LRG NEXT 2021

THE FUTURE OF LOCAL PUBLIC SERVICES

The TERRITORIAL Dimension of SOCIAL CARE Services

Brief #9

PSI Local & Regional Government Workers' Network Series

PSI

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The TERRITORIAL Dimension of SOCIAL CARE Services

Contents

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Cover illustration : Community Health Workers, Nepal

1. BACKGROUND

Social care services provide vital support to individuals, households and local communities ensuring the health, education, well-being, dignity, and socio-economic inclusion of the most vulnerable in our societies. Ranging from child/elderly/disability care to domiciliary assistance; from live-in 24-hour homecare to long-term residential homes; from income support to public/social housing services, social care services are among the most complex and diversified forms of public services. Their provision, funding systems and organisation reflect each country's different paths of economic development, institutional and legal frameworks, societal/ethical choices, as well as cultural expectations. In developing countries – and in some developed economies, too – employment in social care services is overwhelmingly informal, hardly remunerated and highly feminised. In some cases, it stems from a religious/charity tradition rather than from a human right-based entitlement, an approach that has shaped its social organisation and forms of service delivery accordingly.

Whether public, private, or involving the "non-profit" sector (e.g., cooperatives, community organisations, "voluntary" workers etc.), social care services are often provided, funded/subsidised, and regulated by local and regional governments (LRGs) within national policy frameworks. Over the past decades, private operators and capital investors have entered the realm of social care service provision, a sector fulfilling vital care-related needs for which there is a global growing demand. The Covid-19 pandemic has unveiled and magnified the shortcomings, the inequality and the exploitation affecting service users and workers alike when social care service systems are run for-profit and based on patriarchal, gender-segregated assumptions. As they meet several intertwined collective needs and provide socio-economic value to households, communities, societies and economies, all forms of social care services need to be acknowledged as full-fledged public services and be adequately funded and duly regulated to ensure equitable access to quality services for users and decent conditions for workers, be them formal or informal; provided through public, private, or community-based providers.

2. LOCAL SOCIAL CARE SERVICES

As the frontline public institutions having to respond to the immediate needs of residents within their jurisdictions, LRGs directly or indirectly provide, fund, organize, coordinate and – to an extent - regulate multiple forms of social care service delivery in their territories. These may come under several forms and be organised to work in coordination with one another; or be integrated into hybrid teams to meet multiple social objectives, among which are ensuring equitable treatment and social cohesion; guaranteeing basic human and constitutional rights to all citizens; and caring for the most vulnerable. Depending on specific national, regional and municipal arrangements, social care can include a wide range of services including:

- **Childcare** (i.e., kindergarten, crèches, typically 0-6 children, special needs and schooling support, etc.)
- **Elderly and disability care** (i.e., long-term residential homes, community and inter-generational homes, domiciliary and live-in 24-hour care/nursing services, etc.)
- **Domiciliary care, domestic help, transport and leisure services** (i.e. meal catering, home deliveries; household administrative assistance; errand/grocery support and transport; fixing/going to medical appointments; doing housekeeping chores; providing company, leisure and socialisation to isolated/non self-sufficient persons; etc.)
- **Domiciliary health/nursing services**
- **Adult care** (i.e., ensuring and promoting the self-sufficiency and socio-economic integration of people in long-term joblessness, homelessness, mental or physical illness/disability etc.)
- **Social services** (i.e., home care support and guidance to new parents; to parents and youth in difficult situations; referral to dedicated education/rehabilitation services; migrant and refugee reception and integration; income/indebtedness support; shelters for victims of domestic violence or abuse; supervised drug consumption facilities; etc.)
- **Public and social housing**
- **Employment services**
- These are typically channelled either through health, care, education, social and employment service units and/or via integrated service consortiums.

Over the past fifty years, decentralisation has devolved much of the competences for social care services to LRGs without devolving the financial resources and powers needed to adequately fund and staff their physical and social infrastructures. Therefore, LRG funding gaps and unfunded mandates have played a key contributory role in the "marketization" and "individualisation" of the different forms of social care service delivery and access, facilitating the entry of for-profit private operators, capital investors and private equity. This approach has been accompanied by a shift from a collective, community-based approach to care service delivery to a "consumer-based" one founded on users' "individual choices" among competing care service providers.

This has occurred in conjunction with the passing of national legislative reforms that favoured social care service outsourcing and privatisation through measures such as mandatory competitive tendering of LRG services; regressive fiscal reforms; and public subsidies granted to individual service users in the form of care allowances/vouchers to pay public or private care providers alike. Today, even governments, public providers and international institutions have commonly adopted the expression "care economy" or "care industry" to refer to a large share of the sector, hence embracing a commodified conception of these vital public services.

Community Health Workers in Sub-Sahara Africa

Box 1 - Territorial service inequality in social care services in Europe

In Europe, decentralisation with unfunded mandates and pro-privatisation laws has especially occurred in Sweden, in the Netherlands, and in Denmark. In the UK, while a National Health Service (NHS) exists, elderly care and other vital social services are under the responsibility of local councils. In 1991 the UK introduced an internal market rule for local government obliging UK local councils to outsource 85% of their social services. In 2018, Austria abolished the fiscal contribution from private wealth to residential care and the cost was transferred to regional authorities. In Sweden, the 1991 Swedish Local Government Act facilitated the outsourcing of municipal elderly care services to for-profit and non-profit organisations. Later in 2009 the Swedish "Free Choice Systems" Act used incentives to force municipalities to introduce "consumer choice" models in municipal elderly care services. A consequence has been that for-profit elderly care services in Sweden are now concentrated in the most affluent, urban areas such as the capital Stockholm whereas rural areas are still largely services by public providers, reflecting the interest of the for-profit care operators to provide services to the economically most prosperous areas of the country and causing into territorial service inequality. Indeed, according to EUROSTAT (2020), 69% of nursing home beds are now concentrated in southern Sweden, where for profit companies are most active. Likewise, in Germany 57% of nursing home beds are concentrated in the four largest or most prosperous states, and in Italy 57% are in the three largest and most prosperous regions of the North. Regional disparities are particularly acute in Croatia and Lithuania. The for-profit sector bears a responsibility in this uneven regional distribution of social care services. French multinational-care company ORPEA has targeted the affluent regions of France, notably Île-de-France (Paris), Provence-Alpes-Côte d'Azur (Mediterranean coast), Aquitaine and Poitou-Charentes. In Belgium, most ORPEA clinics are in the richer areas of Brussels and Flanders. In Spain 70% of ORPEA clinics are in the capital Madrid.

Source: Lethbridge, J., Privatising our Future: an overview of privatisation, marketisation and commercialisation of social services in Europe, EPSU, June 2021, pp. 4-5 and p.10.

3. PRIVATISATION VS REMUNICIPALISATION IN SOCIAL CARE SERVICES

The Covid pandemic has exposed the flaws of the neoliberal, for-profit approach to care service provision and its unjust model based - on the one hand - on the exploitation of cheap labour - overwhelmingly drawn from a vulnerable female workforce; and on poor quality and inequities in service provision among users and territories on the other hand.

Underfunding, poor regulation, lack of accountability, mandatory competitive procurement of care services, privatisation, tax-avoidance, precarious and exploitative working conditions, as well as and union-busting campaigns by multinational care companies[1] have undermined care service quality and access contributing to avoidable deaths among care service users and workers alike. Many thousands social care workers and users have fallen sick and died, especially in privatised long-term elderly care facilities. Considering the largest share of funding for private social care services is made up of public resources, a social care service system that relies on public subsidies to support for-profit care providers seems even more unjust and unsustainable.

Box 2 – The failure of for-profit social care services

Australia: public funds for private family profits

Australia's six largest family-owned aged care companies make a up a significant and growing portion of the aged care sector and warrant greater scrutiny. These six companies received over $711 million in annual federal funding to operate 130 facilities, with almost 12,000 beds. Several of the largest family-owned aged care companies, owned by some of Australia's richest families, have complex corporate structures, intertwined with trusts, that appear specifically designed to avoid tax. Despite receiving an average of nearly $60,000 per year per resident there is very limited public information available on these companies. These family-owned aged care companies highlight the lack of transparency and accountability on public funding in the aged care sector and provide clear examples of why simple reforms are needed to restore public integrity in both aged care and the broader tax system. While there is no doubt that the aged care sector will require an increase in public funding, there is also no doubt that these families have made considerable profits from a publicly funded industry.

Source: Ward, J., All in the Family. Tax and financial practices of Australia's Family-owned aged Care Companies, CICTAR 2019

Denmark: Better regulation of private companies in social services urgently needed

In Denmark there has been a wide debate about the role of private for-profit companies as providers of social services (e.g. providing housing for children and adults with physical or mental challenges). PSI affiliate FOA has exposed several examples of private social care companies delivering poor quality services while the owners reap large cash rewards. One example involves a very large profit from the 2017 sale of the private institution Søbækskolerne for 18 EUR million (including a special bonus) to multinational corporation Olivia A/S. The institution delivers services to young people with special needs, both educational training and housing. However, the sale did not transfer the physical assets, only the obligations to provide the service. This allows the previous owner to continue to earn a large income by renting out buildings to the new supplier.

Source: Enghausen, T., 'Problems without benefits? The Danish experience with outsourcing and remunicipalisation', The Future is Public, TNI, 2019, p. 71

Box 2

Canada's bleak Covid-19 death toll record in long-term care homes

Canada has the worst record of Covid deaths in long-term care homes among wealthy nations: the proportion of fatalities in nursing homes represented 69 percent of Canada's overall Covid deaths, well above the international average of 41 percent.[2] These have overwhelmingly occurred in privately-owned, profit-oriented long-term care facilities (54% of all facilities), where there is overwhelming evidence of lower-quality care in the privately owned facilities, including under-training and poor treatment of workers, substandard and ageing facilities, overcrowding, and poor infection control capabilities.[3] At the same time, Revera, the second largest private care home operator in Canada, seems engaging in aggressive tax avoidance practices.[4]

Source: Cibrario, D., Weghmann, V., Access to quality local public services for all: a precondition to beat inequality, GOLD VI Working Paper Serie #2, PSI-PSIRU, UCLG-KNOW, November 2021 (forthcoming)

OECD: public subsidies for private social care profits

Although the mix of public and private funding varies considerably from country to country, public financing of care is a major precondition to sustaining modern long term social care systems. The outsourcing of provision – where public financing is mobilised by the state and distributed to service providers rather than carried out directly by the state – is the dominant feature of this model. Analysis of OECD data carried out by Investigate Europe shows that €218bn of state funds goes to care home operators each year, with a further €65bn paid in out-of-pocket fees by residents and families. This second figure however is very likely a substantial underestimate, as it only captures data from some countries, excludes informal care and various associated costs borne by care recipients and families.

Source: Floriek, K., Global report on the effects of privatisation in long-term care services, PSI, unpublished draft, October 2021, p.3

Another form of privatisation in social care services: the growth of "philanthrocapitalism"

The growth of the so-called 'philanthrocapitalist' sector has had a major impact on global health and social care provision in the 21st century. Collectively, philanthrocapitalist 'foundations' spend up to $10 billion annually. The largest share of these funds is de-fiscalised. There are more than 200,000 of them – around 80,000 each in US and Europe. They are also growing in global south with 10,000 in Mexico, 2000 in China and 1000 in Brazil. The majority of these foundations are involved with health and social care and/or poverty alleviation generally. Global NGOs and international bodies like WHO, UN, UNICEF and others have consistently collaborated with health industry conglomerates to promote this PPP-driven agenda. The reliance on philanthropic and 'voluntary' non-profit services to provide vital public services such as health and social care is questionable under a human-rights angle, as it has facilitated privatisation and workers' exploitation and arguably prevents the establishment of modern, formal public health and social care services equitably accessible to all.

Source: Dr. Humber, L., Health and Social Care Workers and the Crisis of Capitalism, PSI, September 2020, p. 12

The evident failure of private health and care service provisions matched with the public outrage spurred by the unbearable images of patients in overwhelmed hospitals and exhausted health and social care workers jointly with the intrinsic gender, social and racial injustice around which this vital service is currently structured, has emboldened societal demands to return social care services in public hands. Workers and their trade unions have played and continue to play a critical role in raising awareness about the socio-economic value of social care services and its recognition as a public service in its own right.

Box 3 – Taking social care services back in-house

Denmark: in-sourcing care services to prevent further bankruptcies

Since 2013, Denmark has experienced 54 bankruptcies in elderly care services, affecting over 13,000 citizens and well over 2,000 employees. Since 2003, municipalities are required by law to offer alternative municipal homecare service options for the elderly (known as 'free choice'). The degree of outsourcing varies from municipality to municipality because it depends on the number of citizens opting for private suppliers. This must be seen because of a 2013 legislative change, which encouraged municipalities to give elderly people "free choice" between private and public home care operators through competitive tendering. But as a side effect, the legislation has multiplied bankruptcies of private care providers. Since the wave of bankruptcies began, many municipalities have reverted to the 'old' public model where the municipality is the main provider of elder care, and where there is competition in terms of quality, not price.

Source: Enghausen, T., 'Problems without benefits? The Danish experience with outsourcing and remunicipalisation', The Future is Public, TNI, 2019

Canada: Saskatchewan makes substantial public investment in long-term care in the aftermath of the Covid pandemic

Canada recorded the worst score of Covid-19 deaths in elderly care services worldwide. Four out of five deaths have either been residents or staff of a long-term care home, largely run by private companies, some of which actively engage in tax avoidance, such as Revera. In 2020, the Canadian Union of Public Employees (CUPE) launched the nationwide 'FixLongTermCare' campaign to take profit out of long-term elderly care, demanding the Canadian Government take over and invest in long-term elder care homes and set a national service quality standard and safe, decent working conditions for staff across all Canadian provinces. The campaign contributed to the 2021 decision of the Government of Saskatchewan to invest 80 million Canadian dollars in long-term care starting with municipalizing two facilities through substantial public investment; to plan 82 renewal projects; and 13 new public elder care homes in rural and remote areas of the province.[5]

Despite the compelling evidence that running social care service on a for-profit basis is not the way to go, some cash strapped LRGs facing post-Covid extraordinary revenue gaps and pro-austerity governments are seeking to push social care privatisations forward. This is the case of Flanders (Belgium), where PSI affiliate CGSP-ALR is fighting against the Flemish government's plans to privatise the public social care sector. PSI and allies also launched an international campaign to 'Rebuild the social organization of care' articulated around five key asks, among which 'Reclaiming' care services into public hands is a critical component.

Bro Jammu union

4. LABOUR RIGHTS AND WORKING CONDITIONS OF SOCIAL CARE WORKERS

Social care services are labour intensive, as they are about providing services that primarily entail forms of human, personalised, face-to-face interactions (e.g., with children, the elderly, the disabled and vulnerable people, etc.). The quality of interpersonal relationships, attention, time and empathy that go into social care often make the whole difference in service quality and in the lives of users.

However, care services can be also capital intensive when they require physical infrastructure, such as kindergarten, long-term care homes, community residences and public/social housing stocks or specific equipment (e.g., medical devices, wheelchairs, vehicles etc.). Investment in infrastructure for capital-intensive social care services are an additional profit opportunity for companies, private equity, and real estate investors, as they invest and then lease back facilities and service-related equipment to at much higher prices both for LRG providers and users.

The labour and capital intensity of formal social care services matched with LRG funding gaps, decades of austerity cuts and local public service de-funding, as well as a global surge in demand for social care services[6] (e.g. due to demographic growth, longer life expectancy, a rise in the incidence of degenerative diseases, increasing socio-economic inequalities, move from extended to nuclear households, women's access to the labour market, etc.) has translated into a progressive retreat of public social care providers and into the stepping in of for-profit operators, private investors and community/"non-profit" providers. This transformation has had a major impact on

the employment and working conditions of social care service professions.

As social care services cannot be fundamentally digitalised, labour cost reduction is the primary item on which private operators boost profits and pay shareholder dividends. The result is low-paid care workers, overwhelmingly migrant women, in precarious jobs with limited or no access to collective bargaining coverage and trade union rights, and with scant vocational training in the different social care professions.

As demonstrated by the overwhelming death toll found in the privatised long-term elderly care facilities, occupational safety and health (OSH) is a major problem. Labour cost reduction directly translate into lower worker-to-patient/user ratios and in the real-time monitoring and control of workers' time through digital tools so that care workers' appointments are maximised and "non-profitable" time minimised – including essential time needed to socialise and interact humanly with users and patients. Third-party violence is also a major issue (e. g. drug-dependent users), especially when worker teams are cut to the bone.

The result is a high level of exhaustion and burnouts among workers, route accidents in between appointments, psychosocial issues related to lack of control over one's times and tasks, and a de-personalisation and de-humanisation of the care relationship that is the essence of social care service quality and workers' ethos and professionalism. Where private providers provide social care services – including some "non-profit" providers, a high incidence of "zero-contract hours" and precarious employment is found.

Besides, where collective bargaining agreement existed (CBAs) for the sector, privatisation and outsourcing have substantially contributed to fragment coverage across public/private/and non-profit CBAs and collective bargaining is brought down to the individual workplace level, undermining CBA coordination power. As a result, conditions and pay are often poorer in for-profit and in the non-profit/community-based social care service provision. This situation has contributed to drive many workers away from social care professions at a time when they are most needed. Just in the 27 EU countries, over 421,000 residential care workers have left the sector.[7]

Box 4: Labour challenges in the social care sector

Employer fragmentation in EU social care services

The care sector tends to be fragmented and dependent upon a multitude of actors. While some care is still provided by (overwhelmingly female) family members, most social care of older people has now shifted to the welfare state. (...)

Within the same country, indeed the same locality, elder care might be provided by public sector entities as well as private non-profit organisations (such as religious charities), small private profit-making firms and as large, multinational care companies. Some of the latter are run by venture capital companies or private equity funds. An example of a hugely fragmented and disparate sector is the English care system, with 18,500 employers across nearly 40,000 establishments. Only five providers make up nearly one-fifth of the sector, three of which are private equity funded.

Source: Pelling, L., On the Corona Frontline. The Experiences of Care Workers in Nine European Countries – Summary Report, Kommunal, Arenaidé, FES, 2021, p.5

UK: using public procurement specifications to secure decent working conditions in social care services

On the backdrop of social care workers' abuse and exploitation by private and "non-profit" providers to which UK local councils have had to outsource social care services, UK public service union UNISON has since 2012 encouraged local councils to sign up to the UNISON Ethical Care Charter. The Charter seeks to establish minimum baseline for the safety, quality and dignity of care services and workers by ensuring employment conditions which do not routinely short-change users and ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels. Commitment to the Charter implies paying the Living Wage Foundation's living wage, renouncing to the use of zero hour contracts, accepting that travel time is paid work time and that the care time allocated to users matches their real needs, not the planning of the provider. Councils which sign up to the Charter are regularly published on the UNISON website. Yet, local councils control over their providers' fulfilment of the Charter's requirements has proved challenging.

Source: UNISON, UNISON urges councils to ensure care staff are properly paid, 9 November 2021

5. WOMEN, SOCIAL CARE SERVICES AND THE CITY

In those economies where women have increasingly entered the paid workforce and there has been a shift from traditional forms of extended families to single-person households demands for formalised social care services have grown. Regardless, the historic social organisation of care perpetuates the undervaluing work and exploitation of the predominantly women, and often migrant, workforce. Women are overwhelmingly represented in care services both in developing and developed countries. They are often racialised, low-skilled and in situations of multiple vulnerability, including low-pay and precarious working conditions.

It is them who have had to shoulder the brunt of the human, social and economic burden of the pandemic both at home and at the workplace, and this for cheap or for free, a de-facto mass exploitation that is still ongoing. In many countries, the formal social care sector and public institutions overwhelmingly rely on the cheap labour provided by women in social care professions work within the household or delivering services to the community.

Box 5 – Women's exploitation in formal and informal social care services

Community Health Workers in South Asia

Community Health Workers (CHWs) play a critical role in providing primary health care, providing information and raising awareness, and facilitating access to public health care to hundreds of millions of rural people. In South Asia, and other parts of the world, Community Health Workers — who are also known as Accredited Social Health Activists or ASHAs in India, Lady Health Workers in Pakistan and Female Community Health Volunteers in Nepal — are almost entirely women who are expected to do this vital work without being recognised as public health workers and without the payment of adequate wages. CHWs, in all countries except Pakistan, are denied the right to receive a minimum wage. Governments have hailed CHWs as "warriors against COVID-19" yet have routinely failed to provide adequate PPE, training, fair wages or support. Their repeated requests for provision of safety kits, masks and sanitisers during the COVID-19 door-to-door visits and surveys has been denied by the authorities. Unions representing CHWs have documented a range of threats and violations experienced during the pandemic. CHWs are facing heightened risks of infection and enduring long working hours, psychological distress, fatigue, occupational burnout, discrimination and physical and psychological harassment. Many CHWs have reported not being paid during the pandemic. Many of these workers provide municipal/state level public services.

Source: PSI, Community Health Work is Work! Global Campaign, 2020

Childcare

Box 5

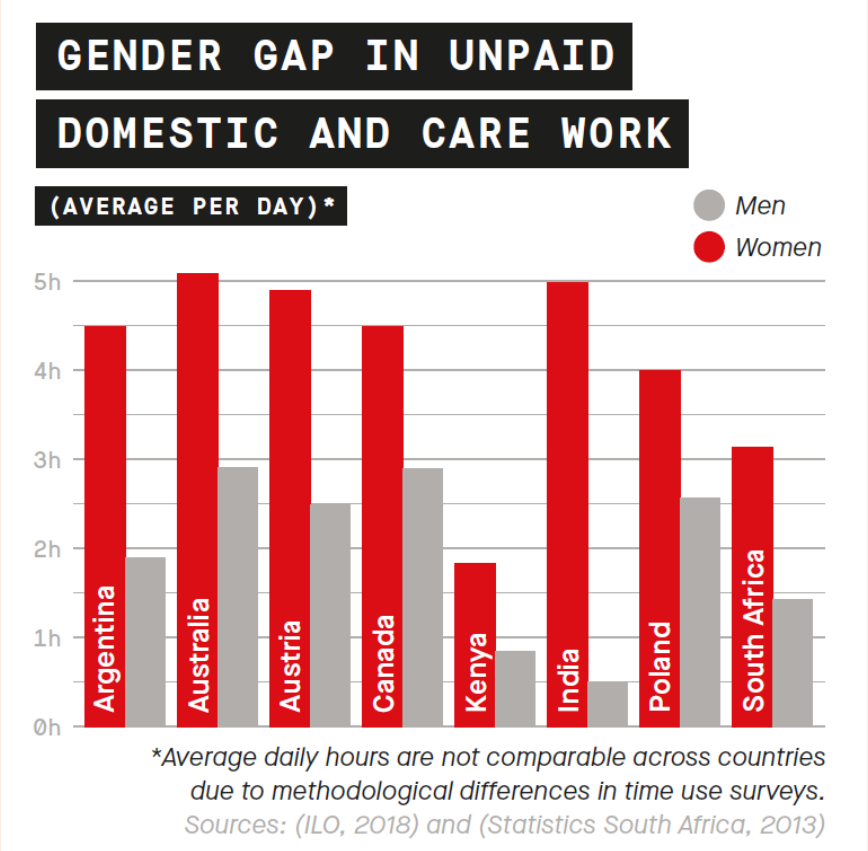
Women's unpaid social care work: data from the UK

It is estimated that 16.4 billion hours are (daily) spent in unpaid care, equivalent to 2 billion people in 8-hour jobs. Women perform 76 percent of this work globally. In the UK:

* Of the 6.5 million unpaid carers in the UK 58%, 3.34 million, are women.
* The economic value of the unpaid care provided by women in the UK is estimated to be £77bn per year.
* Female carers are more likely to be providing 'round the clock' care, with 60% of those caring for over 50 hours a week being female.
* Women are more likely to be 'sandwich' carers - caring for young children and elderly parents at the same time.
* Caring falls particularly on women in their 40s, 50s and 60s. 1 in 4 women aged 50-64 has caring responsibilities for older or disabled loved ones.
* Women aged 45-54 are more than twice as likely as other carers to have reduced working hours as a result of caring responsibilities.

Source: Dr. Humber, L., Health and Social Care Workers and the Crisis of Neoliberalism, PSI, September 2020, p. 26-27

Box 5



Source: PSI, The Social Organisation of Care: A Global Snapshot, October 2021 p.9

Social care services undeniably generate socio-economic value whose monetary and intangible value has long been overlooked by neoliberal orthodox economics and can be hardly captured by measures of GDP, revenues and return on investment (ROI) typically used by private operators. The overwhelming presence of women in care professions both in formal and informal care services and the still dominant patriarchal footprint that has underpinned the organisation of care services in our societies has meant that social care work has been undervalued and underpaid, or bluntly expected to be provided for free by women in the household and in their local community because of traditional gendered beliefs and expectations about women's roles in household and societies. For centuries now, national economies, public institutions, communities and households have collectively been free riding on the cheap or unpaid labour of generations of women. However, progressive LRGs are embracing a different approach to social care services and transforming their local social care services from a feminist and integrated approach to ensure that they "care for those who care", such as in the case of Bogotá (Colombia), Barcelona (Spain) and Mexico City (Mexico).

Box 6 - Bogotá´s Districts Care System ("Sistema Distrital de Cuidado de Bogotá")

Bogotá´s District Care System is a set of services, regulations, policies, and technical and institutional actions that seeks to recognize, redistribute and reduce care work, understanding it as a necessary social function for the daily life of people and the functioning of society. Bogotá has a female population of 4 million. Of these women, 30% (1.2 million) are dedicated primarily to unpaid care work and thus lack financial independence and time to participate in political activities, personal well-being or professional development.

These women belong to the most vulnerable sectors of society:

* 90% of them are low-income.
* 70% of these women have not studied beyond high school.
* 33% are deprived of free time for self-care.
* 21% suffer from physical and mental health problems.

If unpaid care work were paid, it would represent 13% of Bogota's GDP and 20% of Colombia's GDP.

Since October 2020, the District Care System has provided 26.187 services to women, children, elderly, people with disabilities or family members of caregivers (until 15 of September 2021). The innovation of our system lies in simultaneously providing services both for caregivers and for those in need of care. The system is an innovative, context-specific solution for a profound challenge that uses a radical "ease-of-access" modality at a level that has never been tested before. The most demanded service are educational services (51% of all services).

The System has 3 new ways of providing services: Care Blocks, Care Buses and a Door-to-door Care Program:

* Care Blocks: They introduce a new criterion for the city's urban planning that places caregivers and care work at the center and, organizes the city to meet people's needs, instead of the other way around. At Care Blocks we provide professional care to those who need it, while simultaneously offering educational and leisure services for their female caregivers whose time is freed up.

  We also offer "Care School for Men" where men learn to cook, do laundry, iron, etc., with the aim of redistributing tasks within the household. Care Block locations ensure that services can be accessed within a 15 to 20-minute walk, in an 800-meter (0.5 miles) vicinity. Caregivers can access educational or well-being services while State-hired professionals care for the people they care for.

  Currently we have 7 care blocks, our goal is to open 19 blocks by December 2023 (depends on approval of the intersectoral commission of Care System). The operation of 1 care block a year costs USD $4,7 million.
* Care buses: the mobile version of Care Blocks, for those who live far from Care Blocks and in rural or hard to reach areas. One third of the total services offered by the System have been offered by the buses. Care buses guarantee that rural and peasant caregivers have access to care services (for the first time). This is especially important because female caregivers in rural areas of Bogotá, devote more time to care work and often lack basic utilities like running water or electricity. Care buses are equipped with facilities that provide similar services as Care Blocks, ensuring services for those who provide care and those who require care, simultaneously.

  To date we have 2 Care Buses. The operation of 1 care bus a year costs USD $530 thousand.
* Door-to-door care: 14% of full-time female caregivers cannot access Care Blocks or Care Buses due to the conditions of the people they care for, mainly people with severe disabilities, for whom leaving the house is not a possibility.

  The Door-to-Door service will deliver services to this special population in their own households, guaranteeing their access to the System.

Source: Bogotá, District Care System (Sistema Distrital de Cuidado), Metropolis, Cities for Global Health, Database, 2021

6. THE FUTURE OF LOCAL SOCIAL CARE SERVICES

As the need for more, integrated, holistic social care services with a close connection to residents and users increases, and as the challenges of territorial service inequality caused by underfunding and privatisation become apparent, many LRGs are moving into partnering with community-based and non-profit organisations (into so-called public-community collaborations) to provide quality social care services with a close connection to the local communities while delegating and overseeing delivery through strategic public procurement specifications, without necessarily entering into full-fledged privatisation processes.

During the Covid pandemic, some LRGs experimented innovative forms of social care service delivery by swiftly redeploying workers into cross-service mobile teams or creating new forms of social care. For instance, the set-up of multidisciplinary teams composed of social services, health care and public housing workers was a successful experience in some cities, as it allowed to swiftly identify and help homeless people and get them safely into lockdown.[8] While innovative forms of integrated care services involving the community can be highly valuable, extra attention must be paid to ensure that the conditions of the workers employed in community-based and "non-profit" organisations teaming up with LRGs to deliver social care services are decent and safe.

Box 7 – The future of integrated local social care services

Barcelona Care Centre ("Barcelona Cuida") a space for information and guidance for care service users and providers

The Barcelona Care Centre is a pioneering centre that aims to showcase all the city's existing care resources and make them available to everyone. It aims to be a leading centre for providing the general public with information about all the services and resources in the territory, and for promoting exchange and networking among them. Care is a very wide-ranging concept that includes all the activities that are carried out in response to the physical, psychological, and emotional needs of one or more persons in both the private and the public spheres; but above all, care is an activity that some people carry out to help other people. Therefore, care work is included in several city programmes, actions and facilities, and there is an enormous range of people and groups involved in providing and receiving this care.

The centre aims to become:

* A comprehensive information and guidance point for the existing resources in the territory.
* A place where everyone involved in care work in the city can meet and interact.
* A place where individuals, professionals and organisations can coordinate and network with each other.
* A centre that informs city residents and raises awareness about care work.

Source: Barcelona Municipality, Barcelona Care Centre, a space for information and guidance, **2021**

Box 7

Belgium: coping with climate change in the care sector

Delivering social care services is already a tough job in itself. With the impact of the climate crisis already showing worldwide, social care service providers need to anticipate and mitigate adverse impact and ensure service continuation as of now. During the flood in Liège (Belgium) in the summer of 2021, the staff were unable to reach certain hospitals. In Belgium, local social care authorities are working with trade unions to retrofit care facilities, skill and equip social care workers to help users deal with hit waves and anticipate service continuation in case of climate-related catastrophe. The plan includes a vigilance phase in which awareness is raised towards vulnerable groups, a warning phase (when temperature reaches 28 °C) in which measures are taken and an alarm phase. In Belgium, the regions are responsible for phases 1 and 2. The Flemish Agency for Care and Health communicates with the care institutions. Most healthcare institutions in Flanders work with their own heat plan, usually inspired by the national plan. Compliance with the national heat plan is only controlled in the residential care centres.

Source: ITUC-Reset Vlandereen, Coping with climate change in the care sector. A workers' Guide, 2021, pp. 4,6

Envisioning a future integrated approach to municipal care in New York

"A municipal Department of Care could make sure the trash was picked up and the tree pits were weeded. It could pay teens to tend to public spaces and teach them stewardship skills. It would check on seniors in a heat wave and basement apartment dwellers in a flood. A Department of Care would start by asking (…): 'What do you need? What do you hope will change? How can we best accomplish this?' The Department of Care doesn't exist — yet — but the concept of care as a driver for city planning is already gaining traction. The pandemic exposed just how much labor is involved in childcare, health care, street and park maintenance, and technological upkeep. Once people see it, the need for care is hard to unsee. In an architectural context, care links the labour of cleaning with the design of the surfaces to be cleaned, physical infrastructure with social services for its users, landscape with mental health. Care can be demonstrated through org charts and through organizing, through serving food and setting aside land to grow food, through creating public space and training people to take care of it. (…) The Department of Care (…) would coordinate services across existing agencies including health, sanitation and transportation, and team with community-based leaders. Such an agency would fill in the gaps, assisting with permitting, coordinating cleaning regimes, liaising with local groups that could provide services to youth or the unhoused (…). 'Care is more comprehensive than maintenance,' (…) 'It encompasses social interactions and dynamics, cultural practices'".

Source: Extract from Lange, A., "What it means to design a space for 'Care'", Bloomberg City Lab, 4 November 2021

7. CONCLUSIONS

The Covid crisis has revealed how work in fundamental social care services is not a "woman's duty" or a "consumer's market" but a vital public service that must be equitably accessible for all. It has also showed how the neoliberal, for-profit organisation of social care has collectively failed users, households, communities and workers. Social care workers worldwide have long been denied adequate personal protective equipment and occupational safety and health (OSH); have suffered understaffing and precarious work; and have been exploited and unrecognised. Yet, they have continued to provide life-saving services to the most vulnerable, often in extremely difficult conditions and at the cost of their own lives.

As more and more social care services are needed worldwide everyday – including for the planet and nature – a new foundation to remould the social organisation of care is urgently needed. Social care workers' professionalism and sacrifice through the pandemic have been acknowledged and added to the institutional and societal hailing tributed to health and other frontline workers. While such acknowledgement is yet to be translated into concrete measures to avoid the collapse of our social care systems - including substantial public investment in the physical and social care infrastructure, labour rights, decent working conditions and pay for care workers.

However, this realization has triggered a global debate about the need to urgently reconstruct a different social organisation of care-related services that must be public and de-commodified. To meet the multiple, complex social care needs that await ahead they also need to be rooted in equity and quality for users and in decent work. To make this vision a reality, social care services need to be reclaimed, valued, and adequately funded as full-fledged vital public services, and be designed encompassing an inclusive user, worker, feminist and intersectional perspective.

Endnotes

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