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## The equal sharing of care responsibilities between women and men

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\* *The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.*

## 1. Equal sharing of responsibilities between women and men in unpaid care work, including care for older persons and children

West-European societies still rely heavily on informal care despite changes in demography and in labour market and social policy context. We have witnessed the increase in alternative family types, such as single-person household and single-parent families, who cannot rely on immediate help from co-residents. Fertility rates have declined drastically and populations have become more geographically mobile. We have seen an increase in the life expectancy of the population, presumably leading to some increase in the number of years, where care is required. Most Western European societies have also seen an increase in the two-income households in the last decades, and this has given impetus for re-negotiation of the formal and informal division of care work<sup>1</sup>, in the family, and also between the family, market and state. This generalization of the masculinist model of work and welfare to women has, however, not necessarily led to a greater equality of division of care work between men and women (Lewis, 2002a, 2002b).

How are we to understand the impact of these changes for the equal sharing of care responsibilities between men and women? And which dimensions are important to focus on for understanding the variation in national responses? Feminist research, focussing on gender consequences, have helped develop so-called typologies for understanding the country variation in gendered consequences. They point to the cross-points between differences in country welfare policies, cultures, ideas and individual preferences, and lately also the practises have been taken into account.

Typologies focussing on structural criteria has pointed out that countries differ to the extent that labour market policies and regulations enable women to participate on take up paid labour, eg the possibility of taking up part-time work or the development of public sector employment, traditionally providing job opportunities for women. Analysis of structural factors have also emphasised that countries differ in how care policies assist women (and men) by providing services and benefits, that help them reconcile work and family life (eg Lewis, 2002a, 2002b; Rubery and Fagan, 1999)). Typologies focussing on the cultural criteria would rather use individual preferences (eg Hakim, 2001) or societal values and norms (eg Phau-Effinger, 1998) concerning division of care responsibility within the family, and between the family and other welfare sources. However, as Haas (2005) has pointed out the actual practises of men and women also need to be taking into consideration. She finds that the gender balance of sharing care responsibilities between men and women within Europe can be summarised into five main theoretical types, when taking into account policies, culture and practise:

1. the *traditional breadwinner model* – where the man is employed full-time, and the women is in charge of unpaid caring for children and elderly
2. the *modified breadwinner model* – here the man is also working full-time and the woman is engaged in part-time paid work and is mainly responsible for the care work, assisted by partial provisions of care services or educational services.
3. the *egalitarian model* – in this model both men and women work full-time, but due to persistent gender roles and/or inadequate state policies women are still in charge of the caring.

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<sup>1</sup> Care is understood as “...the activities and relations involved in meeting the physical and emotional requirements of dependant adults and children, and the normative, economic and social frameworks within which these are assigned and carried out.” (Daly and Lewis, 2000, p 285)

4. in *the universal care model* – men and women are in part-time paid labour and both engage in the unpaid care work, with/or without the assistance of care policies
5. finally, the *role reversal model* – here men and women have reversed the traditional breadwinner model so that the woman is the breadwinner and the man either works part-time or not at all, and is in charge of the care work.

As Haas notes, the last two models are rather abstract, whereas she finds empirical evidence for the remaining three. However, more than one model may exist in a country at one and the same time. Eg. taking Austria as an example she finds that combinations of work and care are both traditional and at the same time egalitarian, as women might be underrepresented in the labour market, but those women who do work, do this on a full-time basis. Also, norms and values in Austrian society prescribe that children should be cared for in the home, by their mother.

Policies, culture and practises of care, however, also depend on whether the focus is the care for the children or care for the elderly. Ie societal norms about the right childhood may prescribe a different carer role than what is the case for care for elderly. Women and men may therefore to different degree be expected to participate in informal caring. Eg Swedish parental leave policies have for decades emphasised the importance for the child and for the father himself of him taking up parts of the parental leave. This has been advocated as something that would contribute to his professional competences, in addition to benefiting the relationship between the father and the child (Rostgaard, 2002). We find few examples of the same promotion of male values in informal care giving, whereas the presence of males in the formal care giving is in fact often assumed to contribute to a more diverse care giving and in a better work environment.

Despite differences in policies and values, informal care giving is still a normal activity in most countries. Tester (1996) claims that regardless of welfare typology, informal caregiving is by far the largest source of care, and she estimates that the share of informal care is in all countries between 75- 80 % of all care. Other surveys confirm that informal care giving is a normal activity in most EU countries: In 2006, around 20 % of elderly people 65+ received informal care, rising to between 30-60% for the 75+ aged, depending on how informal care is defined (Eurostat, 2006). And earlier surveys have also confirmed that informal care is a gendered activity. On average 31 % of adult women in the EU provide daily care for children compared to on average 15 % six (please clarify whether 15 or 6) of adult men. Men seem, however, to be more involved in the caring for the elderly and disabled. Here, women are still the most active, with on average 8 % providing care, but relatively more men provide care (on average 4 % of all adult men) (Eurostat, 2001). This does, however, not tell us much about gendered difference in the hours of care which are provided, nor what care tasks are performed. Informal carers may provide very different types of informal care, depending on the surrounding support system. Eg in Denmark, informal carers mainly perform practical care, such as shopping and doing the laundry, and help with administrative tasks, whereas the home helper normally provides the necessary personal care (Boll Hansen and Platz, 1995). In other countries where informal carers also provide personal care, a gendered division of care work means that men often mainly perform the practical tasks such as providing transport, fixing the house or contacting local authorities and women provide more personal care (Green, 1988; Evandrou, 1992).

Men and women may perform very different tasks and they may also give different motivations as to why they become involved in informal care giving (Ungerson, 1987) Men and women may also employ

different 'excuses' as to why they are not involved in informal care. Employment seems to be a more legitimate excuse for men for not taking up work than for women (Finch and Mason, 1990). Women also more often find that they are 'negotiated' into caring by their relatives (Ungerson, 1987).

Informal care for elderly is often organised in a specific hierarchy of care, the so-called "hierarchical compensatory model" (Noelker & Bas, 1994), where some kin members are more likely to provide care than others. Typically an adult daughter or daughter-in-law will be responsible for caregiving, but very often it will also be the partner who provides care (Abel, 1990). British scholars were among the first to point out that many informal carers were in fact elderly men, questioning the general assumption that informal care was mainly 'women's business' (eg Arber and Gilbert, 1989) and evidence from other countries has helped us realise that this is a general finding (eg Chapell, 1985).

Informal care is, however, not a constant component in the care puzzle. As Finch (1989) has argued family responsibility does not operate according to any fixed or pre-ordained rules. An informal care decision is a decision which very much depends on the strength of the family relations over time. The increase in divorce is likely to negatively affect the strength of family obligations. Finch sees family obligations as normative guidelines which can be used by individuals for evaluating whether or not to engage in informal caring. Engagement in informal caring will always be an individual decision, taken within a specific context of kin relations. Kin support has accordingly a somewhat unpredictable character.

## 2. The global care chain

With the EU work agenda of 60 % female labour force participation by 2010 and the birth of the Adult worker model, which assumes that men and women are equally employable (Lewis, 2002b) there is increasing awareness that the present childcare facilities are inadequate. It is also realized that there is a growing gap between formal elderly care provisions and the number of elderly requiring care as populations age. Many countries also report of problems of finding labour for the formal care sectors, especially within elderly care, where the status of the job and payment is low. It is estimated that migrant women provide many of the care tasks and domestic services in the private households as part of the global care chain, leaving their own dependants behind them in their home country (Ehrenreich and Hochschild et al., 2002). Within the EU, non-EU nationals are officially estimated to account for over 10% of those employed in this sector (EU, 2003).

Often, the work is unregulated, performed without having a work contract and for very long work hours. Migrant carers might live in the home of the care-recipient and provide care 24-7. Sexual harassment may occur, as well as pressure to do additional work for friends and colleagues) (Anderson and Phizacklea, 1997).

Migrant women make up an increasing share of labour migration, challenging the tradition notion of the male, industrial migrant with the accompanying wife: "Children are carried along by their parents, willy-nilly, and wives accompany their husbands though it tears them away from environments they love" (Lee, 1969).

The male breadwinner concept is, however, still dominant in how we understand migration. For many of these migrant women, migration to developed countries is both economically and socially beneficial for them and their families, and can be a strategy for keeping her family at home out of poverty.

Nevertheless, it also often leads to the restructuring of family life, depending upon whether these women migrate on their own or with children, partner and parents. A study of 407 young immigrants from Central America, China, the Dominican Republic, Haiti and Mexico thus showed that 85% were separated from one or both parents during migration process and 28% were separated from their siblings (Suarez-Orozco and Todorova 2003). Jones et al (2004) made a similar study of 146 adolescents aged 13-16 years in Trinidad, which showed that in 75% of cases it was the mother who was living abroad and in a small number of cases both father and mother were abroad. They also found that the effect on the child could be substantial and in many cases traumatising: Where children had been left in the care of a father, they most often experienced several times being moved to other relatives as the father was unable to care for them.

Whether or not the global care chain is to be viewed as an economic benefit for families who would otherwise be living in poverty or as mechanism which separates families and leaves children uncared for, the new care relationships represented by the influx of migrant labour also create new clashes in the receiving countries, between class, race and ethnicity, and most certainly challenge our conception of what it is to be a good mother (Maher, 2003).

### 3. Policy interventions designed to give effect to equal sharing of responsibilities between women and men

With an ageing population and a decreasing number of children born national policies for addressing the need to reconcile work and family life have come to the fore within EU where initiatives related to care policies have included the parental leave directive and time off for caring for dependants and a recommendation for more formal childcare provision.

#### 3.1 Leave for parents in work

All European member states today provide *maternity leave*. Periods of leave vary from 6 weeks prior confinement and 8 weeks after in Germany to a period of 4 weeks prior and 16 weeks after in Italy. The allowance is usually linked to the net salary or a percentage of it. Maternity entitlements are relatively generous in Central and Eastern European countries, at around 18 weeks or more, reflecting the social policy legacy during the communist era but also that these schemes are still today recognised by governments as being an important support for families. Benefits are also relatively high, often set at 100% of former wages and have stayed at this level even after the transition. Only the Czech Republic and Hungary trimmed benefits, from 90 to 69% and 100 to 70% respectively (Innocenti, 1999).

In compliance with the Council Directive 96/34/EC all Member States have introduced an individual entitlement to *parental leave* for at least 3 months for every female and male worker. Financial compensation is often identified as being among the reasons why fathers do not make more use of parental leave (Christoffersen, 1990; Riksförsäkringsverket, 2000). Some countries provide an allowance during the leave that is means- or non-means-tested, others do not provide an allowance. The duration of parental

leave varies from three months (United Kingdom, Belgium, Ireland and Greece) to when the child is three years old (e.g. Finland, Germany and France). In Italy, Austria and Sweden part of the leave is set aside for the father, a “father's quota”, as an incentive for fathers to use the leave. Eastern and Central European countries have all extensive leave periods, to some degree replacing former periods of widespread practise of providing nurseries for infants and toddlers. Today, most countries offer parental leave until the child is 2-3 years old with a flat-rate benefit, where leave is available for both parents and even extended to grandparents in e.g. Bulgaria (Innocenti, 1999).

*Paternity leave* for the father is generally available in the Nordic countries where the period ranges from 7-14 days, but also France has provision for fathers (11 days), the Netherlands (2 days), Greece (1 day) and Belgium (4 days). In both Portugal and Spain parts of the maternity leave can be transferred to the father.

### **3.2. Child care**

The duration and compensation of leave schemes obviously affects the demand for childcare places. Among the Nordic countries the development of the leave schemes has been especially marked in the demand for childcare places for the children younger than 1 year, e.g. in Sweden the effect of parental leave means that less than 1% of children under 1 year of age are in daycare institutions. However, when children turn 1 year most are in public daycare institutions, making up 21% in Denmark and 35% in Sweden of the 0-2 year olds. In most other countries, the provision of public daycare for the very young children is limited. Here, the emphasis is instead on the provision of nursery schooling for the age group 3-school age, in most cases provided part-time. Family day carers who are individual carers operating from their own home and playgroups, an institution-based part-time group providing a more formal setting for playing and learning, are other alternative care provisions. E.g. in the Netherlands playgroups cover 50% of the 2-4 years.

Under the communist command economy kindergartens were in general available for the 3-6 years olds in the Central and Eastern European countries. However, at the same time as the work-place child care provided by enterprises fell apart, the post-communist philosophy has been bent to “de-institutionalize” children and support stay-at-home parenting. As a result, nurseries for the 0-2 year olds in the Czech Republic and Slovakia have practically ceased to exist (Innocenti, 1999). For the older children, aged 3-school age, places have significantly decreased since the late 1980s. But provision in terms of participation rate has remained stable due to mainly the overall decrease in the number of children born (Ibid). Provision is therefore still comparatively extensive, covering e.g. 86% of children in Hungary. There is no legal entitlement to provision here but the law encourages the establishment of nurseries and kindergartens. Family day caring (please explain what this is) has not become widespread yet; in 2000 there were only about 38 family day carers, who were operating as small enterprises (Vardja & Korintus, 2002). Denmark, Finland and Sweden offer an entitlement to day care services for pre-school children. In most cases from when the child is 1 year, whereas Finland offers it as from birth; here it is also a legal entitlement. Most other countries provide a legal entitlement to a nursery education place. In Spain legal entitlements exist from when the child is over 3 years. Other countries with legal entitlements to nursery schooling are Belgium (2½+), France (2+), Germany (3+), Italy (3+) the Netherlands (4+), Portugal (4+) and the UK (3+).

### **3.3. Care for the elderly**

Denmark is in the lead what concerns the provision of home help to older people with 22% of the 65+ receiving services, closely followed by Sweden (18%). In Spain and Greece only 1-2 % of older people (65+) receive home help. Due to the de-institutionalisation policy, the share of older people in institutions is generally around 3-4% except for the Netherlands where a tradition for offering residential care has led to a high capacity of places. Hungary has experienced a decrease in both the home help and institutional care facilities since the change of regime. 2% of the elderly are recipients of home help and another 2% the residents of residential homes (Vajda & Korintus, 2002).

Several countries have introduced a 'cash for care' system. The introduction of the cash for care option has often been the result of heavy lobbying from the organisations for disabled, working for the introduction of 'self-managed care' (Moss, 2002). One solution is to provide a care allowance for older people to purchase care or to remunerate an informal carer for the loss of earnings. Other possibilities are care leaves for informal carers and the employment of informal carers.

### **3.4. Affordability**

In the Nordic countries the main source of funding is public, stemming from national and local taxes. Care for older people and children is heavily subsidized, e.g. home care in Denmark is free of charge. Overall in EU, parents contribute to the funding of daycare institutions, with the highest fees in private institutions. In general, nursery schooling for the 3-school age children is free of charge, also in the countries outside the Nordic countries. Compulsory insurance schemes finance care for older people in e.g. Germany and the Netherlands (Rostgaard & Fridberg, 1998) while the UK and Spain rely on a mix of private payments and means-tested welfare or social assistance funding for low-income users. Like in the Nordic countries, services for children and older people are heavily subsidized in Hungary (Moss, 2002). Looking at the overall public per capita spending (not including tax transfers) on care benefits as a proportion of GDP among a number of Member States shows that Sweden, Denmark and the Netherlands are all high spenders, while Finland and England situate themselves in the middle, and France and Germany are low spenders (Rostgaard & Fridberg, 1998).

### **3.5. Standards of care**

Standards of care benefits often depend on the setting but also on national criteria. E.g. standards within nursery schooling for children are at some points lower than in the welfare system: staff:child ratios are lower; groups sizes are higher and services are often only provided during term time and may not be available all week or during lunch breaks (Rostgaard & Fridberg, 1998). However, most countries have minimum requirements for setting up services and regularly check through inspections. In addition, childcare is the field where qualifications systems and professional training are most developed (Cancedda, 2002)). Within services for older people, staff ratios differ according to need for specialized attention and care and are thus higher in institutional than in domiciliary care. In a 7 country study, Denmark and Sweden came out with the highest staff ratios in domiciliary and institutional care while England and Finland had a somewhat lower staff ratio in domiciliary care, and Germany a low staff-ratio in institutional care in particular (Rostgaard & Fridberg, 1998).

### **3.6. Care policy logics**

Summarizing the policy logics of care in a number of European countries we find that countries to various degree support the equal sharing of paid labour/unpaid care. Please could you give each of these categories below a name?

In England, Germany and Spain fit into the same model. In terms of child care, also the Netherlands belong to this model, while France in terms of care for the old displays characteristics of this model. Here the ideologies behind motherhood and caring support a cash benefit care model where the implicit and explicit assumption of the women's role is that she leaves the labour market for considerable spells to provide care. The state's contribution to the care pattern is the provision of mainly cash benefits with long periods of leave, low or moderate payments and tax benefits for employers' provision. Service provision is moderate, except for the nursery education of children aged 3 and above. Entitlement to these services is based on citizenship and is available for all children. However, nursery education is part-time and term-time, and does not therefore facilitate the take-up of full-time work for both the man and the woman.

Except for the free public nursery education, services are mainly private and costly. Choice of care arrangements is limited as there is no alternative between cash and care, although in principle the provision of cash benefits allows recipients to choose the form of provision. More problematic, however, is the often low level of the cash benefit, since cash benefits can be part of a cost-containment goal, and the assumption of the availability of a number of providers offering different services. In most cases, the choice as to who should provide care is limited to one provider or a family member, mainly the woman.

Looking at Swedish and Danish policy logic, another model is visible. Here, public service provisions are abundant, and of high standards with full-time, all-year provision of child care and good standards in care for the old. The labour market assumption is that both men and women work, mainly full-time, as living standards require a dual breadwinner income. Cost for services is accordingly manageable and tax credits are non-existent. Cash benefits are, however, more meagre with short leave periods, though with relatively high compensation rates. Entitlement to benefits depends on citizenship, and universalism is thus the predominant welfare principle, sometimes succumbed by limited services. This model provides more choice between work and caring than the previous as some moderate leave provisions accompany abundant services.

Lastly, the Finnish care system for children and elderly displays features, which can be associated with a third model. Also French child care policies and Danish, Swedish and Dutch (only as a low-budget version though) elder care policies may fit into this model. Here, services are abundant and compensation rates of cash benefits allow a choice as to how families want their care arrangement. The labour market presumption is that men and women share paid labour, as they share unpaid tasks. Flexibility is strong in this model, both in terms of work conditions, allowing part-time as well as shorter and longer interruptions of the work contract, and in terms of the benefits. Cash benefits can for instance be moulded to fit labour take-up and changes in levels of service hours can be negotiated. Entitlement to benefits depends on citizenship and rights are individual, while services are affordable and standards high. This enables both men and women to choose between partaking in paid labour or engaging in care responsibilities.



**Table 1. Care policy logics – this table does not print out despite all our edits. Please can you reformat/ resend this table?**

	Female Care-giver Model	Dual Breadwinner Model	Family – Work Model
Countries	England, Germany, The Netherlands (children), France (older people)	Sweden (children), Denmark (children)	Finland, France (children), Denmark (older people), Sweden (older people), The Netherlands (older people – budget model)
Ideology (state, market, family)	High degree of gendered care work. Provision of services from market	High support for state provision	Moderate familism supported by state provisions
Predominant form of benefit	Cash	Services	Cash/services
Generosity	Sketchy and costly  Low compensation level of cash benefits; few day care services for smaller children, universal but part-time provision for older children; few services for older people	High compensation rates but short leave periods; abundant and affordable service provision, amongst other full-time child care but access may be limited	High compensation rate of cash benefits, abundant and affordable services.
Entitlement	Labour market associated rights may bar mainly women from qualifying. Nursery education universal provision	Citizenship based, but limited supply may restrict access. Men may be barred from benefits.	Citizenship based benefits, equal rights for men and women
Employment commitment	Considerable spells out of the labour market for women, full-time male breadwinner	High female and male full-time labour force participation	Flexible work conditions for man/woman
Degree of choice between work and caring	Low	Moderate	High

#### 4. Recommendations

- The gendered division of informal care is situated within the cross-points of policies, culture and practises. Interventions should consider all three dimensions
- Gendered assumptions about men and women's involvement in informal caring differ according to whether we look at child care or elder care, and this is also reflected in practises
- Men and women may provide different informal care tasks
- Informal care obligations are negotiable, dynamic and unpredictable but also still gendered
- The global care chain has created new inequalities and new dependants
- Migrant care workers often suffer from poor living and working conditions
- Policy logics influence the choice between paid labour and unpaid caring for both men and women
- It is important to consider supply of services, length and compensation of leave schemes, quality standards as well as affordability

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