

Care: Feminist Economic Theory and Policy Challenges

Susan HIMMELWEIT

Keywords : Theory of care, Care policy, Sustainability, Relationships, Feminist economics

Introduction

All economists should be interested in care because how any society manages caring for its people has important effects on its economy. First, decisions about how much time individuals spend on care affects what else they can do with their time, and in particular what they can do in the labour market. Second, how much of society's resources are directed to care affects the quantity of resources available for other uses.

There have been various attempts in different countries, using different methodologies, to calculate the economic contribution of unpaid care, because it is not counted in GDP. All have found that

its total value is equivalent to about a third to a half of most countries' GDP (see e.g. Office of National Statistics 2002). Paid care is at the same time becoming an increasingly significant contributor to GDP, with the care industry the fastest growing sector in most developed economies. For example, in the US one-fifth of all workers are employed in work that can broadly be called care, more than the automobile and steel industries combined (Folbre and Nelson 2000, p. 126; Folbre 2006, p. 21).

Care is of particular interest to feminist economists because it is highly gendered. The people who provide care, whether unpaid care at home or paid care as a job, are largely, but not entirely, women. Earlier feminist analysis emphasised the difference between paid and unpaid work and the gender division of labour across paid and unpaid work (Himmelweit 2000). This was a focus on the social relations under which men's and women's labour is performed. Recent feminist economic analysis of care is different; it emphasises the particular characteristics of care as a use-value. This is a focus on the specific characteristics of the output of the activity of caring, not just whether it is paid or unpaid, but on the ways in which care differs from the typical use-value whose production and distribution is analysed in economic theory (Himmelweit 2007; Folbre 2008a, 2008b). The specific characteristics of care that have been noted include:

- that both the supply of and demand for care are affected by social norms. Social norms influence, on the demand side, people's needs for care and, on the supply side, how and by whom that care should be delivered. This, as we shall see below, has effects on how care needs are defined, care responsibilities are allocated and policy on care develops;
- that care involves a personal relationship between provider and receiver. This is quite different from how economic theory characterises the typical marketed good, whose provider and recipient need have no personal relationship. The personal relationship that care requires makes raising productivity in the provision of care very difficult, if not impossible. It also, as we shall see, affects the skills, training, pay and conditions of care workers.
- that caregivers' motivations are intrinsic to the quality of the care they provide: good quality care is not care that is seen to be given reluctantly. Care's quality therefore depends on how its provider feels, or seems to feel, about what they are doing. This and the previous characteristic, the relational character of care, make it difficult to assess the quality of care, which has implications, as we shall see below, for the institutional forms in which care is delivered.

This theorisation of the specific characteristics of the use-value of care can be argued to be the most distinctive contribution to date of feminist economics. It can be applied to both paid and unpaid work. It is a significant addition to the earlier Marxist feminist analysis of the social relations of domestic work, which applied only to unpaid care and was interested mainly in whether and how it contributes to the production of value.

This feminist economic analysis of care is relevant to more general economic analysis, because other goods share care's characteristics to a greater or lesser extent: norms are important in the demand and supply of a number of goods and services, relationships matter in the delivery of many other services, and there are other goods whose quality is hard to assess.

Feminist economic analysis therefore shows not so much how care differs from other goods and services, but rather how it differs from the abstract goods and services of mainstream economic theory. It is not that other goods and services do not have the characteristics of care outlined above. Rather it is that such economic theory assumes away the implications of these characteristics for all goods, and it is only when we come to analyse care that the problem with this assumption becomes apparent.

This paper is structured around those three characteristics of care and their implications. The next two sections concentrate on the first of these, the influence of different shifting social norms on what are seen as care needs and the ways in which these are met. The following two sections examine the cost implications of care involving a personal relationship, and the implications of rising costs for the different sectors of care provision. The next section considers pressures on the quality of care of motivations intrinsic to different sectors of provision. In the final three sections the paper then examines why current systems of care are so gendered, how that renders them unsustainable and policies that would be needed to develop more sustainable care systems for the future.

Defining care: care needs and provision

Care is needed to help some people, those with 'care needs', to be able to do what others can do unaided. Using Sen's capability framework, people's care needs are what they require in order to have a capability set that includes what are generally seen as basic functionings, what it is agreed that everybody should be able to do in that society (Sen, 1992).

By definition, care needs are unequally distributed. Some people have no care needs and others have many. Care 'needs' are so-called because satisfying needs tend to be seen as more important than satisfying 'wants'. This gives meeting needs more significance than meeting wants in how society works and, in particular, in allocating other people's time.

Social norms, though, influence what are thought to be care needs, and these differ across societies. For example, being able to fetch water might be as important a need in some societies as being able to read is in others. Needs can be gendered too: what are thought to be essential functionings can differ between men and women. For example, in some societies for a woman to be able to earn an independent living may not be seen as so important as for a man to be able to do so.

Care needs are met mostly by personal services, which family and friends may provide even at considerable cost to themselves. Not only are needs seen as more important than wants, it can also be that other people's needs are seen as more important than an individual's own wants. Women often pay a considerable cost for attending to other people's needs.

Care needs can also be met by buying care services from the market, either by employing others directly or by purchasing services from firms. Or they can be met by voluntary or community organisations; usually where the family or the market fails to provide care. Such organisations are many and varied: they may charge fees or may provide free care, and they may employ paid workers or be

staffed by volunteers.

There is also public provision of care. This has developed in part because the provision of care has positive externalities. Because others beyond those who would purchase it for themselves or provide it for their family derive benefits from care provision, care would be undersupplied if it were just left to the family and the market to provide. In particular, the care that children receive as a private good has wider economic benefits through improving the future workforce's human capital; by this argument, public provision of much childcare can be justified as a social investment – a good whose future returns to society are not captured in market prices and which is thus under-provided if provision is left to the market. More broadly, high-quality care for children and adults provides externalities both through maintaining social solidarity and reciprocity between generations (lower crime rates, more trust and helpfulness), and by reassuring individuals about how their own care needs will be met. Further, access to care through either the family or the market is unequally distributed. Both income and the availability of family to look after people vary and not in proportion to care needs. For all of these reasons, care is also provided collectively by the state, directly by public provision or indirectly by subsidising the purchase of care on the market.

How different types of care are provided by different sectors of the economy differs substantially across societies and has seen many changes historically. Rasavi (2007) suggests that we can characterise a society's provision of care by a shifting 'care diamond' as in Figure 1. To the three sectors of households, market and state, the diamond adds the community/non-profit sector, which in many countries provides significant amounts of care. Historically, this sector has been particularly important in initiating forms of care that governments have subsequently provided or financed. For example, voluntary provision, motivated by a mix of religious, social and educational commitments, provided the foundation for what became the extensive social care systems of the Scandinavian welfare states (Anttonen, 2005). And in many low-income countries, care provided by local communities and the donor-funded non-profit sector is often the only alternative to family care (Rasavi, 2007). Care provided by the non-profit sector may be allocated by the market, so in Figure 1 market provision by for-profit firms is labelled 'private (for-profit)' to distinguish it from 'community (non-profit)' provision.

The gray area covering part of the care diamond shown in Figure 1 comprises care that is allocated by the market, by being purchased, including all private/for-profit care and some public sector and non-profit care. All other care is allocated by some other means, usually according to need, by state, community or household sectors. The cross-hatched area shows care that is provided by paid workers. These include both public and private sector care workers and some, but not all, who work in the non-profit sector. The remaining care is provided unpaid.

The balance of the provision of care by different sectors varies by country and also varies by type of care. For example, elder care may be provided quite differently from child care. Note that Figure 1 is for the direct provision of care but the financing of it might be different. The state, as noted earlier, can finance provision by any of the other three sectors.

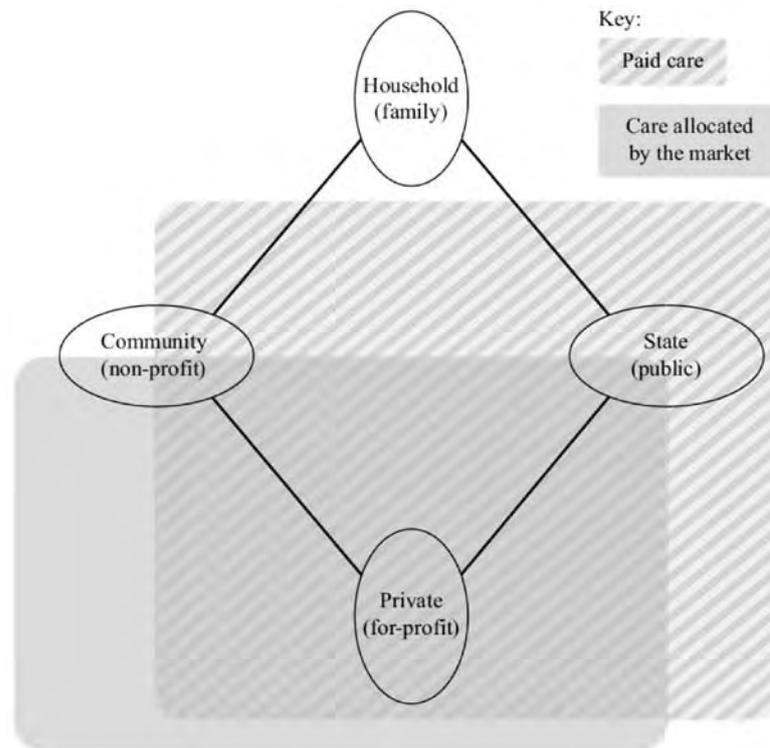


Figure 1: The 'care diamond'

Source: loosely based on Rasavi, 2007, p. 21

Changing care norms

Not only do care norms determine who is seen to need care; there are also social norms concerning the responsibility for care provision. In most societies, parents are expected to take responsibility for providing care to children, but societies vary in how far children are expected to take responsibility for providing care to elderly parents. There are also norms about how far beyond their family people can expect to receive or give care, how much the wider community gets involved, and whose care needs are seen as a collective responsibility. It is clear that in all societies norms about care-giving are highly gendered. Women are expected to take more responsibility and provide more unpaid care than men, and within all sectors, both paid and unpaid care work tends to be seen as more suitable work for women than men. Many feminists see the greater propensity for women to be allocated care responsibilities as the fundamental explanation of gender difference throughout society. Feminist economists tend to try to explain the extent of such gendering, knowing that it varies across societies and can change over time.

My own view on this is that gendered norms about care and responsibility and gendered economic opportunities reinforce each other. There is feedback between them. As economic opportunities change, so do caring norms. For example, as women have entered employment, more people, particularly women, think it acceptable to use paid childcare (Himmelweit and Sigala 2004).

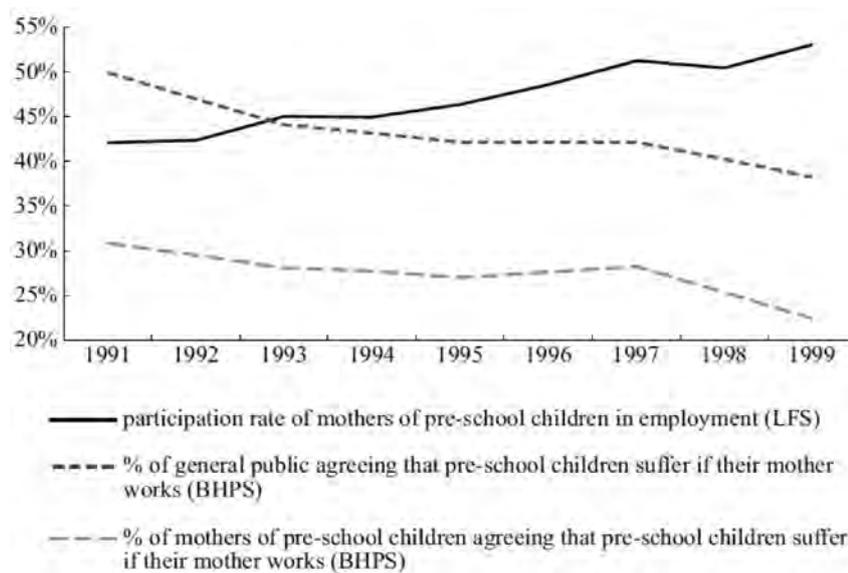


Figure 2: Participation rate of UK mothers of pre-school children in employment, and percentages agreeing that pre-school children suffer if their mother works

Source: Himmelweit and Sigala, 2004, using Labour Force Survey (LFS) and British Household Panel Survey (BHPS)

Figure 2 shows this for the UK in the 1990s. Its solid line shows how the employment participation rate of mothers of preschool children rose through the 1990s. The other two lines show how, as more mothers went to work, the percentage of mothers of preschool children who thought children suffered if their mother worked fell, through the 1990s, and not only among the mothers themselves (the light dashed line) but also among the population in general (the darker dashed line). As more mothers took employment, fewer people thought that children suffered as a result. Time-use studies from many countries show that as women entered employment, men began to do more unpaid child-care, shifting their attitudes too. Men did not participate in much other unpaid domestic work, but they did begin to do some more child care.

This shows that there is positive feedback between norms and behaviour. Norms alone do not explain patterns of care provision. Economic factors matter too. Economic change can therefore be speeded up (or slowed down) by changing (or unchanging) norms. Since both norms and economic conditions influence care provision, such positive feedback between them may mean that care provision develops on quite different paths in different societies. Differences across countries in the distribution of care provision across different sectors of the economy cannot therefore be fully explained by differences in care norms alone. We need to examine the economic factors that shape both care norms and care provision.

Care as a personal service and its rising costs

Over time, rising real wages in high-income countries have led to a decreasing proportion of labour being devoted to the production of goods and an increasing proportion to services. This is be-

cause increasingly expensive labour has been replaced both by capital and by cheaper labour from lower-income countries. A combination of capital investment, labour-saving technological change and off-shoring to keep labour costs down has reduced the amount of labour that high-income countries devote to the production of manufactured goods. There have been similar trends in some services – primarily information services – where technological change has reduced considerably the need for labour, and many of the remaining labour-intensive jobs in data-entry, software design and call centre employment have been outsourced (Folbre, 2006). On the other hand, the proportion of labour employed in care has soared. This is primarily because of the movement of care from the unpaid household sector into the market. But why has the resulting growth in employment not been offset by the same processes that have reduced employment in manufacturing and information services?

The answer lies in care provision being a hands-on personal service: it involves providing physical help at the same time as relating to the person being cared for. This cannot be done at a distance, and provides little scope for raising productivity by technological change because the number of people for whom one carer can care simultaneously is limited. While this limit may differ between different types of care needs, after a certain point spreading care over more people must reduce its quality. Indeed, when it comes to care, measures of high productivity are specifically taken as indices of low quality: a good childcare centre is taken to be one with a high staff-to-child ratio. In general, once the minimum amount of care time required to provide care of a given quality is reached, increased 'productivity' can result only in lower-quality care, because care workers' time cannot be reduced while maintaining standards of care.

The US economist William Baumol noted that industries use labour in two different ways according to the type of product being produced (Baumol, 1967). Many industries, including all manufacturing and some services, use labour just as an input; in these industries, alternative techniques can produce an effectively identical product, so it should be possible to raise labour productivity by capital investment and/or technological improvements.

There are other industries in which labour is not only an input, it is the effective output too, and so if less labour is used, a different product is produced. Baumol was initially interested in the economics of the arts, and used the example of a string quartet; neither cutting the number of players nor playing faster could raise its labour productivity without substantially changing the nature of what it produced. Other such industries include 'health care, education ... and the care of the indigent', 'precisely those in which the human touch is crucial, and are thus resistant to labor productivity growth' (Baumol, 1993, pp. 17, 19). In these industries, there is little scope for raising labour productivity through the substitution of capital for labour or technological improvements.

In industries of the second type, output tends to be measured by time spent (Baumol and Oates, 1972; Donath, 1996). Care is an example of this second type of industry; it is a hands-on personal service in which reducing the time spent cannot in general increase productivity while retaining the quality of care. An hour's childcare takes an hour; it cannot be speeded up. Of course, it is possible to increase the number of children looked after by each childcare worker. But beyond a certain point

this is likely to damage the personal nature of care; using less labour but reducing quality is not a real productivity increase.

That means that, unless quality falls, labour costs in care rise in proportion to wages. Further, labour costs make up nearly all the cost of care; not much capital equipment is used. So, the cost of care in general rises as fast as wages. Since this is not true of other goods in whose production labour productivity can rise, care of a given quality, like listening to a string quartet, becomes relatively more expensive than other goods. This is a particularly severe case of what became known as Baumol's 'cost disease': that as a country's standard of living rises due to increasing real wages, costs in industries in which productivity cannot be increased rise relative to those of more 'progressive' industries, where labour-saving technical progress is possible. This will, over time, be compounded by these progressive industries becoming less labour-intensive, making labour costs a less significant proportion of their total costs, while industries such as care remain as labour-intensive as ever. Since the retail price index includes commodities of both types, in industries in which productivity increases are impossible costs rise faster than inflation, that is, real costs rise, while in those industries in which productivity increases, real costs fall.

It is not that there are no uses for technology in care. Some ancillary care services like the cooking of meals can sometimes be speeded up through the use of technology, and passive care, such as the monitoring of people in case they need help, can occasionally be carried out by fewer people with technological aids, particularly using information technology. The time saved could then be used either to enable people to give better quality care or to speed up the whole care process, reducing its relational quality and thereby producing lower quality care.

The other way to reduce costs is outsourcing. Industries facing rising wage bills sometimes outsource production to lower wage economies to reduce their costs. This is not in general possible for care which cannot be done at a distance; a carer working in the Philippines cannot look after someone in Tokyo. There is a small amount of such outsourcing, particularly in Europe, through people choosing to retire to, or getting medical operations done, in countries where care is cheaper; but that is not a major movement. A much more important trend is the employment of migrant care workers in higher-income countries, which can be seen as an alternative form of outsourcing. This is becoming increasingly prevalent to different extents in all high-income countries, including Japan.

Baumol's argument only applies when wages are rising and doesn't apply directly in lower-income countries with stagnant wages (Rasavi 2007). However, it does affect such countries if they lose their internationally mobile care workers through migration to higher income countries. Such care workers are often the people with the greatest skills and the most expensive training in low income countries, raising the question as to whether it is worth countries that cannot offer high wages training such workers at all. Some countries, notably the Philippines, specifically invest in training care workers, such as nurses for export, so that they send remittances home. For other countries, particularly poorer African countries, migration of skilled care workers is a significant drain on national resources at a time when their skills are greatly needed at home. For example, a third of all the nurses

trained in Ghana now work in the UK, and their training is a large contribution of the low-income Ghanaian economy to the health of the much richer UK economy (Smith and Mackintosh 2007). Such migration may also lead to so-called 'global care chains' in which care workers from poorer countries look after those needing care in richer countries, while leaving behind those that they would otherwise have been caring for to be looked after by others, who may thereby be less available to meet their own family's care needs (Ehrenreich and Hochschild 2002; Yeates 2004).

Effects of rising costs on different care sectors

The effects of rising wages and hence care costs vary across different sectors of care provision. For those doing unpaid care, rising wages make it increasingly worthwhile taking employment. Those with higher earning potential or smaller care responsibilities will increasingly purchase substitute care and take employment as the opportunity cost of being out of the labour market rises. And if some unpaid carers, those who can earn more or have smaller care responsibilities, start taking employment and purchasing substitute care, this may shift care norms to become more supportive of doing so. That may make others who cannot earn so much or with greater care responsibilities also want to take employment, but for many it will be too expensive. This has led to inequality in access to affordable care becoming a major issue in many high income countries today (Himmelweit and Land 2007).

One response by those who cannot find affordable care is to lower the standards of acceptable care and purchase lower quality care. The quality of care provided in the home may also fall because more of the people providing care would rather be doing something else. They may feel trapped into doing it by lack of affordable substitute care, and therefore put pressure on the state to provide or subsidise alternative forms of care and/or to regulate its quality.

What about the effects of rising wages and care costs on private sector providers of care? In a competitive market, profit-making firms must always try to lower their costs. If they cannot do so by raising productivity, the only ways to cut costs are by reducing staffing ratios or employing cheaper workers, either those with less training or those made vulnerable by lack of alternatives, such as migrants. All these ways of reducing costs are likely to lower the quality of care provision.

There are economies of scale ancillary to care provision, partly to do with regulation, since there are fixed costs in compliance, and also in passive care, where staffing ratios can be lower in larger establishments. One way to reduce costs and raise productivity then is to become bigger. And since this also may give market power in setting prices, profitable care providers have every incentive to try to expand.

However, this can lead to over expansion and there have been some spectacular collapses of large scale care providers. This happened in Australia, to the firm ABC Learning, which at the time of its collapse had 70% of the Australian care market and large proportions of the UK and US markets too (Brennan, 2007). Similarly, the largest provider of residential care in the UK, Southern Cross,

collapsed in the summer of 2011. In both cases the government had to intervene because those children and older people could not be left uncared for. The Australian economy would have suffered greatly if the parents of ABC Learning's children had stayed off work to look after them, and there is no acceptance of the idea that old people can be turned out on the street when a residential care home fails financially. Similar issues of moral hazard are therefore raised in the care industry to those in the financial sector. These care providers had expanded at an unsustainable rate, and whether or not they were consciously relying on the state to step in if they failed, in practice the state did do so. For all these reasons, the provision of care by private for-profit providers needs to be very carefully regulated.

Public sector providers and non-profit providers funded by the state or charitable donations are under similar cost pressures. This means in practice that their funding tends to lag behind their actual costs. This is easily misinterpreted as a sign of inefficiency, rather than that rising costs are inherent in the nature of care, necessary to maintaining quality (Himmelweit and Land 2007). This often leads to calls for privatisation of public sector care or opening up voluntary sector provision to competition from for-profit providers. Nearly fifty years ago, it was Baumol's recognition of a similar tendency to blame rising municipal spending on the arts on inefficient administration that led to the discovery of his 'cost disease' (Baumol and Bowen 1965).

Quality of care

Care is a form of emotional labour, where workers are required to feel appropriate emotions to do their work or at least to appear to feel them (Hochschild, 1983/2003). However, unlike in the typical occupations where emotional labour was first analysed, such as being an air hostess, where relationships are typically short term, care often involves more long-term relationships that develop over time. That is not always true. Nurses, for example may only have a short-term commitment to the people they care for, but much of what we call 'care' involves longer-term relationships. As a result, carers learn what particular people require to be well-cared for, and often become attached to those for whom they care, both of which tend to improve the quality of care received. This means that continuity of care matters, not only for very young children, as is well recognised, but also for older people, particularly if they get easily confused.

Some of the skills required in care work concern relating to others. Such skills in particular tend not to be well recognised, because they are not obviously codifiable; people's needs differ so codifying how to look after a particular person may not be possible, though how to be flexible in responding to needs can be taught. Such flexibility is often portrayed as a natural attribute of women rather than a skill that has to be learned and paid for. This low recognition of, and financial compensation for, the skills involved, combined with the attempts by employers to keep costs down, has led to high turnover rates. But, high turnover of staff, because it affects continuity of care, inevitably affects its quality too.

Competition is often argued to improve quality and bring down prices. That efficiency argument has been used for privatisation in care provision too. For competition to have these beneficial effects, customers must be able to assess both what they are purchasing and any alternatives in order to compare quality and prices. But in care, quality depends on motivation and relational characteristics which are hard to assess from outside without experience. In practice decisions about care are often made by people in a hurry with no previous experience and few alternatives. When people have to find a place in residential care for an elderly relative they usually do not have the opportunity to shop around, because the need for care is urgent, and there are few other places available. The same is often true of child care, though perhaps to a lesser extent.

For markets to work, customers must be able to change providers easily without too much cost. Again that is not in general true of care, especially not of residential care, partly because, as we have seen, continuity of care is an important aspect of quality, so changing residential care provider is only done in extremis.

Governments tend to get involved in the regulation and monitoring of care quality and in doing so may try to assess these relational aspects. However, for-profit and other providers are under pressure to reduce costs. A private for-profit provider's duty to its shareholders is to make any cost savings that it can. A belief that good quality will be recognised may help to reduce such a tendency, but there will always be a temptation to make such savings on whatever is not monitored. We have seen that regulations and monitoring systems tend always to run behind the ways that providers have found to cut costs. Rather than trying to monitor private sector providers, it may be more effective for care to be provided through institutional forms that provide alternative motivations for providing high quality care, such as an ethic of public or charitable service might do in public or voluntary sector provision. Such institutional forms may as a result provide better care and also be more trusted by people to do so (Hansmann 1980; Cleveland et al 2007). Trust is an important characteristic because if care is not considered of sufficient quality, those needing care and their families may be unwilling to use it.

Gender and the provision of care

In theory, in nearly all countries, most care is provided 'free' by families, but in practice is paid for by the opportunity costs of unpaid carers, who are mostly women. Care is also available on the market, and while the balance between for-profit and non-profit providers varies across different countries, the costs for both are kept down by care workers being low paid. And in most countries, although not in the very poorest, there is also some state funding for situations where neither the family nor markets provide enough care.

The costs of such publically funded care tend to be kept down by restrictions on who receives it, how much is provided and its quality. Publically funded care may be provided directly by the public sector or through the market: by state tendering of contracts to private sector providers; or, alterna-

tively, by giving money directly to care recipients so that they can buy their own care or employ their own carers. There has been a tendency over the last 10–15 years to move more towards systems that are seen as using the market to provide 'value for money', which could mean either saving costs or improving quality, but inevitably tends to put more emphasis on measurable cost savings.

The quantity of paid care is dwarfed by the amounts of unpaid care, mostly given by women, on which such systems depend. However, while women are the major care-givers in most age groups, in the oldest age group a larger proportion of men than women may be carers. This is because most older carers are looking after their spouses and a larger proportion of surviving men than women in the oldest age group still have a living spouse who might need care. This shows that men can and do care when there is no woman available to do so. However, where there is a woman available, a man doesn't tend to be the primary carer, though he may 'help'.

It is not only gender norms that have made reliance on large quantities of unpaid care by women possible. Low pay and restricted labour market opportunities for women in the paid care sector have contributed to why women of working age are more likely to take on caring roles than men. Within a household, if it is felt that somebody needs to stay at home to care, it is not only gender norms but also their economic opportunities that makes that person more likely to be a woman.

As a result, inequalities in the labour market and in care complement each other. Equal sharing within families becomes an expensive thing to do. Gender norms and gendered economic opportunities reinforce each other and this slows down change, but has not eliminated it.

Sustainability of care systems

However, current pressures are making care systems unsustainable. There is a rising demand for care in Japan, and in most other high-income countries too. This is due in part to demographic pressures that increase life expectancy. To date, increased life expectancy has tended to lengthen the period in which people need and are seen to need care. This is not inevitable. Much, but not all, additional life expectancy is spent without extra care needs. If medical advances in the future concentrate more on improving old people's mobility and fitness, then future increases in life expectancy may not lead to more care being needed, especially if a cure for, or a way of delaying the onset of, dementia is found. The demand for care does not necessarily grow with an ageing population, although so far it has.

Another reason for rising demand for care could be greater recognition of care needs. This may also be fuelled by advances in medicine, leading to greater demand for medical treatment. But whether that necessarily entails great demand for care in the more personal sense is not clear; again it could go either way. And of course better recognition of need does not necessarily mean that such needs are then met; rather it may lead to greater inequality in access to the full benefits of good care and possibly greater recognition of that inequality.

In some, but not all countries, worries about sustainability also focus on the way falling birth

rates are reducing the working-age population as a proportion of the total. But in many countries, who counts as 'working-age' is being redefined by increases in the retirement age and, in any event, whether this is a genuine cause for concern depends on assumptions about who can provide care.

Second, the availability of unpaid care is falling for a number of reasons. One is that those falling birth rates have resulted in the current elderly generation having smaller numbers of adult children to provide care for them, who are also more mobile so may not be in the right place to do so. Further their daughters and daughters-in-law, who have always provided the vast majority of unpaid care to parents, are more likely to be in employment. The rising employment levels of women are shifting demand from unpaid to paid care and increasing the number of people who need at least some of their care needs to be met by paid care.

Expanding opportunities for women outside the care industry provide another pressure on the care system. The main source of employment for women used to be in care, but that is no longer the case. Once women can find employment outside the care industry, wages in care cannot lag far behind those of other sectors. In most high-income countries, there are already recruitment and retention problems in care. Employers are finding it hard to get suitable people to work in care and even harder to keep them. This is not very surprising, because care is an expanding industry with poor working conditions. Pay and conditions may have to improve if the rising demand for care can be met, unless unemployment persists or other disadvantaged workers, such as migrants, can be called on to meet the demand for care. But the supply of such workers is not expandable indefinitely.

Rising inequality of incomes in nearly all developed economies put another pressure on care systems by increasing the proportion of people who can not afford to pay for care unaided. If care costs are rising and the income distribution is widening, more people will have incomes below the level at which they can afford to pay for care themselves. So while rising inequality does not necessarily affect the demand for paid care overall, it does affect demands on the state for help with paying for care.

Public expenditure on care is rising as a result of these pressures, but insufficiently to meet care needs. This was so even before the financial crisis. State budgets for care were rising insufficiently to meet the rising proportion of care that was not being provided by the family or the market. Some policy makers were also becoming concerned that an unfair burden of care costs, in terms of both money and time were falling on particular individuals, those with particularly high care needs and their relatives.

As a result the needs of unpaid carers have been rising up the political agenda. A factor affecting this is that women's voting behaviour is diverging from men's, and women are becoming increasingly recognised as a distinct voting bloc. For example, in the UK, a higher proportion of women than men say that they will not vote for the parties that make up the current coalition government that is bringing in austerity cuts in social services. Another reason why care is an important political issue is that older tend to people vote, which puts limits on the extent to which governments can ignore issues to do with care.

Policy responses

There have been different types of responses to this situation. The first is to try to reverse existing trends and re-establish traditional patterns of care. That response fails to tackle any of the issues discussed above. It is unsustainable, and neither possible nor desirable. Unfortunately, that has not stopped governments from trying it. For example, the UK government has reformed the welfare system to improve the income of one-earner couples relative to those with two earners, which might encourage some women to give up employment. But this would only do so, without leading to resentment, if people really wanted to move back to older patterns. But there is little evidence to support that view, making any attempt to return to traditional patterns of care likely to be a totally ineffective response to the unsustainability of the current care system.

A second response is to tinker at the edges of the existing system. That is often done by trying to reduce the growth of public expenditure by using market solutions to provide paid care, reducing the proportion funded by the state, and at the same time trying to increase the amount of unpaid care provided by families. An example of this is the promotion in the UK of so-called 'personalisation', the idea that everybody should be able to choose what care they are given, by a rejection of public provision of care as 'insensitive mass production'. Instead, choice is supposed to be enabled by giving direct payments to care recipients so that they can buy the care that they want. Such a system will attempt to draw as much as possible on unpaid family care as well as whatever co-funding care recipients and their families might want to add to payments from the state.

If such extension of the use of the market to provide care services were to prove sustainable, it would only be because of the free care and financial support that families provide. However that relies on static gender norms, the assumption that women will continue to provide unpaid family care even as they are increasingly involved in the labour market. In practice, that is likely only to be a temporary stopgap, so would also prove unsustainable in the long run without more structural change taking place.

A third response, which might be more sustainable, is to try to change the dependence of existing care systems on gender divisions. That would entail policies designed to make both men behave more like women, by encouraging them to do more unpaid care, and women behave more like men, by promoting greater equality in the labour market. Both would need to be implemented together. First, to enable men to behave more like women, men's hours of employment would need to be reduced to increase the unpaid care work they can do: one might need other policies to ensure that men actually do it. And then to enable women to behave more like men, policies would need to be brought in that increase women's wages and the quality of their jobs, which should lead to more sharing of employment and caring roles within families.

How could these changes happen? First, they would require labour market policies that make it easier for men to take on caring responsibilities. Patterns set up early in a relationship affect gender divisions of care in later life. Giving parents equal leave and encouragement to look after newborn

children is important, not only because of the caring relationships set up with those children, but also to provide non-gendered caring models for those children as they get older. To get men equally involved in caring as women seems to be key.

This would require regulation of working hours for all; where full time working hours are very long, it becomes hard for households to have two full-time workers. Reducing the hours of employment of full-time workers may not result in households overall putting in fewer hours of employment, but employment and caring could be more equally shared. Paid leave, available for both men and women, would be needed to cover periods requiring particularly high intensity caring. Iceland, for example, gives men and women equal individual rights to leave after the birth of children.

Second, flexible working would need to be made available to all without penalty. Many countries have policies to enable workers to work flexibly to accommodate care commitments, but there are few ways of preventing the costs of that flexibility not being borne by the workers themselves. One possible way is through equality legislation, for example, by outlawing pay penalties for working part-time. Not all countries have the severe penalties for part-time work found in the UK and Japan; indeed in some there is no penalty at all.

Third, gender equality more generally in the labour market would be needed, so that men's and women's time spent caring have similar opportunity cost for a family.

Fourth, not only legislation, but also alternative care services would be required to enable unpaid care to be combined with employment. High quality care services would be needed that are accessible and affordable for everyone. Quality is important if substitute care services are seen as acceptable alternatives to unpaid care. Quality will improve only if there are better pay and conditions, good training provision and a career structure in the care sector: untrained and undervalued workers do not provide the best care. Further, low pay in the care sector is a large contributor to the gender pay gap, which is a major barrier to more equal sharing of caring and employment roles within families. One way to achieve this might be to allow the public and non-profit sectors to set standards in the care industry and use regulations to prevent private for-profit firms undercutting those standards.

Finally, care budgets need to be properly funded for the level of need. More funding for care is needed at present in nearly all countries.

Is this affordable and sustainable? The level of demand for paid care depends on the overall level of employment. It is not clear whether greater equality, with men doing more unpaid care and women doing more in the labour market, will result in more unpaid care being given and therefore less paid care being needed, or vice versa. On that will depend both how much has to be spent on care but also the tax base available for paying for it.

If the net result is a rise in overall employment levels and hours, then the budget for social care provision will have to rise, but that can be paid for by the consequent increase in revenues that is made possible by those greater levels of employment. Paying more for care needs to be recognised as the necessary cost of increasing employment levels. If more care needs to be paid for, there are also more people in employment and the taxes from those extra people can pay for that extra care. To

see this one has to focus on what income is left over rather than the percentage of GDP taken in taxes. While the percentage of GDP taken in tax may rise, disposable incomes will not fall. An economy with higher levels of employment will need to pay for more care, but will also have the resources to pay for it.

But, on the other hand, it could be that this type of solution results in a decreased level of overall employment. This would be the environmentally more friendly solution. Of course, it also might be the more likely outcome in a recession. In that case, with a lower level of employment, there will be lower GDP and also less revenue needing to be spent on paid care.

In future, any trends that lead to increased demand for paid care can provide the increased revenue needed without reducing disposable income. By focussing on the level of disposable income, not on the percentage of GDP that goes in government spending, we can make use of Baumol's analysis again. He showed that although municipal spending rose through rising costs, it could be paid for out of the increased productivity that was leading to those rising costs, and the same applies to care (Baumol and Bowen, 1965).

Nevertheless, there is a current problem because of past underfunding. As women's employment rose over past decades, economies benefited from increased revenues without adequately paying for the consequent care costs. There is no solution to past underfunding besides paying for it. So, quite a large one-off increase in spending on care is needed to get to a situation in which care provision is adequate, but from there it would be easy to move on in a more sustainable way.

(Susan HIMMELWEIT, Professor of Economics, The Open University, UK)

References

- Anttonen, Anneli (2005) 'Empowering social policy: the role of the social care services in modern welfare states', in Kangas, Olli and Palme, Joakim (eds) *Social Policy and Economic Development in the Nordic Countries*, Basingstoke, United Nations Research Institute for Social Development (UNRISD)/Palgrave Macmillan.
- Baumol, William (1967) 'Macroeconomics of unbalanced growth: the anatomy of an urban crisis', *American Economic Review*, vol. 57, no. 3, pp. 415-26.
- Baumol, William (1993) 'Health care, education and the cost disease: a looming crisis for public choice', *Public Choice*, vol. 77, pp. 17-28.
- Baumol, William J. and Bowen, William G. (1965) 'On the performing arts: the anatomy of their economic problems', *American Economic Review*, vol. 55, no. 2, pp. 495-502.
- Baumol, William J. and Oates, Wallace E. (1972) 'The cost disease of the personal services and the quality of life', *Skandinaviska Enskilda Banken Quarterly Review*, vol. 2, pp. 44-54.
- Cleveland, Gordon, Forer, Barry, Hyatt, Douglas, Japel, Christa and Krashinsky, Michael (2007) *An Economic Perspective on the Current and Future Role of Nonprofit Provision of Early Learning and Child Care Services in Canada*, Toronto. <http://childcarepolicy.net/documents/final-report-FINAL-print.pdf> (Accessed 25 May 2010).
- Donath, Susan (1996) 'The other economy: a suggestion for a distinctively feminist economics', *Feminist Economics*, vol. 6, no. 1, pp. 115-24.
- Ehrenreich, Barbara and Hochschild, Arlie Russell (eds) (2002) *Global Women: Nannies, Maids and Sex Workers in the New*

- Economy*, New York, Metropolitan Books.
- Folbre, Nancy (2006) 'Demanding quality: worker/consumer coalitions and "high road" strategies in the care sector', *Politics and Society*, vol. 34, pp. 11–31.
- Folbre, Nancy (2008a) 'Reforming care', *Politics and Society*, vol. 36, pp. 373–87.
- Folbre, Nancy (2008b) 'When a commodity is not exactly a commodity', *Science*, vol. 319, no. 5871, pp. 1769–70.
- Folbre, Nancy and Nelson, Julie (2000) 'For love or money – or both?', *Journal of Economic Perspectives*, vol. 14, no. 4, pp. 123–40.
- Hansmann, Henry B. (1980) 'The role of nonprofit enterprise', *Yale Law Journal*, vol. 89, no. 5, pp. 835–901.
- Himmelweit, Susan (2007) 'The prospects for caring: economic theory and policy analysis', *Cambridge Journal of Economics*, vol. 31, no. 4, pp. 581–99.
- Himmelweit, Susan and Land, Hilary (2007) 'Supporting parents and carers', Working Paper no. 63, Manchester, Equal Opportunities Commission.
- Himmelweit, Susan and Sigala, Maria (2004) 'Choice and the relationship between identities and behaviour for mothers with pre-school children: some implications for policy from a UK study', *Journal of Social Policy*, vol. 33, no. 3, pp. 455–78.
- Hochschild, Arlie Russell (1983, reprinted with new afterword 2003) *The Managed Heart: The Commercialization of Human Feeling*, Berkeley, CA, University of California Press.
- Office for National Statistics (ONS) (2002) Household Satellite Account. www.statistics.gov.uk/hhsa (Accessed 1 February 2010).
- Rasavi, Shahra (2007) 'The political and social economy of care in a development context: conceptual issues, research questions and policy options', Programme on Gender and Development, Paper no. 3, Geneva, UNRISD.
- Sen, Amartya (1992) *Inequality Re-examined*, Oxford, Oxford University Press.
- Smith, Pamela and Mackintosh, Maureen (2007) 'Profession, market and class: nurse migration and the remaking of division and disadvantage', *Journal of Clinical Nursing*, vol. 16, no. 12, pp. 2213–20.
- Waerness, Kari (1987) 'On the rationality of caring', in Showstack Sassoon, Anne (ed.) *Women and the State*, London, Hutchinson.
- Yeates, Nicola (2004) 'Global care chains: critical reflections and lines of enquiry', *International Feminist Journal of Politics*, vol. 6, no. 3, pp. 369–91.