



**Global perspectives on  
the social organization  
of care in times  
of crisis:  
Assessing the  
policy challenges  
ahead**

*Amaia Pérez Orozco*

Gender, Migration and Development *Series*

**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.

Gender, Migration and Development Series

Working Paper 6

“Global perspectives on the social organization of care in times of crisis: Assessing the policy challenges”

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# Global perspectives on the social organization of care in times of crisis: Assessing the policy challenges ahead

*Amaia Pérez Orozco*

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This working paper accompanies “Global Perspectives on the Social Organization of Care in times of crisis: Assessing the Situation”. These working papers result from UN-INSTRAW’s research in migration, gender and development, and the organization’s recently launched work in a new strategic area: global care chains.<sup>1</sup> 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.

The study of global care chains looks more often at Asian migration (or interregional migration as in the case of the US) and rarely at migration from Latin America or 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 in a public debate is three-fold: (1) to show the importance of including caregiving in the discussion of development, (2) to show that we cannot talk about caregiving without considering globalization and migration, and (3) to raise new elements of reflection such as care as an issue of development from a transnational perspective for those already working in the area of social organization of care.

## Principal ideas of the document:

### The link between care, inequality and exclusion

- The long-standing connection between care, social inequality and exclusion from citizenship, which is taking on new and serious global dimensions today, needs to be urgently recognized and addressed.
  - This link is an integral part of care regimes and while it has been systematically tied to gender and socio-economic inequalities in the past, it is today further associated with immigration status.
  - The absence of a sense of social responsibility toward care, coupled with the relegation of care to households (and subsequently to women), the possibility of receiving care itself serves as an indicator and vector of social inequality.
  - An economicist? perspective cannot be used to understand care: the market provision of care fails to follow the simple logic of supply and demand and money is not the only aspect that must be examined. The availability of social networks is a key factor.
  - Care is not socially or economically valued and therefore the burden of caregiving falls upon those who have less of a choice and less decision-making power. Here lies the root of the segmentation by sex, ethnicity and immigration status seen in this type of work.

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<sup>1</sup> This effort broadens the range of topics addressed in the area, which were previously focused on the use and impact of remittances, and is based on the conceptual reflections and findings of previous empirical research (see UN-INSTRAW’s conceptual framework published in 2005 and updated in 2008). With UN-INSTRAW’s new office at Spain’s Universidad Autónoma de Madrid, where a global care chain project researching four case studies between Spain and Ecuador, Peru and Bolivia, as well as between Peru and Chile, is being coordinated, this expansion is physical in nature as well.

- The absence of a debate: Care regimes are formed on the basis of exclusion and inequality, on the sidelines of public debate.
  - Care is part of the hidden development agenda given its role in the private domestic arena.
  - A democratic debate needs to be urgently initiated: who should provide care, who should receive care, how, where, in exchange for what are all topics that need to be discussed. These debates cannot be held with only the voices of unions and employers.

### **Articulating care rights**

- Breaking the vicious cycle between care, inequality and exclusion calls for care rights to be introduced in a way that will constitute a core component of the development process and the way society recognizes its citizens and the rights they enjoy.
- This universal right has yet to be created and is multifaceted. It includes:
  - the right to receive needed care in different circumstances and at different points in one's life.
  - the right to choose whether or not one wants to provide care, combining a right to provide care in decent conditions with a right to not provide care.
  - the right to dignified working conditions in the care sector.

### **Care as a public responsibility**

- Articulating a care rights entails putting an end to the substitutory role that the government tends to play to cover shortcomings faced by households and removing care from targeting policies
- A number of measures can be implemented to articulate this right:
  - Time for care: provisions that will free up time from employment so that it may be devoted to providing unpaid care. However:
    - Those that are not paid may accentuate the greater labour and social vulnerability of women, and some may not be equally recognized for both men and women.?
    - The relevance of this measure and how applicable it is to large-scale contexts in the informal and/or self-employed sectors is questionable because both tend to pivot on formal wage-earning work.
  - Money for care: provided in consideration for caring for a member of the family. However:
    - How should this type of unpaid work, which is already performed, be recognized and valued without further encouraging this situation in which the bulk of care is provided in this manner?
  - Care services: in the household or at specific institutions. However:
    - Who should take charge of these services and how? Should companies be required to provide services to their employees?
    - Should the government offer these services, provide them directly or finance the purchase thereof at private centres or on the free market?

- Guiding criteria for deciding which measures to implement:
  - Care should be recognized as a fundamental component of well-being and not as an instrument for other purposes. Care rights must not be anchored in a productivist argument based on human capital investment.
  - A distinction must be made between health, education, care and social protection and boundaries must be defined between the professionalization of caregiving and other professional skills.
  - The interrelationship between the various facets of the multidimensional right to care may or may not assume the form of positive feedback:
    - Providing and receiving care can easily turn contradictory if, for example, advantage is taken of a mother's role as an unpaid caregiver or if the sector is privatised and care work becomes precarious.
    - Care implies interdependent social relationships; care rights cannot be enjoyed in only one of their two facets (providing or receiving), but rather in both concurrently.

### **Care rights...under what economic regime?**

- Under what economic regime can care rights be articulated and exercised? This question must be answered on an organizational and structural level.
- On an organizational level: how can the "care diamond" be rearticulated if we want to redistribute the burden borne by households?
  - Care services are profitable if a wide range of options are offered based on the affordability thresholds of the care-users and if advantage is taken of unstable, vulnerable employment.
  - Guaranteeing equal access to needed care without impinging upon labour rights requires such care to be provided by entities other than companies (such as the government or the non-profit sector).
- On a structural level, the question is, then, what logic should be followed to determine how the interplay of agents must be structured? Can socio-economic systems that pivot on the accumulation of capital take charge of ensuring care rights?
  - Comprehensive social changes are needed and aspects that constitute the very heart of socio-economic systems must be reconsidered using care rights as a guiding principle.
    - The organization of habitable spaces
    - The organization of time
    - The concept of an ideal worker and typical integration into the economy: the productive-worker model is incompatible with care rights.
  - The debate needs to urgently be redirected toward this structural framework and care rights must not be viewed as a clean? decision based on the most efficient or equitable measures within the range of options available.

## 1. Reversing the link between care and exclusion: Care rights

The primary policy challenge faced in the social organization of care in the era of globalization is recognizing and addressing the long-standing connection between care, social inequality and exclusion from citizenship.<sup>2</sup> This link, perpetuated worldwide although with undeniable, gapping differences depending on the era and location in question, is today taking on new and very serious transnational dimensions.

The link between care, inequality and exclusion constitutes a core component of the various care regimes that exist; as Izquierdo explains, we think of “citizenship based on exclusions, all of which are related to different dimensions of care” (Izquierdo, 2003: 5). And this is systematically tied to gender inequalities and the relegation of the responsibility of care to women. In capitalist societies, care regimes are undergoing major changes that include an intensified privatization of social reproduction and a re-fashioning of the sexual division of labour (see the first working paper). This, in turn, has major global repercussions and increasingly positions immigration status as an axis on which in the link between care, inequality and exclusion, together with gender and class, two other long-standing factors, pivots.

### 1.1. The link between care, inequality and exclusion

The burden of care is resolved in each household based on each person’s access to various

resources. This means that the possibility of receiving care itself serves as an indicator and vector of social inequality. But where does this inequality come from? Care, for the most part, continues to be provided without monetary compensation by members of the family or the community; familism<sup>3</sup> remains the standard model for caregiving. Unequal access (or exclusion of access) to care is closely tied to the availability or absence of social networks and, specifically, family networks. We cannot apply an economist perspective to care in order to understand exclusion: the market provision of care fails to follow “the simple logic of supply and demand” (Carrasco y Rodriguez, 2000: 51) and money is not the only aspect that must be examined. Clearly, the availability of income is a key factor when discussing inequality and exclusion, as it has as much of an indirect effect (establishing what we can term preconditions for care<sup>4</sup>) as it does a direct effect (care purchasing power). Still, even if money is available, there is not always a market able to meet demand<sup>5</sup> or a desire to outsource caregiving services. This is because familism also implies an ethical or moral resistance to contracting out care. Last, a negative correlation between both dimensions tends to exist: a lack of income often encourages the launch of social networks, as in the case of the People’s Kitchens run by women.

The link between care, inequality and exclusion implies ongoing feedback between the assumption of care tasks, inequality in the distribution of work and resources and the risk of exclusion and poverty. Assuming responsibility for caregiving in the home fails not only to give rise to rights (since rights are considered con-

<sup>2</sup> Citizenship is understood here as being able to access one’s rights, i.e.: one’s rights are formally recognized and one is able to effectively exercise them. There is no clear line between inclusion and exclusion but rather a thread of continuity runs through the denial of one’s rights, the formal recognition thereof and the full exercise thereof. Here, a number of economic, social, political and cultural factors are at play.

<sup>3</sup> In its diverse forms: extended to community networks, modified by the partial commodification of care and so on. Generally, it can be said that familism assumes that the responsibility of care falls on the families (of diverse types and with access to different resources) and that, within the family, women are responsible.

<sup>4</sup> For example, having a spacious dwelling is a fundamental factor in the establishment of successful personal relationships in caring for the elderly. In low-income countries, the lack of basic necessities such as a wheelchair turns individuals with disabilities into complete dependents and prevents them from enjoying autonomy in life. In addition, ensuring essential needs are met requires a tremendous amount of unpaid labour whenever access to adequate infrastructure is absent (for example, to carry water, to secure fuel sources and so on).

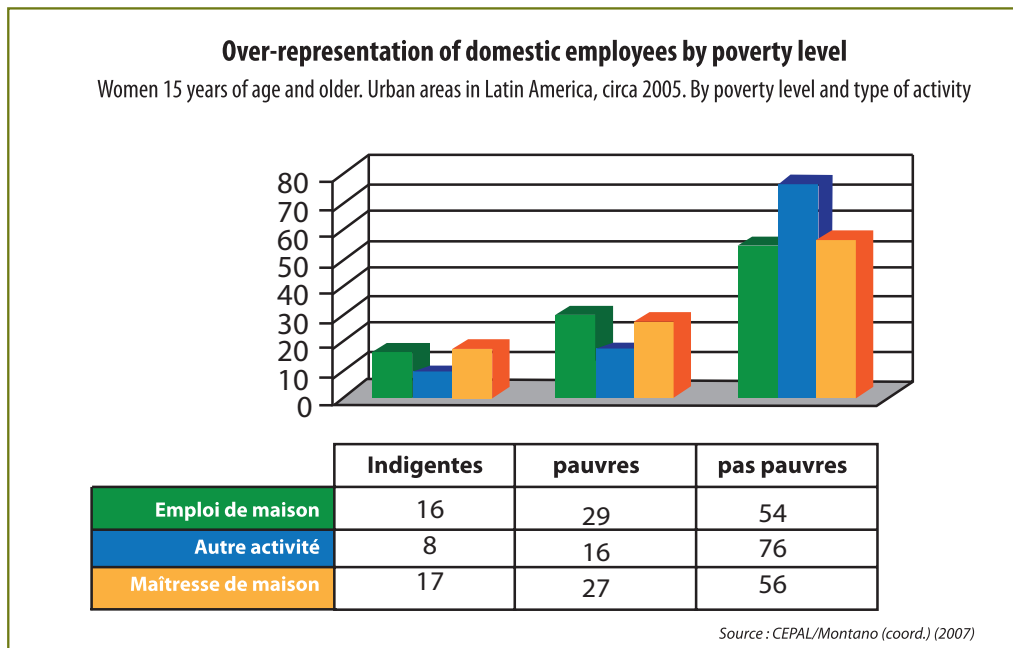
<sup>5</sup> In many middle- and low-income countries, commercial services of the formal kind that provide good quality care are underdeveloped and it is at the most informal end of the market spectrum that care is widely provided (UNRISD, 2007). In higher-income countries, the care market is little more than an emerging sector.

tributory benefits derived from wage-earning work) but it also seriously limits entrance into the workforce.<sup>6</sup> In turn, jobs in the care sector are subject to a “wage penalty” (UNRISD, 2007) and precarious working conditions, which is extreme (nearing or actually in a situation of poverty) in the case of paid domestic work.

The following figure shows the over-representation of indigent and poor women among domestic employees:

immigration status typically seen in this job sector and the distribution of care tasks within the family by axes of power (based on gender and age, above all).

The association between care, inequality and exclusion from citizenship is not new, but it is now taking on a new global dimension as the tie between the internationalization of care and its commodification grows stronger. This in turn strengthens the link between



Care is not socially or economically valued and therefore the burden of caregiving falls upon those who have less of a choice and less decision-making power (resulting from a lack of alternatives, resources and bargaining power, and so on). As Izquierdo explains, “caregiving is avoided like the plague” (2008). Here lies the root of the segmentation by sex, ethnicity and

the quantity and quality of care received and consumption capacity, and increases inequality by social class worldwide. Meanwhile, the labour niches created by this process do not significantly increase a caregiver’s access to rights because employment in the sector suffers from a distinct lack of job stability and is largely informal.<sup>7</sup>

<sup>6</sup> In this connection, certain concepts emerge such as the second-class citizen status of women in the male breadwinner/female caregiver model. In this model, the wage-earning male enjoys direct rights while his wife and children, as dependents, enjoy rights derived therefrom. In addition to the uneven valuation of wage-earning work and unpaid caregiving, this model has also been questioned because it focuses on the household (patriarchal nuclear family). This debate, however, will not be addressed in this paper. Still, it is important to point out that the right to care proposed here is understood as an individual right, not as one of the family.

<sup>7</sup> In fact, both phenomena contribute to the feminization or domestication of this type of work, thereby prompting a transformation in both the type of work (for example, activities previously performed at home, such as care, are transferred to the market) and working conditions (jobs tend to replicate the conditions of domestic work). In turn, the domestication of work is intricately tied to the increase in the number of women in the labour market, a process known as the feminization of labour.



## **Labour discrimination and denial of the domestic workers' voice**

Work in the household is a particularly precarious and vulnerable sector, as shown by the long-standing tie between work in the household and migration, initially between rural and urban settings, but now international. According to ATH-ELE, the Association of Domestic Workers of Biscay (<http://www.ath-ele.com>), this type of work is and has always been "one of poor women".

This type of work is often neglected in general labour legislation and consequently lacks any form of protection (as in the case in multiple Asian countries). In other instances, it is governed by specific regulations that contain provisions that discriminate against other sectors (as in the case of most Latin American countries). Moreover, compliance with these regulations is often lax and, as work in the household constitutes part of the informal economy, labour inspections are seldom conducted.

Another problem surfaces when regulation of the sector is discussed, as negotiations tend to be tripartite in nature, between the government, unions and employers. Wage-earning domestic workers are seldom represented in unions and their specific organizations thus remain on the sidelines of the debate.

In 1948, the International Labour Organization declared that it would consider a specific convention on the sector. But over 60 years later, they have yet to begin its initial draft. During this period of time, paid work in the household has remained unprotected by international regulations. According to reports, the convention will be approved in 2011. Given that only governments, unions and employers are able to participate in its draft, domestic workers are coming together to have their voices heard in the reports and proposals issued by unions and governments. It is therefore in this fashion that they will attempt to participate, albeit indirectly, in the preparation of a regulation of which they are the target population.

Additional information is available at <http://www.domesticworkerrights.org/>

## **1.2. The absence of debate on the link between care and exclusion**

Care regimes are formed on the basis of exclusion and inequality, on the sidelines of public debate and care is part of the hidden development agenda? (UN-INSTRAW, 2008). This lack of debate is a result of the association between care and the private domestic arena, considered irrelevant to political and socio-economic discussions. Who should provide care, to whom, how and in exchange for what are topics that have not been publicly or politically negotiated but rather turned over to the household without giving primary caregivers the opportunity to choose. Still, the answers to these questions are not the result of an individual negotiation in each household but rather the interplay of ethical and moral cri-

teria that are very closely tied to unequal gender relations and the macro-social distribution of work (as emphasized by feminist quarters: what is personal is political). As an initial step to articulating a care rights, stakeholders must begin to openly and democratically debate what occurs in the domestic arena and acknowledge that social structures are at play within the household. The boundary between public matters and private domestic matters must also be renegotiated.

Those with a prominent role in care relations must lead this discussion. In doing so, they will break with a long-standing tradition that has denied them a voice (in terms of their ability to exert political pressure) and only recognized social agents focused on wage-earning work. No debate concerning care regimes can con-

sider unions and employers to have the only legitimate voices.

## 2. Articulating Care Rights

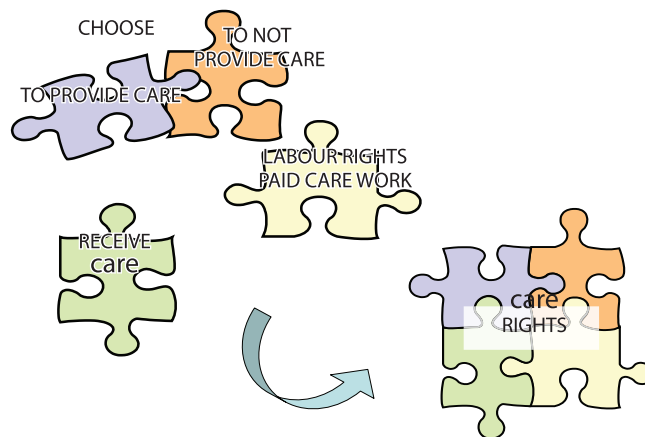
The link between care, inequality and exclusion is created by default in that it is the direct result of the absence of care rights. This vicious circle can be broken with the creation of care that constitutes a core component of society and, consequently, development (understood as “the comprehensive right to fully enjoy human rights,” UN-INSTRAW, 2008: 22) processes. Care rights must be an individual and universal rights enjoyed by all. This holistic perspective, which must inspire development processes, is rooted in a two-sided reality: one in which care is received and provided.

This right, which did not exist previously even conceptually but is on the verge of being constructed, would encompass: (1) a right to receive needed care in different circumstances and at different points in one’s life, which would ensure that this basic need is met regardless of the availability of income or family or personal ties. (2) With respect to unpaid care, the right to choose whether or not one wants to be a caregiver, combining a right to provide care (in dignified conditions) with a right to not provide care.<sup>8</sup> And (3) a right to decent working conditions in the care sector, eliminating penalties in the sector, with particular emphasis on work in the household.<sup>9</sup>

Care rights can be viewed as a guiding principle of social structure. Starting at the first level, what specific rights coincide with the receipt of care, the unpaid provision of care and work in the care sector (second level) should be identified; and last, debate should ensue concerning what measures could be taken (third level).

### 2.1. Public policies

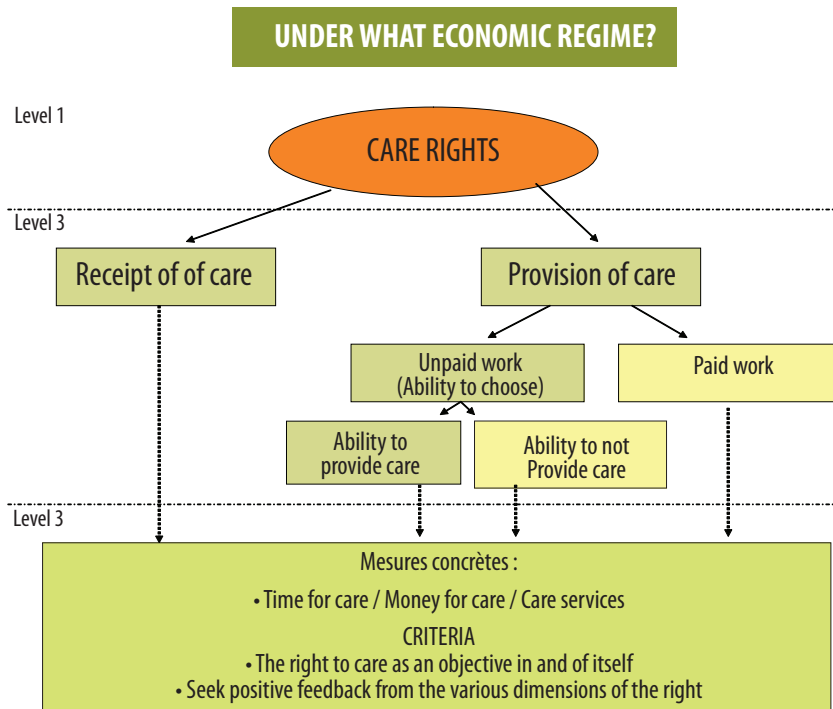
By failing to recognize care as a civic right (as was the case with education and health previously and remains so today in many countries), the state tends to play a substitutory role to cover shortcomings faced by households. It steps in in cases where an individual is unable to secure access to care with his or her own resources: social networks fail and no income is available. Care is part of targeting policies aimed at preventing or mitigating situations of social exclusion and poverty. The proliferation of scattered, fragmented measures and services



are typical of systems in which universal rights are non-existent and in which large segments of the population are excluded. When we talk

<sup>8</sup> This calls for the dimensions of protection that must be provided by welfare states to be revisited. Social protection has often only been provided to guarantee an adequate degree of ‘decommodification’: i.e., the ability to remove oneself from the market (from paid work) and maintain an acceptable standard of living. This assumes that the only social risks that warrant protection are those that affect market work and not those that affect non-market care work. The idea of decommodification (which would guarantee the right to care to some extent since caregivers would not be subject to the state of the job market) must be complemented by that of defamilization. The latter is understood as the ability to stop providing care within the household knowing that there will be schemes in place that will ensure that needed care is provided (i.e., a right to not provide care).

<sup>9</sup> For purposes of clarity, a distinction is made between receiving care, providing care on an unpaid basis and providing care for pay. Still, it should be kept in mind that these three dimensions are not completely separate from one another and that a string of continuity interconnects them. It is based on this connection in fact that political pressure can be and must be exerted. For example, many of the measures that enforce the right to care, to the extent they provide the material conditions to do so (availability of time, allowing for departures from the labour market without detriment to the caregiver’s professional career and ensuring income; consideration for the time devoted to caregiving as time credited to benefit systems; monetary benefits for domestic caregivers, etc.), are themselves redefining the boundary between paid care work and unpaid care work.



about a care rights, for it to be just that (recognized and asserted in conditions of equality), it must constitute a universal right, which makes it thus incompatible with a targeting policy.<sup>10</sup>

In the longest-standing welfare states, the three classic pillars (health, education and social protection) are being complemented by a “fourth pillar” that recognizes the right to receive care in situations of dependency. This dimension of well-being is tied very closely to the ageing of the population and constitutes the first few steps toward recognizing the right to receive care (limited to situations of dependency, a term that tends to include individuals with disabilities, regardless of age).<sup>11</sup> Moreover, so-called work-life reconciliation policies are also being developed.

Care rights can be articulated in various manners. One way to categorize the various measures is to

make a distinction between the time devoted to care, the money used for care and care services. Several of the most heated debates concerning each area are addressed below:

### 2.1.1. Time for care

Benefits are needed to free up time from employment so that it can be devoted to providing unpaid care (maternity and paternity leave, breastfeeding leave, family care leave, shorter workdays and so on). These benefits may be paid or unpaid, just as the time freed up from employment may or may not be credited toward social security. Unpaid benefits are often accused of reinforcing the role of free caregivers assumed by women and accentuating the labour and social vulnerability of women. Most are equally recognized for both men and women but they constitute rights asserted almost exclusively by women. The excep-

<sup>10</sup> The implementation of a right to care requires the gradual introduction of benefits and services that will slowly be extended to the entire population. In this case, decisions as to which social groups will receive priority must be made but the gradual introduction of these benefits and services must not be confused with a desire to target groups, which does not guarantee rights, but rather ensures partial protection in the face of exclusion.

<sup>11</sup> This is a topic of heated debate: Where should the government focus its efforts: on care for those with disabilities or on minimizing the loss of autonomy caused by a disability? That is, should its efforts focus on the right to receive care or on promoting the right to an autonomous life? This relates to the manner in which beneficiaries are viewed: whether their dependency is viewed as an individual, static situation or as a result of the ability of social quarters to accept individuals whose bodies or minds work in a different manner (thereby minimizing the dependency caused by their functional diversity).

tion to this rule is paternity leave, which is not widely recognized and, if it is, it is equivalent to a length of time in utter disproportion to that given for maternity leave.

These benefits are based on paid work in the formal sector,<sup>12</sup> and as such, they are not highly relevant or applicable to large-scale contexts in the informal sector. Beneria (2008) explains that thinking about organized care services in terms of the household may be more relevant since, in the absence of a specific workplace, it tends to be the primary point of reference for others in general and women specifically. This criticism is increasingly applicable in areas such as Europe where a high level of job insecurity blurs the line between the formal and informal labour markets and multiplies the amount of self-employed persons.

### 2.1.2. Money for care

These benefits are provided in consideration for caring for a member of the family. They themselves blur the line between unpaid and paid work in the care sector and are considered highly controversial. This is because some feel that they may contribute to the instability of the sector or constitute a way to take advantage of care that is not entirely free but indeed poorly paid. This perspective is countered by the argument that they serve to assign a value to the work that is indeed already performed in the household by women, and to afford them certain financial independence. In this connection, the crux of the problem lies with how this type of work, which already exists, should be recognized and valued and how the economic and social rights of those who perform the work can be ensured without reinforcing this situation, which is how the bulk of care is provided.

Here lies the classic debate about salaries for housewives. This debate, which was originally

more aggressive in its demands than feasible, has today been recast based on two lines of thought. In terms of the oldest welfare states, the possibility of recognizing and assigning a value to the concept of informal care in the household provided for dependent individuals is being carefully considered. In Latin America, a number of countries recognize the productive role of work in the household in their constitutions (for example, Venezuela and Ecuador), which intertwines with the importance of the active role of women in lower-income segments of the population as the lynchpin of their homes and communities. Against this backdrop, measures such as temporary financial allowances (for example, the Neighbourhood Mothers Mission in Venezuela) are articulated and retirement pensions for housewives are discussed.

### 2.1.3. Caregiving services

Instead of facilitating care provided by family members (by providing time and money for such care), caregiving services to be provided in the household (for example, paid domestic care) or in institutionalised spaces (retirement homes, childcare centres, day-care or overnight-care centres, temporary stay centres, extracurricular activities for children...) could be made available. Private companies could be forced to provide these types of services, much like they are in the case of childcare centres at which a certain number of employees are hired.<sup>13</sup> Alternatively, the government could assume this responsibility whether directly by providing the services itself or indirectly by financing private centres (managed by companies or NGOs) or by granting monetary benefits to finance the free purchase of care on the market. A key debate surrounds what level of privatization of these services is desirable and if they should be accompanied

<sup>12</sup> These benefits are generally tied to employment by a third party although some are gradually being extended (maternity benefits in particular) to self-employment.

<sup>13</sup> These services tend to be associated with the female employees' role as mothers and are non-existent for men, and in addition, only cover childcare. The service is interpreted more as a way to guarantee a woman's right to work.

by a co-payment to be made by care-users (unlike other rights such as the right to health, in which services are often entirely free.). This is a debate that we will revisit later on.

## 2.2. Criteria for identifying specific measures

The decision as to what specific policies should be adopted to articulate care rights must be the product, as previously stated, of a democratic debate. Several guiding criteria that will assist discussion in this area include the following:

### 2.2.1. Care rights must be an objective in and of itself

The very objective of establishing care rights is to have this vital dimension recognized as a basic component of well-being and citizenship. As it has a goal itself, any measures adopted may not be created as instruments to pursue other objectives. This counters a popular argument at the moment in favour of viewing care as a means to investing in human capital and therefore improving productivity and development understood as commercial growth. This argument is used both by health and child education programmes associated with the so-called New Social Policy (in which care is used as an instrument for increasing the stock of human capital looking forward?) and reconciliation policies (as a scheme for efficiently leveraging the human capital of women). The problem is that from the outset this argument excludes the allocation of public resources for those who are not considered potentially productive in a market sense.<sup>14</sup>

### 2.2.2. Differentiating care rights from other rights

Although the care rights as a guiding principle cut across many other social rights, the specific

measures used to articulate them must differentiate them from others such as the right to education and the right to health. A distinction between health, education and care, and so on, results in specific configurations for welfare states and social protection systems. For example, in European countries, the interactions between the “fourth pillar” and the healthcare system are confusing. Whether or not childcare for children aged 3 or below constitutes part of the education system is also debated. Last, this confusion and ambiguity shows that care, although fragmented and scattered, has become a topic of public debate but its emergence is so recent that it lacks a clearly defined focus.

Establishing boundaries between these rights is tied to the distinction made between care work and other professional competencies. Professionalization, defined as a clear identification of tasks, working conditions and required training, tends to shift the perception of the activity from a generic version of care to one of more skilled nature.<sup>15</sup> The risk posed by this trend in professionalization is that, by default, care can end up being associated with many-side tasks that do not require skill.

### 2.2.3. Positive feedback from the various dimensions

Care rights are multidimensional and their various facets are not independent from one another: if an individual receives care, someone else is providing that care; and whoever is providing care, needs care too; different working conditions for work in the household means different family caregiving abilities; and so on. This interrelationship can easily turn contradictory in nature.

One of the most common contradictions seen is the clash between the right to receive care and the right to not provide care. Two examples

<sup>14</sup> It is therefore not customarily used in policies that target the elderly, the disabled or similar groups. It thus becomes a very weak argument when attempts are made to apply it to other areas, for example, in justifying the investment of resources in promoting the equal sharing of responsibility of men and women in the household to better leverage the caregiving capital of men.

<sup>15</sup> For example, in the context of more developed welfare states, the education system is understood to fulfill an educational function in and of itself, and not one of care. There was a debate as to the appropriate age at which children should begin to attend school (and consequently the profession of a child educator) and childcare was proposed.

follow. On the one hand, the time and money devoted to care without outside help guarantee the provision of care by imposing it on the household. This occurs, for example, with the development of solutions such as leaves of absence from work to care for family members and in contexts where there is a distinct lack of retirement homes: if you do not take leave, what is the alternative? On the other hand, the conditional transfer programmes typical of the New Social Policy seek to ensure the well-being of children living in poverty by exercising control over the role of mothers. In doing so, they reinforce the role of mothers as unpaid caregivers. In both cases, the right to choose by either a man or woman is denied but it is experienced differently by men and women. This sex-differentiated denial can occur either directly, such as in cases where mothers themselves –and not fathers – are charged with the responsibility of managing conditioned cash transfers or indirectly, such as in cases where benefits can be exercised by either women or men but it is almost always women who do so).

The contradiction that lies between receiving and providing care can also surface in paid work. For example, the more privatised and commodified the services are (domestic care, nursery schools, retirement homes...), the more they tend to promote job insecurity. Another common contradiction is that of the age-old question, who takes care of the caregivers?<sup>16</sup>

The interrelationship between the various facets of the multidimensional right to care may assume the form of positive feedback.<sup>17</sup> The main objective is to therefore understand the interconnection that inevitably exists between these various facets and to determine a process that will mutually reinforce them and not discard them one after another. We must thus recognize that no clear divide exists between who provides care and who

receives it but rather care is given within a context of interdependent social relationships and that no one can enjoy rights in only one of its two facets but rather in both concurrently.

### 3. Care rights...under what economic regime?

Understanding care rights from a holistic perspective and not as a “right specific to any one group” (Pautassi, 2007) brings us to a final question of paramount importance and much larger scope than the debate on what specific measures should be implemented in the short to medium term: under what economic regime can care rights be articulated and exercised?

This question must be answered on two separate levels. First, on an organizational level: if the objective is to redistribute the burden of care assigned to households (and subsequently to women), in what other way can we propose to structure the so-called “care diamond”? What is the role of each institutional scenario and agent: the market, the government, households, social networks and the non-profit sector? Serious difficulties exist in asserting care rights via for-profit market services. We have witnessed a trend in the care sector of labour rights being violated. Why is the sector penalized in this fashion? Insofar as it is a labour-intensive sector, where human relations are of central importance and where the pace of work is nonnegotiable (as it is based on physiological constraints), using technology to perform human work to increase productivity or to increase the “quantity” of care provided per work unit is quite complicated. This situation has historically been defined as the “cost disease”, which turned care into an uncommodifiable activity, preventing development-oriented logic from prevailing in the sector (where commer-

<sup>16</sup> This shift, which by recognizing women as caregivers disregards their own care needs, is easier if applied to female migrants who, as stated in the first working paper, tend to be recognized solely as agents of care, and never as individuals who need it.

<sup>17</sup> The more nursery schools there are, the more feasible it will be to choose not to provide domestic care for free. If these services are provided as public services with individuals hired to work in decent working conditions, this positive shift in the sector would help improve the quality of care offered. Recognizing labour rights in the care sector and guaranteeing decent conditions for domestic care in and of itself ensures workers are cared for.

cial growth would be considered the driving force of economic development).

One way in which the contradiction between care and business profitability has been countered has been with the gradual decline of working conditions. Why do the workers themselves accept this decline? One source of pressure comes from the sense of responsibility felt by caregivers for the well-being of others, which prompts them to perform the work without it being recognized. This is an example of the “use and abuse” to which the role of caregiver assumed by women is subjected. The increase in the cost of service is another factor, as it makes the quality of the services received vary greatly depending on the purchasing power of the care-users.<sup>18</sup> Overall, broadening the scope of a care rights seems to call for serious limitations to be placed on how commercial matters and a profit-oriented logic will play out. Guaranteeing equal access to needed care without impinging upon labour rights requires such care to be provided by entities other than companies. This thus opens up debate as to which entities these should be and what changes will be required by these non-market areas: the government? the non-profit sector?<sup>19</sup>

On a structural level, the question is, then, what logic should be followed to determine how the interplay of agents must be structured? Looking at socioeconomic systems organized according to a logic of accumulation that ultimately seeks to ensure the proper functioning of capital accumulation processes, is it feasible to have care rights as a guiding principle of the social structure? That is to say: Can a socioeconomic system that pivots on the accumulation of capital take charge of ensuring care rights? To what extent has denying the right to care served as an indispensable factor in containing structural

tensions within an economic system that, by prioritising the logic of accumulation, inhibits a sense of social responsibility in caring for someone’s life? To answer these abstract questions, we would do well to carefully consider, at the very least, three specific factors.

Recognizing a genuine care rights and creating the conditions to ensure it can be exercised calls for comprehensive social changes and for certain aspects at the very heart of the socio-economic system to be reconsidered from this viewpoint, including: the organization of habitable spaces (see the first working paper for urban development models) and the organization of time. A precondition to care rights is the availability of time: to provide care, to receive care, to care for oneself, to involve oneself in reciprocal care relations that go beyond the dichotomy of providing and receiving care. That is to say, care has a cross-cutting quality (it is part of the entire lifespan) and is unpredictable (it can extend beyond the time allotted for a specific resource and set paces of work that can be planned). Furthermore, it cannot be reconciled with the fact that spare time is subject to the time clock of the markets, as is the case today.

This essential renegotiation of free time calls for the concept of standard economic integration to be questioned. A standard or ideal<sup>20</sup> worker is characterized as a “dependable worker bee” (Carrasco et al. 2004): one who does not have care needs or responsibilities of his or her own and who shows up everyday readily available to work. This is the farce that part of the population can play into as long as a hidden network of care work covering all of their needs and responsibilities exists. So-called “work-life balance problems” are rather processes by way of which light is shed on the structural impossibility of expanding this model as the worker standard. Here, the employers demands for the workers’

<sup>18</sup> The conflicts that exist between “conversation and tasks,” “love and indifference,” “exceptionality and justice,” “patience and fees,” “family relations and work relations,” “relations and regulations,” and so on, are resolved in very different manners (Stone, 2000). And it does not seem that there is any simple “reconciliation” between them.

<sup>19</sup> A UNRISD study shows that penalties are significantly reduced in the public sector: “In several countries the significant care penalties found in the private sector are comparatively reduced, though not eliminated when performed in the public sector” (UNRISD, 2008: 15).

time (and mobility) collide with the care needs and responsibilities of these very employees. This is where reconciliation policies come into play, which, in the face of prevailing pressures, end up giving priority to the commercial world since in the end, their goal is not to ensure a right to choose per se but rather the ability to join the workforce.

If care rights are to be consolidated, care workers must be recognized as individuals who have their own care needs and responsibilities in terms of caring for others in their own lives. The ability of the market to regulate itself in this sense, when it must concurrently ensure the success of the process that underpins its very existence (capital accumulation), is thus vitiated from the outset. Last, the current implementation of the productive-worker model in society is incompatible with care rights.

In conclusion, an inherent contradiction exists not only in the attempt to guarantee care rights through commercial growth, but also in the will to do so in a system where the logic of accumulation constitutes the pivotal axis of its socioeconomic organization. Ultimately, these matters, beyond the efficiency, effectiveness and equity of specific measures, frame the discussion within a structural dimension: what economic regime can support the introduction of care rights? The possibility of reconciling the logic of accumulation as the organizational basis of a socioeconomic system with care rights seems unlikely. Constant digressions to the productivist argument of investing in care to invest in human capital show that in the care-accumulation debacle, the end goal (and that which will prevail in the case of conflict) is the proper functioning of for-profit commercial activity. The debate needs to be urgently redirected toward this structural framework and the care rights must not be viewed as a clean decision based on the most pertinent measures within the range of options available.

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<sup>20</sup> We use the term 'standard' here in the sense that it represents the model upon which the labour market is built and toward whom social and economic rights are geared. It is also the mould that women are to try to fit when they join the workforce and that which is used as a model of a poorly termed development that is understood as mere commercial growth.



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