1 Politics of Pandemic Care: Exploring Disruption and Response in International Cross-Country Comparison

Introduction

Since the beginning of the COVID-19 pandemic, non-pharmaceutical interventions (NPIs), such as border closures, closures of schools or physical and social distancing requirements, aimed at curbing the spread of the infectious disease, have profoundly impacted the lives of people. The effects have been especially disruptive for care relations. They impacted the ways in which communities, families and individuals around the world are able to receive and to practice care. Schools, care facilities and hospitals had to deal with fundamental disruptions to their everyday work. Such disruptions of care have left those that were relying on them without a supportive care network or maintenance of fundamental care needs. The COVID-19 crisis and the implementation of NPIs also considerably reinforced already fragile care relationships and precarious working conditions that scholarship on the vulnerability of current care relations has long pointed out. These critical aspects root in the individualist life concepts of liberal societies (e.g. Held 2014, Isaksen et al. 2008); gendered inequalities between paid wage work and unpaid care work (e.g. Duffy 2011); or the neoliberal and unregulated global care chains and illicit and often exploitative networks (e.g. Hochschild 2000, Uhde 2020) which reinforce wage inequalities and hinge on the existence of a globally connected care economy (e.g. Mahon and Robinson 2011; Yeates 2009).

Hypothesizing that the spread of Sars-CoV-2 and the implementation of NPIs have disrupted existing care relations, we argue that NPIs shifted and disrupted care relations mainly along three main

conceptual axes: first, *mobile-immobile*, that is by restricting individual mobility across borders and zones and via requirements to physical distance. Second, *public-private*, that is moving education and child care from public contexts into families due to school closures, access restrictions to care facilities or requirements to self-isolate and quarantine; and third, *offline-online*, that includes shifts towards e-learning or telemedicine. We then explore how various forms of governmental and societal responses and the implementation of digital technologies, called politics of pandemic care, have acknowledged and reacted to these disruptions and shifts from pre-crisis care relations. While these disruptive shifts can be observed worldwide, the pandemic also brought to the fore fundamental differences in how societies and governments value and organize care relations. Especially, we explore how countries have acknowledged and reacted to these disruptions and how digital technologies were implemented to mitigate the adverse effects.

This working paper serves as an introduction to the series *Politics of Pandemic Care*. It frames key concepts and describes the series' main purpose, namely, to explore governmental policies, social initiatives and digital innovations as part of global and national disruptions of care during the COVID-19 pandemic. This series sheds light on the interfaces of national and global care politics and how these are acknowledged and managed in different ways in order to contribute to the improvement of resilience and theorize the implication of the pandemic experience at the intersection of health politics and international relations (e.g. Davies and Wenham 2020).

Care Relations and Their Disruptions

Care relations are understood as infrastructures of care and interpersonal routines and processes. Here, we understand care relations as the ensemble of structures, social relations and meaningful encounters among individuals, families, relatives and communities that stand at the centre of their actions providing dignity, integrity and progress to human lives (e.g. Held 2014, Meier-Gräwe 2020). As such, they are a pivotal ensemble of institutionalized infrastructures, necessary for social development through access to education, shelter, sanitation, health care, or food, as well as practices that improve the quality of life of individuals (Diener and Suh 1997).

Scholarship often equates infrastructures of care with infrastructures of health care, usually focusing on materialized and local infrastructures such as hospitals, care facilities but also private housing equipped with health monitoring systems (e.g. Weiner and Will 2018; Oudshoorn 2012). Other approaches add educational environments (e.g. Stratford et al. 2021), but also networked infrastructures providing water, energy, food and communication (e.g. Steele 2017). Access to these infrastructures of care is regarded as fundamental for social development and quality of life (e.g. Diener and Suh 1997), the fulfilment of basic needs (e.g. Streeten 1984) and livable environments (e.g. Lowe et al. 2015). Care relations also include encounters and relationships among individuals and communities that are founded on the meaningful interactions of people as relational and interdependent human beings (Held 2014: 13). These care relations vary according to the particular needs of individuals, such as among minorities, refugees or homeless people and throughout the life courses, from early childhood care to care of the elderly (e.g. Held 2014; Kittay 2011; Kim 2018; Johnson 2015).

Conceptually, three shifts are key to theorize the disruption of care relations: *mobile-immobile*, *public-private* and *offline-online*. An example of mobile-immobile shifts includes the disruption of transnational care relations due to border closures, particularly with regard to the sudden immobility of foreign care workers. The lack of an extended supportive network for individuals and communities due to requirements to social and physical distancing also falls within this dimension. In comparison, examples of public-private shifts include closures of schools and child day care. Instead of having access to care and education from institutionalized and public settings, children found themselves at home.

Due to the closure of public facilities, families had to privately carry the additional burden of home learning and unpaid child care. The offline-online dimension describes primarily the shift towards digitalization. It includes, but is not limited to, a shift to telemedicine, e-government, and an increased use of technological tools in many different contexts such as education or health. Looking at care relations, an example hereof is the shift towards offering medical advice online instead of in person. While distinct phenomena, it is important to acknowledge that all three dimensions and their shifts are interlinked. The mobile-immobile shift suddenly limited tendencies of increasing global mobility in recent years, while the public-private shift channeled the growing relocation of care and public structures and networks of care support back into private contexts (see e.g. Sevenhuijsen 2003). In these contexts, the offline-online shift in care relations observed during the pandemic was then often the direct response to the shifts in the other two dimensions, also partly accelerating transition towards digitalization.

The implementation of NPIs also worsened difficult elements of pre-crisis care relations (e.g. Rose-Redwood et al. 2020; Yeates and Pillinger 2020). For instance, the majority of Live-Ins, defined as care workers that live for several weeks in the same household of the people they take care of, are migrant female care workers from middle and low-income countries that work under precarious conditions (Steiner et al. 2019). Border closures during the COVID-19 pandemic did not only put their employment at risk, but due to precarious employment contracts, these situations of sudden immobility also triggered further fundamental concerns of continued social and health insurance, the lack of financial support and increasing risk of poverty (Habel and Tschenker 2020). Recent scholarship also highlighted that the burdens of combining home learning and home office and additional, unpaid child care have disproportionately been placed on women (e.g. Boncori 2020).

Pandemic politics of care in a nutshell acknowledges these disruptive effects and looks for remedies, specific responses and reactions. Within this working paper series, we consider the following categories of politics of pandemic care: specific *governmental policies* tailored to counterbalance disrupted care relations, *social initiatives and campaigns* initiated by citizens with the same purpose and the use of *digital technologies* as technology-based response mechanisms to repair care relations.

Governmental Policies

As COVID-19 case numbers began to rise across the globe in early 2020, governments implemented a broad range of NPIs, while facing incomplete information. These countermeasures varied greatly regarding their stringency, scope and spatial contexts. Examples include national, regional or local NPIs, but also financial assistance, material support or tax relief to help citizens throughout the pandemic situation. With second or third waves occurring across multiple regions of the world, governments regularly needed to adjust their policies and NPIs to emerging situations.

NPIs have a considerable impact on the organization of professional, private and social lives, on the schedules and maintenance of economic processes and the continuity of cultural and community activities. Given the focus on care relations and their ruptures during the pandemic, this working paper poses the following question: Which governmental policies were put in place to specifically counterbalance disrupted care relations? This is important not only because of the global role of care and its centrality to human lives, social development and well-being. But further it allows us to assess the extent to which the maintenance of care relations was at the centre of governmental decision-making during the pandemic. Such a perspective allows us to systematically collect and explore governmental responses that specifically target disrupted care relations. Moreover, it allows us to include broader societal concerns and political priorities of how care has been valued, acknowledged and addressed by governments across the globe throughout the pandemic situation.

Social Initiatives and Campaigns

Discussions around care have shaped public discourse, both globally and nationally. In April 2020, as NPIs across the world became more pronounced, the United Nations warned that the spread of the COVID-19 pandemic may roll back the advances made in the fight for gender equality and exacerbate already existing structural inequities (United Nations 2020). As the COVID-19 pandemic exposes inequalities and vulnerabilities in social, political, and economic systems (Bali et al. 2020), the question of how concerns of care have been negotiated by citizens in the public discourse should be examined. Have these public discourses shifted, allowing for public discussion around previously neglected aspects of care?

Consequently, this part of the working paper series brings attention to the public discourse and contemporary debates around care relations. It explores social campaigns and initiatives initiated by citizens as opposed to a sole focus on national governments. This enables us to take a human-centred approach to government responses to the pandemic, assessing not only the discourse, but also those voices and expertise integrated in the public narrative. It also seeks to analyze potential shifts that have occurred within public debates, placing particular attention on intersectional and gendered elements of care. As such, this analysis also provides the opportunity to trace the inclusivity and responsiveness of government-initiated NPIs.

Digital Technologies

Digital technologies such as contact tracing apps or surveillance systems supported governments around the world in monitoring pandemic dynamics and the implementation of NPIs. Additionally, tools and applications for telemedicine or governmental services were implemented to maintain access to health care and to facilitate civic engagement, participation and inclusion (e.g. Ada Lovelace Institute 2020, UN DESA 2020). These and similar technologies have ensured continued access to fundamental governmental and health care services. Yet, it remains largely unexplored how and to what extent digital technologies were specifically designed and developed to serve care contexts - other than health care - during the pandemic crisis.

This part of the working paper series hence explores which digital technologies were designed and implemented to replace disrupted care relations and how the implementation of digital technologies was able to re-establish these care relations. This particularly matters with regard to the digitality and increasing connectedness of contemporary societies.

Concluding Discussion

The COVID-19 pandemic is, due to its cascading effects, not only a global health crisis but also an existential challenge for contemporary societies, economies and global governance. In early 2020, the majority of governments around the world introduced wide-ranging NPIs having considerable impacts on how societies, communities and individuals around the world were able to practice care. The worldwide disruptions of care relations are far from being only an issue of private burden, individual coping strategies or government policies. They carry crucial global political dimensions with regard to the universal, globe-spanning role of care in human lives, the centrality of care in governmental responsibilities and the vulnerable existence of globally connected care dependencies among contemporary societies and economies.

The overarching aim of this working paper series is to highlight how pandemic politics and policies around the world disrupted care relations and how governments, societies, communities and individuals around the world responded to these shattered care relations. The individual contributions

to this series offer overviews about the pandemic politics of care, along three dimensions: governmental policies, social initiatives and campaigns and digital technologies, discussing different response mechanisms including differing societal discourses and innovative usage of digital technologies to maintain care relations. series hence improves our understanding of how current pandemic situations and prospects at the interfaces of national and global politics and care are acknowledged and managed in different ways around the world.

References

Ada Lovelace Institute (2020). *No Green Lights, No Red Lines. Public Perspectives on COVID-19 Technologies*. Online available: https://www.adalovelaceinstitute.org/wp-content/uploads/2020/07/No-green-lights-no-red-lines-final.pdf

Bali S, Dhatt R, Lal A Gender and COVID-19 Working Group, et al. (2020). Off the Back Burner: Diverse and Gender-Inclusive Decision-Making for COVID-19 Response and Recovery. *BMJ Global Health* 5: e002595.

Boncori, I. (2020). The Never-Ending Shift: A Feminist Reflection on Living and Organizing Academic Lives During the Coronavirus Pandemic. *Gender, Work and Organization* 27 (5): 677-682.

Davies, S.E. and Wenham, C. (2020). Why the COVID-19 Response Needs International Relations. *International Affairs* 96 (5): 1227–1251.

Diener, E., Suh, E. (1997). Measuring Quality of Life: Economic, Social and Subjective Indicators. *Social Indicators Research* 40, 189–216.

Duffy, M. (2011). *Making Care Count. A Century of Gender, Race and Paid Care Work*. Rutgers University Press.

Habel, S. and Tschenker, T. (2020). Stay at Work. Zur Situation der Live-In-Pflege in der Corona-Krise. *Soziale Sicherheit* 6: 215–219.

Held, V. (2014). *The Ethics of Care: Personal, Political, Global*. Oxford University Press.

Hochschild, A. R. (2000). Global Care Chains and Emotional Surplus Rethinking Care. In *On The Edge: Living with Global Capitalism*, edited by Will Hutton and Anthony Giddens, 130–46. London: Jonathan Cape.

Isaksen, L. W., Devi, S. U., Hochschild, A. R. (2008). Global Care Crisis A Problem of Capital, Care Chain, or Commons? *American Behaviorial Scientist* 52 (3): 405-425.

Kim, J. (2018). The Other City: Alternative Infrastructures of Care for the Underclass in Japan. *Asian Anthropology*, 17 (1): 1-23.

Kittay, E.F. (2011). The Ethics of Care, Dependence, and Disability*. *Ratio Juris* 24: 49-58.

Mahon, R. and Robinson, F. (2011). *Feminist Ethics and Social Policy: Towards a New Global Political Economy of Care*. University of British Columbia Press.

Meier-Gräwe, U. (2020). Wege in eine Care-Zentrierte Ökonomie. *Aus Politik und Zeitgeschichte (APuZ)* 70 (45): 28–34.

Oudshoorn N. (2012). How Places Matter: Telecare Technologies and the Changing Spatial Dimensions of Healthcare. *Social Studies of Science* 42 (1):121-42.

Ravazi, S. and Staab, S. (2012). *Global Variations in the Political and Social Economy of Care. Worlds Apart.* Routledge.

Rose-Redwood, R., Kitchin, R., Apostolopoulou, E., Rickards, L., Blackman, T., Crampton, J., Rossi, U., Buckley, M. (2020). Geographies of the COVID-19 Pandemic. *Dialogues in Human Geography* 10 (2): 97–106.

Steiner, J., Prieler, V., Leiblfinger, M. und Benazha, A. (2019). Völlig legal!? Rechtliche Rahmung und Legalitätsnarrative in der 24h-Betreuung in Deutschland, Österreich und der Schweiz. *Österreichische Zeitung für Soziologie* 44: 1–19.

Stratford, E., Stewart, S., te Riele, K. and Watson, P. (2021) Making Sense of School Learning Environments as Infrastructures of Care and Spatial Typologies. *Australian Geographer* 52 (1): 43-63.
Streeten, P. (1984). Basic Needs: Some Unsettled Questions. *World Development* 12 (9): 973-978
Uhde, Z. (2020). Das Europäische Care-Grenzregime in einem "Europa ohne Grenzen". *Aus Politik und Zeitgeschichte* (APuZ) 70 (45): 35-41.
United Nations (2020). *Put Women and Girls at Centre of COVID-19 Recovery: UN Secretary-General*. Online available: https://news.un.org/en/story/2020/04/1061452.
United Nations Department of Economic and Social Affairs (2020). *Compendium of Digital Government Initiatives in Response to the COVID-19 Pandemic*. Online available: https://publicadministration.un.org/egovkb/Portals/egovkb/Documents/un/2020-Survey/UNDESA%20Compendium%20of%20Digital%20Government%20Initiatives%20in%20Response%20to%20the%20COVID-19%20Pandemic.pdf
Weiner, K. and Will, C. (2018). Thinking with Care Infrastructures: People, Devices and the Home in Home Blood Pressure Monitoring. *Sociology of Health and Illness* 40 (2): 270–282.
Yeates, N. (2009). *Globalizing Care Economies and Migrant Workers: Explorations in Global Care Chains.* Palgrave MacMillan.
Yeates, N. and Pillinger, J. (2020). *Building Resilience Across Borders: A Policy Brief on Health Worker Migration. Public Services International*, Fernay-Voltaire. Online available: http://oro.open.ac.uk/74133.

This Working Paper Series is published by the members of the project "Assessment of Evolving International Infrastructures and Pandemic Management" at CASSIS/University of Bonn: Katharina Cramer, Maximilian Mayer, Janna Hartmann, Julia Holz, Kilian Knorr, Ga Young Lee, Philip Nock, Annalena Pott, Miriam Siemes and Jan David Zabala Gepp.

It is part of the research project egePan Unimed (Development, Testing and Implementation of regionally adaptive health care structures and processes for pandemic management guided by evidence and led by university clinics). egePan Unimed collects and scientifically analyzes national and international concepts for pandemic preparedness and management in order to align them within a prototypical framework. The overarching aim is to avoid inefficient use of general and intensive care facilities by providing adequate processes for the allocation of resources and for guiding both hospital and and outpatients along a prototypical patient pathway. egePan Unimed is funded by the German Federal Ministry of Education and Research as part of the Netzwerk Universitätsmedizin (NUM) initiative (Grant-No.: 01KX2021).

Suggested Citation: Cramer, K. et al. (April 2021). Politics of Pandemic Care: Exploring Disruption and Response in International Cross-Country Comparison. *Working Paper Series: Politics of Pandemic Care*, No. 1, CASSIS/Bonn University.