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The Social and Political Economy of Care: Contesting Gender and Class Inequalities

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

1. Introduction

Economists working on new growth theory now acknowledge the importance of investments in "human capital", and provide support for public investments in education and training. Indeed the renewed interest in social policy, coming after its neglect in the 1980s, is epitomized by what its proponents call the "social investment state", endorsed by European and the OECD social policy actors. This approach is centered on productive (or active) social welfare, which is understood to mean investments in human capital and in lifelong learning, especially in the capabilities and opportunities of children (Jenson and Saint-Martin 2002; Myles and Quadagno 2000). Yet the reproduction—or care—of human beings involves much more than the formal provision of education and health that is acknowledged in these approaches.

Similarly, the Millennium Development Goals (MDGs) which frame global efforts at poverty reduction in developing countries do not specifically mention care. Yet the achievement of many of the MDGs—whether universal primary education (MDG2), the reduction of child mortality (MDG4), or combating HIV/AIDS (MDG6)—is highly dependent on the provision of paid and unpaid care. How can universal primary education be achieved without the provision of socialization and care to young children which makes them school-ready? How can child mortality be reduced without the unpaid care work provided by mothers and other carers in the home, and the paid care work of health workers in hospitals and rural clinics? (Budlender 2008).

This paper focuses on the arena of care, which is commonly thought of as the activities that take place within homes and neighbourhoods, and are primarily structured by relationships of kinship and community: care of children, and repairing the wear-and-tear on adults whether "able-bodied", ill or frail. But unpaid care work involves many additional tasks such as meal preparation, cleaning of homes, clothes and utensils, and shopping, which are particularly time-consuming in many poorer countries where access to appropriate *infrastructure* (piped water, electricity, sanitation) and *technology* (domestic appliances and ready-made food ingredients) is limited.

Recent decades have seen a noticeable increase in the participation of women in the labour force, although regional differences persist (UNRISD 2005). Women's massive entry into the paid work force—a near-global trend—has squeezed the time hitherto allocated to unpaid care work. At the same time, it is also clear that the narrowing gender gap in terms of labour force participation conceals persistent gender asymmetries in pay and status. These are in part due to the fact that women bear the major responsibility for the provision of unpaid care and often adapt their labour market behaviour to the possibility of combining both.

The classical policy response to women workers' care responsibilities has been through *parental leave provisions*—initially targeted to women, but increasingly now also including men as fathers. While these provisions are important in countries with formalized labour markets, their relevance in many developing countries is questionable where labour relations are largely informal and labour regulations weakly enforced even in formal work situations. The other policy response is the provision of care *services*, especially for young children but also for the frail elderly and those with disabilities, funded and provided through different arrangements (involving enterprises/employers, the state, private for-profit and non-profit organizations).

But many other policy measures, not usually thought of as care-related, actually play an important care function. The provision of *primary education and health services* is seamlessly connected to the unpaid care work assumed by households. For example where public health services have been weakened and cannot meet demand, as in the case of countries with high rates of HIV/AIDS infection, the burden is shifted onto households and communities. New health insurance regulations in many richer parts of the world that have reduced coverage of post-

operation hospital stay produce similar effects. Likewise, in poorer countries where primary educational facilities are under-funded and drop-out rates are high, or where school hours are not adapted to parents' working hours—a situation that is prevalent in many countries regardless of income—the unpaid care burden of household members is intensified. Finally, *social protection measures*—health insurance, old age pensions, child and family benefits and allowances—while not directly providing care, can play an important role in helping purchase essential inputs (food, school materials, health services) which facilitate care, or to buy-in care.

As the record of economic restructuring, including "stabilization and structural adjustment" programmes of the 1980s amply demonstrated, widespread economic insecurity and cutbacks in public provisioning of care-related services such as health and education are not costless. They are deeply disruptive, generate social dislocation and shift the burden of adjustment onto households and communities, within which women in particular often act as "shock absorbers" of last resort (Elson 1991, UNRISD 1995). There are limits to the ability of families and households to supply healthy and well-nourished children, the skilled labour force that a modern economy requires, and the sense of ethics that is conducive to social cohesion (Elson 1998). *A concern for care therefore cuts across sectors (infrastructure, health, education, social protection, labour market policies) and requires a comprehensive approach.*

As **Section 2** will show, the lion's share of care work in all societies, including in high-income countries which have seen an important shift in the provision of care into the paid sectors of the economy, continues to be provided on the basis of kinship, family and friendship relations with no explicit monetary reward. We refer to this as *unpaid care work*—a category that includes both housework and care of persons (see Box 1).

Box 1: A Note on Terminology

Reproduction is often taken to encompass the biological reproduction of human beings, the reproduction of the labour force, and social reproduction more broadly (Edholm et al. 1977). In the 1970s the term reproduction was widely used (e.g. in the "domestic labour debate") to emphasize that women's unpaid work was decisive in reproducing the labour force and in facilitating capitalist accumulation. While this concept is still used, the emphasis has shifted to care.

The terms "unpaid work", "care work" and "unpaid care work" are sometimes used interchangeably. This is wrong and misleading, even though there are some overlapping areas among them.

Unpaid work includes a diverse range of activities that take place outside the cash nexus. It includes: (i) unpaid work on the household plot or in the family business; (ii) activities such as the collection of water and firewood for household use; and (iii) unpaid care of one's child, elderly parent or friend affected by a chronic illness.

- Some elements of unpaid work—for example, unpaid work in a family business—are included in the System of National Accounts (SNA) production boundary and should be included in calculations of GDP.
- Other elements of unpaid work—for example, collection of firewood and water—are (since the 1993 revision of the SNA) included in the SNA production boundary and should be included in GDP calculations, although relatively few countries do this.
- Unpaid care services such as shopping and washing clothes, and feeding or bathing one's child, elderly parent or neighbour are excluded from the SNA and GDP calculations; this is referred to as extended-SNA and some countries measure them in "satellite accounts".

Care work includes (a) direct care of persons such as feeding or bathing them, (b) indirect care where one is responsible for, and supervising, a person needing care but not interacting directly, and (c) supportive services such as cleaning and cooking that provide the preconditions for more direct care. Those with intense care needs include young children, the frail elderly and people with various illnesses and disabilities, but able-bodied adults also require and receive care. Direct and indirect care are often seen as separate from the other activities that provide the preconditions for personal caregiving, such as preparing meals, shopping and cleaning sheets and clothes (housework). But such boundaries are arbitrary, especially since the persons needing intensive care are often unable to do such tasks themselves. Care work can be *paid* or *unpaid.*

But it is not only households that produce care. Care is provided through a variety of social relations and institutions, including *markets*, *states*, and the *not-for-profit sector*. The "care diamond" typology (Razavi 2007) conceptualizes these institutions in a stylized fashion. Of course, this is an oversimplified picture as the institutions providing care work in a more complex manner and the boundaries between them is neither clear-cut nor static. For example, the state very often subsidizes and regulates (sometimes creates) provision through markets and not-for-profit providers. The point of the care diamond, however, is to emphasize the multiplicity of sites where care is produced and the decisions taken by society to privilege some forms of provision over others, with these decisions having implications for who accesses adequate care and who bears the burden.

As we show in **Section 3**, care is widely commodified. Even though care has shifted outside of households, it is still highly feminized. Women have historically entered the labour force in care-related occupations and have tended to remain clustered/over-represented in these occupations. This section will look at wages and working conditions of care workers in public, private-for-profit and not-for-profit sectors.

Section 4 explores the care diamonds in a selected number of developing countries, and how they challenge or reproduce class and gender inequalities. Welfare and care arrangements in developing countries have not received the same level of scrutiny as those in institutionalized welfare states, although families are clearly central, if not hegemonic, in many of those that have been studied (Martinez-Franzoni 2005). There is a need for more nuanced analysis of care regimes to distinguish between different forms of familialism, ranging from what may be called

extensive familialism premised for the most part on women's un-commodified care work to a *modified familialism* through the partial commodification of women's care work. At the same time the role of the state in the care diamond also needs to be underlined because it is of a qualitatively different kind compared to, say, families or markets. The state not only delivers some care services, and partly finances other providers to do so, it also acts as a key decision-maker about the overall design of the care regime through explicit or implicit state policies, programmes and regulations, *or inaction*.

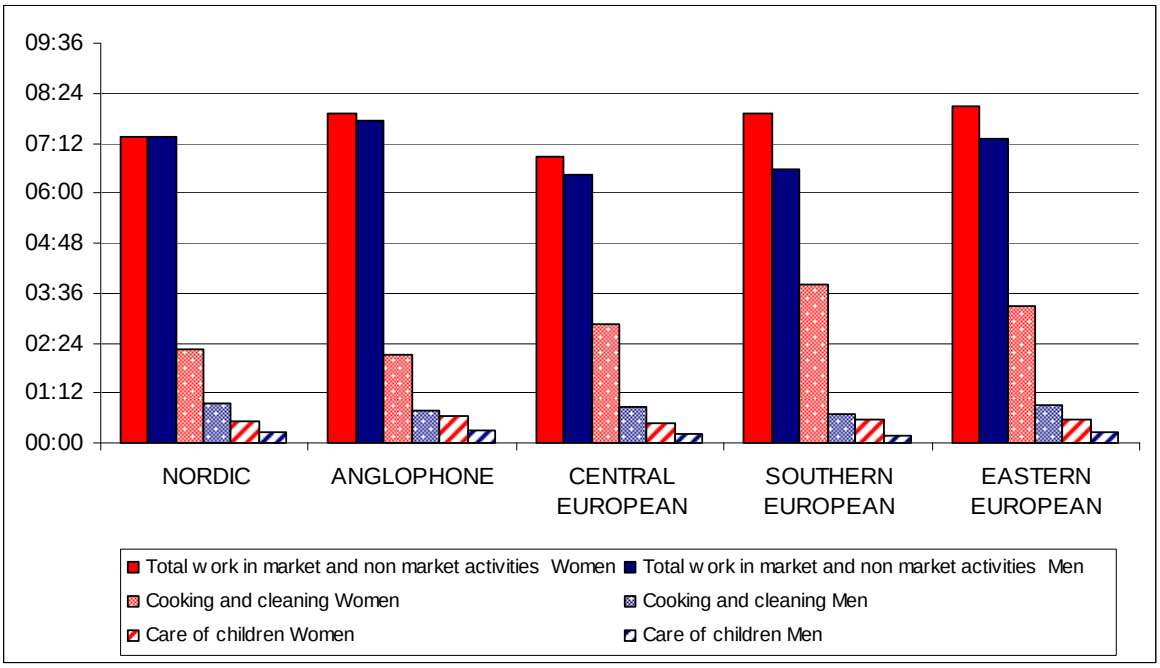
Whether care is seen as an input into economic dynamism and growth, or in much larger terms, as part of the social fabric, how societies organize care has immense social significance—for gender relations and inequalities to be sure, but also for other structures of inequality. Yet despite its salience, it has rarely been possible to turn care into a large-scale social policy issue—indicative of the long and hard struggle ahead not only for advocates of gender equality, but also for those who advocate for better care. Policy attention shifts to care only when its neglect produces negative impacts elsewhere in the system: when below replacement level fertility and population ageing raise concerns about the solvency of social insurance systems and care for the elderly, as in some rich countries today, or in the midst of an extensive social crisis such as that unleashed by the HIV/AIDS pandemic when there is an enormous squeeze on the resources to care for very sick people.

2. Household provision of unpaid care

How much care families and households provide can be measured through the metric of time. The main source of data is from time use surveys. These surveys differ from standard labour force surveys in that they typically ask respondents to report on *all* activities done in a specified period. They tell us how much time is spent by the surveyed population on: a) *non-productive activities*: sleep, leisure, studies, and self-care; b) *employment-related work*, which in developing countries includes both market work and subsistence activities such as subsistence agriculture and gathering fuel and water (also called SNA/System of National Accounts) and c) *unpaid care work* (also called extended-SNA) which includes unpaid housework and person-care (Budlender 2008).

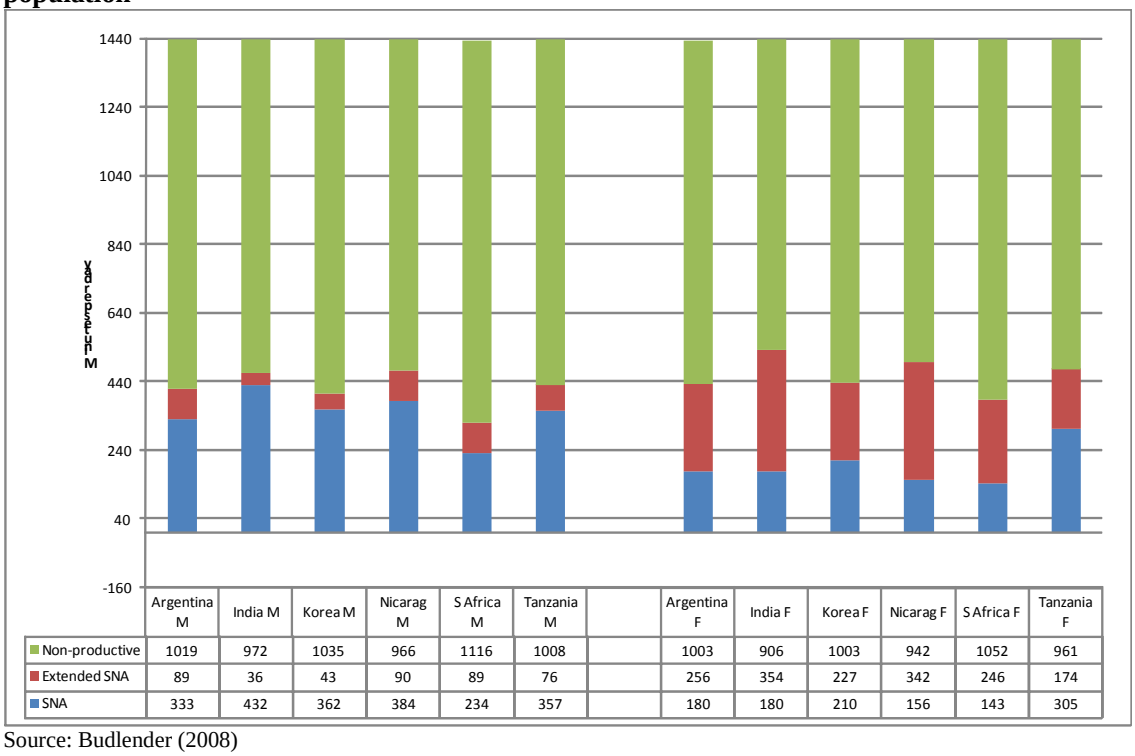
To highlight the significance of unpaid care work in terms of the volume of time that is allocated to it, Figure 1 provides estimates of time use for women and men across selected high-income countries clustered into welfare regimes. Figure 2 gives a similar picture for six developing countries studied in an UNRISD project: Argentina/Buenos Aires, India, Nicaragua, South Africa, South Korea and Tanzania. As is evident from these two figures, despite the well-known difficulties of capturing unpaid care work through time use surveys (Ironmonger 2005), the volume of unpaid care work provided by women and men is very significant.

Figure 1 Mean time spent by women and men in market and non-market work. Selected high-income countries by regime cluster



Source: UNDP (2008)

Figure 2 Mean time spent per day on activities by SNA category, country and sex for full sample population



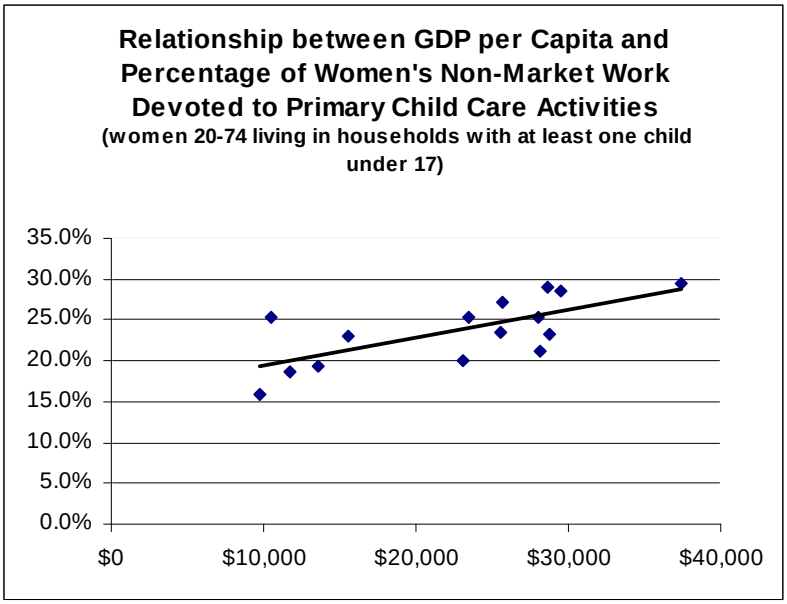
	Argentina M	India M	Korea M	Nicarag M	S Africa M	Tanzania M		Argentina F	India F	Korea F	Nicarag F	S Africa F	Tanzania F
Non-productive	1019	972	1035	966	1116	1008		1003	906	1003	942	1052	961
Extended SNA	89	36	43	90	89	76		256	354	227	342	246	174
SNA	333	432	362	384	234	357		180	180	210	156	143	305

Source: Budlender (2008)

Also remarkable is the large quantity of unpaid care work that goes on in the high-income countries. Conventional wisdom suggests that time devoted to non-market work in general, and unpaid care work in particular, tends to decline in the course of economic development. Yet empirical evidence suggests that non-market work remains remarkably and persistently

important within the advanced capitalist countries. Furthermore, the composition of non-market work seems to shift in the course of economic development, with a decline in the relative share of time devoted to housework and an increase in the relative share of time devoted to the care of children and other dependents. Given the lack of comparable longitudinal data to allow a comparison *over time*, Figure 3 captures this by plotting time allocated by women to childcare activities for fifteen European countries against their GDP per capita. The positive relation shown by the upward sloping curve suggests that time devoted to person-care (especially child care) has some of the characteristics of a "luxury good"—the demand for which rises steeply with income (Folbre 2008). One would have to note, however, that it is also likely that people in higher-income countries would report care of persons *more* than people in lower-income countries because they know that ideologically it is a "good thing" to report.

Figure 3 Relationship between GDP per capita and percentage of women's non-market work devoted to primary child care activities, 15 European countries



Source: Folbre (2008)

To say that a large part of care work in all societies is provided on an *unpaid* basis does not mean to suggest that unpaid care carries no costs: in fact it imposes substantial costs on those who provide it in the form of financial obligations, lost opportunities and foregone earnings—which is not to deny that it also generates intrinsic rewards, stronger family and social ties and good quality services for dependents (Folbre 2006). The costs are unequally borne. Women in general tend to bear a disproportionate share of the work, while many of the benefits go to society more broadly—as children grow up and join the work force and pay taxes. Children may be seen as "public goods" since they provide benefits to everyone, not just their parents and themselves (Folbre 2001).

2.1 Care and demographic change

Fertility rates have been falling across a wide range of countries, suggesting a possible "care dividend" for many countries. But at the same time, the number of potential care-givers may also have been reduced through the reduction in number of members per household (not simply a reflection of fertility decline), the decrease in the number of multigenerational households, and the nuclearization of households. Moreover, population ageing (defined as

an increase in the percentage of a population aged 65 years or older), long-established in developed countries, is now also occurring in many poorer parts of the world. While it is clear that not all older people are frail and in need of care, and that many in fact become care-givers in their later life, having a larger proportion of the population in advanced age (85 years or more) is likely to increase the demand for care.

Summarizing some of the potential demographic impacts of these processes on care, UNRISD constructed a "care dependency ratio" (See Box 2). The Figure in Box 2 shows the "care burden" in six countries that were studied in the UNRISD project. Among the countries covered the care dependency ratio was found to be lowest in Korea, followed by Argentina, and highest for Tanzania, reflecting in particular the relative size of the under-6 cohort. The figures suggest that a caregiver in Korea would, on average, share the responsibility for caring for a single person with at least five other people, while a caregiver in Tanzania would be responsible for more than half of all the care needed by another person.

Box 2 The care dependency ratio (CDR)

The *care dependency ratio* is intended to reflect the relative burden placed on carers in a society. As with the standard dependency ratio, the care dependency ratio is defined in terms of age groups. Those with intense care needs (0-6 years and 85+ years) are given full weight, while those with less intense needs (7-12 years and 75-84 years) get half-weights. Potential care givers fall in the age category of 15-75 years.

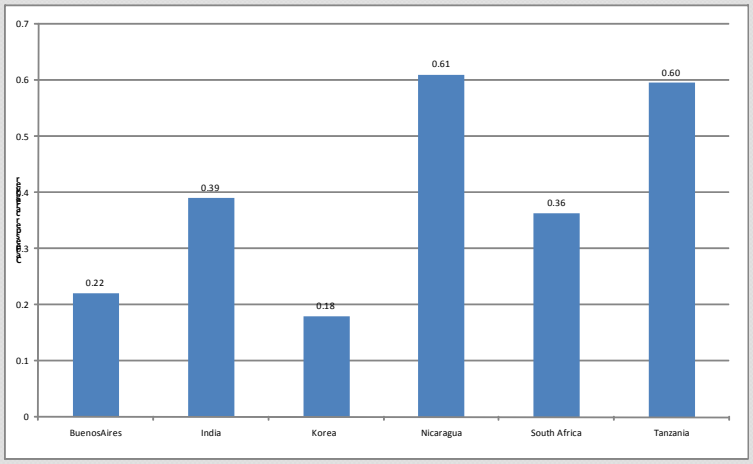
Those needing care:
A=0-6 years; weight: 1 B=7-12 years; weight: 0.5
C=75-84 years; weight: 0.5 D=85+; weight: 1

Potential care givers:
E=15-75 years

Care dependency ratio = (A+B+C+D)/E

The CDR tends to undercount the numbers needing care, as it does not take into consideration those in the carer age group who are disabled or ill (due to lack of adequate data). The undercount would probably be most marked in respect of countries affected by the AIDS epidemic. The care dependency ratio also disregards the fact that *all* people need a certain amount of care.

Care Dependency Ratios



Interestingly, the apparent need for care calculated on the basis of demographic variables does *not* correlate in a simple way with the amount of time that is actually spent on care (as recorded in the time use surveys). For example, while the demographic structures would suggest a lower

care burden in Korea and Argentina, women in these two countries allocate relatively *more* time to person-care than women in Tanzania and India. The extra time spent by the wealthy on care of persons could reflect different factors: the "contracting out" of time-consuming housework by employing others to do this work while the time that would otherwise be allocated to it is spent on person-care; an ideological emphasis on the need for "quality time" to be spent with children (and the *reporting* of that time to enumerators); as well as smaller households among the wealthy, meaning that children are more likely to be cared for separately with fewer economies of scale and less possibility of children caring for each other (Budlender 2008). Moreover, the age at which a child is considered to need care varies considerably (as does the concept of childhood itself) across countries and over time. All of this suggests a complex relation between demographic structure and care.

2.2 Gender inequalities in unpaid care provision

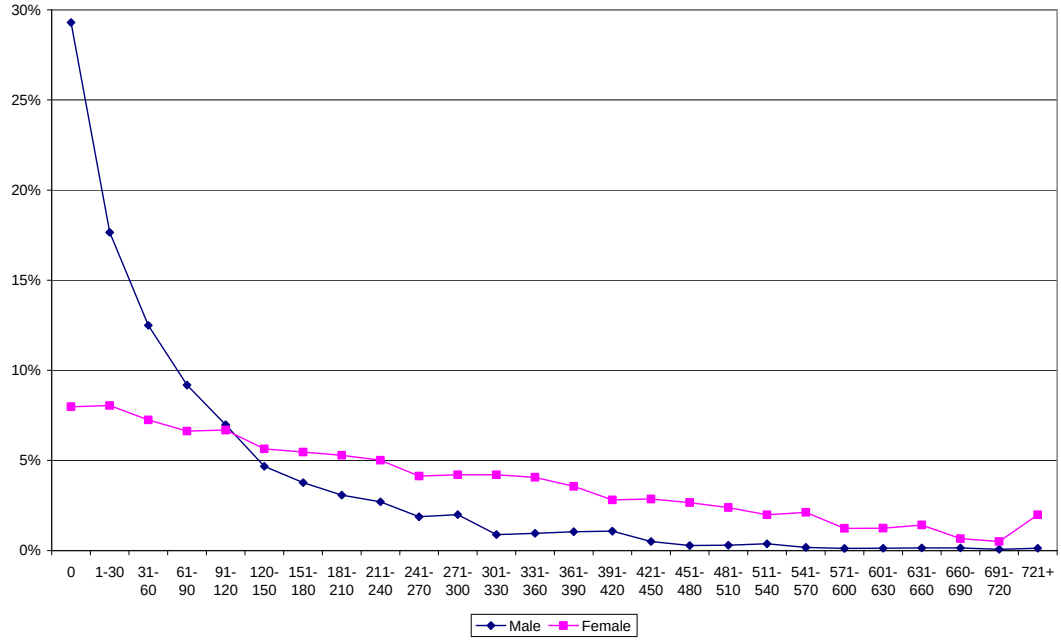
Going back to Figures 1 and 2, the data reveals notable differences in time allocation between women and men. It should not come as a surprise that in all countries women's hours of paid work (or SNA work) are less than men's, while men contribute less time to unpaid care work (UCW). Among the six countries in the UNRISD project, the mean time spent by women on unpaid care work is more than twice the mean time spent by men. The gender gap is most marked in India, where women spend nearly ten times as much time on UCW than men. Men from the two Asian countries, Korea and India, tend to do noticeably less unpaid care work than men in the other countries.

While men in these six countries tend to spend more time on SNA work than women, the gender gap is narrower in this case. The gender gap in SNA work is particularly small in Tanzania. In India, in contrast, men spend nearly 2½ times as much time on SNA work as women do, mirroring the much longer times that women spend on unpaid care work.

If all types of work are combined, women in all six countries allocate more time to work than men—which means less time for leisure, education and self-care. A similar pattern is found among most high-income countries in Figure 1 (with the exception of the Nordic cluster). In general therefore, we can talk of "time poverty" being more prevalent among women than men. But this statement relates to averages (or means), calculated across the population, and there may be significant differences within both the male and female population groups.

To capture such differences Figure 4 shows the distribution of time allocated to unpaid care work across the female and male sample population in South Africa. Close to 30% of males compared to less than 10% of females spent no time at all on unpaid care work on the previous day. At the other end of the spectrum, a negligible number of males, but 2% of women spent longer than 12 hours on unpaid care work. The female distribution has an extremely long tail, while the distribution for men has a short tail. The short tail for males suggests a low variability, i.e. that males do a fairly *consistently low* amount of UCW. The long tail for women suggests the opposite: high variability and, as a consequence, a notable level of in-group inequality. The patterns in other countries showed similar characteristics: greater variability among women, while men seem to do a consistently small amount of UCW.

Figure 4 Distribution of time spent on unpaid care by sex, South Africa



Source: Budlender (2008)

Under what conditions and policy measures do men increase their time allocation to unpaid care work? In her analysis of 20 countries using time-use surveys from 1965 to 2003 Hook (2006) finds that there has been a clear increase in men's participation in unpaid work over time. The increase for fathers is most important where a large share of married employed women works full-time and parental leaves are short and available to men. Female part-time employment, on the other hand, is associated with unaltered male behaviour in the home. This finding suggests that both female employment patterns *and* policy responses to its rising levels (including parental leaves, family allowances, childcare services) can influence the intra-household division of labour by decreasing or increasing fathers' unpaid work time. Interestingly, Hook finds women's full-time employment to have a positive impact on *all* men's (not only fathers) unpaid work time, indicating that the effect goes beyond household-level bargaining. However, as opposed to the trends in paid employment we cannot speak of convergence in unpaid care work, since men's share doesn't exceed 37 per cent in any of the countries.

Korea is the only country in the UNRISD project with two (roughly) comparable time use surveys (1999, 2004), allowing an analysis of change in time use patterns over time. While women's household care burden may have declined slightly in 2004 for those who were employed, whether employed or not, women nevertheless took on a disproportionately larger burden of unpaid care work compared to men, and the gender division of labour remained relatively unchanged. Despite the social welfare expansion of recent years (on which more below), the 2004 Time Use Survey data shows no evidence of women's share of unpaid care work being reduced, nor changes in its division with men. This may be in part at least accounted for by the insufficient time lag between the expansion of social care programmes and the 2004 time use survey. But it may also confirm the argument that the availability of accessible care services does not disturb prevailing gender patterns, and that different policy efforts are needed to persuade men to provide care.

2.3 Other inequalities in unpaid care provision

What explains the variability in the amount of unpaid care work? Is it income/social class, age, having a young child in the household, or race/caste that differentiates patterns? Many of these

factors can reinforce each other. For example, a simple tabulation by age would show a clear pattern of increased engagement in, and time spent on, care of persons with increasing age up to a point. In reality, however, part of this pattern could be explained by the fact that older people are more likely to be married, and more likely to have children, and both of these characteristics in and of themselves tend to result in an increase in engagement in care of persons.

In the UNRISD project, Tobit estimations were used to separate out the influence of different factors (such as gender, age, marital status, income, employment) on the time spent on unpaid care work, and person-care more narrowly (Budlender 2008). Looking at unpaid care work more broadly, as expected, being male tends to result in doing less unpaid care work across all countries. Similarly, having a young child in the household tends to increase the amount of unpaid care work done across all cases. As for age, the common pattern is of an initial increase in the amount of unpaid care work done, followed by a decrease. Where the influence of household and individual income or expenditure were tested and a significant association found, the amount of unpaid care work tended to *decrease* with increases in income. This could be explained by several factors, including the poorer infrastructure (piped water, electricity) and technology available to poor households, less ability to purchase care, and larger household size.

White people in South Africa tend to do less unpaid care work than those of other races—a pattern that can be explained by the greater likelihood that a domestic worker will be employed by the higher status group. Rural people in India and Tanzania tend to do less than urban people despite the fact that they are less likely to have good infrastructure. A possible explanation could be that the dwellings in rural areas are smaller, or that households are larger and the tasks thus shared among more people.

Looking at person-care more narrowly, having a young child in the household is the strongest factor across all countries (even stronger than gender). Being male again tends to result in less care work being done. The pattern with respect to age is similar to that for unpaid care work. Interestingly the pattern with respect to household income varies across countries: where household income is found to be influential, those who are poor tend to do *more* care of persons in Argentina and Tanzania, but less in India. To show differences across poor and non-poor households in person care, we present the data from Argentina in Table 1.

Table 1 Mean time per participant and participation rate in Care of Persons, by sex and household absolute poverty. Buenos Aires, Argentina.

	Care of Persons					
	Women			Men		
	24-hour time per participant	Full-minute time, per participant	Part. rate (%)	24-hour time per participant	Full-minute time, per participant	Part. rate (%)
Total	**03:11**	**04:12**	**32**	**01:50**	**02:32**	**20**
Poor	03:33	04:59	69	01:13	02:01	36
Non-poor	03:07	04:03	29	01:55	02:36	19

Source: Esquivel (2008a)

Close to 70% of poor women devote 5 hours on average to care of persons, while only 30% of women in non-poor households do so, devoting four hours to it. For non-poor men we see lower participation rates and slightly higher mean participants' times, compared to poor men. In short, in Argentina person care does not seem to have the characteristics of a "luxury good", as was noted for the developed countries. This may reflect the greater ease with which non-poor households can purchase care and/or because absolute poverty is also related to restricted access

to care facilities provided by the State or the community, as evidence from Buenos Aires suggests (see section 4.1). Regrettably, regression analysis does not tell whether the fact that the poor, particularly poor women, do more unpaid care work and less paid work, is caused by the limited opportunities for income-earning or itself the reason for limited income-earning (Esquivel 2008a).

3. Non-household provision of care: markets, states and not-for profits

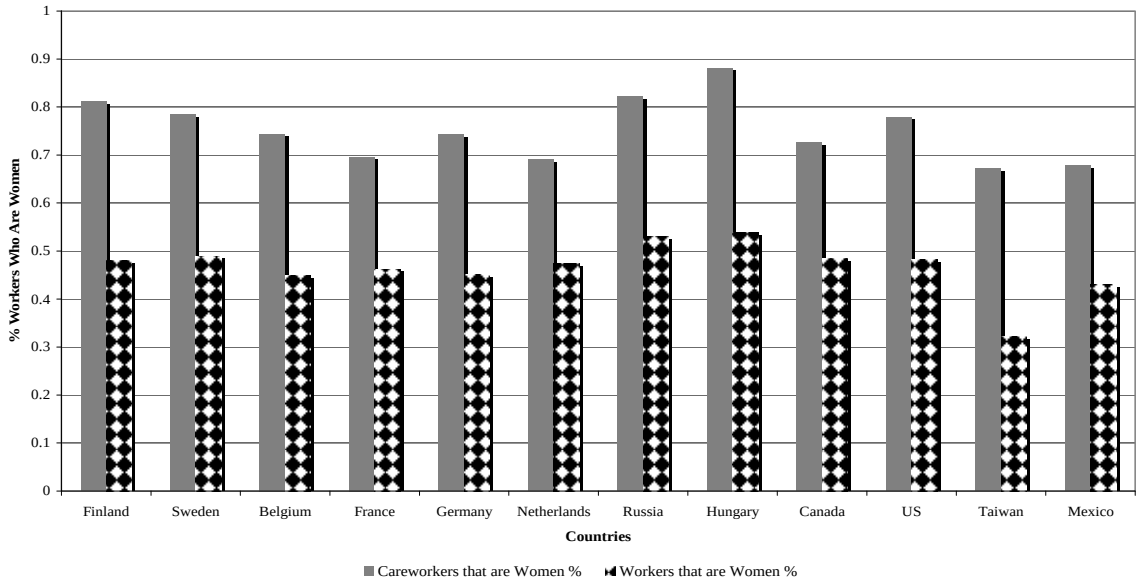
Care provision is no longer confined to the household as many of the intimate tasks we associate with care have "gone public" (Hernes 1987) and are now carried out by market, public or not-for profit providers. As women's labour market participation has reduced time available for unpaid care, the demand for non-household care services has been on the rise and employed care-workers comprise a growing segment of the paid labour force.

The increasing role of "market principles" in care provision has generated heated debates. While supporters of market-based care services stress the increase in efficiency that market transactions will entail, critics bemoan the movement of care into markets on *a priori* assumptions that markets must degrade caring work by replacing motivations of love/altruism with money/self-interest. Both approaches seem problematic.

The first approach ignores all that is known about market failures, imperfect information and the difficulties of monitoring effort and quality—problems that are particularly rife in care markets. Care recipients are not merely consumers and might not have the capacity to correctly assess the quality of care they receive or shop around for better options. There are also many "externalities" from care that go beyond the individual care recipient and, hence, the care services that consumers may choose (given their budget constraints) could be socially suboptimal. For all of these reasons, paid care services can be particularly susceptible to competitive pressures that often generate low-pay/low-quality outcomes. But the second approach is also problematic because it is premised on an idealized view of unpaid care: it ignores the social pressures on women to provide unpaid care, as well as the risks of self-exploitation and economic insecurity to which they are frequently exposed.

The growing provision of care through market, government and community services has not resolved the under-valuation of care, nor the fact that it is carried out predominantly by women. In both developed and developing countries, as a general rule women constitute a larger component of care workers compared to their share of the total workforce. Data available from the Luxembourg Income Study for 12 countries (mostly high-income countries) show that women constitute between 32 and 54 percent of the total workforce, while they constitute between 68 and 88 percent of paid care workers (see Figure 5).

Figure 5. Percentage of Workers Who Are Women, by Care Work Employment, All Employment, and Country



Source: Budig and Misra (2008)

Good quality care, whether paid or unpaid, is very labour-intensive. Unlike in manufacturing for example, productivity growth through mechanisation or technological innovation is difficult to achieve given the strong interpersonal character of care. At the same time, there is a limit to the number of people one worker can care for without jeopardizing the quality of care that is offered. This makes care a comparatively costly endeavour. Attempts to curb the costs of care in private or public institutions may lead to "wage penalties" – referring to the fact that jobs involving care pay less than comparable non-caring occupations requiring similar levels of education and experience. The fact that women often out-number men in caring professions also exerts a downward pressure on wages.

3.1 Cross-country evidence on wage penalties for formal care workers

Paid care work includes a number of occupations that differ significantly in terms of status and skills – with medical doctors at one end of the spectrum, and domestic workers at the other end. Although wages and working conditions of care workers vary across these categories and across countries, there is empirical evidence that some care workers tend to receive lower wages than workers with comparable skill levels in non-care related occupations with otherwise similar characteristics. For the U.S., England et al. (2002) estimated a 5-6 per cent wage penalty for doing care work, controlling for a host of factors including education and background of the workers, and characteristics of the job such as whether it is female-dominated, public sector, or unionized. The penalty was found to be particularly severe for women working in childcare (41 per cent), while men also receive a large, albeit lower, penalty when employed as childcare workers (12 per cent).

Specially commissioned cross-national research for this paper finds net gaps in earnings between care workers and non-care workers to exist more widely (Budig and Misra 2008). Aggregate penalties by country and sex are presented in Table 2. Interestingly, however, the study finds important variations across the twelve countries analysed, with types of care work, employment

sector (public vs. private), gender, and welfare regimes being important variables in determining the existence and severity of care penalties.

Table 2 Effect of Care Sector Employment on Earnings, Net of Human Capital, Labour Supply, Demographic Characteristics, and Job Characteristics, by Gender

	Men	Women
Scandinavian		
Finland	1.1%	1.1%
Sweden	**12.5%**	**23.4%**
Continental European		
Belgium	0.9%	0.9%
France	**-13.4%**	**-25.3%**
Germany	**-10.9%**	**7.8%**
Netherlands	**-13.8%**	**10.9%**
Post-Socialist		
Hungary	**-23.9%**	**-24.1%**
Russia	4.5%	**-17.2%**
Liberal		
Canada	**-17.3%**	**-3.0%**
USA	**-10.1%**	2.0%
Others		
Mexico	**-33.1%**	**-33.1%**
Taiwan	**-8.8%**	**-8.8%**

Source: Budig and Misra (2008)

Penalties seem to be smaller for health as compared to educational care workers. Also, private sector care work seems to be more deleterious on earnings than employment in the public sector (see Table 3). In several countries the significant care penalties found in the private sector are comparatively reduced, though not eliminated when performed in the public sector. In the U.S. alone, care work in the public sector significantly increased the wage penalty for women—a reflection of poorly paid public sector care work, such as elder care workers in Medicaid facilities or preschool teachers in Head Start (England and Folbre 2002).

Table 3 Effect of Public/Private Care Sector Employment on Women's Earnings, Net of Human Capital, Labour Supply, Demographic Characteristics, and Job Characteristics

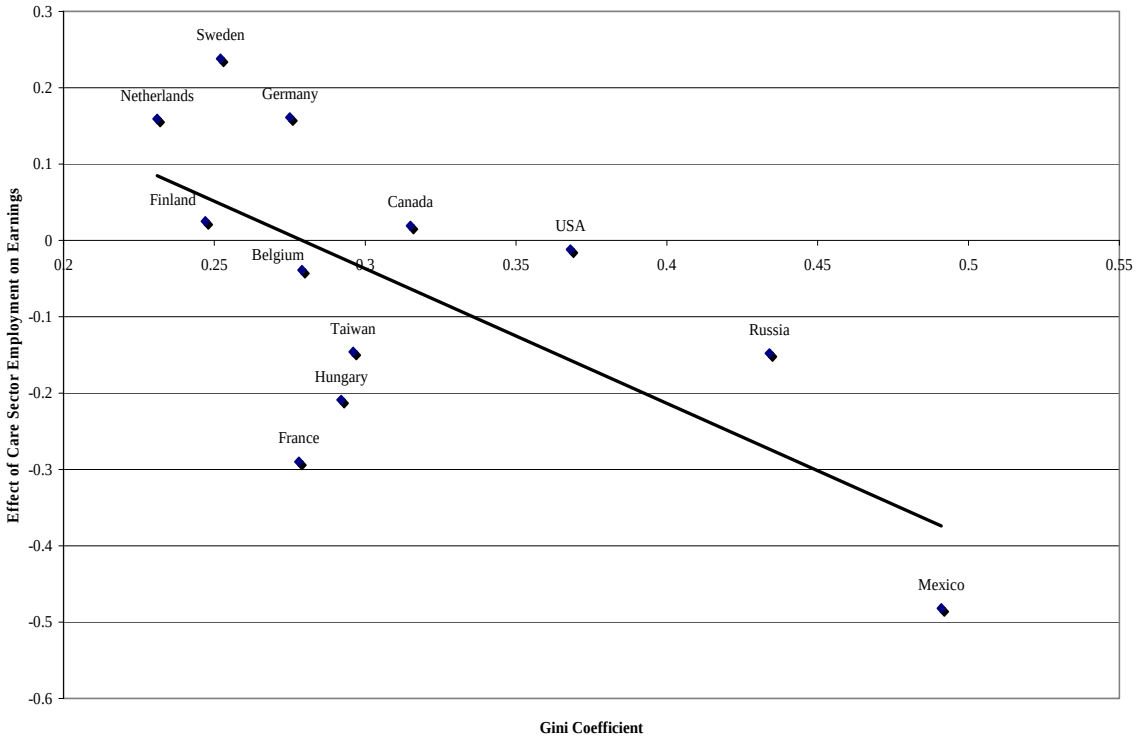
	Priv. Sect. Care	Pub. Sect. Care
Scandinavian		
Finland	Na	na
Sweden	**9.0%**	**28.9%**
Continental European		
Belgium	-2.4%	-2.4%
France	**-37.8%**	**-17.4%**
Germany	**9.3%**	**9.3%**
Netherlands	**15.9%**	**15.9%**
Post-Socialist		
Hungary	**-21.2%**	**-21.2%**
Russia	**-47.3%**	**-10.9%**
Liberal		
Canada	**-15.0%**	**-15.0%**
USA	1.7%	**-7.6%**
Others		
Mexico	**-66.9%**	**-30.7%**
Taiwan	**-15.8%**	**-15.8%**

Notes: Significant effects ($p < .05$, two-tailed tests) are bolded.
Coefficients presented are calculated from models with interaction terms.
* Percentage of Population that is Immigrant is offered as a descriptive statistic, and is not a variable in the regression models.
Source: Budig and Misra (2008)

It has been suggested that the devaluation of care work may be explained by the fact that across countries and time, care work has been performed predominantly by women (England 1992). Indeed, controlling for gender segregation usually lessens the wage penalties to care, indicating that caring occupations do pay less due to their "feminised" character (Budig and Misra 2008). However, it is noteworthy that both women *and* men in care-related jobs are economically disadvantaged vis-à-vis workers in non-care occupations. While men tend to be subject to wage penalties to caring more frequently (as compared to other men in non-caring occupations), women usually suffer from larger care penalties (as compared to other women in non-caring occupations).

One crucial finding from this cross-country research is that policy context matters. As a general rule, wage penalties incurred for performing care work tend to be higher in countries with *greater income inequality, less centralized bargaining through unions*, and a *smaller public sector*. On the other hand, where income inequality is low and the public sector is large, those in caring occupations may even earn wage bonuses as compared to non-care workers with similar characteristics. As such, countries with very high levels of inequality (Mexico, Russia, and the U.S.) are associated with higher penalties to care work (see Figure 5). Where overall income inequality is low and the public sector is large, those in caring occupations may even earn wage bonuses as compared to non-care workers with similar characteristics (as in Sweden). The policy areas that seem to be of particular importance for shaping care workers' wages are *labour market regulations* and the *provision of public care services.* In more weakly regulated labour markets paid care work is more likely to involve low-wage and "docile" labour (i.e. female, migrant).

Figure 6 Effect of Care Sector Employment on Women's Earnings in Relation to Income Inequality Measured by the Gini Coefficient



Source: Budig and Misra (2008)

Policy regimes that value the importance of care through generous public provision of quality care services may have a positive impact on care workers' wages both in the public and in the private sector. The Nordic model of universalistic social care, for example, where all citizens have access to the same level of high-quality public care services (paid for through tax revenues) and actually use these, has received much praise for meeting women's needs as primary carers. The creation of comprehensive public social services in these countries also served as a strategy for enhancing female employment, which is particularly high in the Nordic countries. Additionally, it seems to have had a positive effect on care workers' wages: among twelve countries analysed, only in the Nordic states neither women no men incurred penalties for care work.

The finding that wage penalties are usually greater in contexts with less regulated labour markets, higher income inequality, lower union density and a smaller public sector raises important issues for developing countries, where the informal nature of labour markets are likely to transform wage penalties into an increased poverty risk. Domestic service - as an important source of market-based care provision in many developing countries that employs significant numbers of women - constitutes a particularly precarious source of female employment.

3.2. Poverty among informalized domestic workers

Low remuneration and status as well as poor working conditions of domestic workers are one of the most notorious expressions of the devaluation of care work, and, in some countries also clearly related to these workers' poverty. There is widespread absence of formal regulations like minimum wages, maximum working hours, or mandatory employer contributions to the worker's social security for these workers. Employer control is particularly great in the case of migrant

domestic workers who may face sanctions or deportation if their contracts are not renewed (Anderson 2000).

The growing demand for domestic workers in some developed countries has been associated with increasing levels of inequality (Milkman, Reese, and Ross 1998). It is thus not surprising, that domestic service employment is a significant source of female employment in Latin America, where it also reflects a strong race bias (ECLAC 2007). In India there has been an increase in the number of women domestic workers and their share in the total service employment since the mid-1990s, probably related to the economic reforms (Palriwala 2008, Heintz 2008).

Looking at the situation of domestic workers in two countries marked by intense inequalities, Brazil and South Africa, is revealing. In 2006 domestic service employment accounted for 18.3% of women's and 0.4% of men's employment in Brazil (ECLAC 2007). In South Africa domestic service employment accounted for 16% of female employment in 2005; 97% of domestic workers were female (Department of Labour 2005). With respect to earnings, Table 4 shows that in Brazil, domestic workers' hourly earnings are less than 50 per cent of average hourly earnings of all employed individuals. In South Africa, this share drops to 30 per cent. When compared to other female workers in informal, non-agricultural employment, differences are still substantial, with domestic workers' hourly earnings representing 74 per cent in Brazil and 79 per cent in South Africa.

Table 4 Women domestic workers hourly earnings as a percentage of average hourly earnings in different employment categories

	Brazil (2005)	**South Africa (2004)**
% of domestic workers' hourly earnings of all employed individuals	47.0	30.0
% of hourly earnings of all **female** employees in informal non-agricultural employment	74.1	78.9
% of hourly earnings of all **male** employees in informal non-agricultural employment	58.8	69.2

Source: Heintz (2008)

Given this unfavourable picture in earnings, it is not surprising to find that domestic workers' are more likely to live in poor households than workers from other employment categories (see Table 5). In both countries, male and female domestic workers have a higher than average poverty rate, with almost two thirds of domestic workers living in poor households in South Africa.

Table 5 Working poor poverty rates by employment status and sex

	Brazil (2005)		South Africa (2004)	
	M	**F**	**M**	**F**
Domestic workers	31.0	30.1	60.6	65.4
Informal non-agricultural paid employees	23.2	22.6	52.3	64.9
All employed (formal, informal, agricultural and non-agricultural)	24.0	21.2	35.6	47.1

Source: Heintz (2008)

Some countries have made attempts to improve domestic workers' employment conditions and status. Analysis carried out one year after the coming into effect of new regulations for domestic employment in **South Africa** suggests that labour market interventions can help improve wages and working conditions. The introduction of minimum wages (set above the median hourly wage for 2002) has raised hourly earnings by more than 20 per cent within one year, without apparent negative effects on employment. Other legal requirements like the right to a written contract, paid leave, severance pay, dismissal notice, and the employers' obligation to register workers at Unemployment Insurance Fund, seem to have had similar positive effects, raising the proportion of domestic workers with a written contract from 7 per cent (2002) to 25 per cent (2003) and the share reporting unemployment deductions from 3 to 25 per cent (Hertz 2004).

Similarly, efforts to formalise informal employment in **Argentina** started in 2005 and seem to have benefited domestic workers in terms of their enrolment in pension and health plans. Though still very low, the proportion of domestic workers whose employers effectuated deductions for health and pensions doubled from 4 per cent in 2003 to 8 per cent in 2006 (Cortes 2008). However, average earnings in 2006 were still below minimum wage regulations, an indicator for the weak enforcement of these. It remains to be seen whether compliance with minimum salaries will increase over the years to come.

Although domestic workers constitute an important pillar of care-related work in developing countries, as noted above, paid care workers are an extremely heterogeneous group, including occupations as diverse as doctors, nurses, teachers and childminders. It goes without saying, that these occupational groups face very different wage and working conditions in most countries and are often not affected by the kind of precariousness that domestic service implies.

Indeed, some careworkers are well-organized and have access to formal, secure and relatively well-paid employment, when compared to domestic workers and especially when employed in the public sector. This is the case for professional nurses in South Africa (Lund 2008a) and teachers (including pre-school teachers) in Argentina (Esquivel 2008b). Unusually, the latter is a highly professionalized activity, with almost all pre-school teachers having a tertiary degree. As other educational staff in the Argentine public sector, preschool teachers are highly unionised, with intermediate organisations that negotiate salaries and working conditions with educational authorities on a centralized basis (pre-school teachers' salaries are negotiated along with primary teachers' salaries). Teaching personnel thus counts with a high level of workers' rights – and apparently also job satisfaction.

Given these polarized types of care workers – with different capacities to struggle for labour rights and different levels of empowerment – a "care movement" based on a broad definition of care work and coalition-building across occupational groups could foster the expansion of rights to less empowered workers (Folbre 2006). How to forge alliances across categories of workers with such different levels of income and working conditions remains a difficult political question.

3.3 Community-based care provision

One strategy for dealing with the staff costs of the public health sector and the high demand for services which clearly outstrips the supply of public health services, especially in the context of HIV/AIDS, has been to leave care provision to not-for-profit organizations—as the country evidence below illustrates. Many of these "participatory" programmes directly rely on the goodwill of family and community members who perform the work on a voluntary basis or for very basic stipends. In Tanzania and South Africa, for example, many volunteers seem to have joined the "home-based care" programmes due to widespread unemployment and in the hope of acquiring skills that will channel them into paid employment (Akintola 2004, Meena 2008). In India, many *anganwadi* (public crèches) workers and helpers who are paid low monthly stipends have joined the programme with the hope that their status may be regularised in the future and they be treated as government employees (Palriwala 2008). As field research form various developing countries has shown, while volunteerism is sometimes driven by altruistic motives, in contexts with high levels of unemployment, underemployment and poverty, many "volunteers" may have expectations of reaping future economic benefits from their participation. Indeed, the lack of financial compensation—and the fact that they often incur costs in helping those for whom they provide care—is a current theme among community caregivers who are often poor themselves.

9.4 Care Regimes in Developing Countries

In discussions of social care the Scandinavian care regime has attained something of an iconic status. Among 26 OECD countries, they have the highest figures in terms of expenditure on social care services (i.e. services for the elderly, children under school age, and those with disabilities) as percentage of GDP; Sweden leads the ranking with 5.4 percent (Table 4.2 in Anttonen 2005). The common features of social care in these countries include: extensive public provision of social care services for both children and adults; middle and upper income households being among the users of public care services; and municipalities bearing responsibility for service provisioning. Perhaps the most remarkable feature of this model is its universalism—public care services are not intended only for the poor—which fosters a virtuous circle whereby all benefit and use the system, all feel obliged to pay through taxation (hence quality of services can be maintained), and retrenching them becomes politically difficult. Given women's stake in this system—both as *users* of care services and as *care workers*—their high level of electoral support for the system is not surprising.

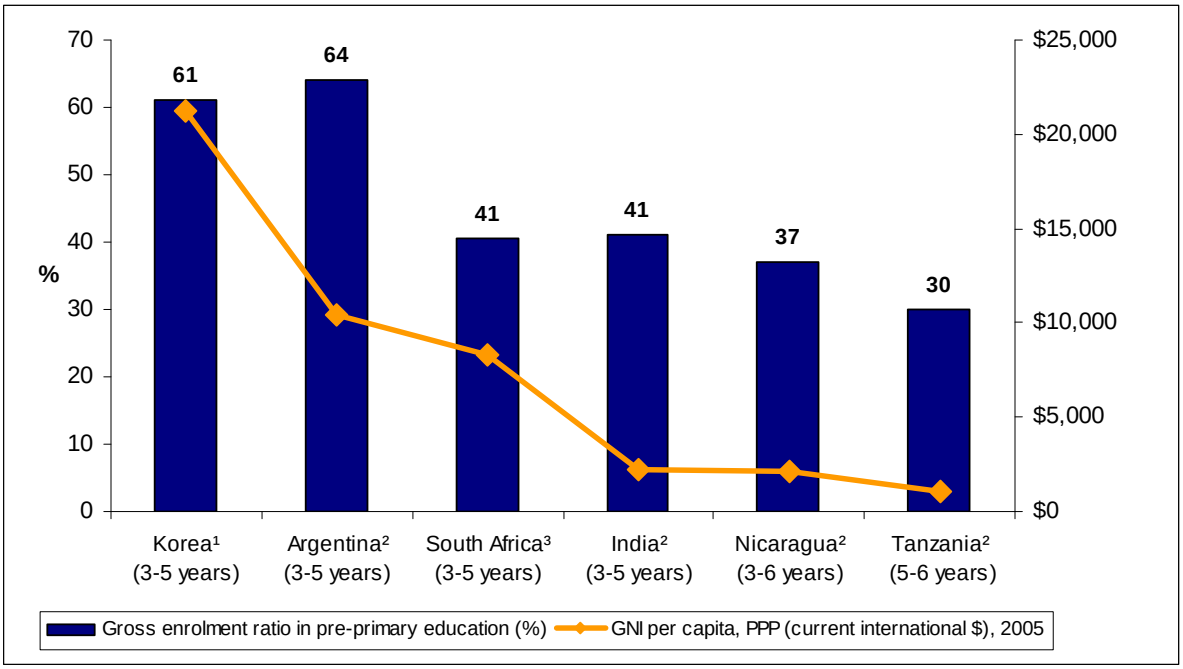
These are important lessons for other countries endeavouring to respond to societal demands for a more *equal sharing* of care obligations between women and men, and between families and the public at large. Below we look at evidence from five countries with different care regimes.

Modified familialism in developmental and stratified regimes: Korea and Argentina

Republic of Korea (thereafter Korea), along with Japan, is often classified as having a highly familialistic care regime, but one that is undergoing change. Both political contestation and demographic imperatives—rapid population ageing and falling fertility rates—have catapulted social care onto the national policy agenda. The state has been responsive: it has extended and redesigned parental leave; expanded early childhood education and early childhood care, and integrated the two systems; provided subsidies to childcare centres and tax exemptions for

families; and introduced Elderly Care Insurance due to begin in 2008 to cover long-term care needs. Children under the age of 3 who were covered by childhood care and education services stood around 19.6 per cent, and the combined enrolment rate in childcare centres and pre-schools were 59.5, 66.4, and 78.9 per cent for 3, 4, and 5 year-olds respectively. The average enrolment ratio for 3-5 year-olds was 61 percent in 2005 (see Figure 7).

Figure 7 Gross enrolment ratios in pre-primary education and enrolment in private institutions as a percentage of total enrolment selected countries



¹ Enrolment ratio from OECD (2008), based on national data from 2005.

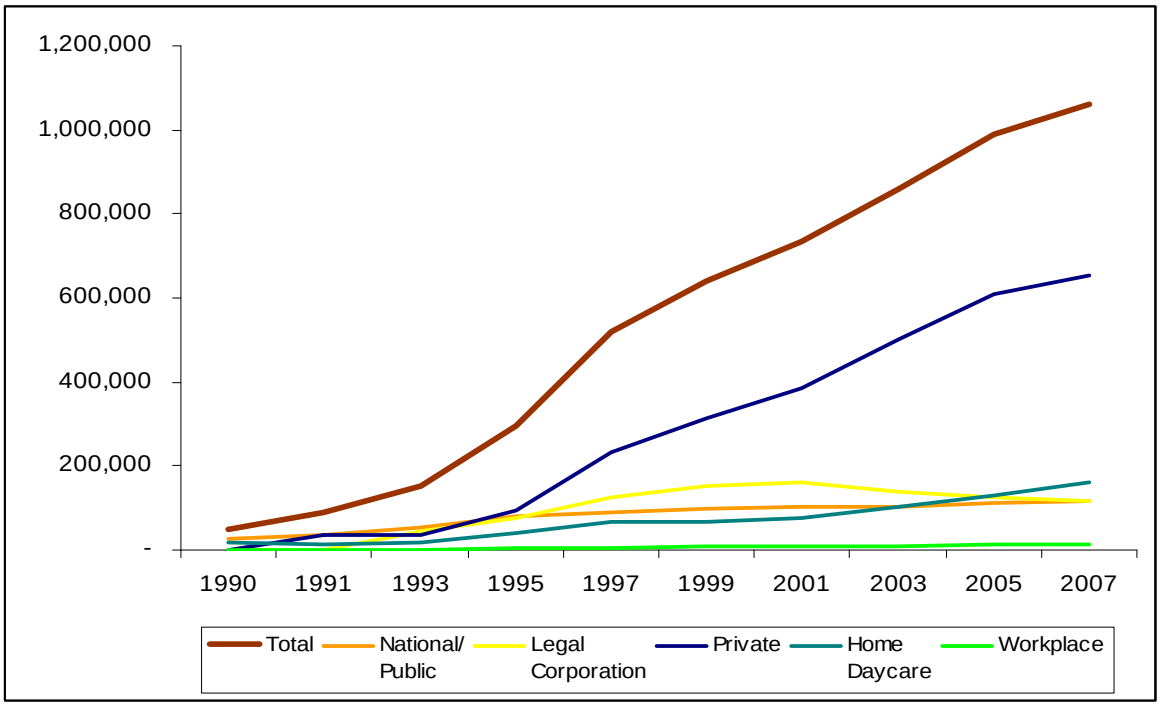
² Enrolment ratio from UNESCO (2007) based on national survey data from 2005.

³ Enrolment ratio from Statistics South Africa (2008) based on GHS 2007; includes daycare and crèches.

Yet what we find in Korea is a proactive state that partially finances and regulates the provision of care, but does not actually deliver most of the services it helps finance (Figures 7 and 8), bearing a resemblance to the state's role in the area of health care. A small proportion of the childcare centres (5.6 per cent where 11 per cent of all children are enrolled), are truly public; the rest are private-for-profit and non-profit centres. The distinguishing feature of public childcare centres is that they are run as part of the public service; their staff members, often with strong educational qualifications, are classified as public servants, enjoy good working conditions and salaries, and are represented by public sector unions. This is clearly not the case with workers in the other sectors, both for-profit and non-profit, who tend to have fewer qualifications and lower salaries, although the institutions are subsidised and regulated by the state. While parents have a preference for public care facilities because of their presumed superior quality, fees are similar across sectors but the government pays subsidies to institutions on a sliding scale based on parents' income. Hence, the same institution may be frequented by children from low- and high-income groups, and the participation of those with lower incomes subsidised by the state.

With the *decentralization* of social welfare, responsibility for implementing the new accreditation and evaluation systems for childcare centres and kindergartens, and for subsidising them, has devolved onto regional and local governments. Hence, progress in implementing the programme has been varied across the country. In a similar vein, the Elderly Care Insurance services are expected to be provided primarily by the market and non-profit sector. The expansion of social care in Korea is therefore hardly market-challenging (Peng 2008).

Figure 8 Children enrolled in Childcare Centers (1991-2007) according to type of provision, Republic of Korea



Source: Based on Peng (2008)

It is interesting that social care provision in Korea has not taken the Scandinavian path of direct public care provisioning, even though this was the policy option proposed by the Ministry of Gender Equality and Family and policy think tanks linked to it. Opposition to this proposal came from the Ministry of Planning and Budget (MoPB) as well as the Private Childcare Providers' Association. MoPB's proposal for care markets and community provision has been presented not only as a family-friendly *social policy*, but also as a family-friendly *economic policy*, framing social services as the "growth engines" for the new economy. After a year and a half of contentious policy debate the proposal for universal public childcare lost ground and agreement was reached to increase childcare subsidies instead (Peng 2008).

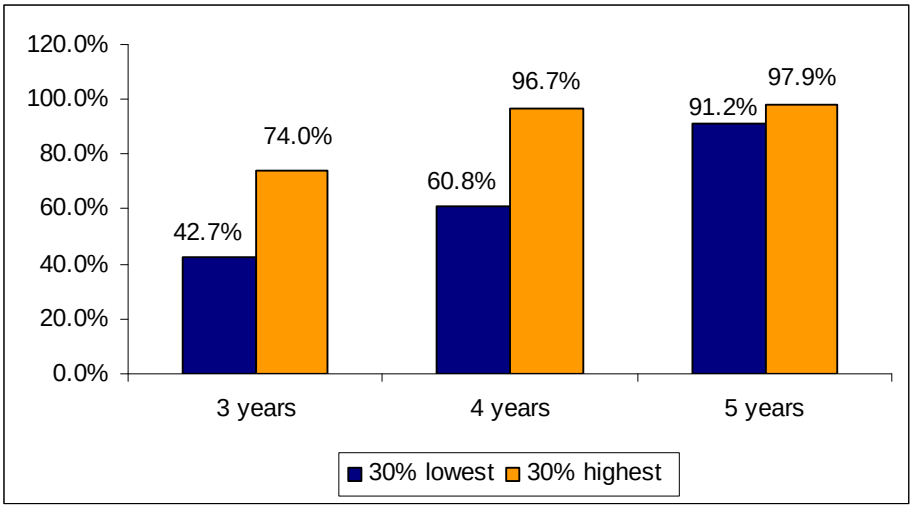
Hence, some degree of de-familialization of care is clearly underway in Korea—through a welfare mix that nurtures both markets and "communities", regulated and subsidised by a high-capacity developmental state that seeks to stimulate service employment as the new growth engine, and entice more women to combine paid work with having children. It is too early to know whether this will be sufficient to produce care services that are of good quality, and also whether the service jobs being created will be "decent" jobs with benefits and security.

While the state in **Argentina** has assumed similarly important responsibilities through the growing provision of free public childcare services and subsidies to market and community provision, significant class inequalities characterize the patterns of service usage.

The availability and coverage of early childhood education in Argentina has gradually increased over the last 20 years and mandatory schooling has been extended to the 5-year-old level – the age bracket which now has reached close to universal coverage. The number of 3 and 4-year-olds attending early education programmes has also increased, but is still far less than the coverage in the mandatory group. The 2006 National Education Act envisions the universalization of early education from age 4, but coverage and quality of service provision are

still disparate and access to quality preschools is limited for children from families who cannot pay for the service. Taking the Greater Buenos Aires area as an example, Figure 9 reveals two important aspects of preschool attendance rates: first, gaps between the poorest and the wealthiest 30 percent of households are still very large. Second, these gaps shrink significantly in the age group for which attendance was made obligatory (age 5), indicating that this measure has had a positive effect on reducing inequalities in access to early childhood education.

Figure 9 Attendance rates by age and per capita household income. Greater Buenos Aires (2006)



Source: Based on Faur (2008).

While around 60 per cent of 3-5 year-old enrolled children attends free public institutions, public child care for lower age groups is still scarce, and the market plays a dominant role in its provision. In urban areas, particularly the Buenos Aires Metropolitan Area, private sector involvement in crèches is even more important.

A further difference can be observed in Table 6 with respect to full-day and half-day crèches in different parts of Buenos Aires. As a general pattern, the private sector covers most children enrolled in *half-day* programmes and is biased towards the wealthier Northern part of town; public half-day programmes are less important, but more common in the poorer Southern neighbourhoods. The great majority of *full-day* programmes are provided publicly and are somewhat more common in the (poorer) Southern part of the city, where the market is almost absent.

Table 6 Enrolment rates of children aged 45 days to 2 years in half-day and full-day programmes by sector and area, City of Buenos Aires (2006)

	% of all enrolled children in each programme
HALF DAY PROGRAMMES	
PRIVATE	**85.5**
Northern Area	58.6
Southern Area	26.9
PUBLIC	**14.5**
Northern Area	4.3
Southern Area	10.2
FULL DAY PROGRAMMES	
PRIVATE	**8.5**
Northern Area	7
Southern Area	1.5
PUBLIC	**91.5**
Northern Area	40.9
Southern Area	50.6

Source: Faur (2008)

The public focus on full-day programmes can be expected to have a positive effect on parents' ability to work. However, access is still limited and in 2006, there were more than 6,000 children on the waiting list (most of this unmet demand being located in the Southern part of town). This reflects the obvious fact that families from wealthier neighbourhoods are better able to satisfy their care needs through the market. The dominance of private *half-day* institutions for the better-off also indicates access to other types of childcare, most likely involving domestic service workers who cover the hours in which the children are not in institutional care.

The insufficiency of existing public and private services vis-à-vis the demand has led the municipal government of Buenos Aires to establish alternative modalities for poor households. The "Childhood Development Centres" provided by the Buenos Aires' Ministry of Social Development and targeted at low-income households is a case in point. One important feature of this service is that the caregivers in the programme are not accredited teachers entitled to the kind of labour rights that early childhood education workers in both private and public institutions enjoy (i.e. minimum salaries, unionization). This programme seems to be creating a group of "second class" care workers and care receivers concentrated in poor neighbourhoods.

Adding to the complexity of the situation is the fact that a significant number of private child care facilities in Buenos Aires, concentrated in rich neighbourhoods, receive high levels of subsidy from the State. While the State also subsidises various informal community and civil society programmes in poor neighbourhoods, community organizations and poor families (particularly women) are required to provide in-kind work or contributions to create and maintain these services. These arrangements are actively promoted by the state that has discovered and draws on bottom-up "community provision" as a way of securing low-cost (and often low-quality) services for the poor.

Extended familialism in agrarian-informal regimes: Tanzania and India

Historically in the course of their expansion both health care and primary education have taken some of the care responsibility—for those who are frail and ill, and for young children—off the

shoulders of families. In many low-income countries where the provision of basic public health and education services remains woefully inadequate, where school drop-out rates are high and where under-funding of public health care delivery systems has led to quality decline and a fall in provision, for low-income people in particular households take on a far larger role in the care and sustenance of their members. To this must be added the heavy demands that a poor and inaccessible infrastructure places on low-income households in particular, and especially on the women and girls in those households. Box 3, drawing on data from the time use module of the Tanzanian Integrated Labour Force Survey (ILFS) carried out by the National Bureau of Statistics in 2006, puts some figures behind this assertion.

Box 3 Time burden of water and fuel collection in Tanzania

The time burden of water collection is significant. If we average the time spent on water collection over the full population aged five years and above, people spend an average of 16 minutes every day collecting water. If we average over only those who collect water, the time per day increases to 28 minutes – nearly half an hour. One-tenth of water collectors spend 54 minutes or more on average per day collecting water.

From the time use data we find that 69% of those reporting collection of fuel were female. When we take age and sex together, 39% of women aged 18-49 years and 16% of men reported some collection of fuel over a seven-day period. Engagement in fuel collection was noticeably lower for girls and boys at 27% and 19%, but higher than suggested by what the household heads reported.

As with water collection, the poorest households are the hardest hit. Thus 42% of females and 22% of males from the poorest households collected fuel, compared to 15% of females and 7% of males in relatively wealthy households. And in rural areas 33% of respondents collected fuel compared to only 7% in urban areas.

In terms of time taken, those who collected fuel spent an average of 25 minutes a day on the task. Nine in ten collectors spent 48 minutes or more on average a day on this task. Given that many would not be doing it every day, the amount of time spent on a particular day could be much longer.

Source: TGNP Forthcoming

In the 1980s (the "lost decade") social sector funding in many countries shrank or remained constant but insufficient to meet escalating needs. This was particularly the case in indebted low-income countries subjected to debt-related conditionalities. Severe under-funding of social services lead to a shortage of drugs and medical supplies, overall deterioration of the physical health and education infrastructure, and low or stagnant wages for personnel leading to low staff morale and increasing resort to informal charging (Mbaga Kida and Mackintosh 2005). There has clearly been some revision of orthodox policies since the early 1990s, and a greater recognition of the developmental role of the social sectors. However, it is far from clear if the increase in funding for the social sectors is being effectively channelled into building up public services that have been so drastically eroded. The emphasis on more decentralization of health and education services, "pluralism" in provisioning, and "community participation"—the lexicon of new social policy —materialize through very diverse practices largely determined by institutional histories and local political dynamics.

In **Tanzania**, as in other parts of Sub-Saharan Africa, creeping liberalization of health services together with the introduction of market principles in the public system during the 1990s, has led to large-scale exclusion. Though exemption and waiver systems were designed to mitigate the impact of user fees on the poor's access to health, widespread difficulties in their implementation have implied a significant financial burden to poor households. HIV/AIDS has placed enormous

additional stress on the formal health care system (both public and private) which had serious problems in addressing citizens' basic needs even in the absence of the pandemic. While the HIV/AIDS pandemic creates ever-increasing demand for health services, human resources are not often sufficient to meet this demand. The total health workforce declined by 28 per cent between 1994/95 and 2000/01 and by a further 10 per cent until 2005/06 (Meena 2008). In part, the shortages may be explained by the international migration of health personnel, particularly nurses, to countries which seem to offer better wages and working conditions.

The combination of generalized poverty, user fees, high work burdens, shortfalls in professional staff, ill health of both care givers and care receivers, and the loss of substantial numbers of the economically active population, confronts families with a completely unmanageable burden (Mackintosh and Tibandebage 2004). A small, better-off segment of society may meet its increased care demands through the market by purchasing professional health services in private clinics and hiring a domestic worker or nurse for home care. But for the bulk of the poor, financial and time demands on family caregivers are likely to increase poverty, consuming already scarce resources and limiting the ability to engage in productive activities.

In several countries of Sub-Saharan Africa, including South Africa, Tanzania, and Uganda, "home-based care" (HBC) programmes have been presented as a substitute for formal health facilities collapsing under the care demands imposed by the pandemic. In theory trained nurses are supposed to offer skilled support and training to the community based "volunteers", and a functional referral system is assumed to be in place to provide specialized care to patients where this is needed. Community volunteers are in theory supplied with a small transport allowance as well as a kit which contains gloves and food supplements. Their responsibility is to visit HIV/AIDS patients in their homes, provide some of the basic care and support, thereby relieving the burden on family members. In Tanzania, the government has advocated strongly in favour of HBC programmes, and with the availability of external funding for these programmes several non-governmental, faith-based and community organizations have responded positively to this call.

However, in practice the HBC programmes face innumerable challenges: the referral systems are weak; volunteers, most of whom are women and themselves poor, receive little training on even the rudimentary skills of how to care for an ill patient and how to take care of themselves while caring; nor are they always supplied with the basic kits and stipends. Additionally, HBC services are severely under-funded, and receive only between 1 and 2 per cent of government and donor spending on HIV/AIDS (Meena 2008). Field research in Tanzania suggests that HBC volunteers can spend long hours every day on care activities that impose major physical and emotional stress, without receiving any compensation (Meena 2008). Yet long hours of work can hardly compensate for lack of training and facilities, and other studies suggest that HBC interventions do not significantly reduce the care burden within households (TGNP 2006). Heavy reliance on external sources of funding has also created serious problems of sustainability, which means little opportunity for individual organizations to accumulate experience in this field, as they shift to other forms of intervention in the hope of attracting funds, or simply collapse.

While global policy pronouncements have re-legitimised the social sectors, economistic thinking within policy circles and analyses based on "rates of return to education" have contributed to the singular focus on primary education. In **India** this has resulted in the neglect of secondary education, the rise of for-profit schooling at all levels, and a fragmented formal elementary-education system (Jha and Subrahmanian 2006). A similar policy neglect characterises early childhood education and care—indicative of the way in which education systems (like health *systems*) have been compartmentalized and their interconnections lost.

Care issues have entered government policy rather inadvertently through attempts to improve nutrition levels, and lower infant and child mortality rates. The Integrated Child Development Scheme (ICDS) which emerged in India as a result of a focus on nutrition and infant and maternal mortality developed a minimal care function over time to the extent that some of the nutrition programmes required that children stay on the premises. This took the form of government crèches or *anganwandis.* However coverage remains small, opening hours are short and erratic, and staff-to-child ratios are abysmally low.

Anti-poverty programmes have not been able to address care needs either, even when these were explicitly considered in the initial design. The workfare programme following the 2005 National Rural Employment Guarantee Act (NREGA) is a case in point. The NREGA aimed at enhancing livelihood security of rural households by legally warranting at least one hundred days of wage employment per year to each household. Recent survey evidence shows that women constitute close to 40 per cent of beneficiaries, a much higher share than in previous employment guarantee schemes, and many of them came from scheduled castes and tribes. Besides minimum standards like safe drinking water, first-aid and hospitalization in case of injury, the provision of work-based childcare facilities was specified in the Act. However, like with many of the other radical features of the scheme, there has been a general lack of concern with actually establishing crèches at the district worksites (Palriwala 2008).

A recent survey in Tamil Nadu, where the share of female labour days is 87 per cent, revealed that many women had been dissuaded from bringing their children to the worksite and some had been turned away if accompanied by a child (Narayan 2008). Those who brought their children faced harassment by supervisors and co-workers. Hence, the women who joined NREGS for survival earnings (especially during the agricultural off-season) often had no choice but to leave their children at home. In most cases, these children were looked after either by their siblings or looked after themselves. Almost 85 per cent of mothers who left their children at home said that if a crèche was provided at the worksite, they would certainly bring their children, particularly the young ones.

Arrested service development in a dualist regime: South Africa

A prominent component of the new thinking on social policy has been the advent of extensive non-contributory social assistance benefits targeted to "vulnerable" individuals in low-income households. Social assistance pensions are channelled directly to the individuals they are intended to benefit, while child benefits and family allowances are increasingly directed to women (or to the prime care-giver) on the grounds that they are more likely than men to spend the resources in ways that enhance family and child welfare. Box 4 explains how these programmes relate to care.

Box 4 Cash transfers to entice care?

Family and child allowances were never intended to pay for care. The idea, rather, was to assist families with some of the material costs of raising children. In the institutionalized welfare regimes there are long-standing debates about the pros-and-cons of different care policy instruments. Policy options range from public or market provision of *care services* (especially for children under school age) which can also enhance female employment, to generously funded *parental leaves* which facilitate parents' (and especially mothers') involvement in paid employment, and finally to direct support for families through *child allowances and tax credits* that can help families buy-in care or provide it themselves. More recently several European countries have put in place a variety of "cash for care" schemes that are *explicitly* meant to assist families in purchasing care (Ungerson 2004).

Cash benefits, especially in developing countries, are also often framed as a measure for reducing poverty and enhancing children's capabilities, rather than as a tool for facilitating care. There are nevertheless implicit assumptions about care embedded within cash benefits: they are meant to assist adults (elderly people and those with disabilities) to care for themselves by purchasing care where necessary, and to facilitate the care work of mothers by allowing them to purchase essential inputs (food, school materials, health services) or to buy-in care substitutes (by drawing in family members or informal carers). In effect, cash benefits are supposed to "crowd-in" *unpaid care* performed by mothers and other carers since the inputs they provide (be it food or vaccination) do not *in and of themselves* translate into enhanced capabilities.

While cash benefits may be a less costly option for the public sector than the provision of social care services, they also carry several disadvantages: they tend to strengthen the provision of care by family members (often women), thereby exonerating other sectors from responsibility; payment is often at a low level; although providing a payment for the work that women have traditionally done may valorize that work, it also tends to confirm mothers/wives/daughters as natural care providers. This last problem could be avoided if payment for care is done in a more gender-neutral form (as in the case of the South African Child Support Grant which is given to the primary carer).

One country that has gone far in extending social assistance grants is South Africa. Initially the non-contributory social assistance covered the white population, and was gradually extended to include Indian and coloured people, and then the African population. Anticipating the political change that was to come, the apartheid government equalized the pensions and grants by 1993, the year before the democratic elections. There has been a large increase overall in the number of grant beneficiaries over the past years, especially the Child Support Grant (CSG) even though it is much smaller than the old age pension (OAP) (200R compared to 870R per month in 2007). Two other grants with increasing numbers of beneficiaries are the Care Dependency Grant, paid to adult caregivers of severely disabled children, and the Disability Grant paid to adults with disabilities; in both cases at least part of the increase in the numbers of beneficiaries reflects the fact that both grants are sometimes awarded to those with AIDS.

As is the case with most cash allowances directed at children, the CSG was introduced in 1998 as a poverty-oriented policy measure, designed to reach children in very poor households. It is means-tested and payable to the primary care giver (not necessarily the biological mother or father) of young children. Estimates suggest that well over 80 percent of eligible children are getting the grant, but administrative and bureaucratic hurdles do exclude others and there are also isolated pockets of the country where the grant seems not to penetrate at all. Nevertheless, studies show the grant acting as a small but useful supplement to the household budget and, as is the case with several other child-oriented grants, it seems to have a positive impact on children's development.

Equally positive findings have been documented for the OAP, which is also means-tested. It has been praised for being well targeted in racial and gender terms (since women live longer, draw the pension earlier, and are poorer), and valued for its reliability. There is also evidence that the

OAP "crowds in" care, contributes to the security of the households in which elderly people live, contributes to the production of livelihoods of elderly people themselves, and of other and younger family members (Ardington and Lund 1996; Case and Deaton 1998; Case, 2002; Lund, 2002).

These positive findings notwithstanding, the proliferation of cash grants targeted to children and elderly people in poor households raises some critical issues. Two in particular stand out. First, the spending on cash grants may have taken the policy and advocacy focus away from the need for public investment in decent social and care *services*. Cash transfers may assist poor households pay "user charges" and purchase necessary material to access poor-quality public health and education services, but they do not substitute for the urgent need to strengthen the quality of public services as the bedrock of public social provisioning. In Brazil, for example, increased public spending on cash transfers seems to have "crowded out" investment in social services (Melo 2007). A similar case of "arrested development" of care services has been argued in South Africa (Lund 2008b).

There has been a substantial increase in the percentage of children less than seven years attending an educational institution. An educational institution in this context refers to school and pre-school, including day care, crèche, and pre-primary. The percentage of children aged 0-4 years who are attending an educational institution increased from 7.6% in 2002 to 16.6% in 2007. The percentage of 5-year-olds who attend increased from 40.1% in 2002 to 60.4% in 2007, whilst in the 6-year age group attendance rates increased from 70.7% to 87.7% (Stats South Africa 2008). But levels of service provisioning and coverage, as Figure 7 shows, are below what South Africa's income would suggest.

At the same time South Africa has included in its 2004/5-2008/9 Expanded Public Works Programme (aiming to create 1 million work opportunities) a component of the public works jobs for "home and community based care". This is an innovative initiative that takes "public works programmes" beyond a singular concern with physical infrastructure (roads, irrigation). In the context of intense care needs associated with HIV/AIDS and the high levels of unemployment in the country, it seems reasonable to use public finance for care-related employment creation—even if most of these jobs will be taken up by women at a low rate of remuneration. The available evidence does not provide any data on gender of workers and their level of pay (Department of Public Works, *Expanded Public Works Programme Second Quarterly Report Year 4*, 2007).

A second concern, from a gender equality standpoint, is that while cash grants channelled through women can assist them in their responsibilities as carers, we cannot assume that they have been designed to do more than that for women *qua women*, for example by giving them a more secure footing in the labour market and greater economic security in the way that accessible care services can do. The fact that old age pensions may be spent on other household members (particularly in contexts of poverty where needs are manifold and other resources may be scarce), also raises the question as to the adequacy of such fungible cash benefits for securing adequate *care* for the elderly person him/herself—especially elderly women who cannot rely on a spouse to care for them in the way that elderly men often can, given the fact that women very often live longer than men and marry or cohabit with men older than themselves.

9.5 Conclusion

Care work remains strongly *feminized* and for the most part *undervalued*, whether it is unpaid and takes place in households, is "voluntary" and takes place in NGOs and churches, or when it is paid and takes place in informal markets or the public sector. Yet these common features

should not detract from the diversities in care provision that this paper has documented which make a difference for both care-recipients and care-givers.

Governments can orchestrate care diamonds with a "mix" of public and private provision that is not exclusionary, that provides accessible services for everyone, and that respects the rights of care workers. But this requires states with both fiscal and regulatory capacities (to subsidise and regulate non-state care providers) as well as a willingness to invest in basic public health and education services and appropriate infrastructure which help reduce the unpaid care work burden that is placed on families and households.

Pluralism in the provisioning of social and care services can have unequalizing, if not exclusionary, outcomes in contexts where the state fails to play this leadership role. In historically more unequal societies pluralism in welfare and care provision easily slips into fragmentation as gaps are filled by providers that offer services of varying quality which cater and are accessible to different segments of the population. In such contexts private provision (of health, pensions, care services) for the better-off may be underwritten by state subsidies while meager resources are channeled into poor quality public services (health, education, care) for the majority who may be asked to make "in-kind" or "under-the-table" contributions. In very low-income agrarian/informal economies both welfare and care provisioning is often left to families and communities with minimal state provisioning, while the better-off seek market solutions which often rely on unprotected and badly paid care workers.

In many developing countries HIV/AIDS has placed unmanageable burdens on states, households and women in particular. At the same time, it has made the social and economic consequences of health sector liberalization and fragmentation painfully visible. It is through HIV/AIDS that the "care crisis" has most fiercely entered international and national policy agendas. If policy-makers and activists start to look at HIV/AIDS from a *care* perspective, they will find powerful arguments for improving care provision in general. In low-income countries affected by the pandemic, this would include a major effort to improve basic social services provision and infrastructure (including water and sanitation) in order to take off some of the burden from families *and* to create decent working conditions for care workers in the public, private and volunteer sectors.

While collective forms of care provisioning can reduce the burden on families, the intra-household distribution itself weighs heavily on women in low-income households, where market substitutes are out of reach. Women's access to paid work has not brought forth an equal sharing of unpaid care work between women and men, evident in women's longer hours of total work across countries. Furthermore, inequalities in these two spheres can reinforce each other. Access to better-paid jobs can be used by women both individually and collectively to bargain for a more equal distribution of unpaid work and to lobby for better societal provision of care services. But, as we have seen above, within paid work women tend to cluster in care services which incur a wage penalty. However, much depends on political and institutional configurations and the strength of constituencies struggling for women's interests. Such constituencies are far more difficult to build and sustain in highly unequal societies (Hassim 2008).

In particular historical junctures women's movements *have* been able to rally around care issues, build political and institutional alliances, and put gender equality on the political agenda. Sweden is a case in point. In the 1960s Swedish feminists effectively used their links to labour unions and the ruling Social Democratic party to place their demands on the government agenda *and* to turn them into policies. It may also be a rather exceptional case given that women's movements in many other countries have not been able to create such links and alliances with ruling political parties. Alternatively, women's movements may try to amplify their voice by working alongside

other social movements. The women's movement in Korea has used such links to integrate care into the larger demands for social policy expansion, and has found a receptive ear at a time when the state is concerned about declining fertility rates and high dependency ratios and keen to entice women into the workforce (rather than facilitate immigration of "cheap" labour). Similarly, state interest in the "quality" of the labour force, underlined by the "social investment" approach, has provided women's movements with opportunities to ally with other rights-based movements, especially child rights, for policy responsiveness in the area of early childhood education and care as evidence from several Latin American countries suggests.

The points to emphasize are that care work *is* productive—it contributes to human capabilities and to economic dynamism and growth. But unpaid care work needs to be more equally shared between women and men within households and communities because while it has its rewards, it also puts those who primarily do this kind of work at a disadvantage in a world that is monetized (Elson 2005)—it limits their access to paid work and the income and social rights that come with such work (Razavi 2007b). Responsibility for care also needs to be more equitably shared between households and society. Shifting some components of care work from households to markets or public sectors does not, in and of itself, reduce its under-valuation; nor does it change the fact that it is done predominantly by women. Care workers (including those who work as "voluntary" or "community" workers) need to be organized to demand better regulation of their working conditions and earnings, and societies and states have to stop under-valuing it as work that is "un-skilled".

References

Akintola, Olagoke. 2004. *A Gendered Analysis of the Burden of Care on Family and Volunteer Caregivers in Uganda and South Africa*. Working Paper, Health Economics and HIV/AIDS Research Division, University of KwZulu-Natal, Durban.

Anderson, Bridget. 2000. *Doing the Dirty Work - The Global Politics of Domestic Labour*. Zed Books, London and New York.

Anttonen, Anneli. 2005. "Empowering Social Policy: The Role of Care Services in Modern Welfare States." In Olli Kangas and Joakim Palme, (eds.), *Social Policy and Economic Development in the Nordic Countries*. Palgrave, Houndsmill.

Ardington, Elisabeth and Frances Lund. 1996. "Questioning Rural Livelihoods." In M. Lipton, F. Ellis and M. Lipton, (eds.), *Land, Labour and Livelihoods in Rural South Africa, Vol 2:KwaZulu-Natal and Northern Province.* Indicator Press, Durban.

Budig, Michelle J. and Joya Misra. 2008. *How Care Work Employment Shapes Earnings in a Cross-National Perspective.* Background Paper for the Flagship Report on Poverty and Policy Regimes, UNRISD.

Budlender, Debbie. 2008. *The Statistical Evidence on Care and Non-Care Work across Six Countries*. Programme on Gender and Development, Paper No. 4, UNRISD, Geneva.

Case, Anne and Angus Deaton. 1998. "Large Cash Transfers to the Elderly in South Africa." *Economic Journal*, Vol. 108: pp. 1330-1361.

Cortes, Rosalia 2008. *Regulaciones, Empleo y Salarios del Servicio Domestico en Argentina, 2003-2006.* Background Paper for the Political and Social Economy of Care Project.

Daly, Mary (ed.). 2002. *Care Work: The Quest for Security*. Geneva, ILO.

Department of Labour. 2005. *Women in the South African Labour Market 1995 – 2005*. Pretoria.

ECLAC. 2007. *Women's contribution to equality in Latin America and the Caribbean.* Report for the X Regional Conference on Women in Latin America and the Caribbean, Quito, 6-9 August 2007.

ECLAC (2007b). *Social Panorama of Latin America 2007*. ECLAC, Santiago de Chile.

Elson, Diane. 1998. "The Economic, the Political and the Domestic: Businesses, States and Households in the Organization of Production." *New Political Economy*, Vol. 3, No. 2: pp. 189-208.

Elson, Diane (ed.). 1991. *Male Bias in the Development Process.* Manchester.

Elson, Diane. 2005. *Unpaid Work, the Millennium Development Goals, and Capital Accumulation*. Paper presented at the Conference on Unpaid Work and the Economy: Gender, Poverty and the Millennium Development Goals. 1-3 October, Levy Institute.

Edholm, Felicity, Olivia Harris and Kate Young. 1977. "Conceptualising Women." *Critique of Anthropology*, Vol. 9/10, No. 3: pp. 101-130.

England, Paula. 1992. *Comparable Worth: Theories and Evidence.* New York.

England, Paula and Nancy Folbre. 2002. "Care, Inequality, and Policy." In Francesca Cancian, Demie Kurz, Andrew S. London, Rebecca Reviere and Mary C. Tuominen, (eds.), *Childcare and Inequality: Rethinking Care Work for Children and Youth*. Routledge, New York.

England, Paula, Michelle Budig and Nancy Folbre. 2002. "Wages of Virtue: The Relative Pay of Care Work", *Social Problems*, Vol. 49, No. 2: pp. 455-473.

Esquivel, Valeria. 2008a. *An Analysis of Time-Use Data on Work/Care Arrangements and Macro Data on the Care Diamond*. Research Report 2 Argentina, The Political and Social Economy of Care Project, UNRISD.

Esquivel, Valeria. 2008b. *Care Workers in Argentina*. Research Report 4 Argentina, The Political and Social Economy of Care Project, UNRISD.

Faur, Eleonor. 2008. *The "Care Diamond": Social Policy Regime, Care Policies and Programmes in Argentina*. Research Report 3 Argentina, The Political and Social Economy of Care Project, UNRISD.

Folbre, Nancy 2001. *The Invisible Heart: Economics and Family Values.* The New York Press, New York.

Folbre, Nancy. 2006. "Demanding Quality: Worker/Consumer Coalitions and 'High Road' Strategies in the Care Sector." *Politics and Society,* Vol. 34, No. 1: pp. 11-31.

Folbre, Nancy. 2008. *Economic Development and Time Devoted to Unpaid Care Activities: An Analysis of the Harmonized European Time Use Survey (HETUS).* Background Paper for the Flagship Report on Poverty and Policy Regimes, UNRISD.

Hassim, Shireen. 2008. *Rethinking Gender Politics in a Liberal Age: Institutions, Constituencies and Equality in Comparative Perspective.* Background Paper for the Political and Social Economy of Care Project.

Heintz, James. 2008. *Employment, Informality and Poverty: An Empirical Overview of Six Countries with a Focus on Gender and Race*. Background Paper for the Flagship Report on Poverty and Policy Regimes, UNRISD.

Hernes, Helge Maria. 1987. "Women and the Welfare State: The Transition from Private to Public Dependence." In Anne Showstack Sasoon (ed.), *Women and the State*, pp. 72-92, London.

Hertz, Tom. 2004. *Have Minimum Wages Benefited South Africa's Domestic Service Workers?* Working Paper presented at the Forum on African Development and Poverty Reduction: The Macro-Micro Linkage, 13-15 October, Somerset West.

Hook, Jennifer L. 2006. "Care in Context: Men's Unpaid Work in 20 Countries, 1965-2003." *American Sociological Review,* Vol. 71, No. 4: pp. 639-660.

Ironmonger, Duncan. 1996. "Counting Output, Capital Inputs and Caring Labour: Estimating Gross Household Product." *Feminist Economics,* Vol. 2, No. 3: pp. 37-64.

Jha, J. and R. Subrahmanian. 2006. "Secondary Education in the Indian State of Uttar Pradesh: Gender Dimensions of State Policy and Practice." In Shahra Razavi and Shireen Hassim, (eds.), *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of "the Social"*. Palgrave, Houndsmill.

Jenson, Jane and Denis Saint-Martin. 2002. *Building Blocks for a New Welfare Architecture: From Ford to LEGO*. Paper prepared for the Annual Meeting of the American Political Science Association, Boston (29 August – 1 September).

Lund, Frances. 2008a. *Paid Care Providers: Nurses, Domestic Workers, and Home-Based Care Workers*. Research Report 4 South Africa, The Political and Social Economy of Care Project, UNRISD.

Lund, Frances. 2008b.*Research Report 3 South Africa*, The Political and Social Economy of Care Project, UNRISD.

Lund, Frances. 2002. "Crowding in Care, Security and Micro-Enterprise Formation: Revisiting the Role of the State in Poverty Reduction, and in Development." *Journal of International Development*, Vol. 14, No. 6: pp. 681-694.

Mackintosh, Maureen and Paula Tibandebage. 2004. *Gender and Health Sector Reform: Analytical Perspectives on African Experience.* In Shahra Razavi and Shireen Hassim, (eds.), *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of "the Social"*. Palgrave, Houndsmill.

Martínez Franzoni, Juliana. 2005. "La Pieza que Faltaba: Uso del Tiempo y Regímenes de Bienestar en América Latina." *Nueva Sociedad,* Vol. 199: pp. 35-52.

Mbaga Kida, Tausi and Maurren Mackintosh. 2005. "Public Expenditure Allocation and Incidence under Health Care Market Liberalization: a Tanzanian Case Study." In Maureen Mackintosh and Meri Koivusalo (eds.), *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. Palgrave, Houndsmill.

Meena, Ruth. 2008. *General Description of Nurses and Home-Based Care Givers*. Research Report 4 Tanzania, The Political and Social Economy of Care Project, UNRISD.

Melo, Marcus André. 2007. "Unexpected Successes, Unanticipated Failures: Social Policy from Cardoso to Lula." In Timothy Power and Peter Kingston (eds.), *Democratic Brazil Revisited*. University of Pittsburgh Press, Pittsburgh.

Milkman, Ruth, Ellen Reese and Benita Roth. 1998. "The Macrosociology of Paid Domestic Labor." *Work and Occupations*, Vol. 25, No. 4: pp. 483-507.

Myles, John and Jill Quadagno. 2000. "Envisioning a Third Way: The Welfare State in the Twenty-First Century." *Contemporary Sociology*, Vol. 29, No. 1: pp. 156-167.

Palriwala, Rajni. 2008. *The Care Diamond: State Social Policy and the Market*. Research Report 3 India, The Political and Social Economy of Care Project, UNRISD.

Peng, Ito. 2008. *Political and Social Economy of Care: South Korea*. Research Report 3 South Korea, The Political and Social Economy of Care Project, UNRISD.

Razavi, Shahra. 2007a. *The Political and Social Economy of Care in a Development Context.* Programme on Gender and Development, Paper No. 3, UNRISD, Geneva.

Razavi, Shahra 2007b. "The Return to Social Policy and the Persistent Neglect of Unpaid Care." *Development and Change*, Volume 38, No.3: pp.377-400.

Statistics South Africa 2008. *General Household Survey 2007*. Pretoria.

TGNP 2006. *There Are Too Many Empty Promises: The Cost is Time and Money for Households Caring for HIV&AIDS Suffers.* Tanzania Gender Networking Programme, Dar es Salaam.

Ungerson, Claire. 2004. "Whose Empowerment and Independence? A Cross-National Perspective on 'Cash for Care' Schemes." *Ageing and Society*, Vol. 24: pp.189-212.

United Nations Development Program (UNDP). 2008. *Human Development Report*. UNDP, New York.

United Nations Research Institute for Social Development (UNRISD). 2005. *Gender Equality: Striving for Justice in an Unequal World*. UNRISD, Geneva.

United Nations Research Institute for Social Development (UNRISD). 1995. *States of Disarray: The Social Effects of Globalization*. UNRISD, Geneva.