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About this paper

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Looking at the right to care through the lens of gender

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Abstract: This article aims to identify the conditions under which a right to care is likely to promote gender equality in the context of long-term care. The first section describes the transformations of the relationship between care and gender (as equality between men and women became a major goal of democratic societies). The second section stresses the tensions thus generated, especially the "care crisis". Drawing on previous recent empirical studies on different public policy models in the domain of long-term care in various European Union countries, this article identifies the conditions under which a right to care is likely to promote gender equality.

Keywords: Care; gender equality; unpaid work; right to care

1. Introduction

This review article aims to describe the historical relationship between care and gender, in its mutual implications and understand their current relation and the relevance of a right to care. It also intends to identify the conditions necessary for the emergence of a right to care that promotes gender equality in the context of long-term care.

The second section of this article presents the historical relationship between care and gender in its mutual implications and describes the current relationship between care and gender. Despite variations in its concrete significance,[1] every culture attributes meaning to what it is *to be a woman* and *to be a man*. This section seeks to unveil the ways through which the relationship between care and gender was formed in western societies, and which tensions and narratives have influenced the ideas of masculinity and femininity throughout the 20th century in the West during its most notable events, such as the early century's women's movements, the woman's question in labour, and the two world wars. Finally, this section aims to portray how care manifests differently in women's and men's lives, curtailing their choices and impairing their participation in the public sphere.

The third section outlines the transformation of women's roles throughout the 20th century and the claim of equality between men and women as a goal of democratic societies. It ascertains the tension generated by such transformation in its relation to care and, particularly, its contribution to the so-called "crisis of care", considering the demographic challenges that European societies face. Following the work of Joan Tronto, the need to value care leads to a consideration of the concept of care as a political concept.

Finally, the fourth section focuses on long-term care, which is especially relevant when considering the "crisis of care". Based on a review of previous recent empirical studies on different long-term care public policy models in

[1] For a perspective on gender as the cultural meaning of sexual difference, see Agacinski 1998.

various European Union countries, this section develops the characterisation of those policies, analyses their models, and identifies the conditions under which a right to care is likely to promote gender equality.

Different sources were used for the development of this article, in accordance with each section's aim. The first two sections result from a review of interdisciplinary literature (mainly, in the fields of history, economy and political philosophy) and the use of statistical data available in databases (*v.g.*, Eurostat) and reports from international organisations, notably, pertaining to the United Nations (UN), the European Institute for Gender Equality (EIGE), the International Labour Organisation (ILO), and the Organisation for Economic Co-operation and Development (OECD). When it comes to the analysis of long-term care in Europe, in section four, a set of articles from the last five years (2016-2021) was selected, through a search by keyword (*gender equality; long-term care; Europe*) in the following search engines/databases: Google Scholar, HeinOnline e JSTOR. The selection of articles used in this research was based on the analysis of its conclusions and their relevance for identifying public policies that promote gender equality. In addition to the literature selected through this method, there is a reference to relevant literature produced before 2016 concerning the most recent literature.

2. The transformation of the relationship between care and gender

Care is a gendered phenomenon. The gendered nature of care has its historical roots in the construction of hierarchical relationships between men and women and is historically and socially tied to women's experiences.

2.1. The historical relationship between gender and care

There are many definitions of care, and they are not always coincident (Thomas 1993, Leira and Saraceno 2002). For this article, we refer to the concept of "care" as developed by Daly and Lewis (2000, p. 285) when they mention care as *social care*, that is

> *… the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out.*

Throughout history, care has fallen upon women, whether as a family or labour duty. Various examples illustrate this claim. In rural areas, women were closer to home, taking care of the children while preparing meals. Women were also the ones that watched for the dying and prepared the corpses for burial. It is also noteworthy that those women who belonged to the petty bourgeoisie trusted their infants and young children to the care of wet nurses and nannies (women), so they could work with their husbands.

Hence, it is not surprising that the feminist vindications of the early 20th century focused, among others, on the valorisation of caring aspects of women's lives, as is the case of maternity. It was then that the seeds of rights that are now perceived as fundamental to achieving gender equality were sown. Paid maternity leave is a prominent example. More progressive ideas were then launched that did not come into practice, such as the "maternity salary" or the recognition of domestic work as productive work, set forth by Nelly Roussel and Marguerite Durant, respectively (Bock 2002).

The beginning of the 20th century – *la belle époque* of feminisms – augured that it would become the "century of women" (Bock 2002, Cova 2013, p. 21). On the eve of the Great War, international movements that gathered people fighting for common goals were on the rise for visibility and political influence. International movements of women were part of them. Some of these movements were founded in the middle of the 19th century, such as the *Association Internationale des Femmes*, the *International Council of Women*, and the *International Woman Suffrage Association*. These movements' international dimension was also seen in the close contact that several national movements – many born out of foreign influence – established with their counterparts (Carlier 2010). They were often linked to an elite of privileged women (Rubio-Marín 2014), with access to education and culture, increasingly present in political and labour public spheres.

At the beginning of the 20th century, female suffrage was an exception. However, this fact did not prevent women from engaging in active political participation, making petitions to vindicate their rights, publicly writing in newspapers, associating with others, and organising women's demonstrations. The resource to violence was often not excluded.

Regarding labour, the matter adds complexity.[2] Earlier in the 20th century, one of the leading social questions was "the woman question".[3] This was the question of the *working woman*, an expression perceived as a contradiction that manifested the different social roles attributed to men and women and its contribution to the gender hierarchisation of labour. In fact, by stressing the vital work of women in taking care of the family and home, there was a legitimisation of the narrative sustaining a family wage, which justified the low wages of women. Keeping the female labour force at a low cost was beneficial for many, especially those who held economic power. As Bock mentions, only trade unions and Catholic Church were serious while upholding that women should not take part in the labour force and advocating the family wage that never existed, considering the meagre wages earned by workers (Bock 2002, Scott 2002).

Hence, "the woman question" was a matter of dichotomic opposition between (paid) production work and (unpaid) reproduction work, [4] as masculinity and femininity identity traits. *Being a man* meant to provide for the family in the public sphere of work, and *being a woman* meant to devote one's life to family in the private sphere of domesticity. In this way, paid work was the way a man becomes a man, but, for the woman – especially for those who were married and had children – being a worker led to an enduring conflict, yet inescapable, due to the low wages ascribed to women.

However, as Scott (2002) notes, the tendency to naturalise the sexual division of labour resulted from social narratives. Women have always worked: alias, there were always working women, as there were always women (and men) that did not need to work. Not only did women work, but it also seems to be the truth that they worked outside the domain of domesticity.

In the face of this reality, one can ascertain that "the woman question" was based on a false narrative, discursively built for reasons concealed by that same narrative. Trade unions, for example, made use of a paternalistic discourse, backed by the pretence need to protect women (especially their maternal function), aimed at restricting women's access to the labour force. Often, they succeeded, but their struggles were usually limited to those occupations where women competed with men. Thus, traditionally female occupations such as domestic services and agriculture remained unregulated. Those were the occupations with the poorest labour conditions. Hence, legislation purportedly designed to protect women produced the opposite effect, increasing women's vulnerability as they were relegated to unregulated and precarious sectors.

Therefore, there is a direct link between the market logic based on paid work and the devaluation of care work. Bergeron (2016) and Carrasco *et al.* (2019) indicate that the invisibility of care work has been beneficial to capitalism, as it contributed to the invisibility of care work costs. Consequently, goods and services provided in the house by women to men, at a very low cost, reflected in increasing profit.

Actually, the separate spheres ideology rests, fundamentally, in a bourgeois ideal underpinned by *the sexual contract*, as named by Pateman (1988).[5] Although this ideology emerged in force in the 19th century (Pfau-Effinger 2004) that does not mean the family model in which the woman is exclusively devoted to reproduction activities and the men's wage is sufficient to provide for the family was transversal to all social classes. Yet, the most widespread consequences of this ideology were the invisibility of the reproduction labour cost, as well as the cementing of a culture that ascribes responsibility for care work to the woman-mother (Carrasco *et al.* 2019), thus creating the basis for the conflict underlying "the woman question", *i.e.*, the conflict between the responsibility for personal and family care and the need to engage in paid work.

The narrative born out of the separate spheres' ideology was so strong that it somehow perpetuated the fiction that until the 20th century women did not work. Similarly, it contributed to the oversimplified narrative that eman-

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[2] It is noteworthy that the mere concept of "labour", as understood nowadays, is a historical construct unknown to ancient societies, where relationships developed as friendship or obedience and trade were perceived as undignified (Veyne 2002).

[3] "The woman question" is overarching, as illustrated by the work of Gisela Bock, *Women in European History*, that stresses the *querelle des femmes* as the common thread of women's history (Bock 2002).

[4] "Social reproduction" is a complex and ambiguous concept. Generally, it encompasses the biological reproduction of the species, the reproduction of the labour force (which entails raising children), and the fulfilment of care needs (Bakker 2007).

[5] For Pateman, the *sexual contract* is "a repressed dimension of contract theory, an integral part of the rational choice of the familiar, original agreement" (Pateman 1988, p. ix). Pateman central claim is that the *sexual contract* underpins the *social contract*, which could not exist without it.

cipation of women was a consequence of the world wars, as opportunities for women to enter the labour force, thus interpreting these wartimes as drivers for women's emancipation. Conversely, war and interwar periods interrupted women's emancipation movements that presented signs of great vitality at the beginning of the 20th century (Thébaud 2002, Taylor Allen *et al.* 2010).

Some women have undoubtedly experienced more freedom and independence (including economic independence) in wartime, which would be difficult in another context. Nevertheless, the cultural consequences of war were fundamentally averse to gender equality: both in the interwar period (mainly in the 1930s) and in post-war (especially in the 1950s), women were culturally compelled to leave their wartime occupations and devote themselves exclusively to family care.

In the 1950s, a confluence of factors favoured the universalisation of the *male breadwinner model*, *i.e.*, the family model composed of a heterosexual couple with children, based on differentiated gender roles: the paid work (production labour) is ascribed to the husband/father and the care work (reproduction labour) rests on the wife/mother.

Factors leading to the universalisation of this model are complex, among them the transition of an extended family model to a nuclear family model, the greater supply of family habitation, the exceptional period of economic growth and employment stability, and generalised access to consumer goods, particularly household appliances. Meanwhile, another crucial aspect to cementing this model was the previous existence of an upper class that strongly influenced the cultural dominance of this model (Pfau-Effinger 2004).

In sum, the upper-class family model, based on the separate spheres' ideology and the male breadwinner model, which was on the rise since the 19th century, has found, in the 1950s, the historical moment for its broader implementation by a significant part of the population. However, the conditions that led to this phenomenon, generating sufficient family income to allow women not to engage in paid work, thus putting in practice this model, were exceptional and did not last long. The "historical irony", as Esping-Andersen (2009, p. 30) notes, is that when this model finally spread to the working class, middle-upper class women began to adopt other life goals based on career building.

As Rubio-Marín (2015)as constitutional subjects, the emancipatory promise of constitutionalism was-from its inception-fundamentally limited by the entrenchment of the separate spheres tradition. Focusing on evolving constitutional jurisprudence in the US, Germany and Italy, the article describes a gradual and still imperfect process of (dis mentions, the post-war period brought progress toward gender equality. However, such progress proved incomplete because it was limited to extending men's rights to women. There was no questioning of the naturalisation of gender difference, underpinned by the separate spheres' ideology that relegated care work to the private sphere of family, where it was "naturally" ascribed to women.

The idea of differentiation and complementarity of the sexes played a vital role in sustaining a differentiated and hierarchised family structure from the post-war period to the 1970s while simultaneously affirming gender equality in the public sphere (labour and politics). Many public policies reflected this ideology, thus perpetuating gender differentiation, even if purportedly aimed at improving women's lives.

In this regard, it is worth remembering *Charles E. Moritz v. Commissioner of Internal Revenue* – case 469 F.2d 466 (10th Cir. 1972). Charles E. Moritz was represented by Ruth Bader Ginsburg, who at the time was leading ACLU (American Civil Liberties Union) Women's Rights Project. The case concerned the denial of a tax deduction to Charles Moritz for being his mother's carer. The law allowed a tax deduction for single women caregivers but excluded single men (Brinkley 2019).

The path towards more complete gender equality has deepened over the last fifty years. On the one hand, blatant legal gender discrimination has been eliminated and gender equality is now affirmed in the public sphere. On the other hand, those steps have proven insufficient to fully realise gender equality. It becomes increasingly evident that the crux of the matter lies in the deconstruction of gender roles that are (still) associated with masculinity and femininity. Such is a cultural deconstruction that, while transcending the world of law, still encompasses it.

Thus, in recent decades, the idea of equality and, mainly, gender equality has been further developed. The European Court of Human Rights (ECtHR) case law illustrates this claim, as it has been affirming gender equality as "a major goal" of the member states of the Council of Europe and advocates a strict scrutiny (using the expression

"weighty reasons") to consider differentiation on the grounds of sex to be compatible with the ECHR. An evolution in the ECtHR case law in rejecting gender stereotypes is particularly noticeable.[6]

Another noteworthy aspect of the fight against gender stereotypes is the set of positive discrimination measures aimed at increasing women's access to leadership positions that have emerged since the beginning of this century, especially in political representation. In this case, the debate goes beyond equality to focus on democracy (Rodríguez Ruiz and Rubio-Marín 2008). Yet, the existing mechanisms, namely gender quotas, are not enough to guarantee equal access to power.

Finally, there is also a growing awareness of the need to encourage a redistribution of gender roles in the family, which is still a traditional stronghold of the private sphere (as opposed to the public sphere). Hence, there is an illusion of equality in assuming that each family, composed of free individuals, is equally free to regulate itself and thus responsible for managing the distribution of responsibilities within it. However, this argument ignores the existence of constraints that limit individual choices. A clear example is the persistence of wage inequalities between men and women, which affects the distribution of responsibilities to provide for the family and responsibilities to care for the family (Barigozzi *et al.* 2020).

A century ago, women's movements fought for the recognition of motherhood's social function and invoked the need to recognise the value of care for society. However, the welfare state had not yet asserted itself at that time. In most Western societies, the claim of equal rights and duties for men and women, both in the civil and political spheres, was still a utopia to fulfil. As the 20th century moved forward, women gained access to men's civil and political rights and increased their participation in the labour force, thus accessing men's rights. However, as the following subsection shows, men have not undertaken a symmetrical path that would lead to a fundamental transformation of gender roles in the private sphere (Marrades 2016). There, women continued to be the primary caregivers.

2.2. The current relationship between gender and care

Care is at the heart of gender equality. Gender relations are built in close association with social expectations regarding productive and reproductive functions that are vital to the progress of society.

Nowadays, the participation of women in the labour sphere is rising. It is also true that men are more engaged in unpaid care work. However, sharing (of both paid and unpaid work) is far from egalitarian (Esping-Andersen 2009). In addition to social norms (not rarely supported by legal standards), families' choices about who will carry out care activities are also determined by economic factors, interconnected in a vicious circle.

Such is the case of parental leave. In the early 20th century, paid maternity leave was one of the most progressive claims of women. At the beginning of the 21st century, most countries promoted maternity leave, to a greater or lesser degree, aiming not only to address women's needs for physical recovery in the postpartum period but also to support newborn care needs. However, paternity leave and the existence of shared parental leave are still an exception today. Even where they exist, their design is not always adequate to pursue the objective of an equal sharing of care responsibilities aimed at promoting gender equality.[7]

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[6] See, *v.g.*, the case of *Konstantin Markin v. Russia* (application no. 30078/06), in which parental leave was denied to a male military which would be granted if he was a female. The ECtHR has stated that "… references to traditions, general assumptions or prevailing social attitudes in a particular country are insufficient justification for a difference in treatment on the grounds of sex. For example, states are prevented from imposing traditions that derive from the man's primordial role and the woman's secondary role in the family", thus rejecting the legitimisation of gender differentiation based on a special biological and psychological relationship between the newborn and the mother. For similar approaches, see *Emel Boyraz v. Turkey* (application no. 61960/08) and *Carvalho Pinto de Sousa Morais v. Portugal* (application no. 17484/15). Withal, the Court has not always adopted the same criteria: see the case *Khamtokhu and Aksenchik v. Russia* (application no. 60367/08 e 961/11), in which the ECtHR found no discrimination based on sex, as invoked by two men sentenced to life imprisonment, from which women (among other groups) were excluded. The ECtHR held the decision by ten votes to seven, thus manifesting dissensus among ECtHR judges regarding gender discrimination in this case. The dissenting opinion of Judge Pinto de Albuquerque stresses that *favor sexus* is a trap based on stereotypes that lessen women.

[7] About the relation between parental leave and the advancement of gender equality, see Rocha 2021caring fatherhood, and gender equality among the couple and in the workplace. There are various designs of parental leave policies, depending on a combination of factors, such as length, income replacement rate and the compulsory nature of leave. This article draws on data from the 16th International Review of Leave Policies and Related Research (2020.

Although regulation on parental leave is neutral, most people taking a substantial part of parental leave are women/mothers and not men/fathers.[8] Several factors relate to these choices (Lomazzi *et al.* 2018), such as social conceptions about the differentiated role of mothers and fathers in the first months of children's lives[9] or the lack of childcare (Pfau-Effinger 2005).[10] Moreover, alternatives to mothers taking parental leave are especially burdensome when sharing leave is not possible and also when the level of parental leave remuneration is low.[11]

In reality, understanding how unpaid work affects women's participation in paid work, and its consequences on the gender pay gap, is vital to understanding the relationship between care and gender equality.

Paid work is provided in return for remuneration, regardless of the conditions under which it is provided. Unpaid work is a much more complex and ambiguous concept.[12] Following Folbre (2006), unpaid work encompasses direct care activities (such as feeding and fulfilling someone's hygiene needs) and indirect care activities (such as meal preparation or house cleaning). Direct care activities are often referred to as unpaid care work and indirect care activities as unpaid domestic work.

Globally, the gender gap in labour market participation is tangible: little less than half of the women and about three-quarters of men participate in the labour force.[13] The gap exists across age groups (UN Department of Economic and Social Affairs 2020).

Unlike men's reality, there is a significant variation in the proportion of women who participate in the labour force in the age group from 24 to 54 years old in relation to their type of household. Extended families (45.1%) or couples with children (48.2%) are linked to lower women participation percentages. Conversely, rates are higher in the case of single-parent families (69%) or one person households (82.4%). Women's care responsibilities, either towards children or dependent adults (especially the elderly), are believed to be the cause of such low levels of female participation in the labour market. On the other hand, the high participation of women in the labour force in the case of single-parent families is related to the dual role they play in these families, being responsible for both the sustenance and care needs of the family. However, when these responsibilities can be shared, women participate less in the labour force (UN Department of Economic and Social Affairs 2020).

Care responsibilities are decisive not only to women's engagement (or not) in the labour force, but also in how they do it. Women predominate in precarious work, such as fixed-term work, temporary work, part-time work, and informal work, which is especially vulnerable (ILO-OECD 2019). In turn, women retreat from modes of work that hamper balance with care responsibilities, such as shift work[14] or overtime (OECD 2017).[15]

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[8] This claim stems from the analysis of national notes from 45 countries worldwide gathered in the *16th International Review of Leave Policies and Related Research 2020* (Koslowski *et al.* 2020), executed by the *International Network on Leave Policies and Research*.

[9] It is the case of Poland, where despite the neutrality of legislation since 2013, more than 98% of parental leave beneficiaries are women (Suwada 2017). Social gender norms ascribing women the role of main carers explains, at least in part, this phenomenon (Kosakowska-Berezecka et al. 2018).

[10] The lack of access to childcare also hinders women's access to the labour market (Jarman *et al.* 2012, Froehlich *et al.* 2020)and generally held that this disadvantages women. In order to understand how far this occupational segregation entails gender inequality it is necessary to examine the vertical and horizontal dimensions of the segregation. The horizontal dimension measures difference without inequality while the vertical dimension measures the extent of the occupational inequality. Two measures of vertical inequality are used: pay and social stratification (CAMSIS.

[11] In fact, when pay for parental leave is lower that work remuneration, economic rationality dictates that the family member with the lowest income be the one taking parental leave. Public policies determining high levels of parental leave pay are key to this constraint.

[12] On conceptual obstacles regarding unpaid work, see Antonopoulos (2011).

[13] Thus, there is a decrease in the labour force participation of both men (in 1995, 79%) and women (in 1995%, 50%). Noticeable, such decrease is more pronounced in male participation.

[14] It may happen that such retreat is not percipient, nor does it stem from women's attitudes, but rather from corporate culture. Take the case of *Lisgráfica*, a company that has undergone an internal reflection driven by their participation in the "*Projeto Igualdade de Género nas Empresas* - Break Even" [Project Gender Equality Within Companies – Break Even] (coordinated by *Instituto Superior de Economia e Gestão*, partnered with *Centro de Estudos para a Intervenção Social*, *Centro Interdisciplinar de Estudos de Género do Instituto Superior de Ciências Sociais e Políticas*, and *Centro de Investigação em Género da Universidade de Oslo*), after which it reached the conclusion that the selection process was biased, resulting in an exclusively masculine work force for printing and an exclusively feminine work force for graphic finishing. The difference was that printing jobs were better paid, among other reasons, because it entailed shift work (Gomes 2017).

[15] The relationship between the modes of feminine participation in labour market and gender equality is also acknowledged both by the European Court of Justice (ECJ) and the ECtHR case-law, that often stresses the risk of indirect discrimination arising from regulation of labour where women dominate. See, for example, case *Di Trizio v. Switzerland* (application n.o 7186/09), and ECJ cases *Bilka-Kaufhaus GmbH versus Karin Weber von Hartz* (ECLI:EU:C:1986:204), and *Ursula Voß versus Land Berlin* (ECLI:EU:C:2007:757).

All these aspects reflect on the persistent gender pay gap, which is, as stated by the European Institute of Gender Equality, the "monetary facade of gender equality" (EIGE 2019a, p. 10). The global gender pay gap stays at 20% (United Nations Economic and Social Council 2020). In 2019 in the European Union, the same indicator remained at 14,1% (Eurostat 2021). However, the average value of the gender pay gap does reveal the impact of care needs' increasement: the total gender gap in net monthly earnings in the EU in households comprised of couples with children under the age of seven rises to 48% (EIGE 2019a).

The gender pay gap is closely related to care responsibilities, as already acknowledged by several bodies. The relationship between unpaid care work and gender inequality is increasingly recognised (Antonopoulos 2011, Ferrant *et al.* 2014). For this reason, the 5th of Sustainable Development Goals (gender equality) focuses precisely on the recognition and appreciation of unpaid care and domestic work (United Nations General Assembly 2015).[16]

Meanwhile, another perspective on the relationship between care and gender relevant to understanding gender inequality in the labour market lies in the high feminisation of professional care work. Since the start, women's participation in public life focused on activities that had become "professionalised" in the private sphere. In fact, at the beginning of the 20th century, the woman-mother was her family's nurse, teacher, nutritionist, and hygienist, to name a few examples. As all these activities were "professionalised" within the family, women gained increased access to education, largely choosing care-related professions, mainly in education and health (Dauphin 2002, Käppeli 2002, Sohn 2002).

Although weakened, this trend has made its way until nowadays' occupational gender segregation. If it is true that many fields are gender-balanced, others are highly feminised or masculinised. For example, there is a strong female presence in health, social services, and education sectors, and a higher prevalence of men in technology, engineering and finance (Adams and Kirchmaier 2016, Cortes and Pan 2017, OECD 2017).

Moreover, masculinised professions are commonly better paid than those where women dominate. This can be partly explained by the fact that men dominate in high-risk jobs, and in positions that often demand overtime or shift work, which is better paid, as mentioned above. Conversely, many women-dominated jobs are related to care activities that are lesser valued (Folbre 2006, Cortes and Pan 2017). One reason for this difference in valuing care work is the naturalisation of care skills, that is, considering that care work, when undertaken by women, is a natural female skill, instead of an acquired skill, whereby there is no added value to care work (England *et al.* 2002, Carrasco *et al.* 2019).

In conclusion, both perspectives on care (as unpaid and paid work) share a common feature: its devaluation.

3. Tensions at the crossroads between gender and care: the "care crisis"

Tensions between gender equality and care responsibilities are one of the major challenges of the 21st century for those societies aimed concomitantly at caring for the most vulnerable and attaining gender equality.

The transformation of women's roles in the 20th century has been appointed as a true revolution (Goldin 2006, Esping-Andersen 2009, Bettio 2016). Like all revolutions, it tends to generate imbalances. Over the centuries, there has been a specialisation of tasks within the family according to the sex that is being transformed, giving rise to services outsourcing and "defamilialisation" (Esping-Andersen 1999, 2009). The transition from a model of gender differentiation to a model of gender equality (*i.e.*, in which each person is freed from gender constraints in their choices) generates imbalances.

These tensions are also exacerbated given the growing need to provide care to dependent people, injecting a sense of urgency to determine how care responsibilities should be socially assigned. Indeed, in Western countries and particularly in Europe, demographic factors leading to population ageing[17] and the foreseeable increase in care needs raise fears of exacerbating those tensions.

Population ageing stems from two factors: the decrease in fertility rate and the increase in life expectancy (UN Women 2020, Ophir and Polos 2021). The rise in longevity can be explained, in the words of Rechel *et al.* (2013,

[16] In fact, the need to recognise of unpaid care work is ever more patent in several bodies' reports and recommendations – see, *v.g.*, Charmes 2019, Ferrant and Thim 2019, UN Department of Economic and Social Affairs 2020, UN Women 2020.

[17] In 2018, European Union's (EU27) ageing index stood at 132,3% (PORDATA - Índice de envelhecimento 2018).

p. 1313), "as both an outcome of, and a challenge for, European health systems", insofar as it entails a predictable increase in the number of people who will need health care. The crux of the matter is the sustainability of health and social security systems. Nevertheless, Rechel *et al.* (2013) draw attention to the fact that the costs of these needs' increment do not justify the premature announcement of the welfare state's death. On the contrary, the reduction of such expenses requires public investment focused, above all, on primary health care and able to match the increase in life expectancy with the rise in healthy life expectancy (Rechel *et al.* 2013), through policies that promote health and disease prevention.

Thus, it is a matter of rights, particularly of the right to health, as a human and fundamental right, meaning the state is responsible for protecting the health of all those under its jurisdiction. In this respect, the guarantee of health service quality, especially primary health care and long-term care, emerges as fundamental aspects of welfare states' sustainability.

However, this issue should also be looked at through the lens of gender. It is worth remembering that most long-term care provided to older people does not occur in a professional set (formal care) but in a context of family or friendship (informal care) (Rechel *et al.* 2013). According to Zigante (2018), 80% of long-term care in the European Union is provided by informal caregivers. A recent report mentions that, also, in the European Union, there are 5.2 million formal caregivers and approximately 70 million informal caregivers (Directorate-General for Employment Social Affairs and Inclusion 2020). Most are women, especially those who provide intensive care (Kalmijn and Saraceno 2008, Schmid *et al.* 2012, Directorate-General for Employment Social Affairs and Inclusion 2020, UN Women 2020).

It is worth remembering that the provision of informal care can bolster inequalities experienced by women, thus adding to the vicious circle of gender inequality. Indeed, suppose informal care is relegated to the exclusively private sphere of the family, without any form of state support. In that case, it is natural that, given the persistent salary disparities between men and women, alongside social gender norms, the economically rational choice will also be a determinant in the family's choice to ascribe caregiving to women (may they be the wife, the daughter or the daughter-in-law of the beneficiary of care). Such a situation places the cost of care on many women,[18] making them more vulnerable to the risk of physical and mental illness and also poverty (Schmid *et al.* 2012, Verbakel 2018, Barigozzi *et al.* 2020, UN Women 2020), because it affects their participation in the labour force without recognising the economic value of informal care, thus generating lower retirement pensions (Estrada Fernández *et al.* 2019, Bartha and Zentai 2020, Lera *et al.* 2021, Ophir and Polos 2021).

Social class and economic power also influence the context of care. This is, in fact, one of the most interesting aspects of Esping-Andersen's (2009) "incomplete revolution". It is not just a matter of highlighting the latent tensions generated by the new and old roles of women in the current set of population ageing,[19] or even observing that, although women's lives have become more like the lives of men, the opposite is not valid. It also entails the realisation that women's new social roles generate new inequalities also among women themselves.

Women are not a homogeneous group. Couples also share responsibilities differently, depending on their level of education and income: the higher these are, the more likely women and men are to share the responsibilities to provide and care for the family. This can be partially explained by the fact that highly educated women have higher incomes, which allows them to outsource care. Therefore, shared care is reduced to a lesser extent since these couples can afford care services provided by the market (Esping-Andersen 2009).

Notwithstanding, outsourced care falls mainly on women with low levels of education and income, many of whom are migrants. Hence, care work is transferred, but it remains gendered. Furthermore, linking care work to unqualified work performed by socially vulnerable people adds to its social devaluation, thus reinforcing its low-status (Casanova *et al.* 2017, Murphy and Turner 2017, Bartha and Zentai 2020).

In this view, it is urgent to design political responses that address these challenges with fairness, under the values of equality and justice, which allow the achievement of both the goal of satisfying care needs in a democratic society and the goal of achieving gender equality for all and not just the privileged.

[18] In this regard, several feminist authors have drawn attention to the relevant externalities that care generates, striving to recognise its value (Fineman 2000, Folbre e Nelson 2000). A recent United Nations report refers to care as a "public good" (UN Women 2020, p. 167).

[19] Despite this framework, Esping-Andersen focuses his work on the matter of children's education, stressing the need to reconfigure the welfare state so that it can provide for the children's educational needs, especially those born from the least favoured couples.

In truth, underlying this issue is the value of care. As already mentioned, referring to unpaid work (comprised in social reproduction), one can distinguish between domestic work and care work. Domestic work encompasses activities aimed at indirectly fulfilling people's physical needs, *v.g.*, meal preparation and cooking, clothing, and cleaning the house. These are easily outsourced tasks, and those who can often turn to the market. However, care work cannot be so easily translated to the market logic because it usually entails, to a greater or lesser extent, a personal and affective relationship between the caregiver and the beneficiary of care.[20] Such is the case of children and teenagers, whose care calls for a relational dimension that transcends market logic but is essential to the quality of care and social reproduction (Bergeron 2016, Carrasco *et al.* 2019).

In this respect, the crux of the matter is the externalities generated by care, that is, its "collateral effects" that translate into benefits for the society at large. Hence, the problem of knowing who should bear the costs of care. As Folbre (2000, p. 137) states:

> *Many people share in the benefits when children are brought up to be responsible, skilled, and loving adults who treat each other with courtesy and respect. Employers benefit from lower monitoring costs when their workers are cooperative, trustworthy, and intrinsically motivated. The elderly benefit if a skilled younger generation of workers generates high Social Security and Medicare taxes. Fellow citizens gain from having law-abiding rather than predatory neighbours.*

Thus, there is the need to think about care from the standpoint of politics, leading to a reconfiguration of care as a public good, entailing changes to the very concept of citizenship and an expansion of social rights to comprise care as a social value. Only in this way will it be possible to correct the path gender equality has followed, marked by the rise of women to the status of men, as citizens and as subjects of law, without the symmetric deconstruction of the status of men, nor of the meaning of citizenship in the face of women's experiences, among which care stands out (Rubio-Marín 2015).

Indeed, care has been conveniently relegated to the private sphere, an aspect acutely noticed since the 1990s by various care theorists from multiple disciplines. The debate then inaugurated led to the expansion of the concept of care and its application to political theory, *i.e.*, the reconfiguration of care as a political concept.

Tronto's *Moral Boundaries* (1993) is paradigmatic of this different way of thinking about care. In this work, Tronto identifies the existence of moral boundaries that exclude those at the margins of societies, thus hindering their political participation. Consequently, Tronto advocates an alternative conception of politics that favours redistribution of power between those whose activities are overvalued and those whose activities are undervalued, hence being marginalised. Tronto considers that the way moral and political boundaries are set leads to a bias that prevents marginalised people's concerns from being considered society's political concerns. These, for Tronto, should encompass care, which she and Fisher had already defined as "a species activity that includes everything we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Tronto and Fisher 1990, p. 40).

The great novelty of Tronto's contribution, at the beginning of the 1990s, was precisely to situate care in the political sphere as a central aspect of human societies, that is, of political societies (Kaufman-Osborn *et al.* 2018). Later, in her work *Caring Democracy* (2013), Tronto highlights the relationship between care and democracy, arguing that, on the one hand, the content of democratic politics increasingly focuses on institutions and practices which entail care and, on the other hand, democracy demands care.

Therefore, the challenge lies in balancing the goal of valuing care (which involves assuming care as a collective – and not only individual – responsibility) and doing so in a fashion that simultaneously fosters the elimination of gender stereotyping around care by promoting the sharing of responsibilities within the family (England *et al.* 2002, Rubio-Marín 2015, Anarte 2020).

In short, without recognising the value of care and its fair consideration, it is not possible to carry out its equitable redistribution in society. Each society's model for distributing care will be determined by many factors, first of all, culture. Liberal and capitalist societies, for example, tend to favour redistribution that embraces market logic

[20] For this reason, some authors resist qualifying care as "work". They find it to be an inadequate framework to address care's subjective and emotional essence (Carrasco *et al.* 2019).

and, in turn, are more reticent to the attribution of responsibilities to the government. Societies with a social matrix will tend to choose public responsibility for care to the detriment of the market.

Yet, regardless of each community's cultural context, there seems to be a common feature: the family's accountability for the care and the need to create mechanisms that further care redistribution within the family since they tend to fall on the family's women.

4. Models of care in Europe: designing a right to care that promotes gender equality

This section draws from the analysis of recent empirical studies to identify relevant features to consider when designing a right to care that promotes gender equality. To this end, the literary review is focused on European countries and on long-term care, *i.e.*, care for dependent adults or children with special needs of care, thus excluding the mere exercise of parenthood, which also entails care. This choice relates to the fact that the relationship between gender equality and both active paternity and shared parenting is more widely accepted and visible than the relationship between gender equality and the provision of long-term care (Hrženjak and Scambor 2019).

Long-term care and, more broadly, the care sector have been identified as comprising social and economic opportunities (Murphy and Turner 2017). The unprecedented demographic phenomena that western and, particularly, European societies are experiencing bring new challenges that demand urgent responses. The low fertility rate, alongside greater longevity, raises fears of an increase in care needs and a decrease in the ability of younger generations to provide such care (Lera *et al.* 2021, Ophir and Polos 2021).

Given these new challenges, namely the sustainability of the welfare state and the redistribution of care responsibilities (Chung *et al.* 2018), in the context of the Social Investment Package, the European Commission has strongly recommended in 2013 that the member states adopt a strategy of innovation and social investment, to guarantee the quality of life at all stages of life and, in particular, among the elderly (European Commission 2013). This strategy focuses on two main aspects: on one hand, health promotion and disease prevention, and on the other, the development of a long-term care system capable of fulfilling its mission of providing ongoing support to dependent people.

However, long-term care systems are not yet prepared to deal with the new challenges posed by population ageing (OECD 2020). For a start, the postponement of the need to resort to long-term care is related to living conditions, which explains that the poorest are the ones who have the greatest need for long-term care (Lera *et al.* 2021). Long-term care is among the 20 principles of the European Pillar of Social Rights that affirm the right to quality long-term care at affordable prices, with particular emphasis on home care services and proximity services, which guarantee maximum independence and autonomy (principle 18).

However, the rhetoric of the European Union is at odds with the disinvestment backed by austerity responses to the 2007-2008 economic crisis. In fact, there was degradation and disintegration of social support that also affected the health and social services, aiming to address increased vulnerabilities that arise in times of economic and financial crisis. This aspect is related to another setback furthered by the responses to the economic crisis: the setback of gender equality indicators. The restrain of government social policies, reducing the number of beneficiaries of social and health services and the continued financial disinvestment in several public services has loaded families with even more care responsibilities (and, within them, women), thus adding to the burden of informal caregivers, who were forced to replace formal care, at the expense of their own time and investment. This situation is reflected in women's participation in the labour force, with repercussions on the gender pay gap (Bettio 2016, Casanova *et al.* 2017, Lera *et al.* 2021).

Therefore, the current discourse on long-term care investment is, to some extent, an inflexion of previously adopted policies. Certainly, rationalisation and optimisation of resources are welcome, beginning with a priority focus on health promotion and disease prevention, as well as on increasing healthy life expectancy. This aspect is crucial for the sustainability of social and health services (Rechel *et al.* 2013). However, the need to improve continued care cannot be ignored.

The gendered nature of long-term care, whether formal or informal, is significant. Informal care is, as mentioned, an essential component of long-term care. Across Europe, and irrespective of formal care supply, families

remain the primary source of care (Le Bihan *et al.* 2019, Barigozzi *et al.* 2020, Bartha e Zentai 2020, Ophir e Polos 2021).

According to the European Institute for Gender Equality, around 62% of informal caregivers are women (EIGE 2019b). Ophir and Polos (2021) have recently presented a new demographic indicator – care life expectancy – which estimates the number of years and proportion of adult life that people spend playing the role of informal caregivers. According to this indicator, at age 15, men will be informal caregivers for 56% of the remainder of their lives and women for 59%. These figures are an average of twenty-three European countries. Despite its figures below average, Portugal has the most significant gender gap (40% for women and 27% for men). However, this study acknowledges several limitations that indicate an even deeper real gap since the study considers only the role of the caregiver (and not the use of time), as well as it attributes a similar level of care intensity to male and female caregivers (thus, not reflecting differences within caregiver roles), and does not discriminate types of care (namely, childcare and adults' care).

It is known that the presence of women is even more pronounced among those who provide intensive informal care (Estrada Fernández *et al.* 2019). Women are also the ones who often take on several fronts of care, being overrepresented in the so-called "sandwich generation", an expression used to describe those who provide care to their parents (dependent adults) while still providing care to their children (a younger generation, but still to some extent dependent), thus holding increased care responsibilities (Murphy and Turner 2017, Ophir and Polos 2021).

Men's participation in informal care is, but some exceptions,[21] substantially different. Their direct involvement in care is less frequent. In fact, men tend to assume a secondary role, characterised by performing instrumental tasks, such as financial support, transport, and housekeeping, while dedicating less time to direct care than women (Estrada Fernández *et al.* 2019, Hrženjak and Scambor 2019). An interesting study on differences in parental care between siblings revealed that daughters usually provide direct care, while sons only do it in the absence of a sister (Barigozzi *et al.* 2020).

Gender differences in informal care provision are associated with both cultural and economic factors, as mentioned above. Social normativity (still) pressures women to undertake care responsibilities. Such burden is reinforced by the gender pay gap, which promotes women's willingness to reduce, or even interrupt, their participation in the labour force (Bettio 2016, Barigozzi *et al.* 2020).

Furthermore, formal care also is gendered. It is a generally undervalued sector of low-skilled and part-time jobs, with high turnover and precarious conditions, often performed by non-educated and socially vulnerable (*e.g.*, migrant) people. These jobs are held mainly by women (Casanova *et al.* 2017, Murphy and Turner 2017, Bartha and Zentai 2020, Directorate-General for Employment Social Affairs and Inclusion 2020).

In terms of public policy strategy, the preference expressed in recent years for the maintenance of long-term care at home is based on good reasons: it seems to address beneficiaries' preference while presenting lower costs than institutional care. However, depending on how care is organised and regulated, there is the risk of increasing informal carers' burden and also increment care jobs' precariousness by hiring unqualified and vulnerable people, who are more prone to accept informal jobs in unregulated sectors (Casanova *et al.* 2017, Murphy and Turner 2017, Barigozzi *et al.* 2020). Hence, the relevance of care for gender equality becomes evident, particularly regarding long-term care. Here, too, tensions emerge between the new social roles of women and the objective of more equal participation both in the labour market and care responsibilities.

Nevertheless, European societies address this challenge differently, giving rise to several models of care, which is not surprising, given the existence of several factors that influence national policies, such as different social norms, available resources, work patterns, and, more generally, cultural traits (Torella 2016). Hence, several models of care have been developed, as follows.

Esping-Andersen (1999) identified a dichotomy that became well known and widely adopted: "familialisation", which refers care to the private sphere of the family, considered the main responsible for care, and "defamilial-

[21] In fact, in older age groups, namely, those above 75 years old, informal care is more egalitarian. Some studies even indicate that men provide more care than women. However, these findings are situated in a particular context: care between husband and wife in elderly couples that live alone (Torella 2016, Abellan et al. 2017, Estrada Fernández et al. 2019, Hrženjak e Scambor 2019, Directorate-General for Employment Social Affairs and Inclusion 2020).

isation", which aims to reduce the individual's dependence on the family, by transferring care provision to the state or the market.

Somehow, these models may be intertwined with Murphy and Turner (2017, pp. 135-136) classification. They distinguish between the "traditional family model eldercare" (that puts the burden of caregiving on the family – that is, on women) and the "Beveridge-oriented care regime" (that ascribes care responsibility to the state), bisected in the universalist welfare models (that typically characterise Nordic countries, based in universal and affordable public services) and liberal welfare models (favouring minimal state intervention and strict criteria in selecting care beneficiaries).

Those who advocate the provision of care by the family often resort to a narrative prone to value affective and non-commodifiable aspects of care that would be lost in their transition to the public sphere (Folbre and Nelson 2000). There is evidence that the quality of care depends, in part, on the quality of the affective relationship established between the cared for and the carer, although not necessarily entailing a family relationship (Bergeron 2016). Defamilialisation, in turn, is thought to be a way of guaranteeing the autonomy and independence of the beneficiary of care while promoting gender equality by mitigating the constraints on women's participation in the labour force (Eggers *et al.* 2018).

One fact worth noting is that many people genuinely want to take care of their relatives, which often translates into a deeply significant experience in their lives, apt to generate a profound sense of personal fulfilment (Grant *et al.* 1998, Grover *et al.* 2017, UN Women 2020). Therefore, the absence of conditions to care is often experienced as an injustice.[22] Interestingly, a recent study on popular support for social care policies revealed that in Norway – one of the countries where formal care is more advanced – there is the idea that the state should assume fewer care responsibilities. Beyond this phenomenon is essentially the perception of the different quality of care provided by relatives (Chung *et al.* 2018).

Thus, in the last decades, public policies recognising the critical role of caregivers and establishing a set of rights associated with caregiving have been on the rise, whether to promote the well-being of caregivers or to allow them to care. The recognition of these rights is an expression of the right to care, insofar as it encompasses the right to receive care, but it is also the acknowledgement of a right to care for.[23] Considering that informal caregivers provide most long-term care and that quality of care depends on the concrete conditions under which it is provided, the relationship between the right to health and the right to care becomes evident. However, the tangible way public policies articulate distributing the burdens of care among the state, the family and the market oscillates. It is possible to find variations between familialising and defamilialising policies.

Consequently, Leitner (2003, 2014) categorises "implicit familialism", "explicit familialism", and "optional familialism". The first occurs in the absence of care policies, whether familialistic or defamilialistic since such circumstances entail the idea that care responsibilities are family's matters. "Explicit familialism", in turn, presupposes the existence of policies that support family caregiving, although it continues to consider care primarily as a family responsibility. As for the "optional familialism", it stems from a combination of defamilialisation policies and policies aimed at supporting caregiving families. In this case, care becomes a family's choice.

Saraceno (2016) presents a classification similar to that of Leitner that distinguishes "familialism by default" (the assignment of care responsibilities to the family, without state support, i.e., identical to Leitner's "implicit familialism"), "prescribed familialism" (based on legal duties that stem from family solidarity) and "supported familialism" (the assignment of care responsibilities to the family, with state support, that is, similar to Leitner's "explicit familialism"). In addition, this author also distinguishes "defamilialization through public provision" from "supported defamilialization through the market" (for example, through cash subsidies that allow beneficiaries to both pay a caregiver and purchase care services in the market). Criticising Saraceno, Le Bihan, Da Roit and Sopadzhiyan (2019) distinguish "supported" from "unsupported" familialism.

Ophir and Polos (2021) distinguish the "universal approach to welfare" state (associated with an abundant provision of public care), the "limited" welfare state (where the family undertakes the role of the primary caregiver

[22] In a Ribeiro's interview (2005, p. 216), this illustrative testimony can be found: "I am shocked that a mother can be with her children at the beginning of their life and I did not have the opportunity to be with my grandparents. It is revolving. It was my choice. The law was not on my side!" (author's translation).

[23] See, also, Marrades (2016), qualifying the right to care as a fundamental social right.

and public provision of care is scarce) and the combined welfare state (similar to Leitner's "explicit familialism" or Saraceno's "supported" familialism). These authors mention that the model showing a lower gender gap is the "universal approach to welfare" state, followed by the combined welfare state and, at last, by the "limited" welfare state.

However, if at first glance there may seem to be some opposition between familialism and defamilialisation, a relevant study by Eggers *et al.* (2018) challenged this claim and the idea that supporting informal caregivers is a cheap way to reduce state social benefits. In reality, familialism and defamilialisation are not necessarily opposites: there may be a combination of both policies. In this way, it is possible to design public policies based on a network of formal long-term care while supporting informal caregivers.

Withal, the existence of social benefits for caregivers is not enough to promote gender equality. Those benefits must also be generous. In fact, the model that seems to contribute most to gender equality in the public sphere and the private sphere is the one that invests simultaneously in supporting informal caregivers and building strong formal care systems. On the contrary, policies advocating meagre support for caregivers while not guaranteeing adequate access to formal care perpetuate gender inequalities, especially among those who do not have the means to turn to the market to meet their care needs (Eggers *et al.* 2018).

According to Eggers *et al.* (2018), generous long-term care are universal (available to all) and with no needs-test or means-test and generous care policies would also be universal and paid at the same level of formal care with access to a social security system.

Eggers *et al.* (2018) conclusion is confirmed by Bartha and Zentai's (2020) study, encompassing the following types of policies: "double earner, unsupported carer" (similar to Le Bihan, Da Roit and Sopadzhiyan's "unsupported familialism"), "loosely fitting to double earner and unsupported carer" (in which a higher generosity level of long-term care can be found and, therefore, a better response to care needs), "loosely fitting to double earner and supported carer" (levels of long-term care generosity higher than the EU average, however, with significant care needs yet to be fulfilled), and "double earner, supported carer" (characterised by high levels of generosity, regulation of care systems and all care needs addressing).

Analysing the levels of gender inequality in various countries that fit these models, Bartha and Zentai concluded that countries closest to the dual earner and supported caregiver model (Nordic countries) manifest a lower gender gap. In fact, informal care is a choice in those countries, not a substitute for formal care. On the opposite extreme, countries that fit the dual earner and unsupported caregiver model (*e.g.* Bulgaria, Romania and Latvia) are those with the most significant gender gap. Hence, these authors identify the conditions under which care systems promote gender equality: strong provision of universal and affordable public services, regulation of home care, care leave (both paid and unpaid), work flexibility, and the regulation of migrant care work (Bartha and Zentai 2020).

In short, a combination of generous policies in terms of both formal and informal care is the model that contributes most to promoting gender equality.

On the one hand, the existence of formal care guarantees that family care is an authentic choice – and not the result of the absence of an alternative: in this way, women whom social gender norms would constrain to guarantee the family's care needs can freely choose to remain in the labour market. Thus, the strong provision of formal care promotes gender equality in the public sphere.

On the other hand, recognising the social value of informal care leads to the valorisation of care in general, which creates conditions for men to undertake both informal and formal care. Therefore, strong support for informal caregivers contributes to greater gender equality in the private sphere and formal care Campo sector(Saraceno 2016, Auth *et al.* 2017, Eggers *et al.* 2018).

However, if long-term care public policies regarding formal and informal care do not translate the recognition of the authentic value generated by care activities, the most likely scenario, considering the complementarity between formal and informal care, is the deepening of gender inequality (Saraceno 2016).

Public policies of low-paid and means-tested support to caregivers do not reflect the provision of care's true value as productive work, thus producing several adverse effects. Firstly, it can trap the caregiver in a situation of economic dependence while minimising their opportunity to obtain in the future an income that reflects the actual value of their care work for society (Estrada Fernández *et al.* 2019, Barigozzi *et al.* 2020, Lera *et al.* 2021). Furthermore, there is a risk of social stigmatisation of informal caregivers, who are perceived not as productive elements of society but as beneficiaries of social benefits (Murphy and Turner 2017).

Finally, the tension that for many women arises from the double burden of providing and care for their families, together with poor public investment in formal care, enhances the emergence of precarious jobs in the care sector, which is highly feminised, thus boosting gender inequality in the labour market and creating a vicious circle that can only be braked through the valorisation of care work, be it formal or informal (Casanova *et al.* 2017, Murphy and Turner 2017, Directorate-General for Employment Social Affairs and Inclusion 2020, OECD 2020).

5. Conclusion

Care is a set of activities and relationships intended to maintain society, namely through the satisfaction of physical and emotional needs of dependent people (Daly and Lewis 2000), such as children, the sick or the elderly that has been ascribed to women. In fact, despite cultural differences, the phenomenon of gender specialisation has been transversal in the course of history.

One of the cultural manifestations of such specialisation in Europe has been the middle-class family model asserted in the 19th century, based on the ideology of separate spheres, which found, in the post-war period (1950s) the conditions for its generalization. This model – the male breadwinner model – assigns paid work to the man/father and housework and care to the woman/mother.

However, this model was based not only on gender differentiation (through their specialisation) but also on a hierarchical construction that reflected the different values attributed to manly and womanly activities. Thus, while taking part in the public sphere through the labour force is valued, care work remains consigned to the private sphere without recognition of the social value it produces.

At the same time, throughout the 20th century (although interrupted by the two world wars), the women's emancipation movement and its struggle for equality have borne fruit, affirming equality between men and women as an objective of democratic societies. However, the path of women's access to men's civil and political rights (that is, access to the public sphere) was not complemented by a symmetrical movement of men's participation in the private sphere that would lead to gender roles interchange.

The analysis of the relationship between care and gender today, *i.e.*, knowing how care activities have a different impact on the lives of women and men, reveals the gendered nature of care, which largely contributes to the persistence of gender gaps, particularly regarding women's participation in the labour market. Women participate less in the labour force than men and even lesser in the case of extended families or couples with children. Such low participation is linked to care responsibilities towards children and dependent adults that fall on women. These responsibilities prove to be determinants of both labour force participation and modes of its participation. Women prevail in fixed-term, temporary, part-time, and informal work but are underrepresented among those who undertake shift work or overtime. In addition, there is horizontal segregation of the labour market. Sectors of activity linked to care activities are strongly feminised (education, health, and social services), while technology, engineering and finance are greatly masculinised.

These different modes of participation in the labour force are reflected in the gender pay gap, which, in turn, is one of the determinant factors in the distribution of care responsibilities within the family, thus generating a vicious circle of gender inequality.

Despite the social and economic constraints that women, in general, still face in terms of equal access to the labour market, the truth is that their participation has been increasing. However, as mentioned, this transformation of women's roles was not complemented by a similar movement of men, thus generating tensions and imbalances. Furthermore, western societies face a new reality: population ageing. In the first place, this phenomenon poses challenges to health and social systems, but also to gender equality.

In fact, the assumption of care responsibilities by families and, within these, by women, without any recognition of the value generated by care, results in the worsening of inequality between men and women since the latter bear the costs of care. Therefore, women are more vulnerable not only to future situations of physical and mental illness but also to poverty. In turn, the mere outsourcing of care, which families with higher incomes can afford, is not a solution, as it tends to perpetuate gender inequalities in the labour market, with such jobs being carried out in precarious contexts and by people (primarily women) in situations of social vulnerability, as it is the case of migrants.

Thus, it is paramount to rethink the place of care in democratic societies, through its valorisation, transferring the costs of care to those who benefit from it: the whole of society. This is the context in which Tronto refers to the relationship between care (as a political concept) and democracy, advocating the need to rethink the content of politics considering the care needs in society.

Long-term care public policies are paradigmatic of the tensions above, and of the social and political hesitation in valuing care, illustrated by the disinvestment in this sector following the austerity policies adopted in the period of the economic and financial crisis at the end of the first decade of the 21st century. Despite the current rhetoric of innovation and social investment in long-term care, the truth is that principle 18 of the European Pillar of Social Rights, which proclaims the right to quality and affordable long-term care, is still far from being a reality. Furthermore, the emphasis placed on home care and the essential role of informal caregivers in long-term care systems must go hand in hand with significant economic investment in this area. If this is not the case, the result is replacing formal care with informal care, transferring the costs of ageing (and the needs for added care associated with it) to families and, consequently, to women, thus increasing gender inequality.

In this context, the right to care emerges as a dimension of a right to be cared for. Moreover, the designation "right to care" encompasses a diverse range of rights that express the recognition of care as a meaningful life experience and the recognition of informal caregivers' social value.

The analysis of the different models of public policies proposed in the considered literature reveals that they are all permeated by the distinction between familial policies (which impose on families – that is, on women – the primary responsibility for care) and defamilialistic policies (which entrust care to the state). It appears, however, that the state can play an active role not only in defamilialistic but also in familialistic policies. In this case, it intervenes by supporting families to care for their members. In the case of defamilialistic measures, state interventions that create universal and affordable public networks of formal care are also distinguished from those that create incentives to purchase formal care in the market.

Depending on the different combinations of these policies, it is possible to identify strong policies supporting formal and informal care at one extreme and weak policies supporting formal and informal care at the opposite extreme. In between, some policies are generous in terms of formal care, but not informal care, and vice versa.

The literature analysed reveals that policies to support formal care and policies to support informal care are not necessarily competing. They can – and should – be complementary, mainly if aimed also at promoting gender equality.

Indeed, the idea that formal care is sufficient to promote gender equality equates gender equality with the creation of conditions for women's participation in the labour market. If not accompanied by the proper valorisation of jobs in the care sector, such a conception can lead to a transfer of women's activities as informal caregivers to employment in the formal care sectors, thus perpetuating gender inequalities. The trap lies in the valorisation of paid work unaccompanied by the valorisation of care. This means that the existence of formal care can only favour gender equality if it is regulated in a way that reflects the value of care for societies, addressing the precariousness of these jobs. Special attention should also be paid to the regulation of home care and the establishment of training and qualification requirements for professionals in this sector, thus guaranteeing the quality of care, which is especially challenging in the private environment of the home.

Finally, it is necessary to recognise the complementarity between formal and informal care. Considering care as a political concept and the centrality of care for the development and maintenance of democratic societies, the state must be the first and the last responsible for care. Indeed, all society benefits from care. Therefore, the costs of care must be borne by everyone, that is, by the entire political community. Even so, saying that the state must pay the costs of care is not the same as saying that it is necessarily through the state's public services that this care must be provided.

Ultimately, in case of need, the state must guarantee quality and affordable formal care (either through a public network or through public funding). However, informal care also presents itself as a relevant reality in many people's lives. Therefore, the possibility of assuming informal care should also be guaranteed by the state, thus materialising the "right to care". Guaranteeing the possibility of choice, both for the beneficiaries of care and for potential caregivers, whenever formal and informal care are interchangeable, is the only solution compatible with plural and diverse societies. In addition, it is the solution that recognises care as a caregiver's right, thus confirming the rele-

vance of this activity as a significant activity. For informal care to be a choice, the possibility of choosing between formal and informal care must be real, which entails the existence of generous levels of formal care.

Returning to this article's central question: which aspects should be considered, in terms of public policies in the context of informal care, which simultaneously allow for the promotion of gender equality? Considering the current costs of informal care for caregivers, it is possible to affirm that promoting gender equality relies on the valorisation of care. Such valorisation can be achieved through a range of rights aimed at guarantying fair remuneration for informal caregivers (at the same level of formal care work). Implementing mechanisms that account for time spent in informal care in retirement income is also necessary. In addition, since care is a complex activity, training is also an essential aspect of this valorisation (especially when the beneficiary of care is a very dependent person). Finally, and considering that there are several levels of informal care provision, the establishment of flexible work regimes, funded by the state, that allow better work-life balance is also a relevant feature of a "right to care".

In sum, a *right to care* can promote gender equality if it is linked to recognising the social value of care. In this way, female caregivers will be less vulnerable to the risks of poverty and dependence, and men's constraints to opting for care will be reduced, thus eliminating the gender gap that persists in care.

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