

HOW TO TALK ABOUT CARE IN THE UK



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This research report was written to share research results, to contribute to public debate and to invite feedback on development and humanitarian policy and practice. It does not necessarily reflect the policy positions of the organizations jointly publishing it. The views expressed are those of the author and not necessarily those of the individual organizations.



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Across the UK, many people providing paid and unpaid care – including parents and guardians of children, paid care workers, and unpaid carers – experience poverty, and great physical and emotional pressures. This is because the care they provide remains largely taken for granted and is not properly supported by governments and wider society. This report outlines key findings from research undertaken to develop a new narrative on care, and test it against its ability to communicate more effectively with the public about the urgent need to value all care – setting the scene for specific calls to action for policy change.

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EXECUTIVE SUMMARY

Across the UK, many people who provide paid and unpaid care – including parents and guardians of children, social care and childcare workers, and unpaid carers supporting disabled, ill and elderly people – experience deep financial hardship and poverty, and are under great physical and emotional pressure.

This is because the care they provide remains largely taken for granted and is not properly supported by governments and wider society. Widespread public and institutional narratives currently dismiss care as an activity of very little or no social and economic value, something that happens privately in our homes, and as low-skilled work.

To change this, we need to tell a new story about care in the UK – one that values *all* care as a vital part of our society and economy, a collective good that has to be adequately invested in and supported by governments.

As part of the *Reframing narratives on care in the UK* project (June 2022 – March 2023), research was conducted to develop a new narrative on care, and test it against its ability to communicate more effectively with the UK general public about the vital importance of care and the urgent need to value it properly – setting the scene for specific calls to action for policy change.

The research was undertaken by Oxfam and The Answer. The project included an Advisory Steering Group composed of Carers Trust, Carers UK, Joseph Rowntree Foundation, the Trades Union Congress, Women Equality Network Wales and the Women’s Budget Group.

The key messages and recommendations from the project are summarised in [this toolkit](#).

The project used a **broad definition of paid and unpaid care**, with unpaid care including the childcare provided by parents and guardians, the care and support provided to disabled, ill or elderly people, as well as household work like cooking and cleaning; and paid care work being about caring for people or doing domestic work for pay – as social care and childcare workers do, for example.¹

The new narrative that the project developed is structured in three parts:

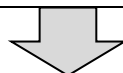
- A fundamental **Premise**, outlining care as a collective activity that holds society together.
- An **Evidence** statement, highlighting key facts about the extent and nature of all care across the UK – both in terms of numbers and activities. It is important to note that the Evidence statement is aimed at providing a flexible framework that can be adapted to new data and analysis that become available.
- Three different **Impact statements** describing the negative consequences of not providing greater support for and investing more in carers, from different perspectives:
 - **Provision** for carers, focusing on the effects on the overall health and care infrastructure, and the wellbeing of wider society;
 - **Economic** consequences of lack of support and investment for carers;
 - **Receivers of care**, focusing on those needing care due to illness, disability and old age.

Premise

Every day across the UK, the work of paid and unpaid carers helps hold society together – it's the invisible network of support, empathy and care for the people who need it most that supports our social and economic foundations.

Evidence

In the UK, more than 10 million² people provide unpaid care and paid care – that's over one in five people. They help our children grow and learn, support disabled people's independence, ensure our elderly relatives live fulfilling lives, and keep our homes running.



Impact statement 1 (Provision): How better provision for carers will reduce suffering and save lives

Without greater support and investment for carers there will be serious consequences for society:

The NHS will struggle to cope even more than it already does, causing more people to suffer and further unnecessary deaths – properly funded social care is key to tackling this escalating problem.

But many carers are already under pressure, undervalued and struggling financially, so without greater investment for both paid and unpaid carers the future and wellbeing of our loved ones is at risk.

Impact statement 2 (Economic): How lack of support for carers can drive them into poverty

Without greater support and investment for carers there will be serious economic consequences for carers:

On average, 600 people a day have to leave employment to do unpaid care for their older and disabled relatives due to lack of workplace support.³

Without access to universal childcare, many parents who want to return to work are simply unable to do so or have to take on low-paid jobs so they can care for their children.

This can have a serious impact on carers' income, and many are pulled into poverty.

Impact statement 3 (Receivers of care): How recipients of care will be negatively impacted by lack of support for carers

Without greater support and investment for carers there will be serious consequences for those who need care most in society:

Our experience of old age would be significantly less positive – missing human connection and lacking the physical and emotional nourishment needed to live a fulfilling life.

Disabled people would find it more difficult to live rewarding, independent lives, and those with serious illnesses would struggle to live with the dignity they deserve.

The research found that the new narrative can help with making care a more significant policy issue for the public.

In the experimental survey used to test the new narrative, '*Care for our children, disabled people and the elderly*' became a top-three policy issue for 38% of respondents who were exposed to the narrative compared with 16% for those not exposed, making it the third most important issue to be addressed, after the economy and health. All three Impact statements worked equally well in shifting views on the policy salience of care.

This research also suggests that in order to raise public awareness of care as a social good and encourage its greater prioritisation as a critical policy issue, it is important that messages:

1. **Present care as a social good that benefits society as a whole and ensures that society functions on a day-to-day basis.** This would help with shifting away from the tendency to view care as something that primarily happens to and supports individuals, rather than something that delivers broader holistic benefits.
2. **Talk about care as an 'invisible network of support, empathy and care' that sustains the nation's social and economic foundations.** This helps convey the social benefits care brings to the UK as well as the concept of 'infrastructure' in a concise and accessible yet powerful way.
3. **Highlight the considerable number of people who carry out a diverse range of caring activities in the UK.** The statistic used here ('more than 10 million') is a starting point to be leveraged as evidence that all care is a crucial social good, and an ever-present collective activity that touches many people's lives. More analysis is needed to develop a more accurate measure of how many people provide paid and unpaid care, using the broad definition of this project. Any statistics used should be expressed in terms that are easy to understand, such as ratios ('over one in five people') or percentages.
4. **Remind people of the wide range of activities that care entails.** This can promote greater understanding and appreciation of the essential role that carers play in society, while also helping people recognise their own personal experiences of care. This wider perspective also helps explain the prevalence of carers and supports the idea that care is a collective social good.
5. **Frame care in terms of the emotional (and not only the physical) benefits it brings to care receivers.** This helps to counter the often negative and pessimistic portrayal of care, especially in the media. By emphasising the positive effects of 'human connection', 'independence' and 'dignity', it is possible to draw attention to the transformative nature of care and help promote a more balanced perspective on the role of carers in society.
6. **Use language that encourages people to see messages as directly relevant to them.** When people can see themselves in a message, it is more likely that they will be responsive to it. This can be achieved by using the possessive pronoun 'our' when talking about recipients of care (e.g. *our* children, *our* elderly relatives, *our* loved ones), experiences (e.g. *our* experience of old age) and collectives (e.g. *our* country).
7. **Highlight the negative consequences for society if carers and recipients of care do not get better support.** This is a powerful way to generate a sense of salience and urgency in tackling the undervaluation of care.

1 INTRODUCTION

Care, both paid and unpaid, plays a vital role in our society and economy: it supports people and communities to grow, develop and thrive. We all experience care at some point in our lives – as children and when we grow older; when becoming parents or grandparents; and when looking after family members or friends who need our support due to illness, old age or disability.⁴

A broader view on care

Carers can be paid or unpaid. Unpaid care work includes childcare provided by parents and guardians, caring for children or adults with additional support needs due to disability, illness or old age, as well as household work like cooking and cleaning. Paid care work is caring for people or doing domestic work for pay – as social care and childcare workers do, for example.⁵

However, across the UK and globally, unpaid and paid care work continue to remain widely undervalued, taken for granted and unrecognised, and receive insufficient support and investment from governments.⁶ This comes with a high cost to carers' own financial, physical, emotional and mental wellbeing.⁷

Many of those providing unpaid care are forced to leave paid work, reduce their working hours or take on more low-paid, precarious forms of employment as they struggle with juggling care responsibilities and paid employment.⁸ Others have to rely on social security benefits that do not provide enough income to pay for essentials.⁹ At the same time, carers often have to face higher costs linked to the care they provide, e.g. for childcare¹⁰ or medical equipment,¹¹ while receiving insufficient support in the workplace as well as from overstretched and underfunded care services (including social care and childcare). This has all been made worse by the pandemic and the ongoing cost-of-living crisis.

- Those providing unpaid care to disabled, ill and older family members and friends are more likely to experience poverty (29%) than those without caring responsibilities (20%).¹² Even before the pandemic, 39% of unpaid carers said they were struggling to make ends meet.¹³ In the midst of the cost-of-living crisis, a quarter of carers said they were cutting back on essentials such as food or heating.¹⁴ In 2022, 91% of unpaid carers felt ignored by the government and 70% reported not receiving enough support.¹⁵
- The poverty rate for working-age parents (23%) is higher than for non-parents (18%)¹⁶ – lone parents are by far the most likely of any family type to be struggling with poverty.¹⁷ In a recent survey of parents and carers of children, 60% of respondents reported that making ends meet while raising a family has become more difficult 'over the last three years';¹⁸ research published in early 2023 also showed that one in five single parents reported using credit to pay for household essentials, and a similar proportion said they had started using food banks.¹⁹

Paid care work, both in social care and childcare, also remains widely underpaid and is characterised by insecure contracts, poor recognition of skills, and lack of training and career progression opportunities.

- In the UK, occupations like childminding and care work accounted for the largest number of employee jobs paid below the real Living Wage in April 2021.²⁰ In England, one in eight of the early-years workforce is paid under £5 an hour,²¹ and 54% of social care workers are paid less than the real Living Wage,²² with over a quarter of the UK's residential care workers living in, or on the brink of, poverty.²³
- Research on the early education and childcare sector during the COVID-19 pandemic found that workers felt demoralised and ignored, and nearly 56% of the childcare settings surveyed were

finding it harder to recruit staff.²⁴ Similarly, 75% of social care workers reported that working during the pandemic caused them worsened mental health and a sharp increase in anxiety.²⁵

Care work is unequally distributed within our communities – women, and especially racialised women, carry out the vast majority of paid and unpaid care work. This means that they are more exposed to the negative impact that the undervaluation of care has on those providing care:²⁶

- Women in the UK provide £328bn worth of unpaid childcare and £50bn worth of unpaid adult care per annum; nearly half of working-age women provide, on average, 45 hours of unpaid care every week, while 25% of men provide 17 hours.²⁷
- Women with Black and minority ethnic (BME) backgrounds are more likely to live in single-parent households and in larger families.²⁸
- Women also represent the majority of paid care workers: across England, Scotland and Wales, around four in five social care workers²⁹ and around 95% of early childhood education and care (ECEC) workers are women.³⁰

1.1 THE NEED TO SHIFT NARRATIVES AROUND CARE WORK

Among the key factors driving the undervaluation of paid and unpaid care work, across the UK and globally, are the **dominant narratives and perceptions around ‘work’**. **These narratives exclude activities that are unpaid or take place in private homes, but also dismiss paid care work as low-skilled, and see all care as an activity that is of no or very little value to the economy.**³¹

There is a critical need to shift these widespread narratives and tell a new story about care – one that values *all* care as a vital part of our society and economy, and a collective good and responsibility that has to be adequately invested in and supported by governments.³² This new story on care would help with building public support for urgent policy change that is focused on recognising, supporting, redistributing and rewarding care work.³³

Ultimately, reframing care as a social good and as a part of the economy is critical to developing transformative care policies and achieving an economy that values wellbeing and equality over growth and extraction.³⁴

1.2 THE ‘REFRAMING NARRATIVES ON CARE IN THE UK’ PROJECT

Between June 2022 and March 2023, Oxfam and The Answer implemented the *Reframing narratives on care in the UK* project, which also included an Advisory Steering Group composed of Carers Trust, Carers UK, Joseph Rowntree Foundation, the TUC, Women’s Equality Network Wales and the Women’s Budget Group.

This framing research project was part of an Oxfam-led multi-country study across the UK, Kenya and Zimbabwe, looking at understanding the views that different audiences hold on unpaid care, informal work and the economy more broadly. The study aimed to identify which narratives on these issues are most compelling to change these views, why, and how to make them work with different audiences.

The project in the UK specifically focused on paid and unpaid care. It set out to:

- a. Understand how the general public across the UK thinks about paid and unpaid care.

- b. Develop new narratives on care work, based on this broader definition, and test them against their potential to shift public thinking towards seeing all care as a key social good, collective responsibility and urgent policy issue.

The project's Theory of Change was rooted in two key assumptions:

- By changing the framing of an issue such as care, a change in the mindset of an audience can be achieved, which in turn can influence wider culture, individual behaviour and specific outcomes (such as policies and public investment).³⁵
- Public pressure can be an important route to influence decision makers, and it also creates the right environment for people to embrace any transformative policies.³⁶

Narratives are simple stories shared across culture that 'explain' the way the world is. They shape people's perceptions of reality and what is possible. New narratives help people see that there are alternatives and choices.

Framing is a way of showing an issue in a new light by telling the story in a different way, e.g. focusing on the positive benefits vs the negative outcomes, or showing how a marginalised group actually has agency.

The project included an Advisory Steering Group, whose members shared insights and expertise on different types of care (e.g. childcare, unpaid care for disabled, sick or older people, paid care work) as well as the link between valuing care and social, economic and gender justice. The aim of working with other organisations on this project was to incorporate existing expertise on care into the framing research, as well as to start fostering wider support for and alignment with the new narrative being developed.

It is recognised that this research is only a first step towards reframing conversations on care, and more collaborative work will be needed to build greater public mobilisation on valuing all forms of care – also recognising the extremely nuanced and diverse nature of care work across the UK.

2 RESEARCH APPROACH AND METHODOLOGY

2.1 FRAMING RESEARCH: WHAT, WHY AND HOW?

Reframing narratives on care in the UK was a **framing research project**. Its aim was to reshape the way the UK public talks and thinks about both paid and unpaid care (as defined in the Introduction above), by developing new narratives and testing their ability to change the terms in which care is debated.

Narratives are fundamental to how people make sense of the world. Numerous narratives are present in society at any one time, but some are more dominant than others. When developing new narratives, it is important to remember that narrative change:

- Creates compelling new stories (reframing) that intuitively ‘make sense’ and shift the way people view an issue – this is done by tapping into pre-existing beliefs and presenting them in a fresh light.
- Shifts narrative power – i.e. it changes who gets to tell stories and, at a deeper level, to claim authority, define issues and assign meaning to those issues.
- Is not about myth-busting existing narratives: refuting a narrative often strengthens it because there are no credible alternatives, and repeating a story, even to criticise it, can simply continue to frame debates in the terms of a dominant narrative.
- Is not just about publicising the right figures: statistics can be used to support narratives (the rational ‘reason to believe’), but they do not create new narratives by themselves. Narratives need to create empathy – by helping people see the world through someone else’s eyes – and create new shared experiences that resonate emotionally.
- Articulates a clear idea that incorporates the interests of a broad swathe of people and groups, as people are more likely to feel motivated to act as part of a collective vision.

2.2 THE RESEARCH PROCESS AND MIXED-METHOD DESIGN

The research employed a mixed-method, iterative approach and included five key stages (Figure 1):

1. An **initial phase of semiotic analysis** was carried out to get insights into the cultural factors that are already shaping public perceptions on care, along with a **literature review** to highlight existing narratives on care.
2. **Initial narrative concepts** were developed from the insights that Stage 1 generated, as well as feedback from the Advisory Steering Group.
3. These narrative concepts were further developed into four **draft narratives that were explored through qualitative discussion groups**.
4. The draft narratives were refined into **the final new narrative**.

5. The efficacy of the new narrative in shifting public views on care was tested through an **experimental survey**.

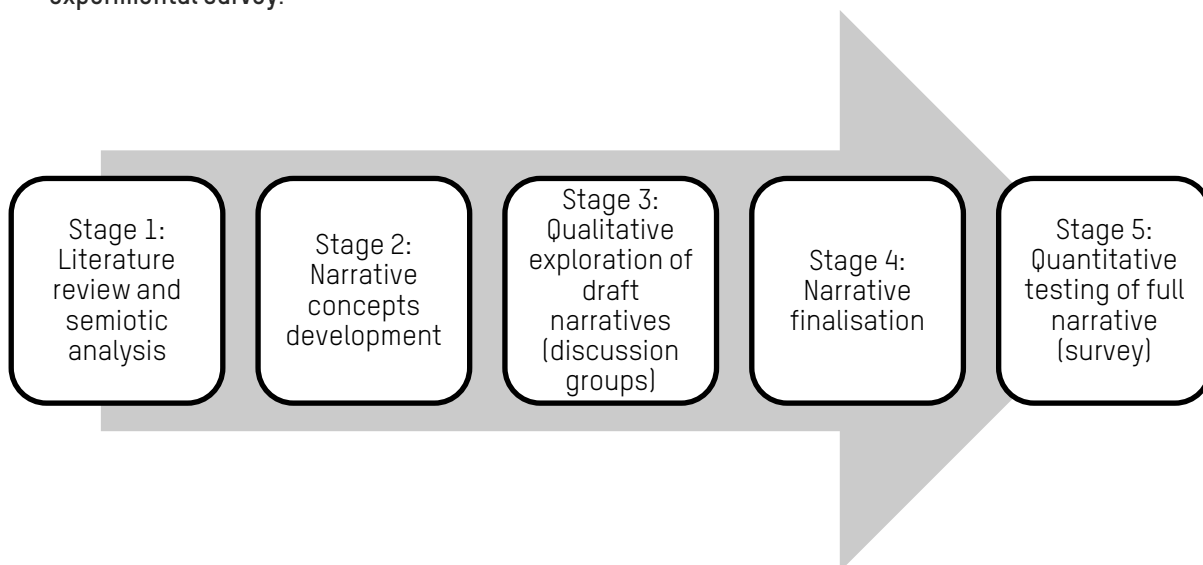


Figure 1: Project phases, including key research steps

2.3 METHODOLOGY FOR EACH KEY RESEARCH STAGE

2.3.1 Literature review and semiotic analysis

The research process began with a review of some of the key **literature** produced by organisations that are active in the sector. This comprised over 60 sources including research papers, sector reports, academic studies and blog posts. The literature review sought to identify:

- Key issues related to care and campaigning concerns of stakeholders.
- What kind of narratives on care were already being used in the sector.

The literature review was supplemented by a piece of **semiotic analysis** which took a broader cultural focus. This included: news stories about care from a range of sources representative of the diversity of UK audiences, including the BBC, ITV, Channel 4, Sky, *The Times*, *The Guardian*, *The Daily Mail*, *The Sun*, *The Independent*, *The Daily Telegraph* and *The Daily Express*; entertainment media, including documentaries and fictional formats; and historical and social sources that relate to care.

Semiotics is a research method used to understand – ‘decode’ – how cultural information that people consume on a daily basis (whether from family and friends, institutions like schools, universities and workplaces, or through the media) influences and shapes perceptions, beliefs and values at a collective level.³⁷

2.3.2 Qualitative discussion groups

The aims of the qualitative discussion groups were to:

- Explore perceptions of care and barriers to valuing it more, including care as a concept (based on the broad definition adopted by the project), its role in society and the range of specific caring roles, with a focus on paid social care and childcare work, unpaid care for those with additional support needs, and caring for children.
- Explore the draft narratives to understand their potential to shift perceptions of care and grow support for policies related to better support for all care.

- Identify which draft narratives to further develop to be tested in the quantitative phase.

Six two-hour group discussions, with five respondents in each, took place online in October 2022.

Participants were selected online and assigned to groups following the structure outlined in Figure 2, i.e. the sample included a range of ages (25–50+); an equal gender split; representation of middle (B) and lower middle class (C1), skilled working class (C2) and working class (D) participants; a split between more left-leaning and more right-leaning political preferences; ethnic minority representation; representation of those with health conditions who may have been recipients of care; and those with a range of caring experiences. While five groups included participants recruited across the UK, one group included participants from Wales only.



Figure 2: Qualitative discussion groups, approach and sample

Respondents completed two pre-tasks before attending the discussion groups, including reflecting on (1) changes that have occurred in people’s personal lives since the pandemic; and (2) the meaning of ‘caring’.

In each session, the discussion was divided into two parts:

1. An open-ended discussion of what care meant to participants and the nuances around their perceptions of care, including questions on what types of carers are more/less valued and how much care is valued by others.
2. Participants were then shown the four draft narratives (for each session, these were introduced in a different order to ensure that ‘order bias’ did not interfere with people’s responses). They were asked to rate the draft narratives individually before they shared their opinions, so the initial impact of each draft narrative could be gauged in a relatively unbiased way.

The full questionnaire utilised to recruit group participants, alongside pre-task instructions, and the topic guide used during the groups are available as a separate technical addendum here.

2.3.3 Quantitative testing

The aim of the quantitative survey was to understand:

- The extent to which the new narrative (developed following the qualitative discussion groups) makes people prioritise care versus other policy issues, and shifts people’s beliefs and attitudes toward caring in the UK.
- The likelihood that the new narrative will motivate some kind of action with regard to making care a policy priority.

The survey was carried out online between December 2022 and January 2023 and was administered to a UK-wide representative sample of 3,000 respondents. Booster samples for Wales and Scotland were added to ensure that analysis could be conducted at nation level.

The survey took an experimental approach. Some respondents were exposed to the narrative (Treatment) and others were not (Control). The Treatment group was then split into three subgroups, with each seeing the same Premise and Evidence, but a different Impact statement (either Provision, Economic or Receivers of care) – as illustrated in Figure 3.

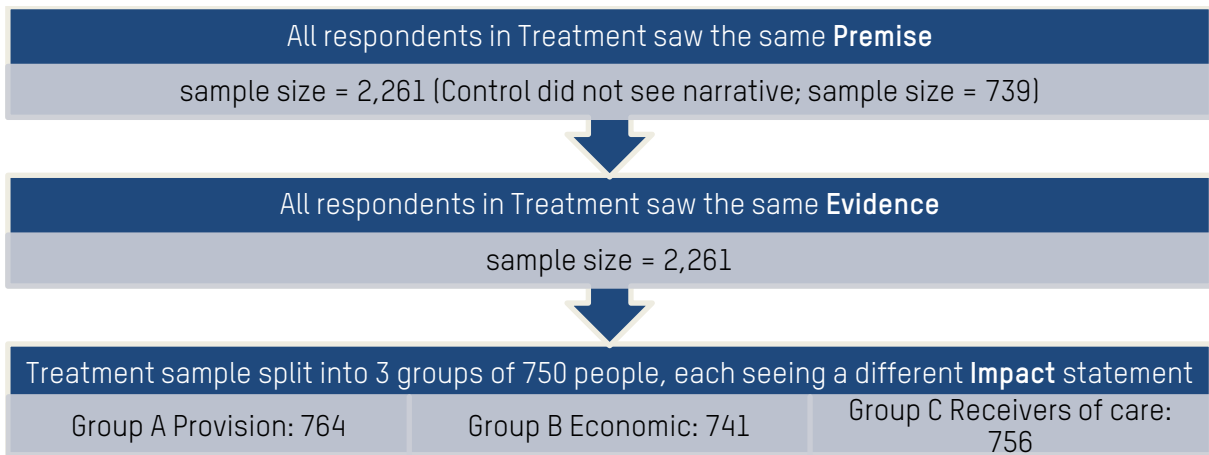


Figure 3: Quantitative testing, Treatment group and subgroups

Overall, two methods were used to measure the performance of the narrative:

1. Control group vs Treatment group approach: the Control group did not see the new narrative and hence provided a baseline measure for the perceived importance of care as a priority for politicians. The Treatment groups did see the narrative, so it was possible to directly compare their perceived importance of care as a priority for politicians against that of the Control group to understand how far the new narrative shifted perceptions.
2. Self-reporting: the research focused on detailed reactions to the narrative by asking people directly how it impacted their thinking.

The full questionnaire, alongside details on the sample recruited, is available as a separate technical addendum here, but overall the survey was structured as illustrated in Figure 4.

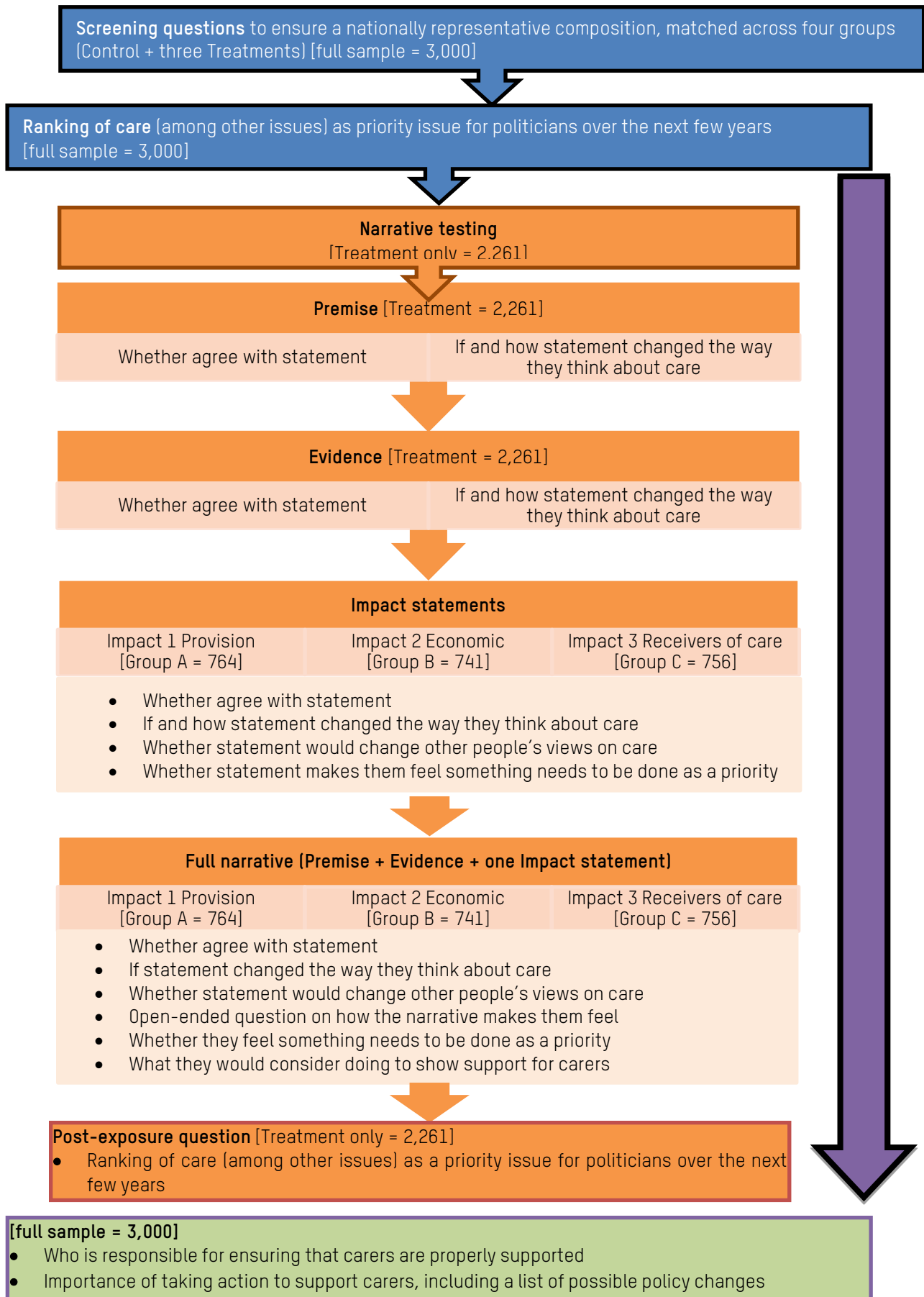


Figure 4: Survey structure

3 KEY FINDINGS

3.1 LITERATURE REVIEW AND SEMIOTIC ANALYSIS

The **literature review** identified a number of important themes around care – drawing on key sources, as outlined in Table 1 – which were used to develop the new narratives.

Table 1: Key themes emerging from literature review

Themes	Key sources
The economic contribution of care	Carers UK. (2015). <i>Valuing Care 2015: The rising value of carers' support</i> ³⁸ Women's Budget Group. (2020). <i>A Care-Led Recovery from Coronavirus</i> ³⁹ David Goodhart. (2020). <i>Head, Hand, Heart: The Struggle for Dignity in the 21st Century</i>
Care as a social good	Oxfam. (2020). <i>Make Care Count</i> ⁴⁰
Care as infrastructure	Women's Budget Group (2020) <i>Creating a Caring Economy: A Call to Action</i> ⁴¹
Invisibility of carers	TUC. (2022). <i>Lifting the Veil: removing the invisibility of adult social care</i> ⁴² We Care Campaign. (2022). <i>The Ones Who Care</i> campaign video ⁴³
The skill of care	Women's Equality Network Wales. (2016). <i>Real-Life Perspectives on Unpaid Care</i> ; Madeline Bunting. (2020). <i>Labours of Love: The Crisis of Care</i>
Universality of care	Joseph Rowntree Foundation. (2022). <i>Valuing and redesigning care will help solve poverty - and benefit all of us</i> ⁴⁴

The **semiotic analysis** identified the following issues with the dominant narratives around care:

- They give low social salience to the skills of carers and what they bring to society, hence contributing to perceptions of care as low value.
- They present carers as dutiful and/or good-intentioned individuals who operate in poor conditions and (in relation to care workers) for low pay, and whose beneficial individual acts are overlooked.
- They focus more on paid social care, particularly in care homes, and less on the large numbers of unpaid carers, who are rendered less visible.
- They overlook the importance of childcare vs other types of care, which is often framed as a personal/private issue, not an issue for government.

3.2 DRAFTING INITIAL NARRATIVE CONCEPTS

Using the findings from the literature review and semiotic analysis, an initial longlist of 12 narrative concepts was developed and grouped under four headings, as shown in Figure 5.

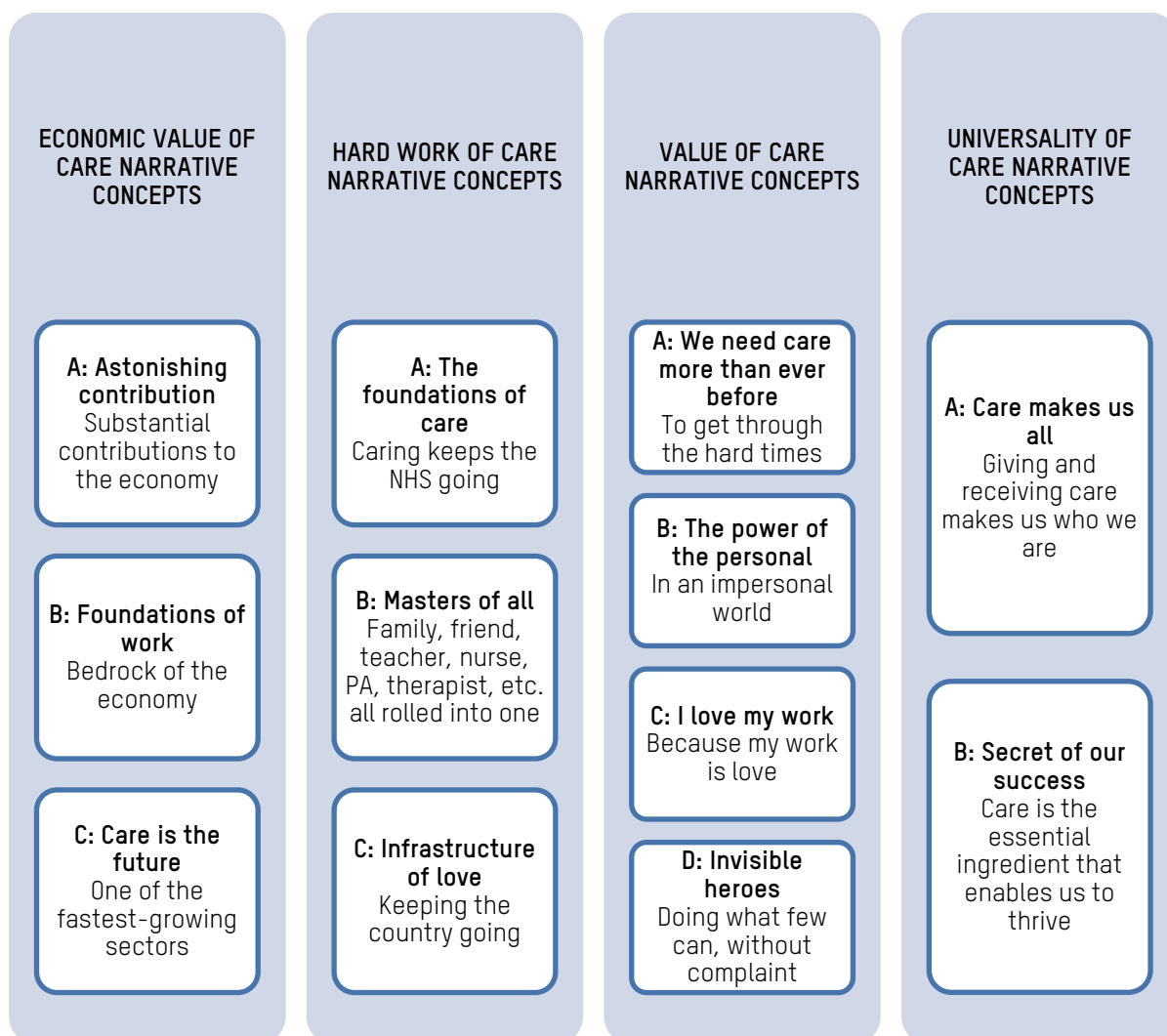


Figure 5: The initial longlist of narrative concepts

This longlist was discussed with the Advisory Steering Group, with the aim of drawing on existing knowledge and expertise to identify the most promising concepts to be further refined and then explored through qualitative discussion groups. Reflections and considerations with the Advisory Steering Group on the longlist focused, for example, on the potential of concepts to be applied across different types of care; their fit with the emerging use of infrastructure-based narratives among various stakeholders calling for better investment in care; and how positively these concepts would resonate with and represent the experiences of carers.

Four concepts were identified to be taken forward into qualitative exploration (Stage 3):

1. Care is the heart of our social infrastructure.
2. Without care we all face an uncertain future.
3. The unique knowledge, skills and qualities of caring.
4. Care: the driving force of the economy.

These four concepts covered a wide range of perspectives around care. They were also themes that the public might be familiar with, but not at a significant level, so had the potential to be used to reframe care in a more positive way.

The concepts were developed into **draft narratives** (i.e. actual text and messages) that were 'complete' enough to be explored in qualitative discussion groups. They were not presented as definitive to group participants, leaving room for participants to respond to and build on individual elements of each narrative. The narrative development process up to this stage is summarised in Figure 6.

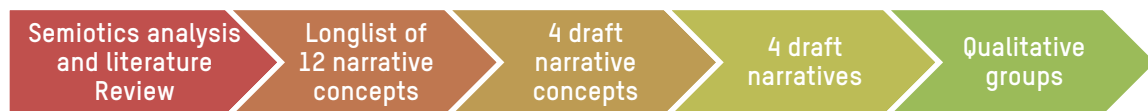


Figure 6: Narrative development process: from twelve narrative concepts to four draft narratives

The four draft narratives that were explored through the qualitative discussion groups are outlined in the technical addendum here as part of the topic guide used to conduct the qualitative discussion groups.

3.3 QUALITATIVE DISCUSSION GROUPS

The qualitative discussion groups focused on exploring:

- Perceptions of care and barriers to valuing it more, including care as a concept, its role in society and the range of specific caring roles.
- The four draft narratives, to understand how and to what extent they could shift perceptions of care and grow support for policies related to better support for carers.

3.3.1 Overall perceptions of care

With regard to perceptions of care, the discussion groups highlighted the following:

- The pandemic increased the value that people attach to care and caring. It was a moment in time where society became more caring. This has left an imprint, where individually everyone recognises the importance of caring to society.
- There was consistent agreement among participants that people providing care (both paid and unpaid) are often unrecognised and under-rewarded. There was debate about the relative skills needed for care work and how they are perceived – but no debate around care being hard work.
- Not all care was equally valued. In particular, paid and unpaid childcare and unpaid adult care tended to be understood as requiring fewer skills or competencies compared with paid adult care.
- Although the value of care was recognised at the individual level, it was not seen as collectively valued by society or by the government or the private sector. This manifested as a sense of resigned cynicism – paid and unpaid carers were seen as relatively silent groups that are easy for governments and society to ignore.
- The lack of a shared and widespread narrative on the positive collective benefits of care was mentioned by respondents as one of the reasons why they did not immediately think about the undervaluation of care/carers as an urgent issue to be addressed.

- Therefore, a motivating sense of collective benefit was absent from people’s understanding of care. The positive references made to ‘Clap for Carers’ during the discussion groups indicates how impactful a narrative around collective benefits can be in terms of shifting perceptions and priorities.
- It was also clear that any new narrative would have to connect all the different types of care activities and carer roles to help ratchet up the value of those that are seen as less significant.

3.3.2 Responses to the draft narratives

Two overall findings emerged from respondents’ reactions to the four draft narratives:

- Coming out of the pandemic, respondents had increased awareness of and appreciation for care, which meant that they were very receptive to the draft narratives. All four draft narratives performed well in terms of appeal and shifting people’s views of carers to varying degrees.
- However, care was competing for headspace against other serious issues, such as the cost-of-living crisis. There was also an overall sense that the government had little interest in making serious changes when it came to providing more support for carers, a pessimism that extended to other public services such as the NHS.

While all four draft narratives performed well in terms of their potential for shifting respondents’ perceptions of care in different ways, the following key variables enabled further comparison of their impact:

- Emotional appeal:** the degree to which a narrative moved people and created empathy.
- Rational appeal:** the degree to which a narrative was convincing or credible.
- Value of care:** the degree to which a narrative made the case for a reassessment of the value of care.
- Case for change:** the degree to which a narrative evoked a sense of immediate need for change.

These variables played an important role in identifying which of the narratives to further develop for the quantitative testing phase. In particular:

- A good balance of emotional and rational appeal is important for a narrative because it has to both move people and feel credible enough to share with others.
- Given that the project’s key objective was to shift perceptions on the value of care, it was also vital that the narrative performed well on this basis.
- A narrative has to present a case for change in order to drive some kind of action on the part of the public.

Figure 7 shows how each narrative performed along these dimensions, and Table 2 summarises feedback from the qualitative discussion groups on each draft narrative across the variables.

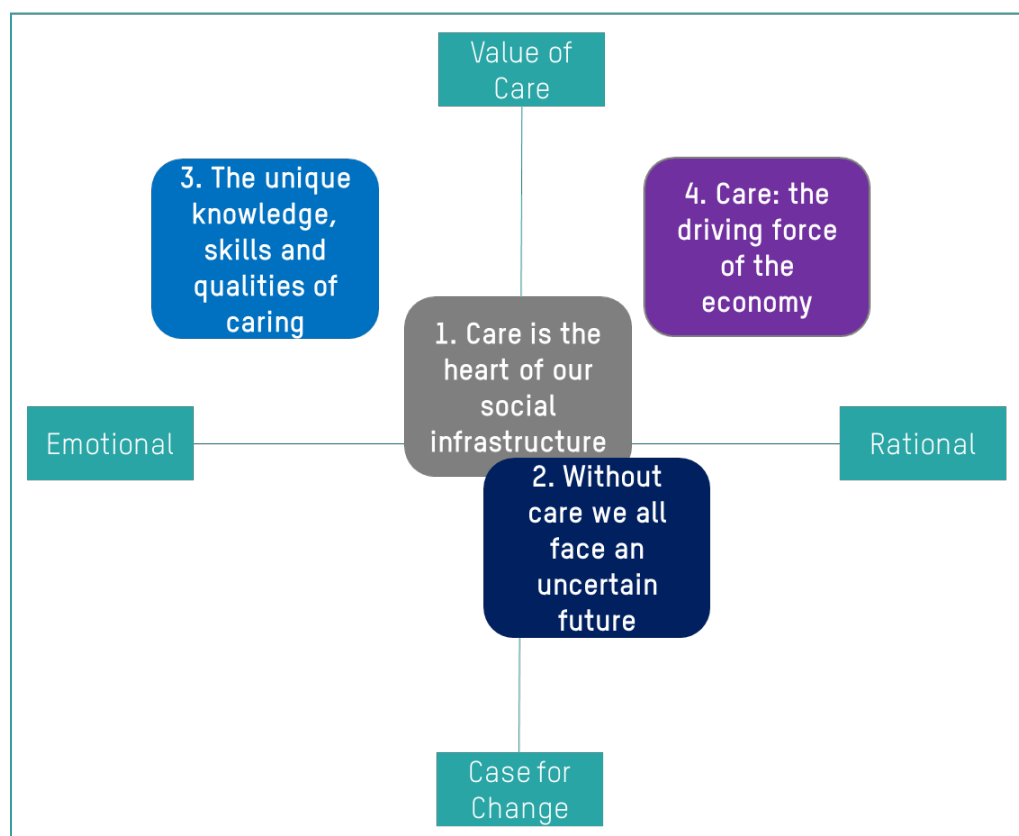


Figure 7: Comparison of draft narratives across key variables

Table 2: Feedback from qualitative groups on the four draft narratives

	(1) Care is the heart of our social infrastructure	(2) Without care we all face an uncertain future	(3) The unique knowledge, skills and qualities of caring	(4) Care: the driving force of the economy
<i>Emotional appeal</i>	Made people feel gratitude towards those doing unrecognised and unrewarded work.	Generated a sense of fear of what might happen if care was unavailable or of poor quality.	Respondents were moved to see carers recognised and their skills given more professional credibility. Seeing carers in a new light surprised respondents.	Respondents were genuinely surprised to see care framed as contributing to the economy, as public services are typically framed as doing the opposite.
<i>Rational appeal</i>	Resonated with how people felt but was expressed in a way they had not seen put into words before, offering a new vision of care.	People recognised and agreed that they and others might require care in the future. Elicited scepticism around the quality of care for elderly people.	Performed relatively weakly , as respondents questioned the credibility of some of the claims.	Once the initial surprise wore off, a more sceptical attitude emerged and some respondents began to scrutinise the numbers and question how they were calculated.

<i>Value of care</i>	Generated surprise by showing the sheer number of carers (paid and unpaid) in the UK.	Tended to generate quite rational personal reflection rather than causing respondents to think about the value of carers. Also very focused on a particular type of care , which made it difficult to look at the broader, society-wide benefits of care.	Encouraged appreciation of what carers actually do on a day-to-day basis.	Favourable comparisons with high-profile, high-value sectors were seen as a powerful way to shift value perceptions of care. But there was also a feeling that this was 'too good to be true', and that if this were the case, this beneficial situation for the economy would be unlikely to cause the government to change anything.
<i>Case for change</i>	Heightened feelings of injustice about how carers are treated by society/governments, by showing the cumulative and central role of care in society. Absence of a call to action, but the consequences outlined in the final section of the narrative helped create a degree of urgency.	Tapped into people's growing awareness of the impacts of an ageing population. Motivated a sense of urgency for change.	Respondents felt inspired by the more human and emotional benefits of caring. However, some raised concerns about the risk of setting precedents that not all carers could live up to , hence excluding those who did not see themselves in the narrative, or compounding the perceived distinction between more professional vs unpaid types of care. Some confusion around the purpose of the narrative, due to no clear broader benefit.	Scepticism around how care generates economic value could end up working against gaining public support for greater investment in care.
<i>Overall</i>	Balances collective benefits of care, credible facts, and the consequences of lack of support for carers.	Emphasises the personal impact of underinvestment in care.	Focuses on the individual and overlooked skills of carers.	Emphasises figures and the economic contribution of care.

The *Care is the heart of our social infrastructure* narrative achieved the best balance across the variables, through combining an emphasis on the collective benefits of care with credible facts and an account of the consequences if more support for carers is not delivered. In fact, this narrative:

- Emphasises that caring is a collective activity that ensures society functions on a day-to-day basis.
- Shows how numerous carers are, and the range of caring responsibilities that they have.

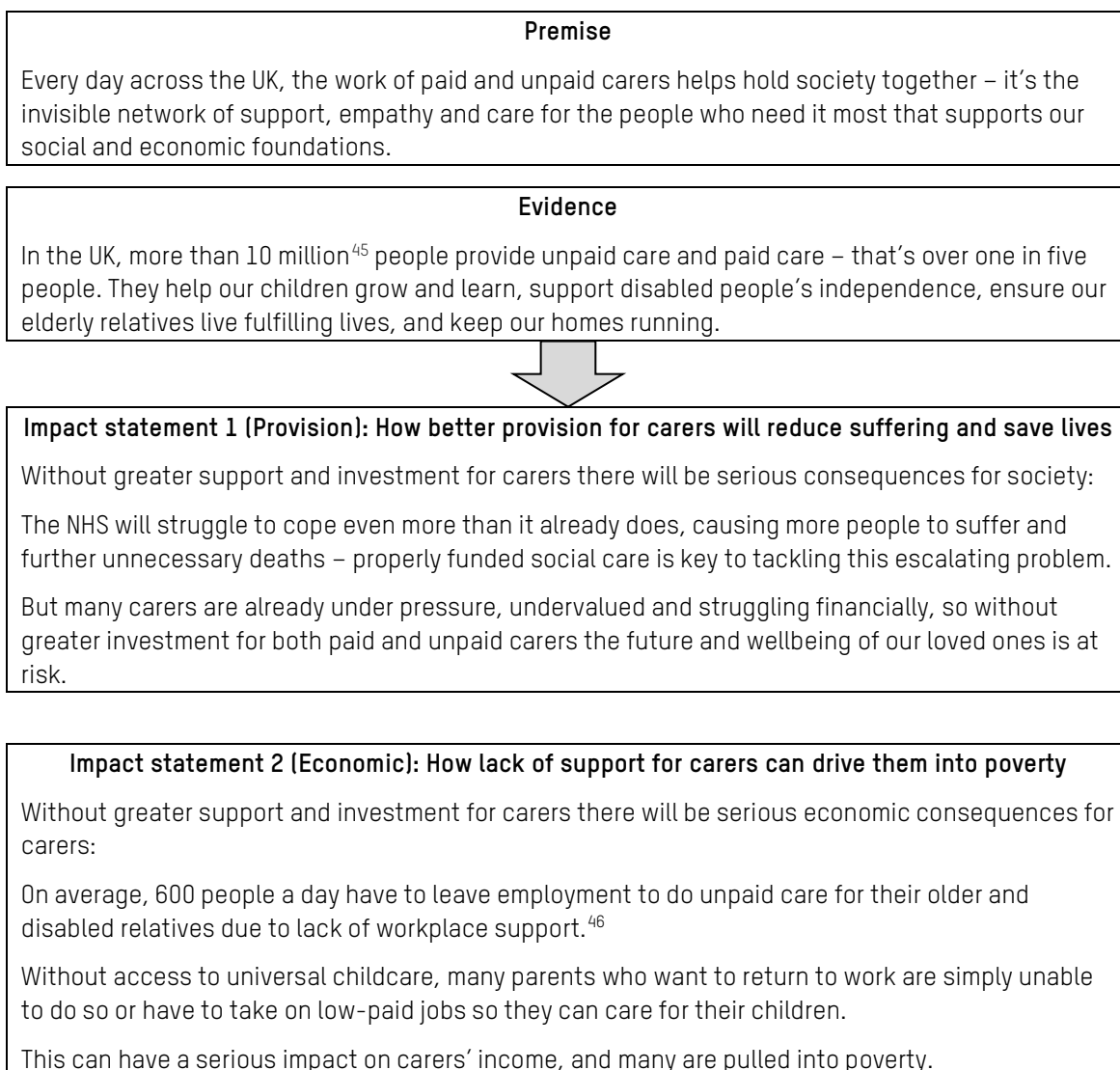
- Provides an ‘umbrella narrative’ that can be used to reframe a wide range of care issues.
- Had emotional resonance with respondents, as well as conveying facts.

Based on this, the narrative was taken forward to be refined and finalised for quantitative testing in the final stage of the research.

3.3.3 Finalising the narrative for quantitative testing

The *Care is the heart of our social infrastructure* narrative was further developed for testing in a quantitative survey. The final **narrative tested quantitatively comprised three key sections:**

- A fundamental **Premise**, outlining care as a collective activity that holds society together.
- An **Evidence** statement, highlighting key facts about the extent and nature of all care across the UK – both in terms of numbers and activities. It is important to note that the Evidence statement is aimed at providing a flexible framework that can be adapted to new data and analysis that become available
- Three different **Impact statements** describing the negative consequences of not providing greater support for and investing more in carers, from different perspectives:
 - **Provision** for carers, focusing on the effects on the overall health and care infrastructure, and the wellbeing of wider society;
 - **Economic** consequences of lack of support/investment for carers;
 - **Receivers of care**, focusing on those needing care due to illness, disability and old age.



Impact statement 3 (Receivers of care): How recipients of care will be negatively impacted by lack of support for carers

Without greater support and investment for carers there will be serious consequences for those who need care most in society:

Our experience of old age would be significantly less positive – missing human connection and lacking the physical and emotional nourishment needed to live a fulfilling life.

Disabled people would find it more difficult to live rewarding, independent lives, and those with serious illnesses would struggle to live with the dignity they deserve.

3.4 QUANTITATIVE TESTING

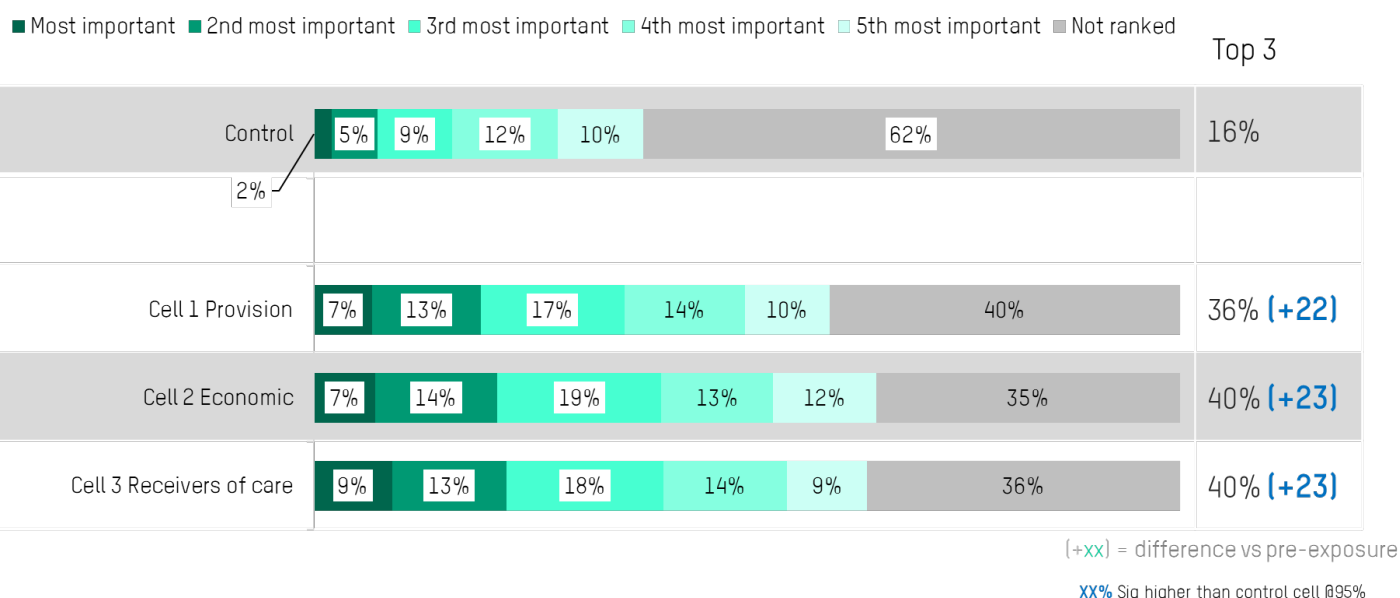
The quantitative findings focus on:

- Impact of the full narrative (Premise + Evidence + any one of the three Impact statements) on how people prioritise care as a policy issue (compared with other issues).
- Impact of each part of the narrative (Premise, Evidence and each Impact statement) as well as the full narrative on people’s own views of care, collective views of care, and the drive to take action to improve support for carers.
- Views (across all respondents, whether they saw the narrative or not – see Section 2.3.3 for details) on who is responsible for providing more support for carers; and what could be done to support them.

3.4.1 Impact of the narrative on views of care as a key policy issue

Care as a priority for politicians significantly increased for respondents who were exposed to the narrative, across all three Impact statements.

As shown in Figure 8, 16% of the Control group (which was *not* exposed to the narrative) saw care as a top-three priority for politicians. For respondents who were exposed to the narrative, over 38% (on average, across the three Impact statements) saw care as a top-three priority for politicians.⁴⁷



Q1a / P01a. Please select the top 5 issues that you think should be the highest priorities for politicians over the next few years. Base: Total Control n=739 Cell 1 Provision n=764 Cell 2 Economic n=741 Cell 3 Receivers of care n=756. (+Percentage) = difference vs pre-exposure. XX% Significantly higher than control cell at 95%.

Figure 8: Ranking of care as a top-three priority for politicians over the next few years

This statistically significant increase in salience was observed across all demographics considered; although there were a few differences in terms of how some groups prioritised care more after seeing the narrative, none were statistically significant. A slightly stronger positive impact on increasing the salience of care was observed among:

- Respondents in Wales and Scotland vs those in England.
- Those aged 35+ vs under-35s.
- Women vs men – salience increased significantly for men who read the narrative, but they started from a lower baseline.
- White vs BME respondents.⁴⁸
- Lower social class (C2DE) vs higher social class (ABC1) respondents – salience increased significantly for ABC1s who saw the narratives, but they started from a lower baseline.
- Carers for adults, those with no experience of care, and those with children vs those that care for disabled children – here it is important to note that the latter group was already more likely to see care as a high priority.
- Those who lean left vs those who lean right.

The demographic with the least pronounced increase was BME respondents. A number of factors may have played a role here. This includes different caring norms within communities – a recent report from Carers Trust Wales⁴⁹ shows that people in some BME communities are less likely to identify as ‘carers’; there is also a lack of faith in the possibilities of social progress and a sense of marginalisation from participation in national issues. More research is needed to disaggregate the groups who fall under this umbrella term and to understand what kind of messages might be even more effective.

It is also worth noting that when asked about priority policy issues, the results from BME respondents showed some significant differences to those of white respondents. Housing and tax were noticeably higher, for example, and the distribution of priority issues was on the whole broader than for white respondents. This could suggest that part of the reason for the lower response regarding salience of care as a policy issue is simply that there is a predictably wider range of issues for this heterogenous group.

Overall, all three Impact statements worked well in increasing salience of care across all demographics; however, if choosing between Impact statements to tailor messages for specific demographic groups, the following have a marginal advantage:

- Impact statement 1 (Provision) – most effective among those caring for adults or children with additional support needs.
- Impact statement 2 (Economic) – most effective among younger (under-35s) and left-leaning audiences, as well as women and lower social class (C2DE) audiences.
- Impact statement 3 (Receivers of care) – most effective for audiences from Scotland and Wales, right-leaning respondents, and older (55+) audiences, as well as men, BME audiences, higher social class (ABC1) audiences and those living with children.

3.4.2 Testing the Premise

There was strong agreement with the overall Premise of the narrative – 85% agreed.⁵⁰

Agreement was strongest among the following demographics: older (55+) audiences, white audiences, those who care for adults, left-leaning audiences, right-leaning audiences, and people in Scotland and Wales.






It was weakest among under-35s, BME audiences, and those who care for children.

The Premise also shifted people’s attitudes towards carers for almost six out of ten respondents (based on self-reported shifts in views).⁵¹

This was most pronounced for: under-35s, women, BME audiences, people in Scotland and Wales, those who care for children, and those who care for adults.

It is notable that the Premise successfully changed people’s attitudes towards carers in some of the demographics who had lower agreement with the Premise.

In terms of how the Premise changed people’s attitudes towards carers, as shown in Figure 9, the majority of respondents reported that the Premise made them more appreciative of the work carers do, or think more about carers being underappreciated; for some, the statement elicited thoughts about the impact of carers on society; only 20% reported no changes at all.

Makes me appreciate the work that carers do more	 45%	Female (48%), Carers of adults (52%), Leans left (51%) more likely to agree
Makes me think more about carers being underappreciated	 45%	Female (48%), Carers of adults (54%), Leans left (48%) more likely to agree
Makes me think more about the impact on society of the work of carers	 36%	18-34 (41%), female (38%), BAME (46%) more likely to agree
The statement doesn't change my views	 20%	55+ (30%), Male (24%), White (21%), those without caring experience (24%), Leans right (23%) more likely to agree
My views change in another way	 2%	

Q3 – How does the statement change your thoughts about carers, if at all? Base: Total in Cells 1-3 n=2261.

Figure 9: How the Premise changes thoughts on carers


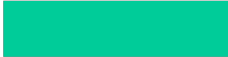
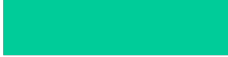


3.4.3 Testing the Evidence

There was strong agreement with the Evidence of the narrative – 81% agreed.

This was strongest among: older (55+) audiences, women, white audiences, higher social class (ABC1) audiences, those who care for children, those who care for adults, those who have children aged 0–15, left-leaning audiences, right-leaning audiences, and people in Scotland and Wales.

It was weakest among under-35s, BME respondents, and those with no caring experience.

Again, only 20% of the sample reported that the Evidence statement did not change their views, while a significant proportion of respondents reported either appreciating carers’ contribution more, or thinking more about the different kinds of carers or about how many carers there are (Figure 10).

Makes me appreciate carers' contribution more	 49%	BAME (55%), CD2E (51%), Lean left (54%) more likely to agree, Scotland less likely to agree (42%)
Makes me think more about the different kinds of carers	 41%	Female (45%), Carers of adults (48%) more likely to agree
Makes me think how many carers there are	 41%	Female (44%), Carers of children (46%), Carers of adults (49%), Lean left (46%) more likely to agree
The statement doesn't change my views	 20%	55+ (30%), Male (25%), White (21%), No caring experience (23%), Lean right (22%) more likely to agree
My views change in another way	 1%	

Q6 – How does the statement change your thoughts about carers, if at all? Base: Total in Cells 1–3 n=2261.

Figure 10: How the Evidence statement changes thoughts on carers

3.4.4 Testing the Impact statements

When the three Impact statements were tested individually, they all performed well in terms of the level of agreement with the statements as well as self-reported shifts in views of care. There were only minor differences in how people assessed each Impact statement.

There was strong agreement with Impact statement 1 (Provision) – 86% agreed.

- This was most pronounced for: women, older (55+) audiences, BME respondents, Welsh audiences, those who care for adults, those with children aged 0–15, and left-leaning audiences.
- 65% of people agreed that the statement changed their own attitude towards carers, and 70% agreed that it would change the attitude of others toward carers.
- 85% agreed that it made them feel that something needed to be done as a priority.

There was strong agreement with Impact statement 2 (Economic) – 83% agreed.

- This was most pronounced for: women, BME respondents, Welsh audiences, higher social class (ABC1) audiences, those who care for adults, and left-leaning audiences.
- 64% of people agreed that it changed their own attitude towards carers, and 72% agreed that it would change the attitude of others toward carers.
- 83% agreed that it made them feel that something needed to be done as a priority.

There was strong agreement with Impact statement 3 (Receivers of care) – 84% agreed.

- This was most pronounced for: women, Scottish and Welsh audiences, older (55+) audiences, white audiences, higher social class (ABC1) respondents, those who care for adults, those who care for children, and right-leaning audiences.
- 65% of people agreed that it changed their own attitude towards carers, and 69% agreed that it would change the attitude of others toward carers.
- 82% agreed that it made them feel that something needed to be done as a priority.

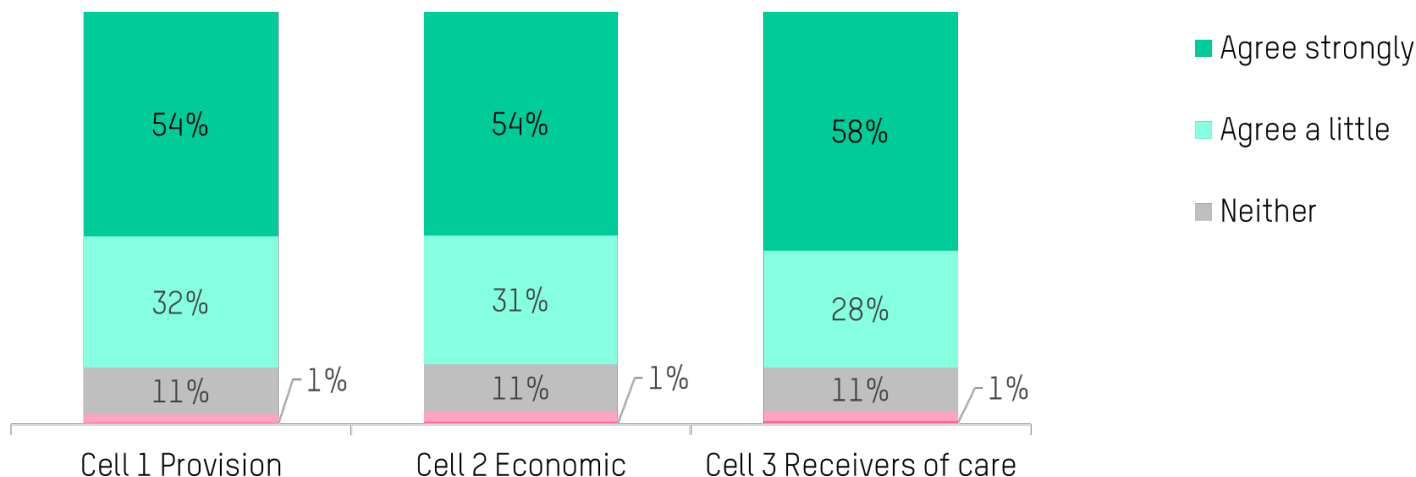
Although there were only minor differences between the responses to Impact statements, we could speculate that Impact statement 1 (Provision) may have generated a slightly stronger sense of priority because it talks about the NHS. Impact statement 1 also saw a higher degree of agreement from BME audiences, again possibly because they are overrepresented in the NHS and feel more affinity with it.

Impact statement 2 (Economic) saw a higher degree of agreement from right-leaning audiences, which suggests that it has more personal, individual appeal.

3.4.5 Testing the full narrative

The final step was to test the 'full narrative', which meant that all three Treatment groups were shown the same Premise and Evidence, and one of the three Impact statements.

As shown in Figure 11, agreement with all three variations of the full narrative was strong.



Q12 – Now looking at everything you’ve read altogether, and thinking carefully about it, how much do you agree or disagree with it? Base: Total Cell 1 Provision n=764 Cell 2 Economic n=741 Cell 3 Receivers of care n=756.

Figure 11: Agreement with full narratives (Premise + Evidence + any one of the three Impact statements)

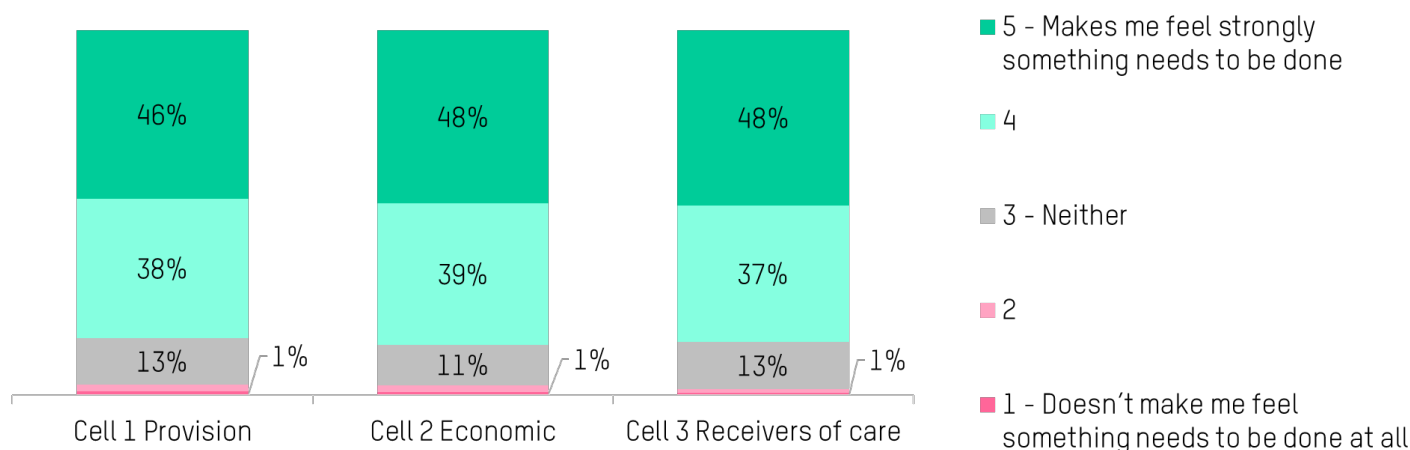
Respondents felt that the narrative changed their minds about carers, and could also change other people’s views on carers.

The high level of agreement around the narratives being able to change the minds of others is generally a positive sign as it suggests that people would feel comfortable sharing them with others, which is an important aspect of narrative dissemination.

The key finding is that all elements of the narrative performed well with all the subgroups of interest, although they were particularly effective with the following groups:

- Premise + Evidence + Impact statement 1 (Provision) – women, carers of adults, those living with children.
- Premise + Evidence + Impact statement 2 (Economic) – white, carers of adults.
- Premise + Evidence + Impact statement 3 (Receivers of care) – carers of adults.

There was good agreement that something needs to be done as a priority across the narrative – 85% agreed, on average, and almost half the sample agreed strongly (see Figure 12).



Q16 – Still thinking carefully about it, how much does this whole statement make you feel something needs to be done about it as a priority? Base: Total Cell 1 Provision n=764 Cell 2 Economic n=741 Cell 3 Receivers of care n=756.

Figure 12: Call to action after seeing the whole narrative

Regarding actions respondents would be most likely to take, signing a petition was the most likely action across all narratives (regardless of the Impact statement they included), followed by talking to friends and family about the issue. A third said that the narratives would influence their voting decisions.

In terms of demographics:

- Signing a petition was stronger for: 35–54s, women, white audiences, lower social class (C2DE) respondents, those from Wales, those who care for adults, and left-leaning audiences.
- Talking to friends and family was stronger for: under-35s, women, BME audiences, those from Scotland, those who care for children, those who care for adults, those living with children aged 0–15, and left-leaning audiences.
- Influencing voting decisions was stronger for: older (55+) audiences, women, white audiences, higher social class (ABC1) respondents, those from Wales, those who care for children, those who care for adults, those living with children aged 0–15, and left-leaning audiences.
- Posting on social media was stronger for: under-55s, women, BME audiences, lower social class (C2DE) respondents, those from Wales, those who care for children, those who care for adults, those living with children aged 0–15, and left-leaning audiences.

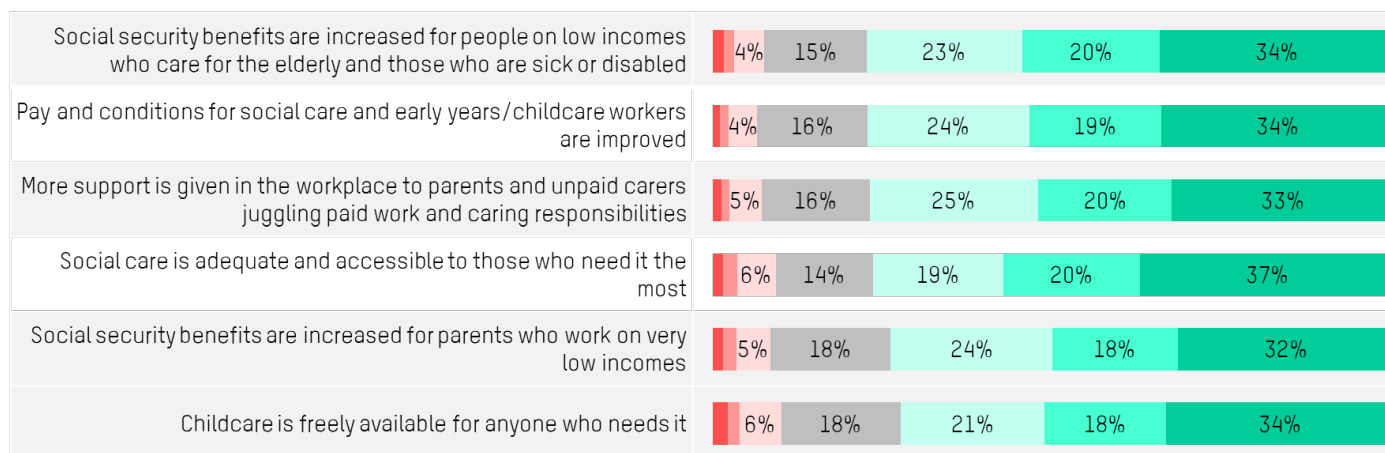
3.4.6 Views on who is responsible and what can be done to better support carers

The final part of the survey, which was carried out with the full sample (n=3,000), including the Control (who did *not* see the narrative) and the Treatment groups, focused on capturing views regarding who is responsible for making sure that all those who are caring, whether paid or unpaid, are properly supported; and how important it is to support carers through specific policy changes.

The issue was seen as primarily government's responsibility, followed by local councils, with local communities and employers/businesses coming in much further down the list.

Finally, there was strong agreement with improving all types of support flagged (Figure 12).

■ Not important at all ■ 2 ■ 3 ■ 4 ■ 5 ■ 6 ■ Extremely important



PQ3 – Please read each of the statements below carefully. Thinking about care work, how important do you feel it is that:
Base: Total n=3000.

Figure 13: Importance of providing more support for carers

Although participants did not differentiate between the various types of support, it is worth noting that ‘social care is adequate and accessible to those who need it most’ performed relatively well with right-leaning audiences vs the other types of support; and ‘freely available childcare’ performed relatively well with BME audiences.

4 CONCLUSIONS

The research shows that the new narrative that was developed, including all its parts (Premise, Evidence, and Impact statements), has the potential to significantly shift public perceptions to value care and make the issue of better support for carers a greater policy priority.

There is strong agreement with the new narrative across different demographics and groups, including more politically right-leaning and BME audiences. It is also clear that the Premise and Evidence parts of the narrative work well when combined with a range of different care issues, meaning they can be used as an 'umbrella narrative' to reframe a wide range of caring issues.

The new narrative has the potential to generate actions, including signing petitions, talking to friends and family about the issue, and influencing voting decisions.

The research also shows where more tailored messages may be required for some groups, including right-leaning and BME audiences, and to some extent those with no care experiences, and men.

The findings from across the research suggest that:

- It is important to talk about the collective benefits of all care, paid and unpaid, for society – we know that care and carers can easily be taken for granted, so we need to explain how their acts add up to a better society.
- Leading with the idea that caring is a collective activity that holds society together and contributes significantly to the wellbeing of the nations can shift people's perceptions of care.
- Framing carers as part of a network across the UK helps people see care as more of a 'system' or 'safety net for society', rather than just consisting of individual acts – this also helps convey the concept of 'infrastructure' in an accessible yet powerful way.
- Talking about the enormous number of people from diverse backgrounds who carry out a diverse range of paid and unpaid caring activities helps make carers more visible as a group.
- There is a need to remind audiences about the scope of caring – from caring for the youngest people (children) to the oldest (90+) and everyone in between.
- It is important to emphasise the emotional benefits that carers bring – human warmth, independence and dignity – as well as the more functional aspects of care.
- Highlighting the negative consequences for society, carers and recipients of care if caring does not get better support is helpful in generating a sense of salience and urgency in tackling the undervaluation of care.

There are also some things to avoid when communicating about care:

- Avoid beginning the narrative with a focus on specific caring activities – instead open by looking at the collective contribution of caring and then talk about how specific care activities contribute to this.
- Focusing exclusively on the challenges paid and unpaid carers face without also highlighting the positive contribution might not be as effective at changing minds, as people tend to already be aware of issues, but not necessarily of the contribution.
- Do not assume that all forms of care are seen in the same way – for example, for some childcare may be considered a family duty rather than a collective responsibility.
- Support facts and figures with emotional arguments that make the facts meaningful.
- Do not assume that claims about carers' contributions to the economy will shift perceptions – the public tend to view these claims with scepticism.

This project is the first step towards telling a new story on *all* care across the UK – a first building block.

More research is needed to explore in greater depth how new messages can address the inequalities that drive the undervaluation of care work, especially with regard to gender and race. It is also necessary to undertake more framing research on messages that can effectively shape public views on specific recommendations for policy change. Finally, each form of care requires more in-depth research to shed light on how it is perceived by the public.

NOTES

- ¹ S. Galandini and I. Ferrer. (2020). *Make Care Count: Unpaid and Underpaid care work across Britain*. Oxfam. DOI: 10.21201/2020.5716. <https://policy-practice.oxfam.org/resources/make-care-count-unpaid-and-underpaid-care-work-across-britain-620952/>
- ² It is important to note that **the Evidence statement was tested quantitatively with the figure of ‘around 15 million’**, which is a composite calculation drawing together the following numbers: ‘13 million unpaid carers for disabled, ill or elderly people’ estimated in the UK in 2020, in Carers UK. (2020). *Carers Week 2020 Research Report*. <https://www.carersuk.org/media/qfif3nz3/cw-2020-research-report-web.pdf>; ‘1.62 million of social care workers in England’, in Skills for Care. (2022). *The size of adult social care in England*. <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>; and ‘328,500 Early Years childcare workers in England’, in Department for Education. (2021). *Survey of Childcare and Early Year Providers: Main Summary*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1039675/Main_summary_survey_of_childcare_and_early_years_providers_2021.pdf
- Although this (‘15 million’) is likely an **underestimate** (as it does *not* include parents of children without additional needs, or paid care workers in Scotland, Wales and Northern Ireland), here, as a starting point, **we suggest a slightly more conservative figure (‘10 million’)** which includes only the estimated number of unpaid carers supporting disabled, sick and elderly people in 2022, in Carers UK. (2022). *Carers Week 2022 Research Report*. https://www.carersweek.org/media/qf0p5u4t/carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf. This is to **take into account the potential risk of ‘double counting’** carers in statistics, as some people juggle different paid and unpaid caring responsibilities (e.g. parents may also be unpaid carers to people with additional needs; and paid care workers might have unpaid caring responsibilities).
- ³ Carers UK. (2019). *Juggling work and unpaid care: A growing issue*. <https://www.carersuk.org/media/no2lwyl/juggling-work-and-unpaid-care-report-final-web.pdf>
- ⁴ S. Galandini and I. Ferrer. (2020). *Make Care Count: Unpaid and Underpaid care work across Britain*. Op. cit.
- ⁵ Ibid.
- ⁶ A. Parvez Butt, C. Coffey, P. Espinoza Revollo, R. Harvey, M. Lawson, K. Piaget, D. Sarosi and J. Thekkudan. (2020). *Time to Care: Unpaid and Underpaid Care Work and the Global Inequality Crisis*. Oxfam. <https://www.oxfam.org/en/research/time-care>
- ⁷ N. Abdo, M. Bolis, E. Holten, M. Jose Moreno, L. Mugehera and A. Parvez Butt. (2020). *Care in the Time of Coronavirus: Why care work needs to be at the centre of a post-COVID-19 feminist future*. Oxfam. DOI: 10.21201/2020.6232. <https://policy-practice.oxfam.org/resources/care-in-the-time-of-coronavirus-why-care-work-needs-to-be-at-the-centre-of-a-po-621009/>
- ⁸ Carers UK. (2022). *State of Caring Report 2022*. <https://www.carersuk.org/reports/state-of-caring-2022-report/>; Gingerbread. (2023). *The single parent employment challenge*. <https://www.gingerbread.org.uk/policy-campaigns/publications-index/the-single-parent-employment-challenge-report/>
- ⁹ Carers Trust. (2022). *I feel like I’ve disappeared*. <https://carers.org/our-social-care-campaign/i-feel-like-i-ve-disappeared>; Child Poverty Action Group. (2023). *Pre-Spring Budget MP Briefing, March 2023*. https://cpag.org.uk/sites/default/files/files/policypost/Pre-Spring_Budget_MP_Briefing_March_2023.pdf
- ¹⁰ Child Poverty Action Group. (2022). *The Cost of A Child in 2022*. <https://cpag.org.uk/policy-and-campaigns/report/cost-child-2022>
- ¹¹ Carers UK. (2022). *Heading for the Crisis: Caught between caring and rising costs*. https://www.carersuk.org/media/q33ba3ae/heading-for-crisis_1-3.pdf
- ¹² Joseph Rowntree Foundation. (2023). *UK Poverty 2023*. <https://www.jrf.org.uk/report/uk-poverty-2023>
- ¹³ Carers UK. (2019). *State of caring: A snapshot of unpaid care in the UK*. <https://www.carersuk.org/media/khgkb3fs/state-of-caring-2019-report.pdf>
- ¹⁴ Carers UK. (2022). *The State of Caring Report 2022*. Op. cit.

- ¹⁵ Carers Trust. (2022). *Pushed to the edge: Life for Unpaid Carers in the UK*. <https://carers.org/downloads/resources-pdfs/pushed-to-the-edge.pdf>
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- ⁴⁵ It is important to note that **the Evidence statement was tested quantitatively with the figure of 'around 15 million'**, which is a composite calculation drawing together the following numbers: '13 million unpaid carers for disabled, ill or elderly people' estimated in the UK in 2020, in Carers UK (2020) *Carers Week 2020 Research Report*. <https://www.carersuk.org/media/gff3znz3/cw-2020-research-report-web.pdf>; '1.62 million of social care workers in England', in Skills for Care (2022) *The size of adult social care in England*. <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>; and '328,500 Early Years childcare workers in England', in Department for Education (2021) *Survey of Childcare and Early Year Providers: Main Summary*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1039675/Main_summary_survey_of_childcare_and_early_years_providers_2021.pdf
- Although this ('15 million') is likely an underestimate (as it does *not* include parents of children without additional needs, or paid care workers in Scotland, Wales, Northern Ireland), here, as a starting point, **we suggest a slightly more conservative figure ('10 million')** which includes only the estimated number of unpaid carers supporting disabled, sick and elderly people in 2022, in Carers UK (2022) *Carers Week 2022 Research Report*. https://www.carersweek.org/media/qf0p5u4t/carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf. This is to **take into account the potential risk of "double counting"** carers in statistics, as some people juggle different paid and unpaid caring responsibilities (e.g. parents may also be unpaid carers to people with additional needs; and paid care workers might have unpaid caring responsibilities).
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- ⁴⁷ Significant differences between each of three Treatment groups (i.e. groups exposed to Premise + Evidence + any one of the three Impact statements) and the Control group (i.e. respondents not exposed to any elements of the narrative) mean there is evidence that the narratives influenced a particular outcome (in this case the policy salience of care).

- ⁴⁸ The BME group in the survey included respondents from Black, Asian and Mixed ethnic backgrounds.
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- ⁵⁰ Overall agreement with all narrative statements (Premise, Evidence and Impact statements) was measured through a 5-point Likert scale: 'agree strongly' and 'agree a little' are counted as 'agreement'.
- ⁵¹ The degree to which all statements (Premise, Evidence and Impact statements) were able to shift people's attitudes towards care was measured through self-reported changes in views. A 7-point Likert scale was used to identify the extent of the change (7=extremely, 1=not at all): points 7–5 are identified as 'agreement'.

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