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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.*

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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 in[Se)15.3(curishe.1(rehoeip-1 -19i96(a)-1.1(bt8atascsl-.0003 Te.2(e not)]TJ-i o3(w)-6

But it is not only households that produce care. Care is provided through a variety of social relations and institutions, including *markets*,

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 (Buda74(r)-6.8(e)3(4a.0269 2tg

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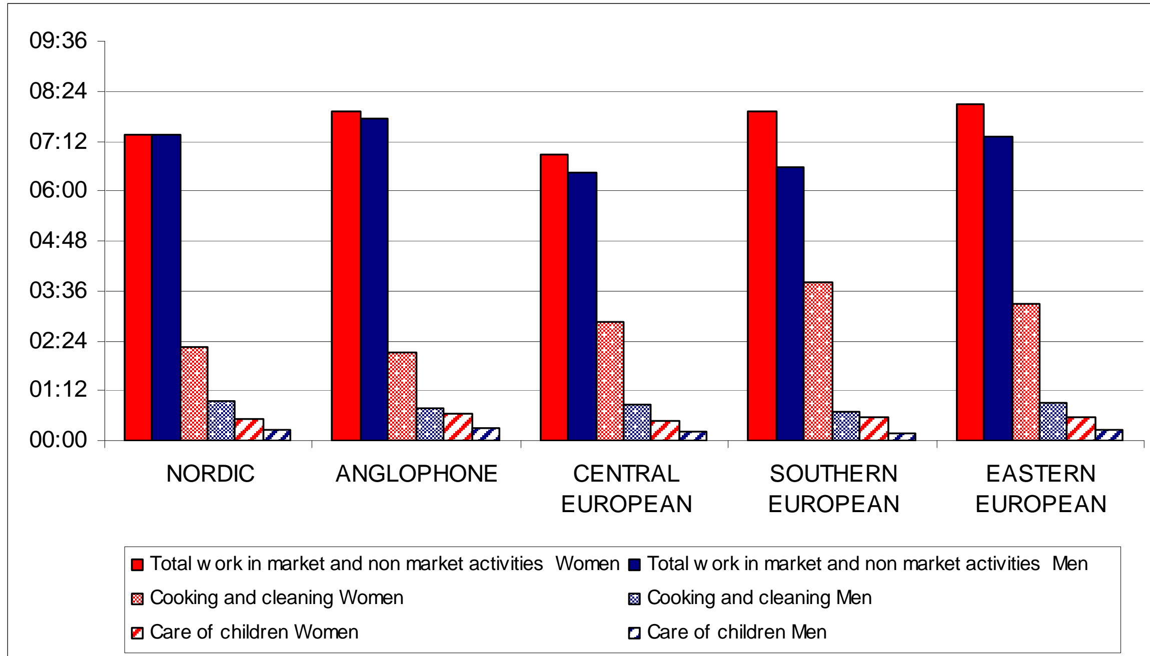
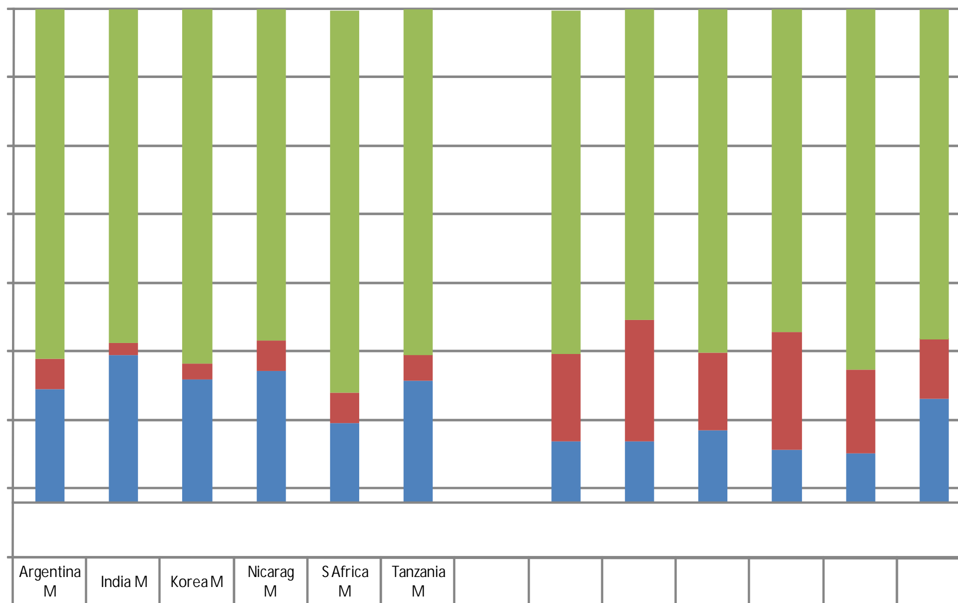
Figure 1 Mean time spent by women and men in market and non-market work. Selected high-income countries by regime cluster



Source: UNDP (2008)

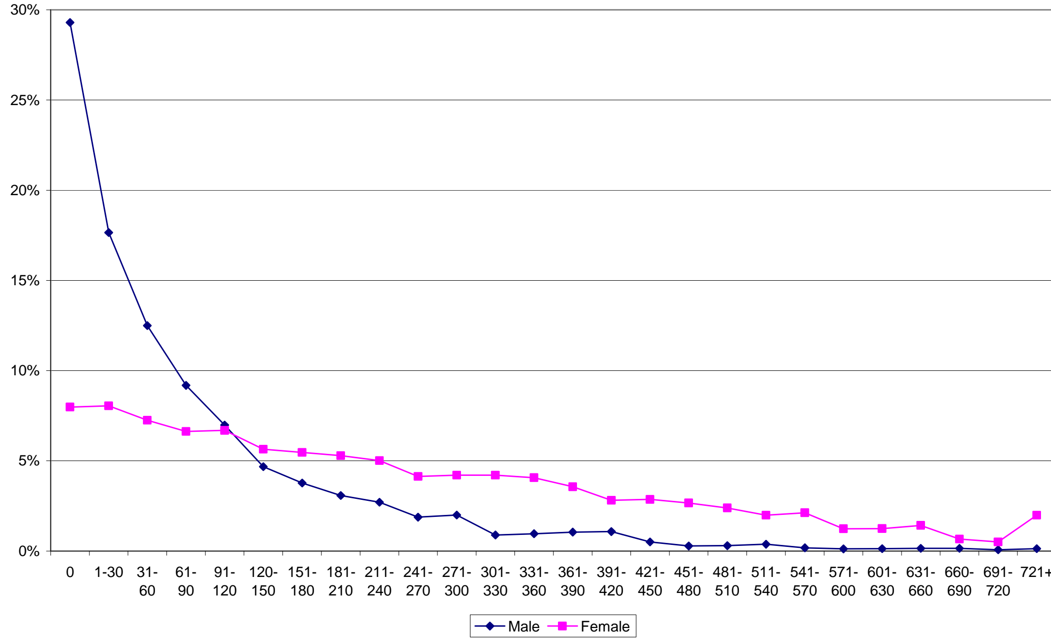
Figure 2 Mean time spent per day on activities by SNA category, country and sex for full sample population



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

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.

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 employ Fe80.4768 0 TD-.0007 Tc.0324 Tw[n)-5.3(in)-5.6(crease th)-5.6n   finew75esBi102owe7lN

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.

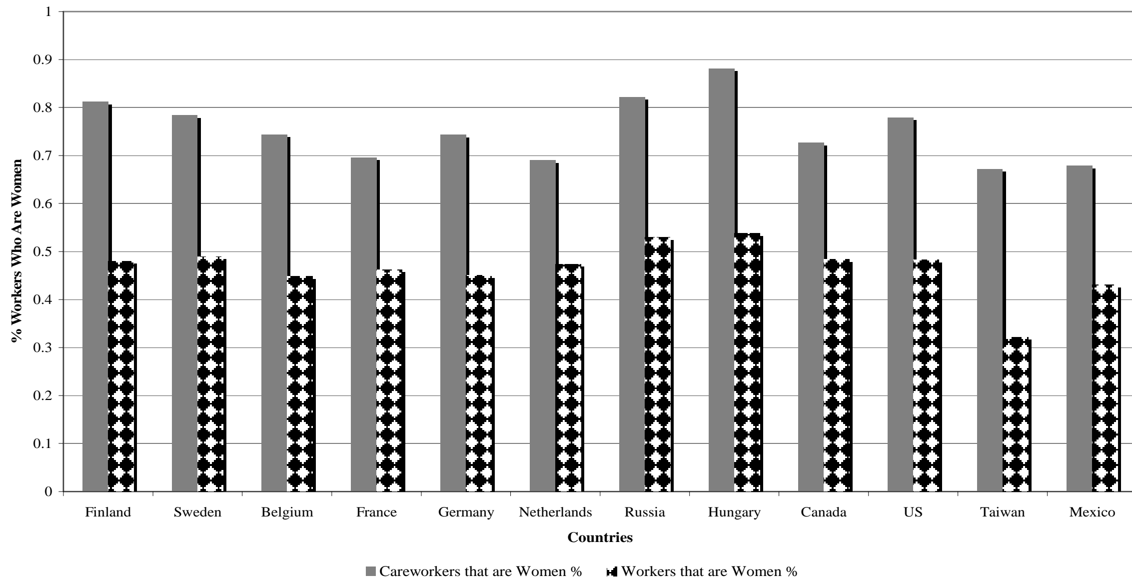
Table 1 Mean time per participant and participation rate in Care of Persons, by sex and household absolute poverty. Buenos Aires, Argentina.

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 wre

to care facilities provided by the State or the community, as evidence from Buenos Aires

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



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		

Figure 6 Effect of Care Sector

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

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 incurai.ti(m)12.1swe3(ers)-tureheose .6(m)12J0 -1.

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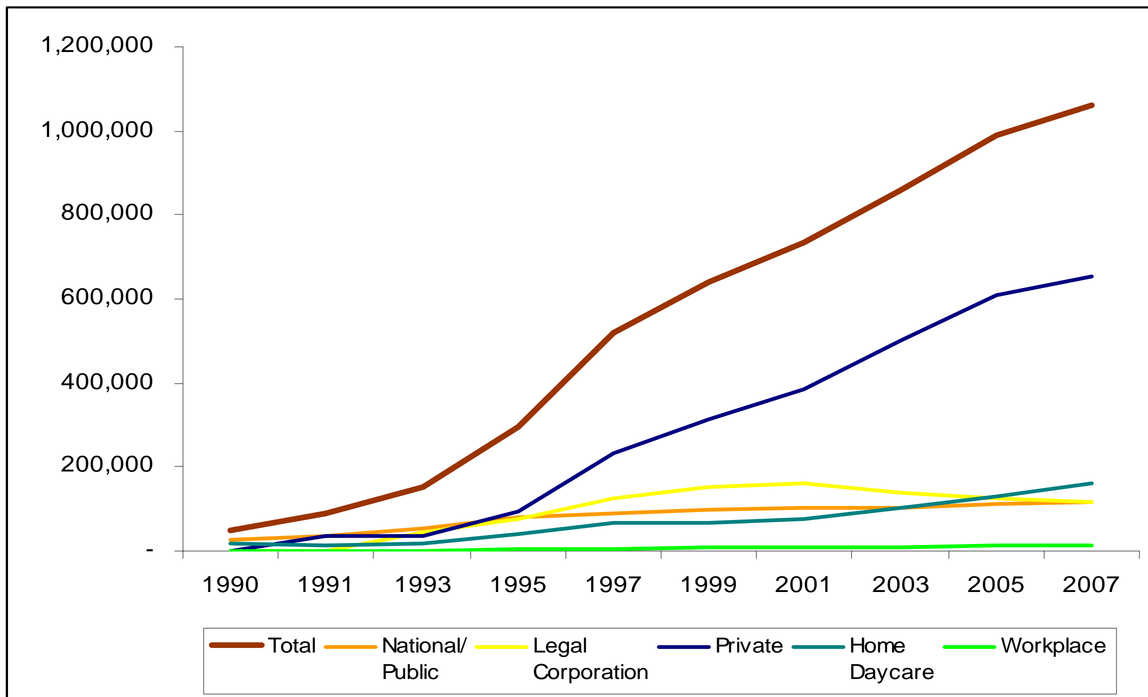
families; and introduced Elderly Care Insurance due to begin in 2008 to cover long-term care needs. Children under the age of 3 who were covered by childhood care and education services

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'

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

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

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.

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

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 tha-5.4(been)-5.4 drmert.7(r3(m)6.8(m)of)-7es rh thaos ham-1.1479 TD0 Tc0 Tc15321 Tw1

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

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