Gender and Public Finance from a Care Perspective

Workshop on Gender Budgeting, Vienna, November 2014

Susan Himmelweit
Open University
s.f.himmelweit@open.ac.uk
Plan of talk

- The importance of care to gender budgeting
- How different types of care are provided – care systems
- Arguments for public financial support for care
- Gender impacts of care policies and how to assess them
- Some difficulties
- Care-budgeting
- Challenging gender and care blind assumptions
- How gender and care budgeting could change the world
Gender budgeting and care

- Gender budgeting requires assessing impact of (spending) policies on existing **gender inequalities**
  - not just of policies designed to impact on gender equalities but all policies
  - involves also critiquing gender-blind assumptions used in standard budget analysis (eg that “work” = paid employment)

- Gender budgeting can be used not just to reduce gender inequalities but knowing about gender effects also makes for more efficient policy more generally ie can help meet other objectives

- Requires knowing about structure and causes of existing gender inequalities in order to assess impact on them

- **How care is provided is crucial to gender inequalities throughout society**
Care and the Economy

• The traditional view of the economy focuses on the processes of material production and consumption – and so side-lines/ignores care-giving

• Feminist economists have insisted that any account of the economy needs to encompass all “provisioning” including:
  – provision for care needs as well as for material consumption

• Women have traditionally been the care providers

• Economic analysis that ignores care is based around an inaccurate androcentric myth:
  – the fiction of “independence” as the norm
What is care? Care norms

- Care services are those that help people do what others can do unaided
  - a socially agreed set of capabilities
- Care is the hands-on provision of such services to those who would otherwise lack those capabilities

So:
- Care consists of physical hands-on services to meet by socially defined care needs
- Norms about these needs vary across societies and across time
  - eg be able to carry water vs being able to read
- And also vary across groups within societies following wider societal expectations:
  - eg for men being able to earn a living vs for women looking after children
- Norms about care needs can and do change
How is care provided? Care practices

• Care is provided both paid and unpaid
  – Only paid care is counted in GDP
  – Unpaid therefore easily seen as “free”

• But unpaid care still has opportunity costs
  – Constrains development of paid economy
  – Constrains individual opportunities

• In most economies:
  – Quantity of unpaid care much larger than of paid care
    • Even in Sweden, paid care is estimated to constitute only one third of total care
    • Value of unpaid care equivalent to a large proportion of GDP (ONS estimates about 1/3 GDP in UK)

• Can see combination of norms about care needs and care practices as constituting a society “care system”
Care provision is highly gendered

• Unpaid care: allocated within households or communities by gender norms
  – Where women are available they do the majority of unpaid care
  – Women more likely to reduce their employment to care
  – Societies/communities vary in the acceptability of using paid care to substitute for (women’s) unpaid care

• Paid care: majority of workers at lower ranks are women
  – Skills used in paid care seen as feminine characteristics and tend to be undervalued
  – Jobs designed for women often more compatible with domestic care responsibilities than other employment
  – Pay and conditions often worse than in equivalent non-care work (not universally)
Gender differences in care structure and other gender inequalities:

- Employment rates
  - Unpaid care responsibilities structure availability for employment
- Pay
  - Those with care responsibilities pay for the “special treatment” they need from their employers
- Occupational segregation
  - Paid care work highly gendered too. Low wages in paid care important constituent of gender pay gap.
- Pensions
  - Women’s lesser incomes when old due to less earnings due to earlier caring responsibilities
- Time-use
  - Time spent on unpaid care leaves less time not only for employment, but also training, networking and leisure
- Need for public support for their own care
  - Women more likely to end up poor and living on their own
  - And are therefore the majority of recipients of publically supported are
## Four different types of care and their requirements

<table>
<thead>
<tr>
<th></th>
<th>Who needs it?</th>
<th>Needs and time scale predictable?</th>
<th>Continuous presence needed?</th>
<th>Can unpaid care can be combined with employment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare</td>
<td>Children (of employed parents)</td>
<td>yes</td>
<td>yes</td>
<td>not at same time</td>
</tr>
<tr>
<td>Rehabilitative care</td>
<td>After events</td>
<td>short-term</td>
<td>Not usually</td>
<td>often</td>
</tr>
<tr>
<td>Care for disabled</td>
<td>Long-term disabled (children and adults)</td>
<td>sometimes</td>
<td>Not necessarily</td>
<td>often</td>
</tr>
<tr>
<td>Aged care</td>
<td>Older people, most are women living on their own.</td>
<td>No – usually increasing then ceases</td>
<td>Not usually</td>
<td>Yes usually</td>
</tr>
</tbody>
</table>
The Care Diamond

- Four Sectors of care provision:
  - Family
  - Private firms
  - Public Sector
  - Community/ non-profits
- Sectors differ by whether:
  - they use paid or unpaid work
  - the market is involved in allocating care
- Balance of different sectors varies:
  - by country
  - by type of care (elder/child etc)

NB Care diamond is for *provision of care*
- financing can be different
- e.g. state can *finance* provision by any of the three other sectors
Arguments for public financial support for care

- **Safety net**
  - For when the family could not or did not provide:

- **Human rights**
  - That those with disabilities had rights to equal, or sufficient, capabilities
  - Introduces idea of care quality
    - Extends rights to public support to where provision is considered not good enough, not just where it’s absent

- **Social Investment**
  - That state spending on care is an investment with financial pay-offs:
    - a more educated, more productive future workforce; less crime
    - enabling unpaid carers to combine care with employment to both contribute to the economy and support themselves financially (more taxes/less spending on benefits)
  - Argument used more for childcare and rehabilitative care than long-term disabled or elder care
Arguments for public financial support for care (cont.)

• Prevention
  • That more investment in care now will prevent need for greater care in the future
    • A version of social investment but with the financial pay-off being in terms of needing to pay for less care
    • Includes recognition of state obligations
    • May hold where general social investment argument does not eg for people who are unlikely ever to being able to take employment

• Social infrastructure
  • Caring system of a society important in itself
    • Determines social framework in which we all live our lives as well as individual well-being
    • Applies to all forms of care

• Promote gender equality
Public financial support of care promotes gender equality in general benefits women particularly.

**Women are more likely to:**

- be recipients of publically funded care
  - partly because poorer - often due to their own previous histories as carers - also live longer on their own)
- live in households that include children or other adults with disabilities needing care
  - NB not true of pensioners - older men more likely to be carers
- within such households to be the providers of unpaid care (and seem to be more likely to be the purchasers of paid care)
- provide unpaid care to those outside their household
- be employed in paid care

*Care policies have significant gender impacts*
Care policies have significant gender impacts

• Not just when they are designed to impact on gender inequalities but all care policies
• In particular cuts in care spending will exacerbate gender inequalities in:
  – Care received and/or its quality
  – Pay and working conditions (paid care sector major contributor to gender pay gap and unequal working conditions)
  – Household living standards (to which public services, including care, contribute)
  – Amount of unpaid care given and individual disposable income both across society and within households
• Conversely increased spending on care should reduce those gender inequalities
• Care policies could be specifically designed to change their gender impact
  – Eg to enable/incentivise men to care more
Assessment of the gender effects of care

• Qualitatively no doubt about the direction of effects, but how do we assess them quantitatively?
• Is it just expenditure that matters? What about quality?

• Baumol: care is among those industries “in which the human touch is crucial”

• For such industries:
  – using less labour just reduces output or its quality
  – there is little scope for raising productivity through introducing labour-saving techniques
  – labour costs are proportional to wages
Care is like playing a string quartet

In playing a string quartet, neither cutting the number of players nor playing faster can raise the productivity of labour because quality just goes down
• This provides a good argument that:
  – spending on care remains a **good quality invariant measure of provision**

• **Gross spending** can be reduced only by
  – reducing numbers receiving care
  – cutting amount of time each receives
  – reducing staffing levels
  – employing cheaper less well-trained staff
  – paying same staff less or reducing their working conditions

• All result in reduced quantity or quality.

• NB **Net spending** can be reduced by increasing user fees/stricter means-testing, but this will appear as cuts elsewhere (in “disposable” income)
Assessing who is affected by any changes in spending on care services?

• Statistics are collected on numbers using different types of care
  – Can make rough estimates of the impact of changes on users by dividing up gross spending according to existing patterns of use

• Simulation models can take account of more factors predicting who uses different types public services
  – Based on household surveys (eg FRS)
  – Predicts service use based on household/individual characteristics

• An then quantify effects on benefits at household/individual level in monetary terms, using spending as measure of benefit, either
  – In absolute terms or
  – As proportion of household income

• Currently always done at household level
  – Could be done at individual level
  – Good arguments for doing both
An example: the Landman Economics public spending model

Combines two types of data:
- Aggregate spending data (broken down by ‘functional category’ of spending) with
- Household data on public service use from several sources:
  - Family Resources Survey (education; social housing)
  - Living Costs and Food Survey (transport; certain categories of health expenditure)
  - General Household Survey (hospital/GP visits; museums and other cultural services)
  - British Household Panel Survey (social care, family social services)
  - British Crime Survey (policing)

Analyses patterns of service use according to various observable characteristics by *households*, including
- their overall gender composition
- the gender pattern of earnings in the household
- Can also break households down further eg by income decile, age, number of children etc.
An example using Landman Economics model: The impact of UK spending cuts, from 2010 up to and including 2015-16 tax year, in real terms:

- Cuts in social care impact strongly on the “living standards” of pensioners, particularly female single pensioners
- Cuts in childcare (“early years”) do not
The impact of UK spending cuts, from 2010 up to and including 2015-16 tax year, as % of household income:

- This is even more apparent if look at cuts as % of household income:
  - because female single pensioners have lower household incomes.
Who is affected by any changes in care-related benefits and allowances?

- Can do similar analysis using tax/benefit models to look at effect of changes care-related benefits and allowances on disposable income

- Really do need a model here in order to see the effect of existing tax/benefit system on disposable incomes of households (individuals?)
  - Then can see the effect of any change in benefits for carers, disability benefits, or childcare subsidies that work though the tax/benefit system, even paid parental leave
  - Need to make assumptions about take up

- A number of such models exist, including Euromod that covers all EU countries

- Average effect of total population of any specific measure, or even of all care-related payments together, even for women, may be small
  - So may be better to look at who are the winners and losers from a policy change and the size of impacts on their household’s disposable income

- Can look at effects of spending cuts and tax/benefit changes together
An example using Landman Economics model: Average weekly gains for UK lone and couple parents from all childcare measures implemented by current government upto 2016, by income decile

- Childcare support has been increased
- Benefits in real terms appear greatest strongest for couples and for those in higher deciles
  - Because most likely to be using childcare to start with
  - To make this gender analysis need to point out % of lone parents that are women
- NB this model assumes no behavioural change
  - Severe limitation in analysing policies designed to incentivise change
Assessing effects on time-use/unpaid care

- Models of distributional effects on household income/living standards assume no behavioural change
  - except perhaps in take-up

- What households do as a result of cuts in service provision or changes in allowances is much harder to assess:
  - do they buy services or do more unpaid care,
  - and/or does someone give up employment as a result of cuts?

- No existing models assess this.

- Time-use surveys not done frequently enough to be useful in assessing whether any changes are due to policy

- Could perhaps build a model based on a time-use survey using variation in local authority spending to assess how people react to changes in spending on services – a future project!
Employment incentives

- Can work out effects of benefits/tax rate changes on “employment incentives”:
  - The net gain from taking/leaving a job, taking account of taxes, loss of means-tested benefits
  - Often highly gendered – through big difference between incentives of first and second earners
    - With joint taxation and/or means-tested benefits

- Policies that not are explicitly care-related can also have gender effects on employment incentives due to gendered care responsibilities
  - Introduction of any new means-tested benefit

- Could expand these models to include childcare and other costs of employment
  - Then could evaluate impact of changes in childcare support, fiercer or steeper means testing etc.
  - Likely to be strong gender effects
  - Another future project

- Some dynamic econometric models are being developed to predict behavioural change as benefits/tax rates change.
  - Again might be able to be expanded to include childcare and other costs of employment
Paid care workers

• Changes in spending on care will have important effects on pay and working conditions in paid care
  – with significant gender effects
  – for economy as a whole, since care industry major and fastest growing employer of women

• These effects can be assessed by industry studies
  – need to look at total remuneration/working conditions too, not just pay gap
  – eg zero-hours contracts can save employers a lot of money even if wage rates unchanged.

• Methods of gender budgeting common to other sectors, so will omit here

• Again policy changes that are not specifically care-related may be more significant in the gender effects, eg:
  – Minimum wage
  – General employment rights (eg rise of zero-hours)

• So these need assessing too
Gender budgeting for care is possible but there are some difficulties:

1) **finding it in the public finances**
Forms of public financial support for care

• Direct provision of services
• Direct support of other providers (for-profit or non-profits)
• Buying of services from other providers (eg through competitive tendering)
• Giving care recipients personal budgets
• Direct payments to care recipients or parents
• Income replacement benefits for carers
  – Paid parental leave
  – Specific benefits for carers
  – Exemption from job search conditions for receipt of income support for those with caring responsibilities
• Tax allowances for partners of carers
  – ??? Includes tax allowances for dependents/transferable tax allowances???
• Tax breaks for employers
  – For setting up childcare facilities/ subsidising childcare costs
  – Structure of national insurance may or may not be care friendly
Expenditure on care found in many different places

- Public services may be provided by central government or (more usually) local authorities.
- Even if local may (partially) depend on central government funding
- Services may come under “social”, “health” or “education” expenditure
- May need to look in different place in (LA) accounts for:
  - Spending on public services
  - Direct grants to providers
  - Purchases of outsourced services
  - Personal budgets
- Direct payments may be paid by local authorities and/or part of national benefit system
- Income replacement benefits usually national but likely to be under a variety of different headings
- Exemptions for care responsibilities are expenditures too

_in theory should not look at any one type of expenditure in isolation since there is likely to be movement between categories_
Gender budgeting for care is possible but there are some difficulties:

2) *catching it in a changing policy context*
Changing policy context:

**Growing use of market** to provide long-term and other types of social care **in three forms:**

1. State contracting out care to private sector providers

2. State allocating publicly-funded care budgets to those judged to have care needs to spend buying their own care:
   - Either from corporate provider or employing own care assistants;
   - Either in the form of direct cash payments or by giving control of personal budget administered by state (local authority)
   - Sometimes with restrictions on use (eg can only employ from approved list of suppliers; sometimes recipients free to use their money as they choose)

3. More of those with care needs and their families having to use their own funds to buy care
   - either to pay full costs of care or to top-up state provision
All three forms of marketisation increasing throughout Europe:

- All can be seen as connected to **attempts reduce/contain/shift care costs paid by state**
  - By using competitive tendering to reduce unit costs/increase value for money
  - By using direct payments to reduce unnecessary spending/shift costs onto care recipients
  - Make failing to uprate/cuts invisible

- Though with a variety of **ideological justifications**
  - choice/effective use of market
  - only way to meet increasing demand without raising costs

- Cost reduction largely through **impact on workforce**:
  - reductions in numbers/time
  - less-unionised/casualised workers
  - employment of disadvantaged workers including immigrants

- Or use of **unpaid care** or **shifting costs onto families**
  - eg in keeping care recipients at home as long as possible
But using other people’s analysis can help put together different sources of finance

- For example: analysis by QualityWatch (2014) of cuts to spending on social care for older adults in England 2009/10 – 2012/3
By 2009/10 public expenditure on most services for older people (whether provided by public or private sector) was already falling;
  • But counteracted by an increase in spending on direct payments
• Between 2009/10 and 2012/3 spending on such services fell much faster:
• But expenditure on direct payments rose only at a similar rate to before 2009/10.
• Cuts were implemented by
  – tightening eligibility criteria to concentrate resources on those with the greatest needs
  – reducing fees paid to providers
  – reducing administrative costs

• Thus:
  – on residential care spending fell less by 13%:
    • Implemented through cuts in fees paid to residential care providers, numbers receiving services unchanged
  – on home and day care by more 23%;
    • By cutting numbers of recipients as well as payments per hour

• And unit costs overall fell by 5% raising concern with Care Quality Commission about quality sustainability
• These cuts took place against a backdrop of increasing demand for social care among older people, as
  – their numbers increased as a proportion of the population and
  – they themselves became on average older and in more need of care.

• Gross spending on social care for older adults fell by 9% but net spending by 15% on average (difference made up by increased user fees) in real terms between 2009/10 and 2012/13

• Expenditure on direct payments rose only at similar rate to before 2009/10
For example, UK government cut its allocation to local authorities by 26% in 2010. But local authorities reacted very differently in terms of their spending on services for older people:
- one third cut by 20% or more,
- a very few increased it
- remainder implemented cuts of 0-20%
For looking at full gender impact of care policy

• Need to take into account:
  – effects on different funding streams
    • May be used differently by men and women (possibly since older people less keen on direct payments)
    • Including user fees
  – at both national and local authority levels
  – across health and social services (and education for children)
    • May be used differently by men and women (age related too)
  – across different types of care
    • May be used differently by men and women (age related too)
  – effects on quality/unit costs
    • May be different for men and women
  – changing needs of the population
    • Some evidence that older women have more physical problems, men more mental ones
• Luckily can get some picture by doing much less and can piggy back on more detailed analyses of others.

• Still need to consider impact of other policies on care

• Any policy that influences people’s decisions about time-use/location can impact on care and therefore will have gender implications.
Care budgeting

So I would argue for “care budgeting” by analogy with “gender budgeting”:

- assessing impact of (spending) policies on existing care provision
- not just of policies designed to impact on care but all policies
- Also involves critiquing care-blind assumptions used in standard budget analysis

Such care budgeting can be used

- not just to improve care, but
- knowing about effects on care also makes for more efficient policy more generally

Why for care specifically?

- Already done automatically for material production eg effects on GDP/personal incomes of budget proposals
- Should therefore do it for the other major component of provisioning too
Critiquing care-blind assumptions used in standard budget analysis

- By analogy with refusing to see employment as the only type of “work”
- Recognise care as part of the “infrastructure” of society, as much as physical infrastructure if not more so
- Challenge idea that spending on physical expenditure is “investment”, while expenditure on care is seen as “current spending”.

- Because:
  - Idea of distinction is that investment has benefits beyond the current period
  - Care has such long-lasting benefits
  - Though prefer to stress that the investment is in ”social infrastructure” to include non-material benefits
  - And avoid the idea that care for children and those who will get better is an investment but not for the old

- This distinction has real effects: governments likely to favour investment over current spending
- Lead to equality and efficiency gains through investment in a “purple economy”
Equality and efficiency of investment in social vs physical infrastructure

- Effects undoubtedly adds to well-being directly and in the longer-run
  - Particularly for women as both recipients and unpaid care givers
  - Physical infrastructure projects can be more dubious
- Has larger stimulus effects
  - Nearly all spent on wages, few material inputs
  - Low pay in sector implies more employment generated and larger proportion of wages spent
- More likely to employ women, given existing gender division of labour
- Employing women may have larger local stimulus effects since women more likely to have to spend money replacing their own unpaid care
- Should aid economy in the long-run with a better educated, more contented population
- Care is basically green as well as purple
  - Cannot go on producing and consuming more things
  - Will have to spend our time learning how to care for each other better.
Gender and care budgeting could change the world!