United Nations Nations Unies

Commission on the Status of Women
Fifty-second session
New York, 25 February – 7 March 2008

PANEL

The equal sharing of responsibilities between women and men including caregiving in the context of HIV/AIDS

Written statement*

Submitted by

Shahra Razavi
United Nations Research Institute
for Social Development (UNRISD), Geneva

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

The Political and Social Economy of Care
An UNRISD Comparative Research Project

Background and policy questions

The dynamics of care are receiving more attention from activists, researchers and policy actors today than they did 20, or even 10, years ago. Why is care important and why should policy-making be informed by its exigencies? Some analysts emphasize the significance of care for economic dynamism and growth—in terms of its contribution to "human capital" and "social investment". Others see care in much larger terms, as part of the fabric of society and integral to social development. How society addresses the need for care has significant implications for gender equality given the fact that in all societies the provision of care—both unpaid and paid—tends to be disproportionately allocated to women and girls **and** it tends to be undervalued (the two feeding into each other).

The current public interest in care is not, however, without precedent. At the beginning of the twentieth century, care issues were also high on the public agenda in Europe at least, as a result of agitation by trade unions and some strands of the feminist movement. Putting in place social provisions such as the "family wage", pensions for single mothers and widows, maternity leave and labour protection for women reflected a certain recognition of the need to liberate people—albeit mothers—from the obligation to do paid work so that they could provide unpaid care. Women's financial dependence on husbands was an integral feature of this "male breadwinner/female carer" model.

How society addresses care thus has substantive social significance—for gender relations and gender equality (as well as other structures of power and inequality). Citizenship rights, critics argue, have omitted the need to receive and to give care. To overcome the gender bias that is deeply entrenched in systems of social protection and to make citizenship truly inclusive, care must become a dimension of citizenship with rights that are equal to those that are attached to employment.

In more recent times, women's massive entry into the paid work force—a near-global trend—has squeezed the time hitherto allocated to the care of family and friends on an unpaid basis. While the decline in fertility across many regions means that there are fewer children to be cared for, demographic ageing in some countries and major health crises in others, have intensified the need for caring services. In many developing countries where public health services have been severely weakened during the decades of market-inspired reform, much of the care burden has inevitably fallen back on women and girls.

At the same time in a wide range of countries, both developing and developed, paid care services have become a growing sector of the economy as a result of women's increasing participation in the paid labour force. These services, in turn, employ many women (as domestic workers, nannies and so on). The pay and working conditions of paid carers are highly contested policy issues. Paid care services are susceptible to competitive pressures that generate low-pay and low-quality services—adversely affecting both care workers and the recipients of care.

Historically and across a diverse range of countries, women from disadvantaged racial and ethnic groups have tended to provide care services to meet the needs of the more powerful social groups, while their own needs for care have been downplayed and neglected. This is evident in case studies of domestic workers and nurses aides in many countries, and raises serious questions about analyses of care that falsely homogenize women's interests. A similar intersection between gender and class/race is evident in "global care chains"—where disadvantaged female migrant workers from the developing world fill in the "care deficit" in the more economically advanced countries as a result of welfare state inadequacies and restructuring, on the one hand, and men's reluctance to take on domestic and care duties, on the other.

Gender advocates have put forward a range of proposals that attempt to overcome the many disadvantages endured by most women because of their responsibilities for caregiving, and sometimes to entice men to contribute more time to caregiving. There are tensions, however, between the different proposals that have been put forward in terms of a wish to **support and value care** and to **liberate women from the confines of caregiving** so as to enable their more active presence in the public sphere. **Ideally, society should recognize and value the importance of different forms of care, but without reinforcing care work as something that only women can or should do** given the adverse consequences of such gendering: women's financial precariousness and their exclusion from the public domain. We turn to the issue of policy options in the last section of this paper.

Clarifying the terminology

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 self-consumption; 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 *services* such as shopping, meal preparation, washing clothes and so on and unpaid care provided for one's child, elderly parent or neighbour are *excluded* from the SNA and GDP calculations.

Care work involves direct care of persons; it can be *paid* or *unpaid*. 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. *Paid carers* include nannies, childminders, nurses and care workers in homes for the

elderly and other institutional settings; they can work in a variety of institutions (public, market, not-for-profit).

Direct care of persons (bathing them, feeding them, accompanying them to the doctor, taking them for walks, talking to them and so on) is often seen as separate from the other necessary activities that provide the preconditions for personal caregiving such as preparing meals, shopping and cleaning sheets and clothes. But such boundaries are arbitrary, especially since the persons needing intensive care are often also unable to do such tasks themselves.

- Domestic workers often undertake some forms of care work (for example, childminding) even though they are not defined as "paid carers".
- Parents caring for their own children while on paid "parental leave" are not, strictly speaking, doing unpaid care work nor can they be classified as paid carers.

Unpaid care work is care of persons for no explicit monetary reward. The largest amount of unpaid care work in nearly all societies takes place within households/families, but individuals also perform unpaid care across households and across families—for other kin, friends, neighbours and community members—and also within a variety of institutions (public, market, not-for-profit, community) on an unpaid or voluntary basis.

The UNRISD Research Project

The countries where in-depth research is being carried out are: Argentina and Nicaragua; India and Republic of Korea; South Africa and Tanzania.

The UNRISD research project conceptualizes the institutions involved in the provision of care as a "care diamond". The care diamond includes the *family/household* (where a lot of care is provided on an unpaid basis), *markets* (which may be formal or informal and which provide care in return for a fee or wage), the *public sector* (which may provide different forms of care directly through a government hospital or crèche employing public sector workers, or indirectly by subsidizing others to do so) and the *not-for-profit sector* (this category could include different type of care provision, by charities, NGOs, or through voluntary and "community" provision). Typologies are always problematic and some forms of provision may fall through the cracks, as in the case of "voluntary" care work that is paid. Moreover, market provision is rarely pure, as the state often subsidizes and regulates market providers. There are, nevertheless, important institutional differences across these diverse points of the diamond, the overlaps notwithstanding.

The countries in context

In terms of structural transformation of the economy, the countries in the project fall into a wide spectrum, with Tanzania and Nicaragua at one end, and the Republic of Korea and Argentina at the other. Low-productivity agriculture constitutes the main source of livelihood for a significant proportion of the population in the poorer countries, where the underdeveloped rural infrastructure imposes a heavy burden of unpaid care work, disproportionately carried by women and girls.

In nearly all countries (with the exception of India, which seems to defy the assertion of a positive correlation between opening-up of the economy and participation of women in the paid labour force) the gender gap in labour force participation seems to have narrowed, with women taking on more of a breadwinning role. This convergence of male/female rates, and especially the increase in married women's labour force participation, has been particularly marked in countries such as Argentina, where women's economic participation, especially during the 1980s and 1990s, functioned as an adaptive strategy to cushion the effects of economic crises on families and to bolster their incomes.

Yet in most countries, reflecting broader global trends, the growth of formal employment has been sluggish at best, and hence much of the newly activated female work force has found itself either in different forms of informal work (employment relationships that are not governed by formal economic regulations and/or basic legal and social protections), or out of work. Compared to the other countries in the project, and for very different reasons, a smaller share of the workforce in South Africa and the Republic of Korea find themselves in informal forms of work, even though "non-standard" forms of employment are rapidly growing in Korea following the East Asian economic crisis of 1997, particularly among the female workforce. **In several countries the major source of non-agricultural employment for women continues to be paid domestic work, taking place for the most part outside the purview of state regulatory, social or legal protections.**

Women's increasing entry into the paid work force is one among several factors that feed into changing family structures and dynamics. Fertility rates have been falling in all project countries with the exception of Tanzania (where the total fertility rate is high and stable), and while the average number of children ever born per ever married woman indicates that the childcare "burden" remains high in several countries, it is diminishing even in countries with hitherto high fertility rates (such as India), along with general improvements in child welfare. The reduction in number of members per household (not necessarily simply a reflection of fertility decline), the decrease in the number of multi-generational households, the nuclearization of households (the extent and reasons for which may be debated), the rising age at first marriage (or union), and the growth of single-parent and (to a lesser extent) single-person households, which have been taking place in most countries (although at very different rates across socioeconomic strata within the same country), are indicative of processes of social and demographic change. These have important implications for care.

Summarizing some of the potential demographic impacts of these processes on care, the project has constructed a **"care dependency ratio"** intended to reflect the relative burden placed on carers in the society. As with the standard dependency ratio, the care dependency ratio is defined in terms of age groups: those needing intense forms of care are placed in the numerator and those providing care in the denominator. But the care dependency ratio tends to undercount the number needing care, as it does not take into consideration those in the carer age group who are disabled or ill to the extent that they need care (given the lack of adequate data). The undercount would probably be most marked in respect of South Africa and Tanzania, where the AIDS epidemic significantly increases the likelihood that an adult will need care. The ratio also disregards the fact that all people need a certain amount of care. To provide some

nuance, the ratio distinguishes between those needing intensive care and those needing a lesser level of care. Despite these limitations, the ratio was considered useful in allowing comparisons between the relative burden across countries and across time.

The ratio is lowest in the Republic of Korea, followed by Argentina, and highest for Tanzania. 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.

As might be expected, the apparent need for care calculated on the basis of simple demographic variables does not correlate in a simple way with the amount of time spent on care (as recorded in the time use surveys). Women (though not men) in the Republic of Korea and Argentina, for example, allocate relatively more time to person care than women in Tanzania and India.

Some of the findings from the time use surveys

Unpaid care work can be crudely divided into household maintenance tasks (cooking, shopping, cleaning, etc.) and care of persons (washing them, taking them to the doctor, attending to their needs, etc.). There are ongoing debates about the extent to which interpersonal care can be adequately captured through time use surveys (given that it often takes place simultaneously with other activities, and that it more often entails "being on call" rather than performing any discrete activity). Such shortcomings notwithstanding, the data show that women are far more likely than men to engage in both household maintenance and care of persons across all the countries.

Women tend to spend more time on unpaid care work (UCW) than men; for all countries, the mean time for women is more than twice the mean time for men. The gender gap is most marked in India, where women spend nearly 10 times as much time on UCW than men. Men from both Korea and India tend to do noticeably less UCW than men in the other countries;

While men in all countries tend to spend more time on paid work than women, the gender gap is narrower in this case (compared to the gender gap in UCW). The gender difference is particularly small in Tanzania. South African and Korean men record the shortest times for paid work, while Indian men record the longest average times.

While time spent on housework tends to fall with increases in income, the amount of time spent on care of persons tends to increase. This raises a question about whether there is a tradeoff between these two types of care, and whether the wealthier person who can hire others to do the household maintenance tasks is then able to allocate more time to care of persons. The extra time spent by the wealthy on care of persons could also be related to an ideological emphasis on the need for "quality time" to be spent with a child for full development, as well as smaller households among the wealthy, meaning that children are more likely to be cared for separately, with fewer economies of scale.

For community care (caring for people outside one's household), in contrast, levels of participation are very similar for men and women except in Argentina (where women record higher levels). **The fact that men's performance relative to that of women is "best" in respect of community care could constitute yet another reflection of the public-private divide: men being more open to participating in unpaid care work when this is in a more public arena.** However, across all countries the participation rates and amount of time spent on community care are noticeably lower than for care of persons, and substantially lower than for unpaid care work defined more broadly.

Tobit estimations were used to separate out the influence of different factors (such as gender, age, marital status and employment) on the time spent on paid and unpaid work. **As expected, *gender* was a significant factor: being male tends to result in doing less UCW across all countries but Nicaragua. For all countries *having a young child in the household* tends to increase the amount of UCW done by women; in most countries (India, Nicaragua, South Africa, Tanzania) the time spent by men on UCW did not change when there were young children in the household. In several countries the presence of young children in the household intensified men's paid work hours. *Being employed* decreased the amount of unpaid care work done. Looking at person care only, having a young child was the strongest factor across all countries (increasing time spent on person care), followed by gender (being male decreasing it).**

The Republic of Korea is the only country in the project where two comparable time use surveys exist (1999, 2004), allowing an analysis of change in time use patterns over time. While time spent by both women and men on personal care and leisure seems to have increased, time spent on paid work has decreased, and so has the time that women allocate to unpaid care work. The country report attributes the reduction in women's unpaid care work to the exponential rise in the availability of childcare services of different kinds during this period. **Yet it is noteworthy that the gender gap in the provision of unpaid care has hardly changed during this period. This seems to 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.**

Unpaid care, paid care and the "cost disease"

Good quality care, whether paid or unpaid, is very labour intensive. The attempt to increase the productivity of care work by increasing the numbers of people cared for at any one time quickly runs into the risk of reducing the quality of the output (the output being the care itself). The difficulty of increasing productivity without cutting into the quality of the output is in fact one of the distinctive features of care work. In other words, there is a definite limit to the number of infants and small children or frail elderly and handicapped adults that one person can care for.

However, productivity increases elsewhere in the economy (in manufacturing, for example) and related wage increases will exert an upward pressure on wages in caring

professions and, hence, the costs of providing care will rise relative to those goods that are experiencing increasing productivity.

In low-wage and low-cost care markets, labour turnover tends to be high, and opportunities for training and retaining labour are rarely used. These factors underpin the vulnerability of paid care services in poorly regulated markets to low-pay and low-quality outcomes. While both consumers of care services and paid carers have an interest in providing and receiving good quality care, there is a limit to how much wage increases can be passed on to care-users who are themselves very often income constrained.

In fact, intense need for care—for example, by adults with serious physical or mental disabilities or chronic illnesses—often coincides with a diminished capacity to earn income. There are conflicting interests involved here with implications for feminist politics: raising the wages of domestic workers and nannies, many of them women from disadvantaged racial and ethnic groups, so that they can actually support themselves and their children at a decent level would mean that many middle-class women would no longer be able to afford the services they are providing.

In many middle- and low-income countries, commercial services of the formal kind that provide good quality care are underdeveloped and cater to a very limited market. In these countries, it is at the most informal end of the market spectrum that care is widely provided—namely through the employment of domestic workers who perform a wide range of domestic and care tasks.

In many of these countries, domestic service has been, and continues to be, typically the largest employer of women in urban areas. The labour "contract" tends to be verbal, while wages are very low and working conditions often poor, with few if any social rights attached to the labour contract. Moreover, the skills necessary for performing domestic and care work are often undervalued. In several countries, gender advocates have lobbied governments to pass legislation that would provide basic labour and social rights for domestic workers, such as minimum wage legislation, and coverage in terms of unemployment and health insurance: Argentina, Chile and South Africa provide some recent examples of countries where such legislative efforts have been made, although their effective implementation would require close monitoring and sustained political pressure.

The growth in different forms of paid care, however, is raising important questions about the quality of care: How are good caring relationships to be sustained between strangers who are systematically thrown into intimate contact with each other? In the private sphere of family and friendship, we assume (or hope) that bonds of filial piety or love will engender good caring relationships. But paid carers meet our needs not because they love us but because it is their job to do so.

There is a simple view within neoclassical economics (along the lines of Becker's NHE) that sees all social behaviour, including intrahousehold and familial relations, as a matter of choice and exchange. From such a perspective, the movement of care into explicit markets should not engender any qualitative change because intrahousehold and family relations, even without explicit prices and budget constraints, reflect the decisions of "rational economic men" (and women). If

anything, the new arrangements may be leading to even more economic efficiency. The opposite view would bemoan the movement of care into markets on a priori assumptions that markets must degrade caring work by replacing motivations of love/altruism with 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 of care—problems that seem to be particularly rife in care markets. Not only children and elderly people, but also working age adults find it difficult to monitor care quality, which undermines arguments about consumer sovereignty. There are 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 provided within the family: it ignores the compulsory side of "altruism" in unpaid caring, or the social pressures on women to provide unpaid care, as well as the risks of self-exploitation and economic insecurity to which unpaid carers are frequently exposed.

How could policy sustain good quality care in the public sphere, which inevitably cannot rely on "love" and "familial piety" for its sustenance? How could professional, skilled, and compassionate forms of paid care be nurtured? What kinds of organizational changes are needed to help establish and sustain successful caring relationships? What are the roles that public policy/regulation should play, and what is the role of trade unions in this process?

It is sometimes assumed (wrongly) that if issues of care were to be taken up by policy makers, then the only possible response would be to provide some kind of cash payment for women, for example, "wages for housework", "mothers' stipends" or "mothers' pensions". While this kind of demand may have been voiced historically by some women's rights advocates (for example, early twentieth century maternalists), it is not the kind of social provision that most modern-day advocates of women's rights prioritize.

The possible policy interventions range through cash payments in the form of caregivers' allowance or citizen's wage (more gender-neutral than a mothers' pension), taxation allowances, different types of paid and unpaid leave from employment, social security credits and the provision of care services. Many of these policy options are already in place in a wide range of European welfare states as well as in other industrialized countries. Some of them may be less relevant for developing countries, for example, paid and unpaid leave provisions may seem of marginal relevance to countries where the great bulk of employment is of the informal kind and involves self-employment. But there are also a number of important social policy options in developing countries that affect the social rights and inclusion of those who provide unpaid care, for example, the design of pension systems and the extent to which they recognize unpaid work as a "contribution", the provision and design of health and education services and the design of various family and child benefits.

Cash benefits, in the form of family and child allowances, were never intended for paying for care. The idea, rather, was to assist families with some of the material costs of raising children, and in the process redistributing resources from smaller to larger families and to a period in the lifecycle of families when they are most likely to be hard-pressed financially. It is only recently that policy has begun to recognize the costs involved in caring for children in terms of the income that the carer has to forego. While family allowances vary widely, a common characteristic is that they often defray only a small percentage of the cost of bringing up children. Moreover, while concern for the well-being of families and children is often the stated aim of these provisions, what states do and the conditions on which benefits are made available carry other implicit objectives and consequences, supporting particular models of the family and of gender relations.

While cash benefits paid to carers may be a less costly option for the public sector compared to the provision of public childcare services, there are several disadvantages attached to this policy option from a gender equality perspective. Cash payments tend to strengthen the provision of care by family members (often mothers), thereby exonerating other sectors from responsibility. In addition, the danger, as mentioned above, is that the payment is often at a low level and brings with it few social security or employment rights. Finally, although providing a payment for the work that women have traditionally done may valorize that work, it also tends to confirm women/mothers as natural care providers. This last problem could be avoided if payment for care is done in a more gender-neutral form, such as through a carer's allowance or even a citizen's wage, which is supposed to cover care contingencies and other life events, and to be open to both women and men, in all sorts of households and caring arrangements.

The feminist social policy literature, on the whole, rates the provision of public services for care-related needs more positively than cash payments. While it acknowledges that this strategy carries heavy financial implications for the public budget, it has several important advantages from a gender equality perspective. **It tends to legitimize care work, provide relatively well-protected jobs for women (at least compared to the market sector), give unpaid carers greater choice in seeking employment, and improve choice and quality on the part of both caregivers and recipients of care (especially those on low incomes).** While it is acknowledged that locating care work within the public sector is not in itself a panacea for the inferior working conditions that often characterize it, it tends to be better paid when it is located in the public sector than when undertaken privately by individuals.

This text is drawn from the following paper where all references and sources are cited.

Shahra Razavi (2007) *The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options*, Programme Paper GD No.3, UNRISD, Geneva. Available full length on: www.unrisd.org