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Towards a Care-led recovery for the European Union?

A feminist care analysis of the National Recovery and Resilience Plans

Mémoire Recherche

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Résumé (Français)

L'Union européenne (UE) a lancé le plus grand plan de relance budgétaire de son histoire pour aider les États membres à mieux affronter les conséquences de la pandémie de Covid-19 : le fonds NextGenerationEU. Considérant que cet instrument inédit a été créé précisément pour réparer les dommages économiques et sociaux immédiats causés par la crise sanitaire, ce mémoire applique une lecture féministe afin d'explorer comment le care y est appréhendé.

En s'appuyant sur la littérature féministe sur le *care* pour analyser les plans nationaux de relance et de résilience (PNRR) de huit pays (Autriche, Belgique, République Tchèque, Allemagne, Finlande, Italie, Lettonie et Espagne), l'objectif de cette recherche est de comprendre dans quelle mesure les impacts socio-économiques négatifs de la crise du coronavirus, subis de manière disproportionnée par les femmes et les groupes défavorisés, se traduisent par une approche axée sur le care dans les PNRR. L'analyse qualitative approfondie (*critical frame analysis*) des plans nationaux complétée par une évaluation quantitative offre plusieurs éléments de réponse.

Premièrement, malgré les incitations limitées vers une transition axée sur une société du *care*, les PNRR étudiés abordent tous cette question, bien que dans une bien moindre mesure par rapport à la transition écologique ou digitale. Deuxièmement, l'analyse qualitative montre que la portée des mesures liées au *care* dans les PNRR reflète les régimes de care (Lohmann & Zagel, 2016). Les pays caractérisés par un niveau de défamiliarisation plus élevé présentent une incidence modérée de telles mesures. Le niveau le plus élevé d'occurrence se trouve dans les pays relevant des modèles d'individualisme/familialisme implicites. En revanche, les pays se situant à l'extrémité supérieure des modèles de familialisation affichent une incidence de mesures liées au *care* soit beaucoup plus faible, soit beaucoup plus élevée. La troisième constatation est qu'il existe une convergence vers des solutions assez similaires en ce qui concerne l'institutionnalisation des soins aux enfants et la désinstitutionalisation des soins de longue durée, mais la reconnaissance des problèmes sous-jacents aux déséquilibres du *care* est formulée de manière contrastée. Une majorité de pays présentent les responsabilités liées aux soins comme un coût ou un fardeau, tandis que d'autres pays présentent plutôt le *care* comme une valeur en soi, comme une question centrale reliant plus explicitement les mesures de soins aux préoccupations d'inclusion, d'équité sociale et de protection sociale. Quatrièmement, l'examen des PNRR a révélé une tendance largement partagée à adopter une perspective axée sur le cycle de vie, en accordant une certaine place à toutes les phases du care (Tronto, 1993), même si - à quelques exceptions près - la plupart des PNRR ne reconnaissent pas la dimension intrinsèquement intersectionnelle et transnationale du care. Bien que leur valeur prédictive reste à traiter avec prudence vu la nature complexe du *care* en tant que bien social (Daly, 2002), ces résultats tendent à corroborer l'idée que la relance peut servir de tremplin pour opérer un changement de paradigme vers une société du care, notamment dans les pays où les niveaux de soutien familial sont moindres, à condition que la volonté de le faire y soit.

Mots-clés : crise du care, régimes de care, égalité des genres, Covid-19, économie féministe, relance

Summary (English)

The European Union (EU) has launched the largest fiscal stimulus package in its history to help Member States better affront the aftermath of the Covid-19 pandemic: the NextGenerationEU fund. Considering that this ground-breaking recovery instrument was set up precisely to repair the immediate economic and social damage brought about by the coronavirus pandemic, this research master thesis applies a feminist care reading in order to explore how care is addressed therein.

By engaging with the feminist literature on care to analyse the resulting national recovery and resilience plans (NRRPs) across eight countries (Austria, Belgium, Czechia, Germany, Finland, Italy, Latvia and Spain), the research question ambitions to understand to what extent the negative socio-economic impacts of Covid-19 crisis disproportionately incurred by women and underprivileged groups translated into a care-led approach in the NRRPs. An in-depth qualitative analysis (critical frame analysis) of the national plans complemented by a quantitative assessment offers several elements of response.

First, the analysis showed that, despite the limited incentives to foster a care transition, the national plans studied all address care, although to a significatively lower extent compared to other types of measures such as those linked to the green and digital transitions. Second, the scope of care measures in the NRRPs mirrors the respective care regimes (Lohmann & Zagel, 2016). Countries characterised by a higher defamilising policy level exhibit a moderate incidence of care measures. The highest level of care measures occurrence is found in countries under the implicit individualism/familialism models. Instead, countries leaning towards the higher ends of familising policy patterns display an incidence of care-focused measures which is either much lower or much higher. The third major finding revealed that there is a general convergence towards rather 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 is contrasting ways. A majority of countries present care responsibilities as a cost or burden, other countries follow a different path presenting care as valuable for itself positioning it as a central issue connecting care measures more explicitly with concerns for inclusiveness, social fairness and welfare protection. Fourth, the examination of the NRRPs revealed a broadly shared tendency to adopt a life-cycle perspective giving at least some degree of consideration to all phases of care (Tronto, 1993) although – besides some notable exceptions – most NRRPs fail to acknowledge the inherently intersectional and cross-border dimension of care.

Although the predictive capacity of these results must be treated with caution care being such a complex social good (Daly, 2002), they tend to corroborate the idea that the recovery can serve as a springboard to operate a care paradigm shift in countries with lower levels of family support providing there is the will to do so.

Key words: care crisis, care regimes, gender equality, Covid-19, feminist economy, recovery

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List of Abbreviations

Covid-19	Coronavirus disease (SARS-CoV-2 virus)
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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[A] society that values care and caring relationships would be not only nicer and kinder, but also more egalitarian and just.

Glenn (2000: 84)

Introduction

The Covid-19 pandemic has left our collective memories as well as individual experiences with lasting marks. From crumbling health care systems to paralysing entire economies and disrupting most social interactions, its long-term consequences have outlasted the immediate effects of the pandemic. To enable its Member States to better affront the aftermath of the resulting health, economic and social crisis, the European Union (EU) launched the largest fiscal stimulus package in its history to help the most affected sectors and regions (European Commission, n.d.-c): the NextGenerationEU fund (NGEU). 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" (European Commission, 2020c), this master thesis (thereafter thesis) applies a feminist care 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 (Karamessini & Rubery, 2013; Pelling, 2021; Sweeney, 2020; UN Women, 2020). The resulting Covid-19 crisis has also unearthed a long pre-existing and much deeper care crisis (Dowling, 2021; Glenn, 2000). Society and families could be kept afloat thanks to the invisible yet essential care work, whether formal or informal, disproportionately concentrated on the shoulders of women and the most underprivileged groups of society. Despite the progressive advances towards gender equality, women continue working double shifts to unsustainable levels (Bianchi et al., 2012; Mascherini & Bisello, 2020). These deep cracks in the system were suddenly exposed by the pandemic lockdown measures but also by the changing work patterns with the teleworking shift likely to become the "new normal" (Schmucker, 2021) and the long-term economic consequences of the pandemic. Umpteen reports namely point to the heavy blow dealt by Covid-19 to the feeble and painfully slow advances by the EU towards gender equality (EIGE, 2021; European Commission, 2021a; Fabrizio et al., 2020). The long-standing care inequalities rooted in gender norms are identified as one of the main sources deepening social inequalities (EIGE, 2021), thereby echoing a large international consensus ringing the alarm bell (OECD, 2021; UN Women, 2018, 2020). In pre-pandemic times, the ILO issued a report already 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" (ILO, 2018). Evidence

unequivocally corroborates the claims that the pandemic severely exacerbated women's economic disadvantages and hardship due to their unequal share of unpaid care responsibilities and their over-representation in undervalued and precarious jobs in the care economy.

Therefore, in light of the current momentum around the EU's recovery efforts to "ensure the recovery is sustainable, even, inclusive and fair for all Member States" (European Commission, 2020c), I set out to investigate whether the feminist understanding of *care*, which has gained new impetus as a result of the Covid-19 crisis, offers new avenues to overcome the stalled advances towards gender equality. Feminist literature 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 policy making spheres. The necessity to better value the care sector has come under the spotlight to become politically acknowledged. To a certain extent, the adoption of some form of care ethics could be detected in political discourse.[1] However, beyond the symbolic clapping for care workers elevating them to heroes (or most accurately heroines), the true question lies in how far the nascent rhetoric for a "caring society" (European Council, 2020) can translate into concrete action living up to those values.

That is why, as the EU is rebuilding itself, this thesis 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 fund. Positing care inequalities as a major impediment to gender inequality (Folbre, 2008), the main scope of investigation will revolve around the following research question: to what extent have the negative socio-economic impacts of Covid-19 disproportionately incurred by women and underprivileged groups translated into a care-led approach in the NRRPs? In order words, 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 national level addressing

[1] To cite just a few examples, the – then – Belgian Prime Minister Sophie Wilmès would repeatedly exhort citizens to "*take care of* themselves and of the others" during the initial and most critical phases of the pandemic in 2020 (own translation from "prenez soin de vous et surtout prenez soin des autres"). ('Sophie Wilmès, Kamala Harris, George Floyd, Donald Trump...', 2020). A sense of *vulnerability* permeated throughout by State of the Union speech by European Commission President Ursula von der Leynen in the midst of the pandemic (European Commission, 2020c) and beyond, namely when announcing the launch of a new European Care Strategy the following year (European Commission, 2021b). In a similar vein, European Council President Charles Michel stressed that European values can only flourish in a "caring society" (European Council, 2020). Outside of Europe, UN Secretary General Antonio Guterres, whilst repeatedly acknowledging the importance of care, stated how "[t]he pandemic has revealed our shared fragility and interconnectedness"(*Guterres*, 2021). Likewise, New Zealand Primer Minister Jacinda Ardern stood out for her leadership focused on kindness and empathy, urging the population to "look after their neighbours, take care of the vulnerable, and make sacrifice for the greater good" (Henley et al., 2020).

one of the main challenges posed by the pandemic: care inequalities. Through the cases 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".

Overall, by choosing this lens I endeavour to anchor this thesis in an intersectional perspective (Crenshaw, 1989) to highlight interlocking forms of inequalities rooted in overlapping sources of inequality such as age, sexual orientation, race, class or disability.

Serving as a foundation for my theoretical framework, *section I* offers a brief review of the relevant feminist literature based on insights from academic research on care since its early developments until more recent policy interpretations. On the one hand, the concept of caring as developed in feminist research offers useful lenses to analyse care in connection with social inequalities and welfare states models. On the other hand, the concepts offered by the seminal work in the field coupled with the more recent literature in the wake of the pandemic are key to assess the challenges of care whilst insisting on public responsibility to ensure sustainable care systems. Grounded in feminist research methods, *section II* outlines in more details the country case selection, the methodological approach, the research hypotheses and material. *Section III* offers a paint brush picture of the development of the recovery measures at EU level before moving to the core of the analysis in section IV with a quantitative and qualitative assessment of care in the respective NRRPs. To that end, the critical frame analysis (Elomäki & Kantola, 2022a; Lombardo & Verloo, 2009; Verloo, 2007) serves to delineate how care is articulated and how the NRRPs construct care comparing the stated aims and the differences in how the proposed measures contribute to a care-led and feminist recovery. Finally, *section V* builds on the previous analysis to formulate conclusions and ways forward.

Section I – Feminist Care: Revisiting the Politics of the Invisible

As its multiple uses in everyday language illustrate, care covers a wide range of realities. It is ubiquitous, rich but also complex and sometime ambiguous. A simple look at dictionary entries immediately reveals its rich array of meanings combining feelings, action, interest, a sense of responsibility, solicitude, a cause for concern but also maintenance (Cambridge Dictionary, n.d.; Merriam Webster Dictionary, n.d.).

A large body of scholarly research has been devoted to care in the past decades. Being such a highly gendered phenomenon, it has occupied a prominent place in feminist thinking (Sainsbury, 2013). 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 significatively across disciplines. Although the different parts of research on care overlap inevitably, I draw on three main overarching strands to structure this literature review – care as labour and value orientation (A), care as a component of welfare state policy (B), care as embedded in global processes (C)[2] – before moving on to the care crisis (D) and its understanding in the recent context of the Covid-19 crisis (E).

A. Conceptualising care as labour and value orientation

Feminist scholars have widely engaged with this concept paving the way for a field of research on its own and a fully-fledged school of thought known as the *feminist ethics of care*[3], which 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)" (Gilligan, 2011). Contributions of care ethics emerging in the 1980s used the perspective of care to give centre stage to ordinary life and the continuous everyday care work necessary to life (Gilligan, 1982; Noddings, 1984; Ruddick, 1989).

As Tronto (2013: 19) put it, "[t]his literature 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." This very flexible concept has found multiple uses from sociology to social work, laws, psychology, political science, philosophy, geography, anthropology, business, communication, education, literary studies, urban studies, postcolonial studies, and theology (ibid).

[2] Daly (2021) suggests a fouth one ("care in the context of the organisation and effectiveness of service provision") but due to space and scope constraints, it is not expanded on. See Daly (2021) for a more detailed account.

[3] see for instance Bubeck, 1995; Clement, 1996; Folbre, 2001; Gilligan, 1982; Glenn, 2000; Glenn et al., 1994; Gornick & Meyers, 2003; Harrington, 2000; Held, 2006; Hochschild & Machung, 1989; Hondagneu-Sotelo, 2001; Kittay, 2020; Knijn & Kremer, 1997; Koehn, 1998; Laugier & Paperman, 2011; Meyer, 2002; Noddings, 1984; Robinson, 1999; Sevenhuijsen, 1998; Tronto, 1987

The work of the US ethicist and psychologist Carol Gilligan has had a major influence in the emergence of the ethics of care. Her seminal publication *In a different voice: psychological theory and women's development* (1982) contributed to what led feminist researchers to open up the reflection from only a rights-based justice and discrimination-focused approach towards considering a more substantive understanding of equality from the perspective of "care". Feminist scholars have thus elevated care on an equal footing with other, more widely acknowledged, basic values such as rights and justice (Barnes, 2007; Kittay, 2020; Sevenhuijsen, 1998). Far from pitting both ethics against one another, this approach maintains that justice is incomplete without care and vice-versa (Laugier et al., 2009).

Another seminal contribution to the field of care ethics comes from the thinking of Joan Tronto who has played an important role in de-gendering and politicising care (Tronto, 1987, 1993, 2013). In fact, she stresses (1995: 142) that "[c]are may be ubiquitous in human life, but it has remained hidden from the conceptual lenses of social and political thought." She thus concludes that "to place care at the center of human life requires that we re-think many of the assumptions that we make about social and political theory."

Tronto underlines that the ethics of care cannot confine itself to the private sphere. She politicises the concept "forc[ing] us to place into the context of people's daily lived lives any political or moral concerns" (Tronto, 1995: 142). Besides, she has conceptualised care with 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" (Tronto & Fisher, 1991).

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 ethic 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 (Abel & Nelson, 1990; Bubeck, 1995; Ruddick, 1998; Tronto & Fisher, 1991).[4] Three important notions arise from this understanding of care.

1) Everyone needs care. Whilst autonomy tends to be socially valued, it is misleading to present autonomy as an innate feature of human life. On the contrary, if people have a sense of autonomy, if is only thanks to a specific constellation of caring relationships and institutions from families to welfare states and the market. At odds with most aspirations of autonomy and independence, it reminds us that we constantly need others to meet our most basic needs. The notion of interdependence is central within this theoretical framework. Some may feel it more or sooner than others according to age, physical endowments, personal situation, background, race, ethnic origin or class (Glenn, 1992).

2) Care is relational. Far from merely acting as rational, goal-maximising, and isolated individuals, people are constantly enmeshed in care relationships far richer than the reductive mother-child dyad (Tronto, 1995: 145). Recognising care as a value thus amounts to recognising dependence and vulnerability as universal traits of human life (Fineman, 2004; Laugier, 2011). There is no point in artificially creating a category made distinctive by their vulnerability because we are all by essence vulnerable beings, even if not equally so. As Paperman (2011) phrased it: *Les gens vulnérables n'ont rien d'exceptionel* ("Vulnerable people are nothing exceptional", own translation). Butler et al. (2016) namely argue that this notion of vulnerability is socially produced. Such a vulnerability analysis therefore enables us to see the structures of our society from a different angle that shall help us to better address our vulnerabilities, which are seen as a common basis for all. Admittedly, categorizing women or other socially disadvantaged groups as vulnerable can be both true and dangerous. We may well find ourselves entangled between the need to point out where it exists and the undesired conclusion that women are by default the weak link in society. As Butler et al. (2016) claim, these institutional protections, still rooted in a paternalistic logic, perpetuate women's and minority's vulnerable position portraying them as devoid of agency. In response, we must think about feminist modes of agency.

The ethics of care brings to the fore the experience of those who facilitate other peoples' autonomy, including children, elderly, people with disabilities or the sick but also perfectly able adults whose autonomy rests one the invisible work of others (Fraisse, 2021; Paperman,

[4] Whilst care is sometimes also interpreted as a concern/interest or as affection/family, this study focuses on care as a *practice*.

2009). This is an important point to bear in mind in relation to the policy implementation of social care often failing to acknowledge the inherent nature of people's vulnerability resulting in unjust distributions of care across gender, race and class as will be discussed below. In the same logic, this approach promotes a comprehensive lifespan including all phases of life rather than just focusing on the beginning (children) and the end (elderly) (Tronto, 2003).

3) 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 (1993: 105-8), each associated with a corresponding moral virtue, which she uses to demonstrate the need to politicise care: a) *caring about* implies acknowledging a certain care need (*attentiveness*); b) *taking care of* involves feeling responsible for finding an adequate response once the need is recognised (*responsibility*); c) *care-giving* corresponds to the act of care whereby the answer to the identified care need is carried out through care work (*competence*), which excludes purchasing care or bringing the money home; d) *care-receiving* is as important as the former three to meet the actual needs in a two-way relationship (*responsiveness*). These four phases may overlap or clash, each being likely to involve different actors who might differ in the goals they pursue (e.g. profit maximisation vs. well-being) and the constraints they face (e.g. time pressure vs. living in dignity). Often, the first two widely enjoy social appreciation whereas the latter two remain largely undervalued (Raïd, 2011).

The originality of Tronto's work lies in her ability to show the links between power dynamics with a feminist concern focused on care too often relegated as a private matter (ibid.). In this sense, social systems of care can only exist through the politicisation of care (ibid.: 63). That is why Tronto proposes to re-define certain boundaries, namely between the public/private. Without going as far as erasing the private sphere, there must be a re-distribution of private and public spheres in such a way that domestic (private) work does not equal social weakness to re-value care work and to de-link 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. In a similar vein, Fraser (2016: 103) speaks of "boundary struggles" to refer to social actors struggling over the boundaries delimiting the economy from society, production from work and work from family.

Whilst women's experience constituted the starting point of the care approach, a major aspect of the analysis also holds that care must transcend the gender perspective (Glenn, 1992;

Tronto, 1987, 1993). Reducing care to nurturant or face-to-face activities namely offers an incomplete account of class and racial hierarchies involving low-paid workers (Duffy, 2005). Therefore, whilst many women may relate with the ethics of care due to their own experience, it is crucial to advocate *politically* for its gender-neutrality (Laugier et al., 2009: 12).

The perspective of care thus brings a central claim on the importance of care for human life, the relations on which it rests as well as the social and moral status of care-givers (Laugier, 2011). Through its reading of social relations as organised around dependency and vulnerability putting the finger on some major caveats in usual accounts of justice, the care perspective is inherently ethical and political (ibid.). Placing human life in the centre, it shifts the focus to the ordinary life and work accomplished both in private and in public.

B. Care as a component of welfare state policy

> *We need to articulate both the right to care and the right to be cared for in more assertive terms moving beyond abstract definitions to the practical demands of social policy [without being] intimidated by accusations that improved care is too costly to consider. What's the economy for, anyway, if not to help realise our vision of good society?* (Folbre, 2008: 381)

The emphasis on care as an analytical concept and its moral dimensions outlined above have relevant implications for our understanding of care as an analytical lens to envision welfare and related policies. Care is not a luxury good and effective care infrastructures cannot be built on personal responsibility (Dowling, 2021). Daly & Lewis (2000: 282) namely argue that 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." Therefore, the redefinition of public policies around care is central to welfare states (ibid.).

This aspect of the literature is interested specifically in the relationship between care and welfare state to assess the need for public support with a focus on modalities of provision. By theorising care, feminist scholars have contributed to challenging the gender-blindness of mainstream accounts on welfare and the economy (Sainsbury, 2013). In detecting the male bias of established welfare accounts (e.g. Esping-Andersen, 1990), they have elevated care from an invisible to a central tenet of society and welfare (ibid). 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 excluded women and failed to account for social entitlements' gender bias (Langan & Ostner, 1991; J. E. Lewis, 1997; Sainsbury, 2013).

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 important place given to care reflecting on: gender and familial ideologies, the inclusion of the private/domestic sphere, reconsidering the access to entitlements, acknowledging the nature of care work as a combination of paid and unpaid work and the public provision of care (Sainsbury, 2013). The identification of care regimes across Europe has offered a new lens to envision welfare states (Bettio & Plantenga, 2004; Glendinning & McLaughlin, 1993; Ungerson, 1995). Welfare states' care policies namely 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 pension 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 (Daly, 2002), see also Annex I .

On the one hand, care sets the relationship between the family, the state and the market, metaphorically conceptualised as the *care diamond* by Razavi (2007) representing the various institutions involved in the provision of care. On the other hand, care policy also has an influence on the intimate human motivations and relations. Care can therefore be considered a complex social good, which Daly (2002: 255) encapsulated within a four-fold classification of care provisions within welfare states: a) *monetary and in-kind social security and taxation benefits* (e.g. cash payments, credits for benefit purposes, tax allowances; b) *employment-related provisions* (e.g. paid and unpaid leave, career breaks, severance pay, flexi-time, reduction of working time); c) *services* (e.g. home helps, community-based support services, child-care places, residential places for adults and children) and d) *incentives towards employment creation or provision in the market* (e.g. vouchers, rearranged working hours, subsidies for private or market care).

Whilst childcare has taken centre stage (Daly, 2010; Ellingsæter & Leira, 2006; Kremer, 2007; J. Lewis, 2009; Mahon & Michel, 2017), gendered considerations of care policies for the elderly have received scant attention chiefly classified in two areas: the shift to home care and the commodification of care (Sainsbury, 2013; Ungerson & Yeandle, 2007). A division persists in the analysis of care concentrating on individual policies (Castles et al., 2010) although some have combined both (Dahl & Eriksen, 2018; Morel, 2007; Pfau-Effinger & Rostgaard, 2011). The concept of social care (Daly & Lewis, 2000: 285) 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" (ibid.: 286).

In examining the possible outcomes of care policies, the three ideal models of gender equality proposed by Fraser (1994) namely offer a useful lens to conceive how various care arrangement can contribute to gender equality. First, the universal breadwinner supposes men and women as equal earners relying on universal care provision for children and the elderly. Second, the caregiver parity model fosters both carers and earners with a special attention to informal and unpaid carers. Third, the universal caregiving (or equal-earner-equal-carer) model strives for the equal sharing of caring and earning between women and men by help of service and measures encouraging informal care addressed to everyone regardless of gender. Each model entails advantages and disadvantages for the achievement of gender equality.

At 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 (e.g. 1992 recommendation on childcare, 2002 Barcelona targets, 2021 Child Guarantee). Care policy remains a very complex issue to address at EU level due to the limited competences, the marginalised position of care in the EU project and the diversity of care regimes across Member States (Caracciolo di Torella & Masselot, 2021; Sainsbury, 2013). However, arguing that an ethics of care is already embedded in EU law, Caracciolo di Torella & Masselot (2021) call on the EU to adopt a "holistic approach to care" mainstreaming care across all EU policy fields.

This very brief glimpse unveils how much the organisation of care is intertwined with gendered norms and values regarding the desired approach to care needs (Daly, 2021). In this regard, the various feminist public policy orientations formulated to ensure caring societies converge in similar directions (Dowling, 2021; Folbre, 2008; Glenn, 2000). First, there is a general agreement on the benefits of defamilising care by offering greater support for care outside the market. Second, changes in the organisation of private/public care provisions are necessary to improve the supply and quality of purchased care services, even if not all care can or should be done professionally. Effort must also include employment practices ensuring that care responsibilities are not penalised. Lastly, feminist scholars underline the importance of developing new systems of accounting for economic growth and government spending in order to challenge conventional accounting systems that mismeasure economic welfare.

C. Care as embedded in global processes

The instability of care in Western societies is rapidly transforming care into a globalised commodity (Peng, 2017; Yeates, 2012), creating new forms of inequality and new care relationships. 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 (A. R. Hochschild, 2014) or from Eastern to Western Europe (Katona et al., 2020; Katona & Zacharenko, 2021) to fill the care gaps caused by a lack of fundamental change in the gender division of labour. This concept denoting "a series of personal links between people across the globe based on the paid or unpaid work of caring" (Hochschild, 2000: 131) unveils the inherently cross-border nature of care which cannot be confined at national level (Degavre & Merla, 2016; P. H. Lutz, 2012; Ruth & Fiona, 2007; Zimmerman et al., 2006). Inevitably, new care gaps are created in the countries of origin, leading to care drains (Akpinar-Elci et al., 2016).

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 the increasing female employment rates has namely resulted in a narrowing capacity to perform care, leading to a "dualized organisation of social reproduction" where care is commodified for those who can afford it and privatised for those who cannot (Fraser, 2016: 104). 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-optimization" (Dowling, 2021: 14). For them, "this means juggling their obligations of working family or deciding in favour of one or the other" (ibid.).

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 (Aulenbacher et al., 2018). By coupling key feminist critics on care as reproductive labour, power and inequality with globalisation and (post-)colonial studies, this strand of the literature is interested in the most invisible amongst the invisible: migrant care workers (Baldassar & Merla, 2013; Parreñas, 2001). It offers an intersectional account of care by demonstrating how policies in the field are closely connected not only with gender but also with social class, race and ethnicity and hence the direct link with migration policy (Daly, 2021).

Illustrating how immigrant women are overrepresented in household services in countries with the poorest public provision of care services (Spain, Italy, Greece), Simonazzi (2009) introduced the *migrant carer model.* In fact, there is a need to consider both the national care regimes and their interplays with migration regimes, considering immigrant care workers' welfare and rights as well (Kofman, 2010). A vicious circle of "double devaluation" is at play here (Glenn, 2000): First, care giving is devalued, invisible, underpaid and penalised, which relegates it to the socially, economically and politically disempowered groups; Second, care work itself is devalued precisely because it is disproportionately concentrated in the hands of the most disadvantaged groups. Not only care work itself is devalued but also care workers, which "further reinforces the view of caring as low-skilled 'dirty' work." (ibid.: 86).

Whether conceptualised as global care chains (A. R. Hochschild, 2014; Yeates, 2012) or as care circles (H. Lutz, 2018), what becomes evident is that care has become a quintessentially mobile and global phenomenon. This reality makes it impossible to think of care along national borders only, in spite of the important role of the national context and policies (Caracciolo di Torella & Masselot, 2021; Sainsbury, 2013).

D. The care crisis

Concerns have been raised about the consequences of the constant undervaluing of care work in national economies, namely with the depletion of those engaged in social reproduction (Rai et al., 2014) and the resulting *care deficits* (A. R. Hochschild, 1995) or the *care crisis* (Glenn, 2000; Fraser, 2016; Dowling, 2021). 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. As underlined by Fraser (2016: 102-3), "capitalist societies separate social reproduction from economic production, associating the first with women, and obscuring its importance and value." She goes on arguing that "[p]aradoxically, however, they make their official economies dependent on the very same processes of social reproduction whose value they disavow" (ibid.). In her view, the capitalist economy free rides on care without granting it any monetised value despite being an indispensable condition for its functioning (see also Federici, 2021). The causes lies 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 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 with a corresponding re-shuffling 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.

As a result, women are increasingly squeezed between the need to juggle with care and work responsibilities, forcing them to cumulate double – if not triple – shifts, especially those who do not have the means to externalise it (A. Hochschild & Machung, 1989), thus fuelling their mental load as well (Dean et al., 2022; Garcia-Alonso et al., 2019; McKeown, 2021).

E. Covid-19 and care: new crisis, same symptoms

In the context of this silent but widely evidenced care crisis, the advent of the Covid-19 crisis has triggered a rapidly growing scholarly interest in the field highlighting the risks and opportunities for gender equality (Rubery & Tavora, 2020) building on the rich evidence about the gendered nature of previous crises like the 2008 financial crisis (Hozic & True, 2016; Karamessini & Rubery, 2013; Women's Budget Group, 2013).

In the continuity of previous work warning that gender budgeting principles have been largely ignored in the design of European economic governance tools (Addabbo et al., 2018; Cavaghan & O'Dwyer, 2018), O'Dwyer (2022) namely draws useful parallels between the gendered nature of the EU's crisis response during the 2008 financial crisis and the current Covid-19 crisis. Her comparative analysis confirms the gendered nature of the EU's crisis response**,** with gendered consequences at each stage of the policy process, building on gendered assumptions about society and the economy. In her view (*ibid.*: 162), "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." Due to a general gender-blindness to the economic underpinnings of inequality, the European economic governance system therefore falls short of the EU's commitment to gender equality and key principles in the Gender Equality Strategy denouncing the economic underpinning of inequalities.

Considering the significant opportunities offered by the NextGenEU fund, O'Dwyer suggests 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. However, the nature and full scope of that impact remains to be measured. In fact, early assessments of the EU's response to the crisis have already revealed the gender-blindness of the NGEU fund (Barry & Jennings, 2021; Klatzer & Rinaldi, 2020) and the heavy reliance on the proactive role played by feminist stakeholders and the European Parliament in advocating for a gendered perspective (Elomäki & Kantola, 2022b).

Beyond the general gender lens adopted in the critical analysis of the response to the Covid-19 pandemic, a tendency to highlight the centrality of care work can be identified from a national (Cahn & McClain, 2020; Cullen & Murphy, 2021), European (De Henau & Himmelweit, 2021), global (Bahn et al., 2020; Robinson, 2021) or more general perspective (Branicki, 2020). For instance, Heintz et al. (2021) stress the interlocking nature of the care, climate and economic crises. On a more specific level, in reaction to the rationalist approaches invoked to legitimise utilitarian logics, masculine and military language used during the crisis management, some critical voices have furthermore raised concerns about how this kind of attitudes exacerbate pre-existing inequalities based on gender or minority background. In this backdrop, Branicki (2020) advocates for a care-based approach, which gears towards genuine social transformation rather than seeing the recovery as part of a linear process towards a return to "normal". Similarly, Dowling (2021:8) argues that "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."

Starting from the wary observations 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 care infrastructure and seriously imperilled women's employment prospects (Klatzer & Rinaldi, 2020). Echoing previous work warning about the "urgent need for policy-makers to adopt an extended macroeconomic perspective taking into account social reproduction, and hence unpaid and informal work" (Addabbo et al., 2018: 77), De Henau & Himmelweit (2021) namely call for investments in high-quality public services. Pleading for a care-led recovery, they argue 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 child and adult care, reducing the disadvantages from unpaid care whilst ensuring good conditions for

care workers. The authors namely note 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" (*ibid*.: 454). Among the sectors in urgent need of reform, long-term care was a low priority for most governments (*ibid.:* 454-5), confirming earlier claims by Folbre (2008) who argued that concerns regarding the impacts of work/family balance on gender equality deserve a broader focus on care to include not only children but also other care needs including for sick and elderly people or those with a disability.

In this backdrop, I would like to explore how these concerns are addressed in the recovery efforts. In the continuity of the above-identified discussion, this study will therefore use care as a framework to analyse another crucial and subsequent step towards the realisation of Europe's recovery process: the response at national level through the NRRPs.

Section II – Care crisis in the EU: Contextualising Policy Reponses

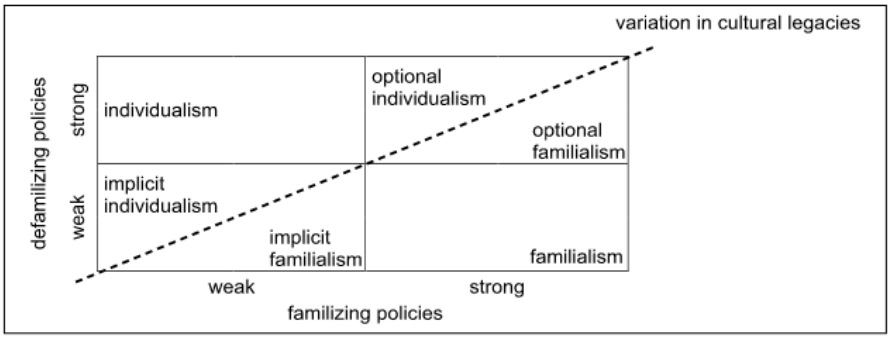
Setting the methodological framework, this section offers more details on (A) the country case selection, (B) the research hypotheses as well as (C) the analytical approach and support.

A. Case selection

Before analysing how the Member State's recovery plans reflect a certain attention to care, the significative diversity of national care and welfare regimes within the EU must be acknowledged. Whilst all countries without exception have been affected by the pandemic (and still are), they did not necessarily stand on the same baseline before Covid-19 hit. Besides merely ensuring geographic balance, the country selection thus reflects a diverse range of care policy models. This thesis 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 & Zagel (2016) is of particular relevance. It proposes a range of ideal-typical patterns of policy outcomes based on the different ways of structuring family dependencies mapped on a four-fold matrix built on the idea that care must be conceived as reciprocal relationships considering gender and intergenerational dependencies (Figure 1). *Defamilizing* policies are understood "as welfare state provisions […]

that reduce care and financial responsibilities and dependencies between family members" whereas *familizing* 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" (ibid.: 52-3).

Figure 1 - Dimensions of welfare state intervention in family responsibilities/dependencies (Lohman & Zagel, 2016)



Countries can be plotted on the dimensions of familising and defamilising policies (figure 1), situating them according to specific ideal-typical outcomes of family policy configurations. It is influenced by key contributions within the field such as the four ideal types of care regimes of Leitner (2003) and the work on intergenerational policy regimes of Saraceno & Keck (2010). Lohmann & Zagel merge the advantages of the former two into one model adding extra nuance. First, it replaces *defamiliarism* with *individualism* acknowledging that gender and intergenerational dependencies may be mitigated by means of individual support without implying that family bonds are undesirable but simply individuals should not be forced to rely on them for their care needs (Daly, 2011). Second, it allows for a more diverse array of configurations extending Leitner's *optional familiarism* and *implicit familiarism* to *optional individualism* and *implicit individualism* connected to factors such as attitudinal and cultural differences across welfare states. The "direction in which countries pull [towards optional individualism or optional familiarism] is to a certain extent defined by predominant family ideals in terms of gender and intergenerational relations" (Lohmann & Zagel, 2016: 55). Rather than placing (de)familising policies on opposite poles, this model acknowledges that welfare states may feature both defamilising and familising policies. Last, the range of EU countries covered (21) is much wider, allowing for a more representative mapping including eastern European countries often omitted (Szelewa & Polakowski, 2008; Szikra & Szelewa, 2010).

Accordingly, I draw on this model for the selection of a set of eight countries covering a representative sample of different ideal typical outcomes on the matrix (Figure 2). Finland constitutes one of the countries coming closest to the individualism policy configuration. Belgium too can be clustered in the individualism configuration but with a slightly more important level of familising and defamilising policies. On the other end, Austria comes closest to the famlialism model. Some countries, like Spain and the Czech Republic, rank lower on both (de)familising policies, with the former closest to the implicit familism model and the latter to implicit individualism. Subsequently, there are instances distinguishable precisely by their borderline position. Latvia does not feature a very high level of (de)familising policies but still scores higher on familising policies. Some studies namely speak of refamiliarisation in post-communist countries (Hantrais, 2004). Italy presents an ambiguous case in between implicit individualism and implicit familialism. Last but not least, whilst Lohmann & Zagel (2016) find no countries from their sample simultaneously featuring strong policy support for both individualism and familiarism (optional individualism/optional familiarism), Germany combines to some extent familising and defamilising policies, which places it at the border between familialism and optional familialism.

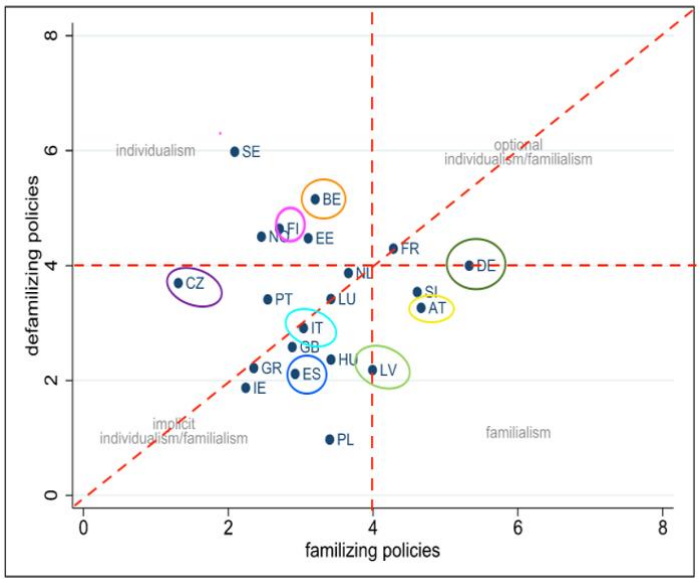


Figure 2 - Familization and defamilization across countries. (Lohman & Zagel, 2016, own annotations in colours)

B. Research hypotheses

My central thesis is that care regime constellations are an important factor in understanding the place of care policy as part of the post crisis reconstruction. In trying to answer the main research question, the analysis will be guided by two main research hypotheses drawing on conceptual considerations of care as well as on de/familiarisation care regimes.

Research hypothesis 1 posits that the localisation of a country on the care model matrix determines the scope/nature of measures related to care in the respective NRRPs. Put differently, the idea is to test the de/familisation and de/gendering effect in the recovery plans.

For instance, in the case of countries closest to the familiarism model where care infrastructures are likely to be less accessible or poorly developed, either the respective NRRPs might go at greater length to make up for the identified care gaps or they might just result in a general lack of attentiveness to and responsibility for care (Tronto, 1993). Likewise, I would expect that the different modalities of care-related measure ranging from (a) monetary and in-kind social security and taxation benefits to (b) employment-related provisions, (c) services and (d) incentives towards employment creation or provision in the market (Daly, 2002), are directly determined by the care regime a certain country corresponds to (or instead aspires to become).

Research hypothesis 2 departs from the more abstract care theory to postulate that care may be addressed in a fragmented manner within the NRRPs. Following the four phases of care of Tronto (1993), we can expect that some phases of care may be privileged over others. The point will be to understand not only whether the NRRPs are concerned with care at the first place (*care about*) but also whether investments and reforms address it properly (*take care of*) and whether sufficient consideration is given to the latter phases of performing the act of care itself in adequate conditions (*care giving*) whilst preserving the dignity and agency of those in need of care (*care receiving*). This hypothesis, in turn, gives rise to further underlying assumptions and sub-questions. Does the presence of a concern for the impacts of certain aspects of care on gender equality in the NRRPs automatically translate in addressing care gaps in a comprehensive approach? Or do some forms of care needs overshadow others (e.g. childcare vs. life-span approach to care)? Following the lines of Folbre (2008) arguing that a broader focus on care beyond work-life balance is often missing, the basic idea is that not all aspects of care may be treated equally in the NRRPs. The literature review namely shows that childcare has often received more attention than other, equally important areas of care: long-term care for adults and non-nurturant care (cleaning, cooking, etc.) which are overwhelmingly performed by underprivileged and under-valorised groups.

C. Analytical approach and support material

Central to my analysis of how care is articulated in recovery efforts is the way discourses of politics also produce corresponding policies (Rönnblom, 2009). In the context of Covid-19, care has undeniably made 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 (*ibid*.).

In a discursive and constructivist approach, this thesis therefore compares how care is envisioned within the NRRPs whose very purpose is to ensure "the construction of a stronger, fairer and more inclusive Europe that is filled with opportunities" in the aftermath of the pandemic (Portuguese Presidency, 2021). More precisely, this exercise was conducted using a critical frame analysis, drawing on the methods developed by Verloo (2007) and endorsed by EU gender policy and frame analysis scholars (Elomäki & Kantola, 2022a; Lombardo et al., 2009). Exploring how policy problems can be portrayed in relation to gender equality within policy documents, this approach can serve to analyse and interpret the processes through which the concept of gender equality acquires different meanings (Lombardo et al., 2009: 10). By means of an analysis centred around diagnosis *(what is/are the problem/s)* and prognosis *(what is/are the solution/s)*, the questions asked revolve around: who is deemed to face the problem of gender inequality? who caused it? who should solve it? to what extent are gender and intersectionality related to the problem and its solution? where are the problem and its solution located in the organisation of citizenship, labour or intimacy? *(ibid.)*

Grounded in the observation that gender equality is "a continuously contested, open concept that can be filled with a variety of meanings" (Lombardo & Verloo, 2009: 3), the critical frame analysis namely introduces the concepts of "fixing, stretching, shrinking and bending" to refer to processes whereby the meaning of gender equality is constantly subject to change (Lombardo & Verloo, 2009; Verloo, 2007). In relation to gender equality, fixing refers to the temporary freezing of its meaning (e.g. formal recognition in legislation), shrinking to its oversimplification as a narrow social problem and solution (e.g. equating gender equality with equal opportunities in the labour market), stretching to the expanding of its scope (e.g. from non-discrimination to substantive equality) and, finally, bending to its instrumentalisation for other goals than gender equality. These concepts are crucial when examining how care is framed in policy discourse. For instance, reconciling paid and care work corresponds to fixing, reducing or stretching gender equality but it comes closer to bending if the underlying aim lies elsewhere than with gender equality *per se* (Lombardo et al., 2009). Family policies and the evolution of their framing in the EU is quite telling in this regard as it shifted from the initial goal of "sharing tasks" within the family as a condition to for equal opportunities for women in the labour market to that of "reconciling work and family life" with a growing accent on

concerns for competitiveness and employment creation (ibid.). Therewith gender equality is bent to market-oriented objective to such an extent that reconciliation policies may seem more focused on addressing demographic decline and promoting economic development than on gender equality (ibid.). Care ("family") policy, which has long been typically associated with the realm of the intimacy, is therefore an interesting field to explore to detect possible shifts in the different ways in which related problems are represented in the wake of the Covid-19 crisis.

Stressing the importance to think beyond the mere binary analysis of inequality which would fail to acknowledge a more complex reality where gender, race, ethnicity, class, age, etc. are intertwined, this method is rooted in an effort to envision inequalities from an intersectional perspective (Verloo, 2007: 25; see also Crenshaw, 1989). It actively questions the extent to which policy discourses represent any other structural inequalities beyond gender as part of the diagnosis and prognosis analysis. Evidence namely shows that despite its relevance, the intersectional dimension is hardly considered by policymakers (Lombardo & Verloo, 2009). This method also seeks to avoid "overgeneralizations concerning the existence of North-South, East-West shifts and gaps in the representation of gender in/equality […] in the analysis of gender equality across Europe in order to not to fall into the trap of stereotypical assumptions about more or less women-friendly states." (ibid.:30).

The construction of care within this research data will be assessed through in-depth qualitative content screening complemented with some quantitative assessments. This analysis explores the material in terms of the investment and reforms committed to in the NRRPs, care issues discussed, constructions of care, preferred actors and proposed policy solutions. Within each category, several subcategories are identified, inspired by those proposed by Elomäki & Kantola (2020) complemented by relevant insights from the care literature (see Table 1). This means that the material is analysed in terms of the activities undertaken by the NRRPs, the care issues discussed therein, constructions of gender equality, preferred actors, proposed policy solutions and the corresponding policy fields. As underlined by Elomäki & Kantola (2022), 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 national level. This also implies that aspects of gender equality left out of the policy agenda can be as telling (ibid.).

Table 1 - Categories of analysis based on Elomäki & Kantola (2020) and complemented with Daly (2002)

Activities	Proactive, reactive, supportive, opposing
Issues	Narrow scope, medium scope, extensive scope
Approaches	Valuable in itself, rights, business and economic benefits, cost or burden, intersectionality, diversity
Actors	State, employer/market, family/household, individuals, Non profit
Measures	Legislation, public services, awareness raising, good practises leaves, cash payments, credits for social security, taxation, services, incentives towards employment creation, incentives for market services
Policy field	Social, employment/labour market, education, health, income

To capture the different ways of articulating care across the selected country case studies, this thesis analyses the NRRPs and the articulation of care therein. But before that, it appears indispensable to understand the general context in which they have emerged. Based on desktop research, the analysis takes place in two steps. First, it briefly outlines the key elements of the NGEU fund put in place by the EU based on primary and secondary sources (Section III). Second, the place of care within the resulting NRRPs is explored (Section IV). More precisely, it draws on primary sources constituting the body of the research material based on (a) the Council implementing decisions on the approval of the assessment of the NRRPs and (b) the annexes to the Council implementing decisions adopted following positive assessment by the European Commission for each country case study respectively. The exhaustive list of the documents analysed in section III and IV is available in part (A) of the bibliography. By analysing these official EU policy documents as a proxy for the NRRPs, the idea is to explore how norms such as (gender) equality, anti-discrimination or solidarity shape the investment and reform plans foreseen at national level. In relation to gender equality and care, this implies enquiring how "gender is constructed in discourses and practices, privilege[s] some representations of the problem/solution of gender equality over others, and by doing so, construct[s] subjects in specific gendered ways" (Kantola & Lombardo, 2018).

Section III: The EU Recovery Plan: context and development

In response to the socioeconomic consequences of the pandemic, the EU announced the launch of a temporary recovery instrument – NextGenerationEU (NGEU) – worth EUR 806.9 billion on 27 May 2020 (cf. Table 2 for a detailed budget breakdown and Annex II for a general timeline). This extraordinary stimulus package is meant to supplement the multiannual

financial framework (MFF). [5] The largest share of the NGEU is to be implemented through the Recovery and Resilience Facility (RRF) with EUR 723.8 billion to spend by the end of 2026 in loans or grants to boost reforms and investments in Member States (Sapala, 2021).

Table 2 - NextGenerationEU break down (European Commission, n.d.-b), all amounts in €, in current prices

Recovery and Resilience Facility (RRF)	**€723.8 billion**
of which, loans	€385.8 billion
of which, grants	338 billion
ReactEU	€ 50.6 billion
Horizon Europe	€ 5.4 billion
InvestEU	€ 6.1 billion
Rural Development	€ 8.1 billion
Just Tranistion Funds	€ 10.9 billion
RescEU	€ 2 billion
TOTAL	€ 806.9 billion

Following the European Commission's proposal for a regulation establishing the RRF on 28 May 2020, the European Parliament adopted a resolution in July 2020 welcoming the recovery instrument a "historic move" whilst nevertheless calling for "the introduction of gender mainstreaming and gender impact obligations (gender budgeting) in both the MFF regulation and the NGEU regulation" It went on demanding that "a transparent, comprehensive and meaningful tracking methodology should be adopted swiftly and adapted, if necessary, during the MFF mid-term revision" (ibid.).

The creation of the RRF presented an opportunity for the EU to materialise its commitment to gender mainstreaming and gender budgeting. [6] As underlined in the Regulation (EU) 2021/241 of the European Parliament and of the Council of 12 February 2021 Establishing the Recovery and Resilience Facility, the RRF "should be a dedicated instrument designed to tackle the adverse effects and consequences of the COVID-19 crisis in the Union." Yet, the initial version of the proposal for a regulation establishing the RRF by the European Commission was equality blind, disregarding the disproportional impact of the pandemic on women or minority groups, with no single mention to gender equality or social care (European Commission, 2020b).

Throughout the legislative process, feminist movements supported by the EP played an active role in calling for a gender-sensitive instrument (Elomäki & Kantola, 2022b). In January

[5] Covering a period of at least five years, the MFF organises and structures the expenditures of the EU with the objective of guaranteeing financial discipline. In practice, expenditure ceilings for broad categories of spendings (headings) are fixed by the MFF regulation (for more information about the MFF see (European Parliament, 2021a).

[6] Gender mainstreaming can be defined as: "The (re)organisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy-making" (Council of Europe, n.d.). Gender budgeting can be defined as: "[A] way of analysing or preparing budgets from a gender equality perspective. This simply means making the needs of all citizens – women and men, girls and boys are reflected in budgets." (European Women's Lobby, n.d.).

2021, the EP adopted a resolution calling for specific measures to enhance gender equality in the NRRPs and stressing that the pandemic exacerbated gender inequalities owing to the care crisis (European Parliament, 2021). Moreover, the report underlines the need for an EU Care Strategy valuing care in a "holistic and life-long approach to care" considering care givers as much as care receivers, stating that the strategy should "aim to improve cooperation and coordination at EU level through relevant initiatives, including under the [RRF]" (recital 25).

Similarly, the *#halfofit* petition urged for "at least half of the volume of the Recovery and Resilience Instrument [to be] spent on women's jobs and the advancement of women's rights as well as equality between women and men" (*#halfofit - We Demand Half of the Corona Funds for Women.*, n.d.). 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 the heart of the demands stressing the need for "a Care Deal for Europe" and alternative methods for GDP calculations.

Eventually, gender equality has been 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[7], with the UN Sustainable Development Goal 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 (European Union, 2021). However, that is broadly as far as it goes. Whilst the regulation is unequivocal on 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 significatively less constraining manner, without any comparable threshold or reporting indicator. References remain on a descriptive level recommending that

[7] The European Parliament, the Council and the Commission proclaimed the European Pillar of Social Rights in 2017 at the Gothenburg Summit. The Pillar sets out 20 key principles which represent the beacon guiding us towards a strong social Europe that is fair, inclusive and full of opportunity in the 21st century. These principles namely include gender equality, work-life-balance, childcare and support to children, social protections minimum income, old age income and pensions, health care, inclusion of people with disabilities, long-term care, access to essential services, secure and adaptable employment, equal opportunities. Source: (European Commission, n.d.-d, n.d.-a).

"[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" (§28). Likewise, mainstreaming is referred to both in relation to 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[8] supposed to achieve resilience for the next generations which singles 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 (European Union, 2021).

Accordingly, Member States were required to submit their detailed plans in the form of national recovery and resilience plans (NRRPs) by 30 April 2021 pending assessment by the Commission and approval by the Council. The countries under scrutiny in this thesis have all successfully passed this procedure with their respective NRRPs adopted by the Council's implementing decisions with the corresponding annexes detailing the measures foreseen, which are precisely the key documents analysed in depth in the next section for each country.

Without binding targets, gender and care considerations present narrower chances to be prioritised in Member States' NRRPs (Barry & Jennings, 2021). In general, EU funding systems namely equate gender equality largely to social policy – rather than the more prioritised domains of economic policy, which is mainly attributable to the perception of care policies as disconnected from the productive economy (ibid.). As underlined by Barry & Jennings (2021), sustainability of the care sector should cover (in)formal care, (un)paid work, private/public services and institution/home/community-based care. However, the absence of care prioritisation is at odds with the social and economic benefits investments in the care economy would generate (De Henau & Himmelweit, 2021). The care sector has been excluded from the market-driven dynamic of the EU. Therefore, better valuing care policies and gender

[8] 1) green transition; 2) digital transformation; 3) smart, sustainable and inclusive growth, including economic cohesion, jobs, productivity, competitiveness, research, development and innovation, and a well-functioning internal market with strong small and medium enterprises (SMEs); 4) social and territorial cohesion; 5) health, and economic, social and institutional resilience with the aim of, inter alia, increasing crisis preparedness and crisis response capacity; and 6) policies for the next generation, children and the youth, such as education and skills.

mainstreaming requires the sort of paradigm shift acknowledging well-being and human interdependence as preconditions for a genuine recovery and resilience of the EU as a whole.

The cost of the lack of recognition of care activities, precarious working conditions, lack of quality long-term care (LTC) and the invisibility of care in policy making are all major challenges that came to light due to the pandemic. Whilst questions of sustainability are of utmost relevance, the RRF is a missed opportunity to seize social sustainability as rooted in care relationships in the lines of a feminist economy as advocated by the European Women's Lobby (2019).

Considering the absence of a definite care focus, which is seen as a failure to deliver on the promise of gender equality commitments (Barry & Jennings, 2021), the next section moves on analysing the way the RRF has been interpreted at national level with regards to care.

Section IV: Analysing Care in Europe's Recovery: from NextGenEU to the NRRPs

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 in the present study have identified it as a horizontal objective resulting in various types of gender-sensitive measures. However, taking a closer look appears necessary to understand how these goals interact with care in the respective national plans. This analytical section thus explores how Member States have used the opportunity of the NGEU to integrate a care dimension in their own plans regardless of the absence of an explicit care criterion unlike the green and digital spending thresholds. Put differently, the analysis is concerned with the uptake of care issues by Member States (cf. Annex III for a summary table).

A. Care policy discrepancies ranging from a cosmetic afterthought to 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 measures foreseen ranges from a total of 40 to 214 whereas the total sum of non-refundable grants per country also varies from EUR 1.8 billion to almost EUR 70 billion (cf. Annex IV). Moreover, Italy's plan differs from the other countries in the present study to the extent that it is the only case including refundable loans (EUR 122.6 billion) besides the grants. Whilst these divergences could be expected to be reflected in how care is tackled within the plans, the picture is slightly more nuanced as will be discussed below.

In screening the respective national plans, not only were "care-focused" measures identified – i.e. referring explicitly and directly to social care –, but close attention was also paid to "care-relevant" measures – i.e. 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 such investment considered as care-focused and a few more secondary, care-relevant measures. On the opposite end, Spain stands out as the frontrunner both in terms of the amount of care-focused (directly related) and care-relevant (indirectly related) measures, followed suit by Italy. Most strikingly, in the case of Austria the total share (20.3%) of measures 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 respective grants at disposal.

Besides the diverging prevalence of care generally speaking, its point of entry of the respective national plans also differs significatively from one country to another. Every NRRP is structured along key components corresponding to thematic chapters with related investment and reform objectives (Annex V). Showing a particularly strong level of support for care-relevant measures, Spain's and Finland's NRRPs are the only ones to include a dedicated chapter so explicitly and holistically devoted to care. Interestingly, it is directly connected to equality and inclusion in the former case (*Action Plan for the Care Economy, strengthening equality and inclusion policies)* and to social welfare and health in the latter case (*Improving the availability of social welfare and health care services and increasing cost-effectiveness*).

In addition to this dedicated chapter, care has been mainstreamed across other chapters in a particularly visible way for Spain (education, employment, health, taxation, pension, digitalisation). This sort of mainstreaming across the different chapters can also be noted in the way Austria structured its plan. Although to a lesser extent than Spain, the link made between equality and care appears in the plan of Latvia (*Reduction of Inequality)* and in the plan of Germany (*Strengthening of social inclusion)* where most care-related measures are featured.

For Italy, in turn, most care-focused measures are concentrated under the chapter *Social infrastructures, families, communities and third sector.* The very labelling already sets a rather different tone with a stronger focus on the family and the community, hinting at the place of

care located in the private sphere. The main exception is made with childcare, which the Italian plan sorts separately under the education envelope (*Strengthening The Provision Of Education Services: From Nurseries To Universities)*. 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 (S*pecial interventions for territorial cohesion*).

In Belgium, care-focused measures are mainly covered as part of the social infrastructure and employment chapters and in Czechia as part of the employment chapters. 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 attention to vulnerable groups.

In this context, it needs to be stressed that many measures in the NRRPs, including on care, reflect the country-specific recommendations (CSRs) formulated in the context of the European Semester in July 2019 and 2020 (European Commission, 2019, 2020). Admittedly, care measures put in place by members states in their NRRPs present an important overlap with some of the challenges pre-identified by the CSRs. All countries are namely called upon by the CSRs to address the sustainability of their health and pension systems (except Czechia in the latter case), which is not irrelevant from a care perspective considering that women often tend to live longer but in poorer health (EIGE, 2021), and hence find themselves in need of greater care. The CSRs were also formulated with a specific reference to long-term care 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 were rather linked to female labour market participation, stressing the need to access both quality childcare and long-term care. Although without direct reference to care, it is noteworthy that Austria was also invited to support full-time employment among 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. In the framework of the CSRs, Latvia is the only country asked to pay particular attention to 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 also called for the improvement of support for families.

Looking at the table in Annex VI comparing how the CSRs are mirrored in the measures proposed in the NRRPs, it turns out that all countries under study show a significant degree of support to the CSRs which are all addressed within their respective investment and reform plans with the only exception of pension which Finland, Italy and Germany do not directly address in their NRRPs. What is even more interesting, is to look at how Member States adopt a proactive attitude with their NRRPs by taking measures not directly requested by the CSRs. That is namely the case for Belgium, Italy, Latvia and particularly Spain who, by opting for an array of additional measures pertinent for care, exhibit a rather proactive attitude. In comparison, Austria, Czechia, Finland and Germany display a supportive approach by covering most CSRs in their NRRPs without necessarily going far beyond what is requested.

In sum, care measures are present across all national plans considered in the present case study, although to different degrees. In spite of the obvious variations, figures indicate that the prevalence of care in the plans seems to align with care regimes whereas the comparative analysis with the CSRs mirrors the type of measures put forth despite the mild direct incentives for the formulation of care measures by the RRF. The next subsection delves into the precise care issues covered within the care-focused measures in the NRRPs.

B. A complex policy issue with no single answer

Looking at the policy fields associated with each care-focused measures in the national plans, significant differences can be observed between certain groups of countries (Annex VII). Spain, followed by Austria, Czechia and Italy display the most extensive scope regarding care issues and the type of policy fields covered. The array of reforms and investments deployed in the Spanish plan is concerned with responding to the rising demands for different long-term care needs at all stages of human life. Addressing not just childcare but also elderly care, care for the disabled and the most vulnerable, the 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 Sustainable Development Goals (SDGs), which are underlying the whole plan." Therefore, considering how much gender equality matters across all 17 SDGs with SDG 5 (4b) namely acknowledging the inequalities arising from the unequal distribution of care work (UN Women,

2018), the Spanish encompassing approach to care seems indeed consistent with the spirit of the SDGs.

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 making a more clear-cut distinction between childcare, elderly care, care for people with a disability or illness, etc. In 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 namely revolve around the implementation of its "care guarantee" with measures entailing "support at national level for (i) welfare audits; (ii) analysis of human well-being and health; (iii) new self-care tools (including mental health promotion methods) that may be used independently; and (iv) referral services" (Council of the EU, 2021: 85).

Overall, there is one issue on 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 on the need to invest in early childcare infrastructures with the creation of facilities and the refurbishment of existing ones. In Germany, 90 000 additional places will be made available thanks to the 'Child Day-care Expansion' investment. Spain foresees investments to establish at least 60 000 new publicly owned and affordable places for children below 3 years foreseeing the operative costs but also teacher's salaries for up to 40 000 new schooling places. Likewise, 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 is no less determined to meet the Barcelona targets with a childcare rate of 33% for children under the age of three. Whereas both Spain and Belgium place a particular focus on vulnerable groups' access to such services, they seem to 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 care givers).

Besides the very infrastructural needs for accessible early childcare, inequalities resulting from childcare responsibilities is also an idea that permeates overall through several specific measures targeting the care needs of people. 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 namely serve "to mitigate the effect of interrupted employment histories, e.g. due to childcare responsibilities, on old-age pension rates." As underlined in the Austrian NRRP (Council of the EU, 2021aa: 90):

In Austria, 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. As a result, the gender pension gap is comparatively large and old-age poverty affects mainly women. The new provision shall enable the parent who is not primarily devoted to childcare to transfer pension entitlements resulting from employment to the other parent (excluding periods for which credits for raising children have been received). The reform consists of two parts. The first shall be the introduction of automatic pension splitting for couples with children. The contribution bases of both parents shall be added together and credited to the respective pension account at 50% each. The second is that voluntary pension splitting shall also be possible for every form of partnership and regardless of parenthood.

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 (Council of the EU, 2021gg: 247):

[C]ompensate 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.

Without necessarily being as specifically focused on the cost of care imbalances, the federal reform planned in Belgium's plan also entails the introduction of a "gender test" as part of its efforts to ensure the financial sustainability of the national pension system.

Besides childcare, 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 in Germany characterised by the absence of any mention thereof. Considering the stakes of long-term care within our interdependent societies, this omission does not go unnoticed and contrasts with other plans aiming at "a people-centred and rights-based support

model" to strengthen long-term care and to trigger a change in the model of support and long-term care. As stated in chapter V of the Spanish plan (Council of the EU, 2021gg: 193):

The main objective of this component of the Spanish recovery and resilience plan is the modernisation and strengthening of social services and social inclusion policies. It puts a particular focus on the long-term care (LTC) model, with the aim of responding 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.

Spain's approach is anchored in a two-fold effort to guarantee optimal conditions for care recipients (simplify administrative procedures, speed up the processing of applications and reduce waiting lists for dependants that are not receiving the services to which they are entitled as well as reducing differences across the territory) as well as for care givers (strengthening the quality of professional services, improving working conditions and increasing the coverage of the different types of financial benefits). The vision enshrined in the measures translate 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" (Council of the EU, 2021aa: 193).

In fact, the plans concerned all share a desire to move towards the deinstitutionalisation of care. National (Spain, Czechia, Italy and Latvia) or regional (Wallonia in Belgium) deinstitutionalisation strategies are namely underpinning several care-related measures. This holistic approach to long-term care is summarised in a rather telling way by the Czech reform of long-term care, which is concerned with the "challenge of fragmented governance and financing of long-term care and a low proportion of community-based and home-based services in Czechia" (Council of the EU, 2021cc: 115). Eventually resulting in a legislative reform, the measures undertaken will help to "[better integrate] health and social long-term care, ensure a stable system of adequate financing of quality long-term services, provide 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. Part of it

shall namely be equipped with modern technologies assisting people concerned in their daily lives, in order to delay or avoid institutionalisation of persons with reduced autonomy or to reduce the length of their hospitalisation.

In the spirit of this specific approach to long-term care, quite some room is given to personal autonomy, particularly through support to persons with intellectual or mental disabilities. Spain namely deploys a detailed action plan revolving around improving the quality of care services, most notably through the construction and refurbishment of (non-)residential and day care centres with a focus on rural areas. Eleven centres corresponding to 1209 places will be revamped according to the underlying principles of the strategy at hand. 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 long-term care services close to the family environment, and construction of new long-term care 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" (Council of the EU, 2021ff: 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. In the same vein, efforts to ensure the accessibility of persons with disabilities to public services can be identified in Spain, from public building access to education, health and transport.

Overall, the focus often lies on the broad category of "dependent people" without always necessarily distinguishing between the elderly, people with a disability or illness. On the downside of this holistic approach to care and to dependent people, it sometimes remains rather unclear who is considered as "dependent" eventually benefitting concretely speaking from this new model. This is slightly more contrasted in the case of Italy, where measures targeting de-institutionalisation 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 persons seeks to enhance social services and living conditions in the favour of non-self-sufficient elderly people, revolving around: 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.

Third and fourth points concern education and health. It lies outside the scope of this study to analyse in details all the education and health measures (care-relevant) in the respective plans. 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 to avoid the deepening of already existing inequalities (especially in Austria, Czechia, Germany, Latvia and Spain). The Spanish plan will namely invest in setting up at least 1 000 vulnerable student support, guidance and psychoeducational service units in school districts. As mentioned above, Italy for instance features amongst the countries most explicitly categorising childcare under the policy field of education, using rather the appellation of early childhood education and care (ECEC). The interventions to strengthen the conditions of access to nursery and kindergarten 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 the poorer South. An effort which then continues with the higher age groups focusing on preventing school dropout and other forms of distress encountered by pupils and improving the education offer.

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 seems, the care for long-term illness and social care (Austria, Czechia, Finland, Italy and Spain). In relation to territorial cohesion, Italy namely 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 to local populations and "a central element of community life, bringing healthcare as close as possible to citizens." More precisely, these pharmacies are expected contribute to the integrated home assistance service. Then comes medical care, illness and patients in critical health condition. In the case of Czechia, a significant set of measures seek to improve its ability to provide medical and supportive care for patients in 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 with the

"establishment of community nursing […] to make a significant contribution to local, low-threshold and needs-based care". As underlined in the plan (Council of the EU, 2021aa: 75):

[C]ommunity 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. The investment consists in the establishment of a network of community nurses close to their patients. […] Community nurses with a further relevant qualification (such as courses on community nursing, family health nursing, public health nursing) shall preferably be employed.

Additionally, Austria is the only country specifically addressing gendered and intersectional inequalities in healthcare with investments targeting pregnant women and young mothers from socially disadvantaged situations. The measures namely aim 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 […]" (ibid.: 69).

Sixth and last policy field, 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 degree 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 re-skilling investment scheme. The Austrian scheme for community nurses mentioned above constitutes another such employment creating measure.

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 overlaps. In short, it emerges quite clearly from this part focusing on care policy fields and issues that the shared concern (the diagnosis) for care deficits does not necessarily translate into the same policy answers targeting care (prognosis). This being said, the general trends can be grouped following similar clusters as those identified in the care regimes: countries leaning towards the familialism care regime adopt a narrower scope of care policy fields (Germany, Latvia), countries from the individualism models are characterised by a medium scope (Finland, Belgium) whereas countries with lower defamilising policies showcase the most extensive scope (Czechia, Italy,

Austria and Spain). The next subsection moves on investigating the particular types of policy tools put in place by the relevant measures in the NRRPs.

C. A measures toolbox gravitating around a service-based approach

In order to assess the specific types of care-focused measures behind the corresponding investments and reforms within the NRRPs from the above-mentioned policy issues, some general patterns can be distinguished based on Daly's (2002) four-fold classification of care policy measures (Annex VIII).

First and foremost, the category of services in the typology of care policy measures is by far the most common type of 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 concerned (all plans besides Latvia) but, in some cases, also the form (e.g. "emergency child care" for job-seekers in Belgium), the scope and the duration of care (e.g. investments to finance the extension of school time "to increase the educational offer of schools and make them open to the territory beyond school hours" as in Italy).

For services towards adult care, a strong focus lies on enabling "the transition from institutional long-term care provision to more community-based care model" (Council of the EU, 2021ff: 49) as in Austria, Czechia, Italy, Latvia and Spain. Investments combine the construction/renovation of LTC facilities and the purchase of appliances, equipment and furniture coupled with investments improving the accessibility of public services at large (outside LTC facilities) "to improve the infrastructure and equipment in buildings where services shall be provided" (Latvia).

Investments in new technologies to enhance telecare is a common care service proposed across the plans, e.g. telephone line and with specific communications and IT equipment located in a care centre or in the users' homes, investments in technology for LTC support and digital support to people with disabilities. The case of Belgium with the digitalisation of ONE[9] can be cited as just one illustrative example. The digitalisation of care through the promotion of telemedicine and telecare shifting the weight from hospital care is an idea that also seems to gain popularity "[w]ith a view to promoting integrated and patient-centred healthcare,

[9] ONE is the "public reference body in the French Community for all matters relating to childhood, child policies, mother and child protection, medico-social support for the (future) mother and child, childcare outside their family environment and support for parenthood"

improving the accessibility, quality and resource efficiency of health services" as stated in the Latvian reform on sustainability and resilience of a human-centred, comprehensive, integrated healthcare system. In the same approach, Finland insists on the need to introduce a "person-centred information system" in remote areas (Åland Islands). By contrast, Austria opts for a different type of "human-centred approach" also offering home-based healthcare services but privileging the in-person approach 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 to education (Austria, Czechia, Finland, Germany, Latvia). Finland is namely very much focused on "reducing the backlog in provision of services arising from the COVID-19 pandemic", particularly for heath and long-term care treatments (Council of the EU, 2021hh: 84-85). Spain also foresees awareness-raising campaigns to promote their deinstitutionalisation strategy and healthy lifestyles and environments strengthening preventive care whilst Finland aims to strengthen its knowledge base in decision-making to increase cost-effectiveness of social welfare and health care services by promoting research on good practices and develop effective monitoring. Moreover, Spain plans the modernisation of social services generally speaking and the redefinition of the "family" through legislative change, which also entails some components impacting care and access to social services.

Moreover, Finland's plan takes an encompassing approach to care measures, which for instance include "support at regional level for integrated multi-sector service management, in-luding social and health services and cultural, sport and nature-related services" (Council of the EU, 2021hh: 84*).*

Crucially, the border between services and other typologies of care measures overlaps in terms of quality of professional care provision from a care workers' right and well-being angle. It arises on multiple occasions: improving working conditions in LTC (Spain), in primary health care (Austria), or both (Finland), redressing the staff/child ratio (Austria), better management of HR of (health)care staff (Latvia), training of health professionals (Spain, Czechia, Latvia) and the prevention of burnout among social workers (Italy). With the emergence of deinstitutionalisation, we also see a trend of changing work patterns of caregivers: home care services for the elderly (Italy, Czechia), community nurses and midwives (Italy, Austria) or the strengthening of small hospitals (Italy).

Moving on to the remaining types of care policy instruments, these are much fewer and far between in the plans in comparison 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 at improving the legal protection and material support (in cash and in kind) for families, with a view to reduce child poverty. It namely plans on "increasing the coverage of the different types of financial benefits" as part of its reform on strengthening long-term care and promoting a change in the model of support and long-term care (Council of the EU, 2021gg: 192). Additionally, a committee of experts for tax reform will be established by Spain "to examine the features of an optimal tax system and make recommendations on how to modernise and adapt current taxation in a coherent manner" with a specific attention given to gender equality. According to the Spanish authorities (ibid.: 235):

The reform shall also be accompanied by an analysis of their distributional impact, with a particular focus on families with children [including] at least the following elements: (i) impact on the overall fiscal progressivity of the tax system; (ii) impact on vulnerable groups; (iii) impact on families with children; (iv) taxation of large corporations; and (v) distribution of taxation between labour and capital taxation."

One area within the monetary and social security typology where Spain is at least partially joined by Austria and Belgium is in the field of pensions. Care-relevant measures are namely foreseen in the pension systems reforms with the streamlining of maternity add-ons (Spain), pension splitting (Austria) or the application of a gender pension test (Belgium). 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 in a majority of countries focusing on the supply of skilled labour generally speaking (Belgium, Czechia, Latvia), targeting care workers (Austria, Italy) and, to some extent, providing decent conditions for care workers conditions specifically (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 leaves, career breaks are left untouched in the package of measures put forth despite the general trend for adult care towards deinstitutionalisations and hence the greater shift to families. Instead, the above-mentioned measures are geared towards keeping people as much and as long as possible active on the

labour market. Other measures that are not directly care-focused nevertheless present some opportunities relevant from a care perspective. In Belgium, federal reforms on mobility to sectors with shortages seek to "mak[e] work more rewarding" are not without an impact on care sectors.

From the above considerations, three different patterns seem to emerge. The first group of countries resort solely to care services whereby the countries concerned (Finland and Germany) happen to lean towards opposing ends of the (de)familising matrix of the care regimes (Lohmann & Zagel, 2016). The second group of countries (Czechia, Italy and Latvia) concentrate their efforts on care services and employment creation 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 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. Moving on from the care measures toolbox put in place, the following subsection continues with an assessment of the co-construction of care and (gender) equality.

D. Care measures: how many hits with the same stone?

Whilst the disproportionate burden of care responsibilities on women is largely acknowledged, this subsection discusses how care is articulated with (gender) equality concerns in the respective NRRPs. There are indeed significant differences between Member States as regards the care issues they prioritise and the way they articulate it with (gender) equality.

In many plans, care policy is almost systematically associated 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 as well as the promotion of female entrepreneurship), these measures mostly contribute to increasing the level of participation of women into 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 – e.g. "*supporting the start-up of women's entrepreneurial activities through mentoring, technical-*

*managerial support, measures for work-life balance" (*Council of the EU, 2021ee: 503) – such initiatives are at odds with the "need to move beyond fixing women and instead fix our systems" (Antonio Guterres, 2021). On a more general note, the issue of unpaid care is hardly ever raised across the NRRPs.

In a similar vein, seeking to address the challenges in the area of labour market and social care, Czechia's plan namely focuses on how to "foster the employment of women with young children, including by improving access to affordable childcare, and of disadvantaged groups" (Council of the EU, 2021cc:114). The stated objectives of "tackling persistent gender inequalities in the labour market, in particular the low labour market participation of women with small children" (*ibid*.) do not, however, give much consideration about the "irresponsibility of the privileged" (Tronto, 1993). Childcare infrastructures constitute a necessary and effective step towards gender equality enabling women to become "equal earners". At the same time, 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". Overall, genuine efforts to move beyond the mother-father-child imaginary remains rather limited and uneven. Czechia could not be more explicit about the aims of its reform on ensuring sustainable financing of childcare facilities "to facilitate return of parents, in particular mothers, to work after parental leave" (*ibid*.: 115).

Likewise, care remains often framed as a burden rather than a central activity in human life. This is perceptible in the general tendency to present care and (female) labour market participation almost automatically side by side. As presented in Italy's investment plan for nurseries and 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" (Council of the EU, 2021ee: 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 or to follow a training as a part of the 're-qualification strategy' of the Brussels-Capital Region. The latter namely seeks to ensure the sustainable integration of vulnerable groups into the labour market through supporting measures.

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. Austria's pension reform to increase 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 three- to six-year-olds.

At the same time, this strong 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 about the importance to increase the adaptability of workers through reskilling/upskilling and labour mobility (Belgium, Czechia, Latvia), limited references are made about the potential opportunities of investing in the skills of workers to orient themselves to the care sector, as if care work was not considered a skilled work as opposed to the provision of digital skills for instance (Spain and Austria being the only exceptions explicitly including caring professions in the list of professions for labour mobility).

Away from the idea of a "caring society", this type of approach seems more geared towards the promotion of care as a means towards a(n) (economically) "thriving society". That is precisely where the concept of "bending" offers a useful lens to conceive the constantly changing meanings of gender equality as a concept repleted with multiple understandings (Lombardo & Verloo, 2009; Verloo, 2007). 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.

A different approach can be detected in the plans of Finland. Whilst pursuing similar goals of improving employment conditions, the Finns take a much more de-gendered approach seeking to tackle disadvantage "among under-represented groups" without systematically stigmatising women or a specific category. In fact, throughout its entire NRRP, the word "women" does not occur at all and gender equality just once (Council of the EU, 2021hh: 61).

Contrary to some countries more explicitly connecting gender equality with childcare, the Spanish reforms excel at applying a de-gendered 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:

A new law on protection of families and recognising their diversity shall be adopted, in order to respond to the demographic and societal transformations that have taken place over the last decades. The aim of this new law shall be to provide legal recognition of the different types of

family structures and determining the benefits and services that they are entitled to depending on their features and income level. To this end the reforms shall include the systematisation, updating and improvement of the legal framework and the protective action that the General State Administration recognises for families, taking into account their diversity, both in terms of social protection (benefits, social services) and legal (reforms in Civil Law for certain groups: unmarried couples, reconstituted families) and economic (taxation, grants, etc.). […] An overarching objective of the reform is to reduce child poverty. A specific focus shall therefore be put on reducing inequalities by providing protection to families with special needs or in vulnerable situations, such as single parent households, or those at risk of poverty or social exclusion.

In Italy, the investment plan financing the extension of school time in order to increase the educational offer of schools is not only "expected to have a positive impact on the fight against early school leaving" (Council of the EU, 2021ee: 413) but it also brings it more in line with changing family patterns and working arrangements.

Additionally, the Spanish plan is the only one formally committing to gender mainstreaming, which is visible in its labour policies and in the development of a tax system "more fit for its purpose" aiming to incorporate a gender perspective. Again, Spain's maternity adds on for parents, mostly mothers, to be compensated 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 (Fraser, 2016; Glenn, 2000; Tronto, 1993). And yet, hardly any direct reference is made inside the plans of how care recipients and givers 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 (Katona et al., 2020; Katona & Zacharenko, 2021), 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 rather striking. As underlined by the Council's observations on the Czech plan, it is unclear how the measures are to address the challenges faced by the Roma community (Council of the EU, 2021c: 30). That is not to mention that reference to LGBTIQ people does not appear even once across the plans. Similarly, despite multiple references to the vulnerabilities faced by elderly or disabled people, the gendered experience of these conditions is obscured.

This being said, it should be pointed out that Finland's reform to streamline the work- and education-based immigration process is not without offering the possibility to address labour shortages in its care economy. Likewise, its investment introducing digital innovations for social welfare and healthcare services "shall take into account vulnerable people's need to ensure accessibility" (p.85). Additionally, it is quite telling how Spain includes reforms and investments to improve the reception systems for migrants and asylum 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 with addressing the needs of migrants (Council of the EU, 2021gg:193-4):

"Reception policies shall be tailored to the needs of vulnerable people and asylum seekers and EU integration objectives, making the whole system more resilient. It shall also set out the level of benefits for basic services for applicants lacking financial resources and for applicants with a more vulnerable profile in need of enhanced protection, aiming to minimise the provision of reception conditions in the form of financial benefits."
"To ensure implementation, a system of indicators including elements such as nationality, gender, ethnicity, vulnerability, conditions in country of origin, etc. shall be utilised in a weighted formula that shall enable an objective calculation of the probability of being granted protection."

It is for instance not without significance that measures concerned with the protection of – or one may say *the care for* – asylum seekers and migrant people are integrated as part of the above-mentioned chapter dedicated to care. What is tempting to interpret as a caring attitude towards the most underprivileged of society is applied in the exact same way for women 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 planed the creation of 700 public utility inclusive and solidarity-based housing as well as accommodation places for poorly-housed groups, which include migrants and women victims of violence as well as homeless people, single people and people in situations of exclusion.

In the remaining NRRPs, the closest we arrive to the situation of care workers from underprivileged background could be found, indirectly, in some labour market measures endeavour to address sectoral shortages and discrimination. These are two issues very present in the care sectors (ILO, 2018; Pelling, 2021; Sweeney, 2020). Especially the Belgian NRRP foresees a significant number of reforms stepping up the fight against discrimination in employment at federal and regional level. Labour market discrimination is tackled either

through corrective measures (e.g. improving the federal regulatory framework of discrimination tests) or through the enhancement of positive actions boosting the integration of vulnerable groups (e.g. integrating job seekers with disabilities in Brussels Capital Region, with a migrant background at Flemish level or women at federal level).

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

In sum, this subsection confirms the conception of gender equality as an elastic concept open to diverse meanings (Lombardo & Verloo, 2009) whereby its interaction with care can be distinguished according to certain patterns. Most countries with lower levels of familising policies namely tend to bend gender equality to employment participation (Belgium, Italy) topped with a general lack of concern for minorities (especially visible 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 middle position combining elements of gender equality as employment- and care-oriented (Austria).

Building up on this gender and intersectional reading of the NRRPs, this section ends with a last part interested in the actors of care guided by the four phases of care (Tronto, 1993).

E. Actors of care: between emerging commonalities and persisting weak links

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

First and foremost, the recognition of the agency of LTC recipients as individuals seems to have gained significative ground. The measures put in place are namely not just considering 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 namely 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 people 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 the care recipients (particularly people with disabilities) to autonomous job seekers with equal rights. This empowerment pattern from "vulnerable" to "working" people constitutes a constant feature amongst the NRRPs. Italy's plan namely 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 does not only speak of "people with disabilities" but of "people with partial work ability" whose employment rate it seeks to enhance through supporting investments improving mental health and work ability.

With some semblance of Tronto's notion of interdependence, several measures offer a greater place to the "community" taking over the role of the traditional providers of care (the family, the state or the market). The Italian Reform on the Framework Law for Disability namely 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" (Council of the EU, 2021ee: 508). The same applies to investments, which shall favour home-based and community-based care settings in respect of the principle of freedom of choice and independent living as is also the case in Czechia's investment on the development of social care.

In 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 labelling of deinstitutionalisation as such, Latvia (Council of the EU, 2021ff: 49) similarly allocates specific investments for the "resilience and continuity of the long-term social care service" in order "to enable the transition from institutional long-term care provision to more community-based care model." What is interesting here is that 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, therewith also extending the traditional conceptualisation of the "family".

This care shift is not without raising questions about the necessary organisational changes as far as caregiving is concerned. With the shift in care actors, some patterns of adaptations can be detected with some measures supporting home-based care support (telecare) and community-oriented solutions (community nurses). What remains to be determined, for instance, is how this will impact families. To this end, investments supporting vulnerable people and preventing institutionalisation build on supporting parenting skills to promote autonomous living and to prevent vulnerability of families and children as is the case in Italy.

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 mother's agency has a lot to win from transferring their disproportionate care responsibilities to early childcare facilities and to schools, this institutionalisation trend is also reflected in the construction of caregivers, with a somewhat different treatment between paid and unpaid carers. 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 certainly questionable whether the attention received is proportionate given their ever-increasing role.

Even without being framed as directly 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 of 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 to women victims of violence or trafficking). Similarly, addressing undeclared work (e.g. Italy) is likely to improve the work 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 reducing temporary employment are specifically 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 namely 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" (Council of the EU, 2021aa: 68, own emphasis; see also Latvia and Czechia). 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 – besides 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 allies in the care process, with states using the opportunity given by the EU to empower local and regional authorities with care-relevant funding through the RRF. 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 early childcare infrastructure in the Walloon Region. Likewise, municipalities in Czechia are tasked with the direct implementation of the establishment of additional social care facilities infrastructure based on the assessment of territorial needs (see also 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, Spain with Finland going a step even further) whereas only one country appears as an outlier (Germany).

Section V: Conclusions

The post-pandemic recovery impulse presented the EU and its Member States with a 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 over several decades requires more than a return to normal but asks for transformative answers rooted in a care-led recovery (Branicki, 2020; De Henau & Himmelweit, 2021; Dowling, 2021). 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 national level (see also Cavaghan & O'Dwyer, 2018; De Henau & Himmelweit, 2021; Elomäki & Kantola, forthcoming; Klatzer & Rinaldi, 2020), this thesis 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 national recovery and resilience plans (NRRPs), the research question asked by this thesis ambitioned to understand to what extent the negative socio-economic impacts of Covid-19 crisis disproportionately incurred by women and underprivileged groups translated into a care-led approach in the NRRPs.

Guided by the assumption that different care regimes constitute an important variable in understanding the different paths for care policy development as part of the post crisis reconstruction, the critical frame analysis helped to identify commonalities and divergences in addressing care within the national plans of the eight countries selected in this thesis (Austria, Belgium, Czechia, Finland, Germany, Italy, Latvia and Spain).

First, the analysis showed that the respective national plans all address care, although with substantial variations and to a significatively lower extent overall compared to other, unrelated measures. Admittedly, the EU's Recovery and Resilience Facility (RRF), which devotes a significatively more prevalent focus to the digital and green transitions, offered rather limited incentives for Member States to foster a care transition. The extent to which the resulting investment and reform plan put forth in the NRRPs to tackle care inequalities thus laid, to a large extent, in Member States' hands.

Second, the closeup examination of care in the NRRPs namely confirmed the first research hypothesis according to which the scope of care measures in the NRRPs mirrors the respective care regimes in place (Lohmann & Zagel, 2016), with the emergence of three distinguishable clusters. Countries characterised by a higher defamilising policy level exhibit a moderate incidence of care measures in their recovery plans (Finland, Belgium). Care

measures 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 which is either much lower (Germany, Latvia) or much higher (Austria). Similar clusters as above appear insofar as the range of policy fields are concerned: individualism care regimes cover a medium range of policy fields related to care measures (Finland, Belgium), implicit individualism/familism care regimes feature a more diverse range of policy fields connected to care measures (especially Spain, followed by Italy and Czechia) whereas 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 (Daly, 2002), these observations tend to corroborate the idea that the recovery can serve as a springboard to operate a care paradigm shift in countries with lower levels of family support providing there is the will to do so.

Beyond the sheer numerical prevalence of care in the list of measures, the third major finding concerns the way the NRRPs pose their diagnosis (*what is the problem?*) and prognosis (*what are the solutions?*) in relation to care inequalities. On the one hand, this thesis showed a general convergence towards rather similar solutions with the institutionalisation of childcare and the deinstitutionalisation of long-term care 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 in determining corresponding trends. A majority of countries namely present care responsibilities as a cost or burden to be mitigated (Belgium, Czechia, Italy, Latvia). Related measures are presented mainly as a way of boosting employment, economic growth and financial sustainability, hence bending the idea of gender equality to those ends. Other countries follow a different path by presenting care as valuable for itself and therefore positioning it as a central issue 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 former two scenarios (Austria) or simply offer too narrow a focus on care to allow to fully grasp the underlying approach

(Germany), which is also telling in itself. Additionally, the types of care measures resorted to in the NRRPs reinforce this idea. The overwhelming majority of countries namely focus almost exclusively on services-centred measures and in-employment care leave provisions are outrightly omitted whilst some notable exceptions like Spain stand out for opting for more diverse types of actions topping up care services with gender-sensitive pension schemes, taxation and monetary and in-kind social security benefits for instance.

Last but not least, the analysis brought a more nuanced picture to the second hypothesis positing that care may be addressed in a fragmented manner by the NRRPs, partly validating and partly infirming it. As opposed to the usually more restricted focus on childcare and work-life balance (Folbre, 2008), the examination of the NRRPs revealed 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 (Tronto, 1993) are given at least some degree of consideration. In particular, caregiving and care receiving are addressed on multiple occasions placing specific emphasis on skills and personal autonomy. This approach attentive to care receivers as well as care givers 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 revealed 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 face the consequences of the care crisis, the solutions offered (care services) only seem to scantly account – if at all – for 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 (Tronto, 1993) 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 "double devaluation" of care work (Glenn, 2000) mainly performed by underprivileged groups. Despite the 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 as the EU announced its commitment to put froward a European Care Strategy (European Commission, 2021b). The EU needs to take bolder leadership in the realm of care policy, acknowledging its centrality but also its inherently cross-border nature. First and foremost, this need to be done as part of the Commission's recovery monitoring efforts, keeping a close eye on the implementation of care measures outlined in the respective national plans through the RRF scoreboard (European Commission, n.d.-b) and the relevant common indicators identified by the European Commission (European Commission, 2021c) as well as through its review report to be submitted to the EP and the Council by Summer 2022. Considering the visible relationship between EU-induced requirements (e.g. spending thresholds for the green and digital transition or requirements to reflect the CSRs more generally speaking in the NRRPs) and resulting measures put forth at national level, upscaling of the place granted to care in the framework of the mid-term revision of the MFF appears essential. In fact, the EP already exhorted the Commission to "[adopt and adapt swiftly] a transparent, comprehensive and meaningful tracking methodology […], if necessary, during the MFF mid-term revision." (European Parliament, 2020).

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" (European Council, 2020).

Annex I – Universe of policy measures for care

Source: Daly (2002: 256)

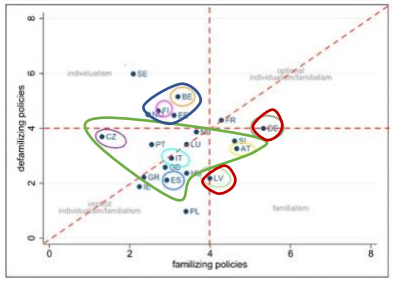
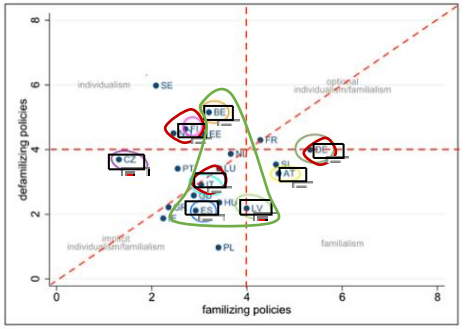
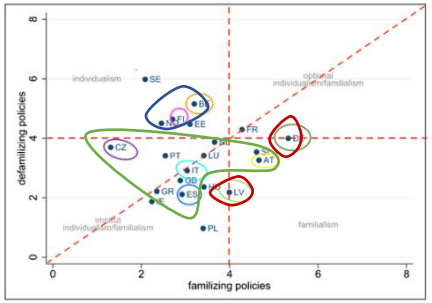
Types of measures	***Policy domain***				
	Social	**Labour market**	**Education**	**Health**	**Income**
Leaves	(un)paid parental, paternity and care leaves	Career breaks, time savings account, employment rights during leave	Educational/training leave for caring		
Cash payments	Means-tested or social insurance benefits paid to carer or care-receiver; child-care vouchers	Severance pay for labour market withdrawal due to parenthood or motherhood		Subsidies/subventions for residential care	
Credits for social security	Credits to carers for pension and other social sec. benefits				
Taxation					Allowances for care-related expenses
Services	Public childcare; home helps; meals on wheels	Workplace childcare	Creches, day care, schools, kindergarten	Residential services	
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

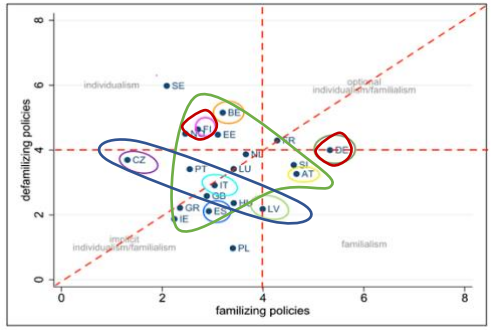
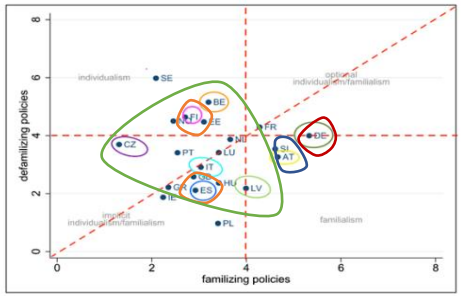
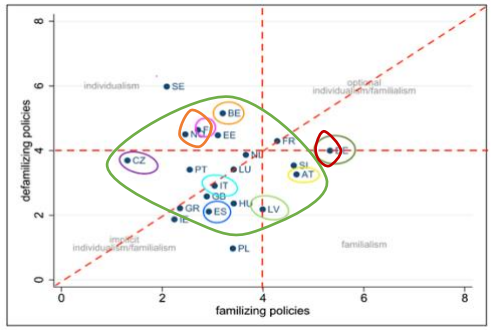
Annex II – Timeline of the EU Recovery Plan

Sources: (European Commission, n.d.-e; European Council, n.d.)

23 April 2020	EU leaders agree to work towards establishing a recovery fund
27 May 2020	**Commission presents a Recovery plan for Europe: "To ensure the recovery is sustainable, even, inclusive and fair for all Member States, the European Commission has proposed to create a new recovery instrument, Next Generation EU, embedded within a powerful, modern and revamped long-term EU budget."**
28 May 2020	**European Commission published its proposal for a regulation establishing a RRF**
17-21 July 2020	After four days of negotiations, EU leaders agreed a deal on a EUR 750 billion recovery package and a EUR 1074 long-term EU budget for 2021-2027
18 December 2020	Council and EP reach a political agreement on the RRF
21 January 2021	EP adopts resolution on improving gender equality during and after the Covid-19 crisis
12 February 2021	**Adoption of the EU regulation (EU) 2021/241 of the EP and the Council of 12 February 2021 establishing the RRF**
30 April 2021	Member States should officially submit their recovery and resilience plans
16 June 2021	Commission endorses Spain's recovery and resilience plan
21 June 2021	Commission endorses Austria's recovery and resilience plan
22 June 2021	Commission endorse the recovery and resilience plans of Latvia, Germany, Italy
23 June 2021	Commission endorse the recovery and resilience plans of Belgium,
13 July 2021	**12 EU countries – including Austria, Belgium, Germany, Italy, Latvia and Spain – received the green light by the Council for the use of the EU RRF to boost their economies and recover from the Covid-19 fallout**
19 July 2021	Commission endorse the recovery and resilience plans of Czechia
3 August 2021	Commission disburses EUR 770 million in pre-financing to Belgium, equivalent to 13% of the country's financial allocation. Belgium is one of the first country receiving a pre-financing payment under the RRF.
13 August 2021	Commission disburses EUR 24.9 billion to Italy in pre-financing, equivalent to 13% of the country's financial allocation under the RRF.
17 August 2021	Commission disburses EUR 9 billion to Spain in pre-financing, equivalent to 13% of the country's grant and loan allocation under the RRF.
26 August 2021	Commission disburses EUR 2.25 billion to Germany in pre-financing, equivalent to 13% of the country's grant and loan allocation under the RRF.
8 September 2021	**Council adopted the third batch of implementing decisions on the approval of NRRPs, including Czechia.**
10 September 2021	Commission disburses EUR 237 million to Latvia in pre-financing, equivalent to 13% of the country's grant and loan allocation under the RRF.
28 September 2021	Commission disburses EUR 450 million to Austria in pre-financing, equivalent to 13% of the country's grant and loan allocation under the RRF. The Commission disburses EUR 915 million to Czechia in pre-financing, equivalent to 13% of the country's grant and loan allocation under the RRF.
4 October 2021	Commission adopted a positive assessment of Finland's NRRP.
29 October 2021	**Council adopts implementing decision on the approval of NRRP for Finland.**
21 January 2022	Commission disburses EUR 271 million to Finland in pre-financing, equivalent to 13% of the country's financial allocation under the RRF.
31 July 2022	**Commission should present a review report on the implementation of the Facility to the European Parliament and to the Council. For that purpose, the Commission should take into account the common indicators and the recovery and resilience scoreboard provided under this Regulation as well as other available relevant information.**

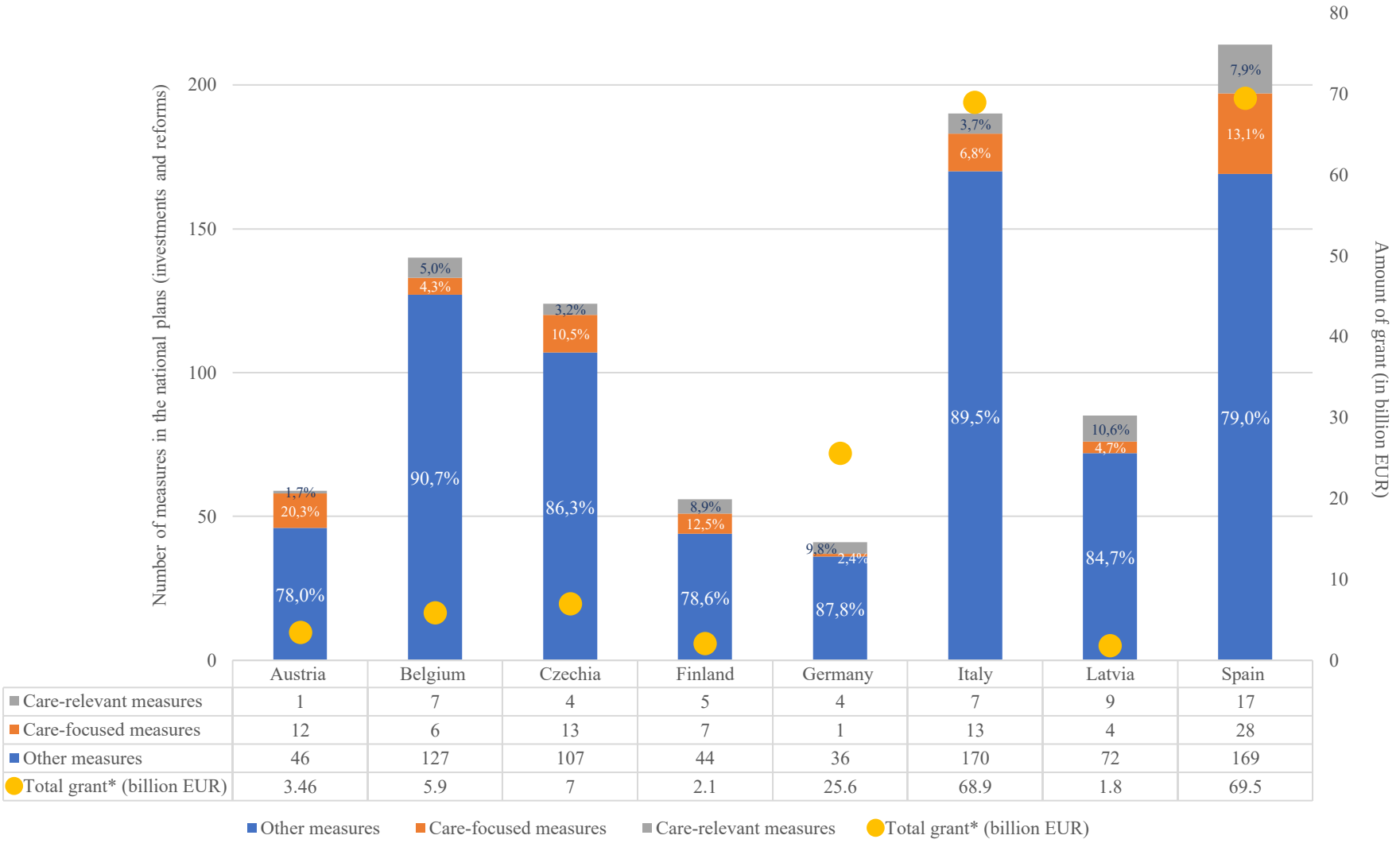
Annex III – Summary table analysing of care in the NRRPs

Activities *In terms of overall incidence*	**Proactive**: Overall, most countries on the lower ends of the defamilising scale of care regimes (Lohmann & Zagel, 2016) exhibit a supportive attitude (**Italy, Czechia**) with some countries standing out in terms of total number of care measures (**Spain**) or overall share (**Austria**).	**Supportive:** Even though countries on the higher ends towards individualism care models (**Finland, Belgium**) tend to present fewer care measures numerically speaking, their overall level of support for care measures remains high when comparing the percentage share. This is especially visible in the case of Finland with a share comparable to Spain and twice as high as Italy's despite a significatively lower grant. Likewise, Finland and Spain are the only two cases to frame care so explicitly as an issue for itself in their respective plans.	**Reactive**: With the exception of Austria, the more countries lean towards familising ends of care regimes (Lohmann & Zagel, 2016), the more the support for care policies remains mild. No countries show opposing attitude but the case of **Germany** is at most reactive with scant focus on care measures despite the comparatively higher grant, followed suit by **Latvia**.	
Activities *In terms of interactions with 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 CSRs are addressed by most countries, namely: Health and pensions systems are addressed by all countries following CSRs, LTC (**Austria** and **Belgium**), integration of care (**Czechia**) and tackling (health)care workforce shortage (**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 pension (**Finland, Italy, Germany**).	
Issues & Policy fields	**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)	

Measures for care	**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**).	
Approach to care	- Care is presented as **valuable in itself** nearing the idea of a "**caring society**" where equality at large is central and where care is an everyone's issue (**Finland, Spain**). - Care measures **combine some elements valuing care** for itself whilst 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 **bend gender equality objectives to labour market participation** striving for a "**thriving economy**" (**Belgium, Italy**) with a lesser concern for minorities (**Czechia, Latvia**).	Only marginal attention is devoted to care (**Germany**).	
Actors of care	**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 to the **community** and **local authorities** taking over from the family, the state or the market - **Institutionalisation of child care** to **offload the family** (mainly women) with an increasing recognition of **formal care givers' conditions**. (**Austria, Belgium, Czechia, Italy, Latvia, Spain**).	Lesser distinction made between the different phases of care portrayed in a l**ife-cycle and de-gendered approach** topped with a stronger insistence on **self-care and well-being** (**Finland**).	The only care receivers given some degree of attention are children (**Germany**).	

Annex IV – Care measures in the NRRPs in relation to overall share of measures and total grant per country

** In the case of Italy, the EUR 68.9 billion grants are topped up with a EUR 122.6 billion loan*



	Austria	Belgium	Czechia	Finland	Germany	Italy	Latvia	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 EUR)	3.46	5.9	7	2.1	25.6	68.9	1.8	69.5

Annex V – NRRPs' constituting components

The components in bold are those covering care-focused and/or care-relevant measures.

Austria	*COMPONENT 1: SUSTAINABLE RECOVERY* *A. SUBCOMPONENT 1.A RENOVATION WAVE* *B.SUBCOMPONENT1.BECO-FRIENDLY MOBILITY* *C. SUBCOMPONENT 1.C BIODIVERSITY AND CIRCULAR ECONOMY* *D. SUBCOMPONENT 1.D TRANSFORMATION TO CLIMATE-NEUTRALITY* *COMPONENT 2: DIGITAL RECOVERY* *E. SUBCOMPONENT 2.A BROADBAND EXPANSION* *F.SUBCOMPONENT2.BDIGITALISATION OFSCHOOLS* *G.SUBCOMPONENT2.CDIGITALISATION OFPUBLICADMINISTRATION* *H. SUBCOM PONENT 2.D DIGITAL AND ECOLOGICAL TRANS FORMATION OF ENTERPRISES* *COMPONENT 3: KNOWLEDGE BASED RECOVERY* *I. SUBCOMPONENT 3.A RESEARCH* ***J.SUBCOMPONENT 3.B RE-SKILLING ANDUP-SKILLING*** ***K. SUBCOMPONENT 3.C EDUCATION*** *L. SUBCOMPONENT 3.D STRATEGIC INNOVATION* *COMPONENT 4: JUST RECOVERY* ***M.SUBCOMPONENT 4.A HEALTH*** ***N.SUBCOMPONENT 4.B RESILIENT MUNICIPALITIES*** *O. SUBCOMPONENT 4.C ARTS AND CULTURE* ***P. SUBCOMPONENT 4.D RESILIENCE THROUGH REFORMS***	**Germany**	*A. COMPONENT 1.1: DECARBONISATION USING RENEWABLE HYDROGEN IN PARTICULAR* *B.COMPONENT1.2:CLIMATE-FRIENDLY MOBILITY* *C. COMPONENT 1.3: CLIMATE-FRIENDLY RENOVATION AND CONSTRUCTION* *D.COMPONENT2.1:DATA AS THE RAW MATERIAL OFTHEFUTURE* *E.COMPONENT2.2:DIGITALISATION OF THE ECONOMY* *F.COMPONENT3.1:DIGITALISATION OF EDUCATION* ***G.COMPONENT4.1:STRENGTHENING OFSOCIAL INCLUSION*** ***H. COMPONENT 5.1: STRENGTHENING OF A PANDEMIC-RESILIENT HEALTHCARE SYSTEM*** *I. COMPONENT 6.1: MODERN PUBLIC ADMINISTRATION* *J. COMPONENT 6.2: REDUCTION OF BARRIERS TO INVESTMENT*
Belgium	***A. COMPONENT 1.1: RENOVATION*** *B.COMPONENT1.2:EMERGING ENERGY TECHNOLOGIES* *C. COMPONENT 1.3: CLIMATE AND ENVIRONMENT* *D. COMPONENT 2.1: CYBERSECURITY* ***E. COMPONENT 2.2: PUBLIC ADMINISTRATION*** *F. COMPONENT 2.3: OPTIC FIBRE, 5G AND NEW TECHNOLOGIES* *G. COMPONENT 3.1: CYCLING AND WALKING INFRASTRUCTURE* *H. COMPONENT 3.2: MODAL SHIFT* *I.COMPONENT3.3:GREENING ROADTRANSPORT* *J.COMPONENT 4.1:EDUCATION 2.0* ***K. COMPONENT 4.2: TRAINING AND EMPLOYMENT OF VULNERABLE GROUPS*** ***L. COMPONENT 4.3: SOCIAL INFRASTRUCTURE***	**Italy**	*A. MISSION 1 COMPONENT 1:* *Axis 1- Digitalization of the Public Administration* *Axis 2 - Justice* *Axis 3 – Public administration* *Axis 4 – Public procurement and payments by public administrations* *Axis 5 – Fiscal-structural reforms (Taxation and public expenditure)* *B. MISSION 1 COMPONENT 2:* *Axis 1 - Digitalization, Innovation and Competitiveness of the Production System* *Axis 2 – Improving business environment and competition* *C. MISSION 1 COMPONENT 3: Tourism and Culture 4.0.* *D. MISSION 2 COMPONENT 1: Circular economy, agri-food and green transition* *E. MISSION 2 COMPONENT 2: Energy transition and sustainable mobility* *F. MISSION 2 COMPONENT 3- Energy efficiency and requalification of buildings*

	M. COMPONENT 4.4: END OF CAREER AND PENSIONS ***N. COMPONENT 5.1: TRAINING AND LABOUR MARKET*** *O. COMPONENT 5.2: SUPPORTING ECONOMIC ACTIVITY* *P. COMPONENT 5.3: CIRCULAR ECONOMY* *Q. COMPONENT 6.1: SPENDING REVIEWS*		*G, COMPONENT 4- Territorial planning and water resources* *H. MISSION 3 COMPONENT 1: Sustainable transport infrastructure* *I. MISSION 3 COMPONENT 2- Intermodality and integrated logistics* ***J. MISSION 4 COMPONENT 1: Strengthening the provision of education services: from nurseries to universities*** *K. MISSION 4 COMPONENT 2: From research to business* ***L. MISSION 5 COMPONENT 1: Employment policy*** ***M. MISSION 5 COMPONENT 2: Social infrastructures, families, communities and third sector*** ***N. MISSION 5 COMPONENT 3: Special interventions for territorial cohesion*** ***O. MISSION 6 COMPONENT 1: Proximity networks, facilities and telemedicine for territorial healthcare assistance*** ***P. MISSION 6 COMPONENT 2: Innovation, research and digitalisation of national healthcare service***
Czechia	*A. COMPONENT 1.1: DIGITAL SERVICES TO CITIZENS AND BUSINESSES* *B. COMPONENT 1.2: DIGITAL PUBLIC ADMINISTRATION SYSTEMS* *C. COMPONENT 1.3: HIGH CAPACITY DIGITAL NETWORKS* *D. COMPONENT 1.4: DIGITAL ECONOMY AND SOCIETY, INNOVATIVE START-UPS AND NEW TECHNOLOGY* *E. COMPONENT 1.5: DIGITAL TRANSFORMATION OF ENTERPRISES* *F. COMPONENT 1.6: ACCELERATION AND DIGITALISATION OF THE BUILDING PROCESS* *G. COMPONENT 2.1: SUSTAINABLE TRANSPORT* *H. COMPONENT 2.2: REDUCING ENERGY CONSUMPTION IN THE PUBLIC SECTOR* *I. COMPONENT 2.3: TRANSITION TO CLEANER ENERGY SOURCES* *J. COMPONENT 2.4: CLEAN MOBILITY* *K. COMPONENT 2.5: BUILDING RENOVATION AND AIR PROTECTION* *L. COMPONENT 2.6: NATURE PROTECTION AND ADAPTATION TO CLIMATE CHANGE* *M. COMPONENT 2.7: CIRCULAR ECONOMY, RECYCLING AND INDUSTRIAL WATER* *N. COMPONENT 2.8: BROWNFIELDS REVITALISATION* *O. COMPONENT 2.9: PROMOTION OF BIODIVERSITY AND FIGHT AGAINST DROUGHT* *P. COMPONENT 3.1: INNOVATION IN EDUCATION IN THE CONTEXT OF DIGITALISATION* ***Q. COMPONENT 3.2: ADAPTATION OF SCHOOL PROGRAMMES***	**Latvia**	*A. COMPONENT 1: CLIMATE CHANGE AND ENVIRONMENTAL SUSTAINABILITY* ***B. COMPONENT 2: DIGITAL TRANSFORMATION*** ***C. COMPONENT 3: REDUCTION OF INEQUALITY*** ***D. COMPONENT 4: HEALTH*** *E. COMPONENT 5: ECONOMIC TRANSFORMATION AND PRODUCTIVITY REFORM* *F. COMPONENT 6: RULE OF LAW*

	R. COMPONENT 3.3: MODERNISATION OF EMPLOYMENT SERVICES AND LABOUR MARKET DEVELOPMENT *S. COMPONENT 4.2: NEW QUASI-EQUITY INSTRUMENTS FOR THE PROMOTION OF ENTREPRENEURSHIP AND DEVELOPMENT OF CZECH-MORAVIAN GUARANTEE AND DEVELOPMENT BANK (ČMZRB) AS A NATIONAL DEVELOPMENT BANK* *T. COMPONENT 4.3: ANTI-CORRUPTION REFORMS* *U. COMPONENT 4.4: ENHANCING THE EFFICIENCY OF PUBLIC ADMINISTRATION* *V. COMPONENT 4.5: DEVELOPMENT OF THE CULTURAL AND CREATIVE SECTOR* *W. COMPONENT 5.1: EXCELLENT RESEARCH AND DEVELOPMENT IN THE HEALTH SECTOR* *X. COMPONENT 5.2: SUPPORT FOR RESEARCH AND DEVELOPMENT IN COMPANIES AND INTRODUCTION OF INNOVATIONS INTO BUSINESS PRACTICE* ***Y. COMPONENT 6.1: INCREASING RESILIENCE OF THE HEALTH SYSTEM*** ***Z. COMPONENT 6.2: THE NATIONAL PLAN TO STRENGTHEN ONCOLOGICAL PREVENTION AND CARE***		
Finland	*PILLAR 1: Green transition supports economic restructuring and a carbon-neutral welfare society* *A. COMPONENT P1C1: TRANSFORMATION OF THE ENERGY SYSTEM* *B. COMPONENT P1C2: INDUSTRIAL REFORMS AND INVESTMENTS IN SUPPORT OF THE GREEN AND DIGITAL TRANSITION* *C. COMPONENT P1C3: REDUCING THE CLIMATE AND ENVIRONMENTAL IMPACTS OF THE BUILDING STOCK* *D. COMPONENT P1C4: LOW-CARBON SOLUTIONS FOR COMMUNITIES AND TRANSPORT* *E. COMPONENT P1C5: ENVIRONMENTAL SUSTAINABILITY AND NATURE — BASED SOLUTIONS* *PILLAR 2: Digitalisation and the data economy will strengthen productivity and make services available to everyone* *F. COMPONENT P2C1: DIGITAL INFRASTRUCTURE* *G. COMPONENT P2C2: ACCELERATING THE DATA ECONOMY AND DIGITALISATION* *H. COMPONENT P2C3: DIGITAL SECURITY* *PILLAR 3: Raising the employment rate and skills level to boost sustainable growth*	**Spain**	*A. Component 01: Sustainable, Safe And Connected Mobility Shock Plan In Urban And Metropolitan Environments* *B. Component 02:Implementation of the Spanish urban agenda: Urban Rehabilitation And Regeneration Plan* *C. Component 03: Environmental And Digital Transformation Of The Agri-Food And Fisheries System* *D.35 Component 04: Ecosystems And Biodiversity* *E. Component 05: Coast And Water Resources* *F. Component 06: Sustainable Mobility (Long-Distance)* *G. Component 07: Deployment And Integration Of Renewable Energy Sources* *H. Component 08: Electricity Infrastructure, Smart Grids And Deployment Of Flexibility And Storage* *I. Component09: Renewable Hydrogen* *J. Component 10: Just Transition* *K. Component 11: Modernisation Of Public Administrations* *L. Component 12: Industrial Policy* *M. Component 13: Support To SMEs* *N. Component14:Tourism* *O. Component 15: Digital Connectivity*

	I. COMPONENT P3C1: EMPLOYMENT AND LABOUR MARKET ***J. COMPONENT P3C2: RAISING THE COMPETENCE LEVEL AND REFORM OF CONTINUOUS LEARNING*** *K. COMPONENT P3C3: RDI, RESEARCH INFRASTRUCTURE AND PILOTING* *L. COMPONENT P3C4: STRENGTHENING COMPETITIVENESS AND BOOSTING GROWTH IN CRISIS-IMPACTED SECTORS* ***PILLAR 4: Improving the availability of social welfare and health care services and increasing cost-effectiveness*** ***M. COMPONENT P4C1: IMPROVING THE AVAILABILITY OF SOCIAL WELFARE AND HEALTH CARE SERVICES AND INCREASING COST-EFFECTIVENESS***		*P. Component 16: Artificial Intelligence* ***Q. Component 17: Science, Technology And Innovation*** ***R. Component 18: Refurbishment And Extension Of Capacities Of The National Health System*** ***S. Component 19:Digital skills*** *T. Component 20: Strategic Plan To Boost Vocational Training* ***U. Component 21: Modernisation And Digitalisation Of Education, Including Early Education 0-3*** ***V. Component 22: Action Plan For The Care Economy, Strengthening Equality And Inclusion Policies*** ***W. Component 23:Newpublicpoliciesforadynamic,Resilientand Inclusive Labour Market*** *X. Component 24: Cultural Industry* *Y. Component 25: Spain Audiovisual Hub* *Z. Component 26: Promotion Of Sports* *Aa. Component 27: Measures And Action To Prevent And Combat Tax Fraud* ***Ab. Component 28: Adapting The Tax System To The Reality Of The Twenty-First Century*** ***Ac. Component 29: Improving The Effectiveness Of Public Spending*** ***Ad. Component 30: Pensions***

Annex VI – Comparative table of the NRRPs and overlap with the CSRs

Source: European Commission (European Commission, 2019, 2020a), Council of the EU (2021a, b, c, d, e, f, g, h, aa, bb, cc, dd, ee, ff, gg, hh)

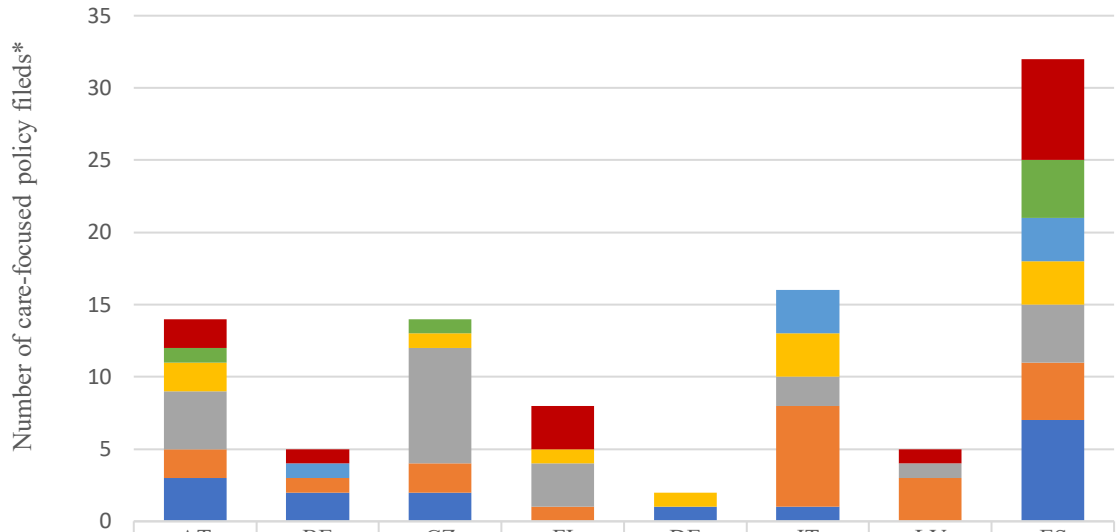
Country	2019/2020 CSRs RELATED TO CARE	ADDRESSED IN THE NRRPs
Austria	sustainability of their **pension** systems	**YES, with a gender-sensitive dimension** Reform: 4.D.2 Increase in effective retirement age Reform: 4.D.3 Pension splitting
	sustainability of their **health** systems	**YES, with a gender-sensitive dimension** Investment: 4.A.3 Development of the electronic mother child pass platform including the interfaces to the early aid networks; Investment: 4.A.4 National roll-out of 'early aid' for socially disadvantaged pregnant women, their young children and families Reform: 4.A.1 Enhancing primary health care Investment: 4.A.2 Funding of primary health care projects Investment: 4.B.4 Investment in the implementation of community nurses
	long-term care (fiscal sustainability)	**YES** Reform: 4.B.2 Reform to further develop care provision
	support **full-time employment among women**	**YES** *Investment: 3.C.3 Expansion of elementary education* (expand provision of childcare facilities, particularly for the under three year old and the opening hours for the three to six years old, to facility the reconciliation of work and family life) Reform: 4.D.7 National Financial Education Strategy ("Women were identified as one of the specific target groups.")
	inclusiveness: education including "**people with a migrant background**"	**YES** Reform: 3.C.1 Improved access to education Investment: 3.C.2 Remedial education package
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	Investment: 3.B.2 Promoting re-skilling and up-skilling
Belgium	sustainability of their **pension** systems	**YES, with a gender-sensitive dimension** Reform R-4.07: 'End of career and pensions' of the Federal State
	sustainability of their **health** systems	**YES**
	long-term care (fiscal sustainability)	**YES, with a gender dimension (but only for Walloon region)** Investment I-4.12: 'Development of public utility housing and housing for vulnerable persons' of the Walloon Region
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	Investment I-2.07: 'Digitalisation of ONE' of the French Community Investment I-4.07: 'Re-qualification strategy' of the Brussels-Capital Region (emergency childcare) Investment I-4.08: 'E-inclusion for Belgium' of the Federal State ("improving the digital skills of the caregivers of vulnerable target group") **Investment I-4.10: 'Gender and work' of the Federal State** **Investment I-4.13: 'Creation and renovation of early childcare infrastructure' of the Walloon Region** Reform R-5.01: 'Cumulation regime and mobility to sectors with shortages' of the Federal State (promote labour mobility towards sectors facing shortages.)
Czechia	**(health)care workers** and the **integration of care**	**YES** Reform 1: Improvement of education of healthcare professionals **Reform 3: Reform of long-term care** **Investment 3: Development and modernisation of social care infrastructure** **Reform 2: Ensuring sustainable financing of childcare facilities** **Investment 2: Increasing the capacity of childcare facilities**
	sustainability of their **health systems**	**YES** Reform 2: eHealth services

		Investment 1: Creation of the Intensive Medicine Simulation Centre Investment 2: Rehabilitation care for patients recovering from critical condition Investment 3: Building a centre for cardiovascular and transplant medicine Reform 1: National Oncological Programme of the Czech Republic – NOP CZ 2030 Reform 2: Supporting and enhancing the quality of preventive screening programmes Investment 1: Establishment of the Czech Oncology Institute Investment 2: Developing highly specialised oncological and hematooncological care Investment 3: Establishment and development of the Centre for Cancer Prevention and Infrastructure for Innovative and Supportive Care at the Masaryk Oncology Institute
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)s	Investment 2: Tutoring of pupils
Finland	**shortages of health workers** to strengthen the resilience of the health system and improve access to social and health services	Investment 2 (P3C2I2): Improving the level of education by increasing student places in higher education (targeted at professional sectors experiencing labour shortages. Such sectors include social and health care)
	support employment and bolster active labour market policies	**YES,** Reform 1 (P3C1R1): Nordic Model of Employment Services
	equal access to social and healthcare services.	**YES, including self-care, regional support, good practice sharing/data collection,** Reform 1 (P4C1R1): Preparation of the social welfare and health care reform in support of implementing the care guarantee Investment 1 (P4C1I1): Promoting the implementation of the care guarantee and reducing the service backlog due to the COVID-19 pandemic Investment 2 (P4C1I2): Strengthening prevention and early identification of health problems Investment 3 (P4C1I3): Strengthening the knowledge base and evidence-based decision-making to increase cost-effectiveness of social welfare and health care services Investment 4 (P4C1I4): Introducing digital innovations for social welfare and health care services
	incentives to accept work and enhance skills and **active inclusion**	**YES, with a particular attention to migrant people and people with partial work ability** Reform 3 (P3C1R3): Streamlining the work- and education-based immigration process Investment 1 (P3C1I1): Development of work ability, productivity and well-being at work
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	**n/a**
Germany	sustainability of their **pension systems**	**NO**
	sustainability of their **health systems**	**YES, without gender dimension (pension/health)**
	inclusiveness: education, vulnerable groups	**YES** 4.1.4 Reform: Educational support for students with a learning backlog
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	4.1.1 Investment: Investment programme 'Childcare-financing' 2020/21: special fund 'Child Day-care Expansion'
Italy	**female labour market participation**, stressing the need to access both quality childcare and long-term care	**YES** Investment 1.1: Plan for nurseries and preschools and early childhood education and care services ("encourage women's participation in the labour market and support them in reconciling family and professional life") Investment 1.2: Plan for the extension of full-time Investment 2 - Gender Equality Certification System Investment 5 - Creation of women's enterprises
	sustainability of their **health systems**	**YES (especially remote areas)** Investment 1. Inner Areas – 2. Territorial Proximity health facilities Reform 1: Definition of a new organisational model for Territorial healthcare assistance network. Investment 1.1: Community Health Houses to improve territorial health assistance. Investment 1.2: Home as the first place of care and telemedicine

		Investment 1.3: Strengthening Intermediate Healthcare and its facilities (Community Hospitals)
	Ensure that active labour market and social policies are effectively integrated and reach out notably to young people and vulnerable groups	**YES** Investment 3 - Strengthening the dual System
	Step up efforts to tackle undeclared work	**YES** Reform 2 - National Plan tackling undeclared work.
	Improve educational outcomes, also through adequate and targeted investment, and foster upskilling, including by strengthening digital skills. / **School dropout**	**YES** Reform 1.3: Reorganisation of the school system Reform 2.1: Teachers' recruitment Investment 3: Structured socio-educational interventions to combat educational poverty in the South supporting the Third Sector
	Address social exclusion notably by improving the adequacy of minimum income benefits, minimum old-age pensions.	**NO (pension) but YES minimum income** Reform: 3.1.2.r. Access to social and employment services in support of the minimum income reform
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	**Reform 1 - Framework Law for Disability** **Reform 2 – Reform for non-self-sufficient elderly persons** **Investment 1 - Supporting vulnerable people and preventing institutionalization** **Investment 2 - Autonomy patterns for people with disabilities** **Investment 1. Inner Areas – 1. Enhancement of community social services and infrastructures** Investment 3 - Housing First and Post Stations Investment 6 - Innovative Plan for Housing Quality
Latvia	sustainability of their **health systems**	**YES** Reform 4.1.1.r: Sustainability and resilience of a human-centred, comprehensive, integrated healthcare system. Investment: 4.1.1.2.i.: Support for strengthening the health infrastructure of university and regional hospitals Investment 4.1.1.3.i. Support for strengthening health infrastructure of secondary outpatient service providers Reform 4.2.1.r.: Provision of human resources and upskilling. Investment: 4.2.1.1.i. Support for the implementation of the human resources development system. Reform: 4.3.1.r.: Sustainability of health care, strengthening governance, efficient use of health resources, increase of total public budget in the health sector. Investment: 4.3.1.1.i.: Support for assessing and improving the quality and accessibility of non- hospital secondary healthcare.
	support for people with **disabilities**	**YES** Investment: 3.1.2.1.i. Measures to promote access to public services and employment for people with disabilities Investment: 3.1.2.4.i. Synergistic development of social and occupational rehabilitation services for the promotion of the resilience of people with functional impairments
	sustainability of their **pension systems**	**YES, with a gender-sensitive dimension** Reform 1 (C30.R1) – Separation of sources of social security funding (childbirth and childcare allowances, iv) expenditure related to early retirement, v) the maternity pension supplement, v) pensions for family members, vi) support measures ('implicit subsidies') to special schemes and vii) the cost of complementing the gaps in contributions for the calculation of the old-age pension.) **Reform 2 (C30.R2) – Maintenance of the purchasing power of pensions, alignment of the effective retirement age with the statutory retirement age, adaptation of the calculation period for the calculation of the retirement pension to new careers and replacement of the sustainability factor by an intergenerational equity mechanism (adapt the current regulation to discontinuous careers and other forms of atypical work.)** Reform 3 (C30.R3) – Reform of the Social Security contribution system for the self-employed **Reform 4 (C30.R4) – Streamlining of maternity add-ons** Reform 5 (C30.R5) – Review of the current supplementary pension system Reform 6 (C30.R6) – Adjustment of maximum contribution base
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	Investment: 2.3.2.3i. Closing the digital divide for socially vulnerable learners and educational institutions Investment: 3.1.1.5.i. Development of infrastructure and equipment of educational institutions **Investment: 3.1.2.3.i. Resilience and continuity of the long-term social care service**

Spain	sustainability of their **health systems**	**YES, with a gender-sensitive dimension** Reform 2 (C18.R2) - Reform of the public health system Reform 3 (C18. R3) - Strengthening cohesion, equity and universality Reform 4 (C18. R4) - Strengthening professional skills and reducing temporary employment Reform 5 (C18.R5) - Reforming the regulation of medicines and improving access to medicines Investment 1 (C18.I1) - Investment plan for high-tech equipment in the National Health System Investment 2 (C18.I2) - Actions to strengthen prevention and promotion of health Investment 3 (C18.I3) - Increased capacities to respond to health crises Investment 4 (C18.I4) - Training of health professionals and resources to share knowledge Investment 5 (C18.I5) - Plan to rationalise the consumption of pharmaceuticals and promote sustainability Investment 6 (C18.I6) - Health data lake
	improvement of **support for families**	**YES, with a gender-sensitive dimension** Investment 3 (C21.I3) - Support to vulnerable students and families Reform 1 (C30.R1) – Separation of sources of social security funding (childbirth and childcare allowances, iv) expenditure related to early retirement, v) the maternity pension supplement, v) pensions for family members, vi) support measures ('implicit subsidies') to special schemes and vii) the cost of complementing the gaps in contributions for the calculation of the old-age pension.) Reform 3 (C22.R3) - Adopt a new law on protecting families and recognising their diversity Reform 5 (C22.R5) - Improvement of the system of non-contributory financial benefits of the General State Administration (l take into account the structural needs of households, notably families with children and people with disabilities)
	Reduce early school leaving and improve educational outcomes, taking into account regional disparities	**YES** Reform 1 (C21.R1) - New organic law on education (covering early childhood education, compulsory primary and secondary education and baccalaureate + improving the inclusive capacity of the system.) Investment 2 (C21.I2): Program for orientation, progress and educational enrichment ("PROA+")
	Ensure that employment and social services have the capacity to provide effective support.	**YES** Reform 2 (C22.R2) - Modernising public social services and giving them a new regulatory framework
	Foster transitions towards open-ended contracts, including by simplifying the system of hiring incentives.	**YES** Reform 4 (C23.R4) – Simplification of contracts: generalisation of the open-ended contract, reasons to use temporary contracts and regulation of the training/apprenticeship contract. Reform 6 (C23.R6) – Permanent mechanism for internal flexibility, job stability and reskilling of workers in transition.
	Additional measures in the NRRPs not directly raised in the CSRs (2019/2020)	Reform 1 (C18.R1) - Strengthening primary and community care Investment 1 (C21.I1) - Promoting early childhood education and care (ECEC) Reform 1 (C22.R1) - Strengthening long-term care and promoting a change in the model of support and long-term care Investment 1 (C22.I1): Long-term care and support plan: deinstitutionalisation, equipment and technology Investment 3 (C22.I3): Spain Accessible Country Plan Investment 4 (C22.I4): Plan Spain protects you from gender violence Reform 4 (C22.R4) - Reforming the reception system for migrants and applicants of international protection Investment 5 (C22.I5): Increasing the capacity and efficiency of the reception system for migrants and applicants of international protection Reform 1 (C23.R1) – Regulation of teleworking Reform 2 (C23.R2) – Measures to close the gender gap **Reform 8 (C23.R8) – Modernisation of collective bargaining** **Reform 9 (C23.R9) – Modernisation of sub-contracting activities** **Investment 2 (C23.I2) – Female employment and gender mainstreaming in active labour market policies** **Reform 3 (C28.R3) – Establishment of a committee of experts for tax reform**

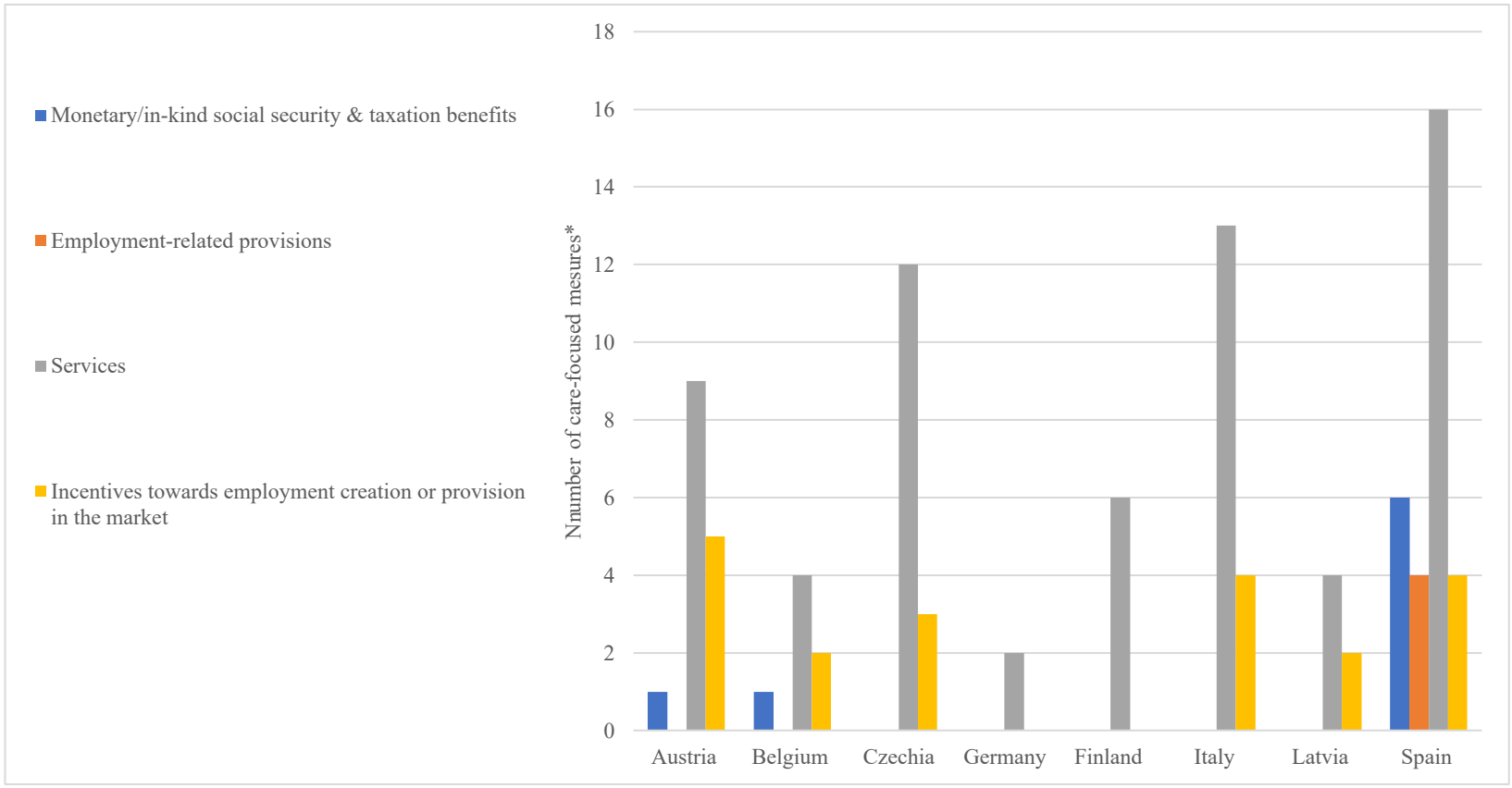
Annex VII – Construction of care measures across policy fields in the NRRPs



	AT	BE	CZ	FI	DE	IT	LV	ES
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 to 18y)	2	0	1	1	1	3	0	3
Healthcare	4	0	8	3	0	2	1	4
LTC, desinstitutionalisation, adult care	2	1	2	1	0	7	3	4
Childcare (0 to 6y)	3	2	2	0	1	1	0	7

*(*some measures target different policy fields and therefore appear in each relevant field)*

Annex VIII – Care measures according to care policy typology (Daly, 2002)



**some measures entail multiple types of action and therefore appear in each relevant field*

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Humans begin and end their lives depending upon others for care; in between those times we never cease being engaged in relationships of care with others, and we never cease needing and providing care for ourselves. As our interdependence in caring grows greater, we need to rethink how we parse out our time, energy, work, and resources to make certain that we, as well as those around us, are well cared for. We cannot rethink these questions in isolation, we can only do so collectively. And in so doing, we will change how we see ourselves in the world and what should guide our most fundamental political choices. Perhaps it is not too late.

Joan Tronto (2013: xv)