"Global perspectives on the social organization of care in times of crisis: Assessing the situation"

Amaia Pérez Orozco

Gender, Migration and Development Series

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Working paper 5

The United Nations International Research and Training Institute for the Advancement of Women (UN-INSTRAW) promotes applied research on gender issues, facilitates knowledge management, and supports capacity-building through networking mechanisms and multi-stakeholder partnerships with UN agencies, governments, academia and civil society.

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"Global perspectives on the social organization of care in times of crisis: Assessing the situation"
Author: Amaia Pérez Orozco
Translation from Spanish: Laura Olsen

United Nations International Research and Training
Institute for the Advancement of Women (INSTRAW)
César Nicolás Penson 102-A
Santo Domingo, Dominican Republic
Phone: 1-809-685-2111
Fax: 1-809-685-2117
Email: info@un-instraw.org
Webpage: http://www.un-instraw.org

Global perspectives on the social organization of care in timesof crisis: Assessing the situation

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This working paper series is the result of UN-INSTRAW's research in migration, gender and development and the organization's recently launched work in a new strategic area: global care chains.[1] UN-INSTRAW is convinced that the formation of global care chains embodies the broader process of the globalization of care and provides a valuable position from which to examine the interrelationship between migration and development. This paper accompanies "Global perspectives on the social organization of care in times of crisis: Assesing the policy challenges ahead".

The study of global care chains looks most often at Asian migration (or interregional migration as in the case of the US) and rarely at migration from Latin America and the Caribbean, which is the focus of these papers. The first paper asks 'what is happening' while the second considers 'how to intervene in what is happening'. Our intention to launch these papers in a public debate is three-fold: 1) to show the importance of including caregiving in the discussion of development; 2) to argue that we cannot talk about caregiving without considering globalization and migration; and 3) to raise new elements of reflection for those already working in the area of social organization of care, such as development issue from a transnational perspective.

Principal ideas of the document:

- The care crisis is a part of the multidimensional global crisis that we are experiencing.

- Care is the invisible base of the economic system:

    - It is understood that care is the responsibility of women and is, for the most part, performed without monetary compensation.
    - Because care work is neither paid nor valued it is not measured; because it is not visible it is not taken into account in policymaking. Time-use surveys are a key tool to end this vicious cycle.
    - Unpaid care work often acts as a cushion that absorbs the costs of readjustments of the economic system. Care's invisibility means that it enters the public debate only when care needs are not being met.

- Care is already global/Global Care Chains

    - Today no aspect of the socioeconomic system is so autonomous that it can be explained within the boundaries of national borders. It is essential to introduce a transnational perspective in the analysis of the demand for and the provision of care.
    - As individuals move, work in the care sector is internationalized. This constitutes what are called 'global care chains': the entanglement of households in different places around the world that transfer care giving tasks from one household to another.
    - Migration transforms the manner in which care is carried out, the resources available for caregiving, the way in which family, maternity and paternity are managed and under-

[1] This work builds upon other topics covered in INSTRAW migration research, which previously focused on the use and impact of remittances. It also derives from conceptual reflections and results of previous empirical work (see UN-INSTRAW conceptual framework, 2005 and its update 2008). This broadening of focus is also physical, since UN-INSTRAW now has an office at the Universidad Autónoma de Madrid, Spain, from which it coordinates four case studies of global care chains between Ecuador / Peru / Bolivia-Spain and Peru-Chile.

stood, and the very concept of what it is to provide (good quality) care.
- Increasingly, supranational actors (multinational corporations, international cooperation agencies, multinational agencies) are involved in the provision of care and the industry is being outsourced to less expensive locations.
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- Impacts of the globalization of care on development: some certainties and many questions

  - The effects on development must be assessed on two levels: in the households directly involved in the care chains, and across the socioeconomic structure.
  - The ambivalent and/or contradictory impacts on households need to be assessed on three levels: 1) the households of employers in destination countries: hiring additional labour for care work is not a miracle solution but a response to urgent needs; 2) transnational households: there are contradictory results between the different areas that guarantee material and emotional reproduction; 3) migrant households: these households often experience a gross violation of their care rights, which include not only the right to receive care but also the right to choose whether they want to perform care or not, and the right to labour standards in paid care work..
  - There is a worrisome shortage of systematic analysis on care's impact on development (care is still fundamentally perceived as a private matter of the family) that is made worse in the country of origin by studies that tend to use imported concepts and methodologies that do not respond to their realities.
  - Migration does not create the serious problems associated with the denial of care rights in the countries of origin, nor does it resolve these problems in the destination countries. In both cases, however, it can reveal the existence of these problems. Is migration serving as a catalyst for the demand for public accountability and social responses?
  - The social reproduction of care is now privatized in a double sense: the responsibility of guaranteeing care remains in the household and care is increasingly purchased in the market.
  - Care continues to be invisible and excluded from public debate. When care leaves the boundaries of the household, it does so in the form of individual buying and selling and not as a right. Care labour is still unfairly distributed between different social groups along gender, class, and ethnicity lines: the sexual division of labour takes on new global dimensions.
  - Both in countries of origin and destination, caregiving has produced changes in gender relations that bring latent problems to light. This tends to result in a process of intensified privatization of social reproduction and in a refashioning of the sexual division of labour. Might this be the old solution of avoiding public responsibilities in terms of care through an unjust distribution of labour, now with a new transnational dimension?

1. What is in crisis?

We are living in a multifaceted global crisis in which the financial crisis has meant the collapse of the current development model. Various crises have impacted social and economic structures: the food crisis, the environmental crisis, the energy crisis and…the care crisis.

Before the outbreak of the financial crisis, the care crisis (or crises[2]) was already being felt in countries both at the centre and periphery. In the former, the crisis consists of a breakdown of the previous model of providing care based on the nuclear Fordist family model and the classic sexual division of labour, in which care was treated as the unpaid responsibility of women in the private, domestic sphere. As expectations of social reproduction change, a redistribution of work becomes necessary that, without taking place, creates strong social and family tensions. In the latter, the crisis refers more to the difficulties of guaranteeing the processes of social reproduction themselves, leading households to deploy new survival strategies. These strategies are also cross-cut by the different responsibilities assumed by women and men, involving different costs and responses from different actors. In order to comprehend the multidimensional global crisis, a first and essential task is to consider care as inherent to it.[3]

The manner in which care needs are being met in different countries is changing. To understand these transformations we need to broaden our perspective to see which care resources flow inward and which flow outward and how each country is affected by what happens in other places. Why, as it is argued in this text, is care being globalized? What significance do these changes have? What is the impact in terms of development of the globalization of care that is embodied in global care chains?

2. Care as the invisible base of the socioeconomic system

The functioning of markets, the future of political structures, the creation of culture and thought… all that we normally assess in order to speak about development has a sine qua non condition: the daily production and reproduction of a population's life and health – the care of everyone.[4] So it can be said that caregiving and reproductive labour are the base on which the entire socioeconomic system is built. Who is in charge of care? How is care performed? How is care compensated? The answer is not simple, but we can identify at least two characteristics: the responsibility of care is understood as women's work[5] and most often care is performed without monetary compensation. In our capitalist society all activity that does not involve monetary flows becomes invisible, and is neither seen nor valued. Although the (in)visibility of socioeconomic processes is multidimensional, that lack of data is an essential aspect that serves to further the problem: because care work is not valued, it is not measured; because it is not visible, it is not taken into account in policymaking.

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[2] Zimmerman et al. (2006) speak of a "multiple crisis of care, including: a lack of care, the commodification of care and the growing role of supranational organizations in the provision of what are called developing countries."

[3] The profound impact on social and economic structures of the crisis of care "is becoming increasingly evident" (as claimed by WIDE at the conference "Economics of the care and crisis care," held in Basel, 18 -20 June 2009, www.wide-network.ch) in contexts affected by HIV / AIDS. The division of responsibilities of care in these settings was the theme of the 53rd Session of the Committee on the Status of Women http://www.un.org/womenwatch/daw/csw/53sess.htm. For a good overview of care, see Esplen (2009).

[4] By 'care', we are referring to the management and daily maintenance of life and health. For the most part, this sustenance is guaranteed daily through women's unpaid work in the home through direct care to people in situations of dependency. For this care work to be performed, certain "care preconditions" (food, cleanliness, etc.) – basic needs shared by all – must be met. The form of care and the meanings associated with it involve deep ethical sentiments and life goals. That is, although care is a routine task, it conveys a "sense of transcendence "(Anderson, 2008); care is a key dimension of human development, understood as being able to live a life with dignity that is worth living.

[5] The association of care with femininity results in an inherent disqualification of knowledge that this work requires; since it is considered 'natural' for women to do, it is not considered skilled work. Ironically, as certain caregiving tasks become professionalized, they are no longer seen as care, but rather as a professional field in which men are more likely to be involved.

Time use surveys are a vital tool to capture the enormous amount of unremunerated work that allows economic structures to function, and thereby capture an essential element to advance the understanding caregiving (who, where, how, to whom, under what conditions etc.) Because the use of time use surveys is fairly recent, their development is still quite rudimentary, especially in terms of methodological quality. But perhaps the principal problem is that the results that they offer are not interpreted together with other data to support public decision making. The richness of the data they offer is not sufficiently exploited nor are they used to understand the system as a whole.[6]

Time Use Surveys: Making visible unremunerated (care) work

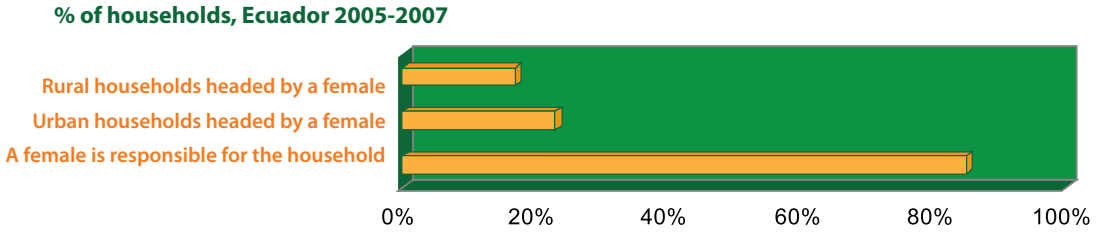
Notwithstanding the very diverse methodologies that use different time use surveys, all tend to confirm the following findings:

Finding 1: Global workload: How and by whom is wellbeing generated?

- Unpaid work is a central component that ensures levels of well-being and economic activity.
- Women work more hours than men, i.e. they assume more than half of the total work time that is socially necessary.
- Most of the time men spend working is dedicated to remunerated activities, while women dedicate more than twice as much time as men to unpaid work.
- The distribution of unpaid work varies between countries: in countries at the periphery the lack of basic infrastructure and technology requires that more time be invested in activities such as collecting water, washing clothes etc. and in countries at the centre less time is spent on care activities.

Finding 2: Heads of households?

From the data provided by time use surveys we can rethink the term head of household. If we consider the main figure in the household as he or she who assumes most of the daily tasks of maintaining the household (through paid and unpaid work), the majority of households are headed by women:



Source: ECLAC and Vásconez et al. (2009)

[6] Budlender (2008) noted some methodological flaws (in the design of the surveys and the survey process itself), but the most notable deficiencies are in the operation and subsequent use of the data. For a guide on how to implement time-use surveys, see UNSD (2005). UN-INSTRAW was a pioneer in the study of unpaid household work, which was one of the institution's areas of focus between 1984 and 1996. For more on time-use surveys please consult: International Association of Time Use Research (www.smu.ca / partners / iatur / iatur.htm) and Center for Time Use Research (www.timeuse.org/).

Finding 3: Differences not only according to sex

It's not enough to analyse time use surveys according to sex; the data must also be considered according to other variables:

- Experiences of unpaid work vary much more among women as a group than among men as a group.
- Social class, the environment (either rural or urban) and ethnicity are factors that explain patterns of time use. In the area of concern, it is especially important to cross examine the data from time use surveys with the migratory experience to be able to understand how the organization of households in the country of origin is reconfigured and to know the possible differences in time use between the native population and the migrant population in destination countries.
    - An example from Spain: the foreign population dedicates more time to remunerated work and less to matters that are not considered strictly necessary (social life, hobbies), while investing in the household and family practically the same amount of time as the Spanish population. It can be concluded that the foreign population has less freedom to choose how they spend their time (National Institute of Data and Statistics, 2003.)
    - An example from Ecuador: by comparing households with and without migrants, it can be seen that: 1) in the former, men dedicate more time to care, although in most households women continue to be the primary caregivers. And 2) women between 46 and 65 make up the majority of care providers; according to the qualitative information, the grandmothers are left in charge of the sons and daughters of migrants (Data from Vásconez et al. 2009).

Care is the invisible base of the system, which is only noticed when it is lacking.

For years, the debates surrounding welfare states have ignored the fact that their social systems are supported by the provision of this invisible work – an unsurprising oversight, given their incapability of understanding the interactions between the market, the state and the household.[7] It's in the moment of the above-mentioned crisis that the relevance of setting up the so-called fourth pillar of wellbeing (care of dependents) is discussed and benefits and services designed to facilitate the reconciliation of personal, family and work life are extended. Care, however, is a base that is implicitly assumed. Thus, the implementation of adjustment policies that reduce the responsibility of the public sector, de facto, assumes that there is a cushion of family work to cover what was once a public responsibility and to make up for the lack of basic services. Similarly, the so-called New Social Policy (typical of many Latin American countries) establishes programmes of conditional cash transfer as the key component of poverty reduction strategies. In these programmes families receive a minimum income if mothers ensure their children's access to education and health.[8] Care is always there, sustaining the population, even if we take its existence for granted. Unpaid care work often acts as a cushion that absorbs the costs of readjustments of the economic system. Care's invisibility means that it enters the public debate only when care needs are not being met.

3. Care is already global: Global care chainss

We speak infrequently about care, but, when we do decide to bring the issue to light, we do so in a restricted manner, limiting the discussion to the territory of the nation state. Care is one of the areas in which the negative effects of what has been called "methodological nationalism" are more strongly felt. In this understanding care is something that can be explained within national borders, without being affected by what is occurring in other spaces. In the current context of globalization it is obviously inconceivable that an element of the socioeconomic system could be so autonomous. An effort must be made to reflect upon what introducing a transnational pers-

[7] For a good analysis of Latin America that integrates these dimensions, please see Martínez Franzoni (2007).
[8] Son the relationship between unremunerated care work and social policy in periphery countries, please see Razavi (2007a and 2007b), Molyneux (2007) and UNRISD (2009).

pective to the analysis of the social demand and supply of care implies. In other words, we need to think about how to understand the social organization of care in the context of globalization.

The (partial and inadequate) solution to the care crisis in developed countries has been to transfer a large part of the work that was previously done by women in the household without pay to the market place. Increasingly, this work is being performed by migrants. Work in the care sector has been internationalized, as much in institutionalized care work – through day care centers, nursery schools, retirement homes, domestic help services, etc. which are managed by the private or public sectors – as in households that directly hire domestic service for the family.

The provision of care is directly linked to the process of feminization of migration. Women are increasingly leaders of migration, driven by the social reproduction crisis to which women respond as though they are the ultimate, if not the only, guarantor of family wellbeing[9] and by the work opportunities in the service sector that the care crisis has opened for them. As the IOM affirms (2008), regardless of the level of education of the migrant, female migrant labour is concentrated in occupations associated with traditional gender roles – these are the service sector in general and, more specifically, the care sector. Household labour is the principal door through which women migrants enter the workforce (and also the trap from which is it difficult to escape).

In turn, the departure of women requires a reorganization of households in the country of origin and a redistribution of the care work for which these women were previously responsible. At the same time, their departure does not mean women lose contact with their families; links with the household

Global Care Chains in Evolution

Lola arrived in Spain in 2005. Her children stayed with her husband in Bolivia (thereby constructing a transnational family). He followed a few months later (and did not assume the role of principal caregiver, since the masculine identity is linked to the role of income provider). Both managed to work, she as a worker in a household (in a typical women's labour niche). Her children stayed first with their maternal grandparents, but Lola was not happy with the situation (household management from a distance) and agreed with her sister in law that she move home (reorganization of family strategies).

When the couple achieved a certain level of job security, they wanted their children to join them before they would need a visa (family strategies affected by immigration policy) but were twice turned away at the airport. Only the oldest managed to enter (family reunification). Lola needed papers and moved with her son to another city where she did contract work (labour strategies affected by immigration policy). She cared for an elderly woman at night and her son slept alone (difficulties reconciling work and family life). She feels the situation is unsustainable.

[9] Not all migration arises from economic necessity – other factors, that are different for women and men, also affect migration. Among the motivations for women to migrate are the desire for greater freedom and autonomy and sexual life, escaping situations of gender violence, etc. (see UN-INSTRAW, 2008).

Are Global Care Chains a "Women's Issue"?

- There are also men who perform care labour: in countries of origin, men increase their dedication to unremunerated care work, especially when staying with young children. However, this is more common in transitional situations and supported by a wide circle of women (care is dispersed). In destination countries, men are increasingly performing care labour, especially for elderly men. However, a man's departure does not usually involve a significant reorganization of the household in the country of origin; that is to say, a man's absence does not bring about the formation of chains. Men, neither before nor after migration, assume the responsibility of being primary caregivers and therefore do not form chains.
- Although care chains are led by women, we must consider the places that other actors, especially men, public institutions and businesses occupy, in order to identify the absence of these actors in terms of accountability and in terms of receiving the benefits of care that results from the chains.

of origin are maintained. They form what are called transnational families, in which the management of family wellbeing acquires dimensions that transcend national borders. This complex process of the transfer of care and the creation of links between different households is what are called global care chains. As we have defined elsewhere, global care chains are 'networks of transnational dimensions that are formed to sustain daily life. These networks are comprised of households which transfer their care giving tasks from one to another on the basis of power axes, such as gender, ethnicity, social class, and place of origin.' (UN-INSTRAW, 2008: 90).

The formation of global care chains entails the creation of 'transnational spaces of care', i.e. links that involve new forms of household management and new forms of attending to an individual's needs without physical contact. Care involves the so-called transnational modes of being: the management of care occurs beyond borders, maternity and paternity become transnational, etc. Care also implies transnational modes of belonging. Migration changes the very notion of what constitutes good care, by whom, for whom, and how it should be carried out. In fact, global care chains always involve a change in caregiving model from the presence of the caregiver to one that emphasizes the provision of financial resources. Furthermore, care constitutes a part of 'transnational social fields'; in other words, care forms part of the local socioeconomic framework that is affected and transformed by migration. In that sense, the ability to meet daily needs at either end of the chain depends on what happens in other states, both at the macro and micro level: changes in employers' households affect the people hired; changes may occur in origin countries due to family reunification processes in destination countries or due to migrants' return; social, migration and labour policies affect the opening of the sector, conditioning the labour opportunities of those who migrate, and consequently, the sending of remittances, etc. Those same care needs are

transformed by important demographic changes that migration produces, making the weight of the sectors most in need of attention, such as minors or the elderly, vary considerably.

It is not only individuals who move internationally, giving rise to the creation of global care chains. There are also private and public agents whose actions have supranational impacts. Put another way, supranational agents are increasingly involved in the provision of care, an aspect that deserves more attention than it has received thus far. A significant part of care may be outsourced as the service sector is liberalized, as in the case of 'telecare services' that provide telephone assistance for elderly and disabled populations. Similarly, the influence of transnational corporations may be increasing as many services are privatized (domestic help, residences, insurance agencies etc., even work in the household) and as large companies diversify the services they offer.

Besides the influence of the private sector, it is also important to note the significance of the public sector in two ways. On one hand, one must consider the influence of multilateral organizations/agencies in decision making with regards to public policies related to care or, more generally, the economic and social policies that predetermine the conditions in which they are designed. As Zimmerman et al. note, "How can individual societies affect positive social change and advance aspects such as improving the status of care work...when the policies of multilateral organizations can work against these efforts? Structural Adjustment policies inhibit the promotion of women and reinforce traditional activities and roles" (2006: 24). On the other hand, international co-operation is increasingly involved in the provision of care, either by providing care directly or by financing its supply. In addition, bilateral social security agreements that coordinate the benefits of welfare states between countries of origin and destination are also on the rise.

Is there an automatic link between the insertion of non-immigrant women in the labour market and the importation of care work?

The migration of women and their insertion in the care sector is driven by the care crisis in destination countries which, in turn, is closely linked to the integration of non-immigrant women into the labour market. But this is not always necessarily the case.

- The care crisis does not always bring about the creation of job opportunities. Although Japan has experienced a care crisis, migrant women had not been contracted until recently.
- The care crisis is triggered not only by the higher rates of labour market insertion of the non-immigrant population and the aging of the population. There are other factors at play, such as the model of urban growth, which significantly hinders the operation of social networks and the extended family, negates public spaces as places where care can be more collective and less intensive, makes the street a hostile place for children, increases commute time, spatially fragments the city into spaces of leisure, care and employment, etc. This pattern of urbanization is at the core of the environmental and energy crisis. The different dimensions of the global crisis feed into each other.
- The demand for foreign caregivers is not always related to the non-immigrant population's lack of time to perform care labour. There are examples, such as in the Gulf countries, where there are very high rates of recruitment of foreign domestic workers, despite the very low rates of inclusion of non-immigrant women in the labour market.

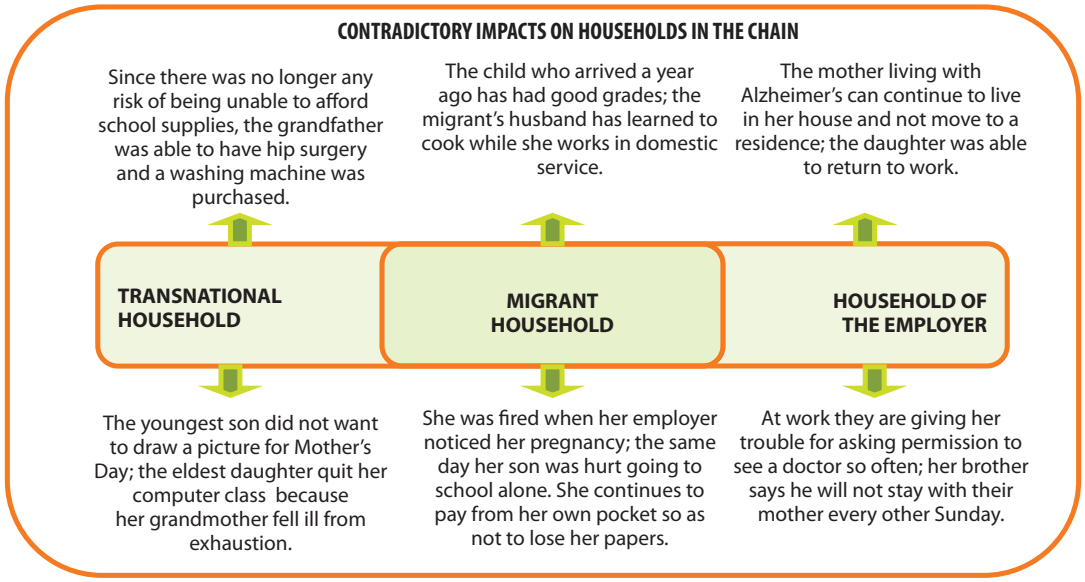
4. Impacts on development: some certainties and many questions

The provision of care is globalizing, linked as it is to the crises in countries of destination and origin and changes in gender relations. How are these changes to be understood in terms of development? As we have argued at UN-INSTRAW (2007b and 2008), this question must be answered on two levels: paying attention to the households directly involved and assessing the impacts on the socio-economic structure as a whole.

4.1. Impacts on the household actors in the chain

The first and most obvious place to evaluate the impact is in the very households that are involved in the chains. As we recall, these households are composed of at least three levels.

At one end of the chains are the households that receive the care work of migrants, and in many cases, households are the direct employers. The impact for those households is undoubtedly positive. That households are resorting to employment or the purchase of other types of services from the market is a response to imperative needs: the coverage of a gap that was not provided for; the freeing up of time to obtain greater quality of life or to dedicate more time to a professional career; the satisfaction of social expectations associated with differentiation of class, etc. However, it must not be thought that this work is a miraculous solution to all care needs nor does it signal the end of unremunerated care work. In fact, the coordination of the different care providers and the coverage of work not provided by contract work remains mostly a female responsibility.



On the other extreme are transnational families formed by the departure of women. The impact on transnational families is not as clearly positive. Are the preconditions of care, which include material aspects, improving due to remittances and is direct care becoming more difficult? Migration is a strategy and receiving remittances allows expectations (or imperative necessities) of material wellbeing to be met. However, the impacts on the provision of care are not clear. In fact, in this regard two rather contrasting viewpoints emerge: family breakdown vs. family recomposition (UN-INSTRAW 2007 and Paiewonsky 2008). One view is an alarmist discourse on the breakdown of the family provoked by the absence of mothers. The other highlights new ways families can function and new ways of transnational mothering that manage to overcome the physical separation.[10] The reality probably falls between the two extremes. However, to be able to reach a more definite conclusion, more and better data is needed, since the current data presents serious methodological deficiencies.[11] We must stress the importance of taking a more nuanced look at families, understanding them as social institutions in reconstruction, units of "cooperative conflict" (as Amartya Sen would say) that act within a broader institutional framework. Such families, within the contexts of departure and arrival, are not homogenous, but rather, diverse, since many factors affect whether migration becomes a factor of vulnerability or strength. (Herrera, 2009). Lastly, we must add the potential problem of tending to the elderly that can arise in countries of net emigration that are dealing with an increasingly older population.

The sending of remittances and the maintenance of family links

Leaving does not imply abandoning family responsibilities back home. On the contrary, migration often occurs in response to household needs and sending remittances is one of the key ways to contribute from afar.

Women send remittances more consistently than men: they do so more frequently, over a longer period of time, and are more responsive to the changing needs of the household of origin. Moreover, women's remittances represent a larger share of their salaries than men's. 60% of remittances sent from Spain to Latin America in 2006 were sent by women. They sent 39% of their wages, whereas men sent 15% (Moré et al., 2008). The ties expressed in terms of remittance sending are even stronger in the case of domestic employees.

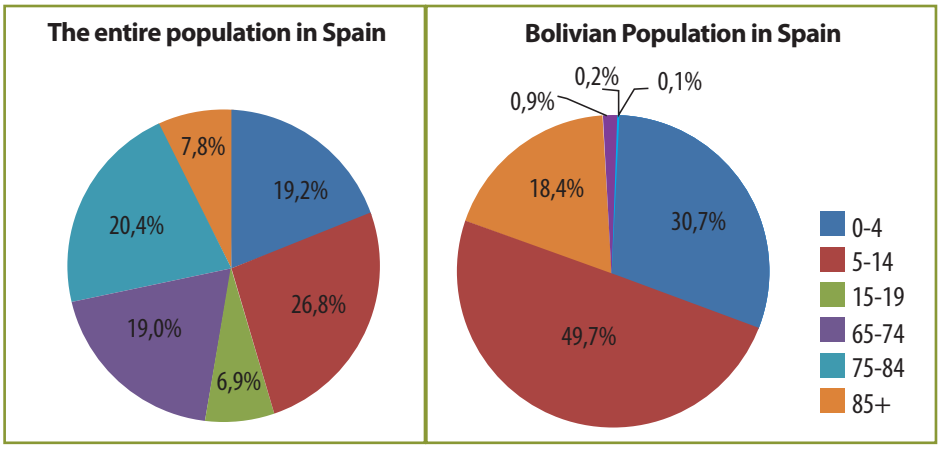
Remittances Sent	All migrants	Domestic staff from Bolivia, Colombia, Ecuador and Peru
At least once a month	19,3%	58,1%
Every three months or yearly	11,5%	15,7%
Occasionally	8,2%	7,8%
Not at all	61%	18,3%
Average amount sent annually	1.895 €	2.052 €

Source: elaborated with data from National Immigrant Survey (2007)

[10] The first discourse is developed in countries of origin at a social level and in the media and, in a probably unintended way, is linked with a third discourse that emphasizes the global inequalities that allow the richer countries to exploit poorer countries. The second is of a more "academic and elitist" approach (Herrera, 2009).

[11] Among the deficiencies, we can state poor quality of information sources, reliability, comparability and validity of measurement instruments as well as design weaknesses (lack of comparability, abuse of cross-sectional analysis, sampling problems). On top of these weaknesses, there is an ideological bias that especially permeates this topic for, as we have stated elsewhere, "it is a matter that touches upon the essential aspects of the social order of gender" (UN-INSTRAW, 2007a).

Special Needs: The demand for care on women aged 18-64



These graphs have been calculated assuming that the care needs vary with age (greater in children and elderly) and those who care are usually women between 18 and 64 years old. They refer only to unpaid care.

They show how different groups of the population create demand for unpaid care labour for which women must answer: for all women in Spain the demand is distributed more or less equally between what is called juvenile dependency (under age) and elderly dependency (aged 65+), with increasing pressure from the latter, which creates difficulties. In contrast, demand for the care of Bolivian women in Spain comes almost completely from minors.

The presence of these migrant women is crucial to help solve the problems that result from the aging of the Spanish population (for both the work they undertake and their contribution to the increase in fertility). But these women also have specific care responsibilities: is there any recognition of this situation in terms of public policy? The tendency to hinder their reunification with their own aging parents would indicate not. This policy does not correspond with the almost complete lack of demand for public services that this population segment presents and can make it impossible for them to turn to a strategy frequently used by natives: the free care labour provided by grandmothers.

There is also a third group to consider: migrant households in destination countries. However, analysis of such households is severely lacking (this being another example of the methodological nationalism that prevails in the approach to studying care).[12] Women migrants tend to be considered only as salaried caretakers, without regard to their own quality of life, nor that of their families. Despite the lack of studies, it can be argued that, because of their particular demographic structure, these families have unique care needs. Thus, for the migrant population the demand for care is, above all, for children (in fact, it is thanks to the migrant population that fertility rates are recovering in many destination countries), while for the native population, the need for care is mainly for the elderly.

On the other hand, the explanatory factors regarding the difficulties of reconciling work and family life are more acute in the experience of

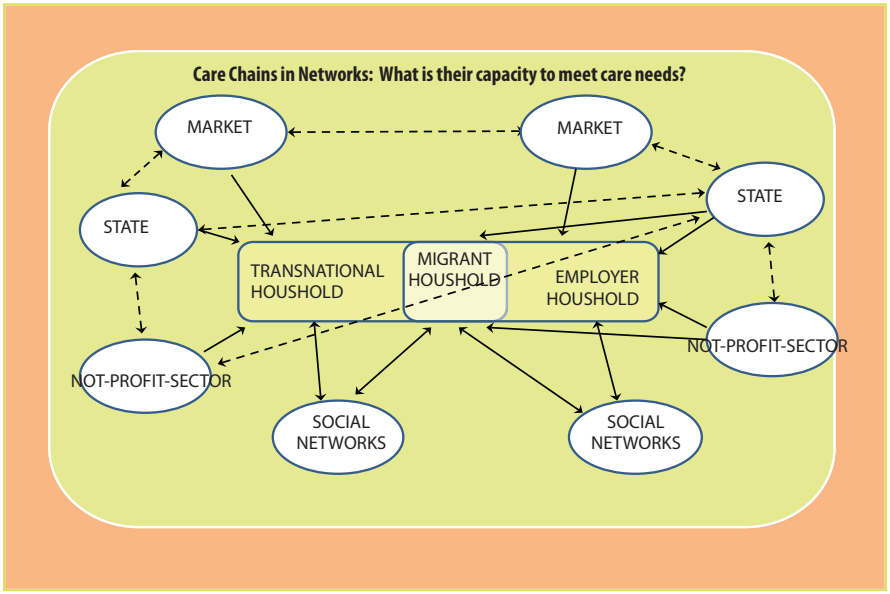
12 Kofman y Raghuram (2007) maintains that the way of seeing the migrants in relation to care is fourfold, but that often only the first two receive attention: (1) persons who migrate as caregivers, (2) those who migrate and leave behind care responsibilities, (3) those who migrate and carry with them responsibilities, and (4) those who migrate and have care needs.

13 Thus, in the case of Spain, as Solé and Flauer affirm in their study of the use of social policies on the part of migrant women: "The findings from the work presented here describe a rather bleak landscape. [...] The result is that the problem shifts from Spanish women to immigrants, so that immigrants (and immigrants' relatives) experience the greatest lack of care"(2005: 17-8).

migrant families, and even more so for those who work in domestic service. These factors include: precarious employment (and its corresponding instability, involuntary flexibility of time and space, poor access to benefits, rights to family/work life balance, and care); a small budget with which to purchase care; and a lack of social networks.[13] Taking all this together, we can state that migrant families face great difficulties in providing care (which are intensified in the case of domestic workers) and do not usually receive adequate attention from public institutions. There are major violations of the right to care, and this constitutes a problem for development of the first order for destination countries.

4.2. Impacts on the macro level

The impact at household level is not always positive, especially if we include the experience of migrant families in the destination country. Beyond the household level, what happens at the macro level? We tend to associate care with the family/domestic realm and this limits our understanding of the effects of the globalization of care on development. Care continues to be understood as a private matter of the family, not as an essential element of the socio-economic structure as a whole. If studies of the impacts on households are scarce, those that go beyond the household and assess the significance for development in a systematic way are in even shorter supply. This research gap is more pronounced in countries of origin, given that attention to care has proliferated recently in destination countries. Little analysis on the provision of care refers to on the periphery countries, and when it does, it tends to use a conceptual and methodological approach that does not correspond to local realities.[14] There are multiple analytical weaknesses when it comes to analyzing the macro-social impact of the globalization of care: (1) the invisibility of care has only recently begun to be addressed in countries at the centre; (2) the invisibility of care is intensified in countries of origin and the analytical tools being applied are inappropriate (an even greater problem for rural areas); and (3) the studies about care in general are based on an implicitly nationalist methodology.



[14] In response to these shortcomings, a project on the Social and Political Economy of care in developing countries was launched by the United Nations Research Institute for Social Development which, in addition to having produced numerous documents of interest and international implementation, examines in detail eight countries: Argentina, Nicaragua, South Africa, Tanzania, India, South Korea, Japan and Switzerland. The results can be found at www.unrisd.org.

In the previous section we have seen that migration has mixed results in terms of care. In the destination country, the results at best are contradictory: the impact on native households who benefit from the work of migrants is positive, whereas for migrant households it is difficult to adequately cover their own care needs, and many native households remain marginalized because they do not have sufficient purchasing power to contract care privately. In the country of origin, the various effects of ensuring material and emotional reproduction of the household also have contradictory results. How then might we interpret this ambivalence and contradiction in systematic terms?

We can state there are serious problems in the social provision of care that migration neither creates in the country of origin nor solves in the country of destination. Rather, in both cases, migration merely reveals existing problems. Put another way, the globalization of care, and particularly the formation of care chains, is making visible existing problems regarding the access and enjoyment of care rights that are caused by poor coordination between the various institutions that should be the responsible for guaranteeing their exercise (in the second working paper we specify, in our view, what these are). Or perhaps it would be more correct to say that the problems would be more visible, if there were social and political will, which currently there is not.

Seen in this light, the question becomes: is the globalization of care serving as a catalyst for the formation of a collective voice to demand public accountability and social responses to these problems, which are now more visible than ever? The answer is disappointing. As Gorfinkiel Diaz remarks, "Perhaps the creation of the market of care labour has made it possible that no other important issues are redefined" (2008: 87).[15] We are witnessing a process that we can call the double privatization of social reproduction in which the responsibility for guaranteeing social reproduction is considered a household responsibility, and where different resources combine – such as unpaid work, public services, and increasingly the purchase of services – resulting in commodification of care.

Providing for care needs is privatized in a double sense. First, much care that was previously performed for free is now bought in the market place. In fact, many recent public care benefits have been designed with a degree of privatization unknown in other pillars of the welfare state. The resource boom in the recruitment of domestic workers, the growing presence of companies in the industry, and the widespread privatization of public services indicate that there is a commodification of care. This phenomenon takes different forms in different countries. While in the richest countries the care market is fairly homogeneous and is characterized by its duality (the majority of the workforce is employed in the most precarious subsectors and only a minority of occupations are well-respected and offer good conditions), in middle-income countries the market of quality services is underdeveloped and the bulk of care is provided by the most informal end of the labour spectrum (Razavi, 2007a).

Second, care is privatized because it is within the space of the household that it is managed, and the coordination of various resources is guaranteed, in accordance with diverse strategies of survival, reconciliation and social promotion.[16] Ensuring care remains a "domestic issue" rather than a responsibility that has been translated into a right to care. Family problems and expectations are to be resolved by themselves, based on families' own ability to manoeuvre, which in turn is determined by their access to public ser-

[15] This same question was raised by the author at the conference "Migrant women, women who care: the new sexual division of labour" (Madrid, 1 - 3 December 2008, ACSUR-Platform 2015 and more, UN-INSTRAW). While Díaz.

[16] We have discussed this same process in which migration is undertaken as an individual response to the lack of basic human rights in our writing about remittances and their use. Remittances are used to purchase in the market health services and education, compensating in this way for the absence of a social safety net (UN-INSTRAW, 2008 and 2009). z

Law of Dependency: Opportunities and Challenges

A law known as the Dependency Act (39/2006) was passed in Spain in 2006. It recognizes individual, universal and subjective rights for people in a situation of dependency to receive care, and it articulates various service and monetary benefits (domestic help, telecare, day and night centers, residences, etc.). This signifies a breakthrough in the construction of the fourth pillar of the welfare state. However, several factors threaten this progress:

- The narrow understanding of "dependence" which leaves out a wide range of situations
- Poor budgeting and coordination between the various administrations involved
- The degree of privatization of services allowed under the law and found in its application, which results in the unequal quality of services and promotes job insecurity/precarious employment
- The creation of the figure of non-professional care in the family which, although declared an exceptional resource, in practice, makes the poorly paid and undervalued work of family caretakers and domestic labourers (often migrants) a fundamental pillar of the law
- The establishment of a system of co-payment that encourages the informality of household work and makes the population at large pay for the enjoyment of a right.
- The application/exercise of the law is stratified by conditions such as: immigration status, region of residence, socioeconomic status, level of acknowledged dependence, sex, etc.

vices, employment situation, purchasing power, educational resources and information, social networks, etc. All this results in an increase in social inequalities, in a particularly marked manner among households with and without migrants in countries of origin and between employers and employees in destination countries.

This dual process of commodification of care and of strengthening of the domestic sphere means that care continues to be marginalized from public debate and, when it does leave the confines of the household, it does so in the form of individual buying and selling and not as a right. Care continues to be invisible. This is linked to the fact that gender inequality is not disappearing, but rather, taking on new forms. Care continues to be associated with women in a double sense: both symbolically and materially (as we mentioned at the beginning). But the differences between women themselves continue to widen, in what some authors have called "a sexual and ethnic re-stratification" of care work. In this way, the sexual division of labour has acquired new global dimensions.

All this leads us to one final question: in both origin and destination there have been changes in gender relations that form the foundation of the globalization of care. In destination countries, such changes in gender relations have been a key factor in the collapse of the previous care model; in countries of origin, the feminization of migration is linked to an earlier process of increasing autonomy and access to women's rights that allows women to assume greater leadership in the migration process. These changes in gender relations expose latent problems associated with the lack of public accountability in the provision of care. However, the fact that the globalization of care brings structural tensions into the open does not necessarily result in a public commitment to remedy these shortcomings, but rather in an intensified process of privatization of social reproduction and a reconfiguring of the sexual division of labour. Is the old tactic of avoiding public care responsibilities through an unfair distribution of labour taking on a new transnational dimension? Our intent is not to provide answers, but to highlight the relevance of asking these questions in terms of development and political responsibility.

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