(Re)thinking Care in a Development Context

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In her recent keynote address at an UNRISD conference on the political and social economy of care, **Joan Tronto** made a strong plea for the need to move beyond the "counting games" of a "world without limits". Much of the marginalization of care, she argued, is due to the belief in unlimited wealth creation and constant gains in efficiency, deeply rooted in contemporary economic thinking. Within this framework, care is conceived as an expensive and dilemma-inducing endeavour, because it tends to run up against the limits of frail human bodies and relationships. In a world without limits, care suffers from "cost-disease" due to its resistance to productivity gains and provokes a "nice person dilemma" according to which those who provide care loose out in an economic structure that rewards participation in the paid economy but offers little or no compensation for care.

Understanding care *not* as a prerequisite to economic growth, but as the center of human life would allow us to shift our priorities from "making money" (the neoliberal agenda) or "making stuff" (the Keynesian one) to "making liveable lives" and "enriching networks of care and relationship". Within such an alternative world, the physical, emotional and relational needs of humans would set the limits within which other concerns (including economic growth, employment, and institutional organization) are addressed.

Tronto's plea echoes what a number of other feminist philosophers have been writing about, among them Martha Nussbaum, Eva Feder Kittay and Carol Gilligan (despite their differences). Their work has questioned some of the cherished premises and assumptions of neo-classical economics ("rational choice" as a model of individual behaviour) and amply exposed the "blind spots" of economic thought, in both its neoclassical as well as political economy versions, namely the privileging of the monetized realms of the economy and the invisibilization of the unpaid economy of care. In effect what Tronto and others are saying is that we need to "get our priorities right"—make the shift from "making money" or "making stuff" to "making liveable lives" and "enriching networks of care and relationship".

This is a vision that enriches our work both as researchers and as activists --- I want to hold on to that vision, but find ways of relating it to the analyses that have been done through the UNRISD country studies which are all too aware of the constraints, both financial/economic and

political/institutional, within which care is embedded, i.e. the constraints that we come up against when "making stuff/making money" has had to take priority over making liveable lives. How do we move from **here** to **there**? A starting point for this exercise must be to try and grasp the substantial differences in the grounded realities across different contexts (the **here's** are very different) and they impose very different sets of constraints upon us in making the shift that Tronto calls for.

Over the past quarter century, feminist researchers have generated a rich literature on welfare states, empirically grounded and theoretically informed, challenging many of the premises and limitations of the mainstream social policy literature.

But this research has been remarkably "local". Many of the trends it has documented are not universal. For example, while in many middle income countries of Asia and Latin America women's labour force participation has increased, this has not been correlated with improved access to social rights associated with care responsibilities.

There *has* been growing academic (and policy) interest in the migration of Southern women to the North where they work as care workers in private homes and public institutions. Although this literature exposes in a powerful way the unequalizing tendencies of policies associated with neoliberal globalization, its empirical focus again has been for the most part on care arrangements and institutions *in the North*.

Care arrangements in developing countries have not received the same level of scrutiny as those in institutionalized welfare states—and the main impetus behind the UNRISD project was to address this lacuna.

If the blindness of the first round of welfare regime literature to families and to gender stratifications left their frameworks incomplete and misconstrued (as many feminists rightly claimed), could something similar be happening within the feminist literature that concerns itself largely with the post-industrial democratic countries of the First World? Would the insights gained from research on care issues in less developed country contexts add something new to the feminist debates on care, requiring some re-thinking and some adjustments to the feminist mainstream?

I do not think that feminist research on care in developing countries is yet at a stage to make any strong claims in terms of new or different care

regime typologies (that is if you believe typologies are useful), but the existing studies (UNRISD project outcomes among them) do suggest a number of key insights which deserve further reflection. Many of these will be presented in greater depth by my colleagues later this afternoon, but here I offer a few preliminary thoughts to begin our conversation … I cluster these under four questions/headings.

(1) Care as a lens

As Jane Jenson (1997) once remarked, in response to those who see the welfare state within a narrowly labourist paradigm as being the outcome of struggles by workers and social democrats for "de-commodification", we can also see the welfare states as being about dependency and care: many welfare programmes provide care, either directly (health, education, early childhood education and care, nursing homes), or indirectly by facilitating care-giving (pensions, child and family allowances, parental leave programmes). Many of these programmes have been central to welfare states, yet apart from pensions they have tended to be treated as secondary programmes.

One might even argue that the 19th century responses to the "social question", which is where we find the underpinnings of the post-1945 welfare states, were preoccupied with problems of dependency and care in old age, in childhood, in sickness, as well as the dependency on charitable and institutionalized care. Unemployment was a problem because it made it impossible for families to care for themselves or to seek help from others. And as Jensen further argues, the *family wage*—a central claim in workers' struggles—despite all its patriarchal underpinnings also had the aim of allowing the breadwinner to earn enough in order to allow the family (or more likely the female mother/wife) to care for itself.

The attraction of thinking about care as a perspective or a lens (rather than a sector or particular set of responsibilities and activities) is that it allows us to *interrogate* broader policies and structures that facilitate or hamper care-giving. And this is particularly (though not exclusively) important in developing country contexts because so much of what are the pre-conditions for care-giving cannot be taken for granted.

Good care, as it has been repeatedly argued, will require a variety of resources including material resources, time and skills.

Whether it is having the appropriate infrastructure and technology to increase the productivity of unpaid domestic work, or very importantly, the availability of paid work to bring in a decent wage, with which to purchase some of the necessary inputs into direct care-giving (the nutritious ingredients with which to feed the family, the transport fees to reach the nearest health centre)—none of these can be taken for granted in a developing country context.

Much of the feminist literature on care has raised the important issue of "time-poverty", something that mainstream approaches to well-being have ignored (time use surveys to fill in the lacunas left by labour force surveys).

Time-poverty, however, cannot be considered without the dimension of material-poverty: it is one thing to be time-poor and income-rich (many professionals working in this city), another thing to be time-poor *and* income-poor (Indian time use survey would seem to suggest that this is indeed the case for many low-income men and women), and yet quite another to be time-rich and income-poor because you are forced into idleness since the development path that is taken cannot generate sufficient paid employment opportunities—a severe problem in the "labour reserve" economies of southern Africa, where capital no longer needs the labour that it pulled from rural households over so many generations and where unemployment rates are around 32% (O'Laughlin 1998). South Africa for example has an unemployment rate of 30.7 per cent for ALL women (36% for African women) and 21.2 per cent for ALL men (25% for African men).

We need a care lens to look at the process of capital accumulation and what happens in the process of development, rather than assuming *a priori* that development/growth will lead to an improvement in care-giving and human welfare.

Looking at macro economic policies through a care lens would mean asking what happens to care-giving and wellbeing in the process of development: does capital accumulation—a necessity for developing countries—facilitate care-giving and enhance human well-being? Or does it come at the expense of both? The process of development has often meant increasing agricultural productivity and diversifying the productive base by nurturing manufacturing industries, typically by increasing outputs of items produced for pay by women. There is a lot of evidence that suggests that capital accumulation that relies on increases in women's paid work to produce exports is not matched by compensating

reduction in the amount of unpaid care work that women and girls have to do to meet their social obligations. As Diane Elson (2005) argues, it is very likely that in these contexts the outcome has been an extension of total time spent by women on paid and unpaid work, as well as a reduction in the quality of the output produced by unpaid work, especially through a "squeeze on time for care".

What happens in periods of crisis to which liberalized economies are so prone? What happens to jobs and incomes of course in part of the question, and an important part (will women be squeezed out of the formal labour market? will male- or female-dominated sectors face redundancies? Will women and men be pushed into precarious forms of work with long working hours?) What happens to public provision of infrastructure, services and transfers is another part. And what happens to time allocation and well-being as more of social reproduction and care is shifted back into the unpaid economy is another critical part of the picture.

(2) The care economy and whatever happened to domestic work?

In much of the literature on care which has the developed world as its point of reference, domestic work is not included in definitions of care (despite the heated "domestic labour debate" of the 1970s). Care work is for the most part defined as the person-to-person relational and emotional interactions that enhance the capabilities of care recipients.

Feeding a child or reading a book to them is care, but preparing the food is not; bathing an elderly person is care, but washing their clothes and sheets is not. Listening to an adult and emotionally interacting with them is care, but shopping and preparing a meal for the family is not care.

The exclusion of domestic work introduces biases (of class and income). Domestic work continues to absorb a significant proportion of women's time among low-income households (not only in low-income countries but also in middle-income countries too) who are not able to commodify their domestic work by hiring domestic workers or purchasing ready-made market substitutes. It is also not conceptually very clear-cut: why is preparing a meal not caring work, while feeding the person is?

We know from both longitudinal studies and cross-country comparisons that as countries become richer the proportion of unpaid work time that is devoted to domestic work declines (use time saving technology, contract

out to cleaners and domestic workers, etc), while the proportion that goes to direct care (or person care) seems to increase. Folbre therefore talks about the demand for person care being "income-elastic" and having the characteristics of a "luxury good" (the poor do less of it, the rich do more).

In the project we constructed a "care dependency ratio" to capture the burden of care-giving in simple demographic terms. Among the countries covered the care dependency ratio was found to be lowest in Korea, followed by Argentina, and highest for Tanzania, reflecting in particular the relative size of the under-6 cohort. The figures we obtained suggest that a caregiver in Korea would, on average, share the responsibility for caring for a single person with at least five other people, while a caregiver in Tanzania would be responsible for more than half of all the care needed by another person.

Interestingly, the apparent **need for care** calculated on the basis of demographic variables does *not* correlate in a simple way with the amount of time that is actually spent on person care (as recorded in the time use surveys). For example, while the demographic structures would suggest a lower care burden in Korea and Argentina, women in these two countries allocate relatively *more* time to person-care than women in Tanzania, India and South Africa where we may be facing a "care deficit".

The extra time spent by the wealthy on care of persons could reflect different factors: the "contracting out" of time-consuming housework by employing others to do this work while the time that would otherwise be allocated to it is spent on person-care; an ideological emphasis on the need for "quality time" to be spent with children (and the *reporting* of that time to enumerators); as well as smaller households among the wealthy, meaning that children are more likely to be cared for separately with fewer economies of scale and less possibility of children caring for each other.

For the poor in poor countries the drudgerous part of care work—the fetching of water, processing ingredients and preparing food—absorbs a huge amount of time, leaving perhaps little time for the more "interactive" part of care. But we would not want to say that they spend little time on care work!

(3)The care diamond—*multiple* institutions to highlight the role of public policies and collective provision of care-services

In addition to using care as a "lens" through which to interrogate the broader economic, social and political structures, in the UNRISD project we have in fact, for the most part, used care in a narrower sense focusing on the so-called "care diamond" (which is also sometimes referred to as the "care sector", e.g. by Nancy Folbre).

The institutions involved in the provision of care are thus conceptualized in a stylized fashion as a care diamond, to include the family/household, markets, the public sector and the not-for-profit sector. Of course, this is an oversimplified picture as the institutions providing care often work in a more complex manner and the boundaries between them are neither clear-cut nor static. For example, the state very often subsidizes and regulates (sometimes creates) provision through markets and not-for-profit providers. And more importantly, the diamond will look very different for different socio-economic groups: there will be different care worlds for different classes (Uruguay and Argentina).

The point of the care diamond, however, was to emphasize the multiplicity of sites where care is produced, the role of public policy and collective responsibility, and the decisions taken by society to privilege some forms of provision over others.

I think we were quite persistent in using this framework because it allowed us to combine a micro level analysis of *unpaid care*—which for the most part takes place through kinship relations—with other forms of care: mediated by market relations, or through collective forms of provision. Why this emphasis on diversity of sites and institutional configurations?

First, there is a view deeply entrenched in the modernization narrative, of a linear path along which all countries move with an inevitable shift from "private", especially family and voluntary provision, of care to public provision (by the state and market).

The assumption is that developing countries cluster into what in the literature is often referred to as highly familialistic regimes where both welfare and care are assured through informal family networks and relations.

While one would not want to deny the important role played by families, and by unpaid female work within families, in providing care, in developing countries (and one would say the same for developed

countries, including the much-praised social democratic welfare states), an exclusive focus on families and households can also be misleading.

There is great diversity among developing countries, evident in the small cluster of countries that we have (purposefully chosen to reflect this diversity) with some displaying relatively high capacity states, both fiscally and administratively, which have also been involved in the provisioning of social and care services and social protection measures historically (Argentina and South Africa are two clear examples, not to mention Korea which is already an OECD country).

Today many other developing countries are also experimenting with social policies—under the label of "human capabilities", "anti-poverty" or "social protection" which either directly or indirectly impact care-giving (for better or for worse as far as gender equality is concerned). We felt that these needed to be interrogated --- in addition to the more explicitly care-oriented policies which resemble developed country policies (such as preschool care and education).

Second, it is important to focus on state social POLICIES and on collective forms of care because—despite some of their well-known shortcomings (care-giving being badly paid and feminized even if in the public sector)—this would get us away from an agenda that is exclusively focused on micro-level interventions aimed at getting more men involved in care-giving as we see in some multilateral policy institutions (not the first time a feminist idea has been picked up by global policy making establishments to reinforce what can be a regressive policy effort to de-legitimize the role of the state and of society to collectively shoulder the cost of care-giving that falls disproportionately on the weaker segments).

I have my doubts if these micro level measures around "fatherhood promotion", for example, would get us very far, at least in many developing countries, where much more needs to be done in terms of putting in place the policies and programmes (publicly funded or subsidised forms of care, income redistribution towards low-income large families) and structural changes (more and better jobs, especially for women) that can help redistribute the costs of care-giving across social class and also make it more viable for women to re-negotiate their care responsibilities.

The limitations of "sharing of responsibilities between women and men" are particularly striking in contexts where a large proportion of households with children are maintained primarily by women without the

physical presence or financial contributions of the fathers of those children. Nicaragua and South Africa are two countries in this category.

(4) Care diamond and the "welfare mix":

Governments can in theory orchestrate care diamonds with a "mix" of public and private provision that is not exclusionary, that provides accessible services for everyone, and that provides good working conditions for care workers. But this requires states with both fiscal and regulatory capacities—to regulate non-state care providers and to underwrite some of the cost of service provision for low-income users. It also requires a willingness to invest in basic public health and education services and appropriate infrastructure as the bedrock of social provisioning to help reduce the unpaid care burden placed on families and households. However, the reason why governments very often get into these so-called "private-public" partnerships is to save costs (especially staff costs). So would need in particular to watch out for the kind of work that these "public-private" mixes offer to their workforce.

Pluralism in the provisioning of social and care services can have unequalizing, if not exclusionary, outcomes in contexts where the state fails to play this leadership role. In historically more unequal societies pluralism in welfare and care provision easily slips into fragmentation as gaps are filled by providers that offer services of varying quality which cater and are accessible to different segments of the population. In such contexts private provision (of health, pensions, care services) for the better-off may be underwritten by state subsidies while meagre resources are channelled into poor quality public or "community" services (health, education, care) for the majority who may be asked to make "in-kind" or "under-the-table" contributions. NICARAGUA

Going back to Tronto's plea, it seems to me that the changing of priorities depends not only on political alignments and the strength and visibility of social movements that champion the priority of better care (along with gender equality), but also <u>states</u> that even if for instrumental reasons are willing to put in place measures to reduce care burdens and equalize opportunities (no denying that many of these efforts have ethnic, race and class biases … wanting more educated, white, women to have children, or migrant or ethnic minority children to be properly socialized), and a country's place in the larger global economy (whether the state/society have any room for manoeuvre in terms of fiscal and policy space).

Project Countries and research reports available on UNRISD website (*).
India, Nicaragua, Tanzania, South Korea, Argentina, South Africa
Japan and Switzerland; Uruguay (desk study)

***RR1—political, economic, social and demographic background**
***RR2—time use analysis**
***RR3—care diamond**
RR4—care workers and their terms and conditions of work (being revised)
RR5—synthesis of findings and conceptual elaboration (due in June 2009)

www.unrisd.org/research/gd/care