RECOVERY WATCH

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TOWARDS A CARE-LED RECOVERY FOR THE EUROPEAN UNION?

A FEMINIST ANALYSIS OF THE NATIONAL RECOVERY AND RESILIENCE PLANS

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RECOVERY WATCH

WHAT IS THIS PROJECT ABOUT?

The National Recovery and Resilience Plans represent the new framework in which European member states identify their development strategies and allocate European and national resources – with the objective of relaunching socio-economic conditions following the coronavirus pandemic.

This process, initiated as part of the European response to the global health crisis, follows the construction of NextGenerationEU. It combines national and European efforts to relaunch and reshape the economy, steering the digital and climate transitions.

For European progressives, it is worth assessing the potential of these national plans for curbing inequalities and delivering wellbeing for all, as well as investigating how to create a European economic governance that supports social, regional, digital and climate justice.

The Foundation for European Progressive Studies (FEPS), the Friedrich Ebert Stiftung (FES) and the Institut Emile Vandervelde (IEV), in partnership with first-rate knowledge organisations, have built a structured network of experts to monitor the implementation of National Recovery and Resilience Plans and assess their impact on key social outcomes. Fact- and data-based evidence will sharpen the implementation of national plans and instruct progressive policymaking from the local to the European level.

The Recovery Watch will deliver over 15 policy studies dedicated to cross-country analysis of the National Recovery and Resilience Plans and NextGenerationEU. Monitoring the distributive effects of EU spending via NextGenerationEU, and the strategies and policies composing the national plans, the project will focus on four areas: climate action, digital investment, welfare measures and EU governance.

KNOWLEDGE PARTNERS

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LIST OF ABBREVIATIONS

COVID-19 ..... Coronavirus disease
CSR ..... Country-Specific Recommendations
EC ..... European Commission
ECEC ..... Early childhood education and care
EIGE ..... European Institute for Gender Equality
EP ..... European Parliament
EU ..... European Union
LTC ..... Long-term care
MFF ..... Multiannual financial framework
NGEU ..... NextGenerationEU
NRRPs ..... National recovery and resilience plans
RRF ..... Recovery and Resilience Facility

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SUMMARY

Considering that the NextGenerationEU fund was set up precisely to help member states repair the immediate socioeconomic damage brought about by the coronavirus pandemic, whilst enhancing their post-pandemic resilience, this policy study applies a feminist reading to explore how care is addressed in this historic EU fiscal stimulus tool.

By engaging with the feminist literature on care to analyse the resulting national recovery and resilience plans (NRRPs) across eight EU countries (Austria, Belgium, Czechia, Germany, Finland, Italy, Latvia and Spain), the ambition is to understand to what extent the NRRPs have adopted a care-led approach in response to the care crisis undeniably exacerbated by COVID-19. An in-depth qualitative analysis of the national plans, complemented by a quantitative assessment, offers several elements of response.

Firstly, the analysis shows that, despite the limited incentives to foster a care transition, the national plans studied all address care, although to a significantly lower extent than other spending priorities, such as those linked to the green and digital transitions.

Secondly, the scope of care measures in the NRRPs mirrors the pre-existing care regimes in place to a significant extent.

The third major finding reveals that there is a general convergence towards similar solutions, with the institutionalisation of childcare and the deinstitutionalisation of long-term care, but the recognition of the underlying problems behind care imbalances is framed in contrasting ways. The majority of countries present care responsibilities as a cost or burden, but some countries follow a different path, presenting care as valuable in itself and positioning it as a central issue, connecting care measures more explicitly with concerns for inclusiveness, social fairness and welfare protection.

Fourthly, examination of the NRRPs reveals a broadly shared tendency to adopt a life-cycle perspective, giving at least some degree of consideration to all phases of care, although – apart from some notable exceptions – most NRRPs fail to acknowledge the inherently intersectional and cross-border dimension of care best exemplified by the absence of consideration for domestic care.

Although the predictive capacity of these results on the actual implementation phase of the NRRPs must be treated with caution, since care is such a complex social good, they tend to corroborate the idea that the recovery can serve as a genuine springboard for a care paradigm shift. This applies, in particular, to countries with lower levels of family support. Yet, considering the limited EU-induced incentives for care investments and reforms in the Recovery and Resilience Facility, it still relies heavily on political will at the national level.

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Keywords:
care crisis, care regimes, gender equality, COVID-19, feminist economy, recovery

1. INTRODUCTION

The COVID-19 pandemic has left lasting marks on our collective memory and individual experiences. From crumbling healthcare systems to paralysing entire economies and disrupting most social interactions, its long-term consequences have outlasted the immediate effects of the virus and its countermeasures. To enable its member states to better face the aftermath of the resulting health, economic and social crises, the European Union (EU) launched the largest fiscal stimulus package in its history – the NextGenerationEU fund (NGEU) – to help the most affected sectors and regions.[1] Considering that this ground-breaking recovery instrument was set up precisely to "help repair the immediate economic and social damage brought about by the coronavirus pandemic",[2] whilst ensuring post-pandemic resilience, this policy study applies a feminist reading to explore how care is addressed therein.

Admittedly, the pandemic has laid bare the importance of sound care systems and social welfare services, which have been chronically undervalued, underfunded and understaffed post-austerity.[3] The COVID-19 crisis has also unearthed a long pre-existing and much deeper care crisis.[4] Society and families can be kept afloat thanks to invisible yet essential care work, whether formal or informal, that is disproportionately concentrated on the shoulders of women and the most underprivileged groups of society. These deep cracks in the system were suddenly exposed by the resulting lockdown measures, but also by changing work patterns, with the teleworking shift likely to become the "new normal"[5] and the long-term economic consequences of the pandemic. Many reports point to the heavy blow dealt by COVID-19 for the feeble and painfully slow advances made by the EU towards gender equality.[6] The long-standing care inequalities rooted in gender norms are identified as one of the main sources of deepening social inequalities,[7] thereby echoing the alarm raised by a large international consensus.[8] In pre-pandemic times, the International Labour Office issued a report warning that "[if] not addressed properly, current deficits in care work and its quality will create a severe and unsustainable global care crisis and further increase gender inequalities in the world of work".[9]

Therefore, this policy study seeks to understand whether a feminist understanding of *care* offers new avenues to overcome the stalled advances towards gender equality. Feminist research has, since its onset, engaged with the impact of care on gender inequalities. With the advent of the pandemic, the idea of care is being rediscovered in policymaking spheres.[10] The necessity to better value the care sector has come under the spotlight for political acknowledgement.[11] However, beyond the symbolic clapping for care workers, elevating them to heroes (or more accurately heroines), the true question lies in how far the nascent rhetoric for a "caring society" can translate into concrete action living up to those values.

That is why, as the EU is rebuilding itself, this policy study takes a closer look at the national recovery and resilience plans (NRRPs) put in place by member states, which delineate the nature of the reforms and public investment funded by the EU to implement the Recovery and Resilience Facility (RRF), the largest part of the NGEU. Positing care inequalities as a major impediment to gender inequality,[12] the main scope of investigation revolves around the following research question: **to what extent have the NRRPs adopted a care-led approach in response to the care crisis exacerbated by COVID-19**? Considering how women and underprivileged groups have been disproportionately impacted, I seek to understand whether the stated aims of offering a response to the crisis, which made the underlying care crisis undeniable, effectively result in reforms and investment plans at the national level to address one of the main challenges posed by the pandemic: care inequalities. By analysing the NRRPs of **Austria, Belgium, Czechia, Finland, Germany, Italy, Latvia and Spain**, I ask, in more general terms, whether the COVID-19 crisis accelerated the realisation of deep-seated care deficits and how this realisation has permeated in the response(s) provided, namely, by the mainstreaming of care across member states' policy agenda to "build back better".

Section 2 offers an overview of the relevant insights from academic research on care since its early development, to more recent policy interpretations and up to the EU's COVID-19 response. Section 3 offers a quantitative and qualitative assessment of care in the NRRPs. Finally, Section 4 formulates conclusions and ways forward in the form of policy recommendations.

2. FEMINIST CARE: REVISITING THE POLITICS OF THE INVISIBLE

As its multiple uses in everyday language illustrates, care covers a wide range of realities. It is ubiquitous, rich but also complex and sometimes ambiguous. A large body of scholarly research has been devoted to care. Being such a highly gendered phenomenon, it has occupied a prominent place in feminist thinking. In the wake of COVID-19, this field is gaining further traction, as many unprecedented care-related challenges arise whilst long pre-existing ones have been unearthed. One of the most difficult tasks inherent to care lies in its very conceptualisation, which varies significantly across disciplines. Although different parts of research on care overlap inevitably, common strands of interest can be identified.

2.1 CONCEPTUALISING CARE AS VALUE ORIENTATION

Feminist scholars have widely engaged with the concept of care, paving the way for a fully fledged school of thought known as the *feminist ethics of care*.[13] It can be encapsulated as "an ethic of resistance to the injustices inherent in patriarchy (the association of care and caring with women rather than with humans, the feminisation of care work, the rendering of care as subsidiary to justice – a matter of special obligations or interpersonal relationships)".[14] Since the 1980s, care ethics has used the perspective of care to give centre stage to ordinary life and the continuous everyday care work necessary to human existence.[15]

In other words, "[it] concerns the moral implications of care from the most local [...] forms of care to the broader social and political institutional settings of care in the modern age, and from caring attitudes to caring behaviours and practices".[16] This very flexible concept has found multiple uses from sociology to laws, psychology, political science, philosophy, communication, education, urban or postcolonial studies.[17]

The ethics of care has led feminist researchers to move from reflecting on only a rights-based justice and discrimination-focused approach to considering a more substantive understanding of equality from the perspective of "care". Feminist scholars have thus elevated care to an equal footing with other, more widely acknowledged, basic values such as rights and justice.[18] Far from pitting both ethics systems against one another, this approach maintains that justice is incomplete without care and vice versa.[19]

Another pivotal contribution to this field lies in its emphasis on the importance of de-gendering and politicising care.[20] Joan Tronto stresses that "[c]are may be ubiquitous in human life, but it has remained hidden from the conceptual lenses of social and political thought".[21] Politicising the concept thus "forc[es] us to place into the context of people's daily lived lives any political or moral concerns".[22]

Significantly, Tronto has conceptualised care with Berenice Fisher based on a landmark definition, viewing it as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web".[23] This broad definition clearly disconnects care and its subjects from what has often been perceived as "natural". It underpins one of the core principles of the ethics of care, which holds that proper care for others is a good, and society should promote the quality of care so that people may live as well as possible. It reveals the value and centrality of activities underpinning care. Rather than seeing society merely as a set of autonomous individuals only driven by rational aims, it makes us see it as a web of people engaged in care relationships. Although this conceptualisation of care may seem rather abstract, one of the core claims lies precisely in its insistence on understanding care as a *practice* entailing a determined ethics as much as an activity.[24]

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Care ethics has used the perspective of care to give centre stage to ordinary life and the continuous everyday care work necessary to human existence.

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2. FEMINIST CARE: REVISITING THE POLITICS OF THE INVISIBLE

Three important notions arise from this understanding of care: (a) *everyone* needs care, meaning that if people have a sense of autonomy, it is merely due to a specific constellation of caring relationships and institutions from families to welfare states and the market; (b) care is *relational*, as people are constantly enmeshed in care relationships far richer than the reductive mother-child dyad;[25] (c) *care is diverse and fragmented*. This fragmented nature is crucial to understand the low value attributed to care. It becomes evident in the "four phases of care" developed by Tronto to demonstrate the need to politicise care:[26]

(1) *Caring about* implies acknowledging a certain care need (*attentiveness*).

(2) *Taking care of* involves feeling responsible for finding an adequate response once the need is recognised (*responsibility*).

(3) *Care giving* corresponds to the act of care, whereby the answer to the identified care need is carried out through care work (*competence*).[27]

(4) *Care receiving* is crucial to meet needs in a two-way relationship (*responsiveness*).

These phases may overlap or clash, each being likely to involve different actors with different goals (e.g. profit maximisation vs. well-being) and constraints (e.g. time pressure vs. living in dignity). Whereas the first two phases enjoy social appreciation, the last two have remained largely undervalued.[28]

The originality of this work lies in its ability to show the links between power dynamics with a feminist concern focused on care, which is too often relegated to a private matter. In this sense, social systems of care can only exist through the politicisation of care. That is why Tronto proposes to redefine certain boundaries, namely, between public and private. Without going as far as erasing the private sphere, there must be a redistribution of private and public spheres in such a way that domestic (private) work does not equal social weakness to re-evaluate care work and to disconnect it from a subordinate, poorly paid, feminised or racialised workforce. This boundary shows the very political nature of this private/public division. Once the socially constructed nature of this boundary is demonstrated, the need to newly delineate these archaic divisions becomes obvious.[29]

Moreover, whilst women's experience constituted the starting point, this approach also holds that care must transcend the gender perspective.[30] Reducing care to nurturing or face-to-face activities offers an incomplete account of class and racial hierarchies involving low-paid workers.[31] Therefore, it is crucial to advocate *politically* for its gender neutrality.[32]

"There must be a redistribution of private and public spheres in such a way that domestic (private) work does not equal social weakness to re-evaluate care work and to disconnect it from a subordinate, poorly paid, feminised or racialised workforce. This boundary shows the very political nature of this private/public division. Once the socially constructed nature of this boundary is demonstrated, the need to newly delineate these archaic divisions becomes obvious."

The perspective of care thus brings a central claim to the importance of care for human life, the relationships on which it rests, as well as the social and moral status of caregivers.[33] Through its reading of social relationships as being organised around dependency and vulnerability, with some major caveats regarding the usual accounts of justice, the care perspective is inherently ethical and political. Placing humans at the centre shifts the focus to ordinary lives and work accomplished both in private and in public.

2.2 CARE AS A COMPONENT OF LABOUR AND WELFARE-STATE POLICY

The above considerations have relevant implications for our understanding of care as a lens to envision welfare policies. Care is not a luxury good and effective care infrastructures cannot be built on personal responsibility.[34] Contemporary welfare states cannot be understood without the concept of care, even more so as "contemporary developments move it to the very centre of welfare-state activity".[35] Therefore, the redefinition of public policies around care is central to welfare states.

Hence, understanding the relationship between care and the welfare state is crucial to assess the need for public support, along with corresponding modalities of provision. By theorising care, feminist scholars have thus contributed to challenging the gender blindness of mainstream accounts of welfare and the economy.[36] They have elevated care from an invisible to a central tenet of society and welfare by detecting the male bias of established welfare accounts.[37] The critique revolves around the nexus between care as (un)paid work and the gendered impacts of welfare, denouncing how the analytical neglect of unpaid care work excludes women and fails to account for the gender bias of social entitlements'.[38]

In an effort to redress these caveats in traditional accounts, feminist scholars have reassessed welfare-state models and policies from a gender perspective, with an importance placed on gender and familial ideologies, the inclusion of the private/domestic sphere, reconsidering access to entitlements, acknowledging the nature of care work as a combination of paid and unpaid work, and the public provision of care.[39]

2.2.1 Care regimes

The identification of care regimes across Europe has offered a new lens to envision welfare states.[40] This policy study draws on the concept of (de-)familisation widely used in cross-country welfare-state comparison, exploring the interaction of financial and care dependencies. The conceptual framework elaborated by Lohmann and Zagel is of particular relevance.[41] In the continuity of prior contributions,[42] it understands *defamilising* policies "as welfare-state provisions […] that reduce care and financial responsibilities and dependencies between family members", whereas *familising* policies are termed as "social policies or regulations that foster dependencies amongst family members by actively lowering their negative social and economic consequences […] such as women's financial dependence on a breadwinner, children's dependence on their parents' care and elderly people's dependence on their adult children".[43] In addition, this model offers extra nuance by acknowledging that welfare states may feature both defamilising and familising policies. It proposes a range of ideal-typical patterns of policy outcomes based on the different ways of structuring family dependencies,[44] mapping them on a four-fold matrix (Figure 1), built on the idea that care must be conceived of as reciprocal relationships, considering gender and intergenerational dependencies. Countries can thus be plotted on the dimensions of familising and defamilising policies, situating them according to specific ideal-typical outcomes of family policy configurations. Accordingly, countries selected in this policy study reflect a representative sample of the different (de)familising policy constellations.

2.2.2 The universe of policy measures for care

Welfare states' care policies can include a large set of measures, spanning from various employment-leave arrangements to working-time flexibility, taxation reliefs, vouchers for purchasing services, care-related credits for pensions and other benefits, and various types of care services across a wide range of possible policy domains, each seeking to meet different needs for time, money or services. Care and its provision within welfare states can, therefore, be considered a "complex social good", which, for the purpose of this policy study, is encapsulated within Daly's four-fold classification of care[45] (see Section 3.2).

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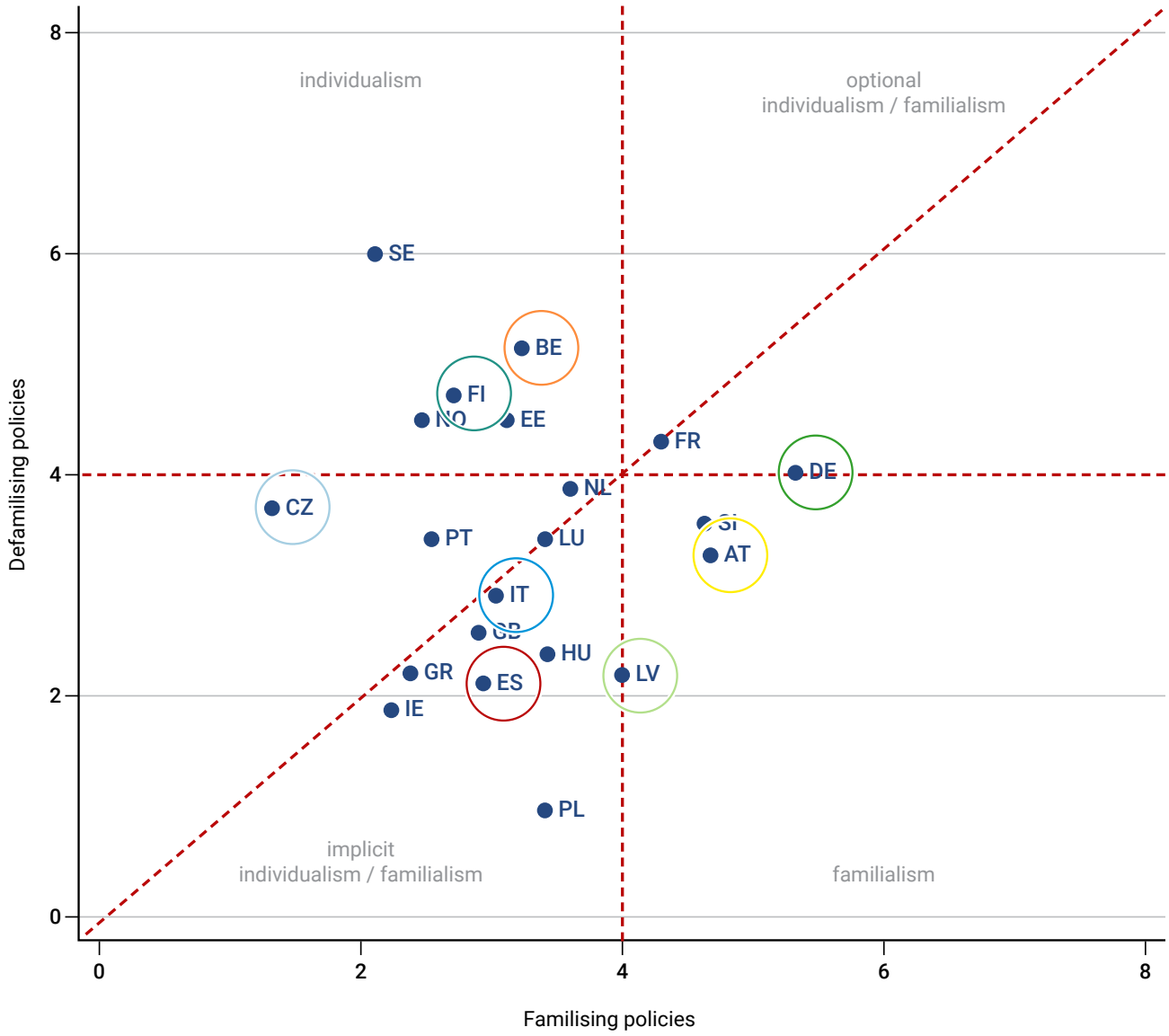
FIGURE 1. Familisation and defamilisation across countries in 2004, composite indices.



Lohmann H. and H. Zagel (2016) "Family policy in comparative perspective: The concepts and measurement of familization and defamilization". Journal of European Social Policy, 1(26): 52-53. DOI: 10.1177/0958928715621712

TABLE 1 - Fourfold classification of care based on Daly (2002)

(a) MONETARY AND IN-KIND SOCIAL SECURITY AND TAXATION BENEFITS

TYPES OF MEASURES	POLICY DOMAIN				
	Social	Labour market	Education	Health	Income
Cash payments	Means-tested or social insurance benefits paid to carer or care receiver; childcare vouchers	Severance pay for labour-market withdrawal due to parenthood or motherhood		Subsidies or subventions for residential care	
Credits for social security	Credits to carers for pensions and other social security benefits				
Taxation					Allowances for care-related expenses

(b) EMPLOYMENT-RELATED PROVISIONS

TYPES OF MEASURES	POLICY DOMAIN				
	Social	Labour market	Education	Health	Income
Leave support for employees	(Un)paid parental, paternity and care leave	Career breaks, time savings account, employment rights during leave	Educational/training leave for caring		

(c) SERVICES

TYPES OF MEASURES	POLICY DOMAIN				
	Social	Labour market	Education	Health	Income
Services	Public childcare; home helps; meals on wheels	Workplace childcare	Creches, daycare, schools, kindergartens	Residential services	

(d) INCENTIVES TOWARDS EMPLOYMENT CREATION OR PROVISION IN THE MARKET

TYPES OF MEASURES	POLICY DOMAIN				
	Social	Labour market	Education	Health	Income
Incentives towards employment creation	Vouchers for domestic employment	Reduction of working time; part-time working			
Incentives for market services	Subsidies towards the costs of care in private provision				Tax allowances for the cost of care in market-run services

Daly, M. (2002) "Care as a good for social policy". *Journal of Social Policy*, 2(31). DOI: 10.1017/S0047279401006572

2. FEMINIST CARE: REVISITING THE POLITICS OF THE INVISIBLE

Whilst childcare often takes centre stage,[46] gendered considerations of other care policies like elderly care have received scant attention.[47] The concept of social care as "the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and normative, economic and social frameworks within which these are signed and carried out" thus helps to "overcome conceptual and empirical fragmentation by defining care as a meta concept, that is, an activity that crosses spheres".[48]

In examining the possible outcomes of care policies, the three ideal models of gender equality proposed by Nancy Fraser[49] offer a useful lens to conceive how various care arrangements can contribute to gender equality:

- the **universal breadwinner model** supposes men and women as equal earners relying on universal care provision for children and the elderly;
- the **caregiver parity model** fosters both carers and earners with a special focus on informal and unpaid carers;
- the **universal caregiving (or equal-earner-equal-carer) model** strives for the equal sharing of caring and earning between women and men with the aid of services and measures regardless of gender.

In the present era of the "dual-earner" model, the externalisation of care work onto families due to the disinvestment of the state from social welfare, coupled with increasing female employment rates, has resulted in a narrowing capacity to perform care, leading to a "dualised organisation of social reproduction", where care is commodified for those who can afford it and privatised for those who cannot.[50] Put differently, "class hierarchies among women have become further entrenched and care deficits merely displaced elsewhere [as] the enhanced autonomy that many middle-class women have achieved brings its own set of problems once freedom is equated with productivism, competition, consumption in continuous self-optimisation".[51]

In fact, the instability of care in western societies is rapidly transforming care into a globalised commodity,[52] creating new forms of inequality and new care relationships. Precisely here lies the source of the "global care chains", whereby western welfare regimes rely on migrant workers – mostly women – from the global south to the global north[53] or from eastern to western Europe[54] to fill the care gaps caused by a lack of fundamental change in the gender division of labour. The idea of global care chains denoting "a series of personal links between people across the globe based on the paid or unpaid work of caring"[55] unveils the inherently cross-border nature of care, which cannot be confined to the national level.[56] Inevitably, new care gaps are created in the countries of origin, leading to severe care drains.[57]

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The role of increased care-work outsourcing in reproducing gender, class and racial inequalities has been at the heart of a growing interest in the resulting inequalities.[58] It offers an intersectional account of care by demonstrating how such policies are connected not only with gender but also with social class, race and ethnicity – hence the direct link with migration policy.[59]

2.3 THE CARE CRISIS

Concerns have been raised about the consequences of the constant undervaluing of care work in national economies, with the depletion of those engaged in social reproduction,[60] leading to *care deficits*[61] and, in turn, the resulting *care crisis*.[62] Tensions around care have deep systemic roots in the structure of society. The care crisis is symptomatic of major contradictions in the organisation of social reproduction: "capitalist societies separate social reproduction from economic production, associating the first with women, and obscuring its importance and value [paradoxically making] their official economies dependent on the very same processes of social reproduction whose value they disavow".[63] In this view, the capitalist economy freerides on care without granting it any monetised value, despite care being an indispensable condition for its functioning.[64] The causes lie with the privatisation and socially constructed gendering of care regimes, making families, rather than society at large, responsible for caring, with women and subordinate groups mainly being responsible. Its origins thus stem from the intermeshing between care, feminisation and privatisation and, hence, its lack of valorisation. In fact, welfare-state retrenchment is at odds with rising care needs due to a constellation of specific circumstances. The large-scale exodus of women from the home to the labour market has never been matched by a corresponding reshuffling of care work. Demographic ageing weighs significantly on the demand for care, and women have joined the labour market not just as dual earners but increasingly as single parents as well. Research provides evidence that "most European care systems were failing to prevent a resurgence of demand for unpaid and informal care due to limitations in the quality, affordability and availability of formal long-term social care provisions" and "high turnover rates and recruitment difficulties due to poor pay and paid working conditions compounded a situation in which care workers were given insufficient training to be able to provide high-quality, person-centred care".[65] Among the sectors in urgent need of reform, long-term care (LTC) has been a low priority for most governments,[66] confirming earlier claims arguing that concerns regarding the impacts of work/family balance on gender equality deserve a broader focus to include not only children but also other care needs, including for adults.[67]

As a result, women are increasingly squeezed between the need to juggle care and work responsibilities, forcing them to accumulate double – if not triple – shifts, especially those who do not have the means to externalise it,[68] thus fuelling their mental load as well.[69]

2.4 COVID-19 AS AN ACCELERATOR OF THE CARE CRISIS

In the context of this silent but widely evidenced and long-existing care crisis, the advent of the COVID-19 crisis has triggered rapidly growing scholarly interest in the field, highlighting the risks and opportunities for gender equality[70] and building on the rich evidence for the gendered nature of previous crises like the 2008 financial crisis.[71]

Echoing previous work warning that gender budgeting principles have been largely ignored in the design of European economic governance tools,[72] Maureen O'Dwyer draws useful parallels between the EU's crisis response during the 2008 financial crisis and the current COVID-19 crisis recovery measures.[73] In her comparative analysis, she convincingly demonstrates the gendered nature of the EU's crisis response in both cases, entailing gendered consequences at each stage of the policy process and building on gendered assumptions about society and the economy. Even though the two crises were different in many ways, women have been simultaneously disproportionately impacted by the long-term employment shocks in both cases, and yet the answers provided by the EU have demonstrated a clear male bias. Following the 2007-2009 great recession, gender-equality principles and goals have been neglected, whilst austerity policies had a more detrimental impact on women's employment prospects.[74] Even though the gender employment gap narrowed in the immediate aftermath – due to greater men's unemployment rates (rather than an amelioration of women's employment) – the response offered negatively affected women's labour market participation in more dramatic ways. The gendered adverse impacts namely became tangible through limited access to public support for working mothers and reduced work opportunities in public services, where women tend to be more active professionally. Likewise, early assessments of the EU's response to the COVID-19 crisis have already revealed the general gender blindness of the NGEU concentrating investments in male-dominated sectors,[75] despite women's direct exposure to the immediate and long-term socio-economic consequences of the pandemic with female-dominated sectors and care responsibilities being severely disrupted.[76] This widely evidenced reality has become known as a "she-cession".[77] In this context, the creation of the RRF presented an opportunity for the EU to finally live up to its gender mainstreaming and gender budgeting commitments.[78] Yet, the initial version of the proposal for a

2. FEMINIST CARE: REVISITING THE POLITICS OF THE INVISIBLE

regulation establishing the RRF was equality blind, disregarding the disproportionate impact of the pandemic on women or minority groups, with no single mention of gender equality or social care.[79] In reaction, the #halfofit[80] petition supported by Members of the European Parliament urged for "at least half of the volume of the recovery and resilience instrument [to be] spent on wom- en's jobs and the advancement of women's rights as well as equality between women and men". Investments in the care economy, the development of resilient childcare services and schools, but also care services from a life-cycle perspective, and the collection of gender-disaggregated data for (un)paid work were at the heart of the demands.

> "A feminist recovery can only materialise if significant investments are channelled into care, reducing the disadvantages from unpaid care whilst ensuring good conditions for care workers."

Eventually, gender equality was merely presented as a horizontal objective in the RRF regulation, with article 18(4)(o) stating that "an explanation of how the measures in the recovery and resilience plan are expected to contribute to gender equality and equal opportunities for all and the mainstreaming of those objectives, in line with principles 2 and 3 of the European Pillar of Social Rights,[81] with the UN sustainable development goal [(SDG)] 5 and, where relevant, with the national gender equality strategy". Member states are expected to explain how the measures in their NRRPs advance gender equality and gender mainstreaming.

Overall, the RRF regulation acknowledges women as one of the social groups most at risk, in particular, due to their overrepresentation in the (health)care workforce, the unbalanced share of unpaid care and the challenges faced by single parents, 85% of them being women.[82] However, that is chiefly as far as it goes.[83] Whilst the regulation is unequivocal for other domains, stating that at least 37 % of the measures included in the NRRPs should contribute to the green transition and at least 20 % to the digital transition, the wording related to care is termed in a significantly less constraining manner, without any comparable threshold or reporting indicator. References remain on a descriptive level, stating that "[i]nvestment in robust care infrastructure is also essential in order to ensure gender equality and the economic empowerment of women, in order to build resilient societies, combat precarious conditions in a female-dominated sector, boost job creation, prevent poverty and social exclusion, and in order to have a positive effect on gross domestic product (GDP), as it allows more women to take part in paid work".[84] Likewise, mainstreaming is referred to in relation to both climate and gender, but in the latter case in an optional manner: the RRF "*is to* contribute to the mainstreaming of climate action and environmental sustainability", whereas "the mainstreaming of [gender equality] objectives *should be taken into account*" (emphasis added). Care is listed neither in the 11 main criteria for assessing the plans nor in the six pillars[85] supposed to achieve resilience for the next generations, which single out children and the youth but not women and other underprivileged groups. When care appears in concrete terms, it is as an add-on to other blocks, as in the regulation's methodology for climate tracking set out in the annex listing possible interventions.[86] It has, however, already been established that, without binding targets, gender and care considerations present slimmer chances of being prioritised in member states' NRRPs.[87]

Therefore, "it is not simply that gender equality concerns should be incorporated into economic policy, but [...] there needs to be an understanding that economic policy already is a gendered policy, albeit one that has often led to increases rather than decreases in inequality".[88] Consequently, due to a general gender blindness to the economic underpinnings of inequality, the European economic governance system falls short of the commitment to gender equality and key principles set out in EU Treaties or in the EU Gender Equality Strategy, which precisely denounces the economic underpinning of inequalities.[89] Considering the significant opportunities offered by the NGEU, feminist analyses are needed more than ever, as European economic governance is entering a new phase with significant room for investments, which, in turn, entails significant gender impacts.[90]

Early research[91] on the gender impact of the recovery supports a care-based approach, gearing towards genuine social transformation, rather than seeing the recovery as part of a linear process towards a return to "normal". In other words, "the kind of recovery that would end the care crisis [...] does not demand a return to a better past but rather a struggle for better future".[92] Starting from the observation that most recovery programmes intend to boost employment by channelling investment in mostly male-dominated sectors (construction/green sectors), there is a need to reconsider how the pandemic has exacerbated care workers' conditions, exposed the poor state of the care infrastructure and seriously imperilled women's employment prospects.[93] Building on previous work warning about the "urgent need for policymakers to adopt an extended macroeconomic perspective taking into account social reproduction, and hence unpaid and informal work",[94] calls are being made for investments in high-quality public services.[95] Pleading for a care-led recovery, it is argued that the recovery must build on social – not just physical – infrastructures and that a care-led – as opposed to a construction-led – recovery has much more to offer in terms of job creation and gender-inequality reduction. Put differently, a feminist recovery can only materialise if significant investments are channelled into care, reducing the disadvantages from unpaid care whilst ensuring good conditions for care workers.

At the EU level, care has often been envisioned from a workers' rights perspective, with a focus on employee leave arrangements for parents, whereas childcare has emerged later with a softer approach focused on setting non-binding targets.[96] Care policy remains a very complex issue to address at the EU level due to limited competences, the marginalised position of care in EU integration and the diversity of care regimes across member states.[97] Arguing that an ethics of care is already embedded in EU law, Caracciolo di Torella and Masselot call for a "holistic approach to care", mainstreaming care across all EU policy fields. EU funding systems tend to equate gender equality largely to social policy, rather than the more prioritised domains of economic policy; this is mainly attributable to the perception of care policies being disconnected from the productive economy.[98] However, the absence of care prioritisation is at odds with the social and economic benefits that investments in the care economy would generate.[99] The care sector has too often been excluded from the market-driven dynamics of the EU. Therefore, placing higher value on care policies and gender mainstreaming requires the sort of paradigm shift to acknowledge well-being and human interdependence as preconditions for the EU's resilience.

At first sight, an analysis of the NRRPs suggests a perceptible commitment to gender equality. Despite limited top-down incentives, with the EU not setting a minimum for spending on gender equality, all

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3. ANALYSING CARE IN EUROPE'S RECOVERY: FROM NEXTGENEU TO THE NRRPS

TABLE 2. Overview of the analysis of care spending across the NRRPs of Austria, Belgium, Czechia, Germany, Finland, Italy, Latvia and Spain.

3.1	**Activities (1)** In terms of overall incidence of care spending in the NRRPs.	**Proactive**: Overall, most countries at the lower ends of the defamilising scale of care regimes exhibit a supportive attitude (**Italy, Czechia**), with some countries standing out in terms of total number for care spending (**Spain**) or overall share (**Austria**).	**Supportive:** Even though countries at the higher ends of individualism care models (**Finland, Belgium**) tend to present fewer care measures numerically speaking, their overall level of support for care measures remains high when compared to the percentage share. This is especially visible in the case of Finland, with a share comparable to that of Spain and twice as high as Italy's, despite its significantly lower grant. Likewise, Finland and Spain are the only two cases to frame care so explicitly as an issue in itself in their respective plans.	**Reactive**: With the exception of Austria, the more countries lean towards familising ends of care regimes, the more the support for care policies remains timid. No countries show opposing attitudes, but the case of **Germany** is most reactive with scant focus on care measures, followed suit by **Latvia**.
3.1	**Activities (2)** In terms of how care spending in the NRRPs mirrors related country-specific recommendations (CSRs).	**Proactive:** Some countries, by opting for care measures beyond what is requested by the CSRs, showcase a certain degree of proactiveness (**Belgium, Italy, Latvia** and especially **Spain**).	**Reactive**: Besides a few exceptions, all care-related CSRs are addressed by most countries, namely, health and pensions systems (**all countries under study**), LTC (**Austria** and **Belgium**), integration of care (**Czechia**), tackling (health)care workforce shortages (**Finland**), female labour market participation (**Italy, Austria, Germany**), inclusiveness in education (**Germany, Austria**) or employment (**Italy, Finland**) and support for disabled people (**Latvia**) or families (**Spain**). In some cases, there is a complete overlap between the CSRs and the NRRPs with regards to care (**Austria, Czechia, Finland, Germany**).	**Opposing:** In a few cases, CSRs are omitted in the NRRPs, namely, in the case of pensions (**Finland, Italy, Germany**).
3.2	**Issues** In terms of the scope of policy fields covered to tackle care in the NRRPs.	**Extensive scope:** **Spain** (7 policy fields) **Austria** (6 policy fields) **Czechia, Italy** (5 policy fields).	**Medium scope:** **Belgium, Finland** (4 policy fields).	**Narrow scope:** **Germany** (2 policy fields); **Latvia** (3 policy fields).
3.3	**Measures** In terms of the types of tools mobilised for care by the NRRPs.	**Diverse set of measures** ranging from legislation reforms to public services, incentives towards employment creation, cash payments, awareness raising, good practises, taxation and social security (especially **Spain**, followed by **Austria** and **Belgium**, although to a lesser extent).	**Main focus on two types of measures**: services and incentives towards employment creation (**Czechia, Italy, Latvia**).	**Sole focus on care services (Germany** and **Finland).**
3.4	**Approach** In terms of how care is valued and presented in the NRRPs.	Care is presented as **valuable in itself** nearing the idea of a "**caring society**" where equality at large is central and where care is everyone's issue (**Finland, Spain**) Care measures **combine some elements valuing care** in itself also acknowledging intersecting inequalities with some elements more explicitly identifying **women as economic actors in need of care support** (**Austria**).	**Care is presented as a cost/burden** and, therefore, corresponding measures contribute to **bending gender equality objectives to labour market participation** striving for a "**thriving economy**" (**Belgium, Italy)** also marked by a lesser concern for minorities (**Czechia, Latvia**).	Marginal attention is devoted to care (**Germany**).
3.5	**Actors** In terms of who are the main actors of care targeted by the NRR.	**Parallel trends of:** **Deinstitutionalisation of LTC**: Care receivers endowed with an **agency** of their own empowered through adequate support for autonomy, offering an important role in the **community**, and **local authorities** taking over from the family, the state or the market. **Institutionalisation of childcare** to **offload the family** (mainly women) with an increasing recognition of **formal caregivers' conditions**. (**Austria, Belgium, Czechia, Italy, Latvia, Spain**).	Less distinction is made between the different phases of care portrayed in a l**ife cycle and degendered approach** topped by a stronger insistence for **self-care and well-being** (**Finland**).	The only care receivers given some degree of attention are children (**Germany**).

Drawing on Elomäki & Kantola (2022), complemented by relevant literature on care. Anna Elomäki and Johanna Kantola, "European Social Partners: Advancing and Opposing European Union's Gender Equality Policies", in *Social Partners and Gender Equality: Change and Continuity in Gendered Corporatism in Europe*, ed. Anna Elomäki, Johanna Kantola, and Paula Koskinen Sandberg, Gender and Politics (Cham: Springer International Publishing, 2022), 171-195, https://doi.org/10.1007/978-3-030-81178-5_8.

3. THE RECOVERY AND RESILIENCE FACILITY: MEASURES AND IMPLEMENTATION OBSTACLES

At first sight, an analysis of the NRRPs suggests a perceptible commitment to gender equality. Despite limited top-down incentives, with the EU not setting a minimum for spending on gender equality, all NRRPs studied have identified it as a horizontal objective, resulting in various types of gender-sensitive spending. However, taking a closer look appears to be necessary to understand how these goals interact with care in the respective national plans. This policy study thus explores how member states have used the opportunity of the NGEU to integrate a care dimension into their own plans, regardless of the absence of an explicit care criterion, unlike the green and digital spending thresholds.

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Central to my analysis of how care is articulated in recovery efforts is the way political discourse also produces corresponding policies.[100] In the context of COVID-19, care has undeniably taken its place in public discourse and its centrality has been widely acknowledged. However, public concern for care does not suffice for the question to be politicised and eventually translated into policy measures and actual spending. This policy study, therefore, compares how care is envisioned within the NRRPs as they were submitted to the European Commission and approved by the Council of the EU (the exhaustive list of documents analysed is available in the Bibliography Section). In practice, the research was conducted using a critical frame analysis method.[101]

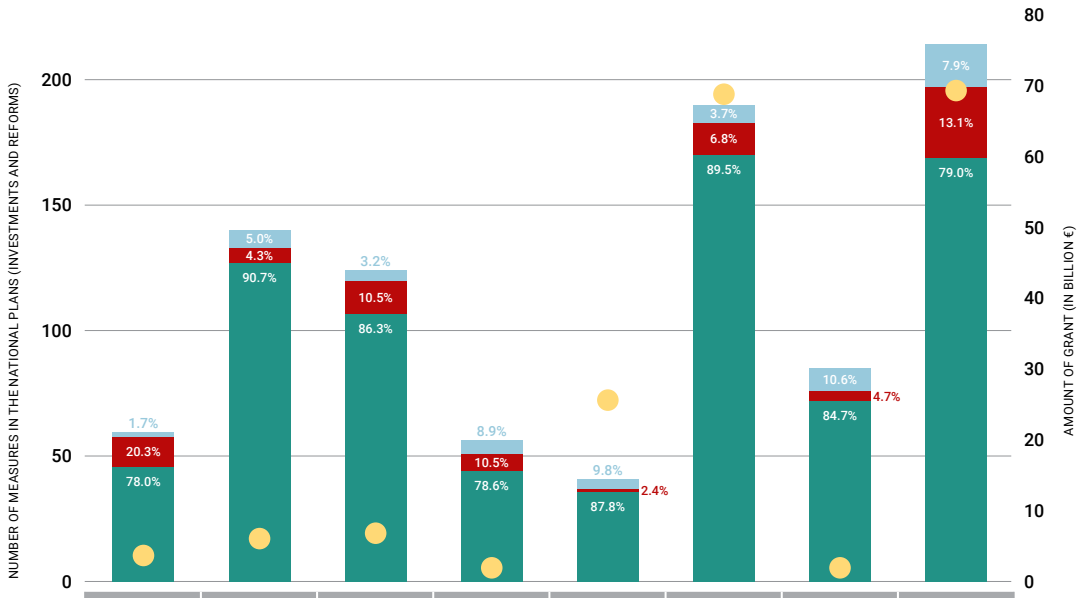
Exploring how policy problems can be portrayed in relation to gender equality within policy documents, it serves to interpret the processes through which the concept of gender equality is "a continuously contested, open concept that can be filled with a variety of meanings".[102] In fact, statements about gender equality – and by extension care – by the member states can be considered as "gender equality performances" and conscious attempts to position themselves as taking the issue seriously, constructing a determined interpretation of gender equality and ways to advance it at the national level.[103] This analysis thus draws on this approach to explore the NRRPs, in terms of the care investment and commitment to reforms (Section 3.1), care policy issues discussed (Section 3.2), the proposed policy solutions (Section 3.3), the different constructions of care and corresponding narratives (Section 3.4) and preferred actors (Section 3.5). See Table 2 for an overview of the analysis.

3.1 CARE IN THE NRRPS: A COSMETIC AFTERTHOUGHT OR AN INTEGRAL COMPONENT?

First and foremost, it needs to be stressed that the NRRPs differ significantly in their general scope and structure. The sheer number of investments and reforms[104] foreseen ranges from a total of 40 to 214, whereas the total sum of non-refundable grants per country also varies from €1.8 billion to almost €70 billion (cf. Figure 2).[105] Not only were "care-focused" investments and reforms identified (referring explicitly and directly to social care), but close attention was also paid to "care-relevant" ones to include more general measures with a potentially relevant impact on care.

The analysis first reveals that the German plan offers only scant coverage of care with no more than one measure considered as being care focused and a few more, secondary, care-relevant ones. By contrast, Spain stands out as the frontrunner in terms of the amount of care-focused and care-relevant measures, followed suit by Italy. In the case of Austria, the total share (20.3%) of spending targeting care outperforms other countries, despite a comparatively lower spending envelope and corresponding total number of measures. Similar observations can be made when comparing the percentage share of countries presenting higher levels of defamilising polices (Finland 12.5%, Czechia 10.5%) with countries presenting lower levels of defamilising policies (Italy 6.8%, Spain 13.1%) in relation to the available grants.

FIGURE 2. Care measures in the NRRPs in relation to overall share of measures and total grant per country.



	AUSTRIA	BELGIUM	CZECHIA	FINLAND	GERMANY	ITALY	LATIVIA	SPAIN
Care-relevant measures	1	7	4	5	4	7	9	17
Care-focused measures	12	6	13	7	1	13	4	28
Other measures	46	127	107	44	36	170	72	169
TOTAL grant (Billion €)	3.46	5.9	7	2.1	25.6	68.9	1.8	69.5

Moreover, the point of entry of care in the respective national plans also differs significantly from one country to another. Every NRRP is structured along thematic chapters with related investment and reform objectives. Showing a particularly strong level of support for care spending, Spain and Finland's NRRPs are the only ones to include a dedicated chapter explicitly and holistically devoted to care. Care is directly connected to equality and inclusion in the former[106] and to social welfare and health in the latter.[107]

In addition to a dedicated chapter, care has been mainstreamed across other chapters, in particular, for Spain (ranging from education to employment, health, taxation, pensions and digitalisation). This sort of mainstreaming across different chapters can also be noted in the way Austria has structured its plan. Although to a lesser extent, the link is made between equality and care in the case of Latvia's (*Reduction of Inequality*) and Germany's (*Strengthening of social inclusion*) thematic chapters featuring most care-related measures.

For Italy, in turn, most care-focused measures are concentrated in the chapter *Social infrastructures, families, communities and third sector*. The very labelling sets a different tone, with a stronger emphasis on family and the community, hinting at the place of care in the private sphere. The main exception is made for childcare, which Italy classifies separately under the education envelope. To a certain extent, Italy's chapter tackling territorial cohesion also addresses care, although on a more general basis (care-relevant measures) through community social services, proximity health facilities and socio-educational interventions to combat educational poverty.

In other cases, care-focused measures are mainly covered as part of the employment (Czechia, Belgium) and social infrastructure chapters (Belgium). A major focus is placed on the physical building capacity of care and its potential for labour market participation by increasing the number of places on offer, with a specific focus on vulnerable groups.

In spite of the persisting barriers to the integration of a meaningful social dimension to the European Semester,[108] it is noteworthy that there is a significant level of symmetry between care measures in the NRRPs and the CSRs formulated in the context of the European Semester in July 2019 and 2020[109] (Table 3). Admittedly, care measures put forth in the NRRPs present an important overlap with some of the challenges pre-identified by the CSRs. All countries are, therefore, called upon by the CSRs to address the sustainability of their health and pension systems.[110] The CSRs were also formulated with specific reference to LTC in the case of Austria and Belgium, the integration of care in the case of Czechia, and to action tackling shortages of health workers to strengthen the resilience of the health system and improve access to social and health services and to (health)care workers for Finland.

For Italy, CSRs focused on female labour market participation, stressing the need to access both quality childcare and LTC. Likewise, Austria was invited to support full-time employment of women and Germany to reduce disincentives to work more hours, including the high taxation of labour earnings, in particular, for low-wage and second earners. Latvia, instead, was requested to improve support for people with disabilities in the realm of social policy. Moreover, inclusiveness through a more general mention of "disadvantaged" or "vulnerable" groups is an issue raised in the field of education (Germany and Austria, including "people with a migrant background" in the case of the latter) and employment policy (Italy, Finland). Finally, the CSRs to Spain called for improved support for families.

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It is noteworthy that there is a significant level of symmetry between care measures in the NRRPs and the CSRs formulated in the context of the European Semester in July 2019 and 2020.

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Looking at Table 3, comparing how the CSRs are mirrored in the measures proposed in the NRRPs, all countries under study show a significant degree of matching with the CSRs, which are mostly addressed within their respective recovery plans.[111] Some member states adopt a more proactive attitude by taking care measures beyond those requested by the CSRs. This is the case for Belgium, Italy, Latvia and particularly Spain. In comparison, Austria, Czechia, Finland and Germany rather display a supportive approach by covering most CSRs in their NRRPs without going much further.

In summary, care measures are present across all national plans under study, although to differing degrees. Figures indicate that the prevalence of care in the plans seems to align with the typology of care regimes at national level, whereas the comparative analysis with the CSRs mirrors the type of measures the NRRPs put forth, despite the limited direct incentives provided by the RRF.

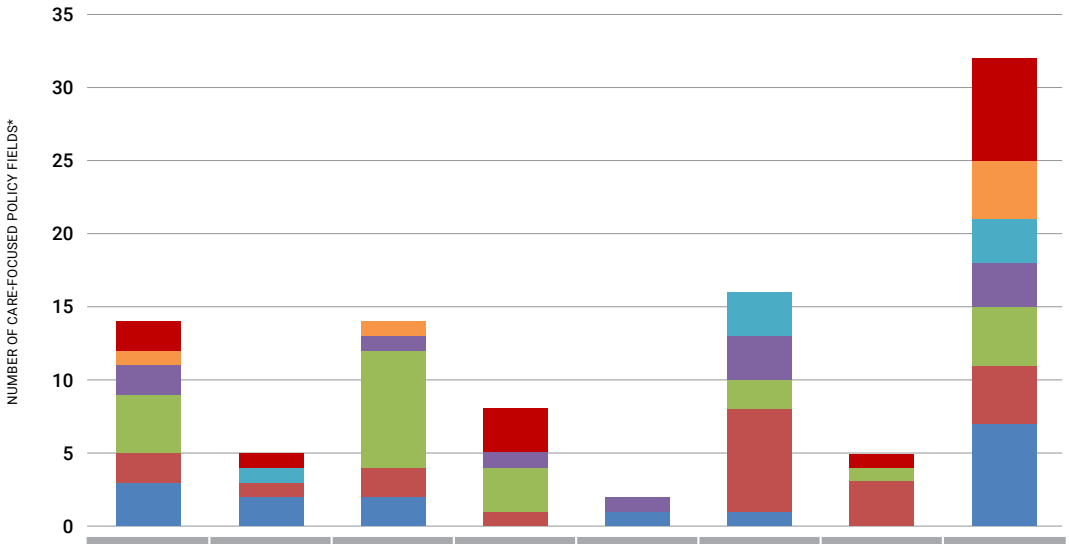
TABLE 3. Symmetry of measures between the NRRPs and the EU CSRs.

	2019/2020 CSRs related to care	CSRs addressed in the NRRPs	Additional measures
AT	Sustainability of pension systems	Yes, with a gender-sensitive dimension	Yes
	Sustainability of health systems	Yes, with a gender-sensitive dimension	
	Fiscal sustainability of LTC systems	Yes	
	Full-time employment support for women	Yes	
	Inclusiveness of education, incl. people with a migrant background	Yes	
BE	Sustainability of pension systems	Yes, with a gender-sensitive dimension	Yes
	Sustainability of health systems	Yes	
	Fiscal sustainability of LTC systems	Yes, with a gender dimension (for Walloon region)	
CZ	(Health)care workers and the integration of care	Yes	Yes
	Sustainability of their health systems	Yes	
DE	Sustainability of pension systems	No	Yes
	Sustainability of health systems	Yes, without gender dimension	
	Inclusiveness of education, incl. vulnerable groups	Yes	
ES	Sustainability of health systems	Yes, with a gender-sensitive dimension	Yes
	Improvement of support for families	Yes, with a gender-sensitive dimension	
	Reduce early school leaving & improve educational outcomes, taking into account regional disparities	Yes	
	Ensure that employment and social services have the capacity to provide effective support	Yes	
	Foster transitions towards open-ended contracts, including by simplifying the system of hiring incentives	Yes	
FI	Shortages of health workers to strengthen the resilience of the health system & improve access to social/health services	Yes	No
	Support employment & bolster active labour market policies	Yes	
	Equal access to social & healthcare services	Yes, including self-care, regional support, good practice sharing/data collection	
	Incentives to accept work & enhance skills and active inclusion	Yes, with a particular attention to migrant people and people with partial work ability	
IT	Female labour market participation, stressing the need to access both quality childcare & LTC	Yes	Yes
	Sustainability of health systems	YES (especially remote areas)	
	Ensure effectiveness of active labour market & social policies & reach out to young people and vulnerable groups	Yes	
	Step up efforts to tackle undeclared work	Yes	
	Improve educational outcomes (namely through adequate investment), foster upskilling (by strengthening digital skills) and address school dropout	Yes	
	Address social exclusion (by improving the adequacy of minimum income benefits, minimum old-age pensions)	No (pension) / Yes (minimum income)	
LV	Sustainability of health systems	Yes	Yes
	Support for people with disabilities	Yes	
	Sustainability of pension systems	Yes, with a gender-sensitive dimension	

3. THE RECOVERY AND RESILIENCE FACILITY: MEASURES AND IMPLEMENTATION OBSTACLES

3.2 ENVISIONING CARE DURING THE RECOVERY: A COMPLEX POLICY ISSUE WITH NO SINGLE ANSWER

FIGURE 3. Construction of care measures across policy fields in the NRRPs



	AUSTRIA	BELGIUM	CZECHIA	FINLAND	GERMANY	ITALY	LATIVIA	SPAIN
Social policy and welfare	2	1	0	3	0	0	1	7
Working conditions and training	1	0	1	0	0	0	0	4
Employment	0	1	0	0	0	3	0	3
Education (school 6 yo 18y)	2	0	1	1	1	3	0	3
Healthcare	4	0	8	3	0	2	1	4
LTC, deinstitutionalisation, adult care	2	1	2	1	0	7	3	4
Childcare (0 to 6y)	3	2	2	0	1	1	0	7

Looking at the specific policy areas associated with each care-focused measures in the national plans, significant differences can also be observed between certain groups of countries (Figure 3).

3.2.1 Scope of policy fields

Spain, followed by Austria, Czechia and Italy display the most extensive scope regarding care issues and the type of policy fields covered.[112] The array of reforms and investments deployed in the Spanish plan is concerned with responding to the rising demands for different LTC needs at all stages of human life. Addressing not just childcare but also elderly care, care for the disabled and the most vulnerable, measures seem to converge with a very broad understanding of care and the inherent vulnerabilities attached to it. Overall, the Spanish approach to care is consistent with its stated endeavour to "align the state budget with the [SDGs], which are underlying the whole plan". Therefore, considering how much gender equality matters across all 17 SDGs, with SDG 5 specifically acknowledging the inequalities arising from the unequal distribution of care work,[113] this encompassing approach to care appears consistent with the spirit of the SDGs.

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Interestingly, it is worth noting that Finland presents social care and healthcare as two almost inseparable sides of the same coin, setting itself apart from other countries that make a more clear-cut distinction between different care recipients. From this perspective, the Finnish plan features a more general but strong insistence on the welfare state throughout most of its care investments and reforms. A central tenet of its care recovery efforts revolves around the implementation of its "care guarantee", with measures entailing support at national level for (1) welfare audits; (2) analysis of human well-being and health; (3) new self-care tools (including mental health promotion methods) that may be used independently; and (4) referral services.

3.2.2. Consensus on support for childcare

Overall, there is one issue for which most NRRPs find common ground: the importance of childcare. The only two cases where childcare is not explicitly addressed are to be found in Finland (see above) and Latvia. Besides these two exceptions, there is a broadly shared consensus for the need to invest in early childcare infrastructures with the creation of facilities and the refurbishment of existing ones.[114] In this case selection, the Italian plan clearly stands out not only for foreseeing the largest number of places newly created (at least 264,480), but also for its marked emphasis on early childhood education and care (ECEC; with a stronger emphasis on education and equal opportunities for children), in contrast with most other plans referring to childcare. In Germany, 90,000 additional places will be made available thanks to the "child daycare expansion" investment. Likewise, Spain foresees investments to establish at least 60,000 new publicly owned and affordable places for children below three years old, including the operative costs, but also teacher's salaries for up to 40,000 new schooling places. Czechia aims to establish 435 new nurseries and to refurbish 370 facilities, stressing the energy efficiency of the newly created buildings. Although exact numbers of childcare infrastructures are not committed to, Austria appears no less determined to meet the Barcelona targets with a childcare rate of 33% for children under the age of three.[115] Whereas both Spain and Belgium place a particular focus on vulnerable groups' access to such services, they differ on the criteria of vulnerability. The former focuses on children in areas of higher risk of poverty or social exclusion and rural areas (as care recipients). The latter focuses on the parents' side by privileging Walloon municipalities characterised by "a low childcare coverage with a low female employment rate, a high share of single parents and a low per capita income" (as caregivers).

Besides the very infrastructural needs for accessible early childcare, social inequalities resulting from childcare responsibilities are also an idea that permeates throughout several specific measures targeting the care

needs of people, as best exemplified by the Italian NRRP. More specifically, families with children considered at risk of poverty or social exclusion are particularly targeted by some minimum-income schemes (Spain, Latvia) and extra school support systems (Austria, Spain, Italy). Similarly, Austria and Spain are particularly concerned with the long-term costs of parents' responsibilities related to childcare within the context of their more general endeavour to ensure the sustainability of their pension systems. The pension-splitting measures foreseen in Austria will serve "to mitigate the effect of interrupted employment histories, [for example,] due to childcare responsibilities, on old-age pension rates" and "to enable the parent who is not primarily devoted to childcare to transfer pension entitlements resulting from employment to the other parent" (p. 90). As underlined in the Austrian NRRP, "it is mainly women who interrupt their employment to bring up children, which leads to long-term financial challenges in retirement due to the lack of contribution periods" (ibid.).

> "Overall, there is one issue for which most NRRPs find common ground: the importance of childcare. There is a broadly shared consensus for the need to invest in early childcare infrastructures with the creation of facilities and the refurbishment of existing ones. "

In a similar but more inclusive vein, accounting for diverse family patterns, Spain intends to invest in the modernisation of social services to strengthen childcare and to introduce a reform to streamline maternity add-ons to "compensate parents, primarily mothers, for the cost of a birth and childcare, in order to reduce the gender pension gap [...] based on an analysis of contribution paths in order to identify which of the two parents was most disadvantaged in their contributory career as a result of the birth of a child, providing that, in the absence of a particularly disadvantaged parent, the mother shall be granted the supplement" (p.247). Although less specifically focused on the cost-of-care imbalances, the federal reform outlined in Belgium's plan foresees the introduction of a "gender test" as part of its pension reform to correct inequalities resulting from women's atypical career paths.[116]

3.2.3 Consensus on support for LTC

Another important component of care addressed in the plans under scrutiny is adult care. To different extents, it is covered in all NRRPs, with just one main exception (Germany). Considering the stakes of LTC, this omission contrasts with other plans aimed at "a people-centred and rights-based support model" to strengthen LTC and to trigger a change in the model of support and LTC. As stated in chapter V of the Spanish plan, "the aim [is to respond] to increasing demand for different LTC services due to an ageing population, promoting innovation and a people-centred care model centred on a deinstitutionalisation strategy" (p. 193).

The Spanish approach is anchored in a two-fold effort to guarantee optimal conditions for care recipients and caregivers. The vision enshrined in the measures translates a real endeavour to gear current care models "towards community care that meets the need and preferences of people in need of support, while ensuring cost efficiency and supporting the families caring for them" (p. 193).

The plans concerned all share a desire to move towards the deinstitutionalisation of long-term care (LTC). National (Spain, Czechia, Italy and Latvia) or regional (Wallonia in Belgium) deinstitutionalisation strategies underpin several care-related measures. This holistic approach to LTC is summarised in a rather telling way by the Czech reform of LTC, which is concerned with the "challenge of fragmented governance and financing of [LTC] and a low proportion of community-based and home-based services in Czechia" (p. 115). Aiming for a legislative reform, the endeavour is to "[better integrate] health and social [LTC], ensure a stable system of adequate financing of quality long-term services, pro- vide incentives for community-based and home-based care, allow access of private providers and improve supervision of social care" (ibid.).

This deinstitutionalisation trend is also visible in the investment plans for the development of public utility housing and housing for vulnerable people in Italy and Belgium (Wallonia), which are to include the construction and energy-efficient renovation of low-rent housing, of inclusive and solidarity-based housing, as well as of homeless accommodation places, with the aim of increasing the supply of social housing for vulnerable groups. Some of the housing should be equipped with modern technologies to delay or avoid the institutionalisation of people with reduced autonomy or to reduce the length of their hospitalisation.

> “Another important component of care addressed in the plans under scrutiny is adult care. To different extents, it is covered in all NRRPs, with just one main exception (Germany).”

In the spirit of this specific approach to LTC, significant attention is given to personal autonomy, particularly through support to people with intellectual disabilities or mental disorders. Spain deploys a detailed action plan revolving around improving the quality of care services, most notably through the construction and refurbishment of (non-)residential and daycare centres with a focus on rural areas. For instance, 11 centres (1,209 places) will be revamped in Spain. Investments in new technologies are also presented as a concrete way of promoting personal autonomy and of providing care in an inclusive environment through telecare solutions. Likewise, the Latvian plan announces that “new places for the provision of [LTC] services close to the family environment, and construction of new [LTC] facilities for 852 seniors in 71 buildings [will be established]”, specifying that “the construction of these buildings shall ensure a maximum of 12 persons per building and fitting each building with appliances, equipment and furniture” (p. 49).

Spain states that at least 90% of the people in the System for Autonomy and Dependency Care (SAAD) shall have access to a basic set of telecare services at home, including services through the telephone line, and specific communications and IT equipment located in a care centre and in the users’ homes.

Overall, the focus often lies on the broad category of “dependent people” without always necessarily distinguishing between the elderly, people with a disability/illness or the different degrees of care needs. It sometimes remains rather unclear who is considered as “dependent” and will eventually benefit from this new model. This is slightly more contrasted in the case of Italy, where measures targeting deinstitutionalisation include reforms and investments seeking to mitigate dependencies related specifically to disability, on the one hand (as does Latvia’s plan), and to old age, on the other hand. The reform for non-self-sufficient elderly people seeks to enhance social services and living conditions in favour of non-self-sufficient elderly people, revolving around the following: the simplification of elderly people’s access to services, the better identification of non-self-sufficiency based on the need for assistance, the provision of a multidimensional assessment and the establishment of individualised projects that promote deinstitutionalisation.

3.2.4 Education and health as care vectors

It lies outside the scope of this policy study to analyse in detail all the education and health measures (care-relevant) in the respective NRRPs. It seems, however, pertinent to reflect on how they have a knock-on effect on (social) care, as none of these fields can be entirely disconnected.

Starting with education, the issue of equal opportunities, inclusiveness and school dropout is a shared concern across most NRRPs, particularly as a result of the learning deficits incurred by the most underprivileged pupils following the pandemic (especially in Austria, Czechia, Germany, Italy, Latvia and Spain). The interventions to strengthen the conditions of access to nurseries and kindergartens is portrayed not just as a way of supporting parenthood but, most notably, is also anchored in an endeavour to eradicate educational poverty, especially in poorer regions.

As far as health is concerned, the main common traits that can be singled out are the promotion of preventive care, universal access to health equity, home-based and community care as a way of reinforcing health systems, the care for long-term illness and social care (Austria, Czechia, Finland, Italy and Spain). In relation to territorial cohesion, Italy encourages complementary health services such as community health houses or pharmacies, which can play a crucial role in rural areas as a point of reference for local populations and "a central element of community life, bringing healthcare as close as possible to citizens". More precisely, these pharmacies are expected to contribute to the integrated home-assistance service. Then comes medical care, illness and patients with critical health conditions. In the case of Czechia, a significant set of measures seek to improve its ability to provide medical and supportive care for patients with more critical health conditions. Echoing the above-mentioned trend of deinstitutionalising LTC, the Austrian investment in the implementation of 150 community nurses posted nationwide offers a rather illustrative example of the "establishment of community nursing [...] to make a significant contribution to local, low-threshold and needs-based care" (p. 75). As underlined in the plan, "community nurses are central contact persons who coordinate various services (such as therapies and social services) and play a central role in the field of prevention [being] close to their patients" (ibid.).

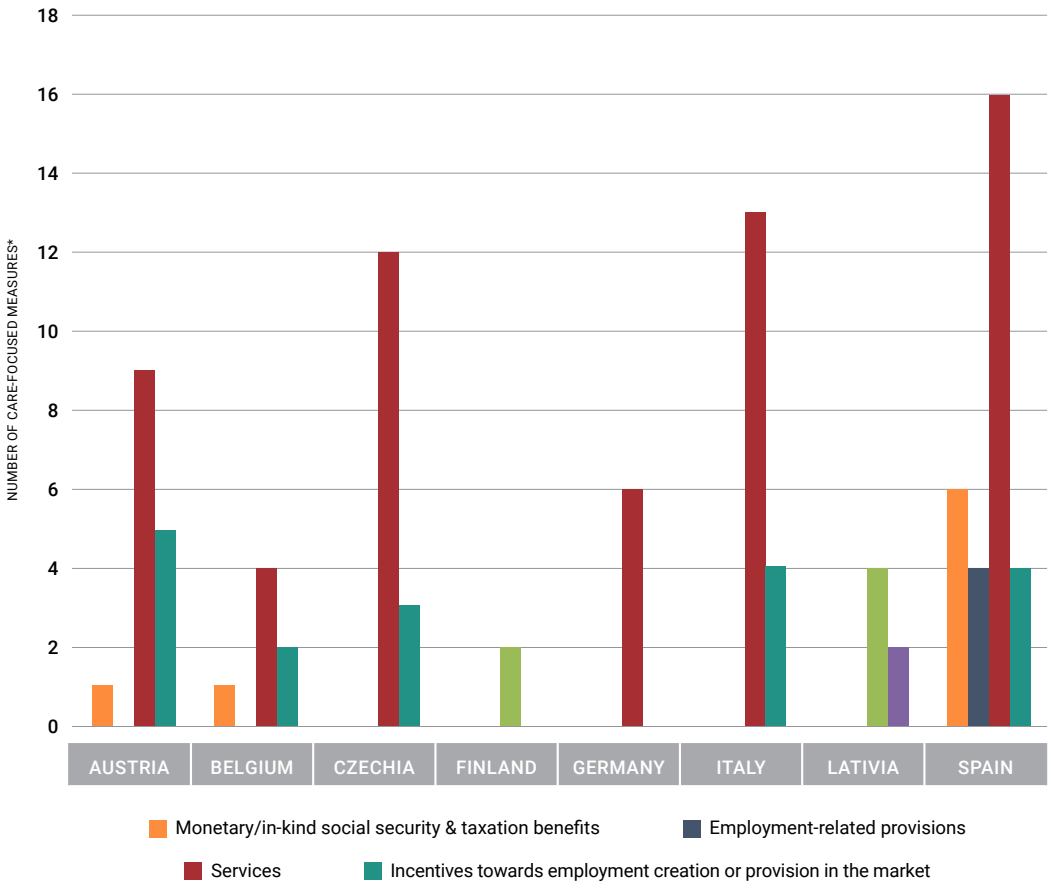
Additionally, Austria is the only country specifically addressing gendered and intersectional inequalities in healthcare with investments for pregnant women and young mothers from socially disadvantaged situations. The aim is to support families in vulnerable situations during the period of pregnancy and beyond through "preventive interventions throughout the phase of early childhood by improving and extending already existing support measures, setting up regional 'early aid' networks and establishing cooperation among all relevant institutions and services in the field of early childhood" (p. 69).

3.2.5 The care dimension of employment

Incentives towards employment creation in the care sector are most explicitly stated as part of countries' efforts to meet the current shortages through active labour market policies. In particular, attention is paid to professional training in caring professions (Spain, Austria), raising the number of people with a higher education degrees targeted at sectors such as social and health care (Finland), reforms addressing shortages of nurses and doctors to strengthen professional skills or the modernisation of sub-contracting activities (Spain). Austria, moreover, offers flexible training methods and focuses on supporting women within its reskilling investment scheme.

As can be drawn from the above, the care measures deployed by member states span a broad policy spectrum, with different degrees of cross-country overlap. In short, it emerges quite clearly from this focus on care policy fields that the shared concern for care deficits does not necessarily translate into the same policy answers targeting care. The general trends can be grouped following similar clusters to those identified in the care regimes: countries leaning towards the familialism care regime adopt a narrower scope of care policy fields (Germany, Latvia); countries using individualism models are characterised by a medium scope (Finland, Belgium); countries with lower defamilising policies showcase the most extensive scope (Czechia, Italy, Austria and Spain).

FIGURE 4. Care spending according to care policy typology based on the four-fold classification of care.



*Some measures entail multiple types of policy action and, therefore, appear in each relevant field.

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3.3 A MEASURES TOOLBOX GRAVITATING TOWARDS A SERVICE-BASED APPROACH

This subsection focuses on the particular types of policy supported by the NRRPs. It draws on Daly's four-fold classification of care policy tools mentioned above.[117]

3.3.1 Care services at the centre of recovery plans

The category of services in the typology of care policy measures is by far the most common instrument put forth in the NRRPs, particularly through the construction of new infrastructures and the renovation of existing ones.

For childcare, not just the physical extension of affordable places is targeted,[118] but also their form (e.g. "emergency childcare" for job-seekers in Belgium), scope and duration (e.g. investments to finance the extension of school time, as in Italy). For services towards adult care, the focus lies in enabling the transition from institutional LTC provision to a more community-based care model, as in Austria, Czechia, Italy, Latvia and Spain. The construction/renovation of LTC facilities, and the purchase of appliances, equipment and furniture, is coupled with investments to improve the accessibility of public services at large (outside LTC facilities), to improve the infrastructure and equipment in buildings where services will be provided.

Investments in new technologies to enhance telecare is a common care service proposal across the plans. For instance, telephone lines and IT equipment located in a care centre or in the users' homes, investments in technology for LTC support and digital support for people with disabilities. The digitalisation of care through the promotion of telemedicine and telecare shifting the burden from hospital care is an idea that is also seeming to gain popularity "[w]ith a view to promoting integrated and patient-centred healthcare, improving the accessibility, quality and resource efficiency of health services" (Latvia). Finland emphasises the need to introduce a "person-centred information system" in remote areas (Åland Islands), whereas Austria opts for home-based healthcare services privileging the in-person service with community nurses.

Besides the investments in purely infrastructural types of services, some plans also invest in guaranteeing universal and inclusive access to healthcare and education (Austria, Czechia, Finland, Germany, Latvia). Finland focuses on "reducing the backlog in provision of services arising from the COVID-19 pandemic", particularly for heath and LTC treatments. Spain foresees awareness-raising campaigns to promote their deinstitutionalisation strategy and healthy lifestyles and environments to strengthen preventive care, whilst Finland aims to strengthen its knowledge base in decision-making to increase the cost-effectiveness of social welfare and healthcare services by promoting research into good practices and developing effective monitoring. Moreover, Spain foresees the modernisation of social services and the redefinition of the "family" through legislative change, with some components impacting on care and access to social services.

3.3.2 Care measures beyond services

Moving on to the remaining types of care policy instruments, these are much fewer and farther between in the plans compared to services. There is some degree of attention to monetary and in-kind social security and taxation benefits, with cases like Spain standing out. In the realm of childcare and support to families, Spain is the only case where actions aim to improve the legal protection and material support (in cash and in kind) for families, with a view to reducing child poverty. It plans on "increasing the coverage of the different types of financial benefits" as part of its reform on strengthening LTC and promoting a change in the model of support and LTC. Additionally, Spain plans to establish a committee of experts for tax reform "to examine the features of an optimal tax system and make recommendations on how to modernise and adapt ccurrent taxation in a coherent manner" with specific attention paid to gender equality (p. 235).

One area within the monetary and social security typology where Spain is, at least partially, joined by Austria and Belgium regards the pension measures mentioned above. Although not specifically care-focused, minimum vital income schemes, as proposed by Spain and Latvia, are still relevant in this regard.

A general tendency to ensure incentives towards employment creation or provision in the market is, at least partially, covered by most countries focusing on the supply of skilled labour generally in sectors with shortages (Belgium, Czechia, Latvia) or specifically targeting care workers (Austria, Italy) and, to some extent, providing decent conditions for care workers (Spain,

Italy). By contrast, (in-)employment provisions in the care measures typology are almost entirely absent, as far as provisions such as (un)paid care leave or career breaks are left largely untouched in the package of measures put forth, despite the general trend for adult care towards deinstitutionalisation identified above and, hence, a greater shift to families. Instead, most measures are geared towards keeping people, as many and for as long as possible, active in the labour market, leaving gendered considerations behind.

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(In-)employment provisions in the care measures typology are almost entirely absent, as far as provisions such as (un)paid care leave or career breaks are left largely untouched in the package of measures put forth.

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From the above considerations, three different patterns can be identified. The first group of countries resort solely to care services, although the countries concerned (Finland and Germany) happen to lean towards opposing ends of the (de)familising matrix of care regimes. The second group of countries (Czechia, Italy and Latvia) concentrate their efforts on care services and employment creation, which are commonly portrayed as two sides of the same coin. The third group relies on a more diversified set of measures, with Spain best exemplifying efforts to tackle care deficits by proposing a whole raft of measures of different kinds, timidly followed by Austria and Belgium. Although these observations must be interpreted with caution, it is nevertheless worth noting an apparent tendency to align with defamilising policies through a dual strategy based on employment creation and care services, topped up by additional measures where the willingness to transform the organisation of care seems the greatest.

3.4 CARE MEASURES: HOW MANY STRIKES WITH THE SAME STONE?

Whilst the disproportionate burden of care on women is largely acknowledged, this subsection discusses how care is articulated with (gender) equality concerns in the NRRPs. Significant differences appear between member states regarding the way they construct care issues with (gender) equality concerns.

3.4.1 Care as a burden for growth

Several NRRPs almost systematically associate care policy with gender considerations on female labour market participation and economic growth (Austria, Belgium, Czechia and Italy). Whilst Italy's employment measures feature several gender-specific commitments (i.e. investments promoting gender equality and equal pay through the gender-equality certification system and the promotion of female entrepreneurship), these measures mostly contribute to increasing the level of participation

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of women in the labour market without necessarily counterbalancing the remaining care inequalities at home. Although the creation of women's enterprise does give care responsibilities some consideration – for example, supporting the start-up of women's entrepreneurial activities through mentoring, technical-managerial support, measures for work-life balance in Italy – such initiatives fall short of the need to "move beyond fixing women and instead fix our systems".[119] Likewise, the issue of unpaid care is hardly ever raised across the NRRPs.

In a similar vein, seeking to address the challenges in the labour market and social care, Czechia's plan focuses on how to "foster the employment of women with young children, including by improving *access to affordable childcare, and of disadvantaged groups*", namely, "*to facilitate [the] return of* parents, in particular mothers, to work after parental leave" (p. 115). The stated objectives of "tackling persistent gender inequalities in the labour market, in particular the low labour market participation of women with small children" (p. 114) do not, however, give much consideration to how this increases the care responsibility on other, less privileged women in the poorly paid care economy without addressing the need to better value the latter and to make men "equal carers" as well. Overall, genuine efforts to move beyond the mother-father-child imaginary remains rather limited and uneven.

Likewise, care often remains framed as a burden, rather than a central activity in human life. This is perceptible in the general tendency to present care and (women's) labour market participation almost automatically side by side. As presented in Italy's investment plan for nurseries, preschools and ECEC services, the "measure is expected to encourage women's participation in the labour market and support them in reconciling family and professional life" (p. 412). That same understanding of care as a burden also permeates in Belgium's plan in how childcare is offered on an *ad hoc* basis, providing "emergency" childcare for parents that were recruited to follow training as a part of the "re-qualification strategy" of the Brussels-Capital Region. It seeks to ensure the sustainable integration of vulnerable groups in the labour market via supporting measures. In other cases, this labour-oriented approach is particularly visible in two ways: the introduction of disincentives to part-time work and the incentives to externalise care duties as much/early as possible. For instance, Austria's pension reform to increase the effective retirement age additionally provides "incentives to return to work after a period of childcare". Hence, investments are geared to "expand the provision of childcare facilities, particularly for the under three-year-old and the opening hours for the three to six years old, to facility [*sic*] the reconciliation of work and family life", seeking to improve early childhood education. Moreover, Austria and Italy will create incentives to extend the opening hours of elementary educational institutions for children from three to six years old.

This focus on employment support is not matched with an effort to present the care economy itself as a job-creating or rewarding sector. Despite much talk of the importance to increase the adaptability of workers through reskilling/upskilling and labour mobility (Belgium, Czechia and Latvia), limited reference is made to the potential opportunities of investing in the skills of workers to orient themselves to the care sector, as if care work was not considered skilled work, as opposed to the provision of digital skills, for instance. Spain and Austria are the only exceptions to explicitly include care jobs in the list of professions for labour mobility.

Away from the idea of a "caring society", this approach seems more geared towards the promotion of care as a means towards a(n) (economically) "thriving society". The recurring focus on employment creation and the concerns for "reconciling work and family life" to enhance competitiveness and market-oriented aims is felt in how the plans mobilise gender equality in relation to care.

3.4.2 Care as an aim in itself

A different approach can be detected in the plan of Finland. Whilst pursuing similar goals of improving employment conditions, the Finns take a much more degendered approach to tackle disadvantage "among under-represented groups" without systematically stigmatising women or a specific category. In Italy, the investment plan financing the extension of school time to increase the educational offer of schools is not only "expected to have a positive impact on the fight against early school leaving" (p. 413), but it also brings it more in line with changing family patterns and working arrangements.

> "The focus on employment support [in the national plans] is not matched with an effort to present the care economy itself as a job-creating or rewarding sector."

Contrary to most countries more explicitly connecting gender equality with childcare, the Spanish reforms also excel at applying a degendered and equality approach to care. Promising efforts in the direction of acknowledging changing family patterns can be illustrated with the Spanish reform to adopt a new law on protecting families and recognising their diversity.[120] Additionally, the Spanish plan is the only case explicitly committing to gender mainstreaming, which is visible in its labour policies and in the development of a tax system "more fit for its purpose" with the aim of incorporating a gender perspective. Again, Spain's maternity add-on for parents, mostly mothers, to compensate for the penalty incurred after childbirth offers another illustrative example of how the Spanish approach to care policies underpins transformative equality objectives focusing on the need to correct other forms of inequity, which won't be erased by the mere principle of "equal rights for all".

Beyond gender-equality concerns related to care, it has been widely evidenced that not all women are faced with the same care injustices.[121] And yet, hardly any direct reference is made in the plans to how care recipients and caregivers may face specific difficulties or needs due to intersecting inequalities. Considering, for instance, how much most countries rely heavily on a migrant workforce to keep their care systems running,[122] this leaves the plans with a major caveat. The invisibility of women within minority groups based on ethnic origin, migration background or sexual orientation in the care process is striking. As underlined by the Council's observations on the Czech plan, it is unclear how the measures will address the challenges faced by the Roma community, not to mention that reference to LGBTQI+ rights does not appear even once in any of the plans. Similarly, despite the vulnerabilities faced by elderly, disabled or migrant people, the gendered experience of these conditions is obscured.

This being said, Finland's investment to introduce digital innovations for social welfare and healthcare services "shall take into account vulnerable people's need to ensure accessibility". Additionally, Spain includes reforms and investments to improve the reception systems for migrants and asylum seekers, as part of its chapter "action plan for the care economy, strengthening equality and inclusion policies", herewith placing the need to address care gaps on the same footing as addressing the needs of migrants.[123] It is not without significance that measures concerned with the protection of – or one may say *the care of* – asylum seekers and migrant people are integrated as part of the chapter dedicated to

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As underlined by the Council's observations on the Czech plan, it is unclear how the measures will address the challenges faced by the Roma community, not to mention that reference to LGBTQI+ rights does not appear even once in any of the plans.

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care. What is tempting to interpret as a caring attitude towards the most underprivileged of society is applied a similar way for female victims of gender-based violence, for whom Spain dedicates a specific action plan, tackling this phenomenon through three specific investment plans, including, for instance, telephone and online support services. In a similar fashion, Belgium plans the creation of 700 public utility inclusive and solidarity-based accommodation places for poorly housed groups, which include migrants and female victims of violence, as well as homeless people, isolated people and those at risk of exclusion.

In the remaining NRRPs, the closest we arrive at the situation of care workers from underprivileged backgrounds can be found, indirectly, in some labour market measures to address sectoral shortages and discrimination. These two issues concern the care sector in particular.[124] The Belgian plan foresees a number of federal and regional reforms stepping up the fight against discrimination in employment. Labour market discrimination is tackled either through corrective measures (e.g. improving the federal regulatory framework of discrimination tests) or through positive actions enhancing the integration of vulnerable groups (e.g. integrating job seekers with

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disabilities for Brussels, with a migrant background for Flanders or women at the federal level).

In the case of Germany, a real gender assessment of care policies is rather challenging, given the very limited space offered to care in the plan. At the same time, it can in itself also be rather telling as well.

In summary, this subsection confirms the conception of gender equality as an elastic concept open to diverse meanings, whereby its interaction with care can be distinguished according to certain patterns. Most countries with lower levels of familising policies tend to bend gender equality to employment participation (Belgium, Italy) topped with a general lack of concern for minorities (especially in Czechia, Latvia). However, it seems that some countries stretch gender equality to encompass intersectionality and to care as a universal value essential in any egalitarian society (Finland, Spain). Instead, countries on the other end of the familising policies matrix of care regimes either seem to shrink the issue (Germany) or to place themselves in a central position by combining elements of gender equality with employment- and care-oriented regimes (Austria).

3.5 ACTORS OF CARE: BETWEEN EMERGING COMMONALITIES AND PERSISTING WEAK LINKS

What unites most NRRPs is a general tendency towards the deinstitutionalisation of LTC and the institutionalisation of early childcare. For the different actors involved in the different phases of care, this entails several important implications.

3.5.1 Towards the deinstitutionalisation of LTC

First and foremost, the recognition of the agency of LTC recipients as individuals seems to have gained significant ground. The measures put in place do not just consider them as mere end receivers in the care chain but as genuine actors within the care process. The recurring insistence on care receivers' rights and autonomy offers a reliable indicator of this endeavour. The plans of Czechia and Spain ground their actions on the UN Convention on the Rights of Persons with Disabilities as an important point of reference. Hence, care receivers are not portrayed as passive or dependent but as actors engaged in other relationships than just in care relationships, namely, as citizens equally contributing and necessitating access to public and community life as bearers of equal rights as well as job seekers with equal rights.

There is a rather visible willingness across the NRRPs to ensure the autonomy of vulnerable people moving on from the image of care recipients (particularly people with disabilities) to that of autonomous job seekers with equal rights. This empowerment pattern from "vulnerable" to "working" people constitutes a constant feature amongst the NRRPs. Italy's plan connects it directly with the broader objective of deinstitutionalisation "by providing community and home-based social and health services in order to improve the autonomy of people with disabilities". In other words, "[the] measure shall promote access to housing and job opportunities, including new possibilities offered by information technology". Likewise, an important detail is that Finland not only speaks of "people with disabilities" but of "people with partial work ability", whose employment rate it seeks to enhance through supporting investments to improve mental health and work ability.

With some semblance of Tronto's notion of interdependence[125], several measures offer a greater place to the "community" to replace traditional providers of care

(the family, the state or the market). The Italian Reform on the Framework Law for Disability endeavours to "modify the legislation on disabilities and promote the deinstitutionalisation (i.e. transfer from public or private institutions to their families or into community-based homes) and autonomy of people with disabilities" (p. 508). The same applies to investments, which should favour home-based and community-based care settings with respect to the principle of freedom of choice and independent living, as in the case of Czechia's investment in the development of social care.

> "The recognition of the agency of LTC recipients as individuals seems to have gained significant ground. The measures put in place do not just consider them as mere end receivers in the care chain but as genuine actors within the care process."

By that logic, other investments in Italy oriented towards territorial cohesion through the enhancement of community social services and infrastructures also seek to tackle "social exclusion and marginalisation, by intensifying the provision of services through the increase of funds for public services delivered by the local authorities" (see also Austria, Belgium, Finland, Spain).

Although not using the label of deinstitutionalisation, as such, Latvia similarly allocates specific investments to the "resilience and continuity of the long-term social care service" in order "to enable the transition from institutional [LTC] provision to more community-based care model" (p. 49). The new LTC model promoted by Latvia is presented as a way to shift from institutional to "family-type" care for people of retirement age, thereby also extending the traditional conceptualisation of the "family".

3.5.2 Towards the institutionalisation of childcare and (formal) care workers' employment conditions

The opposite trend concerns childcare and its growing institutionalisation. Here, we see a generalised attempt to offload the family (mainly women) as the main actors of childcare. Whilst it is obvious that a mother's agency has a lot to gain from transferring disproportionate care responsibilities to early childcare facilities and schools, this institutionalisation trend is also reflected in the construction of caregivers, with a somewhat different treatment between paid and unpaid carers. An unpaid carer's main form of support depends essentially on the availability of childcare facilities, leaving other aspects of social reproduction blatantly untouched, particularly domestic work. Paid, face-to-face carers, in turn, are given at least some degree of recognition, although it remains questionable whether the attention received is proportionate, given their ever-increasing role and the severe lack of valorisation of their work.

Even without being framed as care-focused, the relevance of some general measures remains crucial. In particular, Spain offers a wide range of social reforms for the modernisation of collective bargaining, the regulation of teleworking, closing the gender gaps (as also Italy), the simplification of labour contracts towards the generalisation of open-ended contracts, the modernisation of active labour market policies and subcontracting activities, mechanisms for internal flexibility, the review of hiring incentives, female employment and gender mainstreaming in active labour market policies (namely with training actions in LTC and support for female victims of violence or trafficking). Similarly, addressing undeclared work (e.g. Italy) is likely to improve the working conditions of care workers, avoiding labour exploitation, whereas strengthening the dual system and the universal civil service can bring about new incentives for young adults, who might opt for careers in care work.

On a more specific level, reforms to strengthen professional skills and reduce temporary employment are addressed to face the shortages of nurses and doctors (Spain, Latvia, Austria or in some ways Belgium in terms of "promoting labour mobility towards sectors facing shortages") and recruitment of teachers (Italy). With its reform on enhancing primary health care, Austria seeks to "promote the attractiveness of working conditions for general practitioners *and other health and social professions* in primary health care, particularly in rural areas".[126] The solutions offered by the Austrian investment is "to improve the skills and competences of unemployed,

particularly the low skilled, to prepare them for the future challenges of the labour market and to make them less vulnerable for future spells of unemployment", which is one of the rare cases to identify care skills – nursing, social and caring professions – in addition to technical and digital competences more often framed as future-oriented. Moreover, the funding shall also concentrate on offering flexible training methods and focus on supporting women.

Whilst member states play an important role, given the inherently social nature of care policies, municipalities are recognised as important actors in delivering care, using the opportunity of the RRF to empower local and regional authorities with care-relevant funding. For instance, municipalities "which combine a low childcare coverage with a low female employment rate, a high share of single parents and a low per capita income" will be targeted by investments for the creation and renovation of ECEC infrastructure in Wallonia (Belgium). Likewise, municipalities in Czechia are tasked with the direct implementation of the establishment of additional social care facility infrastructure based on the assessment of territorial needs (as also in Italy and Latvia).

Last, but not least, Finland's NRRP stands out with its cross-cutting focus on self-care and well-being as individuals are acknowledged as fully fledged actors of their own care.

All in all, in the case of actors of care, a certain level of convergence can be noted amongst most countries striving towards the institutionalisation of childcare and the deinstitutionalisation of LTC (Austria, Belgium, Czechia, Italy, Latvia and Spain, with Finland going a step even further); only one country appears as an outlier (Germany).

4. CONCLUSIONS AND RECOMMENDATIONS

The post-pandemic recovery impetus presented the EU and its member states with unique momentum to ignite a transition towards a fairer, more socially sustainable and caring Europe. The sort of recovery that would fix the care crisis experienced for several decades requires more than a return to normal but asks for transformative answers rooted in a care-led recovery.[127] Echoing previous work stressing the need to put care at the heart of the EU's recovery – and more precisely the NextGenEU instrument – boosting efforts to counter the adverse effects of the COVID-19 pandemic at the national level,[128] this policy study has, therefore, conceived of care as a key component for a genuinely more resilient Europe. By engaging with the feminist literature on care to analyse the resulting NRRPs, the results suggest that the extent of the negative impacts of the COVID-19 crisis disproportionately incurred by women and underprivileged groups has been mirrored to a limited extent in the response offered in the NRRPs of the eight countries selected in this policy study (Austria, Belgium, Czechia, Finland, Germany, Italy, Latvia and Spain).

Firstly, the analysis shows that the respective national plans all address care, although with substantial variations and to a significantly lower extent than that of other policy domains. Admittedly, the EU's RRF offered rather limited incentives for member states to foster a care transition. The extent to which the resulting investments and reforms put forth in the NRRPs to tackle care inequalities thus relied, to a large extent, on member states.

Secondly, a close-up examination of care in the NRRPs suggests that NexGenEU, as it currently stands, is rather unlikely to lead to a harmonised care-led recovery due to the persisting divergences in the distribution of care responsibilities amongst member states[129] and the lack of clear EU incentives. Three main clusters can be distinguished. Countries characterised by a higher defamilising policy level exhibit a moderate incidence of care spending in their recovery plans (Finland, Belgium). Care investments and reforms find the highest level of occurrence in countries under the implicit individualism/familialism models, where both familising and defamilising policies rank comparatively lower (Spain, Italy, Czechia). Instead, countries leaning towards the higher ends of familising policy patterns display an incidence of care-focused measures in their NRRPs that is either much lower (Germany, Latvia) or much higher (Austria). Similar clusters to those above appear insofar as the range of policy fields covered in the NRRPs are concerned: individualism care regimes cover a medium range of policy fields related to care spending (Finland, Belgium); implicit individualism/familism care regimes feature a more diverse range of policy fields connected to care spending (especially Spain, followed by Italy and Czechia); countries leaning towards the familism regime relate their care measures either to a very narrow (Germany, Latvia) or to a very diverse (Austria) range of policy fields. Although the predictive capacity of these resulting clusters must be treated with caution, care being such a complex social good,[130] these observations tend to corroborate the idea that the recovery has the potential to serve as a springboard towards a care paradigm shift in countries with lower levels of family support *provided there is the prior will to do so*.

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Beyond the sheer numerical prevalence of care in the list of measures, the third major finding concerns the way the NRRPs frame care inequalities. On one hand, this policy study shows a general convergence towards rather similar solutions. There is a general tendency to strive for the institutionalisation of childcare and the deinstitutionalisation of LTC, with most NRRPs channelling a portion of their care measures into care infrastructures and other related services. On the other hand, the recognition of the underlying problems behind care imbalances

is framed in rather contrasting ways, whereby the care regime models are somewhat less helpful at determining corresponding trends. Many countries still present care responsibilities as a cost or burden to be mitigated (Belgium, Czechia, Italy, Latvia). Other countries follow a different path by presenting care as valuable in itself and, therefore, positioning it as a central issue as part of a "caring society" (Spain, Finland). By connecting care measures more explicitly with concerns for inclusiveness, social fairness and welfare protection, the understanding of gender equality is stretched to care policies. In other cases, measures combine elements of the first two scenarios (Austria) or simply offer too narrow a focus on care to allow the underlying approach to be fully grasped (Germany), which is also telling in itself. Additionally, the very types of tools the care spendings resort to in the NRRPs reinforce this idea. The overwhelming majority of countries focus almost exclusively on services-centred measures, whereas in-employment care-leave provisions are outrightly omitted, despite the case of Spain, which stands out for opting for more diverse types of actions to top up care services with gender-sensitive pension schemes, taxation, and monetary and in-kind social security benefits.

Last, but not least, the analysis brings a more nuanced picture to the fragmented nature of care in the NRRPs, partly validating and partly challenging it. As opposed to the usually more restricted focus on childcare and work-life balance,[131] examination of the NRRPs reveals a broadly shared tendency to adopt a life-cycle perspective. This comprehensive approach to care is also made evident in the way all phases of care[132] are given at least some degree of consideration. In particular, care giving and care receiving are addressed on multiple occasions, placing specific emphasis on skills and personal autonomy. This approach is attentive to care receivers and caregivers, whose well-being and dignity is generally valued through measures to foster the agency of the former and the working conditions of the latter. The analysis also reveals a shared effort to enhance the role of community care rooted in a people-centred model. In that sense, care measures are shaped to empower the different care actors whilst recognising the importance of local ties (e.g. local pharmacies) and solutions (e.g. community nurses and midwives) to facilitate and value all phases of care. However, some major caveats persist when it comes to other equally essential aspects of the different phases of care. Whilst women are largely acknowledged to bear the consequences of the care crisis, the solutions offered (care services) only seem to scantly account for – if at all –the fact that most of it relies largely on a precarious workforce at the crossroads between multiple inequalities based on gender, migrant background, racial/ethnic origin and socio-economic status. In that sense, the fragmentation of care is perceptible here insofar, as most NRRPs fail to acknowledge the inherently intersectional and cross-border dimension of the problem they identify, although with some notable exceptions (e.g. Spain, Finland). Likewise, the worth of non-nurturant and domestic care is hardly touched upon, further entrenching the vicious circle of the "double devaluation" of care work,[133] which is mainly performed by underprivileged groups. Despite significant efforts to move towards a more comprehensive understanding of care, the analysis thus indicates that not all aspects or actors of care are treated equally in the NRRPs.

The lessons learnt from this feminist care analysis of the NRRPs have clear implications and resonate particularly strongly in the current context, not least because the EU unveiled its commitment to care by putting forward a European Care Strategy.[134] After all, a socially sustainable recovery will remain incomplete without a transformative care transition putting into action the idea of a "caring society as a blueprint for ensuring our Union emerges from the current crisis stronger, more united and with greater solidarity".[135]

In light of the above considerations, this policy study calls for the EU and its member states to use the current momentum to take bolder leadership in the realm of care policy, acknowledging its centrality, but also its inherently cross-border nature. This can be done by focusing on the following recommendations:

Timely and effective implementation of care investments and reforms at the national level. First and foremost, it needs to be seen whether those commitments to care investments and reforms identified in this policy study are taken seriously by member states. Moreover, member states need to concretely demonstrate that their plans have had a positive impact on gender equality and on addressing care deficits.

Close-up care monitoring. Throughout the process, the European Commission needs to monitor the implementation of the NRRPs closely, keeping a close eye on the implementation of care spending outlined in the respective national plans through the RRF scoreboard[136] and the relevant common indicators identified. To this end, the collection and analysis of sex-disaggregated and intersectional data based on adequate care indicators should be applied to capture the real impact of the respective national recovery plans (in)directly targeting care.

Gender-impact assessment and care mainstreaming. Considering the lessons learnt about the gendered nature of economic crises, the EU must apply gender mainstreaming and budgeting principles with a transparent, comprehensive and meaningful tracking methodology from the very early phases of policy design. Likewise, member states need to make use of funding programmes and opportunities to proactively build capacity for sound gender-impact assessment and gender/care mainstreaming tools at national and local levels.

Prioritisation of social and care-oriented investments. There is an urgent need to address the lack of focus on the care economy to give it a central place on the EU policy agenda on an equal footing with other policy priorities like the green or digital transitions. Considering how marginally care has been mainstreamed in other domains, this needs to be reflected in ambitious and binding policies accompanied by substantial funding to embed value in care and elevate the care sector through qualitative care services. In particular, this can be done through the multiannual financial framework (MFF) mid-term revision, which offers the opportunity to adapt the programming to redress the focus on the care economy.

Ensure accountability. The European Parliament and the Council need to hold the European Commission accountable for the submission of regular review reports on the impact of the recovery plans, which they need to critically assess in a gender-sensitive and care-oriented manner.

Binding tools and feminist EU economic governance for a care-led recovery. Considering the visible relationship between EU-induced requirements and resulting measures put forth at the national level (cf. the impact of spending thresholds for the green and digital transition as well as the symmetry between CSRs and the NRRPs), upscaling of the place granted to care and gender-sensitive policies through binding tools and governance mechanisms appears essential.

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106 Cf. chapter "Action Plan for the Care Economy, strengthening equality and inclusion policies" of the Spanish NRRP.

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RECOVERY WATCH

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Considering that the NextGenerationEU fund was set up precisely to help member states repair the immediate socioeconomic damage brought about by the coronavirus pandemic whilst enhancing their post-pandemic resilience, this policy study applies a feminist reading to explore how care is addressed in this historic EU fiscal stimulus tool. It analyses how member states have used the opportunity of the NGEU to integrate a care dimension into their own plans, regardless of the absence of an explicit care criterion, unlike the green and digital spending thresholds.

By engaging with the feminist literature on care to analyse the resulting national recovery and resilience plans across Austria, Belgium, Czechia, Germany, Finland, Italy, Latvia and Spain, the ambition is to understand to what extent the NRRPs have adopted a care-led approach in response to the care crisis undeniably exacerbated by COVID-19. An in-depth qualitative analysis of the national plans, complemented by a quantitative assessment, offers several elements of response.

Firstly, despite the limited incentives to foster a care transition, the national plans studied all address care, although to a significantly lower extent than other spending priorities. Secondly, the scope of care measures in the national recovery and resilience plans mirrors the pre-existing care regimes in place to a significant extent. The third major finding reveals that there is a general convergence towards similar solutions, with the institutionalisation of childcare and the deinstitutionalisation of long-term care, but the recognition of the underlying problems behind care imbalances is framed in contrasting ways. Fourthly, examination of the NRRPs reveals a broadly shared tendency to adopt a life-cycle perspective, although most NRRPs fail to acknowledge the inherently intersectional and cross-border dimension of care.

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