

# PUBLIC INVESTMENT IN THE CARE ECONOMY IN THE UNECE REGION: OPPORTUNITIES AND CHALLENGES FOR GENDER EQUALITY IN THE COVID-19 RECOVERY



**UNECE - UN Women series:**  
Rethinking Care Economy and  
Empowering Women for Building  
Back Better

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# TABLE OF CONTENTS

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<b>ACRONYMS AND ABBREVIATIONS</b>	<b>5</b>
<b>SUMMARY</b>	<b>6</b>
<b>1. INTRODUCTION</b>	<b>8</b>
<b>2. THE CASE FOR PUBLIC INVESTMENT IN THE CARE ECONOMY</b>	<b>10</b>
<b>3. THE CARE ECONOMY IN THE UNECE REGION</b>	<b>13</b>
3.1. The legacy and pre-COVID-19 situation	13
3.2. The impact of COVID-19 on care work	17
<b>4. INVESTMENT IN CARE IN COVID-19 RESPONSE AND RECOVERY PACKAGES</b>	<b>21</b>
<b>5. CONCLUSIONS AND RECOMMENDATIONS</b>	<b>28</b>
5.1. Short-term perspectives on investment in the care economy	28
5.2. Medium- and long-term perspectives on investment in care in the recovery	29
<b>PUBLICATION BIBLIOGRAPHY</b>	<b>32</b>

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# ACRONYMS AND ABBREVIATIONS

<b>AFA</b>	Association for Female Affirmation
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>EBRD</b>	European Bank for Reconstruction and Development
<b>EECA</b>	Eastern Europe and Central Asia
<b>EIGE</b>	European Institute for Gender Equality
<b>ESPN</b>	European Social Policy Network
<b>EU</b>	European Union
<b>EUR</b>	Euro
<b>Eurostat</b>	Statistical Office of the European Union
<b>ILO</b>	International Labour Organization
<b>ILOSTAT</b>	International Labour Organization's central portal to labour statistics
<b>MoESTD</b>	Ministry of Education, Science and Technological Development
<b>MODS</b>	Network of Organizations for Children of Serbia
<b>OECD</b>	Organization for Economic Co-operation and Development
<b>PDIFS</b>	Pension and Disability Insurance Fund Serbia
<b>RSD</b>	Serbian dinar
<b>SDG</b>	Sustainable Development Goal
<b>SeCons</b>	SeConS Development Initiative Group
<b>UNDP</b>	United Nations Development Programme
<b>UNECE</b>	United Nations Economic Commission for Europe
<b>UNICEF</b>	United Nations Children's Fund
<b>UN Women</b>	United Nations Entity for Gender Equality and the Empowerment of Women
<b>USAID</b>	United States Agency for International Development
<b>USD</b>	United States dollar
<b>WB</b>	World Bank
<b>WBG</b>	World Bank Group

# SUMMARY

COVID-19 has highlighted the importance of investment in the care economy for successful response, recovery and “building back better” from the pandemic. The report provides evidence on UN Economic Commission for Europe (ECE) member states’ efforts to secure and expand care-focused investment during the pandemic response and the implementation of recovery plans. It documents main policy measures with impacts on financing the care economy. Five main areas are distinguished: Fiscal and tax policy with direct impacts on the care economy, second, economic stimulus action in specific sectors and enterprises, including the care sector and care enterprises. Third, employment protection measures, including subsidies, especially in the care sector; fourth, measures aiming to protect the income of care workers. Fifth is direct support of paid care work, incl. pay, measures to improve working conditions, or emergency recruitment and retention measures. The report provides recommendations on how best to strengthen investment in the care economy in the response and recovery packages, differentiating between short-term and medium/ long-term strategies. It is hoped that the analysis and the promising policy examples can stimulate an exchange of experiences and mutual learning between UNECE Member States, supported by UNECE.

## Key findings

- Care services play a key role for employment generation, economic development and women’s economic empowerment. Therefore, it is logical that care – more specifically public investment in high-quality care services and better conditions for care workers – has to be an essential element of the economic recovery plans from COVID-19.
- There is a far-reaching consensus in the UNECE region that a well-furnished social care infrastructure requires public investments, and that an adequate level of care investment is a precondition for progress toward gender equality. The link between care services and women’s labour force participation is widely accepted as a driver of employment and care policies.

- There is a great diversity in economic conditions and fiscal space for public spending on care throughout the UNECE region and spending patterns vary. For example, the share of spending on long-term care in Central Eastern European (CEE) countries in 2016 was generally less than a half the OECD average. As a consequence, social safety nets and care institutions for families in the region have been weakened and care gaps have appeared, for example in early childhood education and care, and in long-term care services.
- The COVID-19 pandemic has exacerbated care needs, increased the amount of paid and unpaid care work and deepened care gaps. Rapid assessments of the social and economic impact of COVID-19 showed that women everywhere increased their amount of unpaid work, both in absolute number and as a share of the additional amount of work related to the pandemic. Working conditions in the care sector deteriorated, and care employment was not shielded from the impact of the pandemic.
- Numerous measures in the emergency response and recovery packages in UNECE member states had direct impacts on the care economy. However, the economic stimulus packages and emergency support measures in response to COVID-19 so far have largely not prioritized support for the care economy. Especially care services were not adequately protected, supported, or even expanded in the pandemic response. Most investment in the care economy has a longer time horizon, which is part of the reason why it was not prioritized in the COVID-19 emergency response, but needs to be addressed in the recovery process.

## Key recommendations

A recovery from the pandemic that strives to “build back better” has to include the care economy among its central areas of focus. Responding to the interconnected needs in paid and unpaid care work and furthering women’s economic empowerment have to be central objectives. There are short-term and



longer-term perspectives on the relevance of investment in care for the pandemic response and the post-pandemic recovery process. Investment in care can be an instrument for addressing intersecting forms of economic and social inequality.

#### *Short-term perspectives on investment in the care economy*

- Emergency packages and budget reallocations in response to COVID-19 need to prioritize care. Where necessary, virements between line items are needed to secure care provision during the COVID-19 response.
- Childcare services and schools are essential for child development and women's employment participation, before, during, and after the pandemic.
- To enhance the efficiency and effectiveness of investments in care during the emergency, policies are needed that simplify governance of the provision and financing of care services.
- Emergency enterprise support needs to explicitly include care enterprises and self-employed care providers. They need to be included in all direct financial support schemes, as well as programs to protect employment and avoid unemployment.
- Adequate support for parents and all workers and self-employed with care responsibilities needs to be included in emergency measures, especially during the closure of care services. This can include parental leave schemes and benefits, entitlements to home work, reduced working time, or flexible working time arrangements.
- Redistributing care responsibilities between women and men has to be a central objective of care policies during the pandemic, to stop and reverse trends of a solidification of stereotypical gender roles during the emergency.

#### *Medium and long-term perspectives on investment in the care economy*

- In the recovery process, countries should not fall back into previous patterns of austerity after a crisis, at the expense of care and social infrastructure and women's rights.
- Investment in care during the recovery needs to strategically prioritize the physical and human care infrastructures. Recovery from the pandemic can provide opportunities to close pre-existing care gaps and address inequalities in the access, affordability, and quality of care.
- Care workforce shortages, as well as low pay, inadequate working conditions and the precarious employment situation of care workers, including migrant care workers, have to remain at the center of attention during and after the pandemic.
- Care services need to be strengthened through public investment, in the interest of high quality standards and good institutional governance.
- Tax policies will play a central role for an inclusive and sustainable recovery from the pandemic, as fiscal space is a core constraint for care-focused investment.
- Improved data is needed for "care budgeting" (i.e. assessing care-focused impacts of policy decisions) and gender budgeting of post-pandemic recovery plans. Enhanced and improved data collection on the care economy will support evidence-based pro-care decisions.

# 1. INTRODUCTION

Paid and unpaid care work are fundamentally intertwined with women's economic empowerment and gender equality. The care economy' is "essential to the healthy and prosperous existence of human beings as well as to the sustainability of economies and societies." (ILO 2018a). The importance of care has become very visible during the COVID-19 pandemic and when analyzing the pandemic response and recovery policies throughout the UNECE region. (ActionAid International 2020; Care Collective 2020b; Kabeer et al. 2021).<sup>2</sup> In the COVID-19 pandemic, care work has held together the fabric of families and societies.

Care work, paid and unpaid, is mostly done by women. This is true in UNECE member states and around the globe. Because of their roles in the care economy and the low value and recognition assigned to care, women are limited in their economic and social opportunities. Paid and unpaid care work jointly shape women's labour market involvement. Women are very often employed in paid care jobs; in addition, they provide a large share of unpaid care work, and therefore they rely on care services to be able to engage in the labour market. However, the provision of unpaid care by women remains largely taken for granted in economic and social policymaking, and the relevance of care to economies and societies continues to be overlooked by policy and decision makers – as has been the case during the COVID-19 pandemic and the response and recovery measures undertaken by governments (Women's Budget Group 2020; OECD 2020c; UN Women, Cantillon and Teasdale 2021).

Women's multiple roles in the care economy have shaped the gender impact of the COVID-19 pandemic. First, as providers of paid care work, women have been central in the fight against the pandemic, for example in hospitals and long-term care institution. Often, they have been directly exposed to the virus. Yet women were not only exposed as medical personnel. Also, the

majority of health facility service-staff are women – in areas such as cleaning, laundry or catering.

Second, in their roles as unpaid care providers, women have been heavily impacted by the measures that were implemented throughout the UNECE region to slow the spread of the virus: Care institutions closed, at least temporarily, and the provision of care returned to individual households. Consequently, women took on an additional burden of unpaid care work (UN Women, Cantillon and Teasdale 2021). The impact of closed care institutions has been especially heavy on single parents, an overwhelming majority of them also women.

A sustainable and transformational approach to the recovery from the pandemic requires a care-oriented policy shift. The care economy's central role for societies and resilient economies, for women's economic empowerment and gender equality has to move to the center of attention. Care holds societies together in a pandemic. Without attention to the importance of the care economy as a whole, and the leverage of care services for women's economic empowerment, the economic recovery from the pandemic will be impeded (Sultana and Ravanera 2020).

The present report focuses on public investment in the care economy in the UNECE region in the context of the COVID-19 pandemic. It applies a broad understanding to the notion of "investment in care". Government spending on care services and other spending with impacts on the care economy (only health care, long-term care and childcare are addressed here), is termed "investment in care" here, specifically as "investment in paid care". It is regarded *investment* in care (rather than public *consumption*) because it yields returns to the economy and society: The quality of life is protected and enhanced, and human capabilities are developed and maintained, thereby contributing to sustainable human development.

1. The "care economy" as used in this report entails economic processes around the provision of care in a variety of settings and across formal and informal economies. It comprises, for example, health, childcare or social services as well as unpaid care work by family and community members, which is of great economic value but remains often uncounted.
2. Care work here is understood to comprise both paid and unpaid work. The provision of care entails the production of goods and services for the physical, social and emotional wellbeing of care dependent individuals and groups such as children, the elderly, the sick, and people with disabilities, as well as of healthy, working-age adults.



Focusing on paid care work, the report provides evidence on UNECE member states' efforts to secure and expand care-focused investment during the response to the SARS COV2 pandemic and the implementation of recovery plans. It documents the main measures included in COVID-19 response and recovery packages with important impacts on paid care work, including fiscal and tax policies, economic stimulus action in specific sectors and enterprises, measures covering employment protection such as subsidies, especially in the care sector, and measures to protect care workers' income. Lastly, attention focuses on direct investment in support of paid care work, including pay and improved working conditions.

The report faces important limitations in scope and availability of information. At the time of writing (at the beginning of 2021), data is still limited. UNECE member states are still facing new waves of the pandemic, while continuing and even expanding response measures, including through the restructuring of public budgets and mobilization of additional funds. Reporting on investment and spending is incomplete. With respect to the health sector, for example, it is impossible to compare the distribution of pandemic-related spending between numerous purposes such as equipment, testing capacities, or salaries.

Moreover, available fiscal space in UNECE member states to mitigate the pandemic's impact and continue, or even expand, investment into the care economy differs significantly. Expectedly, in high-income countries, emergency packages were larger in general. There was a wider use of tax measures and financial support for labour market interventions and investment into health system capacity were more expansive (Ladd and Bortolotti 2020). However, while financial space differs significantly, the case for public investment in care applies in different conditions, making it even more important to reflect on the effectiveness and efficiency of specific measures.

The report is structured as follows: Following the introduction, section 2 lays out available evidence on the benefits for public investment in the care economy, focusing specifically on the employment impacts of investment in care. Section 3 addresses the care economy in the UNECE region, both with respect to the diverse institutional legacy and role divisions in pre-COVID-19 times, as well as with respect to the impact of COVID-19 on paid care work in the region. Section 4 provides an overview on governmental responses to COVID-19, focusing on key measures of response and recovery packages affecting investment in care. The final section offers conclusions and recommendations, both with a short term and a medium/ long-term perspective on investment in the care economy during the COVID-19 response and recovery.

## 2. THE CASE FOR PUBLIC INVESTMENT IN THE CARE ECONOMY

The case for public investment in care has been argued convincingly with the help of cross-national evidence (Women's Budget Group 2016, 2017; Ilkkaracan et al. 2015; Ilkkaracan et al. 2019; Ilkkaracan 2018; Çağatay et al. 2017). Care services play a key role for employment generation and economic development. Therefore, it is logical that care – more specifically public investment in high-quality care services and better conditions for care workers – has to be an essential element of the economic recovery plans from COVID-19 (Heintz et al. 2021).

Investment in care can be regarded as an antidote against the “motherhood employment penalty”, the negative impact that motherhood has on women's economic empowerment<sup>3</sup> (ILO 2019). The gap between the employment-to-population ratio for women living with and women living without children aged 0–5 years has been proposed as indicator for the motherhood employment penalty. In Hungary, the Czech Republic, Austria, Slovakia, Estonia, Germany, Finland, Latvia and Switzerland, it was found to be the highest in the world in 2018. Among these countries, the gap ranges from a maximum of 42.2 percentage points in Hungary, 27.4 percentage points in Germany and 20 percentage in Switzerland (ILO 2018b).

Three benefits of public investment in care are directly related to women's employment:

- First, investment in care generates employment directly in the sectors where the investment takes place (e.g. childcare facilities), as well as indirectly in adjacent sectors of the economy (e.g. services to care institutions, such as cooking, laundry etc.). Both are sectors of the economy that typically employ large numbers of women. Therefore, investment in care is considered positive for women's employment.
- Second, investment in the care economy allows women who are currently outside or at the margins of the labour market because of their care responsibilities, to engage more fully in employment.<sup>4</sup>
- Third, investment in the care economy contributes to poverty reduction (through increased income) and educational progress and reflects a society's recognition of and commitment to care and is a central element to women's empowerment.<sup>5</sup>

Each of these positive impacts of investment in the care economy will be elaborated in some more detail in the following section. First, investment in care has a direct and an indirect employment impact. It is reflected immediately in care sectors that employ many women: Child-care institutions, elderly-care services, health and care-related services. Moreover, it is seen in neighboring economic sectors that are directly linked to care services (ILO 2019; UNRISD 2016; Ilkkaracan

3. Women's economic empowerment goes beyond their employment, however. “Economic empowerment is the capacity of women and men to participate in, contribute to and benefit from growth processes in ways which recognize the value of their contributions, respect their dignity and make it possible to negotiate a fairer distribution of the benefits of growth. Economic empowerment increases women's access to economic resources and opportunities including jobs, financial services, property and other productive assets, skills development and market information.” OECD DAC Network on Gender Equality 2011.

4. This is not per se an impact on women. More women will benefit, because the current division of unpaid care responsibilities leads to the marginalization of many women in the labour market or their exclusion from employment because of a lack of care responsibilities.

5. Here, savings in public expenditure from the reduction in unemployment or social security payments that otherwise would have to be made are not addressed, nor the expected increase in tax revenue through increased employment (Women's Budget Group 2016: 56).

et al. 2015).<sup>6</sup> Depending on the structure of the supply chain in a specific economic setting, additional jobs in adjacent sectors may benefit women or men to different degrees.

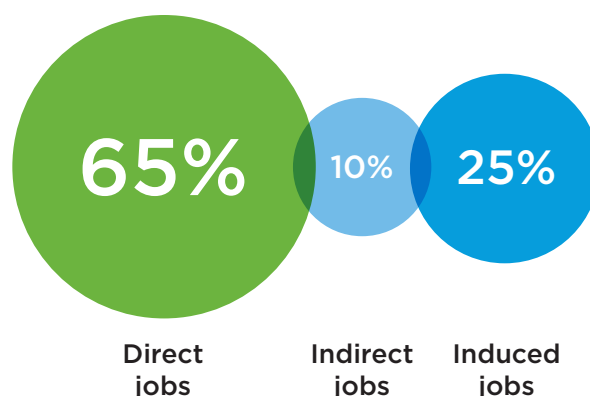
A simulation for Turkey has estimated that an increase in public expenditure for early childhood care and preschool education of 1.18 per cent of GDP could potentially generate 719,000 jobs directly in these care sectors and indirectly in other sectors (Ilkkaracan et al. 2015). Other studies show that the employment impact of investment in care applies in different economic settings and is not dependent on institutional traditions with respect to the extent of state intervention in the provision of care services to the population (Women’s Budget Group 2016).

In addition to the direct and indirect employment impacts of investment in care, investment can induce the creation of jobs in other sectors through the expansion of household income. New demand is created for goods and services such as food, clothing, caring services and leisure. Research in the US has estimated that investment in care would induce the creation of new jobs, for example if caregivers spend a share of their income at a local restaurant which in turn will hire new staff because of increased demand (Pollin et al. 2009) (see Figure 1).

Secondly, affordable and good-quality childcare and long-term care services enable persons with care responsibilities – de-facto most often women – to juggle their roles as carers and economic providers more successfully (Gromada et al. 2020). Investment in the care economy will contribute to integrating more women into the labour market and to furthering their labour market success and career advancement. These are important components of women’s economic empowerment through the opportunity to gain an independent income.

Employment rates of women aged 18-54 tend to be higher in countries that have a higher share of GDP invested in public expenditure on pre-primary education, long-term care services and benefits, and maternity, disability, sickness and employment injury

**FIGURE 1:**  
Direct, induced and indirect jobs as a share of total job creation through investment in care infrastructure – care sector investments would have positive spillovers



Source: Palladino and Mabud 2021

benefits (ILO 2019). Conversely, a high percentage of women who are outside the labour force give unpaid care work as main reason why they do not work for pay (ILO 2019). According to ILO data, 11.3 per cent of women in Europe and Central Asia are full-time unpaid care workers (ILO 2019).

Cultural norms that assign care work to women result in an unequal gender division of unpaid care work in families. This results in a “care penalty” for women, intersecting with other causes of labour market inequity such as race/ethnicity or educational background. The care penalty plays out as occupational segregation, discrimination against mothers (and, by extension, young women as “potential mothers”) in pay and career advancement, as well as gender differences in job continuity and hours worked (ILO 2019; Budig et al. 2012). Care penalties can be caused by women’s responsibility for childcare as well as care responsibilities for elderly family members who are cared for informally at home. A study in the US has shown that for every 2.4-3 women whose parent received formal home care, one additional daughter worked full-time (Shen 2020).

6. Studies have used input-output data to trace the impact of new investments in care sectors throughout the economy. Input-output models quantify how an industry’s demand for goods and services from other industries would change as levels of economic activity change (i.e., as more care is provided) and how increased economic activity would allow a larger portion of the workforce to consume more goods and services throughout the rest of the economy. Effects on employment are usually computed by using the ratio of total employment to final output (the number of jobs created when one additional unit of output is produced).

A lack of high-quality and affordable care can also have a negative effect on business productivity. A study on absenteeism in the US has calculated that the lack of childcare cost companies \$3 billion annually in 2004. Family caregiving more generally costs businesses over \$30 billion annually due to absenteeism, shifts to part-time work, turnover, and workday interruptions in 2006 (Shellenback 2004; Dastur et al. 2017).

Thirdly, investment in the care economy not only contributes to poverty reduction (through increased income) and the development of human capabilities, but also reflects a society's recognition of the value of care more generally and commitment to supporting care. The recognition of care and investment in care play a "transformative role in advancing gender equality", including through the recognition, reduction and redistribution of unpaid care work (ILO 2019, 2018a).

Public investment in care thus can be considered essential for sustainable human development, bringing income to individual households and wider economic benefits for society (Samman et al. 2016). Care benefits both recipients and providers of care – and everyone falls into either of these categories, or both, at some point in their lifetime. The above-cited study on Turkey found that a social care expansion targeting disadvantaged households could reduce the relative poverty rate by as much as 1.14 percentage points, versus 0.35 percentage points in the case of increased spending on physical infrastructure (Ilkcaracan et al. 2015).

Investment in quality care has long-term benefits for human capabilities and the quality of life. This has been emphasized in studies on early education and care, considering the benefits of high quality care for child development, for example. Unfortunately, however, standard systems of national accounts do not measure the immaterial and longer-term contributions of care: "The SNA (system of national accounts) classification fails to recognize the long-term productive contribution of the social infrastructure that employment in the teaching and caring industries builds, through creating and maintaining the stock of 'human capital'" (UNRISD 2016). Feminist economists have long criticized the exclusion of unpaid care work from national accounting (Waring 2003; Hoskyns and Rai 2007; Folbre 2008). Others have emphasized that reflections on the social value of care and the benefits of care investments have to include a concern about care providers and recipients, and take into consideration the particular nature of care as an expression of human relationships (e.g. Tronto 1993; Folbre 2004).

# 3. THE CARE ECONOMY IN THE UNECE REGION

## 3.1

### The legacy and pre-COVID-19 situation

There is a great diversity in economic conditions and fiscal space for public spending on care throughout the UNECE region. Still, there is a far-reaching consensus in the UNECE region that a well-furnished social care infrastructure requires public investments, and that an adequate level of care investment is a precondition for progress toward gender equality. At the same time, however, a “care crisis” has been observed: health, long-term and childcare services in UNECE member states have long faced staff shortages, uneven pay and inadequate working conditions, a widespread use of precarious employment contracts, a vast imbalance in the burden of unpaid care work between women and men, and inequities between households able to afford to pay for care and those unable to afford care services, while suffering from inadequate support for unpaid care providers.

There is a great diversity in concrete policy frameworks on care across the UNECE region. Yet, despite the differences there is a strong policy tradition acknowledging the state’s role, next to families and the private sector, in setting and implementing care policy. The link between care services and women’s labour force participation is widely accepted as a driver of employment and care policies in regional political fora (United Nations Economic and Social Council 2019)

When analyzed in more detail, patterns of care provision differ in the region, both between subregions and type of care services. With respect to care for the ageing population, for example, care in Northern Europe is mainly provided by the public sector and is characterized by a high share of formal care and lower family engagement in day-to-day care. In Southern and Eastern Europe, there is a strong tradition placing the family as the main provider of care services for the elderly (UNECE 2015). In Central Europe, in turn, the care responsibility is more evenly shared between family and public institutions. Divergent

trends have become visible over the last decades. In many countries where publicly funded care services have dominated in the past the share of informal care has increased. The responsibility of the family and the community has been promoted, sometimes as a justification for the reduction of the role of the state. In turn countries in which most care tasks have long been performed informally may aim at strengthening the public care sector. Also, across the UNECE region, the organization, regulation and provision of care are increasingly being decentralized, with regional and local authorities being entrusted with more responsibilities (UNECE 2015).

Public expenditure on long-term care across the region is low by international comparison. An ILO report on long-term care in Central Eastern European (CEE) countries in 2016 pointed out that the share of public long-term care expenditure in terms of GDP was generally less than a half the OECD average (Hirose and Czepulis-Rutkowska 2016). It was 0.7 per cent in the Czech Republic, 0.74 per cent in Poland, and 0.53 per cent in Serbia, as opposed to 1.7 per cent of GDP in the OECD countries. The report emphasized the risks connected to low investment in care: “Since the financing of long-term care benefits relies largely on the State and local government budgets, it is particularly vulnerable to the countries’ unstable fiscal conditions” (Hirose and Czepulis-Rutkowska 2016).

Similar challenges emerge in the health care systems in the region. Especially in the wake of the financial crisis of the early 2000s and subsequent austerity programmes, public spending on health care systems was cut in numerous UNECE member states. Between 2007 and 2011 the share of public spending for the health sector fell in 44 countries, at least at some point during the time period. It was lower in 2011 than it had been in 2007 in 24 countries (Thomson et al. 2014).

With respect to childcare services, the picture in the region is also diverse. Countries in Europe and Central Asia developed safety nets for families, including state-funded early education and care for pre-school-aged children during the second half of the 20<sup>th</sup> century. This tradition eroded, to some extent, over recent decades when financial responsibilities and the governance of care services increasingly shifted from the state to the private sector and to family-based provision of childcare. In the years before the COVID-19 pandemic, a range of UNECE member states have expanded efforts to increase the availability of childcare services, but demand for care far exceeds availability throughout the region (UNICEF 2019).<sup>7</sup> In most EU members, for example, the provision of quality childcare and early-childhood education has increased over the last decades.<sup>8</sup> On average, 34 per cent, or approximately 5 million, children under age 3 attended early childhood education and care facilities in the European Union in 2019, while at least 95 per cent of children should participate in early childhood education as of age 4 (European Commission/EACEA/Eurydice/Eurostat 2019).

Public expenditure on early childhood education and care differs greatly between UNECE member states (see Figure 2). An OECD study showed that spending in a number of UNECE member states exceeds the OECD average, but there are also numerous UNECE member states with below average investment in childhood education and care (OECD 2019).

Preschool education coverage tends to be higher in Central and Eastern Europe than in Central Asia but is lower everywhere among children from poor and minority ethnic families and in rural areas, as well as children with disabilities. In Serbia, for example, more than 75 per cent of children from the wealthiest families take part in pre-school education, compared

to just 20 per cent of those from the poorest families – a problem that reflects limited pre-school places in poorer communities (Cantillon 2021). While the enrolment in pre-schools in the EU was 95 per cent in 2016, 38 per cent of parents who used organized childcare found its cost difficult to cover (Gromada et al. 2020).<sup>9</sup> The cost of childcare is also known to be a factor why women do not return to their paid work after giving birth, as data from the USA and other high-income countries documents (Ansel 2016).

For the age group between three years and mandatory school age, formal, non-family care and education is largely considered normal today in EU member states (European Commission/EACEA/Eurydice/Eurostat 2019). For many years, however, parents, in particular mothers, could only enter, or re-enter, the labour market if they had grandparents' help with childcare (Herlofson, K., & G.O. Hagestad. 2012). This is still the case in European countries with low investment in formal childcare services: The highest level of intergenerational support and care was found in the Central and Eastern European counties, as well as in Italy, Greece, Hungary and parts of Spain and Austria (Jappens, M., & J. van Bavel 2012). More recently, EU member states have strengthened their shared political commitment to investment in childcare services, with the goal of improved the access to education of young children and to attract more people – especially women – to the labour market.

The availability of early childhood education and care facilities for children below the age of three is generally more limited than for older children, and investment in services for children below pre-primary age is often much lower than for pre-primary school age children (see Figure 2). However, enrolment differs significantly between and within countries. Enrolment rates for below age three are between 15

7. The study covered Armenia, Bosnia and Herzegovina, Kosovo, Kyrgyzstan, Moldova and North Macedonia. Enrolment doubled in Kyrgyzstan (from around 10 per cent to almost 20 per cent) and increased by a third in North Macedonia (from just above 20 per cent to almost 30 per cent). The increase ranged between 1 and 10 percentage points in the other countries (UNICEF 2019).

8. In March 2002, the European Council set out targets for childcare by 2010 (the so-called “Barcelona targets” to provide childcare to at least 90% of children between 3 years and the mandatory school age, and at least 33% of children under 3 years of age). In 2009, the target for early childhood education was raised to 95% by 2020. In February 2013, the European Commission adopted the Recommendation ‘Investing in Children: breaking the cycle of disadvantage’ as part of the Social Investment Package. [https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52009XG0528\(01\)&from=EN](https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52009XG0528(01)&from=EN)

9. Gromada et al. 2020: Authors’ calculations using the European Quality of Life Survey (EQLS) 2016 round: average of ‘a little difficult’ and ‘very difficult: to a question ‘Q82 To what extent did cost make it difficult for you to use childcare services? 1. Very difficult 2. A little difficult 3. Not difficult at all’ for 28 countries that at the time of data collection were European Union members.

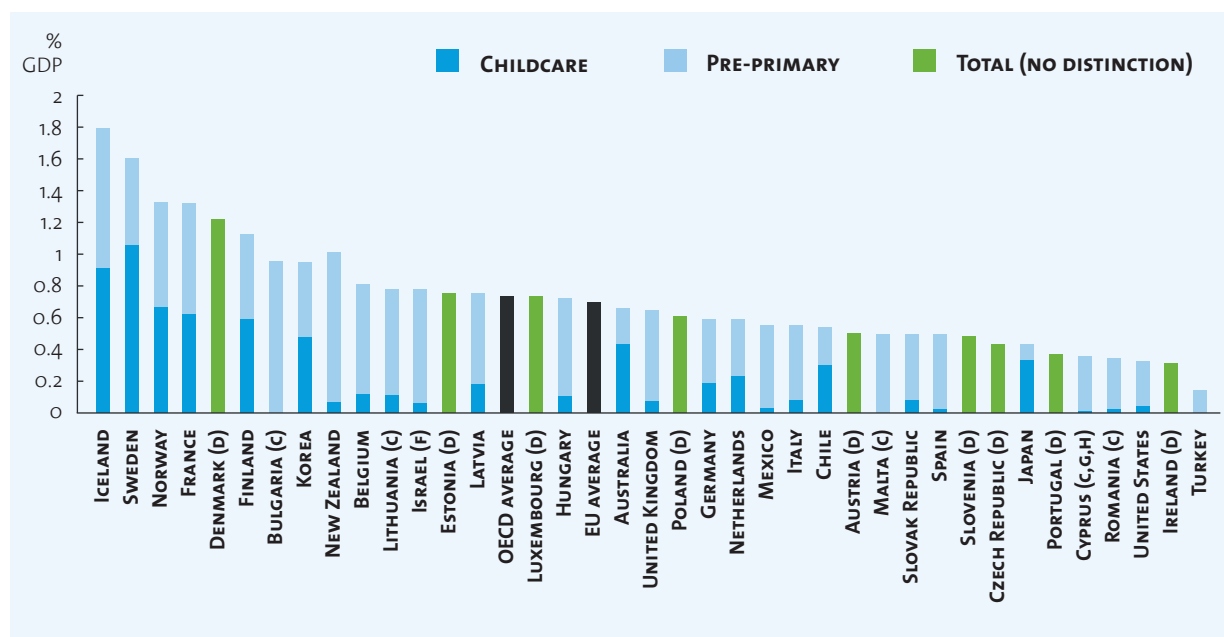


and 23 per cent in Central and Eastern Europe (except in Romania where the rate is 3 per cent). In other countries, enrolment ranges between 2 and 15 per cent (except for Belarus, where it is 29 per cent).<sup>10</sup>

In practice, a majority of European children below three years of age are cared for at home, and the unpaid care work is overwhelmingly done by women.

**FIGURE 2:**

**Public expenditure on childcare and pre-primary education and total public expenditure on early childhood education and care, as a % of GDP, 2015 or latest available**



Note: In some countries local governments play a key role in financing and providing childcare services. Such spending is comprehensively recorded in Nordic countries, but in some other (often federal) countries it may not be fully captured by the OECD social expenditure data.

a. Data for Poland refer to 2014

b. For Croatia, data on expenditure on pre-primary education not available.

c. For non-OECD EU member states (Bulgaria, Cyprus, Croatia, Malta and Romania), the data are not adjusted for any differences in the entry age for primary schooling and cover all public expenditure on childcare and pre-primary education regardless of the age of those using/enrolled in services.

d. For Austria, Czech Republic, Denmark, Estonia, Ireland, Luxembourg, Slovenia, Poland, and Portugal, data cannot be disaggregated by educational level.

f. The data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

g. Footnote by Turkey: The information in this document with reference to « Cyprus » relates to the southern part of the Island. There is no single authority representing both Turkish and Greek Cypriot people on the Island. Turkey recognizes the Turkish Republic of Northern Cyprus (TRNC). Until a lasting and equitable solution is found within the context of United Nations, Turkey shall preserve its position concerning the "Cyprus issue";

h. Footnote by all the European Union Member States of the OECD and the European Commission: The Republic of Cyprus is recognized by all members of the United Nations with the exception of Turkey. The information in this document relates to the area under the effective control of the Government of the Republic of Cyprus.

Source: [For OECD countries, OECD Social Expenditure Database For Bulgaria, Cyprus, Croatia, Lithuania, Malta and Romania, Eurostat](#)

10. Based on data for 17 of the region's countries (UNECE).

Public spending on education (including preschool education) in **Kyrgyzstan** has historically been high. The share of the state budget allocated to education, healthcare, and social protection peaked in 2013 at 62.3 per cent. In 2019 the share of these expenditures decreased to 37.3 per cent, due to cuts in spending on healthcare and social protection, while the largest share was dedicated to education. The share of expenditures to education grew from 19 per cent in 2010 to 26.4 per cent in 2019 and to 26.6 per cent for the first nine months of 2020.

The demand for preschool care continued to grow for years, but supply remained inadequate. Over the past five years, the number of preschool organizations has increased by 36 per cent. At the end of 2019, 1.6 thousand preschool educational organizations operation in the country, covering more than 208 000 children (25 per cent of children). This was an increase of 29 per cent compared to 2015. Disparities in coverage are high, particularly between urban and rural areas. In urban areas, affordable childcare centres are overfilled, in rural areas, childcare services are very limited or non-existent, except for compulsory preschooling (UNECE, Ablezova 2021).

Arrangements regarding the political and financial responsibility for the provision of care services (child care, as well as other types of care services) have a big impact on the availability and affordability of services for families. In most cases local governments are responsible for public early childhood education and care facilities, often with limited or no earmarked central funding. Since local authorities are often operating on severe budget constraints or even budget deficits, childcare and pre-school services are not expanded, or even not offered at all (Palihovici 2021). This explains part of the discrepancy between the care service provision in urban and rural areas. In some countries (e.g. Bosnia and Herzegovina, Croatia, Kazakhstan and Turkey) a significant share of care providers are private, typically serving high-income families in urban environments (UNICEF 2019).

ECE countries have high or medium-to-high levels of overall employment in the care sector, and the share of women in the care sector is particularly high (ILO 2018a).<sup>11</sup> For example, on average 76 per cent of health-care workers in the EU are women, as are 83 per cent of home-based elderly or disabled care workers, 93 per cent of childcare workers and teaching assistants, and 93 per cent of domestic cleaners and helpers (EIGE 2020). The care sector, while feminized as a whole, is also horizontally and vertically segregated by gender and ethnicity. In most UNECE countries, men predominate among the better qualified and better paid

physicians, while women aggregate in the lower-paid groups such as among nurses and home care providers: around 90 per cent of nurses are women (ILO WESO database, 2015). In the UK, survey data showed that people from ethnic minority backgrounds, particularly Indian, Black African and Black Caribbean people are over-represented at lower levels of occupational hierarchies, especially in frontline health and social care roles, compared to White people (Women's Budget Group et al. 2020).

Demographic changes, including low fertility and population aging, pose important challenges to the provision of care in the entire UNECE region. Care services, particularly the long-term care sector, face massive challenges in the recruitment and retainment of qualified personal, while the numbers of elderly persons grow. Unattractive working conditions and low payment are challenges to the recruitment of younger people: therefore, the median age of professional care staff is high and rising faster than in other sectors.

Responding to staff shortages by recruiting migrant care providers is a common practice in many UNECE countries, with implications for both countries of origin and recruiting countries, often both from the UNECE region. Migration flows of groups of the working age population, from rural to urban areas and from emerging economies towards Western Europe or the Russian Federation, are widely acknowledged challenges in UNECE member states with impacts on care needs

11. ILO data includes care workers in education, health, and domestic environments (employed by households), as well as non-care workers in care sectors (ILO page 194).

and the provision of care. International outmigration of women care workers has intensified the challenges to the provision of care in countries of origin over the last decades.

Addressing the care crisis and bolstering the care economy has been on the political agenda in the region already before the COVID-19 pandemic. Gaps between the demand and supply of childcare services have grown in many UNECE member states in recent years, as did inequalities in the access to and affordability of services, for example between rural and urban environments. Throughout the region, research is showing that those with the greatest care needs

have the least ability to pay for it – young families, single parents, and the elderly bear the highest cost of care and have the least available income (Palladino and Mabud 2021). Many older persons and their relatives face problems in finding affordable care services. Responding to the volume of unmet care needs in the region, in 2014, UNECE recommended that, in an environment of economic crisis and the threat of fiscal austerity, spending decisions should avoid exacerbating inequalities (UNECE 2014). Stimulatory spending must target not only male-dominated sectors of the economy so that women also benefit from the resulting job creation (Çağatay et al. 2017).

## 3.2

### The impact of COVID-19 on care work

Over the year 2020, the pandemic's economic impact and its regressive distributional consequences, globally and in the UNECE region, have become more and more visible (Ladd and Bortolotti 2020; OECD; OECD 2020b; OECD 2020c). The COVID-19 pandemic has aggravated preexisting economic and social inequalities, and posed additional socio-economic challenges, like increasing unemployment and poverty risks (Georgieva and Gopinath 2020). Progress toward gender equality has been put at risk by the pandemic.<sup>12</sup>

The pandemic's impact on care work is visible in four developments: Women's unpaid care workload has increased, second, women are reducing their paid work or dropping out because of an increased unpaid care load, and third, women's labour market position has become more vulnerable, including in the field of paid care work. All three trends need to urgently be addressed in policy responses to the pandemic and require investment in care for a sustainable and gender-sensitive response. Fourth, the pandemic exposed inadequate working conditions in paid care work.

First, the amount of unpaid care work done in private households has increased during the pandemic. This has mainly been a consequence of the closure of care and education institutions, but also because of care

needs of sick or convalescent COVID-19 patients. Over 48 million children in 18 countries and areas<sup>13</sup> in the European and Central Asian subregion have been affected by school closures, including early childhood centers and preschools in 2020 (United Nations). Women across the region have carried the main share of the additional unpaid work because the gender division of care work is highly skewed.

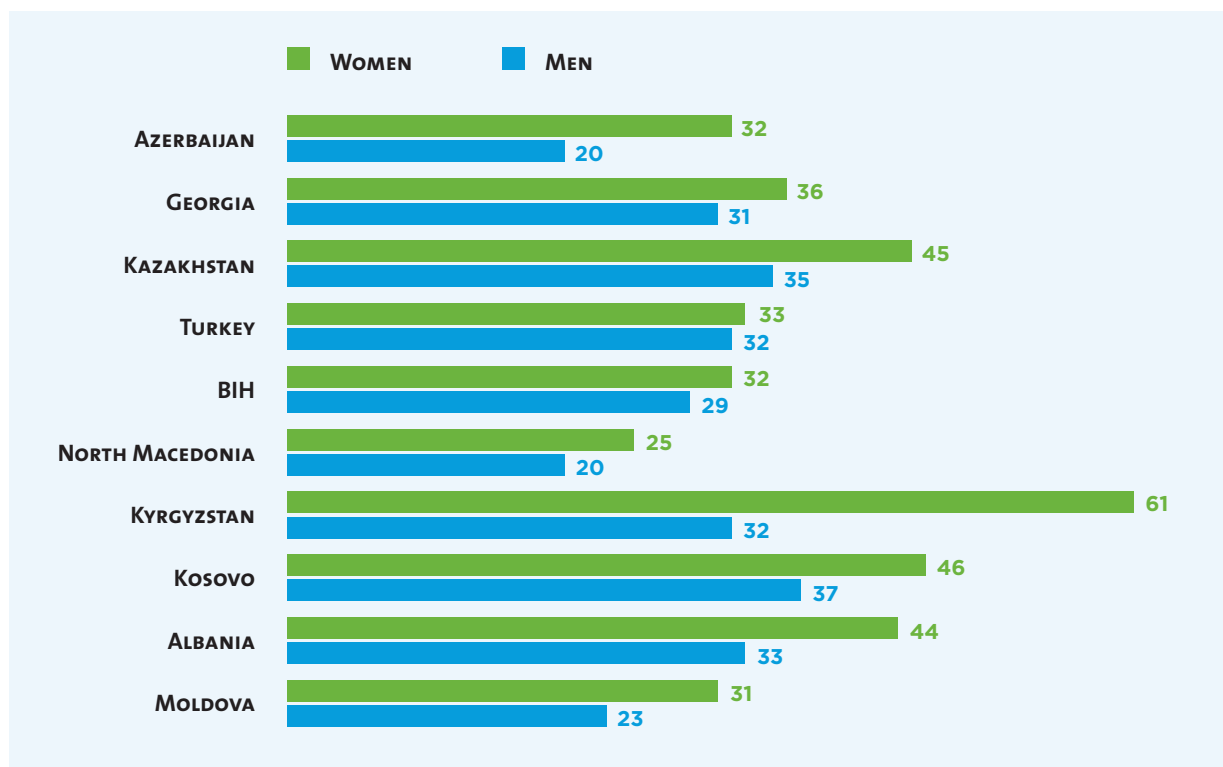
Rapid assessments of the social and economic impact of COVID-19 showed that women everywhere increased their amount of unpaid work, both in absolute number and as a share of the additional amount of work related to the pandemic (e.g. (UN Women Ukraine 2020; UN Women Turkey 2020; UN Women North Macedonia 2020; UN Women Republic of Moldova 2020).

The need to combine unpaid childcare and paid work caused severe pressures on everyone with care responsibilities. Therefore pandemic-related leave for parents and measures to facilitate working from home became essential policy instruments that saw a rapid increase in attention throughout the region during 2020. Support for parents was made available in a great number of UNECE member states (see Table 1). Some form of pandemic-related parental leave was

12. The focus here is on women's employment and care work. Yet the pandemic has also had consequences for women in other areas. For example, since the beginning of the pandemic, violence against women and girls has intensified UN Women 2020.

13. This figure includes Kosovo, in accordance with Security Council Resolution 1244 (1999).

**FIGURE 3:**  
**Proportion of respondents spending more time on at least two unpaid care activities during COVID-19, by sex**



Source: UN Women Rapid Gender Assessment Survey on the Impacts of COVID-19, April-May 2020

available in most UNECE member states during the peak of the first wave of the pandemic. In some cases, pre-existing leave provisions were extended, such as parental leave or maternity leave, in others, new leave entitlements were introduced in response to the emerging needs linked to the pandemic.

Depending on the type of policy, the impact of pandemic-related support for additional unpaid work on public spending differed: Some of the measures implemented by member states are low-cost, from the point of view of the state budget, such as legal protections against the dismissal of employees who are absent because of childcare responsibilities. In general, all benefit entitlements are more cost-intensive, such as the inclusion of self-employed in childcare benefit schemes, new benefit schemes or additional childcare leaves (see Table 1). Still, there are significant differences in terms of the overall burden of care support on public budgets during the pandemic, depending on the level of benefits, entitlement criteria etc.

Second, emerging data suggests that women in the UNECE region are reducing their paid work or are dropping out of the labour market (Barišić and Consiglio 2020; Borroni and Cenerelli 2020). Qualitative research indicates that women are responding to the increased pressure caused by additional unpaid care work due to the closure of care institutions, and time pressure brought about by simultaneous home office and home schooling requirements (Bundesinstitut für Bevölkerungsforschung 2020). Women with small children and single parents perceived this pressure most intensely (Cantillon and Teasdale 2021). Women’s support infrastructure often vanished almost completely due to the weakness or absence of care institutions, and the requirements of social distancing and the protection of vulnerable groups which implied that grandparents could not take over unpaid care responsibilities (Huebener et al. 2020).

**TABLE 1:**

**Care-related leave available to parents during the COVID-19 pandemic<sup>14</sup>**

Extension of numbers of days of childcare leave and protection against dismissal (based on pre-existing leave schemes)	Germany, Czech Rep, France (reduced benefit) Italy, Liechtenstein, Norway, Poland (sharing leave between parents is explicitly allowed), Portugal (income replacement at 2/3 wage), San Marino, Slovenia Greece (time bank) Leave and benefit available for self-employed: France, Portugal, Switzerland
Protection against dismissal of parents who are absent for care responsibilities	Slovakia, Spain, Turkey
Childcare leave for the self-employed	Extension of pre-existing scheme: France, Portugal, Switzerland New leave scheme: Czech Republic, UK, US
New childcare leave provisions introduced	Belgium (part-time), Cyprus, Greece, Luxembourg, Malta, Romania, Spain, Sweden, Switzerland, UK, US, Uzbekistan
Extension of maternity leave (based on pre-existing schemes)	Hungary, North Macedonia, Kazakhstan
Extension of paternity leave (based on pre-existing schemes)	North Macedonia
Prolongation of parental leave for parents currently on leave	Hungary, Latvia
Extension of sick-child leave (extension of pre-existing schemes to include child quarantine and hospitalization)	Finland, Poland, Portugal (incl. grandchild), Slovakia, Uzbekistan
Leave to care for other family members (not children)	Czech Republic, Turkey (unpaid)
Subsidies for employers / employees who are absent for childcare reasons	Subsidy for employees: Montenegro, Slovakia Subsidy for employers: Austria, Croatia, Portugal, Slovenia

Source: Steinhilber 2020

Third, women’s labour market situation has become more precarious, unemployment has increased, and income from paid work reduced. Women have seen their incomes decline and their livelihoods at risk. For example, between April and May 2020, women’s earnings decreased between 15 percent (North Macedonia) and 52 percent (Turkey) in the region (UN Women and UNDP 2020b).

14. Source: UNDP 2020; OECD 2020d.

In many countries, pandemic-related layoffs affected many women with precarious, temporary or short-term contracts in the services sector, including retail, hospitality, and tourism. In Austria, 85 per cent of the new unemployed during the pandemic were women (ÖGB). In the UK, low earners were seven times as likely as high earners, and women were one third more likely than men, to work in shutdown sectors: one in six (17 per cent of) female employees were in such sectors, compared to one in seven (13 per cent of) male employees. A higher share of young women than young men under the age of 25 worked in sectors that were shut down as a result of the social distancing measures in the spring of 2020 (36 per cent of young women, 25 per cent of young men worked in these sectors) (Joyce and Xu 2020; ÖGB).

Many women in paid care jobs have been heavily affected by effects of the pandemic. In the US, one in four childcare providers, almost exclusively women, lost their jobs during the first eight months of 2020. It has been estimated that as many as half of all child care places could be lost through the pandemic (Jessen-Howard and Workman 2020; Venugopal Ramaswamy 2020; Crerar 2020). Women with low levels of education and women of color or ethnic minorities have been hit disproportionately by the closure of care facilities, both as unpaid caretakers as well as employees of care institutions (Women's Budget Group et al. 2020; Venugopal Ramaswamy 2020). The closure of child care appears to force parents of color to switch jobs more frequently, not to work, to turn down promotions, and to work part-time (Novoa 2020). "It is clear from the scale of women dropping out of the labor force today that without intervention, the pandemic will reverse women's labor force participation for years, if not decades, to come – thereby taking an enormous toll on our economic health" (Palladino and Mabud 2021).

Fourth, the pandemic has exposed the need for major investments in paid care services and improvements in job quality and pay. Paid care workers, a majority of them women in all areas of care work, saw their work quality deteriorate in the fight against the pandemic.

Health and long-term care workers are directly exposed to the virus, as were teachers and childcare workers once the services reopened. The European Center for Disease Control estimated a 3.4-fold higher risk of infection with COVID-19 for frontline health workers than for the general population. In April 2020, early in the pandemic, data on COVID-19 transmissions among health care workers indicated a nine per cent infection rate in Italy, and a 14 per cent rate in Spain (UN News 2020). Infections among female health workers in some UNECE member states have been twice that of their male counterparts, illustrating the women tend to do jobs where they might be less able to protect themselves. In Spain, 75.5 per cent of infected health care workers were women, in Italy 69 per cent, and in the US 73 per cent (UN Women 2020a). The lack of personal protective equipment and testing during the first months of 2020 has contributed to the high rates of infection among care workers. For weeks, if not months, personal protective equipment for health care professions was unavailable.

To confront the COVID-19 crisis with the available human resources, several member states lifted legal regulations of working conditions and overtime restrictions or other working time regulations, and cancelled holiday entitlements of care workers (ILO 2020a).<sup>15</sup> Many care workers thus faced heavy additional workloads, including long working hours and a lack of rest periods. In **Uzbekistan**, frontline healthcare workers (82 percent of whom are women) reported on the impact of work-related pressures: Half of the female healthcare workers reported suffering from anxiety, burn-out and depression (United Nations Uzbekistan 2020). In France two thirds of nurses declared that their working conditions deteriorated since the onset of the pandemic. 43 per cent expressed doubts if they would continue in their profession in five years (Ordre National Infirmiers 2020). In **Spain**, 56.6 per cent of health workers presented symptoms of posttraumatic stress disorder, 58.6 per cent of anxiety disorder, 46 per cent of depressive disorder and 41.1 per cent felt emotionally drained (Luceño-Moreno et al. 2020).

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15. The ILO Guidelines on decent work in public emergency services (2018) set out the principles for defining working time arrangements during the emergency.



# 4. INVESTMENT IN CARE IN COVID-19 RESPONSE AND RECOVERY PACKAGES

Just as the care economy plays a central role in the fight against the pandemic, it is at the heart of the policy response and recovery. When the pandemic hit, governments of UNECE member states responded quickly with large-scale fiscal packages (Anderson et al. 2020). Immediate fiscal impulses entailed additional government spending on interventions such as the purchase of medical resources, employment protection measures, or subsidies to enterprises and

the acceptance of foregone revenues, for example as a consequence of reduced or cancelled taxes. Many member states deferred certain payments such as taxes and social security contributions, and some deferred the servicing of loans or the payment of utility bills (Steinhilber 2020). Other liquidity provisions and guarantees included export guarantees, liquidity assistance, credit lines through national development banks (Anderson et al. 2020) (see Table 2).

**TABLE 2:**  
Discretionary 2020 fiscal measures adopted in response to SARS COV-2 by 18 November 2020\*, % of 2019 GDP

COUNTRY	IMMEDIATE FISCAL IMPULSE	DEFERRAL	OTHER LIQUIDITY / GUARANTEE	LAST UPDATE*
Belgium	1.4%	4.8%	21.9%	22/10/2020
Denmark	5.5%	7.2%	4.1%	01/07/2020
France	5.1%	8.7%	14.2%	05/11/2020
Germany	8.3%	7.3%	24.3%	05/08/2020
Greece	3.1%	1.2%	2.1%	05/06/2020
Hungary	0.4%	8.3%	0.0%	25/03/2020
Italy	3.1%	13.2%	32.1%	22/06/2020
Netherlands	3.7%	7.9%	3.4%	27/05/2020
Portugal	2.5%	11.1%	5.5%	04/05/2020
Spain	4.3%	0.4%	12.2%	11/11/2020
UK	8.3%	2.0%	15.4%	18/11/2020
US	9.1%	2.6%	2.6%	27/04/2020

The ratio of the 2020 measures to 2019 GDP is chosen, because the 2020 GDP outlook was very uncertain. The category 'Other liquidity/guarantee' includes only government-initiated measures (excludes Central Bank measures) and shows the total volume of private sector loans/activities covered, not the amount the government put aside for the liquidity support or guarantee (the amount of which is multiplied to cover a much larger amount of private sector activity).

\* The cut-off date is earlier for some countries, see at the country specific descriptions.

Source: Anderson et al. 2020

A first round of response packages was implemented soon after efforts to contain the virus began in spring 2020, followed by subsequent packages over the course of the year and the beginning of 2021. In most countries, various rounds of budget revisions took place to address the crisis to make emergency funds available for the response to the pandemic. However, as a gender budgeting study of the emergency response to COVID-19 in the Western Balkan region suggests, budget revisions over the course of 2020 did not account for the needs of greatest relevance for women’s employment and the care economy (UN Women 2021). Additional fiscal packages in response to the second and third, and possibly fourth waves of the pandemic were developed in early 2021.

The support packages inevitably lead to an increase in fiscal deficits and accumulated public debt (ILO 2020b;

UN Development Group for Europe and Central Asia and Regional Coordination Mechanism). Some countries sought emergency financing from international lenders to finance the fiscal emergency packages (IMF 2020). EU member states agreed on a €750 billion recovery fund to support the COVID-19 response composed of a mix of grants and loans (Cyclus and van Ginneken 2020).

Numerous measures in the emergency response and recovery packages had direct impacts on the care economy, including impacts on paid care work.<sup>16</sup> In EU member states, for example, emergency financial aid was available to reinforce healthcare systems and short-term interventions addressed at the working conditions of front-line care workers during the pandemic, including the purchase of personal protective equipment (European Council 2020).

**TABLE 3:**  
**Overview of COVID-19 response measures with significant impacts on paid care work**

<p><b>1. Tax policies with impacts on the care economy, subsidies</b></p>	<ul style="list-style-type: none"> <li>• Tax relief for enterprises, including care services (e.g. kindergarten, long-term care providers)</li> <li>• Changes in tax rates (e.g. reduction of VAT), tax moratoria</li> <li>• Subsidies (e.g. social insurance, housing, electricity)</li> </ul>
<p><b>2. Economic stimulus actions in targeted sectors and enterprises</b></p>	<ul style="list-style-type: none"> <li>• Targeted supports to particularly affected sectors, including care sector</li> <li>• Measures addressing women entrepreneurs (including microenterprises), focus on care enterprises (including women-led care enterprises)</li> <li>• Measures addressed at self-employment (including women/ all with care responsibilities, and sectors where women are over-represented)</li> </ul>
<p><b>3. Preserving employment, especially in the care sector</b></p>	<ul style="list-style-type: none"> <li>• Employment protection (including care workers and workers with care responsibilities), incl. emergency care services</li> <li>• Public works programs</li> <li>• Measures addressed at workers in non-standard forms of employment, informal economy, gig-work etc.</li> </ul>
<p><b>4. Income protection / measures directly addressed at care workers</b></p>	<ul style="list-style-type: none"> <li>• Cash/ income support, e.g. bonus payments; income boost for low-income care workers</li> <li>• Measures to counter the exacerbation of gender pay imbalances caused by COVID-19</li> <li>• Measures to address the income generation/ protection of women-headed households</li> </ul>

16. With respect to unpaid care work, many countries introduced policies to support parents, de-facto primarily mothers, dealing with the increase in unpaid care work (see section 3.2. and Steinhilber 2020). The remainder of this section will focus on paid care work only.

**5. Direct investment in support of paid care work, incl. pay, working conditions, recruitment and retainment**

- Strengthened investment in the health sector; measures addressing pay and working conditions
- Strengthened investment in care sectors (including elder care, long-term care, social work)
- Programmes focusing on the recruitment and retainment of care workers
- Special measures addressing domestic workers and domestic service
- Measures focusing on migrant domestic workers (in country of destination and/or country of origin)

Source: Steinhilber, Silke (2020): *Women’s economic empowerment and the care economy in the UNECE region: The impact of economic and social policies during the COVID-19 response and recovery*. Edited by UNECE. UNECE (Policy Brief on Gender, 1). Available online at [https://unece.org/sites/default/files/2021-01/PBrief\\_Care%20Economy\\_Covid%20response\\_o8012021\\_1.pdf](https://unece.org/sites/default/files/2021-01/PBrief_Care%20Economy_Covid%20response_o8012021_1.pdf)

Five main areas can be distinguished when analysing the impact of COVID-19 response packages on the paid care economy (see Table 3): The first is fiscal and tax policy with direct impacts on the care economy, the second is economic stimulus action in specific sectors and enterprises, including the care sector and care enterprises. The third group of measures covers employment protection measures, including subsidies, especially in the care sector; followed by, fourth, measures aiming to protect the income of care workers. A fifth area of attention is direct support of paid care work, incl. pay, measures to improve working conditions, or emergency recruitment and retainment measures.

**Tax policies and subsidies**

Member states saw themselves forced to accept reduced state revenues as consequence of the pandemic response packages: the tax burden of individuals and companies was reduced, at least temporarily, in many member states, including through tax moratoria and changes in tax rates, e.g. through a reduction of VAT. Companies providing paid care services, including childcare services and health or long-term care providers that benefited alongside others from tax policies and subsidies, yet were not addressed explicitly by tax policies or subsidies. The same applies to support for SMEs through tax measures – many care services are small or micro enterprises, often headed by women.<sup>17</sup>

In **Kazakhstan**, SMEs were exempt from personal income tax and social payments (social tax and insurance) for six months (from April through September 2020). Benefitting sectors included tourism, transport, information technology (IT), consulting, private education, and private healthcare.<sup>18</sup>

In the **Russian Federation**, enterprises from ten heavily affected sectors (including tourism, hospitality, and education) were granted the right to postpone all tax payments.<sup>19</sup>

In **Serbia**, payroll taxes and contributions were deferred during the period of the state of emergency, and the payment of corporate income tax for the second quarter of 2020 was delayed.<sup>20</sup>

In **Tajikistan**, for the months of May to August 2020, enterprises were allowed to postpone the payment of social security contributions.<sup>21</sup>

In some cases, in Belgium for example, tax packages included deductions for companies that facilitate working from home for their employees with care responsibilities. Yet there is no evidence so far about specific tax incentives for companies that expanded child or other

17. Since research has documented the specific vulnerabilities of women-owned enterprises, and the fact that women-owned enterprises are often SMEs, including enterprises offering care and personal services, it is likely that they benefited from measures addressed at these types of private enterprises.

18. <https://home.kpmg/xx/en/home/insights/2020/04/kazakhstan-government-and-institution-measures-in-response-to-covid.html>

19. <https://стопкоронавирус.рф/what-to-do/business/nalogovie-kanikuly.html>

20. <https://oecd.github.io/OECD-covid-action-map/>

21. <http://www.president.tj/ru/node/23055>

care services during the pandemic-related closure of care institutions, a measure that could have addressed the care needs of essential workers, for example.<sup>22</sup>

### Economic stimulus action in targeted sectors and enterprises

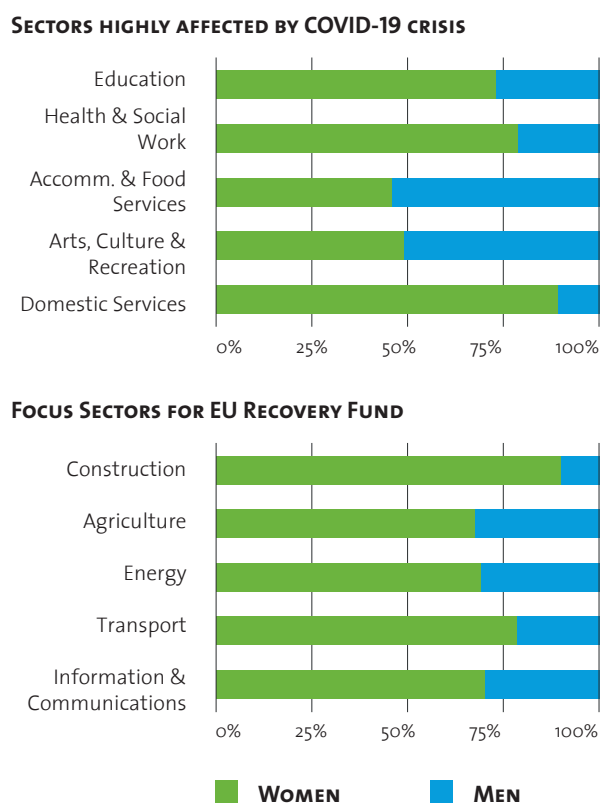
Economic stimulus actions targeting heavily affected sectors and enterprises were applied across the UNECE region (see Table 2 above). Like in the case of tax measures, data is still emerging to assess to what extent care enterprises, including the many small and medium care enterprises owned by women, benefitted from economic stimulus packages. Despite the public recognition of the importance of care, only a few countries included care services explicitly among the most affected enterprises. Targeted economic support, such as subsidies, emergency loans or facilities, did include the care sector in Armenia, Norway, Slovakia and Switzerland. Pandemic-related enterprise support schemes rarely addressed self-employed women, including self-employed care providers.

In **Armenia**, preschools and childcare service providers were explicitly included in the government-sponsored emergency business support program.<sup>23</sup>

Direct financial support to enterprises providing childcare services was included in the pandemic response packages for enterprises affected by the lockdown measures in **Norway, Slovakia, Switzerland** and some states in the **US** (OECD 2020d; UNDP 2020).

For the EU, a gender impact assessment of the COVID-19 Recovery Fund indicates an imbalance between highly affected sectors and sectors benefiting from the EU Recovery Fund. Highly affected sectors by the lockdown measures employ a high share of women, including education, health and social work. They have benefited less than male dominated sectors of the economy such as construction, agriculture, energy of transport, from emergency support (Klatzer and Rinaldi 2020) (see Figure 4).

**FIGURE 4:**  
Sector analysis of EU Recovery Fund by gender



Source: Klatzer and Rinaldi 2020, based on EuroStat data

Economic stimulus packages in response to COVID-19 so far are not reflecting the relevance of paid care work that has become so obvious during the pandemic response. Looking toward the recovery, calculations suggest that economic stimulus action could be particularly beneficial if focused on incentivizing the creation or expansion of care services (Henau and Himmelweit 2021). In the short-run, subsidies and the adaptation of legal requirements for care enterprises would be needed to maintain or potentially expand the offer of care services during the pandemic and support care enterprises to comply with hygiene requirements. A study by the Local Government Association in the UK, for example, estimated potential extra costs of £6.606 billion for social care providers for maintaining safe staffing levels and providing personal protective equipment (PPE), as well as the need for enhanced

22. Prior to the pandemic, tax deductions were possible in Italy for companies signing firm-level collective agreements with specific measures to reconcile work and private life. Between 2017 and 2018, around 1,500 firms benefitted from this incentive.

23. [https://covid19.gov.am/en/business\\_and\\_coronavirus](https://covid19.gov.am/en/business_and_coronavirus) (action 3).

cleaning of care homes and other care settings (Local Government Association 2020).

### Preserving employment, especially in the care sector

The protection of employment was a main objective of member states' emergency response packages. Numerous member states included care workers among the groups entitled to subsidy schemes designed to avoid lay-offs. Paid care workers were rarely explicitly addressed as targets of employment protection measures.

A few countries, however, introduced specific subsidies to protect the employment of childcare workers. These programs were intended to safeguard the supply of childcare services during the emergency response, as well as for the recovery period. Childcare services, so the argument, should be able to resume immediately once the social isolation measures ended or were relaxed.

Next to the objective of protecting employment relations, ensuring the continued functioning of childcare services is also critical for other essential public services. Many health-care workers throughout the region who were leading the fight against the coronavirus were faced with an impossible choice between caring for victims of a pandemic and caring for their own children at home while childcare services were closed (Fetters 2020). In several countries, including Austria, Belgium, Germany and the UK, a reduced number of schools and childcare facilities remained open throughout the lockdown period, offering necessary services mainly for children of essential workers. This included the children of health-care workers (Germany), as well as postal workers and transport workers, among others. In some cases, children of single parents, or children of parents working in other sectors of the economy could also attend classes, as well as socially vulnerable children.

Further innovation in the field of flexible work arrangements, flexible cooperation between care providers and employers, incentives for enterprises in the development of innovative solutions, e.g. time banks of working hours, flexibilization of working weeks, job sharing has been discussed with greater intensity than before 2020. However, innovative measures in this regard have so far not been prioritized as care investments in governmental budgets (International Finance Corporation 2019; UNICEF et al.).

In **Slovakia**, a targeted subsidy for childcare workers was developed. Approximately 21 million Euros from the OP Human Resources were dedicated to maintaining the capacities of kindergartens. The state contributed 80 per cent of employees' average wages for April, May and June 2020. The measure ensured that employees did not have to be laid off. Thanks to these resources, childcare could be provided again as soon as social isolation measures were relaxed and the child care institutions reopened, so that mothers had a place for their children when they returned to the labour market (UN Women and UNDP 2020a).

In the **UK**, subsidies were made available for companies early on in 2020, initially for a three month period: Employers were able to apply for a grant to cover 80 per cent of workers' wages (up to a sum of £2,500 per month) in cases where they are unable to attend work due to service disruption or isolation (TUC 2020). This included companies providing care services.

Emergency childcare services for essential workers remained open during the lockdown measures of the first wave of the pandemic in **Austria, Denmark, France, Germany, Latvia, the Netherlands** and the **UK**. Under specific circumstances, emergency care services were made available to single parents who did not hold essential jobs, or children with special needs (OECD 2020d; UNDP 2020).

### Income protection and other measures directly addressed at care workers

The recognition of the importance of care work in the fight against the pandemic has expedited calls for wage increases for care workers, at least temporarily. Fiscal emergency packages in the region typically included a concern about the income of paid care workers, especially health care personnel.

Paid care work is characterized by low wages and challenging working conditions, globally and in the region, as well as gender wage gaps. There are big differences among UNECE member states, however, with respect to the overall wage levels of care workers. In France,

women care workers experience a care penalty of 29 per cent of hourly wages (against a penalty of 10.6 per cent for men care workers). In Germany, women care workers have a bonus of 9.3 per cent. With a wage bonus of 30 per cent for women care workers (and 8.3 per cent for men), Sweden is the best place to be a care worker from a pay perspective (ILO 2018b). The situation between member states is also diverse with respect to gender wage gaps. For example, nurses and midwives, the biggest occupational group in the most feminized health-care occupations, receive lower wages than doctors and assistant professionals, with gaps ranging from 12 (Germany) up to 60 percentage points (Poland). In Belgium, the Russian Federation and UK, nurses' wages are almost half those for doctors (respectively 51, 47 and 48 per cent), while in Spain they correspond to 35 per cent.

Wage increases in the public care sector have been implemented in a few countries in response to the pandemic. However, most increases so far apply to selected groups of workers in the health sector only or were short-term measures. For example, many emergency fiscal packages included one-time bonus payments and extra time-off. Nineteen UNECE member states reported that additional financial support and compensation above normal salaries was provided to health care workers involved in the COVID-19 response. This generally took the form of one-time bonus payments (Bosnia and Herzegovina, Estonia, France, Greece, Germany, Hungary, Italy, Kyrgyzstan, Romania, Russian Federation, Ukraine) or monthly bonus payments for the duration of the crisis (Albania, Latvia) from the central government (Williams et al. 2020). Some countries paid bonuses only paid to workers dealing with COVID-19 patients. In a few countries, bonus payments included long-term care workers as well.

In most cases, paid care workers in informal economic arrangements, for example in home-based long-term care, were excluded. Only Spain and Italy included support for domestic workers into the emergency packages.

**Serbia** introduced a 10 per cent increase in salary of health sector workers and a 10 per cent increase in the salary of long-term care workers in nursing homes (Cantillon 2021).

In **Georgia**, a pay raise for teachers and medical personnel in mountainous regions was included in the response packages to the pandemic.<sup>24</sup>

In **Ukraine**, a top-up of 300 per cent of their salary was paid to medical personnel working with COVID-19 patients (personal income tax was withheld but the state compensated the amount of the tax in full for the top-up).<sup>25</sup>

Bonus payments for long-term care workers were paid in **Germany, France, Slovenia** (for all essential workers) and **Tajikistan** (OECD 2020c).

In the **Republic of Moldova**, a one-time cash assistance of approximately 600 US dollars was paid to healthcare workers who work directly with patients who are infected with the COVID-19 virus (OECD 2020a).

In **North Macedonia**, doctors and medical staff of infectious disease clinics and departments, and all members of emergency medical teams, received a 20 per cent salary increase for May and June 2020 via a home payment card (OECD 2020d).

### Direct investment in support of paid care, incl. working conditions, recruitment and retainment

Member states have implemented a wide range of measures in direct support of paid care services as part of the fight against SARS COV-2. Direct financial support for paid care services reached from financial bonuses to mental health support and practical support such as free accommodation and transport for health workers.<sup>26</sup> The purchasing of personal protective equipment and other occupational health and safety amenities was also a component of COVID-19 response packages across the entire region.

24. [https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19?fbclid=IwAR1kw-bhrbuPvsfcPSB0swdCjkX3K5losZQUZko\\_wuhP7lcLkYY2U9sZt-M#G](https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19?fbclid=IwAR1kw-bhrbuPvsfcPSB0swdCjkX3K5losZQUZko_wuhP7lcLkYY2U9sZt-M#G)

25. <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19#U>

26. Expenditure on technical equipment as well as direct payments to hospitals to compensate for the loss of income caused by the requirement to refrain from treatments that are not urgent are not covered in this report.



In **Romania**, health workers could apply for accommodation support when providing services to patients with COVID-19 (OECD 2020d).

In **Denmark, France**, and the **UK**, funds were disbursed to establish confidential support hot-lines and counselling provisions for health care workers offering assistance in dealing with personal and work-related difficulties as a result of COVID-19 and associated violence against healthcare workers (ILO 2020c).

Legal provisions regarding occupational illnesses and accidents at work were adapted in **Spain** and **Ukraine** to cover COVID-related illness and consequences (OECD 2020d). The adjustments are important given the high number of care workers who became ill with COVID-19 during the first wave of the pandemic. The majority of health care workers benefitting from the change are women.

Most investment projects in the area of paid care, however, have a longer time horizon and were therefore not included in COVID-19 response and recovery packages. Care workers have, for example, for a long time mobilized for decent work and pay in the care sector. Also, pay equity has been an aspect of concern. The gender pay gap in paid care work is on average 26 per cent in high-income and 29 per cent in upper-middle-income countries in the UNECE region (ILO 2017).

There is a need to ensure the monitoring and compliance with labour legislation for informal care workers, mainly in private households. These are typically women migrant domestic workers. Unless the care sector is well-funded and regulated by strict standards, there is a continued risk that care providers receive low wages and care facilities may not meet quality standards. Investments in the pay and working conditions of the care workforce are therefore needed to increase the overall recognition of care and to reduce the prevailing occupational segregation by gender that locks women in low-pay, low-recognition occupations (Gromada et al. 2020).

The fact that qualified staff is lacking in the care sector in many UNECE member states has also been on political agendas for years. It became particularly obvious during the pandemic. The recruitment and training/retraining of new personnel and the prevention of the withdrawal of care workers from their jobs after the end of the pandemic must be a concern of highest priority in the post-pandemic recovery plans.

# 5. CONCLUSIONS AND RECOMMENDATIONS

The care economy is playing a central role in the fight against the COVID-19 pandemic, at different levels. Care is essential in the fight against the infection, the protection of vulnerable groups of the population, the education of children and the physical and psychosocial support for everyone affected by the pandemic. The main share of care work is provided by women, both paid and unpaid. Care work happens in private and public spaces, it includes domestic work and family-based tasks, as well as interactions in institutions. The pandemic has shed new light on the relevance of care for social wellbeing and sustainable development, goals that have long been on political agendas and are firmly enshrined in the SDGs.

A recovery from the pandemic that strives to “build back better” has to include the care economy among its central areas of focus. It should be based on the understanding that the care economy can be a motor for the recovery from the pandemic. A recovery from the pandemic has to address the interconnected needs in paid and unpaid care work and uphold women’s economic empowerment as central objective. However, there was a “crisis of care” in the UNECE region even before the pandemic, so mitigating the effects of the pandemic may not be enough (Care Collective 2020a). Therefore, care-focused investment in the pandemic recovery should also be conceived as an antidote to

the impact of policies during the past decades on the care economy in the region, including austerity policies implemented after the financial crisis. Investment in care can lead to a “high road to care work” (ILO 2018a), increase gender equality and contribute to sustainable development especially if it entails reducing and redistributing unpaid care work between women and men, is based on the recognition of the economic and social value of care work, rewards quality care accordingly and gives voice to the perspective of paid and unpaid care providers (Heintz et al. 2021; ILO 2018b).<sup>27</sup>

Sidelineing care in the pandemic response would be short-sighted and not reflective of the economic and social benefits of care. While there will be pressures to return to austerity policies after the pandemic, the benefits of investment in care have been documented. The pandemic thus offers an opportunity to depart from a path that, in the past, has presented cuts in social spending and investment in care infrastructure as effective measures against economic crises. “Building back better” thus can mean the acknowledgment of sustained investment in care as vital to societies and as force to boost economic recovery and job generation.

There are short-term and longer-term perspectives on the relevance of investment in care for the pandemic response and the post-pandemic recovery process.

## 5.1

### Short-term perspectives on investment in the care economy

The fight against the pandemic has highlighted the important role of care in all aspects of social life. The care economy thus needs to be sheltered from the pandemic’s immediate consequences. Unpaid and paid

care providers need support to cope with the increased care needs caused by the pandemic, and safe care provision under pandemic conditions needs to be insured by all necessary means.

27. It has been argued that the paradigm shift reflected in increasing investment in care can also contribute to solving the ecological crisis, as care services tend to have a low carbon footprint Heintz et al. 2021.

1. Emergency packages and budget reallocations in response to COVID-19 need to prioritize care. Where necessary, virements between line items are needed to secure care provision during the COVID-19 response. A concern for care and concerns for gender justice and women's economic empowerment are closely intertwined. Immediate needs arising in the care economy, such as the supply of personal protective equipment and the additional cost of hygiene and equipment have to be adequately addressed in emergency packages, as well as funds to ensure workplace quality and safety.
2. Childcare services and schools are essential for child development and women's employment participation, before, during, and after the pandemic. Much more attention would be necessary to develop adequate short-term solutions that allow maintaining care and education institutions open or re-open as fast as possible under adapted conditions. Investment in technical solutions like air filters, as well as investment in digital infrastructure, additional hygiene and safety equipment, more individualized COVID-19-compatible education services for children with special needs or earlier vaccination for childcare staff and teachers could be items for consideration, of course under consideration of fiscal circumstances. It is feared that the effects of mandated care service closures on women's employment will increase over time and persist even after the reopening (Russell and Sun 2020).
3. To enhance the efficiency and effectiveness of investments in care during the emergency, policies are needed that simplify governance of the

provision and financing of care services. Multi-level financing and governance can pose a challenge to ensuring care services during the pandemic. Economic stimulus packages can therefore increase budget transfers to subnational levels in the interest of support for the care economy. The enhanced collaboration between governments at the local level, employers, trade unions, private sector and non-profit care providers can ensure accessible and affordable care services, including safe childcare and long-term care during the pandemic.<sup>28</sup>

4. Emergency enterprise support needs to explicitly include care enterprises and self-employed care providers. They need to be included in all direct financial support schemes, as well as programs to protect employment and avoid unemployment.
5. Adequate support for parents and all workers and self-employed with care responsibilities needs to be included in emergency measures, especially during the closure of care services. This can include parental leave schemes and benefits, entitlements to home work, reduced working time, or flexible working time arrangements. The development of innovative solutions could be supported at local levels. While care-focused emergency support is essential for families to get through the pandemic, state support for care needs can also play an important role when aiming at supporting the private sector's efforts to deal with the crisis.
6. Redistributing care responsibilities between women and men has to be a central objective of care policies during the pandemic, to stop eventual trends of a solidification of stereotypical gender roles during the emergency.

## 5.2

### Medium- and long-term perspectives on investment in care in the recovery

As governments in the UNECE region continue to address the immediate consequences of the SARS-COV2 epidemic's subsequent waves, simultaneous discussions are already focusing on the post-pandemic

reconstruction and lessons learned from the experience. One year after the onset of the pandemic, evidence abounds that any medium and longer-term perspective of post-pandemic reconstruction must

28. For employer-supported childcare, see International Finance Corporation 2020, 2019, and UNICEF et al.

entail a systematic and crosscutting concern for the care economy, with respect to both unpaid and paid care work. Governments play a key role in supporting household-based care provisions and in redistributing care from households to the state and markets through a range of policies and programmes that provide and/or regulate care services. All these measures should be underpinned by adequate financing – often at local or municipal level as well as efficient mechanisms for implementation.

1. A renewed awareness on the importance of care opens a window of opportunity for ensuring that care services are financed adequately, with accessibility, affordability and high quality as core objectives of care policies. The experience with the financial crisis in the early 2000 illustrates the need to expand current levels of care financing (Thomson et al. 2014). It is crucial that in the recovery process, member states do not fall back into previous patterns of dealing with the aftermath of economic crises, namely austerity at the expense of social infrastructure and women's rights. Cuts in social spending have not only been shown to have negative impacts especially on women, but also on the economic recovery itself, in particularly on employment (Seguino 2015). Proposals for an austerity path dealing with the debt incurred during the pandemic therefore will have to be closely revised for their implications on the care economy. Plans for the negotiation of international aid should be analyzed through gender and care lenses, with the support of international organizations.
2. Medium and longer-term plans for the recovery from the pandemic need to strategically focus on expanding the physical and human care infrastructures. Investment in care during the recovery can provide opportunities to close pre-existing care gaps and address inequalities in the access, affordability and quality of care services. Additional investment in the care economy could, for example, address urban – rural care gaps, as well as gaps between different population and age groups (Gromada et al. 2020; Cantillon 2021; Ablezova 2021). Addressing pre-existing and new gaps simultaneously will also require new reflections about the redistribution of roles and responsibilities between the market, the state, and the household – alongside the necessary redistribution between

women and men. Care deficits have been shown to be costly to the private sector already before the pandemic (Gammage et al. 2019). Closing deficits can thus play an important role in the economic recovery.

3. Care workforce shortages, as well as low pay, inadequate working conditions and the precarious employment situation of care workers, including migrant care workers, have to remain at the center of attention during and after the pandemic. The pandemic has highlighted, once again, the need to develop effective recruitment, training and retention strategies in all care sectors, and to improve the working conditions for all care workers. The situation differs across the UNECE region and solutions to the undersupply of care workers lie far beyond investment in care. Yet public investment remains a key factor for solving the care workforce shortage and creating decent work in the interest of high-quality care and decent work.
4. Beyond a concern for physical infrastructure and human resources, it is necessary to include a concern for the institutional strengthening of care services through public investment, in the interest of high quality standards and good institutional governance of care services. Investment in digital infrastructure for care services also has to be included among the considerations for high quality care provision. The pandemic brought to light far-reaching deficiencies in this respect.
5. Investment in care can also be an instrument for addressing other intersecting forms of economic and social inequality that constrain sustainable human development. Many employment sectors that would benefit from the employment impact of care-focused investment are dominated by low-wage workers – the majority of whom are women, often women of color or ethnic/national minorities and migrant workers. These are precisely the workers who have been disproportionately harmed by the pandemic. Investment in care can therefore also contribute to greater labour market justice. Through employment generation, care investment will also strengthen contributory revenues. Without such interventions, the long-term health and economic impacts could be severe, worsening gender inequality and other forms of stratification.

6. Tax policies will play a central role for an inclusive and sustainable recovery from the pandemic, as fiscal space is a core constraint for care-focused investment. Efforts to ensure progressive and inclusive tax systems after the pandemic will have to address dimensions of equality and care (Mooij et al. 2020). When considering trade-offs between growth and social inclusion, investments in care and the contribution of care work to sustaining and developing human capabilities have to become part of the equation.
7. Improved data will be important, both for “care budgeting” (i.e. assessing care-focused impacts of policy decisions) and for gender budgeting of post-pandemic recovery plans. Therefore, enhanced and improved data collection on care services in member states will play an important role for evidence-based decisions about investment in the care economy. Improved data collection entails, for example, the collection of periodic time-use data, so that an improved picture of all forms of care work is obtained (paid and unpaid, by women and men). Improved data will allow to address, for example, existing inequalities in care service provision (e.g. by geographical region, by age and income group etc.). The cost and benefit of investment in care in terms of employment creation and quality of care, among other factors, should be systematically evaluated based on a transparent expenditure monitoring and reporting system.

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