

# THE CARE ECONOMY IN LATIN AMERICA: Putting care at the centre of the agenda

Valeria Esquivel





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“The care economy in Latin America: putting care at the  
centre of the agenda”

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**UNDOING  
KNOTS  
INNOVATING  
FOR CHANGE**

**THE CARE ECONOMY  
IN LATIN AMERICA:**  
Putting care at the  
centre of the agenda

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# Prologue

With this second publication of the “Undoing knots, innovating for change ” booklets, the United Nations Development Programme (UNDP) Regional Centre for Latin America and the Caribbean, through its Gender Practice Area, again provides Latin American governments and citizens with an innovative reflection that puts the themes of equality and care work in the centre of the development agenda for the region. As the name indicates, these booklets seek to untie knots, connect the dots, and overcome obstacles to allow advances in equality; they also attempt to highlight transcendental themes, provide new perspectives on long-running debates, present twists on traditional solutions, and look for alternative paths in social and economic policy.

This proposal re-examines and institutionalizes an old practice from UNDP’s regional project “América Latina Genera: knowledge management for gender equality” ([www.americalatinagenera.org](http://www.americalatinagenera.org)): creating knowledge products designed to promote dialogue and discussion on themes of gender equality. This project is now part of UNDP’s Gender Practice Area, an area that links and coordinates different

regional initiatives mainstreaming gender themes and the empowerment of women, provides technical and substantive support for national and regional capacity building, creates learning communities, and builds alliances to promote strategic actions to eradicate inequalities.

“Undoing knots, innovating for change” presents today the reflections of Argentinean economist Valeria Esquivel, *The Care Economy in Latin America: Putting Care at the Centre of the Agenda*. The objective of this booklet is to facilitate a conceptual clarification of the care economy, through an analysis of its theoretical evolution within the literature produced in English-speaking countries, and the ways it has been used and understood in the Latin American region where the marks of poverty and income inequality, labor market segmentation, and socio-political fragmentation are evident. Esquivel argues the great potential of the care economy continues to be a contribution to installing “care” as a public policy issue, removing it from the private realm and reducing its association with women and the home. From this necessary approach,

the limits and peculiarities facing the construction of an agenda of care within a framework of gender equality and possible ways for progress in the region, by providing tools for the diagnosis of the “policies of care”, are identified.

**Gender Practice Area Team, UNDP’s Regional Centre for Latin America and the Caribbean.**

**Panamá, 2011.**







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# 1. Introduction

In recent years, the “care economy” has become part of the vocabulary of United Nations agencies, governmental gender equality offices, some governments, and various activist groups. It is used to articulate demands for child-care services (with some emphasis on care for older adults as well), labour market regulations, pension coverage for “housewives” and “salaries for homemakers.” It is also used to address the “crisis of care” in demography. It is related to “care regimes” and the “social organization of care.”

These various themes and conversations have diverse academic origins, and feminist economics<sup>1</sup>—under which the concept of the “care economy” was developed—is only one of them. Other literature related to characterizing welfare regimes and analyzing social policies has also contributed to these theories. The debates around the “care economy” in the region

may be “top down” and “from the outside in,” since this concept appears more frequently on a supranational level than in demands made by women (we must ask ourselves why this is the case). Also, the origin of the “care economy” debates is in countries currently dealing with a “crisis of care” for the elderly, due to aging populations and falling fertility rates – a situation that differs from that of Latin America.

Still, the “care economy” has been a very fruitful concept in the region for articulating gender equality demands and initiating dialogue with policymakers. This is because the “care economy” has the advantage of combining various “economic” concepts— the market place, the financial and monetary arena, and the production of goods and services, where income and revenues are generated and the conditions of daily life for the population are determined, with “care”— something intimate, linked with emotions, and involving daily activities. In this sense “care economy” is definitely a more powerful concept than other similar

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<sup>1</sup> Feminist economics is a heterodox research program, the result of a critique of “gender blind” orthodox economics complemented with academic feminism (Strassman, 1999).

concepts previously used such as “unpaid work,” “domestic work,” “reproductive work” and even “care work,” because it presents a less abstract alternative to them. Also, because “care” – whether it is paid or not, whether it is done at home or outside of the home – truly implies an interpersonal relationship- it is given and received. With this understanding, the “care economy” evolves from the previous emphasis on the costs that providing care carries with it to care providers (women) to a new emphasis on the contributions to the welfare of those receiving care (Benería, 2003: 169). As the receipt of care is fundamentally identified with dependent groups (young children, elderly adults, the sick and disabled), the care economy overlaps with debates about social protection, also organized around the idea of “risks” forced upon some population groups.

These different “uses” of the care economy are not without ambiguities. With its emphasis on the care of dependents, the concept has more resonance among those designing social policies than for economic policy makers. The “economic” of the care economy appears diffusely, or too general to be operational, which ends up leaving the functioning of economies unquestioned (the “hard” aspects related to macroeconomic policies). Moreover, the political agenda of the care economy is not clear-cut either regarding the steps to be taken once visibility and recognition of the contributions of care to welfare are achieved: what follows suit in

terms of policy prescriptions? Remunerating care? Whose care should be remunerated? Do we redistribute care? Among whom? For whom?

From a gender perspective, an additional difficulty is the fact that care continues to be associated with the “feminine”, with “softer” connotations than “unpaid work” or “domestic work,” categories defined by opposition to paid work or the labour market. “Care” is (or can be) more palatable to conservative ears than “work”, which usually hold maternalist or essentialist views regarding the place of women in society (Bedford, 2010). Care is also a theme disputed by certain professionals (increasingly called “care workers”), in whose discourse care is “non-expert knowledge,” distinct from their professional practices and close to “assistance” (this is particularly emphasized by teachers). In healthcare, “care” is standardized and categorized (preventative, palliative, etc) in ways that also do not appear in academic discussions.

Despite these difficulties, the great potential of the care economy continues to be helping install “care” as a public policy issue, removing it from the private realm and reducing its association with women and the home. The care economy is powerful for providing a comprehensive view of social protection. Both concepts include a set of care needs (not just health, not just education), and make visible situations where public policies take unpaid care provided by families for granted. The care economy calls

into question what is generally understood by “economics” (GDP) and also, more novel although still incipient, typical welfare measures based solely on monetary income. In addition, it makes it possible to consider the ways in which economic policies impact the provision of unpaid care.

What agendas have been articulated and can be articulated around the care economy? What is special about these agendas in our region, where the marks of poverty, income inequality, labour market segmentation, and socio-political fragmentation are evident? Who sustains or could sustain these agendas? Why are demands for and relating to care not more clearly expressed? Before

attempting to put forward some answers to these questions, the first section clarifies the theoretical evolution of the concept of the “care economy” in the English-speaking literature, the ways in which it has been used and understood in the region, and its intersections with “care” and with “the economy.” The second section reveals the limits that the construction of a care agenda faces, along with the possible routes for its advance in the region within a gender equality framework. The second section also provides practical tools for a diagnosis of “care policies.” This document concludes with a brief section of final comments.



## 2. The conceptual framework

### 2.1. The conceptual origins of what is now known as the “care economy”

What is now known as the “care economy” in the region has its origin in the so-called “domestic work debate.” This debate, developed during the 1970s, sought to understand the relationship between capitalism and the sexual division of labour, with a ruling class (husbands) and a subordinate class (housewives) (Gardiner, 1997; Himmelweit, 1999). As such, domestic work was considered a requirement of capitalism (or complementarily, of men who “exploited” their women) and should therefore be abolished (Himmelweit, 1999). This effort to incorporate domestic work in conceptualizations of Marxist origin was made, however, at the expense of leaving out of the analysis family forms that do not correspond to the archetypal heterosexual

couple, and also ignores the efforts undertaken for future generations of workers in raising children (Molyneux, 1979).

Later, “reproductive work” was understood as “necessary” for reproducing the workforce, both present and future (Benería, 1979; Picchio, 2003). The definition of the contents of reproductive work was not different from the contents of domestic work (“all tasks related to the satisfaction of the household’s basic needs, such as clothing, sanitation and health and food transformation” [Benería, 1979: 211]). However, it was not necessary to abolish reproductive work, but rather to understand its unequal distribution in terms of gender as having its origin in the subordinate position of women, and their disadvantageous insertion into the workforce. The focus, then, was placed above all on emphasizing the “visible costs” for women that accompany the provision of reproductive work.

As in the debate on domestic work, the perspective is aggregated or “systemic”: through reproductive work, homes (and the women in them) sustain the functioning of economies to ensure the “quantity and



quality” of the workforce on a daily basis (Picchio, 2003: 12). Because it is carried out “beyond” the market sphere (that is to say, without a payment involved), reproductive work becomes “invisible” in standard measures of the economy, which reinforces its low social valuation. Measuring, making visible, and valuing reproductive labour and incorporating this value in macroeconomic modelling and in aggregate measures of economic activity was a logical development of the conceptualisation of reproductive labour as a macroeconomic category. This is the origin of the ‘accounting for women’s work’ project, crystallised in the Beijing Platform for Action (Benería, 2003: 131). This is also the origin of efforts to measure reproductive work through surveys on time use<sup>2</sup> in developing countries, and in our region (Esquivel et al, 2008).

In the last fifteen years, the focus shifted again “from work to care,” paraphrasing the title of a book edited by Susan Himmelweit (2000) that recounts this evolution. Within the literature produced in English-speaking countries, the “care economy” emphasizes the relationship between the care of children and the elderly in the domestic sphere, and the characteristics and availability of care services (Folbre [2006]; Himmelweit [2007]; Razavi [2007]). In these conceptualizations, “care work” is defined “as the activities and relations involved in meeting the physical and emotional requirements of dependent

adults and children” (Daly and Lewis, 2000: 285, emphasis added). The material aspect of this work is only one of the dimensions of the “care relationship,” along with motivational and relational elements. The emphasis on care has its origin in philosophical contributions on the “ethics of care,” like those of Joan Tronto (1993) and also feminist conceptualizations that place care as a central characteristic of welfare regimes (Daly and Lewis, 2000).

In defining care work “more specifically (than reproductive work), focusing on the labour process rather than the relationship to the site of production (home versus market) or the production boundary (in the SNA or not)” (Folbre, 2006: 186), the care economy extends the boundaries of reproductive work to also analyze how the content of care in certain occupations, usually feminized, penalizes workers in those fields (see the articles edited by Razavi and Staab, 2010). These studies have shown that care workers in sectors such as education, health, and domestic service –sectors where women are overrepresented and where the idea that women are “naturally” equipped to provide care persists– tend to have lower salaries than in other sectors.

However, the emphasis on “direct” care activities of people excludes the most instrumental activities, domestic work itself – cooking or cleaning, for example – with the

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<sup>2</sup> Time use surveys allow the quantification of time dedicated to distinct activities over a day or week for men and women of different ages. The volume of domestic and care work can be quantified through these surveys.

argument that these activities lack “relational” content and are, therefore, easily replaceable by substitutes from the market. In developed economies, “home life is becoming more and more concentrated in sharing meals or telling bedtime stories for which substitutes cannot be purchased” (Nelson and Folbre, 2000: 129) and in which gender differences would be more acute (Himmelweit, 2000: xvii).

There are at least two problems with this conceptual shift. In principle, it is clear that in our economies, women and men who provide unpaid care are also those who do more domestic work, and it is unclear whether gender differences are more or less pronounced in one or the other type of work<sup>3</sup> (Budlender, 2008). Moreover, domestic work can be thought of as an “indirect care” or a “precondition” for direct care to occur (Folbre, 2006; Razavi, 2007). The fact that the degree of commodification of domestic work depends on households’ technology and income underscores the fact that the distribution of housework cannot be thought of independently from the existing degree of income inequality and poverty level. Moreover, one could argue that sharp differentiation between care work and domestic work is a “first world bias,” similar to the artificial differentiation between domestic work and subsistence production in rural contexts (Wood, 1997).

But more importantly conceptually, however, is the emphasis placed on care of dependents, and the definition of care relationships as profoundly asymmetric. If in the “debate about domestic work” children and dependent people were absent, in the current debate on the care economy, non-dependent adults have completely disappeared from the picture.<sup>4</sup> Women have ceased to be subordinate and dependent on their husbands, and function as autonomous adults (although not without mandates and social pressures that call that autonomy into question) and care providers.<sup>5</sup>

Thus described, the care of dependents evokes a dualist (and static) conception of dependence as a “personality characteristic” and as the opposite of autonomy (Fraser and Gordon, 1994). This concept is applicable only to very young children, it is dubious the same framework applies to dependent adults, like frail, elder, or disabled adults (Williams, 2009: 29). However, receiving care is not necessarily opposed to independence or personal fulfilment, and autonomous adults may also give and receive care on reciprocal terms, such as the care that occurs among friends, significant others, and family members. In effect, it is not dependence or independence, but rather, “interdependence,” which characterizes the human condition (Tronto, 1993).

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<sup>3</sup> An aspect that, certainly, will be highly dependent on the context. In the city of Buenos Aires, for example, gender differences appear to be more marked in domestic work than in care work.

<sup>4</sup> Only in the latest contributions to the debate, the care for able-bodied adults is acknowledged, though in passing (Folbre, 2006: 186; Himmelweit, 2007: 581).

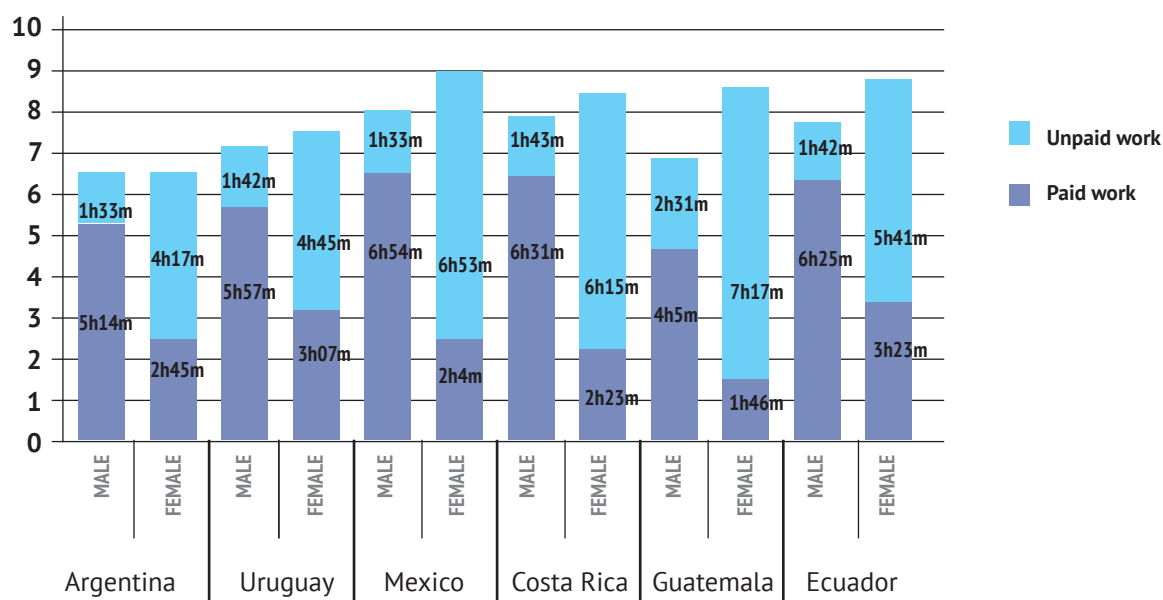
<sup>5</sup> Pérez Orozco (2006) goes even further, to suggest that women “obtain” their autonomy by putting someone else in a dependent position.

## Box 1

### INEQUALITIES IN THE DISTRIBUTION OF UNPAID WORK WITHIN HOUSEHOLDS

The graph shows the total workload by gender, differentiating paid work from unpaid work, for six countries in the region (Argentina, Costa Rica, Ecuador, Guatemala, Mexico, and Uruguay). The average daily hours devoted to unpaid work by women varies between approximately four hours in Argentina to a bit above seven hours in Guatemala. Among men, time spent on this type of work never surpassed two hours per day. The exception is Guatemala, where men undertake almost two and a half hours of unpaid work, a phenomenon explained by the magnitude of unpaid agricultural work that occurs in this country.

**Graph 1. Workload by type, according to gender. Selected countries in Latin America, various years.**



These gender gaps in unpaid workloads are very different according to ages of household members and, as expected, increase at central age groups, coinciding with the presence of young children in the household. However, in all age groups the gender gap remains- more or less accentuated- and this applies even to the groups younger than 15 years old and those older than 65. This is because young girls and older adults are involved in the care of dependents, beginning with siblings in early ages, then children and parents during middle age, and finally, with a frail or disabled spouse at old age.

Sources: CEPAL (2010a) y Esquivel, V. (2009)<sup>6</sup>.

<sup>6</sup> Esquivel, Valeria (2009) *Uso del tiempo en la Ciudad de Buenos Aires*, Colección Libros de la Universidad N° 33, Universidad Nacional de General Sarmiento: Los Polvorines.

Moving away from the pair “autonomous caregiver – dependent care recipient” we reach richer soil, understanding both the needs of care along with the responsibilities of providing care as they are ideologically and socially constructed. We remember there is nothing “natural” in them (or very little, only when thinking of very young children or of people whose life is at risk). This critical look also allows us to analyze from a feminist perspective the discourses (and public policies) that assign some women care-taking roles, and limit those roles for other women or men (Barker, 2005). Also, this sheds light on the “social relationships” that occur in households and families, in particular the social (as opposed to “private”) aspects of gender inequality in workloads and standards of living (Gardiner, 2000).

The exclusion of care of non-dependents in general and of domestic work in particular from the “care economy” is problematic precisely because it is still the case that autonomous men, and not only dependents, benefit from women’s care work and housework to sustain their standards of living (Picchio, 2003: 11). Ignoring these other components of “old” reproductive work in the analysis eliminates a feature of persistent gender inequality,<sup>7</sup> particularly acute in contexts where low income and poverty do not allow access to market substitutes for these services. In these cases, gender inequalities might not be solved by the simple expedient of ‘outsourcing’ housework – work that is provided by domestic workers

(mostly women) in particularly vulnerable *de jure and de facto* conditions (Valenzuela and Mora, 2009).

It could be said that this conceptual evolution from domestic work to reproductive work and from there to unpaid care work (both direct and indirect) is the shift from “seeing the household as a site of work, although it undoubtedly still is, to seeing it as a site of care, which undoubtedly always was” (Himmelweit, 2000: xviii). The analyses that understand care work as only a macroeconomic or systemic category tend to omit the fact that this work sustains interpersonal and family relationships and “produces” wellbeing (Benería, 2003). The analyses that are only interested in the relational content of care tend to leave out material and even financial dimensions of care work in general and of domestic work in particular, often disregarding its clear links to gender and class inequalities (Razavi, 2007: 16).

## 2.2. The care economy and “care”

Precisely, building on the fact that care produces wellbeing, a vast literature produced in developed countries has used the concept of “care” as an analytical category for the analysis of “welfare states.” Because care is at the intersection of social and gender relationships, and due to the particular ways in which states, through their policies, imprint these relationships with the responsibilities of providing care, “care” becomes a dimension

<sup>7</sup> This argument is valid for our economies and also for developed economies. The intersection between class and gender has very little presence in specialized literature in developed countries, but not necessarily so little impact on their realities (see Barker, 2005).



from which to analyze social policies (Daily and Lewis, 2000). In this analysis, inspired by academic feminism, the “care policies” – a broad range of policies, including payments to those who provide care or need to receive it, public care services, and provisions within the job market such as maternity/paternity leave – are analyzed from the perspective of both those receiving care as well as those providing care, paying special attention to whether the design and application of policies reduces (or exacerbates) gender inequities in the distribution of care work and paid work (Razavi, 2007).

In this sense, Diagram 1 compares the “logic of social protection” with the “logic of care.” (See page 19) Defined as the “minimal level of income or consumption guaranteed by the state as a right for all citizens and residents” (UNRISD, 2010a: 136) within a universalist approach, the logic of social protection adheres, however, to a traditional conception of welfare as equivalent to a minimum level of consumption (or measures the lack of welfare as income poverty). The availability of the domestic work and the care necessary to transform income into consumption is taken as given, and income transfers do not comprise “money for providing care or receiving care” but only to consume a basic basket of minimum goods and services that does not include this care in a broad sense.

## Box 2

### EXPANDED WELFARE MEASUREMENT

Income- whether from the labour market or not- is the standard measurement of welfare, as it indicates the purchasing power of households and, as such, constitutes a good approximation of household consumption. However, household consumption is higher than actual expenditures on goods and services, since the domestic work and the unpaid care performed within households lead to expanded consumption possibilities for household members. The assessment of “services” provided by domestic work and care complements monetary income, and provides an “expanded” measure of welfare.<sup>8</sup> Time use surveys showing domestic and care work are greater at low-income levels, support the idea that a certain degree of substitution exists between domestic work, care, and monetary income (since there are some available market substitutes for the former). As a result of this pattern, incipient literature analyzing the distribution of the “extended income” has found that the value of domestic work and unpaid care has an equalizing role, since in some circumstances may compensate for monetary income inequities.<sup>9</sup>

However, even if the “expanded income” measure is greater than monetary income, it does not mean it is sufficient. To determine sufficiency, an independent measure of household needs is necessary. The calculation of absolute poverty measures requires a definition of needs using a “combined” minimum of monetary income and domestic and care work. Vickery (1977) and Harvey and Mukhopadhyay (2007)<sup>10</sup> have shown there is a minimum level of domestic and care work implicit in calculating the poverty line (defined as the income necessary to purchase a basic bundle of goods and services) and that in certain households this minimum level of domestic and care work cannot be provided due to the extensive hours of paid work required, making them “time poor” households. The aggregated value of market substitutes for this work changes the standard poverty line, demonstrating that some “not poor” households according to incomes are, in reality, poor because they cannot achieve the combined minimum of consumption and substitutions for domestic and care work.

<sup>8</sup> Folbre, Nancy (2009) “Inequality and Time Use in the Household,” in *Handbook of Economic Inequality*, ed. Timothy Smeeding and Wiemer Salverda, New York: Oxford University Press.

<sup>9</sup> Zick, Cathleen D., W. Keith Bryant and Sivithree Srisukhumbowornchai. 2008. “Does housework matter anymore? The shifting impact of housework on economic inequality,” *Review of Economics of the Household*, 2008, No. 6:1–28; Frazis, H. y J. Stewart (2006) “How Does Household Production Affect Earnings Inequality? Evidence from the American Time Use Survey,” U.S. Bureau of Labor Statistics Working Paper 393.

<sup>10</sup> Vickery, C. (1977) “The Time Poor: A New Look at Poverty” *The Journal of Human Resources* 12(1): 27–48; Harvey, A.S. and A. Mukhopadhyay (2007) “When Twenty-Four Hours is not Enough: Time Poverty of Working Parents,” *Social Indicators Research* 82(1): 57–77.

Within the social protection framework, the care work that is covered is exclusively that that households cannot provide, either because it requires expert knowledge (health, education) or because it is brought up by extreme dependence (for example, disability). Even focusing on dependent groups such as young children or the elderly, it is assumed that the families will provide the care required on a daily basis. The weakness of these assumptions becomes evident when daily care ceases to be provided for free within households. The “emergence” of the need to care for elderly adults, once cared for by their families, that led to the Spanish Care Law (Fassler, 2009), or the inability of families to respond to the care needed by AIDS patients (Mkandawire, 2009, cited in Bedford, 2010) are cases in point.

Using the “logic of care” as a standpoint involves tracking the ways in which care of dependents is provided in distinct spheres (households, communities, the state, and the market). This look at the “localization” of care illustrates not only care provided in households, but also differences in gender, class, and generation among those providing the care (Daly and Lewis, 2000; Razavi, 2007; UNRISD, 2010a).

Forexample, when households and the market play heavier roles in care provision, access to services is highly correlated with family incomes. In highly unequal contexts, such as the Latin American region, the expanded role of the market in the provision of care (which

therefore has to be paid for) deepens income inequality and exacerbates the difficulties that women from poor households face in providing care, accessing the labour market, and generating an income. In contrast, with greater public (free) care provision and high coverage levels, access to care services has an equalizing potential not only in terms of those who receive care (if the quality of the care provided is guaranteed) but also in terms of options for those providing care, when compared to situations where these services do not exist or have limited coverage.

The state not only provides care services, but also, and fundamentally, regulates (either actively or by omission) the provision of care in other spheres. The “logic of care” makes it evident the ways in which certain state interventions underscore the provision of care by families and women in them. For example, maternity leave (and in some cases, the leave to care for an ill family member) for eligible female employees – which can be thought of as “time to care” – protects the rights of (formal) workers and recognizes the social function of maternity and care provision. However, if equivalent leaves for fathers do not exist, labor laws end up emphasizing the “secondary” role of men in care provision, and their “main” breadwinning role (Faur, 2006). On the other hand, if access to the labour protections to maternity only occurs in the formal labour force, female workers in the informal sectors face particularly vulnerable situations.

**Diagram 1. The Logic of Social Protection and the Logic of Care**

Logic of Social Protection	Common Aspects	Logic of care
Definition of risks and identification of vulnerable population groups.	Groups of dependents (children, elderly adults, and the chronically ill).	Definition of needs and identification of distinct areas of provision.
Assignment of "individual/private" rights or	universal perspective (sometimes with "minimum" levels).	Conflicting rights)
Income transfers which do not include "money for receiving care."		"Money for receiving care" or "money for providing care" (debated).
Focused care services, catering for specific care needs.	Care services (with varying degrees of coverage)	Care services according to needs of caregivers and dependents. Universal coverage.

Source: Author.

Similarly, but related to poverty reduction policies, the designation of mothers as beneficiaries of “conditional” cash transfers only after meeting certain requirements related to care provision – such as children’s attendance in health and educational programs – not only does assign care responsibilities exclusively to poor mothers, but also draws a blurry line between the income necessary to maintain a minimum level of consumption (proper social protection), and the “money for care” implicit in the conditionality (UNRISD, 2010a: 197; Molyneux, 2007). When, as in Argentina’s case of Plan Familias, the conditionality was associated with the benefitting mothers’ exit from the labour market, the “money for care” becomes “money for not doing paid work.” In this case, public policy is indicating not

only who should provide care, but also who belongs in the labour market (Faur, 2011b).

In this final example, public policy puts at odds a mother’s right to participate in the job market with the right of her children to receive care. Although it is a false dichotomy (mothers are not the only ones who can provide care, and they may be able to do both paid work and care work), the “logic of care” emphasizes that “conflicting rights” exist when it is assumed that care will be provided by families and women, not only “risks” for vulnerable or dependent groups who need care (Faur, 2011a) (see Diagram 1). Indeed, this perspective incorporates both the right to receive care and the rights that may come into question regarding obligations when providing care, providing a lens to examine and resolve these inherent tensions.

The examples mentioned above also show a peculiarity in the region: tensions associated with the allocation of rights and obligations related to care are not resolved in the same way in different social strata. While high income households can partly outsource their care needs using a series of paid care services (including domestic employees), as income decreases commodification of care is lower, and the role of informal and “community” care services grows, as does care provided by the household itself. These differences among income strata in care provision are not just about “modes:” care needs and the high costs of providing them- both direct and indirect, associated with loss of income-generating opportunities- are a structural cause of high levels of poverty in households with a critical number of dependents, and the impoverishment (or relatively low ability to escape from poverty) of households and the women in them (Valenzuela, 2004).

In this context, social policies neither assign care roles nor offer care services and transfers equally to different social strata. Although such differentiation would be expected, given the redistributive role of social policy, it sometimes occurs at the expense of reinforcing gender differences, or even worsening (instead of reducing) income inequality. For example, some child care services are based on “voluntary” work by women, appealing to their “natural” wisdom and therefore paying them a meager (or no)

salary for their services, and thus exacerbating gender stereotypes. In other cases, “social” care services have been differentiated from those under the regulation of educational authorities, reducing the qualification and numbers of staff requirements for the former and thereby compromising the quality of the services and the working conditions of care workers. As a result of these trends, a growing literature produced in the region uses the “social organization of care” concept – more than the “care regime” suggested in critical literature on “welfare regimes” – to refer to a less monolithic or “regimented” approach to social policy (Faur, 2009).<sup>11</sup>

As social protection, care policies can also be based on principles of universality in service provision and solidarity between genders and generations, with a goal of promoting equal access to care (ECLAC, 2010a: 227). However, because equal access to care may lead to tensions regarding who should be providing care, and also because the ways in which ensuring access to care is highly dependent on the context, these principles may not be, by themselves, sufficient rules for action.

One point that has attracted particular attention is the means (and policies) through which greater involvement of men in care can be achieved. Indeed, it is likely that the redistribution of care responsibilities between men and women within households occurs as a result of changes in the employment

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<sup>11</sup> Among the assessments of the “social organization of care” that could be mentioned are Rodríguez Enríquez (2007), Salvador (2009), Martínez Franzoni et al (2010), Filgueira et al (2009), Faur (2011b).



of women and men (i.e., a redistribution of paid work) much more than as a result of direct interventions aiming at making men more involved in care work (or at least, not explicitly discouraging their involvement). However, a number of indirect interventions, including care services provision, can facilitate the presence of women in the labor market, contributing to gender redistribution in “remnant” care.<sup>12</sup>

Labour regulations, such as paid or unpaid leaves, or those regulating the length of the workday or shift, although they apply only to workers in the formal sector, may still have an indicative role even for workers in informal sectors. Either way, it is important that equity in access to care cannot be exclusively based on equal provision by men and women, not only because not all households follow the heterosexual couple raising children model (nor children are the only potential dependents), but also because in times of extreme resource shortages, care – no matter how evenly provided within households – may not reverse or counterbalance material insufficiencies (Bedford, 2010). Indeed, the logic of care does not replace, but rather complements, the logic of social protection.

### 2.3. The care economy and the “economy”

How much “economy” is there in discussions about the “care economy?” When compared

to how powerful the concept has been in articulating a critique of social policies, the answer is “not much.” Perhaps even more complex, when economic analyses are carried out on related themes, some of them – even those done using a progressive perspective – still bear the stamp of orthodox economic views.

If social policies present an opportunity for redistribution, the economy is the site of the distribution. The risk is of focusing solely on social policies and leaving intact (unexplained and unquestioned) the processes that create the actual distribution of income, time, and resources; with social policies designed to counteract the “collateral” effects of economic functioning. When social policies are only “compensatory” in nature, it is easy to lose sight of both the social content of economic policies and the economic content of social policies (Elson and Cagatay, 2000).

This last point – the economic content of social policies – is timidly articulated in some literature as justification for providing care services. A (quite traditional) argument maintains the economic system “loses” the contributions of women when they are not participating in the labor market, and identifies the provision of care services for children as enabling for that participation.<sup>13</sup> In an argument resembling human capital theory, some authors claim that the investment in

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<sup>12</sup> Services that provide all care required have not been proposed as care services.

<sup>13</sup> There is type of efficiency argument in this type of argument, because the care is in the “public sphere” or “collective” it should be more efficient (in terms of fiscal indicators, such as number of children cared for by an adult) than that provided privately. The “loss” is, in reality, the difference between the productivity of women in the labor market and productivity in their care. The problem (as will be discussed shortly) is that all of these arguments use “full employment” reasoning.

education and health strengthens the quality of the workforce, productivity, and ultimately impacts potential GDP growth. In these formulations, the “investor state” would no longer be the old developmentalist state, but rather a state applying efficiency criteria to determine the application of scarce resources to social policies whose “performance” will be assessed over the long term (Razavi, 2010). Although this approach is possibly better than those that purport targeted social policies to address “emergency” situations, it carries the same “efficient” undertones (Williams, 2009).

While valid (it is clear that inefficiency, understood as a waste of resources, is not good in any scenario, much less in our countries), these perspectives leave a critical element out of the puzzle: the “demand side.” The Latin American experience tells us that beyond the characteristics of the supply of labour, the demand for labour also matters, and shortcomings may arise if the economic dynamics do not support an appropriate rhythm of job creation. The impact of the recent international crisis is a vivid example of the detrimental effects that negative demand shocks can have on our economies (and corrective measures, implemented or not, are clear examples of governments’ economic views).

Of course, if forecasted levels of GDP growth bring the labour market closer to full

employment, issues related to the quality of the workforce will emerge, along with the aforementioned arguments supporting the need to “activate” women, facilitating their entry into the workplace by freeing them from their care duties. But short from full employment, education and the quality of the workforce do not replace job creation.<sup>14</sup> In these cases, the “economic content” of policies related to care services could also be the state creation of genuine and quality employment in provision of health and education services. A similar argument was used to support the need for creating public employment in response to the crisis, but with a focus on generating “social infrastructure” (Antonopoulos, 2010). Public spending applied to providing care services (both in infrastructure provision and operational performance) is more labour-intensive than standard public investment, and, given the current gender structure of employment, it creates more jobs for women. A possible criticism, however, is that the operational component also increases public spending over the medium term. Arguments about the efficiency of these expenditures might counter this criticism, in the style of the “investor state”!

Considering the economic content of care policies does not complete the comprehensive vision proposed by the “care economy.” The care economy does not just measure, evaluate, and incorporate into economic analysis care-

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<sup>14</sup> I am referring here to the social policies (very popular during the 1990s) that focused on improving the “employability” of the workforce in a context of high unemployment.  
<sup>15</sup> It should be noted the expansion of care services can be undertaken generating public employment and infrastructure, or also by financing “community” schemes with public resources. In macroeconomic terms, the effect is similar, although the second option tends to be “cheaper” due to the relatively more precarious working conditions when compared to first option. The effect, therefore, is differential in terms of the labor protection the care workers receive, and possibly also in terms of quality of loans/provisions.

providing “sectors” (including households and the market provision of care services), but also questions the economic system as a whole. The care economy challenges the ways in which the distribution of time, income and jobs is generated, and puts welfare creation at the centre of the analysis.

Among the various distributive conflicts spanning the economic system (between real and financial capital, between capital and labour, among different social classes, between men and women), the care economy focuses on the conflict between production (with its tensions between profits and wages) and reproduction (or living conditions understood in a broad sense, sustained with income and unpaid care work) (Picchio, 2001 and 2003). In our region, where income inequities (both labour income and household income) make up a central aspect of economic performance, gender gaps in unpaid care work – which themselves produce income inequality – are superimposed on income inequalities, reinforcing each other.

In effect, in monetary economies like ours, asset ownership and paid work provide most income generation, and, therefore, constitute the most important determinants of living conditions. But not everyone has assets, or the ability to enter the labour market. The quantities of jobs generated by the economy, and their characteristics (in terms of income, formality, stability) depend on countries’ production structure and their approach to macroeconomic policy. Those who eventually occupy these various positions vary, in turn, depending on the characteristics of the

labour supply (in terms of education, age, gender), on whether it is possible for them to “reconcile” paid work with care responsibilities, and how care needs are distributed.

Care needs are not distributed equally among households, and they depend on the households’ stage in the life-cycle. Also, care responsibilities are not equally assumed by women and men within households, nor do households have equal access to services that may help distribute the care workload. “Balancing” work and family life depends on the circumstances under which paid work is performed, and is associated with regulation of working time and the existence (or lack thereof) of care policies (Martinez Franzoni, 2010).

The problem is that, beyond inequalities in existing employment opportunities, the labour market prioritizes people without care responsibilities (or those who behave as though they do not have them): men (and some women) who are “ideal workers” manage to “commodify” their labor force more easily (or fully) than those who do not fit the ideal profile. But, in the majority of cases, neither earnings nor family structures allow the lifestyle of the “male breadwinner.” This aspect of the labour market prevents the successful integration of those who cannot meet the standards of the ideal worker, reducing their income and, therefore, their quality of life. This exacerbates existing trends in income inequality in our economies, and also contributes to devaluing care work, as the work that is opposed to paid work and has no “market value” (Folbre, 2006).

Hence the labour market, the main mediator of income generation opportunities, is “gendered”. Without proper regulation, the labour market reinforces gender disparities in the distribution of care burdens and amplifies poverty and income inequality (Elson, 1999). For the same reason, the care economy emphasizes labour market regulation, even though not all social and labour policies are consistent in what they propose as “solutions”, precisely because these different “solutions” differ in the ways they settle the tensions between rights and obligations to work in the market and provide care (Martínez Franzoni, 2010).

As long as care remains mostly provided by women, female caregivers and their dependents will remain the exception to the “ideal worker” rule, and will have a subordinate and vulnerable economic position. Economic dependence and a less advantageous entry into the labour market constitute the “costs” of caring for caregivers. These are costs in terms of income, “free” time, and access to resources mediated by one’s position in the labour market. The “social organization of care” is the other side of the “organization of paid work” coin.

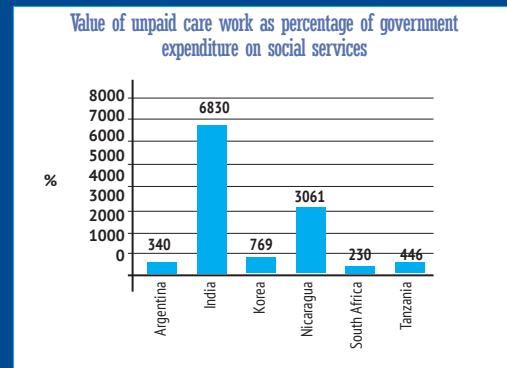
But this is only half of the issue at stake. On the “benefitting” side of care, there are dependents, non-dependents, and the system as a whole. Unpaid care work operates as a “free transfer” (similarly, for example, to household income consumed by all household members independent of whether they generated that income), a “subsidy” from those who provide care

to those who receive it, which has the potential to offset, to some extent, income inequalities (see Box 2). In addition, unpaid care work has the characteristics of a “public good” – the society as a whole, and not just those receiving care, benefits from it, and, therefore, total benefits outweigh total costs (Folbre, 2004).<sup>16</sup>

### Box 3

#### THE VALUE OF UNPAID CARE WORK AS A PROPORTION OF SOCIAL EXPENDITURES

Assigning a monetary value to unpaid care work (comprising direct and “indirect” care work in the form of domestic work) allows comparison of the whole of this work relative to other monetary aggregates such as GDP, the value of paid work, or governments’ social expenditures. Based on Budlender (2008),<sup>17</sup> the graph shows how the value of unpaid care work compares to expenditures in social services in different countries. The comparison is interesting in as much these services might be substituted for one another.



Source: udlender (2008).

Despite high variability, the value of unpaid care work is many times the public sector expenditures in social services in the selected countries. In countries like India and Nicaragua, the very high relation of the value of unpaid care work relative to social expenditures suggests a very low provision of social services by the state. In all the countries, the proportions are very high: in the best of cases, like in South Africa, the value of unpaid care work is more than double the total salaries paid to the staff working in the provision of public social services. These data clearly show that the provision of care services in these countries is overwhelmingly supported by the unpaid work carried out within households and families, and provide arguments for the need to increase social expenditures to reduce the burden on households and the women in them.

<sup>16</sup> The argument here is broader than the argument that contributions to child care produce “human capital” formation. It also includes unpaid domestic work as allowing the development of everyday life.

<sup>17</sup> Budlender, Debbie (2008) “The Statistical Evidence on Care and Non-Care Work across Six Countries”, Gender and Development Programme Paper Number 4, UNRISD: Geneva.



Therefore, unpaid care work also constitutes a “subsidy” from households to the public sphere (the state and the market) (Picchio, 2003).

The distributive conflict between production and reproduction is, then, a conflict between living conditions for unpaid care providers (more often female) – assuming those who need care receive it – and ways in which society supports (or does not support) the costs of the provision of care from which it benefits everyday. This is a “structural” conflict: it depends on the countries’ development style, both in terms of the level of unpaid care work upon which a society “depends” and “needs”, and its distribution in terms of gender, class, and generation. The care a society “needs” depends on its demographics (the number of dependents), and also on the very definition of “dependence” and “need,” concepts that are socially constructed. In addition to demographic factors, the unpaid care work a society “has” also depends on the shares of women and men participating in the labour market, and whether this participation hinders unpaid care provision.<sup>18</sup>

The old “male breadwinner-female carer” model, and the “family wage”, are examples of one way to “solve” this conflict – perhaps least extended in Latin America, given the family configurations (nuclear families) and the labour market functioning (formal workers) implicit in such model.

Another way of solving the conflict between production and reproduction is the “wages for housework” campaign. Although this agenda has some vitality in the region, the “political actor” in this case (housewives not participating in the labour market) is decreasing as a proportion of the population of younger women<sup>19</sup>. In both cases, income is redistributed in a “progressive” manner while work done follows a “conservative” pattern, reinforcing gender stereotypes.

Informal labour markets, family structures other than the nuclear family, high income inequality for those doing paid work, and conflicts between production and reproduction emerge in interpersonal negotiations. At this micro level, women’s lesser income, the lack of access to free care services, and gender images all reinforce differences in capabilities and power between women and men, and between women belonging to different economic strata. In extreme situations, such as in the presence of chronic illness or HIV/AIDS in households without the resources for addressing them, or in situations where state help is weak or non-existent, this distributive conflict might confront those who need care with those who provide it (EGM, 2008). This distributive conflict between production and reproduction also emerges in times of economic crisis, when the unpaid care work helps compensate for lower household incomes, a situation highlighted in feminist economics literature based on

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<sup>18</sup> For a typology of Latin American countries relative to both aspects, see Martínez Franzoni (2007 and 2010).

<sup>19</sup> Demands for care work remuneration have sustained the “pensions for housewives” agenda in the context of contributory social security systems, as in the case of Argentina and Venezuela. While these initiatives are framed discursively in the broad framework of the “care economy”, they are by no means universal (placing restrictions on the age of the beneficiaries, for example). They are in truth related to the provision of minimum incomes to cover specific population groups, not to (badly) pay for care work.

Latin American experience in the 1980s and the Southeast Asian crises in the late 1990s (Elso, 1995; Floro and Dymski, 2000).

Indeed, the “male breadwinner bias” in economic policies is present in the prioritization of male employment within employment generation policies, in the “inactivation” policies for poor women implicit in certain conditional transfer programs, and in the absence of policies designed to reconcile work and family responsibilities. More subtly, this bias is also present in macroeconomic regimes that rely solely on employment generation to improve social indicators without addressing the ways in which, at the same time, care is provided (Elson and Cagatay, 2000). This implies, on one hand, that the participation of women in the labour market, and therefore their employment, is less than it would be if women could redistribute their care burdens. In addition, the “market bias” in economic policies is closely related – that is, the prioritization of access to goods and services through the market, in opposition to access as a right (entitlement) – since, ignoring the provision of care, public policies leave space for the commodification of care services. When this happens, employment opportunities for women are positively associated with income levels, generating or further deepening inequality.

Finally, in opposition to the economic agenda in the Beijing Platform for Action, which proposed “a model of economic growth that is egalitarian, inclusive, participatory, people-centred, sustainable in terms of the environment and accountable, and based on a rights-based approach to much public service delivery” to achieve gender equality (EGM, 2009: 55), an orthodox agenda has predominated, which prioritized price stability over employment generation (Elson and Catagay, 2000). In our region, this type of orthodox model combine low inflation, exchange rate appreciation, and foreign debt along with high unemployment, large informal sectors, and/or strong migration processes.

Arguably, then, the economic agenda of the care economy is one that generates opportunities for decent employment for men and women, reducing unpaid care work when it exists due to a lack of public infrastructure in basic services and transport, and redistributing care provision among households and society as a whole, and among men and women, within a framework of sustainable development (and not just GDP growth) (Elson, 2008).



## 3. Constructing an agenda for care in Latin America today

### 3.1. Limits in the construction of an “agenda for care”

Complaints about difficulties constructing an “agenda for care” in the region frequently appear in the literature. These difficulties match those of constructing other progressive agendas, without a doubt. But the “format” such agenda has taken could also present some limitations, which should be addressed for it to succeed.

The word “care” as used here encompasses a range of activities and policies that are not necessarily named in such a way by those who are involved in the process of designing and implementing them. Specialists in education, in policies to address children’s needs, or those focusing on anti-poverty, social security, health, or labour market policies do not necessarily think in terms of care – although

some of their dimensions fall within the “logic of care.” This should not be a serious problem – beyond establishing a common language – except that in some of these areas care has a different meaning than that used here. Among education specialists, “care” is associated with “assistance,” performed by families and seen as the opposite of “education”. In health, care has special and distinct meanings in medical attention, while, from the “logic of care” perspective, all health services are care services. These differences in the meaning of “care” for various actors require special attention to avoid misunderstandings. The risk is that those designing and implementing health and education policies understand “care” as an academic construction, far from their own concerns. The advantage is, undoubtedly, the construction of a “comprehensive” approach from the “logic of care” – one that cuts across education, health, social programs, the labour market, etc.

On the other hand, the “crisis of care” has been discussed in our region: aging populations, coupled with the still significant presence of children, and the increase in the number of people with special care needs implies

the “demand” for care has increased, and is expected to increase even more in the coming years in the region (ECLAC, 2010a: 175). At the same time, growing numbers of women in the labour market and changes in family dynamics and household sizes indicate a decrease in the traditional “supply” of care from women (Cerrutti and Binstock, 2009). Both processes question – as they have done in more developed societies for decades – whether care can continue to be thought of as the sole responsibility of families and the women in them, and therefore as a “private” matter.

However, the appeal to the “crisis of care” can be risky. The idea of “crisis” evokes urgency, and yet it is true that in many Latin American societies a “demographic bonus” still exists, and will continue to exist for a while (ECLAC, 2010a). In a continent subject to recurring macroeconomic crises, the idea of “crisis” associated with medium-term processes may not be as clear, and could be interpreted as an “imported” problem from other societies, far from our own. (It is interesting that the agenda for care of elderly adults – a European-type care agenda – has advanced more strongly in Uruguay, one of the oldest societies in Latin America.) An additional risk is that the idea of a “crisis of care” is easily associated with the “crisis of the family,” and in general with discourses that blame women who do not “adequately” fulfil their care roles for any

kind of social malfunctioning.

Additionally, demography may produce “challenges” and “windows of opportunity” in population phenomena, but these are not “inevitable” demographic outcomes in the sense of determining a unique future path.<sup>19</sup> Moreover, while tensions between the number of dependents and autonomous adults are resolved within families, family structures are not homogenous and are closely related to income levels (Cerrutti and Binstock, 2009). Therefore, other factors interacting with the demographic dimension – particularly income distribution and women’s participation in the labour market – may be equally or more important than demographics in determining whether such “care crisis” exists.

Another point to consider is how powerful “care” is in articulating families’ and women’s demands, in a regional context of high inequality in income distribution. Indeed, it is possible that profound differences in the provision and the reception of care in different social strata accounts for the lack of a stronger “bottom up” voicing of care demands. Some groups – those with relatively more capacity for voicing their demands and influencing the public agenda – have no conflict providing for care, hiring care services outside or within the home (in the form of paid domestic workers) in order to make care and paid work compatible for adult household members.

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<sup>19</sup> Based on a commentary by Marcela Cerrutti (demographer), in the International Seminar “Políticas de cuidado, género y bienestar”, IDES/UNFPA/UNICEF, October 14, 2010, Buenos Aires.

Far from the point where these services would be saturated and the “cost disease” emerges (a problem of “relative productivity” between different economic sectors that might emerge when an economy operates near full employment)<sup>20</sup>, care services in the private sector continue to be high quality and yet relatively inexpensive for these affluent enough families. The state of the labor market – particularly high levels of informality and income inequality –coupled with the weak regulation of domestic service, and the unique conditions of paid workers in this sector (individualized relationship with the employing household, high turnover, and low unionization) also make paid domestic work an “accessible” service. The characteristics of “care arrangements” in these sectors emphasize the private (and partially commodified) nature of care.

In parallel, in low-income groups, care continues to be seen as the responsibility of women, with men sometimes “helping” with activities they do not claim as their own (Martínez Franzoni et al, 2010; Faur, 2006). And, although it is not well resolved, “private” care – provided within households – could be preferred when compared to poor quality care services (Martínez Faronzi et al, 2010; Faur, 2006). In effect, the fragmentation of quality and coverage of care services – which, as previously mentioned, exacerbates income differences – also dilutes a right-based approach to access (Faur, 2011b).

Similarly, poverty reduction programs- which emphasize maternity as an exclusive role that women in poor households should prioritize -show- a “maternalism for the poor” perspective that supports neither gender equality nor income redistribution. These types of institutional “messages” “depoliticize” demands for care services, for which a demand exists but is experienced as an individual problem (Faur, 2011b; Martínez Franzoni et al, 2010). The construction of care as a dimension of public policy could possibly make these demands visible and help families and women articulate them.

### **3.2. The construction of an agenda for care today**

How should we frame, then, an agenda for care policies in the region? On the one hand, the agenda for care policies should remain, faithful to its origin, within the framework of an agenda for gender equality. The passage of “care” from feminist academic analysis to concrete social policies involves the risk of losing its roots and acquiring “familial” and “maternal” connotations, reinforcing care as women’s/mothers’ “proper” behaviour and men’s/fathers’ “improper” (or secondary) behaviour (Bedford, 2010).

The agenda for gender equality is likely to be diluted when the agenda for care focuses exclusively on needs of dependents, especially in the case of children, erasing tensions between the provision and the reception of

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<sup>20</sup> Because, having reached “optimal scale,” it is unlikely to increase work productivity in care sectors without jeopardizing quality, it is said in these sectors that productivity is “delayed” compared to average levels in the economy, which generates pressure to decrease salaries and/or increase prices (Himmelweit, 2007).



care (Razavi, 2010). In these cases, which uncritically emphasize the superiority of maternal care and treat different types of care as dichotomous (care by mothers/families or care by care services) instead of as complementary, demands for gender equality may fall to the background in order to ensure the provision of family care which is, in effect, provided by women/mothers.

But, while the agenda for care should be associated with an agenda for gender equality, gender equality should not be the only support for the agenda for care. And not because the gender equality agenda is not crucially central for equity and the generation of citizenship, but because regrettably, the gender equality agenda is still seen as a “secondary” agenda. The agenda for care has the potential to be assumed by a number of actors involved in social politics from different areas – health, education, social programs – whose expert knowledge enriches this perspective.

Also more difficult, but equally necessary, is the dialogue with those who implement macroeconomic policy from a heterodox perspective: the scale and design of direct employment policies, interventions and regulations in the labour market, and the ways in which public policy influences the productive structure and the generation of employment opportunities for women are all issues that can and should be considered within the care economy.

### 3.3. The care policies

Various “lists” of care policies have been proposed. They appear in United Nations agencies’ documents, like the latest ECLAC publications (2010a), the UNDP/ILO report (PNUD/OIT, 2009), the UNRISD report (2010a), or the CSW recommendations in 2009 and 2010. They are also in academic texts such as Benería (2008) and in “advocacy” reports like the Care Pack published by BRIDGE in the United Kingdom (Esplen, 2009) or the text “Hacia un sistema nacional de cuidados” from the Uruguayan Gender and Family Network (Fassler, 2009).

#### Recuadro 4 CARE POLICIES<sup>21</sup>

A policy environment that recognizes and values care as the bedrock of social and economic development has to respect the rights and needs of both care-givers and care-receivers. In such a context care-receivers would have universal and affordable access to care, as well as choice and control over how any help or assistance necessary to facilitate their independence is provided. Unpaid care-givers would be able to care in ways that strengthen the well-being and capabilities of the ones they care for without jeopardizing their own economic security. And care-giving would become a real option, with adequate recognition and reward. While concrete policy options are country and context specific, a number of policy priorities can be identified guided by these principles:

- Invest in infrastructure and basic social services.
- Ensure adequate and reliable source of income.
- Create synergies between social transfers and social services.
- Build on existing programmes to cover care needs.
- Recognize care workers and guarantee their rights.
- Make care more visible in statistics and public debates.

21 Based on UNRISD (2010b) Why Care Matters for Social Development, Research and Policy Brief 9, Geneva. UNRISD.

In almost all cases, recommendations revolve around a greater involvement of the state in providing care services, both for its positive implications for dependents (especially in the case of small children) and for the accompanying increased female participation in the labour market. In many cases, also, the need to guarantee minimum income and infrastructure levels as a precondition for providing care has arisen, supporting in a more or less explicit way heterodox macroeconomic policies. While there is still debate about the role of cash transfers (conditional or not), they are seen as complementary and not as opposed to the provision of care services. In some cases, the need to collect time use data in order to understand (and monitor changes in) unpaid care work is included in the list. The need to protect care workers, especially domestic workers is also included. With much less frequency, claims to remunerate care appear in the form of “wages for housework” or “pensions for housewives”. In summary, it could be said that “care policies” can be grouped in those that in diverse ways (including monetary resources) “offset” some of the costs of care that continues to be provided by women (paying for care), and those that “empower” women, allowing them to do other things in addition to (or instead of) providing care (redistributing care).

There is no lack of ideas, then. But how can we evaluate care policies? And how could possible changes in policies already in place be identified?

### **3.4. Towards a diagnosis of care policies**

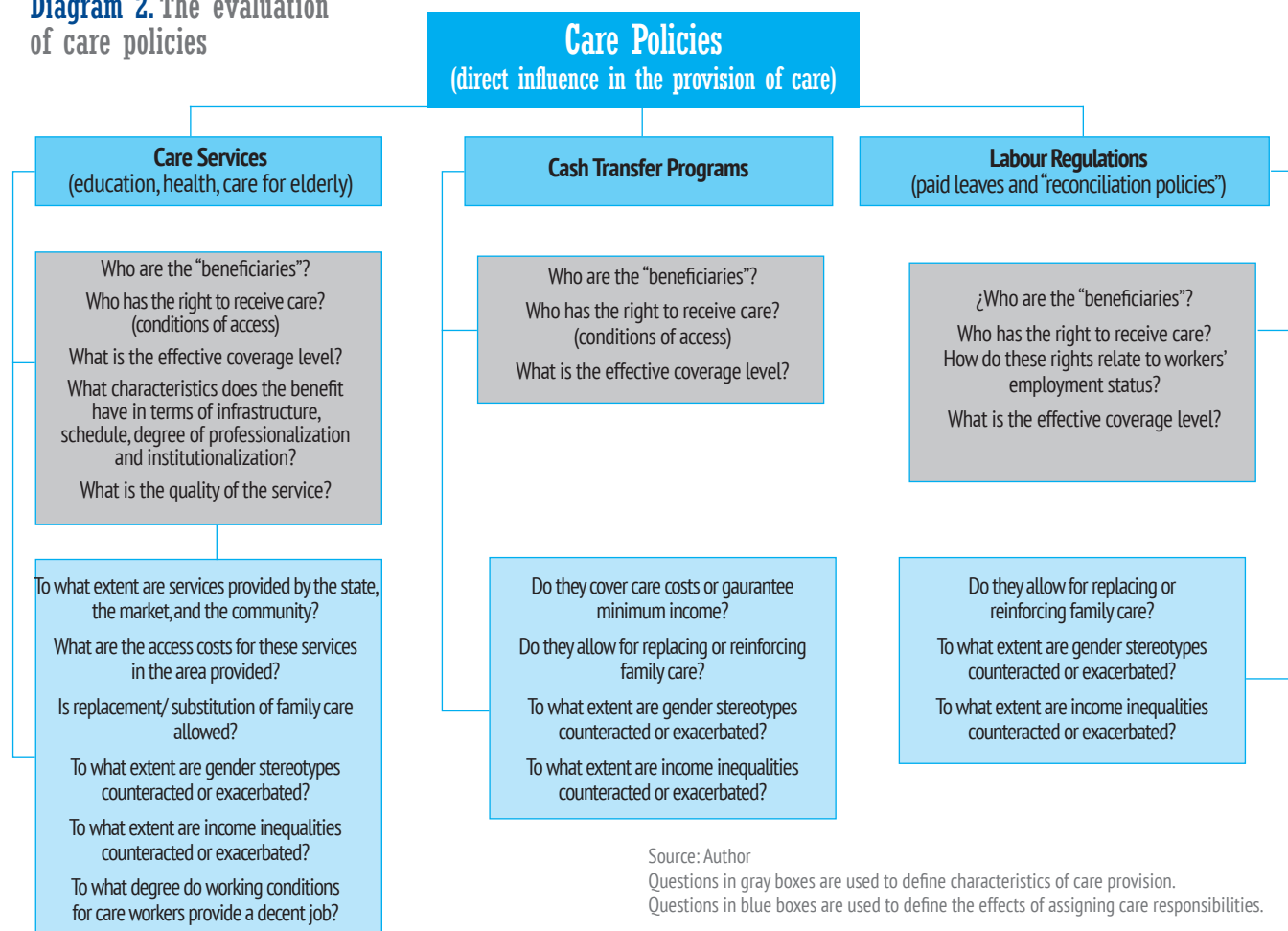
The starting point for a diagnosis of care policies is a survey of policies that have among their

objectives to directly influence the allocation of care responsibilities. In Diagram 2, the policies identified are care services, cash transfers, and labor regulations. These dimensions match those identified in literature as “care services,” “money for care,” and “time for care” (Ellingsaeter, 1999 cited in Faur, 2009). As such, health, social, and poverty reduction policies – which are not commonly referred to as “care policies,” even though they are so – are analyzed from the “logic of care.”

From this perspective, the degree to which care is explicitly taken account of by these policies; who these policies define as subjects of care (“dependents”), and as responsible for care provision (care-givers); the way in which conditions for access are defined; whether there are gender biases in access and coverage (in our societies, it is more likely that gender biases emerge among those designated “responsible” for providing care than among those receiving care); and if through the policies income inequality is addressed or not are all dimensions at stake (see Diagram 2).

For example, take the case of evaluating care services for preschool age children. From the “logic of care” perspective, the starting point is identifying ways in which the public policy designates those who are “beneficiaries” of these services. While a traditional perspective centered on education would consider the children as the beneficiaries of this service, from the “logic of care,” the beneficiaries are also families and women who would otherwise provide the care. An examination of this type “discovers” aspects

**Diagram 2.** The evaluation of care policies



of the daily organization of care services, such as daily schedules or proximity to households are as important as formal access conditions when it comes to the effective utilization of services. What, then, are the conditions of access? Who actually effectively access services? Is access paid for? Is access segmented by socioeconomic status? Do children of different economic strata have access to various types of services? The answers to these questions allow an understanding of the degree fragmentation (or, conversely, universalization) in the provision of these services, and identify if service provision (or the lack thereof) exacerbates or counteracts gender and income inequalities.

At the aggregate level, this policy “mapping” can also help in analyzing the degree of complementarity, overlap, or even contradiction among different policy interventions, along with identifying “gaps” in care – voids filled (or not) by families – for groups of dependents sparsely covered or not covered at all. Thus, this analysis highlights the necessary changes in existing policies to guarantee the rights of dependents and caregivers, and, eventually, also the need for new care policies.

The second step is the identification of the relationship between these care policies and

the functioning of the labour market. How does the social organization of care relate to the organization of paid work? To answer this question, the first dimension to consider is investigating whether the access to care services for dependents is related (or not) to the position within the labour market of those who have care responsibilities. If access is more connected to formal employment and/or to income/earnings, women with fewer resources will have more restricted options for participating in the labour market, or their participation will be more difficult. Conversely, when access to care services and transfers is decoupled from the position of caregivers in the labour market, there is greater potential for guaranteeing care of dependents and the full participation of men and women in the labour market (and possibly, a greater redistribution of care within households).

The second dimension is related to the degree of coordination (or lack thereof) among the organization of paid work and care services. With greater informality, and less regulation of working hours – that is to say, the more variable, flexible, or extensive working hours may be – it is more difficult to easily organize provision of care services, especially when the latter have limited opening hours. In this case, tensions emerge between the rights of workers in general and the rights of care workers. The case of the unregulated working schedule of domestic workers, which precisely covers the gap between working hours of parents and working hours for those in care services, appears as a particularly clear example of this tension.

The third step is to examine macroeconomic policies from the “logic of care” perspective. The effects on the level, structure, and dynamism of job creation create the most obvious route through which macroeconomic policies impact the provision of unpaid care, generating “transfers of working time” between the spheres of the monetized economy and the non-monetized care economy (Himmelweit, 2002). These transfers, however, are not gender neutral, and may generate redistributions among men and women, or a total work overload when paid and unpaid working hours are added. From the perspective of increasing “net” welfare, the loss of minimum thresholds of leisure time in cases when paid and unpaid working hours are excessive has to be added to unpaid care work replacement costs (in the form of care services or substitution for domestic workers). In this way, the net welfare increase becomes smaller than that brought about by the increase in income (also see Box 2).

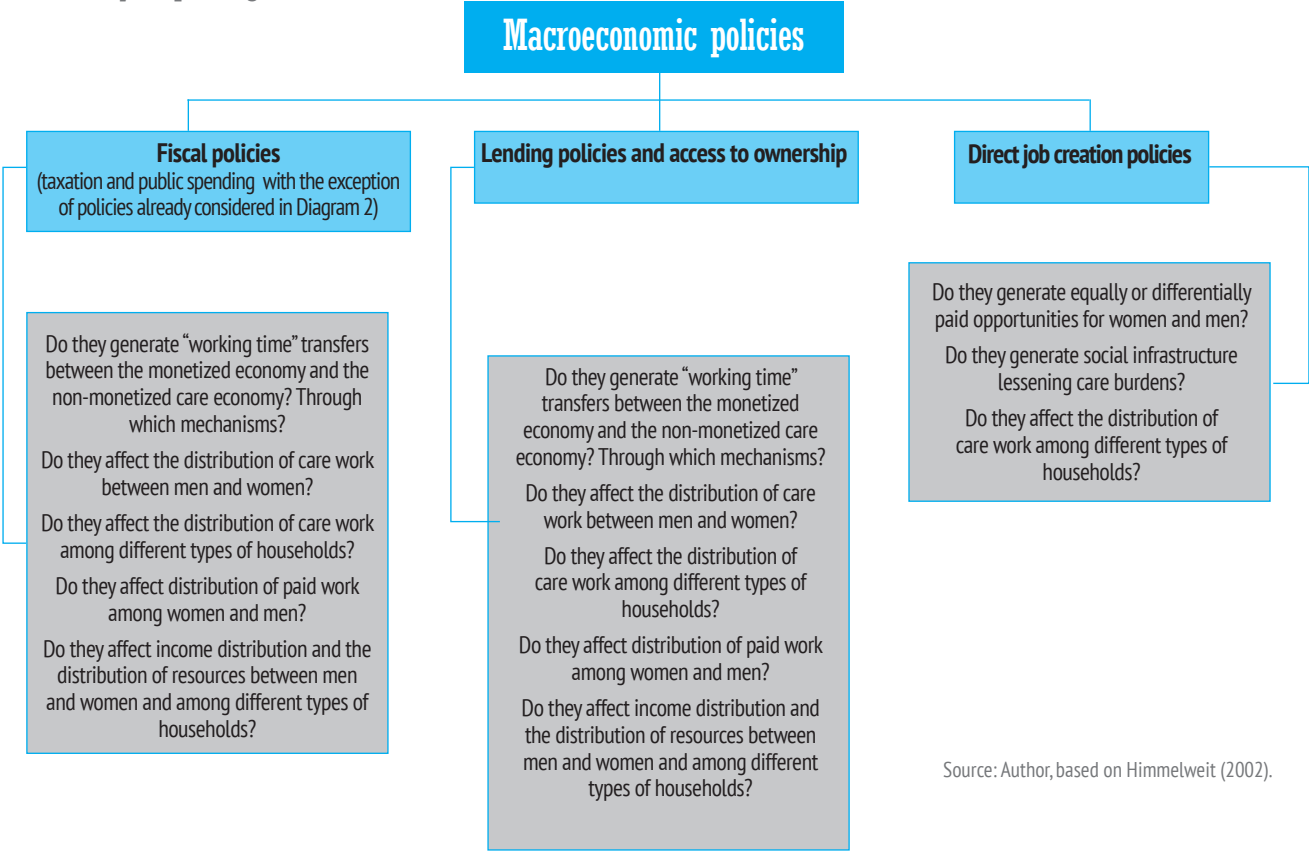
This type of analysis is particularly necessary in the case of public job creation programs, not only because employment opportunities for men and women differ depending on their expected care responsibilities, but also because the type of public infrastructure these plans generate has the potential to contribute to reducing unpaid work on the community or social level (through the provision of basic infrastructure) and care work (through the provision of social infrastructure). (Antonopoulos, 2007).

Macroeconomic policy also influences in a less evident way (but not necessarily with

less intensity) the distribution of care work (see Diagram 3). Taxation systems may create incentives that privilege or punish different models of care provision, indicating preferences in public policies for specific patterns of care work and paid work (for example, imposing lower tax rates to households following the “male breadwinner-female carer” model) (Grown,

2010). Credit policies may penalize women’s access to credit, and in this way, generate fewer opportunities for women’s income and consumption. Public policies – beyond direct care policies – may also, through their influence in the provision of public infrastructure and the characteristics of public employment, impact unpaid care provided by women and men.

**Diagram 3. Diagnosis of policies indirectly impacting care**



Source: Author, based on Himmelweit (2002).



## 4. Final remarks

The “care economy” helps opening debate on social, labour, and economic policies from a perspective that is complementary to social protection as well as to the analysis of the gender impact of economic policies. “Care” as an analytic category allows a fuller understanding of the tensions between dependent and non-dependent care needs, and the ways in which care is provided, adding to both types of (already established) analyses a dimension not always contemplated but crucial to their functioning. Indeed, “care,” although invisible, is never “private” but heavily intertwined with the “social” – in terms of gender and class – and the “public” – in terms of the policies directly and indirectly impacting the provision of care.

Because there is no single way to organize and ensure the provision of care and the rights of caregivers (paid or not), there is also no single policy of care. The remuneration of care agenda, or alternatively, the redistribution of care are both in force in the region, although with nuances

and different relative strengths. In some cases, relatively new discourses about the care economy (emphasizing the remuneration of care) are used to justify traditional poverty reduction policies, or policies related to increasing the coverage of contributive social security regimes. Fortunately, the recent Latin American Consensus of Quito and Brasilia – the outcomes of the X and XI Regional Conference on Women (ECLAC, 2007 and 2010b) – indicate very clearly the necessary redistribution of a portion of care provided by families to the public sphere, and move toward a larger role of the state in care provision.

To accompany and sustain such supranational agreements and implement them, it is imperative to build a care agenda “from the bottom up,” and base it on a gender equality agenda. For this to occur, the construction of a common language among various policy makers will be especially necessary, to enhance cross-sector dialogue as well as participation of different political actors (in particular, women from different income strata) that are able to politicize care not as something naturally feminine, but as an essential dimension of equality and welfare.

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