UNRISD Research and Policy Brief 9

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Why Care Matters for Social Development

Care work, both paid and unpaid, contributes to well-being, social development and economic growth. But the costs of providing care are unequally borne across gender and class. Families in all their diverse forms remain the key institution in meeting care needs. The challenge is to forge policies that support them and are grounded in certain key principles: recognize and guarantee the rights of care-givers and care-receivers; distribute the costs more evenly across society; and support professional, decently paid and compassionate forms of care.

The Issue

Unpaid care work includes housework (meal preparation, cleaning) and care of persons (bathing a child, watching over a frail elderly person) carried out in homes and communities. Such work contributes to well-being and feeds into economic growth through the reproduction of a labour force that is fit, productive and capable of learning and creativity. Women perform the bulk of unpaid care work across all economies and cultures. Furthermore, it is estimated that if such work were assigned a monetary value it would constitute between 10 per cent and 39 per cent of GDP.[1]

Despite its economic value, unpaid care work is not included in labour force surveys. Nor is it brought into the calculation of GDP. It is therefore invisible in representations of the economy that inform policy making. Similarly, despite its importance for meeting many of the Millennium Development Goals (reducing child mortality, achieving universal primary education, combating HIV/AIDS, reducing maternal mortality), the MDGs themselves do not mention unpaid care work.

Paid care services such as childcare, elder care, nursing and teaching also constitute a growing part of the economy and of employment in many countries. In the United States, for example, professional and domestic care services have grown from employing 13.3 per cent of the workforce in 1900 to 22.6 per cent in 1998 (almost as many workers as the manufacturing sector). In India, there has been a significant increase in the numbers of domestic workers over the last decade of economic liberalization. When care work is decently paid and protected, it can meet the interests of both workers and users of services. But this is not often the case.

[1] These figures have been calculated for the six countries that formed part of the UNRISD study, by multiplying the estimated number of hours spent on unpaid care by a "generalist wage", i.e., using the average wage paid to a worker, such as a domestic worker or housekeeper, who would carry out virtually all care-related tasks (Budlender 2008).

UNRISD Research on Political and Social Economy of Care (2007–2009)

This Research and Policy Brief summarizes selected findings from the UNRISD project *Political and Social Economy of Care*. The project included six in-depth country studies from three regions: South Africa and Tanzania; Argentina and Nicaragua; and India and the Republic of Korea. Countries were chosen based on two criteria: first, for each region, one country with a more developed and another with a less developed social policy architecture; and second, the availability of at least one time use survey. Teams in each country researched four related issues: (i) economic, social and demographic change over the past 20 to 30 years; (ii) data from time use surveys; (iii) social and care policies and institutions; and (iv) selected groups of care workers (their wages, working conditions, and how they meet their own care needs and the care needs of their dependents). Japan and Switzerland were also studied so as to provide comparisons of care systems in two industrialized economies. Five thematic papers complemented the country-level research.

All country reports, thematic papers and Programme Papers are available for download from the UNRISD website (www.unrisd.org/research/gd/care); see, also, UNRISD Sources and Further Reading, below.

Why should development policy be concerned about care? Some would emphasize its importance to processes of economic growth, whether in terms of its contribution to "human capital" formation or as a component of "social investment". Others see care more broadly, as part of the fabric of society and integral to social development. How societies address care also has far-reaching implications for gender relations and inequalities.

The need to address care through public policy is now more urgent than ever. Women's massive entry into the paid workforce—a near-global trend—has squeezed the time hitherto allocated to the care of family and friends on an unpaid basis. At the same time, population ageing in some countries, and major health crises (especially HIV and AIDS) in others, have intensified the need for care services. In many developing countries where public health systems have been severely weakened during the decades of market-oriented reform, much of the care burden has fallen back on women and girls.

Care underpins social and economic development, yet arrangements for its provision in developing countries have been little studied. UNRISD research has begun to fill this gap.

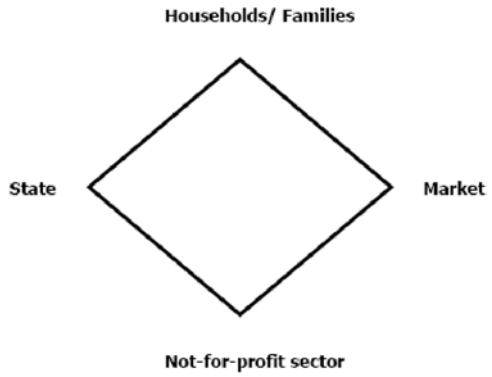
Research Findings

UNRISD findings challenge the view that only more developed countries can afford specialized care provision by the state and market, while poorer countries have to rely on unpaid family and community solutions. Explicit care policies may be rudimentary in many developing countries. But a wider range of policies influence the supply of care: infrastructure development, social service provisioning and social protection programmes. Furthermore, many developing country governments *are* experimenting with new ways of responding to care needs in their societies. The variations across countries in how social and care policies are taking shape hold important policy lessons.

Different institutions are involved in care provisioning...

Four main institutions are involved in the design, funding and delivery of care: households and families, markets, the state and the not-for-profit sector. These institutions can be represented as a "care diamond" (figure 1). Yet they interact in complex ways, and the boundaries between them are neither clear-cut nor static. For example, the state often funds care services that are delivered through non-profit organizations. Furthermore, the role of the state is qualitatively different from that of other pillars of the care diamond, because it is not just a *provider* of public care services, but also a significant *decision maker* when it comes to the rights and responsibilities of other institutions. Whether and how the state makes use of its role is fundamental for defining who has access to quality care and who bears the costs of its provision. The effective creation, regulation and funding of care services can increase the access, affordability and quality of care and reduce time burdens placed on unpaid care-givers. Parental leaves, family allowances and other transfers can be financed through taxes or social insurance programmes, thereby socializing some of the costs assumed by unpaid care-givers.

Figure 1: The care diamond



...and their role varies across countries and shifts over time

When the state lacks the capacity (or political will) to adequately provide, fund and regulate care, families and households inevitably take on a greater share of its provision. This is not limited to developing countries. In countries as diverse as Italy, Japan, Spain and Switzerland, most families are left to make their own arrangements for care provision, sometimes by hiring informally employed migrant workers. In the context of economic crises in particular, as public provisioning of infrastructure and welfare services is eroded, care responsibilities are often shifted back onto families. At the same time purchasing basic necessities and care substitutes also becomes difficult due to the fall in earnings and the disappearance of jobs.

Women bear the main burden of unpaid care provision...

Women carry out the bulk of unpaid care work, and not just in times of crisis. Indeed, despite important variations in demographic, economic and social indicators, gender gaps in the time allocated to unpaid care are large and significant across countries. More women than men participate in unpaid care work and allocate substantially more time to it (figure 2). For all countries included in figure 2 the mean time women allocate to unpaid care work is twice that for men; the gender gap is most marked in India and smallest in Tanzania.

Figure 2: Mean time spent per day on SNA work and extended SNA work
(in minutes, by country and sex for full sample population)

* The System of National Accounts (SNA) distinguishes production that should be included in calculations of GDP and production that should be excluded. SNA work includes the production of all goods (whether or not they are sold on the market). In respect of services, in contrast, only those that are sold on the market are included.
** Extended SNA—or unpaid care work—refers to work that is excluded from the calculation of GDP. Housework in one's own home, and unpaid care for children, elderly people, the ill and disabled are not included in the calculation of GDP.
Source: Budlender 2008

Unpaid care holds intrinsic rewards for many care-givers. However, in societies where recognition and reward generally rest on an individual's participation in the paid economy, such work implies significant costs in the form of financial obligations, lost opportunities, foregone earnings as well as physical and emotional stress. Furthermore, in poorer countries where access to suitable infrastructure and labour-saving technology is limited, many of the tasks associated with unpaid care are particularly time-consuming and arduous.

... and they spend more time on paid and unpaid care combined than men

While women spend less time on paid work than men, they do spend more time working if all types of work (paid and unpaid) are combined. This means less time for leisure, education, political participation and self-care. As may be expected, the presence of young children (under six years of age) significantly increases the time spent on unpaid care, as does household income. Indeed, women in low-income households allocate more time to care-related tasks than in high-income households, a reflection of the limited possibilities for purchasing care services, larger household size and lack of infrastructure. Time-use data on fuel collection in Tanzania illustrate this point. While 42 per cent of females and 22 per cent of males from the poorest households report some time spent on fuel collection, the shares drop to 15 per cent and 7 per cent respectively in relatively wealthy households.

An enabling environment for care-giving requires different kinds of resources

Good care requires a variety of resources including *time and material resources*. While *time* is a key input into care provision in both developing and developed country contexts, there are several other critical *pre-conditions* for care-giving, including the availability of:

- *paid work* (or in its absence, *social transfers*) to ensure sufficient income with which to purchase the necessary inputs into direct care-giving (providing acceptable nutrition, paying transport fees to reach the nearest health centre);
- appropriate *infrastructure and technology* (water and sanitation, domestic technology) to increase the efficiency and lessen the burden of unpaid domestic work; and
- enabling *social services* (health, primary education) to complement unpaid care-giving.

None of these can be taken for granted in a developing country context. In addition to these broader enabling conditions, ensuring adequate care also requires specific policies with a direct bearing on care provision.

Leave provisions and cash payments cannot substitute for care services

Specific care-related policy interventions can be broadly categorized into three areas: time, financial resources and services.

- While *paid care leaves* (such as parental leave) provide care-givers with some time and resources to care for dependents, they rarely reach workers who are informally employed; they can also reinforce care-giving as women's work if they are restricted to female workers (as is the case in many countries). In Argentina, for example, the law that stipulates a three-month maternity leave at 100 per cent wage replacement applies to only half of the female workforce.
- *Cash transfers* can assist families financially with the cost of bringing up children. However, where transfers are targeted to mothers and made conditional (children undergoing regular health checks, mothers attending workshops on nutrition) they can add to the already heavy workloads of poor women without involving men in such work.
- The provision of accessible and affordable *care services* (public crèches, preschools) can give unpaid carers the option of engaging in other activities, including income-earning, while ensuring a level of care and safety for their dependents. If done properly, investment in preschool and childcare services can generate new employment opportunities, free up women's time for participation in the paid economy and yield future returns in terms of child development.

A public-private mix of care services requires state regulation and financing

Many developing countries, especially middle-income ones, putting in place care services face the challenge of expanding coverage in ways that do not reproduce existing inequalities. While higher income households usually have a range of options, such as private childcare as well as hiring domestic workers, the ability of lower income households to purchase care is limited. Pluralism of service provisioning can thus slip into fragmentation as gaps are filled by providers offering services of varying quality and catering to different segments of the population. An effective and equitable mix of public and private provision demands a fairly capable state that can regulate market and not-for-profit providers. Yet a public-private mix is often advocated in contexts where such capacity is weak.

In many lower income countries care services tend to be inadequate. However, some of the infrastructure for providing these services may already be in place. Examples include the crèche-nutrition units (*anganwadis)* in India, the childcare centres in Nicaragua, or the Home-Based Care programme in Tanzania. Yet public financing of these schemes is extremely low, and their reliance on very low-paid and "voluntary" work is not supported by adequate training and resources.

Care is feminized and often undervalued whether carried out in the market or the public sector

Care work includes numerous occupations that differ significantly in terms of status and skills (from medical doctors to domestic workers). Although wages and working conditions of care workers vary across the spectrum and across countries, commodified forms of care share two salient features: they are overwhelmingly staffed by women, and the workers, regardless of gender, often face wage discrimination vis-à-vis workers with comparable skill levels in non-care-related occupations—a so-called care penalty. Generally, this penalty is higher in countries with greater income inequality, less centralized bargaining through unions and a smaller public sector.

Much poorly paid care takes place in informal markets. Domestic workers, for example, make up a large share of female employment in many lower and middle-income countries. Many of them are still excluded from formal labour regulations on minimum wage, maximum working hours or mandatory employer contributions. The heavy reliance of even *public* social services and programmes on what is invariably labelled "voluntary" or "community" work is another cause for concern. This is very often shorthand for unpaid or underpaid work.

The reliance on "voluntarism" in fiscally constrained settings is problematic

Community participation in social programmes aimed at orphans, people living with HIV and AIDS, and children in poor communities very often means a reliance on the unpaid or underpaid work of women who are themselves very often among the poor. Although the monetary cost of social programmes is thereby reduced, it is questionable whether this volunteer support is appropriate in a context where

Illustration: The public-private mix in Argentina and the Republic of Korea

Class and regional differences in access to preschool education for five-year-olds have been reduced substantially in Argentina by making enrolment mandatory for this age group. However, enrolment rates for children from lower income households remain only a fraction of those of children from higher income households in the younger age groups, where public provision is limited and the market plays a dominant role. Since low-income families cannot afford private childcare, they face long waiting lists for public crèches, rely on less professionalized community services or on unpaid care by family members.

In the Republic of Korea—where the state partially finances and regulates, but does not necessarily deliver, childcare services—the private-public mix does not seem to reinforce social inequalities in the same way. Government subsidies are on a sliding scale based on parents' income and paid directly to the institution where the child is enrolled. Hence, the same institution may be frequented by children from low- and high-income strata, with the participation of those from lower income families subsidized by the state.

families, especially women, already face multiple demands on their time. It is also not clear what "voluntarism" means in a context where poverty is extensive and/or unemployment high, or when access to the few services available is conditional on "voluntary" work.

The home-based care programmes that have mushroomed in the context of the HIV and AIDS pandemic across sub-Saharan Africa illustrate this problem. These programmes are standing in for public health services that—after years of neglect and under-funding—cannot meet the surge in demand. Yet the fact that these programmes are being rolled out in a context of stress and scarcity, without adequate funding and training, risks displacing care responsibilities onto un-resourced "communities" (that is, local women), "volunteers" who are in reality very often underpaid employees, and unpaid carers in households (again, very often, women and girls).

Policy Lessons

A policy environment that recognizes and values care as the bedrock of social and economic development has to respect the rights and needs of both care-givers and care-receivers. In such a context care-receivers would have universal and affordable access to care, as well as choice and control over how any help or assistance necessary to facilitate their independence is provided. Unpaid care-givers would be able to care in ways that strengthen the well-being and capabilities of the ones they care for without jeopardizing their own economic security. And care-giving would become a real option, with adequate recognition and reward.

While concrete policy options are country and context specific, a number of policy priorities can be identified guided by these principles.

- ***Invest in infrastructure and basic social services***
  Investment in infrastructure (water, sanitation, electricity) in low-income countries can significantly increase the efficiency of unpaid domestic work. The

- ***Create synergies between social transfers and social services***
  Pensions and child/family allowances complement, but cannot substitute for, quality and accessible care services. The state has an important role to play in financing, regulating and providing care services. This is increasingly recognized in the area of childcare, where the challenge is to expand coverage in ways that reduce class and regional inequalities. One or two years of mandatory preschool can be an effective step in this direction. Policy debates on care for the elderly, on the other hand, often focus on financial issues, such as pensions. Meanwhile, the need for practical support in carrying out daily activities and the demand for long-term physical care are often neglected. In many countries these are now urgent issues requiring policy attention.

- ***Build on existing programmes to cover care needs***
  Low-income countries can build on existing social care programmes. The expansion of child nutrition centres into quality preschool/educational centres with wider coverage, or support for community-based health programmes through training, and resources for meals, transport and medical kits, can help provide better working conditions *and* improve the quality of care.

- ***Recognize care workers and guarantee their rights***
  Policy makers must lead the shift from a strategy that relies on market and voluntary provision of care that is of the most informal and exploitative kind, to one that nurtures professional, decently paid and compassionate forms of care. This requires effective regulation and monitoring by states. Organizations of care workers and of care-users also need to be involved in order to build public confidence in such services and sustain their financing through general taxation. Non-profit organizations and civil society associations play an increasingly important role in the delivery of care services. It is the duty of the state to create clear standards on the rights of volunteers (health and safety at work, regular stipends), and to recognize them as workers given their growing numbers in the care workforce.