Progressive Economy Forum

PROVOCATION

CARE AND THE PANDEMIC

A PROGRESSIVE APPROACH TO THE ECONOMICS OF CARE

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The pandemic has exposed how dependent on care we are not only as individuals, but as a society. But our care system, already struggling well before the outbreak of the coronavirus, has failed to cope. Care work is poorly-paid and insecure, whilst the entire system suffers from chronic underfunding. Government promises to fix the system have concentrated only on funding, which is important, but falls well short of a comprehensive plan for care.

A new approach is needed, recognising the immense importance of care to our economy and society, with care work properly supported in all its forms, effective support from the public sector, and an integration of the care system into our wider social and physical infrastructure.

Care and the pandemic

The pandemic has exposed how dependent on care we are, not only as individuals, but as a society. Our care system hasn't done well. Far too many people died in care homes from Covid-19, with those surviving suffering terrible loneliness through restrictions imposed on contacts. Others were infected in their own homes by care workers moving between clients with inadequate personal protective equipment. Yet others were left completely isolated as the domiciliary care system broke down and/or friends and relatives could no longer visit.

And many other people's lives were disrupted because care was disrupted. Parents had to reorganise their work lives around the care of their children, while the carers of adults found themselves having to do far more as support services failed or were judged unsafe.

But that effect was uneven. Many men may have seen for the first time what it was like to have to fit employment around care responsibilities, but women put in far more extra hours and were more likely to lose or give up their jobs because of care responsibilities. Childcare uncertainties have compounded this situation, putting previous success in reducing gender inequalities at risk.

The pandemic also revealed the bad treatment of people who care (both paid and unpaid) and how that treatment contributed to the failures of the care system in the light of Covid-19. Care workers unable to get secure contracts that paid enough to avoid having to take multiple jobs inevitably helped transmit the virus around the sector. Covid exposed how dependent we are on the (gender) norms that keep such people working responsibly despite the poor working conditions and low pay – but it is not clear how long that can continue.

In short, we have a social care system that is unstable and no longer trusted, with care homes likely to close because both death and mistrust have reduced occupancy rates. It was totally unprepared for a pandemic and threadbare, reflecting an uncaring society and policy makers not recognising how dependent we all are on the care of others. These were problems in our care system before the global financial crash. Austerity since then has only made them worse. The government has promised to fix social care once and for all - but all it means by that is fix how it is paid for, as in the recent announcement of new "Social Care Levy" that in its first years will mainly go to the NHS. This is an important issue - funding matters - but the fundamental problems in our care system, on which this essay concentrates, go far deeper than that.

Care needs and care systems

We have an economy with the wrong priorities!

What matters most to people is what they can do or be - their "capabilities". People need care when, without support from others, they don't have the capabilities needed to have good lives and to function in society, so that receiving the care they need is what is most important to their health and prosperity.

This should also be true of how we consider economies: that their health and prosperity is best measured by capabilities of the people that make them up. But in practice we are very far from that when an economy's health is talked about in terms of its GDP growth. GDP counts only resources that can be transferred to others, roughly what can be bought and sold, so takes no account of capabilities. A society with a more capable, better cared for, more educated, healthier population is no better off in GDP terms than one whose population has far fewer capabilities if their marketed output is the same.

A just society that prioritised the needs of the least well-off, and recognised that capabilities are what really mattered, would therefore put its first priority on enhancing the capabilities of those with care needs, the least well-off in capability terms. This is not to treat such people as special cases. Debates about care policy tend to pose the need for care as an unfortunate happening, not the normal part of the life course that it is. We all need care as infants and most people receive care at other times in their lives; a rich society wanting to benefit all its members therefore needs a way of ensuring that care needs are met and are met well.

All societies do in practice have "care systems": practices, norms and expectations for how and in what circumstances care needs are recognised and provided for. No society could survive without such a care system. Constructing the urgent need for care policy as the result of an aging society, fails to recognise that all societies need ways of organising how people throughout the life course are cared for, not just those in which increasing numbers of older people are poor, frail and lonely.

The development of our care system

In all known societies, families/households and particularly the women within them, whether family members or servants, provide the majority of care, backed up by charitable and community support. Within this system providing care is part of the domestic division of labour; requiring and giving care does not necessarily mean being seen as dependent or rule out contributing to the domestic economy. But this was and remains an unreliable care system; families and communities vary in their capacities and willingness to provide care in ways that do not necessarily meet all members' care needs.

Like other domestic activities traditionally carried out unpaid by women, care has partially moved into the paid economy. Such outsourcing has been both cause and consequence of women's increasing opportunities to participate in types of paid employment beyond domestic service, with money earned in employment used to buy substitutes for what women previously produced in the home. This happened later for care than for many other activities, partly because the productivity gains from outsourcing have been smaller and partly because gender norms allocating care to women within the family may have been stronger than for other domestic activities. Both factors are consequences of the importance of relationships in providing care: productivity gains in care are small because relationships cannot be mass produced and gender norms are strong because relationships matter to people. And both remain true today.

Problems in outsourcing many previously domestically produced goods necessitated state intervention in the form of employment regulation, food and other product standards and public-sector provision. Some reasons for intervention are distributional, that relying on the market results in inequalities of provision unacceptable to public opinion. Care is a case in point, more people favour care being provided to those who cannot purchase it themselves than consider something should be done about the underlying income inequality.

State intervention is also needed when market provision is dysfunctional. Such intervention has proved particularly necessary in care where the scope for the continual cost-cutting through mechanisation and mass production that transformed the provision of many other consumption goods was limited. Care needs are often, but not necessarily, met by hands on services, in which relationships between caregivers and care-receivers matter. Preserving such relationships severely limits the extent to which productivity gains that cut labour costs are possible in care provision.

Employers can cut costs in care only by employing fewer people or by employing more vulnerable or less well qualified staff to pay them less, but this inevitably lowers the quality of care provided. As a result, state intervention has been needed to regulate standards and the costs of care have remained high, out of the reach of most families without government subsidy or provision. Care policy has in practice been driven by a variety of motives, including increasing women's participation in the labour force and, for childcare at least, improving the life chances and productivity of the future workforce.

Norms more supportive of gender equality were part and parcel of this change. Feminism helped, but so did rising levels of inequality and the development of a consumer society. Together these ensured that productivity gains would be taken in the form of higher earnings, rather than reduced hours of employment, raising aspirations with respect to living standards in terms of consumption and making the two-earner household the norm. That increasing numbers of people needed non-familial care was a direct result of such changes – but bemoaned rather than celebrated as a product of greater gender equality.

While countries varied in their approach, eventually policy makers in most of Europe and North America applauded that trend; they appreciated the extra tax revenue that women workers provided but gave inadequate attention to how the care given previously by women would now be provided. In practice, the exhausting solution was women's "double shift", at least where incomes were low and public services unavailable.

More recent developments

Until late in the 20th century, policies expanding the provision of public services had the broad support of both the working class and national industrial capital which depended on that working class for its labour force. However, far less was spent on care provision than gained in tax revenue from women's employment. What care was provided was seen as an unfortunate cost rather than a contribution to a better and more productive society – perhaps in part a

reflection of attitudes to the women it enabled to enter the labour force. As a result paid care became bifurcated, between low quality public provision that recipients often found unresponsive to their wishes and increasingly expensive private provision, which became seen as the only way to get provision responsive to individual needs. This was reinforced in England by increased means-testing of publicly provided care, solidifying divisions and further reinforcing a negative view of publicly provision *per se*.

In the late twentieth century, the consensus that both capital and labour benefited from public services broke. Power shifted away from industrial capital employing workers in the UK, towards globally mobile capital, much of it financial, with little or no direct interest in the productivity of any national working-class. The welfare state's collective pooling of risks and redistribution over the life-course became seen as costly and a threat to the provision of individual insurance and savings products by the financial sector. Public services were privatised to develop markets and reduce expenditure, with state subsidy available only for the neediest. However, given the inherent difficulties in reducing costs in care, privatisation has inevitably both lowered care quality and workers' conditions and pay. This process was going on well before the global financial crisis, and the additional austerity imposed after it was just an opportunity for those intent on dismantling the welfare state not to let a good crisis go to waste.

What's wrong with what we have now?

Paid care - the care "industry" - makes up by now a large part of our care system, although still dwarfed quantitatively by the amount provided unpaid in families. Like other industries it contributes to the economy both by providing employment (a lot of it – it is easily the fastest growing sector in most high-income countries and growing fast in low- and middle-income countries too) and by providing a type of output, care, without which the rest of economy cannot function. Industrial policy needs to take account of this vital fast-growing strategic industry.

However, profit-making is not an efficient way of delivering care. The logic of the market producing high quality and value for money relies heavily upon consumers being able to promote efficiency and quality control and through well-informed choices and exit from the market if they choose. Policy promoting privatisation ignores the ways in which care does not conform to this model. The effective use of the market is hampered by care, particularly residential care, being often a "distress purchase" made in circumstances where choice is limited and knowledge about alternatives and relative quality hard to obtain. High transaction costs of subsequently switching care providers can then lock residents into a poor-quality provider.

That staffing ratios are often taken as an indicator of quality, a result of the importance of relationships, shows that what is meant by "efficient" care needs to be carefully defined. Improvements are not impossible, but they are likely to take the form of enhancing the quality of what workers can do rather than cutting their numbers. But care is a highly labour-intensive industry with relatively few non-labour costs (except rent for residential care). Care providers forced by competition to cut costs, can do so only by reducing staffing levels or employing

cheaper less well qualified or more vulnerable workers. All of which impacts negatively on quality.

Not-for-profit providers and the public sector are subject to similar pressures, but not being specifically geared to maximising profits allow for alternative normative frameworks, including the professionalism of their staff and/or the altruism of their supporters, to keep up quality. When pressures to cut costs are not overwhelming, both sectors can provide higher quality care, and surveys show that on average they outperform the private for-profit sector on quality. Pressures coming from reduced local authority budgets can, however, force those not directly driven by the profit motive to behave as if they were just to survive.

It is profit as motivation not profit-making itself that is the problem. There are some small profit-making providers who provide excellent care: but many of these are for-profit because that was effectively the only institutional form they saw open to them, not their main motivation. The good care they are providing is *despite* not *because* they are for-profit.

However, there is another sector of the industry that is definitely motivated by profit. The growing financialisaton of the economy more widely has impacted on the care sector, which (from the point of view of finance) has regular payments to "securitise" (convert into a financial asset), economies of scale to reap, and in some case land holdings to collateralise. This has concentrated some of the industry into large chains often run by risk-taking private equity, untransparent about their tax status, with little or no previous experience in the care industry but eager to load debt onto it. The failure of such chains would wreak such devastation on residents and other care recipients that they have become "too big to (be allowed to) fail" with consequent moral hazard issues – in other words, the companies can take on even more financial risk, knowing government will bail them out. At the moment, the care sector is still dominated by small providers, but they are increasingly being squeezed out by such chains, and absent specific intervention residential care at least is likely to become just another financialised industry.

And what wrong with how it's conceived?

Failure to recognise the dependence of the economy on the rest of society allows it to undermine the "care economy", just as it does to the environment or "natural economy". Our care, education and health systems (both paid and unpaid) that produce healthy, well-educated and well-cared for people together make up our social infrastructure, which is just as necessary to the continued health of the economy and its people as its physical infrastructure. They are "infrastructure" because they have benefits that accrue more widely to society than just to its direct recipients and will therefore be under provided unless there is public investment to fund its wider social benefits.

Concentration on the level of GDP has had a particularly poor effect on care policy because unpaid care, which is not counted in GDP, makes up such an important part of our care system. As a result, it appears less significant than it is. Further, because spending on care, like other

investment on social infrastructure, is not investing in a physical entity like a bridge a road or a building, it is not counted as investment. Expenditure is simply seen as a cost with no financial assessment made of its benefits as would be done with investment in physical infrastructure. This biases spending away from social infrastructure. All solutions seem expensive when the state is unwilling to account for the social benefits that will accrue.

What needs to change?

Hopefully, the lessons of covid won't be forgotten too quickly. The failings of the current care system mean that a new approach is urgently needed in which:

1. Care is recognised as central to society and a caring economy with a well-functioning care system is developed. This requires valuing what matters, abandoning GDP growth as a policy goal and substituting the enhancement of the well-being and capabilities of the population. Using economic growth as the measure of progress is neither sustainable nor desirable. A caring economy not only provides for all care needs, it also ensures that women's contributions to meeting those needs are recognized and shared, an important step in dismantling gender inequality.

2. The purpose of care is redefined as enabling capabilities rather than providing services. This requires ensuring as much as possible control by care recipients of what they want to do. Unlike the current notion that care work is unskilled, just doing for others what people do for themselves, enabling capabilities would be recognised as skilled work, requiring specialised training and professional standards, making care work a career that both men and women are proud to enter.

3. Alongside high-quality professional care there is still unpaid care, but it is freely given and so benefits the care giver as well as the care recipient. To make this happen unpaid carers have good support services and are not penalised in other ways for the care they give. Society is organised on the assumption that everyone has caring responsibilities, with employment and other aspects of life being organised flexibly to accommodate them. Opportunities could be provided for those without immediate care responsibilities voluntarily to participate in care too.

4. The institutional forms by which care is delivered need to change. The present care system in which most care is provided for-profit is clearly dysfunctional and likely to become more so. The public sector should take overall responsibility for care provision, centrally funded, but locally provided. However, many care recipients feel distrustful of public provision, in particular of its ability to give control to care recipients. To meet their demands and to inject new thinking into public provision, innovative forms of not-for-profit organisation will also be needed, such as co-ops integrating the interests of care workers and care recipients.

5. The care sector is recognised as a strategic industry and the resources necessary to provide an effective care infrastructure invested in it. The national accounts need reform

to recognise the benefits of investment in care and other forms of social infrastructure. Such investment would also be a good stimulus to the economy, providing far more jobs than an equivalent investment in construction, and with far fewer emissions and better gender equality effects.

6. Care needs to be developed along with other forms of social infrastructure. For example, an integration of care and housing policy could transcend the bifurcation of care provision into domiciliary or residential, by developing a range of different intermediate solutions to meet people's needs and preferences. Similarly with town planning: as high streets become less focused on shopping, care centres, providing a range of services and bringing together a variety of people, could be placed right in the centre of towns, giving care and its recipients the visibility they deserve.

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About PEF

The Progressive Economy Forum (PEF) was founded and launched in May 2018. It brings together a Council of distinguished economists and academics to develop a progressive and sustainable macroeconomic programme and to foster wider public engagement with economics. It opposes and seeks to replace the current dominant economic narrative based on austerity.

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