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A “macro” view on equal sharing of responsibilities between women and men

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A “macro” view on equal sharing of responsibilities between women and men¹

I am currently working on the analysis of time use data. However, these reflections will refer to this work only tangentially. The design of time use surveys and the analysis of time use data require clear-cut categories on what activities constitute housework, care of persons, or voluntary work. Responsibilities are a more slippery concept, because they might refer also to a “state of mind” (Folbre *et al* 2005). I will stick to focus on the activity content of “responsibilities” throughout this piece. I start by analyzing different definitions of “care responsibilities” which I regard as most effective to think about gender inequality.

I have chosen to focus on macro or “systemic” issues related to care responsibilities as a result of the conversations in the Online Discussion organised by DAW on “Women and Men: equal sharing of responsibilities” (Braunstein 2008). In particular, I would like to challenge the view that gender inequalities in care responsibilities are “cultural” and their consequences are “economic” that was voiced in many interventions. I think that complex processes of cultural and economic mutual determination are in place with both cultural and economic “results”, and will focus on some economic and policy issues “behind” the cultural. To make my point clear from the outset, I am reluctant to focus too much on micro and “individualistic” approaches if they obscure structural aspects that can and should change by engaging in political debates and struggles.

Some definitions

A striking feature of the literature on the “care economy” has been the transition from the study of “household labour” to the study of “care”. Literature on household labour typically does not address caring activities (childcare, elder care), while most of the current emphasis on care assumes implicitly that housework is, somehow, “done”. Such dichotomization stems perhaps from a utility-based framework where housework is conceptualized as a “disutility” – the idea that everyone would like to avoid it if they could– while childcare provides “utility” or “process benefits” to the person who *chooses to* (or has a preference for) caring for children. Concordantly, housework is assumed to be fully commodifiable, while there are no market substitutes for true “love labour” (Lynch, 2007). A micro perspective on care (at least in developed countries) will therefore abandon housework and focus on care (particularly childcare), the limits to its commodification and the restrictions to “collectively” provide it without deteriorating its quality. This focus has been enormously rich in providing for a critique of certain childcare policies, for questioning the penalty attached to care work irrespective of it being paid or unpaid (England, Budig and Folbre 2002) and for showing the limits that care poses to the “efficiency” discourse (Himmelweit 2007).

But the dichotomy between housework and care of persons might be less useful when we look in aggregate terms. Households and families still perform both, and people are more likely to perform housework than care work. Time devoted to both housework and care work poses limits to engage in income-generating activities. Both are work, irrespective of whether there are process benefits associated to them (there might also be process benefits in paid work). In developing country contexts it may be less clear that housework can be commodified (either because there are no market alternatives or because they are not

¹ I would like to thank Debbie Budlender for engaging with me in reflecting on these issues, and editing this piece. Remaining errors are my responsibility.

affordable), and when it is commodified by hiring paid domestic workers might have a “care of persons” component attached. Housework, care of persons and “community” work (which are referred to as *unpaid care work*, [Elson 2000]) all contribute to reproduce the labour force (the existing one and the future one [Picchio 2003]), all are prone to vary in order to accommodate for negative shocks originating in the market economy, and all are related to and influenced by the different ways paid work is organized and remunerated.

I will therefore refer to unpaid care work throughout this piece as comprising housework, care of persons and voluntary work. Technically, unpaid care work is the equivalent to “non-SNA work”. This is the definition recently adopted by the UNRISD Project “*The Political and Social Economy of Care in a Development Context*” (Razavi 2007) and by the BRIDGE Care Pack (BRIDGE forthcoming).

Care work

Caring for others, providing care, working for pay in the care sector... women and men can do them all. Certainly, all of us need to be cared for at many stages of our lives: constantly, as it is the case of children or some old people; very intensively, as it happens with the ill; by professionals when our lives are at risk (if we are fortunate enough); on a daily basis, as able adults are cared for by other adults. *We all receive and provide care at some stage of our lives, as being vulnerable is part of our condition as human beings* (Tronto 2007: 39). However, not all of us become full-fledged carers: responsibilities for caring are ascribed on the basis of gender, and fall disproportionately on women, both within households and in the paid economy, up to the point of considering them a distinctive ‘feminine’ quality.

Care has been defined in many ways. Starting from Joan Tronto’s broad definition of caring “*as a species activity that includes everything that we do to maintain, continue, and repair our world so we can live in it as well as possible*” (1993: 103), some authors have stressed relational aspects of care, defining the care activity as the relationship between the caregiver and the care receiver (Jochimsen 2003: 237). This relationship is, more often than not, asymmetrical, when the care receiver *depends on* the care giver to fulfil her/his needs (Himmelweit 2007: 581). That’s the fundamental difference between caring for dependents and caring for able-bodied adults: in principle, as able-bodied adults we can decide when to commit to care for some other able-bodied adult, and when to break this commitment.

In particular, *unpaid care work* has been defined as “*labor undertaken out of affection or sense of responsibility for other people, with no expectation of pecuniary monetary reward*” (Folbre 1995: 75; also in Waerness 1984), which arises “*out of a social or contractual obligation, such as marriage or less formal social relationships*” (Chen *et al* 2005: 24).

Unpaid care work is a resource-intensive activity. It requires time, an appropriate location, monetary income and skills. Time use surveys show that unpaid care work is performed on a daily basis and in generally inflexible daily schedules, and that this imposes constraints to those who perform it. They also show that, at least in developing countries, direct care of persons requires increasing amounts of housework (Budlender, 2008). Therefore, being a carer imposes restrictions to participate in income-generating activities, in taking up certain jobs or career paths, in being able to care for oneself and having some time at one’s disposal.

Care is necessary, yet undervalued; not intrinsically gendered as a category, yet still women’s work. In the liberal tradition, care is a “romantic trap” that keeps women’s subordinate status,

and its commodification –along with a greater participation of women in the public sphere– the road to gender equality. In the socialist tradition, valuing care requires the reorganization of the gender division of labour and its sharing between women and men (Barker 2005). Clearly, greater commodification can sometimes change the very nature of care, as not all care can be transferred to the public or market spheres (Gardiner 1997: 240). And women’s participation in labour markets is typically concentrated in poor quality/low pay sectors (often linked to care), particularly in developing countries (Chen *et al* 2005). On the other hand, the distribution of unpaid care work has proven extremely resistant to change, as time use studies around the globe attest (Benería 2003: 150).

The organization of care in developing countries: Some complexities

Through a myriad of laws, regulations, public provision of care services, and omissions, and lack of coverage, states define who receives care, who provides it and who bears the costs of care provision (both paid and unpaid). In doing so, states shape and reproduce gender relations by allocating tasks and obligations to the two sexes (Sainsbury 1999: 5). In practice, *care regimes* –the rules and norms that regulate care provision– are characterized by the “sites” of privileged care provision (family, market, community), the degree of state involvement in it, and the ways care provision is supported and eventually compensated for (Jenson 1997, cited by Razavi 2007: 20).

At the micro level, the organization of care mirrors that of the paid work. In developing countries, the “male breadwinner/female carer model” has historically had less influence, as it requires formal labour markets and sufficiently high earnings to pay for the “family wage”. On the contrary, women typically enter the labour market as secondary earners or producers (i.e., in subsistence) to supplement family income, while retaining their role as carers (Elson 2005: 9). In developed countries, ethnic-minority and migrant women enter the labour market as nannies, housemaids and domestics, keeping care sector wages low, averting the “care crisis” and making possible a continuous flow of care commodification, at least for (women in) the upper-classes (Charusheela 2003: 294).

To a certain extent, who steps in to meet care needs is a distributive issue, as costs of care provision are spread out along gender, generation and class lines. As women bear a disproportionate share of the costs of care, “equal sharing of responsibilities between women and men” is one way of solving one of the distributional aspects of care.

Yet gender inequality in the distribution of unpaid care work is not the *only* problem with care. Given the entrenched gender inequalities in care burdens, the focus on (re)distribution between women and men is certainly the right one to apply when those who need to be cared for receive the care they need. However, while minimum levels of provision seem to be guaranteed in developed countries –and care quality emerges as a key issue (Folbre 2006)– developing countries may face absolute *care deficits*, as some crucial care requirements are simply *not met* and neither families nor the community can compensate for state absence or retrenchment. In these circumstances, even “equal sharing of responsibilities between women and men” would not suffice to provide the care required.

Focusing on the *micro* distributional aspects of care diverts the attention from situations in which there is no micro solution from either the carer or the carer recipient’s point of view. In such cases, providing care depletes the carer’s human capabilities and puts families and individuals at risk. The financial costs of providing care (both the costs of medicines and of

forgone earnings) are immediate and palpable, and in some situations available resources might not suffice to provide adequate care. In such cases, it is the state that should bear some of the costs, and protect the rights of those made vulnerable by unfortunate circumstances.²

I worry that the emphasis on micro distributional issues *only* might contribute to maintain the status quo and discourage the voicing of demands through political organization.

Care can be thought of at the *macro level*, focusing on the *absolute levels of wellbeing that should be achieved in any given society*, on the one hand, and on who bears the costs, on the other. We could think of an aggregate amount of care that is required (out of a normative stance related to minimum standards of living), identify the resources needed to perform it and see who and to what extent different sectors provide the care needed. In this way, both gender inequalities in caring and care deficits (i.e., the situations in which care needs are not being met) can be made visible and policies to tackle them can be imagined and implemented³. The interplay of unpaid care work, and paid care work funded/provided by the market, the state, the families and the community can be clearly outlined if one proceeds in this way⁴.

A macro focus is critically needed when analyzing care responsibilities in contexts of poverty and extreme poverty. Care deficits often go hand in hand with other dimensions of deprivation (employment; income; infrastructure; opportunities), reinforcing inequality. Undernourishment, deficits in sanitation infrastructure, absence of primary prevention can increase the incidence of several diseases. Deprivation also means tougher conditions for those who are responsible to care. And even when everyone in the family is healthy, coping with everyday care needs is harder and more time-consuming as compared to better-off households, which are usually smaller in size, better equipped and might resort to paid domestic work. Time use surveys show this imbalance between poor and better-off households. In the case of Buenos Aires, women and men in poor households spend longer times in unpaid care work than non-poor households, and poor women do more unpaid care work than poor men. It is not clear though that this hard work can fully compensate for the lack of income implied by being below the poverty line⁵.

A macro focus does not dismiss the micro distributive conflict. As it was mentioned, the ways in which the state provides, funds, and regulates the provision of care bears immediate distributional results (between women and men, and between classes and generations). Ideally, states should guarantee minimum standards of care for all citizens, and “share” some of the costs of the carers by either reducing unpaid care work or compensating for some of their costs. The way in which this is done can reinforce or counterbalance gender differences in care burdens (see the policy section). Still, the important thing is that when the State deserts its role, families, the market or the community, struggle to fill the gaps in ways that in most cases *amplify existing inequalities*.

² The “community” can also help. But again, there is not much role for the community when redistribution is not the solution (when resources other than time are required).

³ For a proposal of how to measure these theoretical care needs, see Budlender (2008).

⁴ These ideas resemble the “care diamond” laid out in Razavi (2007).

⁵ Whether unpaid care work and income are substitutes or complements is a matter of debate. On the one hand, there are no market substitutes for some forms of care (i.e., “parental care”) (Himmelweit 1999). On the other hand, for housework to be instrumental in providing for consumption, it has to be combined with a minimum level of “market inputs” which require income (i.e., spending longer time preparing a meal can never compensate for the total absence of ingredients).

Macroeconomics behind gender inequalities in care responsibilities

Poverty and extreme poverty are not “biblical plagues” but the result of bad macroeconomic policies, underdevelopment and regressive distribution of income. The emphasis in micro distributional aspects in unpaid care work runs the risk of mimicking the kind of policies that propose to (miraculously) reduce poverty by “mobilizing hidden resources of the poor”, as if resources existed and redistribution alone (and “efficiency gains”) would do the trick. If anything, “efficiency gains” certainly arise out of the collective provision of some care services (because there are some economies of scale to gain) and the “social” costs are minimized when the social and physical infrastructure improves. Time use surveys have shown that some “private” (households) and “invisible” costs are disproportionately high (long journeys to reach medical help, wood and water fetching, long cooking times, etc.) and more than justify the provision of “public” infrastructure.

Beyond (old) developmental policies, there is room for macroeconomic policy to alleviate poverty and reverse some inequalities. The neoliberal tide elevated to axiom the idea that there is not much to do, and inequalities soared. Indeed, macroeconomic policies (fiscal policy, monetary policy, exchange rate policy, trade policy) are not neutral in distributive terms. Some groups are more able to harvest the fruits of growth, while others bear more fully the costs of adjustments. Specifically, because of their disproportionately high unpaid care work, women can suffer particularly from macroeconomic crisis (brought about by trade liberalization, fiscal adjustment, exchange rate devaluations, etc.) and from the unemployment that recession or sluggish growth brings about (Cagatay, Elson and Grown 1995; Grown, Elson and Cagatay, 2000).

Linking time-use data analysis to policy

Before turning to concrete spheres of policy interventions, this point refers to time-use data analysis to support them. Beyond the obvious good quality requirements (Esquivel and Budlender 2008), an innovative approach would be to link the supply of unpaid care work (*time inputs*) with the “demand” for care in order to identify and value care deficits, following the “macro” approach described above. Building satellite accounts might help identify aggregate flows and differentiate unpaid care work burdens. They in turn could be compared to maximum tolerable levels of work.

There are all sorts of difficulties associated to this, and the fact that time-use surveys measure the care provided by selected individuals, but (generally) not the numbers of those being cared for, is not a minor one. Another problem with time use surveys is that there is no indication of the intensity of time use other than the existence of simultaneous activities, so neither “economies of scale” nor “dilution” (low quality care) can be calculated if outputs are unknown.

Background information is required to assess the incidence of some policies on reducing and redistributing unpaid care work burdens. Among them, the availability and use of care services might reduce the need for respondents to do unpaid care work themselves. Inclusion of more questions relating to use of various services, such as childcare services or the presence of domestic paid workers, would enhance interpretation of the patterns of time use. Indicators derived from the responses to these questions could also be used as control variables in regression analysis. From a policy perspective, these questions, if sufficiently detailed, would allow analysis of what types of people are accessing services offered by

government, the private sector, non-profits or other providers in the community. A similar argument could be made for including a range of questions on the availability of infrastructure and services such as piped water and electricity.

An analytical framework to evaluate policies

I would like to briefly define two broad categories of policies that could be put in place to fill care deficits and increase gender equality. These are “macro level” policies and policies for equal sharing of care responsibilities between women and men.

At the macro level, policies should be judged on whether they *strengthen citizenship*. If receiving care is considered a right, then entitlements supersede compensatory measures. Neither insufficiency in care (care deficits) nor unprotected and impoverished carers should exist. Alternative policy packages and “care models” can be contrasted through the lenses of citizenship. The “rights” perspective can be useful to take cases to Courts and also as a tool to legitimate political claims and build political consensus around care issues.

At the micro distributive level, Susan Himmelweit (2002: 64 – 65) established a set of criteria to evaluate policies, organized around three principles: a) the assessment of the effects of policies on paid and unpaid care work by tracking the transfers of work from paid to the unpaid and vice versa; b) the assessment of the effects on the distribution of paid and unpaid care work between men and women on both the paid and unpaid economies; and c) the assessment of gender inequality both within and *between* households.

Suggested policies: Macro-level policies

State provision of minimum social and physical infrastructure: State provision of health care (including prevention), education (including early education), childcare and elder care, transportation, water and sanitation should be insisted upon. Only when minimum levels of provision are guaranteed can we think about “marginal” transfers of responsibilities between the public, the market and the family, and how these transfers alter the distribution of responsibilities between women and men in the private sphere. Below this threshold, States are deserting from their role and unpaid care work becomes a “subsidy” to public sector provisioning (Antonopoulos, 2008: 15).

Good macroeconomic policy⁶: Different macroeconomic regimes produce different outcomes in terms of employment generation, real wages, income distribution, poverty levels *and* gender inequalities. A priori, those which focus on employment generation and living wages perform better in terms of overall inequalities. Directing taxation and expenditure, fiscal policy can counterbalance existing gender inequalities.

Direct labour market interventions: If economic growth is not enough to bring about protected and decent employment, then macroeconomic policies (and social policies that focus on their “casualties”) have to be complemented with active labour market policies. Direct job creation, in particular in sectors that reduce unpaid care work burdens could contribute to fill care deficits *and* provide income to the workers (Antonopoulos 2008) (but it

⁶ I resist the use of the qualifier “pro-poor”, because it comprises macroeconomic policies that result in either income distribution improving *or* worsening.

should be clear that this has to be *decent* employment). Also, public policy should enhance the position of own account workers in terms of their “economic security” (Chen *et al* 2005).

Suggested policies: Policies to work towards equal sharing of responsibilities between women and men

Reconciliation policies: in some contexts, introducing parental leaves and children allowances, and having good social security systems, ease the care burdens by providing resources for those in need of care, or by lowering the costs of those who provide care. In some other contexts, with pervasive levels of informality and low levels of labour law enforcement these measures might sound utopian (and are ineffective). In such contexts, direct provision of care services might perform much better (Benería 2008).

Social policies that do not reproduce gender stereotypes: there is abundant literature on the fact that many “anti-poverty” programmes in Latin America have a “functional” approach to women’s participation in them. They are based on the idea that cash transfers to women are better spent in “meritorious” goods and services than equivalent cash transfers to men; and exalt women’s altruism and “care skills”. In so doing, they perpetuate women’s disadvantaged *position*, even if material conditions are improved (Chant, 2008; Molyneux 2007). Care becomes a duty for poor women and a “choice” for affluent women, whose households could eventually resort to different combinations of state provided and market provided care services. Social policies should be designed to contribute to tackle gender inequalities in care burdens, instead of taking them for granted and building on them⁷; and to truly *alter* the distribution of entitlements and income.

⁷ For an example of such a programme, see Schmukler (2006)

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