $10 trillion per year, or around 13 per cent of global GDP.[6] There has been no systematic effort to incorporate unpaid work into national income accounts, leaving its contribution to economic activity and growth largely ignored by policymakers.

There is also a distinct gender dimension to the distribution of unpaid work. Globally, women perform around 76.2% of such work, more than three times the average for men.[7] Based on time-use data from 67 countries covering 66.9% of the global working-age population, the median time spent daily on unpaid caring by women is 4 hours and 29 minutes, compared to 3 hours and 20 minutes for men.[8] While helpful for summarising the global picture, these median values hide considerable variation among country contexts. No country has a gender equal distribution of unpaid work, but the Northern European countries come closest, with men in Sweden, Norway, and Denmark performing 44.7, 43.9, and 43.4 per cent of the total, respectively. The lowest share of unpaid work undertaken by men is in Mali, Cambodia, Pakistan, and India, where men perform 8.0, 8.7, 8.9 and 9.5 per cent respectively.[9]

Unpaid caring work has implications for the take-up of paid employment, contributing to women's reduced labor force participation. Caring responsibilities exclude high numbers of women from participating in the waged labor force either at all, or to the extent they would like. Thus, while unpaid care is often seen as "costless," this perspective neglects the depleting effect of such activity on those who carry out care. Figure 2 summarizes women's and men's involvement in paid and unpaid work by region. It is noteworthy that women not only undertake less paid work as a result of their unpaid care work, but that their entire working day is longer than that of men. The disparity is most apparent in low-income countries.

Figure 2: Time spent daily in unpaid care work, paid work, and total work, by sex, by region and by income group[10]



The unequal distribution of unpaid care work was recognised in the SDGs, with target 5.4 calling for public policy measures to lighten the overall burden on families, as well as for the redistribution of unpaid work within the family and household.

An undervalued and feminized paid workforce

The lack of value given to unpaid care work carries over to paid caring work. In many contexts, the paid care workforce is highly feminized, low-wage and poorly regulated. Moreover, migrant and minority ethnic workers are also overrepresented in the care workforce in developed countries.

The ILO defines paid care work as "care work performed for profit or pay within a range of settings, such as private households (as in the case of domestic workers), and public or private hospitals, clinics, nursing homes, schools and other care establishments."[11] This category includes a wide range of personal service workers, such as nurses, teachers, doctors, and personal care workers, including domestic workers. Using this inclusive definition of the care sector, the paid care workforce is estimated to represent 11.5% of total global employment.[12] Approximately two-thirds of the global care workforce are women, and this proportion rises to over three-quarters in the Americas and in Europe and Central Asia. Care work accounts for 19.3% of total female employment, compared with 6.6% of global male employment.

Whilst some professionalized sectors of the care work force—particularly those in health and education settings—are organized and relatively well paid, those delivering personal care in residential settings and in people's homes typically receive low wages, experience poor working conditions, lack job security, and have little opportunity to attain qualifications or pursue positive career paths. The pandemic has made the poor working conditions of the elder and social care workforce in particular newly visible.

Domestic workers often have the highest degree of precarity and the lowest pay, and in many instances experience casual and unpredictable employment relations with no formal contract sor working time restrictions.[13] They account for at least 2.1 per cent of total global employment, with some 70 million domestic workers employed by households across the world. Of these, 49 million (70%) are women, and 21 million (30%) are men. Domestic workers are often "hidden"—unregistered and beyond the reach of labor protection systems—and there is evidence that this makes them vulnerable to violence from employers. Many are also migrants, which makes it more difficult for them to claim rights or protection outside of their regions or countries of origin.

A (global) justice issue

Economic trends such as growing inequalities between high- and low-income countries and the insecurity, vulnerability, and instability caused by economic crises have combined with gender-related factors (e.g. abuse, family conflict, and discrimination) to increase the numbers of women who migrate in order to obtain paid work.[14] Remittances have become key not only for households and communities, but also for a number of developing-country governments, which have promoted labor export in order to earn foreign exchange to offset debt.

Transnational migration of low-wage migrant carers from poorer countries has been termed the "Global Care Chain."[15] Originally coined to describe the pattern of migration in which women leave their own families in developing countries to care for children in higher-income countries,[16] it has now been extended to include transnational care workers involved in elder care[17] and other forms of caring work such as health, educational, sexual, and religious care.[18]

It is estimated that by 2015, there were some 11.5 million migrant domestic workers, accounting for 17.2 per cent of all domestic workers globally.[19] Of these, almost 80% were found in high-income countries, where they represent almost two thirds of all domestic workers in those countries.

3. Impact of the COVID-19 Pandemic on the Care Crisis

The COVID-19 pandemic has starkly revealed the central role of both paid and unpaid care work in economies and societies, as well as exposed the inequalities in how care work is distributed.[20] At the same time, the pandemic has further exacerbated the care crisis, increasing the demand for care with a disastrous impact for those with unmet care needs, as well as a disproportionate impact on the women who are more likely to be providing (paid and unpaid) care.

Exposing the failure of market-driven care

In many places, with the exception of some northern European countries, COVID-19 has exposed the failure of market-driven systems of elder care and social care that were already plagued by staff shortages and safety issues even prior to the pandemic.[21]

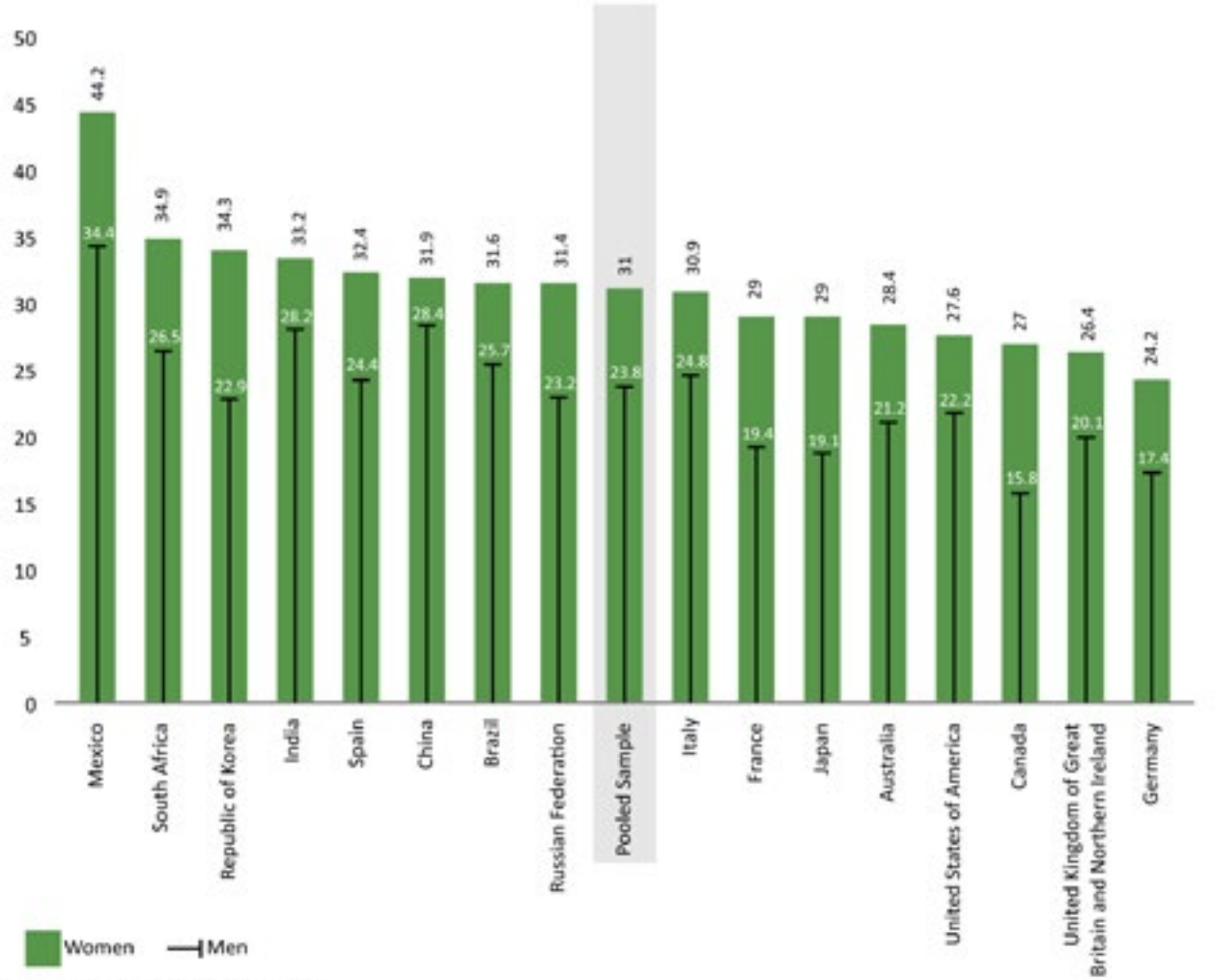
Stretched long-term care providers struggled to mount an effective response to COVID-19. Moreover, the fragmented nature of the care economy in countries with market-driven approaches—where care is delivered by a range of private and public providers—also meant that it was difficult to achieve a coordinated response. As a result, there were workforce and PPE shortages, as well as insufficient testing, in many settings. Further, the lack of value ascribed to social and elder care often meant these settings were deprioritized relative to healthcare settings, when decisions were made around resource allocation and about the discharge of potentially infectious patients from hospital.[22] Combined, these factors meant care homes were on the frontlines of the pandemic in many countries, with significant impacts on residents and staff. In the UK, for example, some 40% of all COVID-19 deaths during the first wave (mid-March 2020 to mid-June 2020) occurred in care homes, and there were 35,067 excess deaths among care home residents over the same period.[23] In France and Belgium, it is estimated that half of COVID-19 deaths occurred in care home settings.[24]

Increasing unpaid care, especially for women

Since the beginning of the pandemic, there has been an intensification of unpaid care work. In a number of countries, the pandemic has led to parents having to take on tasks such as home schooling and childcare as facilities closed during lockdowns. Others have continued care for elderly or disabled family members without the support of community facilities, or taken on new roles to avoid the risks of infection and isolation in residential facilities.

While unpaid care has increased for both men and women as a result of COVID-19, the increase was greater for women. Figure 3 sets out results of survey research for UN Women that looked at hours spent on childcare by men and women in 16 countries.[25] Similar findings extend to other types of unpaid care.

Figure 3: Average hours spent per week on childcare during COVID-19 pandemic, by sex (Source: UN Women 2020)[26]



Source: Ipsos poll fielded 22-15 October 2020.

Note: the sample size for the poll is 14,509 individuals aged 16 to 74 from 16 countries: Australia, Brazil, Canada, China, France, Germany, India, Italy, Japan, Mexico, Russia, South Africa, South Korea, Spain, United Kingdom. The age group for Canada and USA was 18 to 74 years. Childcare responsibilities were proxied by specific tasks and activities such as physical care of children, overseeing them and teaching and remote learning. The hours spent in childcare prior to the pandemic and during COVID-19 was collected using a seven-point scale: 0 hours per day; 1-2 hours per day; 3-4 hours per day; 5-6 hours per day; 7-8 hours per day; 9 hours or more per day and not applicable. The data presented in the figure are only for women and men who reported spending any time in childcare - a sub-sample of 8,000 individuals.

Unsurprisingly, this situation has led to knock-on effects for employment and earnings. More women than men have given up paid work due to childcare pressures.[27] There are indications that this has contributed to a rise in female poverty. UN Women estimates that by 2021, COVID-19 will have pushed an additional 47 million women and girls into poverty.[28] Female-headed households are often those hardest hit, since they tend to be larger, dependent on fewer adult earners, and less able to access credit or other productive inputs.

Exposing inequalities in care workforce

Workers in elder and social care settings, particularly those delivering direct personal care to older people and those with long term illnesses and disabilities, are often employed on the margins of labor regulation regimes. The pandemic highlighted both the composition of the care workforce, and the conditions under which they work, which have also led to new pressures on those workers.[29]

In most national contexts, “essential” social care workers are drawn from the most marginalized groups in society—Black and minoritized communities, migrants, undocumented workers, and unorganized workers—and often paid

at, or below, the minimum wage.[30] Evidence from the UK, Europe, and North America indicates that these long-term care workers were disproportionately exposed to infection and suffered high levels of morbidity and mortality.[31] In the UK, the highest mortality rate of any occupational grouping during the first lockdown was "caring, leisure and services,"[32] and within this group, care workers and home carers saw the highest rates (more than twice as high as those of doctors and nurses).[33] Nguyen et. al. found that Black and minority ethnic health and care workers in the UK and USA had a five-fold increase in COVID-19 risk compared to the general community, whereas non-Hispanic white workers faced a three-fold increase.[34] Black and minority ethnic workers were also more likely to report inadequate PPE or reuse of PPE.[35]

In developing countries, the majority of workers in designated "essential" occupational categories were excluded from limited social protection schemes, and many were compelled to continue working to meet household survival needs even when sick, in spite of the risks to their health and that of their families. There were also examples of reprisals against health and care staff who spoke out about unsafe working conditions.[36]

Revealing limited scope of gender-sensitive policymaking

The pandemic also exposed that policymaking is still too often undertaken in a gender-blind way. This meant that while some policy measures sought to mitigate the unequal impacts of the gendered care economy (see Box 2), the majority did not.

Data collected by the United Nations Development Programme (UNDP) and the UN Women COVID-19 Gender Response Tracker, which monitors the extent to which governments' responses to the global protection have taken into account women's needs, reveal that only one in eight countries worldwide have measures in place to protect women against social and economic impacts.[37] The tracker examines measures across three domains, those that tackle violence against women and girls (VAWG), support unpaid care, and strengthen women's economic security. Only 25 countries have introduced measures that cover all three areas. These may include the provision of helplines, shelters, or judicial responses to counter the surge in violence against women and girls during the pandemic, cash transfers directly targeted at women, and the provision of childcare services or paid family and sick leave.

Regional disparity is very marked, as shown in Table 1, which provides a breakdown of measures by domain and region. In the African region, for instance, 212 out of 539 measures were gender sensitive. However, only 10 were directed at unpaid care, compared with 117 concerning VAWG and 85 aimed at women's economic security. Europe was the region with the highest number of measures tackling unpaid care. These mainly took the form of parental leave and financial support for parents, or direct support for vulnerable children (see examples in Box 2). Unfortunately, the majority were temporary measures that have now ended, and the challenge is now to ensure permanent improvements in the economic position of women and carers.

Table 1: COVID-19 measures by region, gender sensitivity, and type[38]

Region	All Measures	Gender Sensitive	Unpaid Care	Violence Against Women	Women's Economic Security
Africa	539	212	10	117	85
Americas	752	360	42	223	95
Asia	770	281	25	184	72
Europe	908	361	91	242	28
Oceania	143	85	12	66	7
Total	**3,112**	**1,299**	**180**	**832**	**287**

Box 2: Examples of gender-sensitive COVID-19 measures that address unpaid care

Canada provided an Emergency Response Benefit for parents with children who are unable to earn income due to their daycare provision being closed. This was set at $500 per week and was available for a limited time from March 2020 to October 2020.

Brazil temporarily doubled the benefit entitlement of single mothers from April 2020 to December 2020.

Argentina introduced a number of initiatives, including a scheme that provides minimum wage for six months to women leaving relationships due to domestic violence.

Uruguay implemented a one-off doubling of Family Allowances under the Equity Plan, which was paid in April/May 2020 and benefitted 118,000 households.

Finland provides full cover for parental loss of income where children are placed under quarantine, leading to an absence from work. This is done with a sickness benefit payment via Kela, Finland's social security system.

Sweden introduced a temporary benefit for parents who have to stay home to care for children. This was set at 90% of their usual income, and is currently available until 30th September 2021.

Cook Islands provided a temporary additional child benefit payment of $100 during the school closure.

South Africa increased the Child Support Grant, which is paid for around 12.5 million children, by R500 ($26) per month for the period from June 2020 to October 2020.

India provided 500 rupees ($6.50) a month to 200 million vulnerable women between April and June 2020.

4. Towards a Caring Economy

The experience of the pandemic has made visible the fact that economies are as much predicated on reproductive activities as on productive and financial ones.[39] As economies and societies emerge from the pandemic, building back better will require a focus on providing solid foundations to the caring economy.

Most fundamentally, this will require a rearticulation of the goal of economic activity to be concerned, first and foremost, with ensuring the well-being of all people, and the maximization of the capacity of every person, regardless of their age and (dis)abilities. Recognizing the value of care to the economy is the first step in prioritizing it within policymaking.

Beyond this high-level goal, there are a number of specific measures that can foster the development of solid foundations for the caring economy within country contexts, as well as globally. These follow the call from UN Women, echoed most recently by the Gender Equality Forum, to "recognize, reduce, and redistribute,"[40] and are set out in this section as a series of policy recommendations around three core objectives:

- Redefining economic measures, reforming national accounting practices, and securing resources for investment in care
- Transforming paid and unpaid care work
- Creating the political momentum to support the care economy

However, given the significant variation in how care is organized in different national contexts, as well as their varying fiscal resources, we recommend that as a first step, countries establish a "National Care Commission" that can investigate the implementation of these recommendations in the national context (see Box 3 for more detail on establishing a National Care Commission).

Box 3: Establishing a National Care Commission

National contexts vary significantly not only in terms of the fiscal resources at a country's disposal, but also in terms of how care is currently organized across paid/unpaid and formal/informal sectors. Moreover, institutional contexts also vary considerably.

For this reason, it is vital that each country establish a National Care Commission to bring together key stakeholders from the public, private, and non-governmental sectors with the task of devising a plan for an integrated care system.

The role of such a Commssion should include:

- Mapping care needs across the life-course, and how these are currently met through paid/unpaid caring (including gender distirbuton)
- Identifying ways of achieving a more equitable distribution of caring that better meets needs, with a focus on the UN's "3Rs": **Recognize** and reward of care; **Reduce** the burden of caring; and **Redistribute** caring between men and women as well as between the paid and unpaid sectors.
- Map how improvements to the caring economy will be achieved, including plans for funding, legislative changes, and institutional change.

Redefining economic measures, reforming national accounting practices, and securing resources for investment in care

To build a strong caring economy that fosters well-being, the value of care needs to be recognized at the heart of economic governance: in economic measures and with regards to how "investment" and "expenditure" are defined in national accounts.

Recommendation 1: Make unpaid work visible in headline economic indicators

In almost all countries, the most important economic indicator is the Gross Domestic Product (GDP), which measures the market value of output. Most governments aim to maximize the growth of GDP, in the belief that this will increase living standards. However, today, economic growth is not correlated with improvements in well-being, but instead is associated with rising inequality and severe environmental degradation. Moreover, the focus on GDP as a measure of economic output renders unpaid work invisible, even though the evidence from all over the world demonstrates that the visible paid economy could not function without it.

Despite decades of research to develop alternative measures, such as the Genuine Progress Indicator (see Box 4), there has been no systematic effort to shift away from GDP or to find another way meaningfully incorporate unpaid work within national accounts. Economic indicators matter because ultimately these are what policymakers work towards. Until unpaid work is counted in national accounts and headline economic measures, it is unlikely to receive the attention it needs from policymakers and politicians. Experience has also shown that the creation of separate satellite accounts for unpaid work, as occurred in the UK for example, and well-being measures, as trialed in New Zealand, have had little impact on economic policymaking. The replacement of GDP would not need to occur in all countries at the same time, but it is likely that if influential economies made the switch, others would follow.

Box 4: Genuine Progress Indicator and the limits to GDP

The Genuine Progress Indicator (GPI) is a metric designed to take fuller account of the well-being of a nation. It starts with gross output (as measured by GDP) and then adjusts this figure by adding in positive externalities, such as unpaid labour, and subtracts negative externalities, such as income inequality and environmental degradation. The result is a single number much like GDP. For this reason, it has been suggested as a direct replacement for GDP that more accurately reflects progress towards societal well-being and environmental sustainability. The specific design can be adapted for different circumstances and related indicators, such as the Index of Sustainable Economic Welfare (ISEW), have been developed. GPI and ISEW calculations have been undertaken for a number of economies by thinktanks and academics to demonstrate their workings in practice.

For a good summary of these, see Tim Jackson and Nat McBride's 'Measuring Progress?' here: https://www.surrey.ac.uk/sites/default/files/2018-03/11-05-measuring-progress-final.pdf

In addition, the US State of Maryland used the GPI from 2010. More details can be found here: https://dnr.maryland.gov/mdgpi/Pages/default.aspx

The limits to GDP are widely recognised by leading economists, including the Nobel Prize-winning economist Joseph Stiglitz, and by international institutions, such as the European Commission, European Parliament and the Organisation for Economic Co-operation and Development (OECD). Stiglitz was involved in the "Beyond GDP" initiative started by the European Commission and carried forward by the OECD, as co-chair of the Expert Group alongside Jean-Paul Fitoussi and Martine Durand. Recognizing the deficiency of GDP as an indicator of societal well-being and prosperity, they advocated replacement of GDP with a suite of indicators that are able to better capture well-being, human capital and resources (including caring resources), inequality, and environmental sustainability. The Beyond GDP report is available here: https://www.oecd.org/social/beyond-gdp-9789264307292-en.htm

Recommendation 2: Redefine spending on care as "investment" rather than "expenditure"

Economic policy has historically treated public spending on paid care as consumption, meaning it is treated as a cost to the economy, rather than as an investment that contributes to human capital, productive workers, individual capabilities, and social cohesion. This approach, in turn, is mirrored in a range of business practices within the care economy that treat people as disposable units of human capital—such as zero-hour contracts, denial of sick or care leave, and the failure to provide COVID-19-secure working environments.

In order to thrive, an economy and society requires investment in the social, as well as the physical, infrastructure. While investment is generally thought of as meaning investiment in physical assets that produce economic output over time, such as roads and bridges, investment is needed in social infrastructure: social services such as health care, social care, and education, which also contribute over time to the well-being of society as well as to immediate service users. The UN Women Gender Equality Forum recently called for national governments to move towards investing between 3 and 10% of GDP in quality, equitable public services.[41]

There are strong economic arguments for public investment in the care of the young, older people, and people with ongoing disabilities. Economists have demonstrated, for numerous country contexts, that such investment would do more than investment in physical infrastructure to increase total employment (see Boxes 5, 6 and 7) as well as generate significant fiscal returns.

In addition, investment in care would contribute to reducing inequality and promoting inclusion in several ways. Firstly, such investment would reduce the burden of unpaid work, which disproportionately falls on women, limiting their economic participation and agency. Secondly, it would increase employment, particularly for women, given the current distribution of women and men by occupation. If investment is married with efforts to drive up pay and conditions (see Recommendation 4), the gender-equalizing benefits could be substantial.

Box 5: Value of investing in care

Simulation results for selected OECD countries using data for the period 2010 to 2013 showed that investing 2% of GDP in public care services would create almost as many jobs for men as investing the same amount in construction industries in the UK, US, Germany, and Australia—but, additionally, would create up to four times as many jobs for women.[42] Women's employment rate would rise by up to 8 percentage points in the US and more than 5 percentage points in the UK, Germany, Australia, and Japan, reducing the gender employment gap in each of these countries. Further, the significant public investment boost would have larger positive effects on economic growth and debt reduction in the mid-term (by 2030) than the same investment in construction.

Box 6: Investing in childcare in Canada

The employment and economic benefits of investing in the care economy have also been reported for Canada, where researchers calculated in 2008 that each $100 that was invested by the Quebec government in childcare returned $104 to the provincial government and $43 to the federal government.[43]

Box 7: Investing in childcare in South Africa, Uruguay, and Turkey

De Henau et al (2019) calculated the employment generating and fiscal effects of investing in free high quality universal childcare in South Africa, Uruguay, and Turkey.[44] Although the total annual cost of such investment could be as high as 3-4% of GDP, the study estimates that net costs can be reduced significantly as a result of substantial fiscal returns in the form of increased tax revenues (see table below summarising the results of the economic modeling). Such investment would reduce gender inequality in earnings and employment by raising the employment rate of women.

	South Africa	Turkey	Uruguay
Enrollment	Universal	Universal	Universal
No. children 0-2 years per staff	4.5	5	3.5
Pay/qualifications	Medium/high	High/high	High/high
Gross investment (as % of GDP)	3.2%	3.7%	2.8%
Net funding gap (as % of GDP)	2.1%	2.0%	1.4%
% rise employment rate (all)	6.3%	4.1%	3.5%
% rise employment rate women	10.1%	5.7%	5.3%

Recommendation 3: Accessing funding to invest in care

Even if the need for investment in the care economy is accepted, the challenge of how to access funding remains. While this is a long-term issue, it is surmountable.

Firstly, as the WHO has indicated, the pandemic has demonstrated the potential role that Official Development Assistance (ODA) can play if targeted more effectively towards the creation of global public goods, such as health systems. WHO called on the multilateral system to raise financing and disperse funds where needed. Although focused in the first instance on the health sector, a similar approach could be applied to the urgency of financing paid and unpaid care systems, which have been shown to be crucial to economic and social well-being.

Secondly, the pandemic has highlighted the potential for solidarity taxes as a funding mechanism. Solidarity taxes have been used to raise funds to cover the COVID-19 emergency in both the global North and South, including Kenya, South Africa, Nigeria, Argentina and Uruguay (see Box 8). In addition, the IMF has also proposed temporary tax increases on corporations that have made high profits during the pandemic.[45]

Box 8: Solidarity Taxes[46]

Argentina adopted a one-off special levy on rich citizens, while **Bolivia** passed a longer-term wealth tax and **Morocco** imposed a "solidarity contribution" on companies and wealthy citizens. **Uruguay** introduced the COVID-19 Sanitary Emergency Tax, set at 5 to 20% for 2 months (April-May 2020). It applied to nominal remuneration and benefits (in cash or in kind) derived from personal services provided to the state, departmental governments, autonomous state entities, and decentralized services.

However, solidarity taxation, whether of income or wealth, is by its nature time-limited and aimed at specific emergencies. Fiscal support for the care economy needs to be ongoing and long-term. The UN system could consider setting up a Post-COVID-19 Solidarity Fund to finance poorer countries' efforts to support the range of care activities, which are indispensable to their economic survival. This would be a reversal of the imposed austerity policies of the past, and could augur a new approach given the insights of the pandemic period. Such an approach could learn from moves toward innovative development finance.[47]

Recommendation 4: Learn from community best practice how to make the most of limited resources in fiscally constrained countries

Countries with limited fiscal resources have in the past looked to community-led and/or NGO-provided childcare provision. In Indonesia, for example, childcare expanded rapidly, but without a significant increase in public investment. This experience points to some of the dangers that can come with such an expansion model, such as significant variability in quality and access.[48] Worker co-operatives are another alternative that has been suggested for low-income countries. However, while some of these provide promising models (see Box 9), they have yet to be undertaken at scale.

Box 9: SEWA Childcare Co-operatives

The Self-Employed Women's Association (SEWA) set up the Sangini Child Care Workers Co-operative in Ahmedabad, India in 1986. It now has 13 childcare centers, caring for 350-400 children aged 0-6 years. Women contribute around 17% of the cost of childcare, with the remainder made up from funds raised via other SEWA co-operatives, donors, and public subsidies. Most of the working mothers (64%) using the centers said that they were able to increase their working hours due to the childcare provision.

Innovative community-based care programs may also provide a relatively cost-effective means of addressing care needs. The Programa Major Cuidado (PMC) in Belo Horizonte, Brazil, is an example of such a program (see Box 10).

Box 10: Programa Major Cuidado (Older Person's Care Program, or PMC)[49]

The city government of Belo Horizonte has developed an intersectoral approach to community based health and social care for care-dependent older people, which offers an alternative to residential long-term care, or to the assumption that family members, usually women, will take on this task. Taking a holistic approach to the needs of family members as well as of older people, trained PMC workers support between one and three families, offering 10-40 hours of support a week. PMC carers are recruited from similar communities, and paid a basic wage. They are jointly supervised by local health and social assistance center staff. This program supports family carers with respite care while building up their competence and care skills.

The PMC schemes, which were started back in 2011, provided a structure on which to build support for communities during the COVID-19 pandemic in 2020. This multi-agency community-based approach offers an innovative solution, facilitating home-based care while supporting and training family members in appropriate care skills. Paid care work offers carers a degree of professionalism, and links their work with wider health and social work teams.

Transforming paid and unpaid care work

Investment in the care economy would enable care work, which has been undervalued and neglected despite its crucial role, to be recognized and appropriately compensated.

Recommendation 4: Recognize the value of unpaid care work and encourage a more equal gender distribution

The distribution of unpaid care work is a key contributor to gender inequality, and the pandemic has intensified its disproportionate burden on women. It is vital that policies are implemented that both recognize the value of unpaid care work to society, and encourage more equal sharing between men and women.

Such policies need to make it easier for people to combine paid and unpaid work, particularly via leave and flexibility policies to support those with caring responsibilities. Further, given the potential for unpaid care work to reduce the opportunities for earned income, the value of unpaid care should be recognized by compensating the carer via the social security system. In addition, it must be recognized that responsibility for care cannot just be left to individual family members (who in most cases will be women). The responsibility for both funding care services, and fulfilling care activities, must be supported by public policy, which shares the risk with individuals and families (see Recommendation 2 above).

In addition to adequately funding care services as set out in Recommendation 2 above, there are a range of other measures available to policymakers. These include, for example, dedicated fathers' leave (Box 11), caring leave (Box 12), and even potentially shorter working weeks (Box 13) and Universal Basic Income (UBI) schemes (Box 14). There are also important initiatives which recognize the rights of workers to take leave to care for older relatives and to cover other care responsibilities.

Box 11: Father's leave

Ensuring that fathers can care for children from an early age is key to disrupting the gendered division of childcaring. Evidence from a number of countries shows that providing dedicated fathers' leave increases uptake.[50]

In **Sweden**, equal rights to parental leave were introduced in 1974. However, uptake remained low until 1995, when a dedicated one month of fathers' leave was introduced. At that point, uptake went from 9% to 47% over a period of 8 years.

Similarly in **Quebec**, introduction of dedicated 5 weeks of fathers' leave at a replacement rate[51] of 70% saw fathers' uptake increase from 21.3% to 74.9% (over the same period, fathers' uptake in the rest of Canada fell from 11% to 9% under an SPL system with a 55% replacement rate).[52] It is also worth noting that time-use data from Quebec shows that fathers taking up their quota of leave spend more time in unpaid care work and their partners spend more time in paid work.

Box 12: Caring leave

In **Sweden**, the Care for Related Persons Act (1988) provides a right to leave to care for seriously ill relatives. Up to 100 days are available per cared individual, and this is compensated for through the National Insurance System.

In **Italy**, unpaid carers are entitled to 3 days leave per month, which is paid for through the national social security agency.

Box 13: Shorter working week

Advocates argue that a shorter working week for all would encourage a more equal sharing of paid and unpaid work.[53] Suggestions for the length of the working week vary, but there is growing momentum behind calls for a 4-day working week. In Sweden, there were a number of trials of a 6-hour working day.[54]

Trials have been conducted by both individual companies and public bodies, and some have also implemented this as a permanent change.[55] One of the most high-profile was Perpetual Guardian, a New Zealand insurance company with 240 staff. Perpetual Guardian trialed a 4-day week (with the same pay) for 6 months, and made the switch permanent after finding staff had increased well-being and reduced stress, and there was no cost to productivity.

Box 14: Universal basic income

UBI is a tax-free, unconditional, and non-contributory basic weekly income provided to every individual as a right. In its full form, it would replace current means-tested benefits, with advocates arguing that UBI would significantly reduce administrative burden and provide a better fit for the modern, flexible workforce than existing benefit systems. Guaranteeing a basic income, advocates argue, would support unpaid work by removing financial pressure to engage in paid work where this competes with caring or other responsibilities and needs.

Trials of more limited versions of UBI, usually targeted at disadvantaged groups, have been conducted in Finland and by charities and development agencies in developing countries.[56] The Finland trial gave monthly payments of 560 Euros to 2,000 unemployed people, but the government has so far stopped short of extending this beyond the trial.

Recommendation 5: Transform paid care work to provide decent pay, conditions, and standards

Political acknowledgement of the importance of care work to the economy and to society needs to encompass both the paid and unpaid elements of the care economy. The pandemic has highlighted the poor pay and conditions of many in the care economy, and it is vital that action is taken to ensure decent pay and working conditions, as well as training and opportunities for career progression.

Improving work conditions and standards is necessary not only for the benefit of workers in the care economy, but also to ensure safe and quality provision for recipients of care. Adequate funding (as per Recommendation 2) will be key, with market-driven models and underfunding responsible for significant pressure on labor costs in the sectors over the past several decades. The Nordic economies have led the way in improving the status and conditions for care workers and have also shown that this translates into better outcomes (see Box 15).

Box 15: Nordic model of care

The Nordic economies—Sweden, Norway and Finland—have developed a concept of caring economics, which emphasise empathy and care, cooperation (between government and citizens), and trust and solidarity.[57] The Nordic model of the care economy stresses quality—in terms of the nature of the care delivered, as well as the pay and working conditions and status of care workers across the care sectors, which are far superior to those in other OECD economies.[58] There are significantly more care workers per capita in these countries than in other comparable European countries, providing wider access to childcare, social care, and eldercare.[59]

Heintze (2013), in her typology, describes elder and social care systems in these countries as "universal public systems with high service integration." There are high levels of professionalization and low access thresholds. She estimates that expenditure, as a proportion of GDP, is at around 1.8 to 4%.[60]

In terms of early childhood education and childcare (ECEC), Iceland has the highest expenditure in the OECD at 1.8% of GDP, followed by Sweden (1.6%), Norway (1.3%), France (1.2%), and Denmark (1.2%).[61] This enables universal access to high-quality ECEC,[62] with Denmark having the highest rate of participation for low-income 0-2 year olds (just over 60%).[63] Investment in ECEC contributes to reducing the gender employment gap, with Sweden and Iceland having some of the highest levels of maternal employment in the OECD,[64] and the lowest overall gender employment gaps. It has also been shown to contribute to reducing socio-economic inequalities by improving outcomes for disadvantaged children and narrowing the gap between immigrant and non-immigrant children.[65]

In terms of the size of the investment in care, it is important, as de Henau et al (2019) note, to evaluate this in the context of net investment in care services, since additional revenue from employment and economic activity generated to some extent offsets the initial investment required. This factor is particularly important for middle-income countries (see Box 7).

Improving pay and conditions also has the potential to create wider economic benefits (see Box 16).

Box 16: Economic benefits of raising pay

A study of selected OECD countries assesses the employment effects if the wages of care workers were to be raised to the same level as the wages of construction workers.[66] It found that investment in care continues to outperform investment in construction in total employment creation in at least 60 per cent of all European countries covered by the study.

Another study looked at the economic costs and benefits of increasing employment and lifting conditions in the care workforce to Scandinavian levels.[67] To achieve this, a net annual spending of 2.7 % of GDP would be required. It would generate 2.4 times the employment created by the same net spending on construction, and nearly 2,215,000 jobs in the economy as a whole, raising the overall employment rate by 5.4 percentage points and reducing the gender employment gap by 3.9 percentage points.

For domestic workers, who often have the worst conditions and face the greatest precarity, the adoption and enforcement of the ILO Convention on Decent Work for Domestic Workers is imperative.[68] This convention seeks to address a range of issues including information on terms and conditions, hours of work and rest periods, remuneration and right to minimum wages where applicable, occupational health and safety, and social security protection. There are also specific recommendations to protect live-in workers and migrant domestic workers, and for the regulation of employment agencies, as well as a mechanism for setting disputes. Although difficult to enforce, the convention has been ratified by over 30 countries, including Argentina, Mauritius, Madagascar Uruguay, Mexico, and Sweden, and several countries have passed new laws or regulations improving domestic workers' labor and social rights, including Venezuela, Bahrain, the Philippines, Thailand, Spain, and Singapore. Legislative reforms have also begun in Finland, Namibia, Chile, and the United States, among others.[69]

Creating the political momentum

If care is so central to all our lives, why is there no international mobilization for change?

This is a question that has exercised politicians, analysts, practitioners, and carers' groups for many years, and one that is made more urgent by the current pandemic. COVID-19 provides an opportunity to reframe the discussion around the care economy in order to make it a political priority.

Recommendation 6: Reframe the care debate to put care at the heart of economies and society

A number of feminist recovery plans have articulated the central role of care within economies and societies post-pandemic.[70] Drawing on these, we recommend that following key messages are communicated to national legislatures and international institutions to reset and reframe the debate around care:

- The right to receive care, the right to care, and the time for care is a human right, and intrinsic to conceptions of well-being and capabilities.
- Care is a gendered activity, and as such, any commitment or policies to achieve gender equality, including the SDGs, must include attention to how care is delivered, by whom, to whom, and under what conditions.
- Public policies to reform the care economy, particularly those based on the feminist argument for investment in the social infrastructure, are widely perceived to be costly and beyond the fiscal possibilities of low-income economies in particular. However, such investment can act as a stimulus to even poor economies by boosting employment and local demand, and this debate urgently requires reframing to make these benefits visible.
- Recognising the reality of different care economies is central to policy reform and change:
    - *In highly formalized economies, developing an appropriate care economy strategy, with decent working conditions, remuneration, social protection, training, and career progression, is central.*
    - *In less-developed countries, and particularly where the informal economy is the majority economy, acknowledgment of the role of informal carers and domestic workers must be a major part of policy reform.*
- In all economies, recognition and support for unpaid family care requires public support in the form of cash transfers, access to complementary services and professionals, and community assets and programmes.

The political opportunities for reframing the care debate are also aided by examples of countries putting care at the centre of their policy planning (see Box 17 for Biden's care plan and Box 18 for Uruguay's introduction of a National Integrated Care Service). Moreover, as a low-carbon and labor-intensive sector, the care economy is also aligned with the need to transition to greener economic models. Concerted and urgent action is required now to take advantage of these openings.

Box 17: Biden's care plan

The Biden campaign's pre-election Economic Recovery plan promised a raft of investments—both physical and social—to provide American families with appropriate childcare at different ages, and to ensure an eldercare programme that would offer dignified, accessible, and low-cost care in the home, in communities, and in long-term facilities. The size of the proposed investment is considerable. While political realities may dilute the immediate implementation of this $775 billion plan, the blueprint that puts care and the rights of carers throughout the life-course at the heart of the economic recovery will inspire many, and open a conversation in the United States and beyond.

Box 18: Uruguay's National Integrated Care System: a model for other countries[71]

Uruguay has, over the past six years, undertaken substantial reform of the ways care is recognized and delivered. These reforms were informed by UN Women's 3Rs (recognize, reduce, and redistribute) and undertaken with an explicit focus on gender equality. The National Care Plan, published in 2015, stated that the aim of the new National Integrated Care System "...is to generate a co-responsible model of care, shared by families, government, community and market; highlighting that it should be especially shared by men and women, so that Uruguayan men and women may share care responsibilities in an equitable manner as an attempt to do away with the unjust gender-based division of work that has historically characterized our society, and which still does."

Central to the reforms has been the recognition of a right to care through the National Care Act and the establishment of the National Integrated Care Service (NICS) to meet the care needs of children, disabled people, and the elderly. Implementation is driven by the National Care Plan and overseen by the multi-stakeholder National Care Board. Key to the NICS is expansion of services so that the burden of unpaid caring can be reduced. There is also a focus on training and development to ensure that the value of care work is recognized and appropriately rewarded, as well as enhanced regulation of care to ensure quality provision. Finally, there is a focus on communication with the aim of transforming cultural and social norms around caring in order to encourage a more equitable distribution of labor.

The Uruguyan model points to the value of intervening at multiple levels—from financing expansion of services, enhancing regulation, and ensuring appropriate institutional oversight to, finally, transforming socio-cultural norms and values.

5. Conclusion and Summary of Recommendations

After decades of neglect, the COVID-19 pandemic has brought into view the vital role that the care economy plays in the functioning of economies and societies. It has also brought into sharp relief the deep crisis at the heart of it. Care recipients and providers of care have been on the COVID-19 frontlines, and our ability to mount an effective response to the pandemic has been hampered by a legacy of undervaluing and neglecting care work, whether paid or unpaid, and the sector as a whole.

It is urgent that countries build back better, with thriving care economies at their foundation. Public support for this effort is high, with our dependence on the caring economy more visible than ever.

From how we define economic success to how we allocate our resources, care must be a priority. This is not just the "right" thing to do. It also makes economic sense. Investment in the social infrastructure has been demonstrated, time and again, to deliver employment and fiscal benefits. It is also aligned with the need to transition to greener economic models.

In short, prioritizing the care economy will pay dividends not only for those in need of care and those that provide care, but also help to build stronger, sustainable economies and more equal societies.

Given the variation in national contexts, this report recommends that countries establish a National Care Commission to develop an integrated, context-sensitive response to the care crisis in order to achieve the transition to caring economies. These commissions should consider how the seven key recommendations in this report, which are based on the 3Rs put forward by UN Women, can be implemented in the local context.

Specifically, these seven key recommendations are:

- Make visible unpaid work in headline economic indicators to ensure that caring work recieves due recognition and comes to the attention of social and economic policymakers.
- Redefine spending on care as "investment" rather than "expenditure" in recognition of the long-term dividends that investment in care yields, including its employment and fiscal benefits.
- Learn from best-practice community examples to secure resources for expanding care services in low- and middle-income countries.
- Develop ongoing, sustainable funding to invest in care, including from novel financial instruments, to ensure that provision is adequate to meet needs.
- Recognize the value of unpaid care work and encourage a more equal gender distribution in order to reduce the burden on women and promote gender equality.
- Transform paid care work to provide decent pay, conditions and standards in recognition of the value that caring provides to all of us.
- Reframe the care debate to put care at the heart of the economy and society in order to build a political consensus to support the care economy.

The time to act is now.

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