THE STRUCTURE OF CARE WORK AND INEQUALITIES AMONG CARE WORKERS

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UNPAID CARE WORK

It is widely accepted that unpaid care work is mostly – but not entirely – performed by women. Time-use surveys across both developed and developing countries have consistently found that women and girls account for around 70 percent of the time spent on unpaid care work in households.[1] Later studies have estimated the proportion to be as high as 76.2 percent.[2]

Figure 1 (based on time-use surveys in different countries) reinforces this point, suggesting that in both developed and developing countries, women spend a significantly longer time than men on direct care of household members as well as indirect care (here described as 'routine housework'). Several points emerge from these data. Total unpaid care activities (both direct and indirect) tend to vary with levels of per capita income: more time is spent by both men and women taken together in relatively poorer countries. It also depends upon the state of public provision, even in advanced economies: total time spent on such unpaid work in Sweden (42 hours per week) was less than in the United States (60 hours per week). Both women and men tend to spend longer on indirect care activities than on direct care, and the time spent is substantially longer in developing countries, where there are fewer amenities and basic infrastructures available. Thus, total time spent on indirect care activities in Mexico averaged 41.42 hours per week, compared to only 18.55 hours per week in South Korea. The gender differences are marked, of course, but vary dramatically across countries. In Turkey, women spend more than 36 hours per week on unpaid care, nearly nine times the time spent by men. Women in Mexico spend even longer on unpaid care (nearly 39 hours per week) but this is four times the time spent by men. The lowest gap occurs in Sweden, where the time spent by both sexes is also substantially lower: women spend nearly 13 hours per week on unpaid direct and indirect care activities, while men spend just above 11 hours per week on average on such work. Clearly, levels of per capita income and infrastructure development, the extent of public provision and the gender construction of societies all play roles in determining both the extent and the distribution of unpaid care work.

1 UNDP. 1995. *Human Development Report*. New York; World Bank. 2012. "Gender Equality and Development," *World Development Report 2012*. Washington DC: International Bank for Reconstruction and Development and the World Bank.

2 ILO. 2018. Care work and care jobs for the future of decent work. Geneva: ILO.

Figure 1: Time spent on unpaid care work, leisure and sleeping. Men and women aged 15–64, minutes per day

	Routine housework	Care for household members	Sports	TV or radio at home	Sleeping
Australia 2006	93 / 168	27 / 64	23 / 16	159 / 123	513 / 514
Austria 2008–09	79 / 170	21 / 47	33 / 27	117 / 101	505 / 513
Belgium 2005	97 / 167	9 / 23	29 / 18	148 / 124	494 / 513
Canada 2010	83 / 133	21 / 44	32 / 21	123 / 99	493 / 507
China 2008	48 / 155	13 / 33	24 / 22	132 / 122	540 / 544
Denmark 2001	107 / 145	20 / 35	25 / 20	132 / 115	479 / 497
Finland 2009–10	91 / 137	13 / 31	37 / 30	147 / 111	507 / 514
France 2009	98 / 158	15 / 35	37 / 24	124 / 103	506 / 513
Germany 2001–02	90 / 164	10 / 27	27 / 27	121 / 100	488 / 497
Ireland 2005	49 / 135	29 / 94	23 / 17	95 / 76	488 / 506
Italy 2008–09	51 / 213	13 / 33	34 / 25	110 / 91	495 / 499
Japan 2011	24 / 199	7 / 26	17 / 14	127 / 140	472 / 456
South Korea 2009	21 / 138	10 / 48	31 / 23	125 / 120	461 / 462
Mexico 2009	75 / 280	15 / 53	15 / 8	86 / 71	496 / 488
Netherlands 2005–06	63 / 134	19 / 42	22 / 20	92 / 84	498 / 516
New Zealand 2009–10	76 / 142	16 / 44	19 / 15	132 / 118	522 / 529
Norway 2010	59 / 104	19 / 26	21 / 18	123 / 87	461 / 492
Poland 2003–04	93 / 194	15 / 39	28 / 17	153 / 124	502 / 511
South Africa 2000	69 / 200	3 / 34	15 / 2	108 / 95	552 / 570
Spain 2009–10	76 / 127	20 / 42	24 / 12	166 / 139	510 / 514
Sweden 2010	79 / 95	17 / 25	18 / 16	124 / 89	503 / 543
Turkey 2006	21 / 261	14 / 51	10 / 4	126 / 117	504 / 512
United Kingdom 2006	66 / 133	34 / 62	24 / 19	154 / 126	476 / 491
United States 2010	82 / 126	19 / 41	25 / 12	162 / 136	509 / 522

Source: R. Levtov, N. van der Gaag, M. Greene, M. Kaufman M, and G. Barker. 2015. *State of the World's Fathers: A MenCare Advocacy Publication.* Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance. Data from OECD based on National Time Use Surveys. Adapted from: *Balancing Paid Work, Unpaid Work and Leisure.* Organization for Economic Co-operation and Development website. http://www.oecd.org/gender/data/balancing-paidworkunpaidworkandleisure.htm

Taking care of one's own household and family members' needs may be a labour of love, but it is also a labour of sorrow and drudgery. Not for nothing has Folbre described the people who perform such care work as 'prisoners of love'.[3] Unpaid care work, though embedded in feelings of obligation and commitment to others' well-being, is also rooted in patriarchal structures that interact with it. The issue that is often referred to as 'work/life balance', and is seen to be particularly important for working women, is really often about balancing care

work responsibilities with paid employment. In most societies, the responsibility for care provision is ultimately seen as the woman's domain within families and even extended families, including by women themselves. As is well known, this responsibility for unpaid care within families then determines paid work participation; that is, unpaid care work shapes the ability, duration and types of paid work that can be undertaken.[4]

This particular feature of unpaid care work by women is sharply evident in the experience observable in India.[5] The decline in women's workforce participation rates in India has been much discussed, yet the more significant shift is rarely noted: that from paid or recognised employment (even if in the form of unpaid contributing family work on the family farm or in the family enterprise) to unpaid work of direct and indirect care activities for the household. In India, the greater requirements of unpaid work within the household – whether because of lack of amenities forcing women to spend hours collecting water or fuelwood for household use, or because of lack of access to healthcare and childcare facilities forcing women to spend more time looking after the children, the elderly and the sick within families – has been associated with declining participation in recognised employment (that is, work for pay or profit), especially in rural areas. Recognition of such trends dramatically changes the interpretation of recent labour-market trends in India. In rural areas, many women are not only engaged in 'domestic duties', but also were involved in the 'free collection of goods (vegetables, roots, firewood, cattle feed, etc.)' for household consumption. Micro surveys have pointed to the urgent need for water and fuelwood collection in particular, and the longer hours spent on such collection, as a major source of increase in such work. Such unpaid and unrecognised work accounts for 80 percent of all women workers. This example points to the urgent need for reducing some of these unpaid indirect care activities through the provision of basic infrastructure such as electricity, reliable piped water and access to affordable fuel supplies.

Some of these forms of unpaid care work can also be affected by technologies that reduce the difficulty, drudgery and time spent on such activities. For example, access to basic gadgets such as grinding machines and food processors can reduce the time spent on processing foods in preparation for cooking them, but such machines are still not available to the large majority of women in developing countries who are engaged in cooking for the family on a daily basis. Washing machines are still similarly seen as luxuries in most parts of the developing world.

Yet public policy rarely considers such aspects and these remain low down in the policy priorities of governments in many developing countries. Indeed, even policy measures that are designed to improve social conditions often end up adding to unpaid labour, simply because it is effectively so invisible to most policy makers. For example, the reform process in China reshaped the institutional arrangements of care for children and elders, and thereby affected women's choices between paid work and unpaid care responsibilities.[6] This had implications for women's workforce participation, as well as for the well-being of women and their families. Similarly, Budlender and Lund showed that in South Africa, the disruption of family life – largely the result of state policies in the apartheid era and thereaf-

3 Nancy Folbre. 2021. *The Rise and Decline of Patriarchal Systems.* London: Verso Books.

4 Antonopoulos, Rania., 2009. "The unpaid care work : paid work connection," *ILO Working Papers* No. 86, International Labour Organization.

5 Jayati Ghosh. 2009. *Never Done and Poorly Paid: Women's work in globalising India.* New Delhi: Women Unlimited.

6 Sarah Cook and Xiao-Yuan Dong. 2011. "Harsh Choices: Chinese Women's Paid Work and Unpaid Care Responsibilities under Economic Reform," *Development and Change*, 42(4): 947–966.

ter – has resulted in a situation in which many women have to play the role of both breadwinner and caregiver, most obviously when they are in single-parent or women-headed households, but even when this is not the case.[7] However, they must deal with this double burden in a broader context of high unemployment and very limited economic opportunities, which reduces their ability to provide remunerative jobs and to provide the desired level of care for their families.

Indeed, traditional patriarchal attitudes towards care can even affect intergenerational patterns of female labour-force participation. It has been found for example that in southern Europe, adult children choose to live close to their families so as to take advantage of the low labour-force participation rates of their own mothers, which enables them to reconcile paid work with bringing up children.[8] While this is possible because of the intergenerational gap in female labour-force participation, this reliance on the unpaid labour of the older generation (especially mothers/grandmothers) is also driven by the extent of rationing of public childcare services.

As Razavi[9] has noted, the institutions involved in the provision of care may be conceptualised in a stylised fashion as a 'care diamond', to include the family or household, markets, the public sector and the not-for-profit sector that would include voluntary and community provision. How this 'diamond' is effectively structured depends crucially on state policies, and it in turn determines both the quality of care received in that society and the conditions of its care workers.

FROM UNPAID TO UNDERPAID: THE CARE WORK CONTINUUM

The extent of unpaid care work in a society is not only important in itself: it is also crucial in shaping societal attitudes towards both care work and its remuneration, especially when it is performed by women, who are the dominant providers of unpaid work in most societies. Simply put, where there is a large amount of unpaid work that is performed in a society, and where the bulk of that is performed by women, especially migrant, from ethnic minorities and low-income groups, the participation of women in paid care services tends to be much more disadvantaged. Since the unpaid labour performed by women in domestic care is home-based, therefore invisible, and not remunerated (and often not even recognised), it is easier for society in general to undervalue such work in general, whether it involves care of the young, the old and the sick or other forms of care activity. And this in turn leads to lower wages and worse working conditions, especially when many of the paid care workers involved in such activities are also women. The very existence of the unpaid-paid work continuum therefore affects not only the bargaining power of paid care workers, but also social attitudes to them and to their work, and indeed their own reservation wages and self-perceptions.

In the absence of adequate recognition and effective regulation, the above dynamics can contribute to a general undermining of wages, working conditions and social protection for care workers. The implications of the unpaid-paid continuum are exacerbated by other features of care work that operate to create occupational and wage discrimination against such workers. Thus, care work is often performed by those with lower educational attainments, even though the level of skill required is often quite high, albeit socially unrecognised. A disproportionate share of such work is typically performed by those who are in any case disadvantaged in the labour market – women, certainly, along with other categories like immigrants. The nature of such work – for example, being more amenable to part-time employment and informal contracts – also contributes to its devaluation both in market terms and in social perception.

As a result of these various factors, care work may involve a wage penalty even when it is performed by men. A study of 12 countries that include advanced, transition and developing economies based on not just the well-recognised care occupations like teaching, medicine and nursing, but also those involved in community care like police work and personal protection, found significant variation in the care-work effect on wages across countries, not only between women and men but also by worker characteristics, and by national and policy context.[10] Care workers (in paid employment) in this study were generally found to be more educated and more likely to be in public employment. This should have led to relatively higher wages, other things being

7 Debbie Budlender and Francie Lund. 2011. "South Africa: A legacy of family disruption," *Development and Change*, 42(4): 925–946.

8 Katia Nicodemo. 2009. "Childcare and mothers' labour supply in southern European countries", *VoxEU*, available at https://voxeu.org/article/childcare-and-mothers-labour-supply-southern-europe

9 Razavi, S. From Global Economic Crisis to the 'Other Crisis'. *Development* 52, (2009: 21–22).

10 Michelle J. Budig and Joya Misra. 2010. "How care work employment shapes earnings in cross-national perspective", *International Labour Review*, 149(10). Reprinted in Mark Lansky, Jayati Ghosh, Domonique Meda and Uma Rani (eds) 2017. *Women, Gender and Work Volume 2: Social Choices and Inequalities.* Geneva: ILO.

equal, but that was not the case: rather, they found that care employment typically entailed wage penalties. This was generally true for men as well, except in the Nordic countries; but generally the wage penalties were larger for women care workers. This led the authors to conclude that care work does not pay less because it is less skilled, but because it is disproportionately performed by women. Obviously, the socio-economic and institutional context matters: care workers were found to be relatively better off in countries with lower income inequality, higher union density, larger public sectors and higher public spending on care.

Esquivel has shown how the sex-typing of unpaid care work extends to domestic workers, who are almost invariably women (certainly in Argentina of which she provides a case study).[11] The association of unpaid care work with 'natural' female characteristics – and not with skills acquired through formal education or training – further implies that most domestic workers have low formal educational credentials, reinforcing their low earning capacity and poor bargaining power. The general tendency to undervalue women's work is obviously magnified by widespread informality in the provision of such work. More recently, cost-cutting measures in the public sector driven by the push for fiscal austerity in many countries has aggravated this tendency, by shifting the performance of such work from public employees (who are typically provided at least some remuneration, regulation of working conditions and status as workers) to unpaid work within families and communities.

INEQUALITY IN CARE WORK AND AMONG CARE PROVIDERS

It is evident that care work is extremely heterogenous, ranging from the very highly skilled and well-remunerated activities of professionals such as specialised doctors, to the poorly paid activities of in-home caregivers, including domestic workers, who provide what are seen to be relatively unskilled services in an informal setting. High-status care work often receives a substantial earnings bonus, while low-status care work incurs a wage penalty that tends to be amplified in less regulated labour markets.[12] Meanwhile, the low-status care workforce tends to be more feminised, often older, typically less educated and more likely to be engaged in non-standard employment than the high-status care workforce.

Indeed, even within the same industry, various forms of care work are neither equal nor equally valued, even in the same industry. For example, a high degree of differentiation has been found between health care workers in South Africa.[13] The range of work extends from formal-sector, secure, strictly regulated and highly institutionalised and unionised jobs to the private-sector jobs of nurses (better paid) and social workers (less well paid) to volunteers (lowest paid and often with the most demanding conditions). Interestingly, it was found in the context of the HIV-AIDS pandemic that, in addition to the aggregate wage penalty on care work, the task-shifting brought about by the pandemic put greater burdens on the lowest paid (or even unpaid) workers, thereby increasing inequality even among female workers in this sector.

The interplay between public and private involvement in care activities affects both the quality and remuneration of care work. A study of the Republic of Korea found significant differences in both the levels and the trends over time, as between care activities directed to the young and those directed to the elderly.[14] The expansion of public involvement in childcare along with increased regulation of such activities led to some improvements in the conditions of childcare workers. However, for elderly care, the opposite forces of deregulation and commercialisation of elderly care (and therefore greater reliance on the market) operated to worsen conditions for workers involved in this activity.

In some cases, inequalities across care workers are actually intensified and aggravated by the nature of public provision of care services and social protection systems, which also distinguishes between different categories of work and generates substantial inequalities in the provision of care. For example, many public

11 Valeria Esquivel. 2010. "Care workers in Argentina: At the crossroads of labour market institutions and care services", *International Labour Review*, 149(4): 477–493.

12 See Frances Lund. 2010. "Hierarchies of care work in South Africa: Nurses, social workers and home based care workers," *International Labour Review*, 149(4), reprinted in Lansky, Mark, Jayati Ghosh, Dominique Meda and Uma Rani (eds) *Women, Gender and Work Volume 2: Social Choices and Inequalities.* Geneva: ILO; and Naomi Lightman. 2017. "Discounted labour? Disaggregating care work in comparative perspective." In Lansky, Mark, Jayati Ghosh, Dominique Meda and Uma Rani (eds) *Women, Gender and Work Volume 2: Social Choices and Inequalities.* Geneva: ILO.

13 Frances Lund. 2010. "Hierarchies of care work in South Africa: Nurses, social workers and home based care workers".

14 Ito Peng. 2009. "The Political and Social Economy of Care in the Republic of Korea," *Gender and Development Programme Paper No. 6.* Geneva: UNRISD.

services in India increasingly rely on the unpaid or underpaid labour of women.[15] In school education, a parallel stream of teachers and 'education centres' emerged in many states as a result of the emphasis placed by the Sarva Shiksha Abhiyan (Education for All Programme) on increasing school enrolment. This enables the hiring of local women, who have some schooling but no other pedagogical qualifications, as teachers for monthly wages as low as one-tenth or even less of the standard teacher salary. Similarly, the Integrated Child Development Scheme (ICDS) operates on the basis of very poorly paid *anganwadi* (crèche) workers and helpers, who receive a fraction of the legal minimum wage and none of the rights and protections accorded to other public employees. Patriarchal attitudes thus reinforce 'the ideology of gendered familialism in public discourse and policy, which reiterates care as a familial and female responsibility and works to devalue and diminish the dimensions of care.'[16] The latest Indian government programme to rely dominantly on the unpaid labour of women is the National Health Mission, which relies on an Accredited Social Health Activist (ASHA) in each village, who is supposed to provide the link between the community and the government health system, and become the first port of call for any health-related matters, especially for less privileged groups. These ASHAs, who are described as 'volunteers' but tasked with multiple crucial responsibilities, including even early diagnostic practices and health advice, are paid even less than *anganwadi* workers and have no security of tenure or any other form of worker protection, even though they are ostensibly the ones running this major government scheme.

There is similar evidence for Nicaragua, where Martínez Franzoni and Voorend found that despite major economic, political and policy shifts, the role of female voluntary work remains persistent and pivotal, and indeed was significant long before the onset of neoliberal policies.[17] Since only the most basic social services were provided by the state, and coverage was far from adequate, households and communities played a more dominant role than did public institutions. In addition, most public programmes were dependent on strong family and community participation in the form of voluntary work by women, which has been and continues to be vital for the viability of many public social programmes.

It is worth noting that such reliance on unpaid or low-paid work of women to run essential public programmes is not unique to poor developing countries, but extends even to developed countries that apparently have well-developed public systems for both social services and worker protection. Thus Elson has pointed to the fact that in the Netherlands, public schools and public hospitals are highly dependent on the 'volunteer' work of parents, and of relatives of patients, who are predominantly women who work on an unpaid basis to ensure that the schools and the hospitals run effectively.[18]

The inequalities that characterise care work are most clearly expressed in domestic work as paid employment, which necessarily relies upon not just gender constructions, but also inequalities across households who operate as the demanders and suppliers of such work. Thus, the greater the income inequality in a country, the greater the likelihood of the proliferation of paid domestic work. But on a more fundamental level, the nature of the expansion of this form of women's work is determined by the gender construction of societies across the world, whereby women remain responsible for the care economy and social reproduction even when they are engaged in work for pay or profit, and so transfer some of this burden of previously unpaid work onto paid workers (usually other women). This has been associated with the globalisation of the care economy, with the growing use of migrant workers across and within countries, as well as the growth of part-time domestic work.

Paid domestic work is not only one of the oldest occupations, but also one of the 'emerging' activities that account for the work of increasing numbers of women workers in many developing and developed countries. Estimates based on official statistics from 117 countries suggest that there are at least 53 million domestic workers worldwide, with women workers constituting more than four-fifths of the number. Domestic work accounts for at least 7.5 per cent of all women in paid employment in the world, while in some regions this ratio is much higher, such as Latin America, the Caribbean and the Middle East.[19]

Given the heterogenous nature of care work, it is also inevitably the case that there are also highly trained professional workers involved in care activities, and

15 Jayati Ghosh. 2009. *Never Done and Poorly Paid: Women's work in globalising India.*

16 Rajni Palriwala and N. Neetha. 2011. "Stratified familialism: The care regime in India through the lens of child care", *Development and Change*, 42(4): 1049–1078.

17 Juliana Martínez Franzoni and Koen Voorend. 2011. "Who cares in Nicaragua? A Care Regime in an Exclusionary Social Policy Context," *Development and Change*, 42(4): 995–1022

18 Diane Elson. 2005. *Unpaid Work: Creating Social Wealth or Subsidizing Patriarchy and Private Profit?* Levy Economics Institute.

19 ILO. 2011. Global and regional estimates on domestic workers, *Domestic Work Policy Brief* No. 4 (Geneva).

many of them command relatively high salaries and remuneration as well as reasonably secure and good working conditions and social protection, such as medical specialists. Interestingly, it is the societies that show the greatest prevalence of formal care, the lowest prevalence of time spent in unpaid care work and the most significant amounts of public provision of care services (such as Sweden) that also show the least inequality among care-service providers. This is probably another element in ensuring consistently better-quality care for all recipients, and is clearly a pattern that deserves emulation.

Conditions of paid care work

The quality of care work varies not only with the skill, training and commitment of the care providers, but also the conditions under which they work. A dominant proportion of care workers already face adverse labour-market conditions, as well as other forms of inequality or discrimination as women or migrants or less educated workers from lower-income households, and this means that their bargaining power tends to be weak.

In general, among employed care workers, the worst-off care workers in terms of conditions of work are usually paid domestic workers. Despite its growing prevalence, domestic work in most countries remains largely unrecognised, generally undervalued, and almost always poorly regulated. Lack of regulation and extension of basic forms of labour and social protection to domestic work is to a significant extent the result of its very nature, since it is typically performed in individual households by workers without external monitoring of the terms and conditions of employment or easy possibilities for association. Since most domestic workers are women (and often migrant women) they are even less likely to be in a position to organise and demand their rights collectively. It is usually perceived as something less than regular work by both employers and the workers themselves, and contracts are usually determined bilaterally in conditions of unequal bargaining power without strong awareness of either labour-market conditions or the legal rights of the workers. The relatively high proportion of child labour in this activity is also a reflection of the sheer difficulties of monitoring and regulation.

The ILO (International Labour Organization) Convention on Domestic Workers, 2011 (No. 189), simply by pointing to some of the essential features necessary to ensure that domestic work is 'decent work', has effectively illustrated how much of this is lacking in most countries today, across both advanced economies and poor developing countries. Thus, simple requirements such as a written contract, minimum wages, clear provision of weekly and annual holidays, restricted time of work and payment of overtime, social-security coverage, maternity protection, and so on, are mostly simply not met in the case of most domestic workers. While this is strongly the case in countries where much of the workforce is already informal, it is also true of many rich societies where local workers operate in more regulated environments, where much domestic work is performed by migrants.

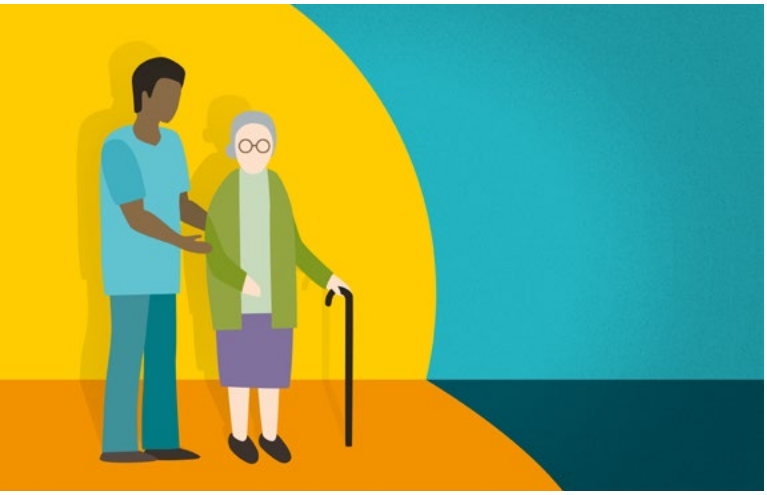
For other forms of care work, especially indirect care, the implicit social denigration of such activities that results from so much of it being performed in unpaid labour within families and communities leads to a broader prevalence of the combination of low wages and poor working conditions, with little or no worker protection or social protection of the kind that is normally accorded to other workers. In many cases, this is also true of direct care work which is also typically treated as something that can be relied upon to be delivered within families and therefore not deserving of much remuneration or social valuation These tendencies are aggravated by the gender dimension that tends to ascribe most such work to women and undervalue it, in a self-reinforcing swirl. As noted above, this is sometimes even true of care workers in public employment, as was seen in the case of health and early childcare workers in India.

The affective element in care work also plays a role in getting care workers to accept adverse conditions, including relatively lower wages, long hours and harsh working conditions because of their consciousness of the possible negative impact upon care recipients of the withdrawal of their services. Folbre has noted that the peculiarly emotional aspects associated with caregiving can result in greater susceptibility of caregivers to exploitation by employers (and certainly in cases of unpaid care work):

> *'The distinctive features of care help explain many institutional arrangements. Owners, employers, and managers are less likely to come into direct contact with clients or patients than are direct care workers. They can generally engage in cost-cutting strategies without suffering the consequences. They may even feel confident that the adverse effects of their decisions on clients will be buffered by workers' willingness to sacrifice by intensifying their efforts or agreeing to work overtime. This emotional hostage can turn workers into prisoners of love, reluctant to walk out on strike or even to leave an occupation in which they know they are badly needed.'*[20]

20 Nancy Folbre. 2014. *Who Cares? A feminist critique of the care economy.* New York: Rosa Luxemburg Stiftung New York Office.

Overall, however, such relatively cynical strategies on the part of employers are not only more difficult to sustain over time (as they result in high burnout or less willingness of younger workers to enter into such professions), but may also be counterproductive in terms of leading to lower quality of care simply because of the pressures of being overworked.



Because of the specific and personalised nature of their work, care workers may also be under threat of violence and aggression at work more frequently than workers in many other occupations. A study of violence against nurses in Minnesota, USA found that nurses frequently experienced work-related violence, including physical (13.2 per 100 hundred nurses per year) and non-physical assault (38.8 per 100 nurses per year) by patients, which in turn affected their morale and sense of safety at work and led to higher levels of work-related stress.[21] Susceptibility to various forms of violence at work is particularly marked for domestic workers, especially live-in workers, because of the highly personalised and informal nature of their work engagement, the power hierarchies that are evident on a daily basis and the relative isolation from others beyond their employers that is often found in such cases.

Social protection of care workers is generally a major area of concern. Because so much care work is performed under informal conditions (and much of it, as already noted, is performed in unpaid and even unrecognised ways), care workers generally tend to be even more deprived of most forms of social protection than workers in other activities. Obviously, moves towards the social protection floor that provide some universal coverage of social protection to all in a society would also benefit care workers. But in addition, the formalisation of care work is a critical issue of public policy. In some countries, there have been moves towards such policies, for example with attempts to enforce at least some of the conditions of the ILO Domestic Workers' Convention for domestic workers, or attempts to ensure social-security provisions like health insurance and pension benefits to domestic workers and other informal care workers in some countries of Latin America. But this is still an area in which much more work needs to be done and many more specific policies need to be developed and implemented.

Clearly, therefore, much care work is performed under difficult, demanding and poorly paid conditions, which as pointed out in Article 1 in this series, 'Defining care: conceptualisations and particularities', can contribute to lowering the quality of the care services thereby delivered. As argued by UNRISD, a 'high road' to care-service provision would be one that explicitly caters to the needs of the care-service workers themselves, who ensure that they are willing and able to provide good-quality services.[22]

Globalisation of care work

The globalisation of care work has many aspects, and its gendered nature has generated much analysis, including in terms of how it has corresponded to the dynamics of capitalist accumulation in both sending and receiving countries. One aspect that has been covered by several studies is that of cross-border migration of nurses. Yeates has shown how such migration maps onto institutional formations so closely that it is possible to speak of a global 'nursing labour migration-industrial complex', forming a global nursing-care chain similar to the value chains that operate in manufacturing.[23] For the sending countries, the benefits in terms of remittances received may be outweighed by the loss of such skilled workers within their own economies, as the (mostly developed) recipient countries effectively export their nursing-care crises to the poorer countries of origin of migrant nurses.

Valiani explored the political economy of health care in three countries, which determines the importing and ex-

21 Nancy M. Nachreiner, Susan D. Gerberich, Andrew D. Ryan, and Patricia M. McGovern. 2007. "Minnesota nurses' study: Perceptions of violence and the work environment", *Industrial Health*, 53: 272–278.

22 UNRISD. 2016. *Policy Innovations for Transformative Change*. Flagship Report, Chapter 3: "Care policies: Realising their transformative potential". Geneva.

23 Nicola Yeates. 2010. "The globalisation of nurse migration: Policy issues and responses", *International Labour Review*, 149(4): 423–424.

porting of temporary migrant nurses.[24] The study examined conditions of work and out-migration in the Philippines, the world's largest supplier of temporary migrant nurses; wages, working conditions and in-migration in the United States, the world's largest demander of internationally trained nurses; and Canada, which is both a supplier and a demander of internationally trained nurses. The analysis highlights the ways in which the global integration of nursing labour markets have deepened unequal exchange between the Global North and the Global South.

Another major area of the globalisation of care involves domestic work, which has become increasingly significant in the past few decades along with other processes of economic globalisation. Many (perhaps even the majority) of domestic workers may be migrants of different kinds, although this is very hard to estimate. For example, UN Women suggests that 80 per cent of all female migrant workers are domestic workers.[25] The global number of cross-border migrant women involved in domestic work in the country of destination was estimated to be between 17 and 25 million in 2007[26] but the numbers could well be higher at present. Many domestic workers are also internal migrants, coming from developing to more developed regions or from rural to urban areas in search of work on their own or with families.

For example, in Asia, women cross-border migrants come predominantly from three countries: the Philippines, Indonesia and Sri Lanka. In the Philippines, women migrants have outnumbered their male counterparts since 1992, and in all these countries women make up between 60 to 80 percent of all legal migrants for work.[27] The majority are in services (typically low-paid domestic service, as care givers or housemaids) or in entertainment work. While Filipina women tend to travel all over the world, women from the other two countries go predominantly to the Middle East and Gulf countries in search of employment. Around 56 percent of the migrant workers from Sri Lanka are women employed as housemaids, who go to work predominantly in Saudi Arabia, Kuwait and the United Arab Emirates. Legal migration from Indonesia is dominated by women taking up domestic work in Singapore, Malaysia and Hong Kong.[28]

This domination in informal and care activities makes women migrants less able to ensure for themselves much of the legal protection of workers that would otherwise prevail in the destination area. Domestic work is often excluded from the legal framework surrounding work contracts, and because it does not come with legally enforceable contracts that protect the workers, and so allows for exploitative work conditions involving long hours without overtime payment, absence of other rights, and so on. Domestic workers typically also do not benefit from freedom of association, even when it is legally permitted or encouraged in the destination country, and therefore do not have many of the rights that collective action by workers and trade unions would try to provide for workers. They are also apparently more likely to face problems such as delayed wage payment or even non-payment of full wages, or transfer of wages into accounts that they cannot access. Migrant domestic workers are often also the victims of unequal access to basic public services, including most importantly health services. This is particularly important given the special needs of women, especially with regard to reproductive health care. There is typically inadequate or no provision of maternity benefits and even the possibility of dismissal on pregnancy. Obviously, irregular immigration status exacerbates the risk of exploitation of women migrant workers, who may be more likely to accept very adverse conditions simply for fear of being exposed and possibly deported.

Domestic service is one of the most common occupations of women migrants from developing countries to developed ones. This is particularly true in some European countries like France, Italy, Spain and Greece, as well high- and middle-income countries in Asia and the Gulf states. In the 1990s, this was also encouraged by official policies: a significant proportion of the migrants who entered Italy, Greece and Spain through the quota system were women domestic workers, and they also dominated among those migrants who were subsequently regularised. For some developing countries, this is now the major component of migration: in Sri Lanka between 1996 and 2001, housemaids made up between 75 and 91 percent of all female migrants, and more than half of all migrants.[29]

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24 Salimah Valiani. 2011. *Rethinking Unequal Exchange: The global integration of nursing labour markets.* Toronto: University of Toronto Press

25 UN Women. n.d. "Domestic workers: sweeping invisibility", accessed from: https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Trust%20Funds/FundGenderEquality/FGE_Domestic_Work_2017-2018_Annual_Report.pd

26 Panell and Altman. 2007. "Closing the Gap: Feminist Perspectives on Policies affecting Immigrant Labour in the Domestic Services Industry in Europe. Paper presented at New Migration Dynamics: Regular and Irregular Activities on the European Labour Market, Nice, 17–39

27 Maruja M. B. Asis. 2003. When men and women migrate: Comparing gendered migration in Asia. Papers by Experts for UN Women Consultative Meeting on *"Migration and mobility and how this movement affects women"*, Malmo, Sweden (2 to 4 December 2003). Available from: https://www.un.org/womenwatch/daw/meetings/consult/Sweden03docs.htm

28 Jayati Ghosh. 2016. "Capturing work: The journey of the National Sample Survey Organisation", *Sarvekshana* Special Commemorative 100th Issue.

29 CM Siddique. 2004. "On migrating to Canada: the first generation Indian and Pakistani families in the process of change." In *The Indian Diaspora: Dynamics of Migration*. N. Jayaram (Ed.). Indian Sociological Society. Sage Publications India: New Delhi.

The migration of women workers can lead to an international transfer of the job of providing care, as is illustrated by the example of migrant women workers from the Philippines. Many such women perform domestic tasks – the labour involved in social reproduction – that are still the lot of women in the more developed industrial societies in Europe or North America, or the more dynamic and rapidly growing developing parts of Asia such as Hong Kong, Singapore and South Korea, or the oil-exporting countries of West Asia and the Gulf. They thereby potentially free such female labour for more active participation in the paid labour market, and contribute to the economic growth of the receiving country. Kremer and Watt also argue that this type of migration increases the wages of low-skilled natives and provides a fiscal benefit by correcting tax incentives towards home-based production.[30]

The gender division of labour permeates and even drives the migration process, creating demand in the receiving society and enabling migration from the sending society. This reflects the fact that in both regions women have not been able to negotiate a more equal division of labour within the household, so that social reproduction remains their responsibility. This three-tiered involvement of women in the international transfer of domestic labour becomes an important, even if often unnoticed, feature of the accumulation process in the host society. It becomes an important factor driving economic booms, even if its role is not as explicitly evident as the feminisation of export-oriented manufacturing, for example.

It also contributes to the growth of the sending economy through the mechanism of remittances. In general, because female migrants typically work in service activities related to the care economy, they are typically more stable over the business cycle of the host economy than the remittances out of male migrant workers' incomes, which are more dependent on employment in manufacturing and construction.

At the same time, the concerns of social reproduction in the sending society still remain. It has usually been the case that migrant women's own household responsibilities back home must be fulfilled by other women, since the gender division of labour at both ends of the migratory spectrum still leaves women primarily responsible for the domestic work, whether in paid or unpaid fashion. This housework back home is often performed by women relatives, such as mothers, sisters and daughters. But the very large wage differentials across sending and receiving countries can allow such migrant workers in turn to relegate their own domestic work by hiring poorer local women to care for their children and perform necessary household tasks. In turn, such women may even be migrants from rural areas who have come into cities and towns in search of income. This is also associated with the social phenomenon of 'diverted mothering', which has been defined as the process in which the 'time and energy available for mothering are diverted from those who, by kinship or communal ties, are their more rightful recipients.'[31] Historically, this was observed among Black female domestic workers in the United States, who had to leave their children behind, saw them infrequently, and instead lavished their time, attention and love on other more privileged children for whom they were paid to care. But this description can now be just as easily valid for women from developing countries who perform paid domestic work and childcare functions in rich industrial countries. And, in turn, their children back home could then be the recipients of diverted mothering from even lower-paid domestic workers. This is indeed a global value chain in the provision of care and domestic services, akin to that described for nursing.

The various difficulties faced by migrant women and migrant care workers may be compounded by institutional constraints. Local trade unions typically do not concern themselves with migrant workers, and even less with female migrants. In some cases, migrants are explicitly not allowed to join local unions by law, and even when this is allowed, migrant women usually face additional obstacles in joining unions and face other kinds of resistance and hostility from other workers, because of perceptions that they are driving down wages and working conditions in the host countries. Usually the only substitute for such union protection is through the NGOs that are focused on providing services and protection to migrants, but their coverage is limited in geographical and quantitative terms. In some countries there are even formal constraints imposed on access by women migrants to the legal system, such as loss of work permit on filing a case against an employer. But in addition, there are other social, cultural and economic barriers that can prevent them from accessing and benefiting from all their legal rights. One basic constraint is often lack of sufficient knowledge of the local language and consequent inability either to be fully aware of their rights or lack of ability to go through the required channels to demand their rights. Women engaged in domestic work may be under the constant watch of employers and therefore not be

30 Kremer, Michael, and Stanley Watt. 2006. "The Globalization of Household Production".

31 Engster, D., and Metz, T. (2014). *Justice, Politics, and the Family* (1st ed.). Routledge: p. 253.

able to communicate with others to compare situations or report abuse. There is the possibility of hostility or indifference of officialdom. There are issues of occupational safety and physical and psychological health, such as exposure to dangerous chemicals because of cleaning work, lack of access to prompt and adequate health care, and depression resulting from isolation, as well as other hazards related to harassment in various forms. Lack of outside contacts and isolation from peers, fear of reprisal, and other methods such as withholding of passports by employers all contribute to a web of exploitation and have been found to be a major cause of prolonged exploitation of women migrants in some cases.

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Recent books

The Making of a Catastrophe: Covid-19 and the Indian Economy, Aleph Books (forthcoming 2022).

When Governments Fail: Covid-19 and the Economy, Tulika Books and Columbia University Press (2021, co-edited).

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ABOUT THE PROJECT

It took us a global pandemic to realise that we depend on care. But despite all the clapping from the balconies, caregivers continue to live and work in precarious and vulnerable conditions. It is high time for a care revolution! We need to move away from a profit-driven model of growth to a care-driven model. In this spirit, the Foundation for European Progressive Studies and the Friedrich-Ebert-Stiftung launched a Social Democratic Initiative for the EU Gender Equality Strategy, placing the role of care work and care jobs at the center of our common activities. By raising the question "Does Europe Care for Care?", we focus on care as a cross-cutting issue and promote the cross-fertilization of progressive thinking between stakeholders across Europe. Building on our network of care experts, this Care4Care Policy Brief Series gives center stage to a long overseen phenomenon that deserves the fullest political relevance and attention. The series identifies common challenges and possible good practices across countries, whilst drawing concrete recommendations with the objective of feeding into national and EU level policy responses.

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Vital Yet Vulnerable: Europe's Intra-EU Migrant Caregivers

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